21-16696

IN THE UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

MARCIANO PLATA, et al.,

Plaintiffs-Appellees,

v.

GAVIN NEWSOM, et al.,

Defendants-Appellants.

RELIEF REQUESTED BY NOVEMBER 30, 2021

On Appeal from the United States District Court
for the Northern District of California

No. 4:01-cv-01351-JST
The Honorable Jon S. Tigar, District Judge

EMERGENCY MOTION TO STAY UNDER CIRCUIT RULE 27-3; MOTION FOR EXPEDITED BRIEFING

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(ii) **Facts Showing the Existence and Nature of the Emergency:**

As more fully set forth in the motion, this appeal challenges the district court's September 27, 2021 and October 27, 2021 orders requiring Defendants to implement a mandatory vaccination policy affecting workers entering California Department of Corrections and Rehabilitation (CDCR) prisons, among others. The district court's October 27 order requires full vaccination of covered individuals by January 12, 2022. Depending on the vaccine chosen, employees would have until December 1, 2021—about two weeks from now—to receive their first dose. An emergency stay is thus

necessary to preserve the status quo concerning the central issue on appeal. Relief is needed no later than November 30, 2021.

(iii) **Why the Motion Could Not Have Been Filed Earlier:**

Before filing the district-court stay, Defendants requested clarity from the district court on whether they were subject to any deadline to implement the mandate, and met and conferred with the Receiver regarding an implementation deadline. Only on October 27 did the district court impose a deadline for implementation. Before the court had even imposed an implementation deadline, Defendants timely moved for a stay in the district court, but the court's earliest available hearing date was November 17, 2021. After hearing, the district court denied the motion.

(iv) **Notice to the Parties and the Other Parties' Positions:**

The undersigned notified counsel for Plaintiffs by email on November 17, 2021, of Defendants' intent to file this motion. Plaintiffs and the Receiver responded that they oppose the request for a stay. Service of this motion will be effected by electronic service through the Court's CM/ECF system.

(v) **Relief Was First Sought in the District Court:**

Defendants requested a stay from the district court on October 25, 2021, and it was denied on November 17, 2021.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: November 18, 2021

Respectfully submitted,

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INTRODUCTION

State Defendants move to stay the district court's unprecedented orders mandating full vaccination of workers in California Department of Corrections and Rehabilitation (CDCR) institutions by January 12, 2022. These orders, which are the first and only ones of their kind, far exceed the district court's authority under the Eighth Amendment and Prison Litigation Reform Act (PLRA), and represent extraordinary judicial interference with state operations and responsibilities that will irreparably harm the administration of the state prison system. Furthermore, resulting staffing shortages may place the safety of inmates, staff, and the public at serious risk.

California has led the nation in responding to the COVID-19 pandemic. In the prison context, Defendants made extensive efforts to ensure the safety of staff and incarcerated persons by significantly reducing the incarcerated population to its lowest level in decades, implementing strict masking and social distancing protocols, and prioritizing early vaccinations of incarcerated persons. Defendants began vaccination efforts at the earliest possible time, offered over 99 percent of incarcerated persons the vaccine at least once, successfully vaccinated approximately 80 percent of the incarcerated population, have required unvaccinated staff to get tested twice

a week in lieu of vaccination and wear N95 masks, and have required that correctional healthcare workers be vaccinated.

Despite these efforts, the district court determined that Defendants were deliberately indifferent to the risks posed by COVID-19 because they do not require every staff member who interacts with inmates to be vaccinated. The district court misapplied the Eighth Amendment's standards, and its conclusion conflicts with this Court's recent decision in *Fraihat v. U.S. Immigr. & Customs Enf't*, 16 F.4th 613 (9th Cir. 2021). And absent a stay pending appeal, the district court's unprecedented interference in state prison administration and operations will cause irreparable harms. CDCR's available officer cadet pool has diminished since the beginning of the pandemic. In the face of existing staffing challenges, substantial staff resistance to coerced vaccination will result in shortages of correctional officers and other prison staff and impair prison operations and security. The orders will also prove harmful to incarcerated persons because some prisons will likely need to reduce programming so remaining staff can focus on providing essential and constitutionally mandated services.

These irreparable harms cannot be justified by current circumstances or the record. The level of active cases in the prisons has remained relatively low since March 2021, hovering around 200 active cases as compared to

over 10,000 active cases in December 2020. And the number of serious COVID-19-related illnesses that require hospitalization have remained extremely low. Out of the State's thirty-four operating prisons, fifteen prisons currently have no active inmate cases. Fairly balancing the rights and interests at stake, this Court should stay these unprecedented judicial vaccine-mandate orders pending the outcome of this appeal. In the alternative, Defendants request expedited briefing and argument.

FACTUAL AND PROCEDURAL BACKGROUND

I. THIS CLASS-ACTION LAWSUIT CONCERNS MEDICAL CARE IN CALIFORNIA PRISONS.

Plaintiffs filed the underlying class-action lawsuit in 2001. *See Plata v. Newsom*, 445 F. Supp. 3d 557, 560 (N.D. Cal. 2020) (discussing the history of the suit). Less than a year later, California "conceded that deficiencies in prison medical care violated prisoners' Eighth Amendment rights," *Brown v. Plata*, 563 U.S. 493, 507, (2011), and stipulated to a remedial injunction the district court has since enforced, *Plata v. Newsom*, 445 F. Supp. 3d at 560. The district court then appointed a Receiver to manage CDCR's medical system. *Id.* The Receiver has broad authority over the "medical delivery component of the CDCR" and those workers who "perform services related

to the delivery of medical health care to class members," but does not have general authority over all prison workers. (APP-201–02.)

II. IN A RULING ADDRESSING MANAGEMENT OF THE COVID-19 PANDEMIC, THE DISTRICT COURT DETERMINED THAT DEFENDANTS WERE NOT DELIBERATELY INDIFFERENT.

In April 2020, the district court denied Plaintiffs' motion for an order requiring CDCR to "reduce population levels to safe and sustainable levels in light of the COVID-19 pandemic." *Plata v. Newsom*, 445 F. Supp. 3d at 559. After reviewing all of Defendants' efforts, including the early release of thousands of inmates, as well as other operational measures to combat COVID-19, the district court concluded "without difficulty" that Defendants' actions were reasonable and did not violate the Eighth Amendment. *Id*. at 568. While musing that it might adopt different measures if it were solely responsible for prison health care, the court "[could not] conclude that Defendants' actions [were] constitutionally deficient." *Id*. at 564.

III. THE DISTRICT COURT ISSUED AN ORDER TO SHOW CAUSE REGARDING MANDATORY VACCINATION FOR PRISON INMATES AND STAFF.

In August 2021, the Receiver filed a report recommending that access to CDCR's institutions be limited to staff who provide proof of vaccination, or who have received a religious or medical exemption—a proposal that

would impact staff who work outside of the medical delivery system. (APP-116–140.) The report also recommended that incarcerated people who choose to work outside institutions or accept in-person visits must be vaccinated or establish a religious or medical exemption. (APP-118.)

That same month, the district court issued an order to show cause as to why it should not order CDCR to implement this policy.[1] (APP-112–15.)

IV. DEFENDANTS PRESENTED EVIDENCE OF THEIR EXTENSIVE EFFORTS TO COMBAT COVID-19 IN PRISONS.

The district court conducted regular case management conferences focused on pandemic management, and Defendants complied with its orders and worked with the Receiver to implement COVID-19 protocols. (APP-68–69.) Defendants presented the court with evidence of their considerable efforts to combat COVID-19 in correctional institutions, promote vaccination, and ensure adequate medical care for affected inmates.

Defendants first made COVID-19 vaccines available to certain incarcerated persons and staff in December 2020, and have since expanded voluntary vaccination programs and vaccinated over 78,000 class members

[1] The court later modified the briefing schedule so the parties could address a recent California Department of Public Health order requiring vaccination of individuals who provide health-care services to inmates. (APP-109–11.)

and over 35,000 prison staff. (APP-57.) The percentage of prison staff who received at least one dose of a COVID-19 vaccine increased from about 53 percent on August 6, 2021, to about 68 percent currently. (*Id.*); *see* https://www.cdcr.ca.gov/covid19/population-status-tracking/ (last accessed Nov. 18, 2021).

By August 2021, nearly 99 percent of CDCR's inmate population had been offered a COVID-19 vaccine at least once.[2] (APP-93.) About 80 percent of the incarcerated population has accepted at least one dose of the vaccine. *See* https://www.cdcr.ca.gov/covid19/population-status-tracking/. Consistent with then-current public health guidance, CDCR and California Correctional Health Care Services (CCHCS) promptly began offering booster shots to eligible immunocompromised patients, as well as institution staff, and then to non-immunocompromised patients. (*Id.*) As of October 22, 2021, 7,195 eligible patients had been offered a booster shot, and 6,412 had accepted it. (*Id.*) To reduce the risk of serious illness and hospitalizations, CDCR and CCHCS also provided infected patients with the

[2] The majority of incarcerated persons who have not yet been offered the vaccine had been away from the institutions for court proceedings, or are new arrivals who will promptly be offered the vaccine. (APP-93); *see* Cal. Code Regs. tit. 15, § 3999.305 (requiring an initial health screening for new arrivals).

newest and most effective therapies where indicated, including monoclonal antibody treatments. (APP-59.)

These vaccination programs and other efforts have greatly reduced the risks of infection among class members. (APP-59.) As of October 24, 2021, out of a prison population exceeding 99,300, CCHCS reported three patient hospitalizations and about 187 active cases. (*Id.*) By contrast, in late December 2020, there were over 10,000 active cases among the incarcerated population. (*Id.*)

Defendants have also adapted their approach in response to evolving public-health guidance regarding the COVID-19 virus. For example, CDCR developed specific guidelines for operating during the pandemic, suspended public visiting, and suspended intake from county jails at various times. (APP-145–46.) CDCR implemented symptom screening for individuals entering the prison system, enhanced cleaning efforts throughout the prison, and widely distributed hand soap and sanitizer. (*Id.*) Also, CDCR reduced its population by over 23,000 inmates between March and December 2020, to reduce the risk of COVID-19 transmission within its facilities. (APP-

147.) Other mitigation efforts include frequent testing and physical distancing.[3] (APP-146–48.)

Since August 2021, employees who are not vaccinated must test for COVID-19 twice per week in order to enter CDCR prisons. (APP-95.) And, starting earlier this month, all unvaccinated workers must wear a N95 mask while performing job duties on institution grounds. *See* https://www.cdcr.ca.gov/covid19/order-regarding-mandatory-covid-19-vaccinations-for-workers/ (last accessed Nov. 18, 2021). Additionally, CDCR has implemented stringent protocols regarding inmate movement. (APP-091, 144–53.) Expert testimony established that, in conjunction with relatively high rates of vaccination among the incarcerated population, these measures will significantly mitigate the spread of the virus. (APP-103.)

CDCR has promoted vaccination among its staff by 1) implementing additional paid leave for eligible staff, including for vaccine-related illness; 2) providing monetary prize opportunities for staff who get vaccinated; and 3) instituting a COVID-19 mitigation advocate program focusing on educating staff about vaccination. (APP-93–94.) CDCR also implemented a

[3] Additional information regarding COVID-19 response efforts can be found on CDCR's website. (APP-91 (*citing* https://www.cdcr.ca.gov/covid19/covid-19-response-efforts/) (last accessed Nov. 18, 2021).)

public health order from the California Department of Public Health mandating vaccines for workers who provide health care and health care services, and those who are regularly assigned to specific health care settings within correctional facilities. (APP-94–96, 100–03.) The order's purpose is to protect medically vulnerable populations and, secondarily, ensure a sufficient supply of workers in high-risk health care settings. (APP-101.) The overwhelming majority of medically vulnerable patients in CDCR prisons—for example, 93 percent of those over 65 years of age—are protected by vaccination. (APP-102–03.)

V. THE DISTRICT COURT FOUND THAT DESPITE THEIR EFFORTS, DEFENDANTS WERE DELIBERATELY INDIFFERENT TO INMATES' MEDICAL NEEDS AND ISSUED MANDATORY VACCINATION ORDERS.

The district court found that Defendants had "undertaken significant measures to combat the virus," including the measures discussed above, efforts to improve ventilation, and developing a centralized command center and multidisciplinary teams to coordinate responses to outbreaks. (APP-67.) Despite acknowledging Defendants' multilayered efforts to reduce the COVID-19 risk, the district court concluded Defendants were deliberately indifferent to the serious medical needs of the incarcerated population because they had not required mandatory vaccinations for prison workers

statewide. (APP-74–86.) The court rejected Defendants' arguments that current measures or other, less-intrusive alternatives—for example, a vaccination requirement for inmates or continued efforts to increase voluntary vaccination among staff—would reasonably abate the risk of serious harm. (APP-86.) In doing so, the court ignored current public health guidance indicating that the best form of protection against serious illness and death is for an individual to be vaccinated, and not simply to ensure that others around the unvaccinated individual are vaccinated. (*See* APP-103–04.) The court therefore ordered Defendants to implement a requirement that access to CDCR institutions be limited to workers with proof of full COVID-19 vaccination (or a religious or medical exemption). (APP-87–88.)

In compliance with the order, Defendants and the Receiver jointly filed a plan regarding mandatory vaccination, but Defendants specifically noted that they did not agree with the timeline presented in the plan, "continue[d] to have serious reservations about implementing the Receiver's broad mandatory vaccine recommendation due to the impact of implementing this plan on staffing and operations statewide," and discussed with the Receiver modifying the implementation timeline as they considered a motion to stay implementation of the September 27 order. (APP-62, 64; CD 3707.)

At the district court's direction, Defendants and the Receiver continued to discuss implementation issues and timeline, including the need to provide the requisite notice to employee representatives before implementation. Dissatisfied with progress on implementation, the district court on October 27, 2021 ordered that full vaccination of the persons covered by its mandatory-vaccination order occur no later than January 12, 2022. (APP-42–44.) To comply with the court's newly identified deadline for compliance, the Receiver and CDCR jointly issued a memorandum requiring that employees receive a first dose of the two-dose Moderna vaccine no later than December 1, 2021. The last date for the first dose of the two-dose Pfizer vaccine is December 8, 2021, and the last date for a single-dose of the Johnson & Johnson vaccine is December 29, 2021. *See* https://www.cdcr.ca.gov/covid19/order-regarding-mandatory-covid-19-vaccinations-for-workers/. Workers who do not comply will be subject to progressive discipline, including pay reductions, unpaid suspension, and ultimately termination. (APP-27–28.)

VI. DEFENDANTS APPEALED, AND THE DISTRICT COURT DENIED THEIR MOTION TO STAY THE VACCINATION ORDERS.

Defendants appealed from the district court's mandatory-vaccination order, and later amended their notice of appeal to encompass the order

setting a vaccination compliance deadline.[4] (APP-65–66, 40–41.) Defendants also sought a stay in the district court and moved to shorten time for the hearing. (Court Docket (CD) 3715, 3719; APP-38–39.) Though Defendants requested an earlier date, the court's earliest available date for hearing was November 17, 2021. (APP-34–37.) The district court denied Defendants' request for a stay. (APP-5–11.)

ARGUMENT

I. THIS COURT SHOULD STAY THE MANDATORY-VACCINATION ORDERS.

A stay is a matter of judicial discretion governed by "sound legal principles." *Nken v. Holder*, 556 U.S. 418, 433–34 (2009) (citation omitted). In ruling on a motion for a stay pending appeal, this Court considers four factors: (1) the likelihood that the movant will succeed on the merits; (2) whether the applicant will suffer irreparable injury without a stay; (3) whether the stay will substantially injure other interested parties; and (4)

[4] The California Correctional Peace Officers' Association (CCPOA) intervened and separately moved to stay the vaccination mandate, and initiated an appeal, case no. 21-16816. (CD 3665, 3714, 3722.) In addition, the Service Employees International Union, Local 1000 (SEIU) submitted amicus briefing opposing the mandatory-vaccination policy and supporting a stay on behalf of over 12,000 members. (CD 3656; APP-31–32.)

whether the stay is in the public interest. *Nken*, 556 U.S. at 434; *Lair v. Bullock*, 697 F.3d 1200, 1203 (9th Cir. 2012).

The first two factors are analyzed on a "sliding scale in which the required degree of irreparable harm increases as the probability of success decreases." *Golden Gate Rest. Ass'n v. City & Cty. of San Francisco*, 512 F.3d 1112, 1116 (9th Cir. 2008) (citation omitted). At one end, "the moving party is required to show both a probability of success on the merits and the possibility of irreparable injury." *Id*. at 1115 (citation omitted). At the other end, if the "balance of hardships tips sharply in its favor," the moving party must show the appeal raises "serious legal questions." *Id.* at 1116.

All factors, however balanced, favor a stay here.

A. Defendants Have a Substantial Likelihood of Success on the Merits.

The evidence before the district court regarding Defendants' COVID-19 response shows they have a substantial case for relief.

1. The Court Incorrectly Applied the Eighth Amendment Standard and Disregarded Defendants' Ongoing Efforts to Reduce the Risk of COVID-19 Among the Incarcerated Population.

Eighth Amendment claims involve two elements: one objective and one subjective. For prison conditions to meet the objective standard, there must exist a "substantial risk of serious harm," *Farmer v. Brennan*, 511 U.S. 825,

837 (1994), and that risk must be "so grave that it violates contemporary standards of decency to expose *anyone* unwillingly to such a risk," *Helling v. McKinney*, 509 U.S. 25, 36 (1993).

For the subjective component, courts ask whether a prison official was aware of, and disregarded, "an excessive risk to inmate health or safety." *Farmer v. Brennan*, 511 U.S. 825, 837 (1994). This factor centers on a defendant's "mental attitude," and whether that attitude shows deliberate indifference. *Id*. at 839. The subjective standard is exacting, and courts have rejected attempts to dilute it. *See Estelle v. Gamble*, 429 U.S. 97, 105–07 (1976) (deliberate indifference is the "unnecessary and wanton infliction of pain," and not negligence). When officials respond reasonably to a risk of harm, even if the harm was not averted, there is no Eighth Amendment violation. *Farmer*, 511 U.S. at 844.

Here, the district court's deliberate-indifference analysis is erroneous. While COVID-19 presents a serious risk of severe disease or death to unvaccinated individuals, society does not "consider[] the risk" of a vaccination-or-testing regime to be "so grave that it violates contemporary standards of decency to expose *anyone* unwillingly to such a risk." *Helling*, 509 U.S. at 36; *see also Rhodes v. Chapman*, 452 U.S. 337, 347 (1981) ("conditions that cannot be said to be cruel and unusual under contemporary

standards are not unconstitutional"). Indeed, every day, millions of Californians risk encountering unvaccinated persons, and potential exposure to COVID-19, when they report to work, attend school, or otherwise interact with other people in ways that are necessary for society to function. *See*, *e.g., Hines v. Youseff*, 914 F.3d 1218, 1231–32 (9th Cir. 2019) (when "millions of free individuals" lived in an area endemic for valley fever and tolerated a heightened risk of the disease, "yet no societal consensus has emerged that the risk is intolerably grave," reasonable officials could infer that the risk is one "society is prepared to tolerate"); *Caroll v. DeTella*, 255 F.3d 470, 472 (7th Cir. 2001) (Posner, J.) (the Eighth Amendment does not require officials to provide an environment "completely free from pollution or safety hazards").[5]

In any event, Defendants "responded reasonably to the risk." *Farmer*, 511 U.S. at 844. Defendants made vaccines widely available to the prison population, and vaccination is the best way to protect class members from serious illness and death. (APP-92–93, 103–04.) Defendants have also taken aggressive measures to reduce the chances that inmates will contract

[5] The vaccination mandates permitted exposure to unvaccinated staff who have a medical or religious exemption, implicitly acknowledging that such exposure does not violate the Eighth Amendment. (APP-087.)

COVID-19—measures the district court previously relied on to conclude Defendants had not violated the Eighth Amendment, *see Plata v. Newsom*, 445 F. Supp. 3d at 559–68—such as reducing the prison population, masking and social-distancing mandates, enhanced cleaning measures, quarantine/isolation protocols, patient screening, movement restrictions, and testing mandates. (APP-49–60, 89–104.) And they have offered vaccines to their employees, continue to incentivize vaccinations, and require unvaccinated workers to get tested twice a week and wear an N95 mask while on prison grounds. (APP-93–95.)

These measures do not evince "reckless disregard" of the health or safety of incarcerated persons. *Farmer*, 511 U.S. at 839–40. Indeed, Defendants' vaccination-or-test policy aligns with the recent guidelines issued by the U.S. Occupational Safety and Health Administration, which recommends a mandate for employers similar to that which the district court found constitutionally deficient. *See* https://www.federalregister.gov/documents/2021/11/05/2021-23643/covid-19-vaccination-and-testing-emergency-temporary-standard (last accessed Nov. 18, 2021).

This Court's recent decision in *Fraihat* is instructive.[6] The *Fraihat* plaintiffs, U.S. Immigration and Customs Enforcement (ICE) detainees, asserted the government's COVID-19 directives showed deliberate indifference. *Fraihat*, 16 F.4th at 618. The district court issued an injunction imposing a "broad range of obligations" on ICE officials. *Id*.

After examining ICE's various efforts to respond to the virus, this Court reversed. *Fraihat*, 16 F.4th at 635–36. The Court characterized the deliberate-indifference standard as "formidable," which reflects the "core principle, grounded in the separation of powers, that far-reaching intrusion into matters initially committed to a coordinate Branch requires a commensurately high showing sufficient to warrant such a significant exercise of judicial power." *Id*. at 619, 636. This Court concluded the deliberate-indifference finding was unsupported because ICE's efforts, which included requirements for hygiene supplies and cleaning, housing protocols for detainees, protective equipment, social distancing, cohorting, and isolation, simply "[could not] be described" as "reckless disregard" to a risk of harm. *Id*. at 638.

[6] *Fraihat* applied the Fifth Amendment's objective deliberate-indifference standard, but the decision shows the high bar that a plaintiff must meet to satisfy either the subjective or objective standard.

Fraihat highlights two important principles. First, executive branch officials must "have some discretion in addressing a complex problem" like keeping inmates and staff safe while meeting operational imperatives during "a public health crisis unlike any that we have encountered in our time." *Fraihat*, 16 F.4th at 639, 642. Second, the "constitutional line" cannot be drawn based on the "court's idea of how best to operate a detention facility." *Id*. (*citing Bell v. Wolfish*, 441 U.S. 520, 539 (1979)). "[T]he operation of our correctional facilities is peculiarly the province of the Legislature and Executive Branches of our Government, not the Judicial." *Bell*, 441 U.S. at 548. "[W]hether one would characterize" CDCR's response to COVID-19 "as strong, fair, needing improvement, or something else, it simply cannot be described in the way that matters here: as a reckless disregard of the very health risks it forthrightly identified and directly sought to mitigate." *Fraihat*, 16 F.4th at 638. Thus, Defendants have a substantial case for relief.

2. The Court Further Erred in Finding That the Proposed Mandatory Vaccination Policy Satisfies the PLRA's Needs, Narrowness, and Intrusiveness Requirement.

Under the PLRA, a court may not grant prospective relief regarding prison conditions unless the relief is "narrowly drawn, extends no further than necessary to correct the violation of the Federal right, and is the least

intrusive means necessary to correct the violation of the Federal right." 18 U.S.C. § 3626(a)(1)(A).

The district court lacked authority to order prospective relief because, as discussed above, Defendants' response to the COVID-19 pandemic did not violate the Eighth Amendment. *See Gilmore v. People of the State of California*, 220 F.3d 987, 998 (9th Cir. 2000) (addressing the PLRA's restrictions on a court's equity jurisdiction). The district court compounded that error in finding its mandatory vaccination policy satisfied the PLRA's restrictions on prospective relief.

"[N]arrow tailoring requires a fit between the remedy's ends and the means chosen to accomplish those ends." *Brown v. Plata*, 563 U.S. at 531 (quotation marks and citations omitted). Here, the undisputed facts demonstrate that being vaccinated is the safest way to protect an individual against experiencing severe complications from a COVID-19 infection. (APP-103–04, 135.) A recent study found that "fully vaccinated individuals with breakthrough infections have peak viral load similar to unvaccinated cases and can efficiently transmit infection in household settings, including to fully vaccinated contacts." (APP-12.) Thus, vaccinating all class members rather than all prison workers would be a more narrowly tailored

remedy—especially since, despite extensive efforts, COVID-19 cannot be kept out of CDCR prisons entirely.

In its September 27 order, the district court ordered the Receiver to "consider efforts to increase the vaccination rate among the incarcerated population, including whether a mandatory vaccination policy should be implemented." (APP-88.) But the district court dismissed Defendants' argument that vaccinating the remaining unvaccinated class members (a small minority of the total class) is more narrowly tailored than mandating vaccination for virtually all prison workers.[7] The court believed this question was not before it because "neither the Receiver nor any party has recommended that vaccination be required for all incarcerated persons." (APP-85.) This was clear error because the availability of a narrower vaccination option is indisputably relevant to whether a broader vaccine mandate satisfies the PLRA's narrowness requirement.

The district court also rejected Defendants' contention that voluntary vaccination efforts will continue to raise vaccination rates among both prison employees and inmates. (APP-86.) This too was an error. Staff

[7] Defendants argued that a policy of vaccinating class members was more narrowly tailored than the Receiver's recommendation (APP-105–08), implicitly endorsing a more measured, less intrusive approach than the worker-vaccination mandate the district court imposed.

vaccination rates increased by about five percentage points in May and June 2021, ten percentage points, between August and mid-October 2021, and an additional five percentage points since mid-October. (APP-57–58, 142–43) *see* https://www.cdcr.ca.gov/covid19/population-status-tracking/. Especially when Defendants continue encouraging staff vaccination, there is every reason to expect vaccination rates will continue to rise. (APP-93–94.)

The district court erred in concluding that none of the alternatives Defendants identified to mitigate the COVID-19 risk passed constitutional muster. For this reason, as well, Defendants are likely to succeed on the merits of this appeal.

B. The State Faces Irreparable Harm Absent a Stay.

It is "difficult to imagine an activity in which a State has a stronger interest, or one that is more intricately bound up with state laws, regulations, and procedures, than the administration of its prisons." *Woodford v. Ngo,* 548 U.S. 81, 94 (2006). Less than two years ago, the district court acknowledged, "courts must give due regard for prison officials' unenviable task of keeping dangerous men in safe custody under humane conditions" and "consider arguments regarding the realities of prison administration." *Plata v. Newsom*, 445 F. Supp. 3d at 562 (*citing Farmer*, 511 U.S. at 845, and *Helling*, 509 U.S. at 37) (internal quotations omitted).

The Director of CDCR's Division of Adult Institutions testified regarding her serious concerns that the vaccine mandate will cause irreparable operational harms throughout the State's correctional institutions. (APP-49–55.) Her predictive judgment, grounded in experience and based on current data, is entitled to deference. *Bell*, 441 U.S. at 547–48 ("Prison administrators therefore should be accorded wide-ranging deference" to adopt policies that "in their judgment are needed to preserve internal order and discipline and to maintain institutional security"); *BNSF Ry. Co. v. Surface Transp. Bd.*, 526 F.3d 770, 781 (D.C. Cir. 2008) (Kavanaugh, J.) ("It is well established that an agency's predictive judgments about areas that are within the agency's field of discretion and expertise are entitled to particularly deferential review, so long as they are reasonable") (citation omitted).

With its unprecedented mandate, the court replaced the expert judgment of prison executives with its own, significantly impeding the State's ability to fulfill its responsibilities under state and federal law. California's prisons will likely experience a substantial increase in staff vacancy rates if a vaccine mandate is implemented—a concern confirmed by data from two medical institutions. At California Medical Facility and California Health Care Facility, staff were subject to a California

Department of Public Health order mandating vaccination by October 14, 2021. (APP-52.) As of November 9, 2021, about 5.2 percent of correctional officers at California Health Care Facility had neither complied with the vaccination requirement nor sought an exemption. (APP-26–27.) For officers at California Medical Facility, the rate was about 2 percent. (*Id.*) The October 14 deadline was later extended when a state court temporarily enjoined enforcement of the mandate, but the statistics are telling because there was an 11-day window where staff were past the compliance deadline. (APP-25–26.) Resistance at some staffing-challenged locations is likely to be even higher—for example, there are at least two prisons in remote locations where it is difficult to recruit, and the low staff vaccination rates indicate the prisons are at risk of losing an even greater percentage of their workforce.[8] (APP-27.)

A non-compliance rate of around five percent would be devastating to CDCR's operations.[9] (APP-28, 52–53.) Institutions cannot operate safely

[8] One institution, High Desert State Prison, has already been forced to deactivate one of its facilities because of staffing shortages. *See* https://www.lassennews.com/staffing-shortage-forces-deactivation-of-high-desert-state-prisons-b-yard/ (last accessed Nov. 18, 2021).

[9] Defendants anticipate the district court's order will be significantly more disruptive to prison operations than the California Department of Public Health's mandatory-vaccination order. CCHCS has contracts with

without a sufficient number of correctional officers, who are responsible for maintaining safety and security within the prisons. (APP-50–51.) There may be insufficient staff available to adequately respond to security threats, increasing the risk of physical injury to inmates and staff. (APP-52.) High vacancy rates among correctional officer positions can also severely impact prison operations, requiring reductions in inmate work programs, educational opportunities, recreation, and basic services. (APP-51–52.) Normal programs may need to be limited to ensure delivery of essential services like medical care and meals. (APP-51.) Vacancies also necessitate involuntary overtime, contributing to fatigue, burnout, injuries, and extended periods of leave. (APP-51–52.)

Compounding potential workforce shortages, over 700 correctional officers are unvaccinated and eligible for full retirement benefits. (APP-54.) There is a serious risk that many of these experienced officers will choose to retire rather than be vaccinated. (*Id.*) Also, the number of recent cadets has made it difficult for CDCR to timely replace officers who quit or retire. (APP-54.) Vaccine mandates may further reduce the number of academy

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healthcare services providers and is generally able to fill vacancies in health care positions. (APP-59–60.) There are no similar contracts for correctional officers. (APP-55.)

graduates who will take positions in state prisons—about 76 percent of recently-graduated cadets are unvaccinated.[10] (APP-54.)

Noncustodial workers like culinary staff, electricians, plumbers, maintenance and warehouse workers, and administrative staff are also essential to the smooth functioning of correctional institutions. (APP-51.) If non-compliance rates observed at the medical prisons are consistent across these groups of workers, there would be a further detrimental impact on prison administration and operations. (*Id.*)

Though prisons can maintain essential functions for a limited time in the face of severe staffing shortages, those shortages go hand-in-hand with potentially serious harms. (APP-30.) If this Court does not stay the mandatory-vaccination orders, the State could face a severe aftermath, including the possibility of injuries to inmates and staff that may have been avoided had CDCR prisons been fully staffed. This potential for irreparable harm outweighs any harm from a temporary continuation of the status quo, particularly given CDCR's extensive (and successful) efforts to reduce the

[10] Statistics from Washington State bear out these concerns. As a consequence of their vaccine mandate, the Washington Department of Corrections lost 4.5 percent of prison staff. (APP-45–48.) If CDCR were to lose a similar percentage of its officers (equaling nearly 1,300 individuals), normal operations would not be possible in all prisons. (APP-50–53.)

risk of serious illness and hospitalization from COVID-19, masking mandates, twice-weekly testing protocol, and high success rate in vaccinating class members. All of these facts weigh in favor of a stay.

C. The Public Interest Favors a Stay.

Where the state is a party to a lawsuit, the balance-of-equities and public-interest factors merge. *Nken v. Holder*, 556 U.S. at 435. Here, the public interest is best served by a stay of these extraordinary judicial vaccine-mandate orders to avoid the risk of serious staffing shortages at CDCR institutions that could impact safety and security for both prison staff and the inmate population. Relief is needed on an emergency basis before December 1, 2021, because that is the deadline for workers who choose the Moderna vaccine to receive their first shot.

As Defendants' evidence shows, a stay would help avoid disruptions to rehabilitative programming for the incarcerated population. (APP-25–30, 49–55.) It would also serve the public interest by helping ensure sufficient prison staff to provide inmates with essential and constitutionally-mandated services, such as medical and mental health care. (*Id.*) The risk of harm to the incarcerated population from COVID-19 is also a primary concern, but the number of active cases has remained relatively low since March 2021, and vaccination of incarcerated persons has successfully reduced rates of

serious illness among the prison population. (APP-57–59.) While the world remains in the grip of this devastating pandemic, there is no way to achieve perfect safety for anyone.

Finally, given the January 12, 2022 compliance deadline, the public interest also favors a stay so CDCR employees, and other workers, do not need to make a choice between resignation, discipline, or vaccination—a choice with irrevocable effects. This decision, and the resulting staffing shortages, may be avoided if the orders are ultimately overturned.

Defendants are aware of no other prison system in the country that is subject to a court-ordered staff vaccination mandate on the basis of the Eighth Amendment. Because CDCR's ongoing efforts have been largely successful at curbing the serious risks associated with the virus, the hardships associated with losing substantial numbers of mission-critical prison staff tips the balance in favor of a stay pending appeal.

II. IN THE ALTERNATIVE, DEFENDANTS REQUEST AN EXPEDITED BRIEFING SCHEDULE.

If this Court denies Defendants' motion for an emergency stay, it should expedite consideration and disposition of this appeal. This comports with the PLRA's policy of ensuring that orders granting prospective relief do not stand longer than necessary. 18 U.S.C. § 3626(a)(1)(A). Defendants

request a December 20, 2021 deadline for the filing of the opening brief and a January 20, 2022 deadline for the filing of the answering brief. Defendants also request that this appeal be given priority for hearing under Circuit Rule 34-3. The irreparable harm discussed above establishes good cause to expedite consideration of this appeal.

CONCLUSION

Because all factors weigh in favor of granting a stay pending appeal, Defendants ask that the Court stay implementation of the two contested orders. Alternatively, Defendants request an expedited briefing schedule.

Dated: November 18, 2021

Respectfully submitted,

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UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Form 17. Statement of Related Cases Pursuant to Circuit Rule 28-2.6

Instructions for this form: http://www.ca9.uscourts.gov/forms/form17instructions.pdf

9th Cir. Case Number(s) 21-16696

The undersigned attorney or self-represented party states the following:

○ I am unaware of any related cases currently pending in this court.

○ I am unaware of any related cases currently pending in this court other than the case(s) identified in the initial brief(s) filed by the other party or parties.

◉ I am aware of one or more related cases currently pending in this court. The case number and name of each related case and its relationship to this case are:

Marciano Plata, et al. v. California Correctional Peace, et al. (9th Cir. No. 21-16816).

These appeals challenge the same orders imposing injunctions that were issued in the district-court action Plata v. Newsom, et al., N.D. Cal., No. 4:01-cv-01351-JST.

Signature /s/ Martha Ehlenbach **Date** November 18, 2021

*(use "*s/[typed name]*" to sign electronically-filed documents)*

CERTIFICATE OF COMPLIANCE

I hereby certify that this emergency motion complies with the type-volume limitation of Ninth Circuit Rules 27-1 and 32-3 because it contains 5,440 words. This emergency motion complies with the typeface and the type style requirements of Federal Rule of Appellate Procedure 27 because it has been prepared in a proportionally spaced typeface using 14-point font.

Dated: November 18, 2021

/s/ Martha Ehlenbach
Martha Ehlenbach
Deputy Attorney General

21-16696

IN THE UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

MARCIANO PLATA, et al.,

Plaintiffs-Appellees,

v.

GAVIN NEWSOM, et al.,

Defendants-Appellants.

On Appeal from the United States District Court
for the Northern District of California

No. 4:01-cv-01351-JST
The Honorable Jon S. Tigar, District Judge

APPENDIX OF RECORDS SUBMITTED IN SUPPORT OF DEFENDANTS' EMERGENCY MOTION TO STAY

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APPENDIX OF RECORDS

Defendants-Appellants respectfully submit copies of district-court filings that are relevant to their motion for a stay pending appeal, in compliance with Federal Rules of Appellate Procedure 8(a)(2)(b)(iii) and 27(a)(2)(B). The documents are bates-stamped "APP."

Date	Docket No.	Description	APP Pages
11/17/21	3757	Order Denying Defendants' Request for a Stay	5–11
11/11/21	3742-2	Defendants' Request for Judicial Notice in Support of their Reply for Motion to Stay Order Re: Mandatory Vaccinations (excerpts)	12–24
11/11/21	3741-1	Supplemental Declaration of Connie Gipson in Support of Defendants' Reply for Motion to Stay Order Re: Mandatory Vaccinations	25–30
11/08/21	3735	SEIU Local 1000's Motion for Leave to File Amicus Curiae Brief Regarding Motions to Stay (excerpts)	31–32
11/04/21	3733	Transcript of October 28, 2021 Case Management Conference (excerpts)	33–37
10/30/21	3731	Defendants' Supplemental Notice Re: Motions to Stay Orders Re: Mandatory Vaccinations	38–39
10/30/21	3730	Defendants' Amended Notice of Appeal	40–41
10/27/21	3721	Order Setting Deadline for Mandatory Vaccination	42–44
10/25/21	3715-4	Request for Judicial Notice in Support of Defendants' Motion to Stay Order Re: Mandatory COVID-19 Vaccinations Pending Appeal (excerpts)	45–48

Date	Docket No.	Description	APP Pages
10/25/21	3715-3	Declaration of Connie Gipson in Support of Defendants' Motion to Stay Order Re: Mandatory COVID-19 Vaccinations Pending Appeal	49–55
10/25/21	3715-2	Declaration of Diana Toche, DDS, in Support of Defendants' Motion to Stay Order Re: Mandatory COVID-19 Vaccinations Pending Appeal	56–60
10/12/21	3694	Notice of CDCR and the Receiver's Submission of a COVID-19 Vaccination Plan for Certain CDCR Workers and Incarcerated People (excerpts)	61–64
10/12/21	3693	Defendants' Notice of Appeal (excerpts)	65–66
09/27/21	3684	Order Re: Mandatory Vaccinations	67–88
08/30/21	3662	Declaration of Diana Toche, DDS, in Support of Defendants' Response to the Order to Show Cause	89–97
08/30/21	3661	Declaration of James Watt, MD, MPH, in Support of Defendants' Response to the Order to Show Cause	98–104
08/30/21	3660	Defendants' Response to Order to Show Cause Regarding Receiver's Mandatory Vaccination Policy (excerpts)	105–108
08/20/21	3653	Order Modifying Schedule on August 9, 2021 Order to Show Cause	109–111
08/09/21	3647	Order to Show Cause Re: Receiver's Recommendation on Mandatory Vaccination	112–115
08/04/21	3638	Report of the Receiver Regarding a Mandatory COVID-19 Vaccination Policy (excerpts)	116–140
06/25/21	3605	Joint Case Management Conference Statement (excerpts)	141–143

Date	Docket No.	Description	APP Pages
12/09/20	3508	Declaration of Connie Gipson in Support of Defendants' Opposition to Plaintiff's Position on Quarantine in Housing Units with Shared Air Space	144–199
02/14/2006	473	Order Appointing Receiver	200–208
--	--	Docket, *Plata v. Newsom, et al.*, USDC, N.D. Cal., No. 4:01-cv-01351-JST (excerpts)	209–238

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

MARCIANO PLATA, et al.,

Plaintiffs,

v.

GAVIN NEWSOM, et al.,

Defendants.

Case No. 01-cv-01351-JST

ORDER DENYING MOTIONS TO STAY PENDING APPEAL

Re: ECF Nos. 3715, 3722

Before the Court are motions to stay filed by Defendants and Intervenor California Correctional Peace Officers' Association ("CCPOA"). ECF Nos. 3715, 3722. Defendants and CCPOA seek to stay pending appeal this Court's order mandating vaccination against COVID-19 and its order setting a January 12, 2022 implementation deadline. *Plata v. Newsom*, ___ F. Supp. 3d ___, 2021 WL 4448953 (N.D. Cal. Sept. 27, 2021) (ECF No. 3684); ECF No. 3721. The Court will deny both motions.

The issuance of a stay is a matter of judicial discretion, not a matter of right, and the "party requesting a stay bears the burden of showing that the circumstances justify an exercise of that discretion." *Nken v. Holder*, 556 U.S. 418, 433-34 (2009). The Court must consider four factors in exercising its discretion: "(1) whether the stay applicant has made a strong showing that he is likely to succeed on the merits; (2) whether the applicant will be irreparably injured absent a stay; (3) whether issuance of the stay will substantially injure the other parties interested in the proceeding; and (4) where the public interest lies." *Id.* at 434 (citation omitted). Under Ninth Circuit precedent, the movant "must show that irreparable harm is probable and either: (a) a strong likelihood of success on the merits and that the public interest does not weigh heavily against a stay; or (b) a substantial case on the merits and that the balance of hardships tips sharply in the

[movant's] favor." *Leiva-Perez v. Holder*, 640 F.3d 962, 970 (9th Cir. 2011) (per curiam).

On the merits, the Court already considered and rejected the majority of Defendants' and CCPOA's arguments in its September 27, 2021 Order re: Mandatory Vaccinations. *Plata*, 2021 WL 4448953. Nothing in the parties' briefs persuades the Court to change any of the conclusions it reached in that order. Nonetheless, several issues warrant further discussion.

Both movants point to the Ninth Circuit's opinion in *Fraihat v. U.S. Immigration and Customs Enforcement*, 16 F.4th 613 (9th Cir. 2021), as intervening authority that requires reconsideration of the Court's order. In that case, the Ninth Circuit vacated a nationwide preliminary injunction that "imposed a broad range of obligations on the federal government" related to protecting immigration detainees from COVID-19. *Id.* at 618.

Fraihat did not change the deliberate indifference standard this Court applied when it determined that a mandatory vaccination order was required by the Eighth Amendment. Nor does *Fraihat*'s reasoning require a different outcome when applied to the facts of this case. First, in contrast to the broad preliminary relief ordered in *Fraihat*, *see id.* at 629-34, this Court's order is narrowly focused. Additionally, unlike the preliminary injunction reviewed in *Fraihat*, the Court's order comes nearly two years into the pandemic, not "almost immediately" into "an unprecedented and evolving public health problem." *Id.* at 619. The district court in *Fraihat* issued its preliminary injunction order on April 20, 2020, *id.* at 629 – three days after this Court concluded that Defendants were not, at that time, acting with deliberate indifference, *Plata v. Newsom*, 445 F. Supp. 3d 557, 562-69 (N.D. Cal. 2020) (ECF No. 3291).

Many months later, the record in this case now establishes deliberate indifference – and in ways that were not present in *Fraihat*. Here, Defendants are ignoring undisputed medical and scientific evidence, as well as the opinions of their own expert. Nothing similar was present in *Fraihat*. Defendants attempt to manufacture a medical dispute based on a study published in the *Lancet* on October 28, 2021, ECF No. 3742-2, but Defendants misrepresent the findings of that study.[1] They assert that the study found that vaccinated individuals "are just as likely to spread

[1] It is not clear that this study presents "fact[s] that [are] not subject to reasonable dispute," as required for the Court to take judicial notice, but the Court nonetheless considers it. Fed. R. Evid.

the delta variant to contacts in their household as those who have not had a vaccination." ECF No. 3741 at 11. However, while the study confirms that vaccinated individuals who are infected with the delta variant have similar peak viral loads and can spread the disease as readily as infected individuals who have not been vaccinated, it also reports that its findings are "consistent with the known protective effect of COVID-19 vaccination against infection." ECF No. 3742-2 at 11. As the summary to the study explains, "*Vaccination reduces the risk of delta variant infection and accelerates viral clearance*. Nonetheless, fully vaccinated individuals *with breakthrough infections* have peak viral load similar to unvaccinated cases and can efficiently transmit infection in household settings, including to fully vaccinated contacts." *Id.* at 2 (emphasis added). In other words, the study stands for the proposition that vaccinated individuals, *once infected*, may, at least initially, spread the delta variant to the same extent as unvaccinated individuals. But it does not support Defendants' misrepresentation that vaccinated individuals are "*just as likely* to spread the delta variant to contacts in their household as those who have not had a vaccination." ECF No. 3741 at 11 (emphasis added). To the contrary, because vaccinated individuals are less likely to become infected in the first place and also experience accelerated viral clearance, it remains undisputed that vaccinated individuals are less likely to infect others. The *Lancet* study therefore does not undermine the Court's prior conclusions.

Moreover, subsequent to the Court's mandatory vaccination order, Defendants' own expert has now concluded that "COVID-19 vaccination of all employees of the CDCR without a valid contra-indication or exemption is the single most effective intervention available to prevent cases and outbreaks of COVID-19, both among those who are vaccinated and those who cannot be vaccinated." ECF No. 3738-1 at 15. Defendants' expert has also opined that prisons "are highly unlikely to be able to prevent or control outbreaks of COVID-19 solely through the application of non-pharmaceutical interventions," *id.*, thus undercutting Defendants' and CCPOA's contention

201(b). Similarly, the Court has considered the news articles for which Defendants have requested judicial notice, even though it is unclear whether those articles – and, in particular, the facts contained therein – are proper subjects of judicial notice. ECF Nos. 3715-4, 3742; *see, e.g.*, *Ali v. Intel Corp.*, No. 18-cv-03981-LHK, 2018 WL 5734673, at *3 (N.D. Cal. Oct. 31, 2018) ("Courts do not take judicial notice of newspaper articles for the truth of the contents of the articles.").

that other COVID-preventive measures are sufficient to reasonably protect Plaintiffs. In other words, Defendants' position is that, notwithstanding all other measures they continue to implement, staff working at two institutions and in healthcare areas systemwide must be vaccinated to protect the incarcerated population – but Defendants and CCPOA have presented no basis for reaching a different conclusion as to all other institutions. It is unreasonable, and shows reckless disregard, for Defendants to refuse to implement what their own expert has determined is the "single most effective intervention available." *Id.* This is not a case where medical opinions differ.

The State's adoption of vaccine mandates for other groups of state employees further underscores Defendants' deliberate indifference. The Court previously described the California Department of Public Health's August 5 and August 19 orders, which mandated vaccines for workers in healthcare facilities and healthcare areas in correctional settings. *Plata*, 2021 WL 4448953, at *3. The day after the Court's September 27 order, CDPH issued a third vaccine mandate that covers workers at "adult and senior care facilities and in-home direct care settings." CDPH, Order of the State Public Health Officer re: Adult Care Facilities and Direct Care Worker Vaccine Requirement, https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Adult-Care-Facilities-and-Direct-Care-Worker-Vaccine-Requirement.aspx (Sept. 28, 2021). All three of these orders were premised on the State's desire to protect vulnerable populations in settings where workers have frequent contact with such individuals. Notably – in contrast to Defendants' position in this case, where they suggest that a mandatory vaccine for incarcerated persons is a better solution than a mandatory vaccine for staff members – none of the CDPH orders, nor any other directive from the State, requires any members of vulnerable populations to become vaccinated. Instead, consistent with Defendants' expert's view that staff vaccination is the most effective intervention available, the CDPH orders adopt that intervention. Defendants' different treatment of incarcerated persons, except for those who are confined at the two facilities covered by the August 19 CDPH order, shows reckless disregard for the safety of those persons.

In sum, for the reasons set forth above and those discussed in the Court's September 27

order, the facts of this case satisfy the "formidable" standard for deliberate indifference. *Fraihat*, 16 F.4th at 636. Defendants have "disregarded an excessive risk to [Plaintiffs'] health and safety by failing to take reasonable and available measures that could have eliminated that risk." *Id.* (quotation and alteration marks omitted). As the Court previously explained, "Defendants are aware of a substantial risk of serious harm to incarcerated persons, and, although they have taken many commendable steps during the course of this pandemic, they have nonetheless failed to reasonably abate that risk because they refuse to do what the undisputed evidence requires." *Plata*, 2021 WL 4448953, at *1. Defendants and CCPOA have demonstrated neither "a strong likelihood of success on the merits" nor "a substantial case on the merits," and their motions to stay must therefore be denied. *Leiva-Perez*, 640 F.3d at 970.

Even if Defendants and CCPOA had made a showing of likelihood of success on the merits, the balance of hardships and the public interest weigh sharply against a stay. Defendants' and CCPOA's dire predictions of what might happen in the absence of a stay are speculative. Although some staff might choose to resign or retire rather than comply with a vaccine mandate, the level of staff departures is unknown at this time.[2] Defendants also base their predictions of harm on circumstances resulting from implementation of the August 19 CDPH order, yet – in contrast to their position in this case – they persist in implementing that order, including defending it against CCPOA's legal challenges. Similarly, notwithstanding its claims of irreparable harm, CCPOA acknowledged at the hearing on these motions that it has not sought immediate review of the state court's denial of its motion to preliminarily enjoin the August 19 CDPH order. Additionally, to the extent that Defendants and CCPOA rely on potential staff shortages in arguing for a stay, they have not considered that COVID outbreaks – which mandatory vaccination would help prevent – also result in staff shortages. *See, e.g.*, *Plata*, 2021 WL 4448953, at *6 (noting that approximately 5,500 staff had to quarantine in the past year "either because they have themselves contracted COVID-19 or because they 'are identified as close contacts of an infected individual'").

[2] It is also not clear to the Court that, in seeking a stay, a party can rely on harm that might occur if employees choose not to follow directives that implement a court order. That would appear to give contumacious employees an undue ability to determine when a court can enforce orders that require an employer to comply with the law.

CCPOA argues that some of its members will face irreparable harm absent a stay because they will be forced to choose between maintaining their employment or taking a vaccine that they do not want. The vast majority of courts to have considered this issue have concluded that such a choice does not constitute irreparable harm that warrants enjoining a vaccine mandate.[3] *E.g.*, *Smith v. Biden*, No. 1:21-cv-19457, 2021 WL 5195688, at *8 (D.N.J. Nov. 8, 2021), *appeal filed* (3d Cir. Nov. 10, 2021) ("To date, every court that has considered the allegation that the potential loss of employment due to an employee's decision not to comply with an employer's COVID-19 vaccine mandate constitutes irreparable harm has rejected it."); *Bauer v. Summey*, ___ F. Supp. 3d ___, 2021 WL 4900922, at *18 (D.S.C. Oct. 21, 2021) (rejecting plaintiffs' assertion of irreparable harm where plaintiffs argued that the challenged policies "leave them with effectively two options: receive the COVID-19 vaccine and give up their constitutionally protected rights to bodily autonomy and privacy, or refuse to receive the COVID-19 vaccine and risk losing their jobs, a constitutionally protected property interest"); *Mass. Corr. Officers Federated Union v. Baker*, ___ F. Supp. 3d ___, 2021 WL 4822154, at *7 (D. Mass. Oct. 15, 2021) ("While Plaintiffs' members may suffer the harm of losing employment, it is well settled that the loss of employment is not considered irreparable for the purposes of an injunction."); *Beckerich v. St. Elizabeth Med. Ctr.*, ___ F. Supp. 3d ___, 2021 WL 4398027, at *7 (E.D. Ky. Sept. 24, 2021), *reconsideration denied*, 2021 WL 4722915 (E.D. Ky. Sept. 30, 2021) (finding no irreparable harm where "Plaintiffs are choosing whether to comply with a condition of employment, or to deal with the potential consequences of that choice"); *but see BST Holdings, L.L.C. v. OSHA*, ___ F.4th ___, 2021 WL

[3] In addition, that Defendants and CCPOA waited approximately one month before filing their motions to stay weighs against a finding of irreparable harm. *E.g.*, *Dahl v. Swift Distrib., Inc.*, No. CV 10-00551 SJO (RZx), 2010 WL 1458957, at *4 (C.D. Cal. Apr. 1, 2010) (18-day delay between filing of complaint and motion for temporary restraining order "implies a lack of urgency and irreparable harm"). Both movants argue that they did not delay in seeking a stay because the September 27 order did not set a timeline for implementation, but this argument is unpersuasive. The September 27 order imposed a vaccine mandate and required an implementation plan to be filed, thus giving all parties notice that a vaccine mandate would be imposed. Defendants argue that the implementation deadline was unclear, but they jointly filed an implementation plan with the Receiver setting forth a November 29, 2021 deadline. ECF No. 3694 at 5. Moreover, Defendants and CCPOA appealed the Court's September 27 order, and Defendants filed their motion for a stay pending appeal, without waiting for the Court to order a specific implementation deadline. ECF Nos. 3693, 3714, 3715.

5279381, at *8 (5th Cir. Nov. 12, 2021) (finding irreparable harm because a vaccine-or-test mandate "threatens to substantially burden the liberty interests of reluctant individual recipients put to a choice between their job(s) and their jab(s)" (footnote omitted)).[4]

Finally, even assuming that Defendants and CCPOA might face some irreparable harm, the balance of hardships and the public interest would still weigh against a stay. This Court has determined that its mandatory vaccination order is required to protect the constitutional rights of persons incarcerated by the State of California, and that Plaintiffs face a substantial risk of serious harm, including serious illness and death, in the absence of a vaccine mandate. Defendants "cannot suffer harm from an injunction that merely ends an unlawful practice," even if they were to "face[] severe logistical difficulties in implementing the order." *Rodriguez v. Robbins*, 715 F.3d 1127, 1145-46 (9th Cir. 2013), *abrogated on other grounds sub. nom Jennings v. Rodriguez*, 138 S. Ct. 830 (2018). And, "[e]ven considering the economic impact on [CCPOA members] if they choose not to be vaccinated, when balancing that harm against the legitimate and critical public interest in preventing the spread of COVID-19 by increasing the vaccination rate, particularly in congregate facilities, the Court finds the balance weighs in favor of the broader public interests." *Mass. Corr. Officers*, 2021 WL 4822154, at *8.

Defendants' and CCPOA's motions for a stay pending appeal are denied.

IT IS SO ORDERED.

Dated: November 17, 2021

JON S. TIGAR
United States District Judge

[4] *BST Holdings* has since been consolidated and assigned by the Judicial Panel on Multidistrict Litigation to the United States Court of Appeals for the Sixth Circuit. *In re: OSHA, Interim Final Rule: COVID-19 Vaccination and Testing; Emergency Temporary Standard, 86 Fed. Reg. 61402, Issued on Nov. 4, 2021*, MCP No. 165, ECF No. 3 (JPML Nov. 16, 2021).

Community transmission and viral load kinetics of the SARS-CoV-2 delta (B.1.617.2) variant in vaccinated and unvaccinated individuals in the UK: a prospective, longitudinal, cohort study

Anika Singanayagam, Seran Hakki*, Jake Dunning*, Kieran J Madon, Michael A Crone, Aleksandra Koycheva, Nieves Derqui-Fernandez, Jack L Barnett, Michael G Whitfield, Robert Varro, Andre Charlett, Rhia Kundu, Joe Fenn, Jessica Cutajar, Valerie Quinn, Emily Conibear, Wendy Barclay, Paul S Freemont, Graham P Taylor, Shazaad Ahmad, Maria Zambon, Neil M Ferguson†, Ajit Lalvani†, on behalf of the ATACCC Study Investigators‡*

Summary

Background The SARS-CoV-2 delta (B.1.617.2) variant is highly transmissible and spreading globally, including in populations with high vaccination rates. We aimed to investigate transmission and viral load kinetics in vaccinated and unvaccinated individuals with mild delta variant infection in the community.

Methods Between Sept 13, 2020, and Sept 15, 2021, 602 community contacts (identified via the UK contract-tracing system) of 471 UK COVID-19 index cases were recruited to the Assessment of Transmission and Contagiousness of COVID-19 in Contacts cohort study and contributed 8145 upper respiratory tract samples from daily sampling for up to 20 days. Household and non-household exposed contacts aged 5 years or older were eligible for recruitment if they could provide informed consent and agree to self-swabbing of the upper respiratory tract. We analysed transmission risk by vaccination status for 231 contacts exposed to 162 epidemiologically linked delta variant-infected index cases. We compared viral load trajectories from fully vaccinated individuals with delta infection (n=29) with unvaccinated individuals with delta (n=16), alpha (B.1.1.7; n=39), and pre-alpha (n=49) infections. Primary outcomes for the epidemiological analysis were to assess the secondary attack rate (SAR) in household contacts stratified by contact vaccination status and the index cases' vaccination status. Primary outcomes for the viral load kinetics analysis were to detect differences in the peak viral load, viral growth rate, and viral decline rate between participants according to SARS-CoV-2 variant and vaccination status.

Findings The SAR in household contacts exposed to the delta variant was 25% (95% CI 18–33) for fully vaccinated individuals compared with 38% (24–53) in unvaccinated individuals. The median time between second vaccine dose and study recruitment in fully vaccinated contacts was longer for infected individuals (median 101 days [IQR 74–120]) than for uninfected individuals (64 days [32–97], p=0·001). SAR among household contacts exposed to fully vaccinated index cases was similar to household contacts exposed to unvaccinated index cases (25% [95% CI 15–35] for vaccinated *vs* 23% [15–31] for unvaccinated). 12 (39%) of 31 infections in fully vaccinated household contacts arose from fully vaccinated epidemiologically linked index cases, further confirmed by genomic and virological analysis in three index case–contact pairs. Although peak viral load did not differ by vaccination status or variant type, it increased modestly with age (difference of 0·39 [95% credible interval –0·03 to 0·79] in peak $\log_{10}$ viral load per mL between those aged 10 years and 50 years). Fully vaccinated individuals with delta variant infection had a faster (posterior probability >0·84) mean rate of viral load decline (0·95 $\log_{10}$ copies per mL per day) than did unvaccinated individuals with pre-alpha (0·69), alpha (0·82), or delta (0·79) variant infections. Within individuals, faster viral load growth was correlated with higher peak viral load (correlation 0·42 [95% credible interval 0·13 to 0·65]) and slower decline (–0·44 [–0·67 to –0·18]).

Interpretation Vaccination reduces the risk of delta variant infection and accelerates viral clearance. Nonetheless, fully vaccinated individuals with breakthrough infections have peak viral load similar to unvaccinated cases and can efficiently transmit infection in household settings, including to fully vaccinated contacts. Host–virus interactions early in infection may shape the entire viral trajectory.

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Introduction

While the primary aim of vaccination is to protect individuals against severe COVID-19 disease and its consequences, the extent to which vaccines reduce onward transmission of SARS-CoV-2 is key to containing the pandemic. This outcome depends on the ability of

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Research in context

Evidence before this study

The SARS-CoV-2 delta variant is spreading globally, including in populations with high vaccination coverage. While vaccination remains highly effective at attenuating disease severity and preventing death, vaccine effectiveness against infection is reduced for delta. Determining the extent of transmission from vaccinated delta-infected individuals to their vaccinated contacts is a public health priority. Comparing the upper respiratory tract (URT) viral load kinetics of delta infections with those of other variants gives insight into potential mechanisms for its increased transmissibility. We searched PubMed and *medRxiv* for articles published between database inception and Sept 20, 2021, using search terms describing "SARS-CoV-2, delta variant, viral load, and transmission". Two studies longitudinally sampled the URT in vaccinated and unvaccinated delta variant-infected individuals to compare viral load kinetics. In a retrospective study of a cohort of hospitalised patients in Singapore, more rapid viral load decline was found in vaccinated individuals than unvaccinated cases. However, the unvaccinated cases in this study had moderate-to-severe infection, which is known to be associated with prolonged shedding. The second study longitudinally sampled professional USA sports players. Again, clearance of delta viral RNA in vaccinated cases was faster than in unvaccinated cases, but only 8% of unvaccinated cases had delta variant infection, complicating interpretation. Lastly, a report of a single-source nosocomial outbreak of a distinct delta sub-lineage in Vietnamese health-care workers plotted viral load kinetics (without comparison with unvaccinated delta infections) and demonstrated transmission between fully vaccinated health-care workers in the nosocomial setting. The findings might therefore not be generalisable beyond the particular setting and distinct viral sub-lineage investigated.

Added value of this study

The majority of SARS-CoV-2 transmission occurs in households, but transmission between fully vaccinated individuals in this setting has not been shown to date. To ascertain secondary transmission with high sensitivity, we longitudinally followed index cases and their contacts (regardless of symptoms) in the community early after exposure to the delta variant of SARS-CoV-2, performing daily quantitative RT-PCR on URT samples for 14–20 days. We found that the secondary attack rate in fully vaccinated household contacts was high at 25%, but this value was lower than that of unvaccinated contacts (38%). Risk of infection increased with time in the 2–3 months since the second dose of vaccine. The proportion of infected contacts was similar regardless of the index cases' vaccination status. We observed transmission of the delta variant between fully vaccinated index cases and their fully vaccinated contacts in several households, confirmed by whole-genome sequencing. Peak viral load did not differ by vaccination status or variant type but did increase modestly with age. Vaccinated delta cases experienced faster viral load decline than did unvaccinated alpha or delta cases. Across study participants, faster viral load growth was correlated with higher peak viral load and slower decline, suggesting that host–virus interactions early in infection shape the entire viral trajectory. Since our findings are derived from community household contacts in a real-life setting, they are probably generalisable to the general population.

Implications of all the available evidence

Although vaccines remain highly effective at preventing severe disease and deaths from COVID-19, our findings suggest that vaccination is not sufficient to prevent transmission of the delta variant in household settings with prolonged exposures. Our findings highlight the importance of community studies to characterise the epidemiological phenotype of new SARS-CoV-2 variants in increasingly highly vaccinated populations. Continued public health and social measures to curb transmission of the delta variant remain important, even in vaccinated individuals.

vaccines to protect against infection and the extent to which vaccination reduces the infectiousness of breakthrough infections.

Vaccination was found to be effective in reducing household transmission of the alpha variant (B.1.1.7) by 40–50%,[1] and infected, vaccinated individuals had lower viral load in the upper respiratory tract (URT) than infections in unvaccinated individuals,[2] which is indicative of reduced infectiousness.[3,4] However, the delta variant (B.1.617.2), which is more transmissible than the alpha variant,[5,6] is now the dominant strain worldwide. After a large outbreak in India, the UK was one of the first countries to report a sharp rise in delta variant infection. Current vaccines remain highly effective at preventing admission to hospital and death from delta infection.[7] However, vaccine effectiveness against infection is reduced for delta, compared with alpha,[8,9] and the delta variant continues to cause a high burden of cases even in countries with high vaccination coverage. Data are scarce on the risk of community transmission of delta from vaccinated individuals with mild infections.

Here, we report data from a UK community-based study, the Assessment of Transmission and Contagiousness of COVID-19 in Contacts (ATACCC) study, in which ambulatory close contacts of confirmed COVID-19 cases underwent daily, longitudinal URT sampling, with collection of associated clinical and epidemiological data. We aimed to quantify household transmission of the delta variant and assess the effect of vaccination status on contacts' risk of infection and index cases' infectiousness, including (1) households with unvaccinated contacts and index cases and (2) households with fully vaccinated contacts and fully vaccinated index cases. We also compared sequentially sampled

URT viral RNA trajectories from individuals with non-severe delta, alpha, and pre-alpha SARS-CoV-2 infections to infer the effects of SARS-CoV-2 variant status—and, for delta infections, vaccination status—on transmission potential.

Methods

Study design and participants

ATACCC is an observational longitudinal cohort study of community contacts of SARS-CoV-2 cases. Contacts of symptomatic PCR-confirmed index cases notified to the UK contact-tracing system (National Health Service Test and Trace) were asked if they would be willing to be contacted by Public Health England to discuss participation in the study. All contacts notified within 5 days of index case symptom onset were selected to be contacted within our recruitment capacity. Household and non-household contacts aged 5 years or older were eligible for recruitment if they could provide written informed consent and agree to self-swabbing of the URT. Further details on URT sampling are given in the appendix (p 13).

The ATACCC study is separated into two study arms, ATACCC1 and ATACCC2, which were designed to capture different waves of the SARS-CoV-2 pandemic. In ATACCC1, which investigated alpha variant and pre-alpha cases in Greater London, only contacts were recruited between Sept 13, 2020, and March 13, 2021. ATACCC1 included a pre-alpha wave (September to November, 2020) and an alpha wave (December, 2020, to March, 2021). In ATACCC2, the study was relaunched specifically to investigate delta variant cases in Greater London and Bolton, and both index cases and contacts were recruited between May 25, and Sept 15, 2021. Early recruitment was focused in West London and Bolton because UK incidence of the delta variant was highest in these areas.[10] Based on national and regional surveillance data, community transmission was moderate-to-high throughout most of our recruitment period.

This study was approved by the Health Research Authority. Written informed consent was obtained from all participants before enrolment. Parents and caregivers gave consent for children.

Data collection

Demographic information was collected by the study team on enrolment. The date of exposure for non-household contacts was obtained from Public Health England. COVID-19 vaccination history was determined from the UK National Immunisation Management System, general practitioner records, and self-reporting by study participants. We defined a participant as unvaccinated if they had not received a single dose of a COVID-19 vaccine at least 7 days before enrolment, partially vaccinated if they had received one vaccine dose at least 7 days before study enrolment, and fully vaccinated if they had received two doses of a COVID-19 vaccine at least 7 days before study enrolment. Previous literature was used to determine the 7-day threshold for defining vaccination status.[11–13] We also did sensitivity analyses using a 14-day threshold. The time interval between vaccination and study recruitment was calculated. We used WHO criteria[14] to define symptomatic status up to the day of study recruitment. Symptomatic status for incident cases—participants who were PCR-negative at enrolment and subsequently tested positive—was defined from the day of the first PCR-positive result.

Laboratory procedures

SARS-CoV-2 quantitative RT-PCR, conversion of ORF1ab and envelope (E-gene) cycle threshold values to viral genome copies, whole-genome sequencing, and lineage assignments are described in the appendix (pp 13–14).

Outcomes

Primary outcomes for the epidemiological analysis were to assess the secondary attack rate (SAR) in household contacts stratified by contact vaccination status and the index cases' vaccination status. Primary outcomes for the viral load kinetics analysis were to detect differences in the peak viral load, viral growth rate, and viral decline rate between participants infected with pre-alpha versus alpha versus delta variants and between unvaccinated delta-infected participants and vaccinated delta-infected participants.

See Online for appendix

We assessed vaccine effectiveness and susceptibility to SARS-CoV-2 infection stratified by time elapsed since receipt of second vaccination as exploratory analyses.

Statistical analysis

To model viral kinetics, we used a simple phenomenological model of viral titre[15] during disease pathogenesis. Viral kinetic parameters were estimated on a participant-specific basis using a Bayesian hierarchical model to fit this model to the entire dataset of sequential cycle threshold values measured for all participants. For the 19 participants who were non-household contacts of index cases and had a unique date of exposure, the cycle threshold data were supplemented by a pseudo-absence data point (ie, undetectable virus) on the date of exposure. Test accuracy and model misspecification were modelled with a mixture model by assuming there was a probability p of a test giving an observation drawn from a (normal) error distribution and probability $1-p$ of it being drawn from the true distribution.

The hierarchical structure was represented by grouping participants based on the infecting variant and their vaccination status. A single-group model was fitted, which implicitly assumes that viral kinetic parameters vary by individual but not by variant or vaccination status. A four-group model was also explored, where groups 1, 2, 3, and 4 represent pre-alpha, alpha, unvaccinated delta, and fully vaccinated delta, respectively. We fitted a correlation matrix between

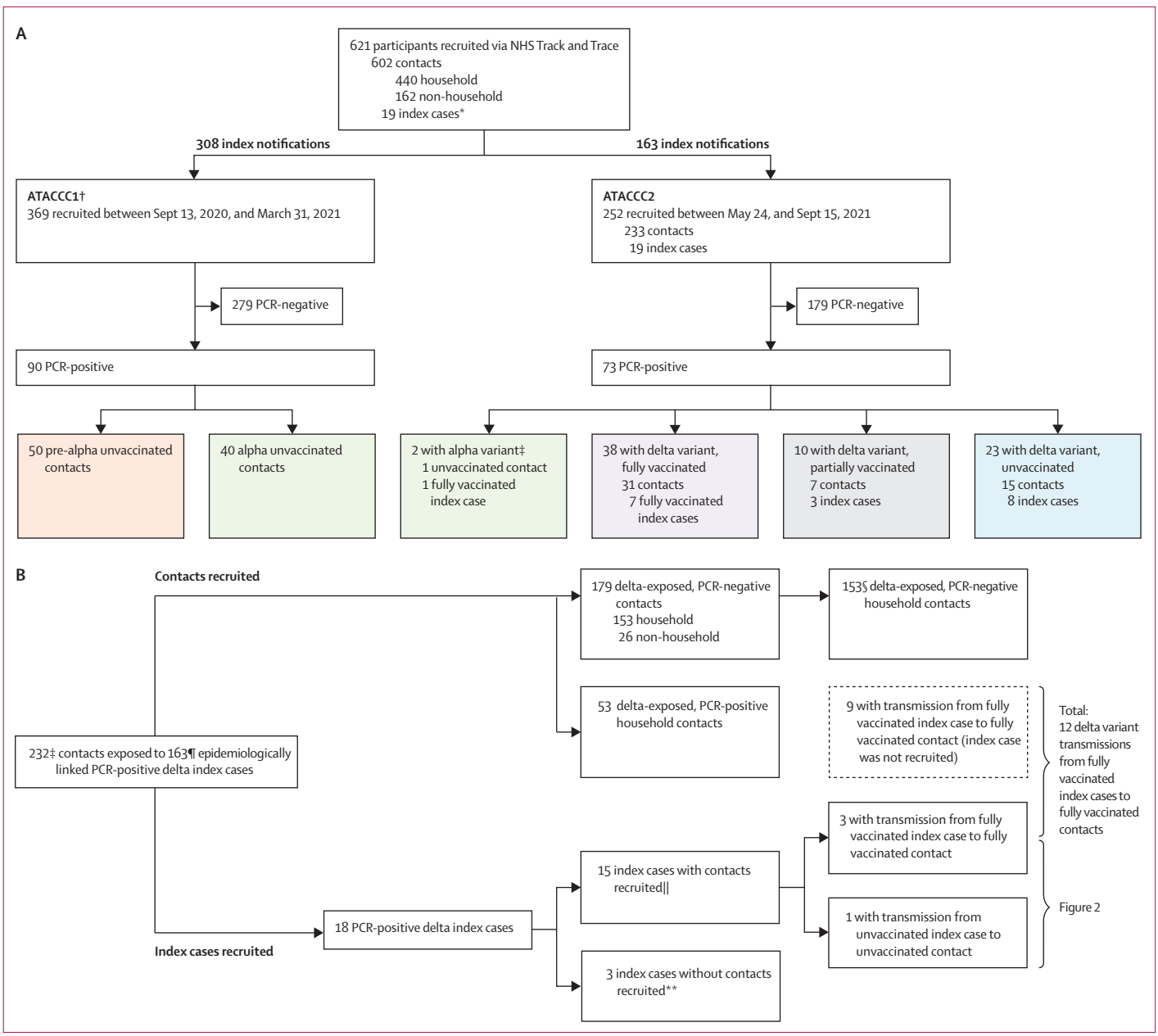


Figure 1: **Recruitment, SARS-CoV-2 infection, variant status, and vaccination history for ATACCC study participants**
(A) Study recruitment and variant status confirmed by whole-genome sequencing (ATACCC1 and ATACCC2 combined). (B) ATACCC2: delta-exposed contacts included in secondary attack rate calculation (table 1) and transmission assessment (table 2). NHS=National Health Service. *All index cases were from ATACCC2. †All contacts. ‡The two earliest PCR-positive cases from the ATACCC2 cohort (one index case and one contact) were confirmed as having the alpha variant on whole-genome sequencing (recruited on May 28, 2021). This alpha variant-exposed, PCR-positive contact is excluded from figure 1B. §One PCR-negative contact had no vaccination status data available and one PCR-negative contact's index case had no vaccination data available. ¶Vaccination data were available for 138 index cases of 163. ||The contacts of these 15 index cases are included within the 232 total contacts. **These three index cases without contacts are only included in the viral load kinetics analysis (figure 3) and are not included in tables 1 and 2.

participant-specific kinetic parameters to allow us to examine whether there is within-group correlation between peak viral titre, viral growth rate, and viral decline rate. Our initial model selection, using leave-one-out cross-validation, selected a four-group hierarchical model with fitted correlation coefficients between individual-level parameters determining peak viral load and viral load growth and decline rates (appendix p 5). However, resulting participant-specific estimates of peak viral load (but not growth and decline rates) showed a marked and significant correlation with age in the exploratory analysis, which motivated examination of models where mean peak viral load could vary with age. The most predictive model overall allowed mean viral

load growth and decline rates to vary across the four groups, with mean peak viral load common to all groups but assumed to vary linearly with the logarithm of age (appendix p 5). We present peak viral loads for the reference age of 50 years with 95% credible intervals (95% CrIs). 50 years was chosen as the reference age as it is typical of the ages of the cases in the whole dataset and the choice of reference age made no difference in the model fits or judgment of differences between the groups.

We computed group-level population means and within-sample group means of log peak viral titre, viral growth rate, and viral decline rate. Since posterior estimates of each of these variables are correlated across groups, overlap in the credible intervals of an estimate for one group with that for another group does not necessarily indicate no significant difference between those groups. We, therefore, computed posterior probabilities, *pp*, that these variables were larger for one group than another. For our model, Bayes factors can be computed as *pp*/(1–*pp*). We only report population (group-level) posterior probabilities greater than 0·75 (corresponding to Bayes factors >3) as indicating at least moderate evidence of a difference.

For vaccine effectiveness, we defined the estimated effectiveness at preventing infection, regardless of symptoms, with delta in the household setting as 1 – SAR (fully vaccinated) / SAR (unvaccinated).

Role of the funding source

The funder of the study had no role in study design, data collection, data analysis, data interpretation, or writing of the report.

Results

Between Sept 13, 2020, and Sept 15, 2021, 621 community-based participants (602 contacts and 19 index cases) from 471 index notifications were prospectively enrolled in the ATACCC1 and ATACCC2 studies, and contributed 8145 URT samples. Of these, ATACCC1 enrolled 369 contacts (arising from 308 index notifications), and ATACCC2 enrolled 233 contacts (arising from 163 index notifications) and 19 index cases. SARS-CoV-2 RNA was detected in 163 (26%) of the 621 participants. Whole-genome sequencing of PCR-positive cases confirmed that 71 participants had delta variant infection (18 index cases and 53 contacts), 42 had alpha variant infection (one index case and 41 contacts), and 50 had pre-alpha variant infection (all contacts; figure 1A).

Of 163 PCR-positive participants, 89 (55%) were female and 133 (82%) were White. Median age was 36 years (IQR 26–50). Sex, age, ethnicity, body-mass index (BMI) distribution, and the frequency of comorbidities were similar among those with delta, alpha, and pre-alpha infection, and for vaccinated and unvaccinated delta-infected participants, except for age and sex (appendix pp 2–3). There were fewer unvaccinated females than males (p=0·04) and, as expected from the age-prioritisation of the UK vaccine roll-out, unvaccinated participants infected with the delta variant were significantly younger (p<0·001; appendix p 3). Median time between exposure to the index case and study enrolment was 4 days (IQR 4–5). All participants had non-severe ambulatory illness or were asymptomatic. The proportion of asymptomatic cases did not differ among fully vaccinated, partially vaccinated, and unvaccinated delta groups (appendix p 3).

No pre-alpha-infected and only one alpha-infected participant had received a COVID-19 vaccine before study enrolment. Of 71 delta-infected participants (of whom 18 were index cases), 23 (32%) were unvaccinated, ten (14%) were partially vaccinated, and 38 (54%) were fully vaccinated (figure 1A; appendix p 3). Of the 38 fully vaccinated delta-infected participants, 14 had received the BNT162b2 mRNA vaccine (Pfizer–BioNTech), 23 the ChAdOx1 nCoV-19 adenovirus vector vaccine (Oxford–AstraZeneca), and one the CoronaVac inactivated whole-virion vaccine (Sinovac).

It is highly probable that all but one of the 233 ATACCC2 contacts were exposed to the delta variant because they were recruited when the regional prevalence of delta was at least 90%, and mostly 95–99% (figure 1B).[10] Of these, 206 (89%) were household contacts (in 127 households), and 26 (11%) were non-household contacts. Distributions of age, ethnicity, BMI, smoking status, and comorbidities were similar between PCR-positive and PCR-negative contacts (appendix p 4). The median time between second vaccine dose and study recruitment in fully vaccinated contacts with delta variant infection was 74 days (IQR 35–105; range 16–201), and this was significantly longer in PCR-positive contacts than in PCR-negative contacts (101 days [IQR 74–120] *vs* 64 days [32–97], respectively, p=0·001; appendix p 4). All 53 PCR-positive contacts were exposed in household settings and the SAR for all delta variant-exposed household contacts was 26% (95% CI 20–32). SAR was

	Total	PCR positive	PCR negative	SAR (95% CI)	p value
Contacts					
All	231	53	178	23 (18–29)	NA
Fully vaccinated	140	31	109	22 (16–30)	0·16
Unvaccinated	44	15	29	34 (22–49)	..
Partially vaccinated	47	7	40	15 (7–28)	NA
Household contacts					
All	205	53	152	26 (20–32)	NA
Fully vaccinated	126	31	95	25 (18–33)	0·17
Unvaccinated	40	15	25	38 (24–53)	..
Partially vaccinated	39	7	32	18 (9–33)	NA

χ^2 test was performed to calculate p values for differences in SAR between fully vaccinated and unvaccinated cases. One PCR-negative contact who withdrew from the study without vaccination status information was excluded. NA=not applicable. SAR=secondary attack rate.

Table 1: **SAR in contacts of delta-exposed index cases recruited to the ATACCC2 study**

	All household contacts (n=204)*	Fully vaccinated contacts (n=125)		Partially vaccinated contacts (n=39)		Unvaccinated contacts (n=40)	
		PCR positive (n=31)	PCR negative (n=94)	PCR positive (n=7)	PCR negative (n=32)	PCR positive (n=15)	PCR negative (n=25)
Fully vaccinated index cases (n=50)	69	12	31	1	8	4	13
Partially vaccinated index cases (n=25)	35	7	12	3	10	3	0
Unvaccinated index cases (n=63)	100	12	51	3	14	8	12

Non-household exposed contacts (n=24, all PCR negative) were excluded. One PCR-negative household contact who withdrew from the study without vaccination status information was excluded. One PCR-negative household contact who could not be linked to their index case was also excluded. *The rows below show the number of contacts exposed to each category of index case.

Table 2: **Comparison of vaccination status of the 138 epidemiologically linked PCR-positive index cases for 204 delta variant-exposed household contacts**

not significantly higher in unvaccinated (38%, 95% CI 24–53) than fully vaccinated (25%, 18–33) household contacts (table 1). We estimated vaccine effectiveness at preventing infection (regardless of symptoms) with delta in the household setting to be 34% (bootstrap 95% CI –15 to 60). Sensitivity analyses using a 14 day threshold for time since second vaccination to study recruitment to denote fully vaccinated did not materially affect our estimates of vaccine effectiveness or SAR (data not shown). Although precision is restricted by the small sample size, this estimate is broadly consistent with vaccine effectiveness estimates for delta variant infection based on larger datasets.[9,16,17]

The vaccination status of 138 epidemiologically linked index cases of 204 delta variant-exposed household contacts was available (figure 1B, table 2). The SAR in household contacts exposed to fully vaccinated index cases was 25% (95% CI 15–35; 17 of 69), which is similar to the SAR in household contacts exposed to unvaccinated index cases (23% [15–31]; 23 of 100; table 2). The 53 PCR-positive contacts arose from household exposure to 39 PCR-positive index cases. Of these index cases who gave rise to secondary transmission, the proportion who were fully vaccinated (15 [38%] of 39) was similar to the proportion who were unvaccinated (16 [41%] of 39). The median number of days from the index cases' second vaccination to the day of recruitment for their respective contacts was 73 days (IQR 38–116). Time interval did not differ between index cases who transmitted infection to their contacts and those who did not (94 days [IQR 62–112] and 63 days [35–117], respectively; p=0·43).

18 of the 163 delta variant-infected index cases that led to contact enrolment were themselves recruited to ATACCC2 and serial URT samples were collected from them, allowing for more detailed virology and genome analyses. For 15 of these, their contacts were also recruited (13 household contacts and two non-household contacts). A corresponding PCR-positive household contact was identified for four of these 15 index cases (figure 1B). Genomic analysis showed that index–contact pairs were infected with the same delta variant sub-lineage in these instances, with one exception (figure 2A). In one household (number 4), an unvaccinated index case transmitted the delta variant to an unvaccinated contact, while another partially vaccinated contact was infected with a different delta sub-lineage (which was probably acquired outside the household). In the other three households (numbers 1–3), fully vaccinated index cases transmitted the delta variant to fully vaccinated household contacts, with high viral load in all cases, and temporal relationships between the viral load kinetics that were consistent with transmission from the index cases to their respective contacts (figure 2B).

Inclusion criteria for the modelling analysis selected 133 participant's viral load RNA trajectories from 163 PCR-positive participants (49 with the pre-alpha variant, 39 alpha, and 45 delta; appendix p 14). Of the 45 delta cases, 29 were fully vaccinated and 16 were unvaccinated; partially vaccinated cases were excluded. Of the 133 included cases, 29 (22%) were incident (ie, PCR negative at enrolment converting to PCR positive subsequently) and 104 (78%) were prevalent (ie, already PCR positive at enrolment). 15 of the prevalent cases had a clearly resolvable peak viral load. Figure 3 shows modelled viral RNA (ORF1ab) trajectories together with the viral RNA copy numbers measured for individual participants. The E-gene equivalent is shown in the appendix (p 2). Estimates derived from E-gene cycle threshold value data (appendix pp 5, 7, 9, 11) were similar to those for ORF1ab.

Although viral kinetics appear visually similar for all four groups of cases, we found quantitative differences in estimated viral growth rates and decline rates (tables 3, 4). Population (group-level) estimates of mean viral load decline rates based on ORF1ab cycle threshold value data varied in the range of 0·69–0·95 $\log_{10}$ units per mL per daxes 4; appendix p 10), indicating that a typical 10-day period was required for viral load to decline from peak to undetectable. A faster decline was seen in the alpha (*pp*=0·93), unvaccinated delta (*pp*=0·79), and fully vaccinated delta (*pp*=0·99) groups than in the pre-alpha group. The mean viral load decline rate of the fully vaccinated delta group was also faster than those of the alpha group (*pp*=0·84) and the unvaccinated delta group (*pp*=0·85). The differences in decline rates translate into a difference of about 3 days in the mean duration of the decline phase between the pre-alpha and delta vaccinated groups.

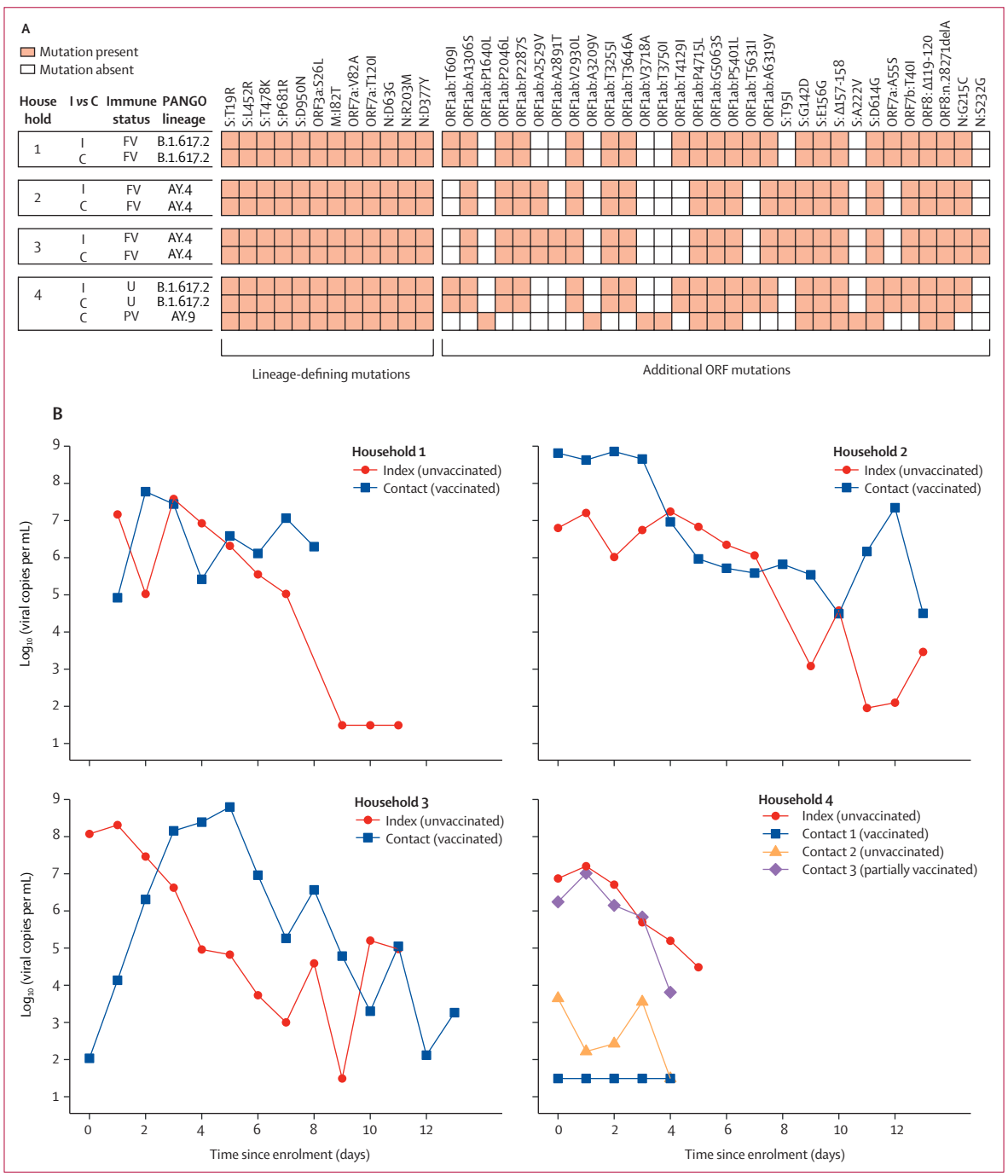
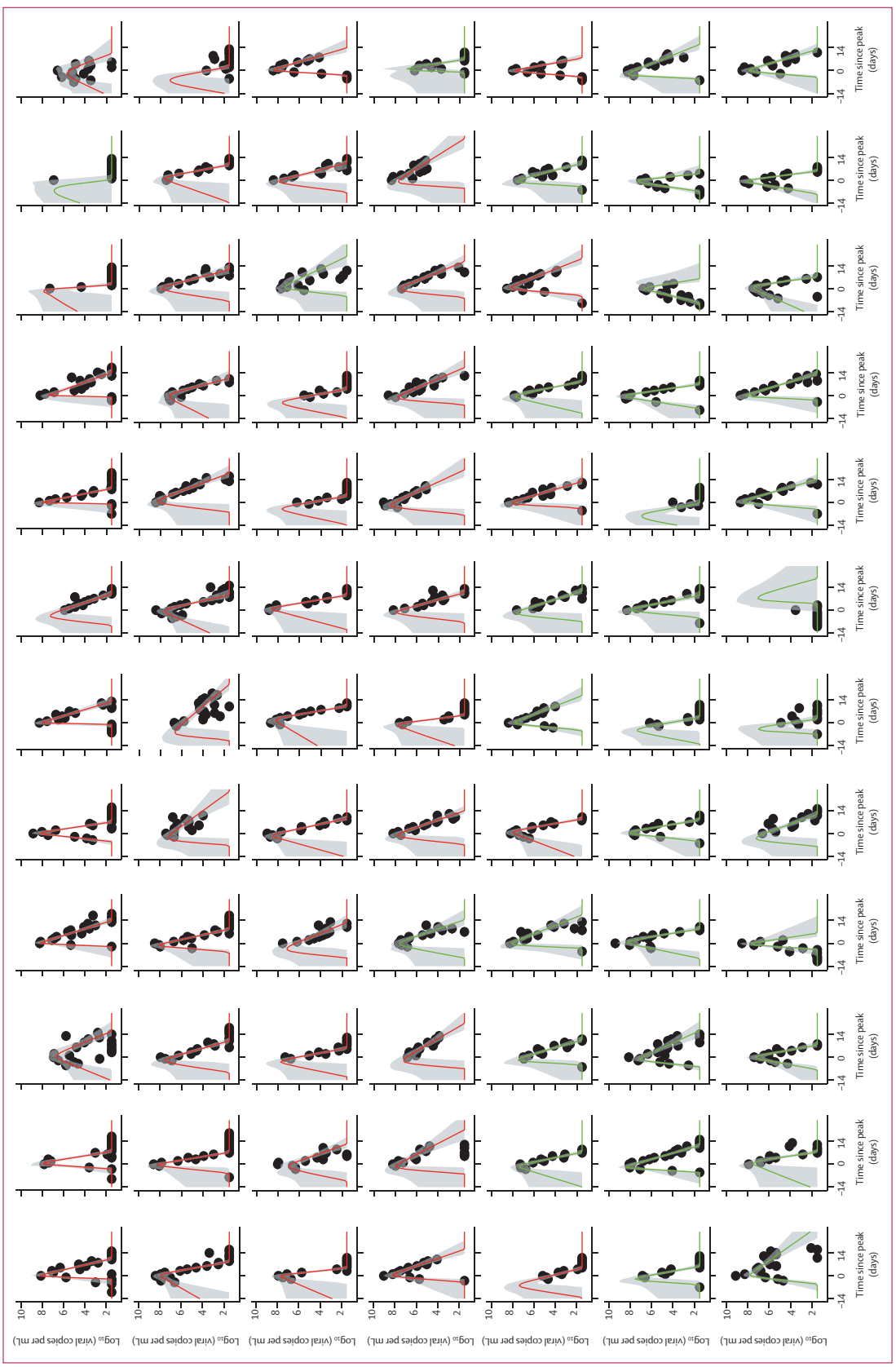


Figure 2: **Virological, epidemiological, and genomic evidence for transmission of the SARS-CoV-2 delta variant (B.1.617.2) in households**
(A) Genomic analysis of the four households with lineage-defining mutations for delta[18] and additional mutations within ORFs displayed to give insight into whether strains from individuals within the household are closely related. Lineages AY.4 and AY.9 are sub-lineages of delta. (B) Viral trajectories and vaccination status of the four index cases infected with the delta variant for whom infection was detected in their epidemiologically linked household contacts. All individuals had non-severe disease. Each plot shows an index case and their household contacts. Undetectable viral load measurements are plotted at the limit of detection ($10^{1\cdot49}$). C=contact. I=index case. FV=fully vaccinated. ORF=open reading frame. PV=partially vaccinated. U=unvaccinated.

Viral load growth rates were substantially faster than decline rates, varying in the range of 2·69–3·24 $\log_{10}$ units per mL per day between groups, indicating that a typical 3-day period was required for viral load to grow from undetectable to peak. Our power to infer differences in growth rates between groups was more restricted than for viral decline, but there was moderate evidence (*pp*=0·79) that growth rates were lower for



(Figure 3 continues on next page)

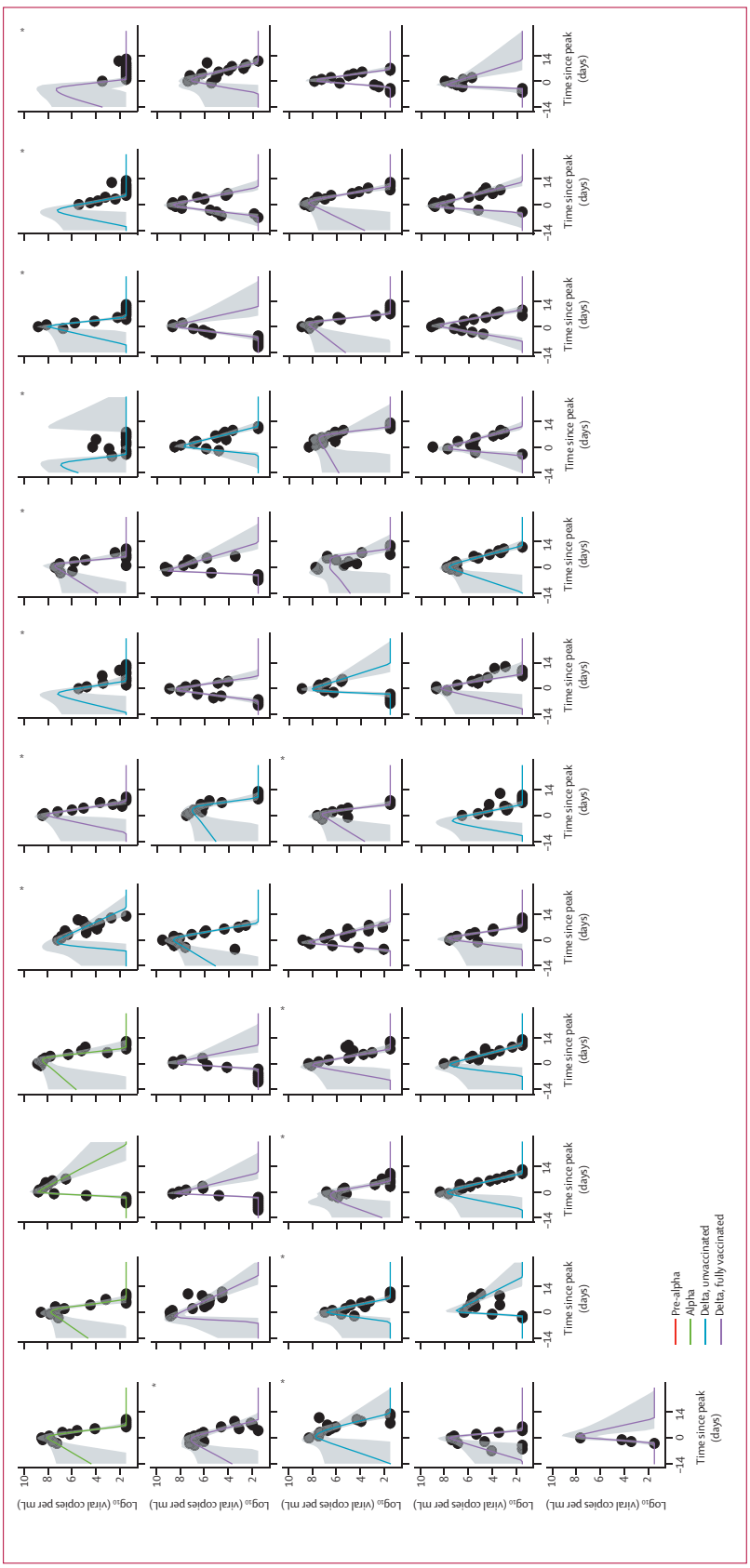


Figure 3: **ORF1ab viral load trajectories from 14 days before to 28 days after peak for 133 participants infected with pre-alpha or alpha variants (uncaccinated), or the delta variant (vaccinated and unvaccinated) variants**
Black circles are measured values, with the first datapoint for each participant being taken to the day of enrolment. Plots are rooted on the day of peak viral load for each participant, denoted as day 0 on the x-axis. Curves show the model posterior median estimate, with a 95% credible interval shading. 133 infected participants, comprising 114 contacts and 19 index cases. *Index cases.

	VL growth rate (95% CrI), log_{10} units per day	Posterior probability estimate is less than pre-alpha	Posterior probability estimate is less than alpha	Posterior probability estimate is less than delta (unvaccinated)	Posterior probability estimate is less than delta (fully vaccinated)
Pre-alpha (n=49)	3·24 (1·78–6·14)	..	0·44	0·27	0·21
Alpha (n=39)	3·13 (1·76–5·94)	0·56	..	0·32	0·25
Delta, unvaccinated (n=16)	2·81 (1·47–5·47)	0·73	0·68	..	0·44
Delta, fully vaccinated (n=29)	2·69 (1·51–5·17)	0·79	0·75	0·56	..

VL growth rates are shown as within-sample posterior mean estimates. Remaining columns show population (group-level) posterior probabilities that the estimate on that row is less than an estimate for a different group. Posterior probabilities are derived from 20 000 posterior samples and have sampling errors of <0·01. VL=viral load. CrI=credible interval.

Table 3: **Estimates of VL growth rates for pre-alpha, alpha, and delta (unvaccinated and fully vaccinated) cases, derived from ORF1ab cycle threshold data**

	VL decline rate (95% CrI), log_{10} units per day	Posterior probability estimate is larger than pre-alpha	Posterior probability estimate is larger than alpha	Posterior probability estimate is larger than delta (unvaccinated)	Posterior probability estimate is larger than delta (fully vaccinated)
Pre-alpha (n=49)	0·69 (0·58–0·81)	..	0·07	0·21	0·01
Alpha (n=39)	0·82 (0·67–1·01)	0·93	..	0·60	0·16
Delta, unvaccinated (n=16)	0·79 (0·59–1·04)	0·79	0·40	..	0·15
Delta, fully vaccinated (n=29)	0·95 (0·76–1·18)	0·99	0·84	0·85	..

VL decline rates are shown as within-sample posterior mean estimates. Remaining columns show population (group-level) posterior probabilities that the estimate on that row is less than an estimate for a different group. Posterior probabilities are derived from 20 000 posterior samples and have sampling errors of <0·01. VL=viral load. CrI=credible interval.

Table 4: **Estimates of VL decline rates for pre-alpha, alpha, and delta (unvaccinated and fully vaccinated) cases, derived from ORF1ab cycle threshold data**

those in the vaccinated delta group than in the pre-alpha group.

We estimated mean peak viral load for 50-year-old adults to be 8·14 (95% CrI 7·95 to 8·32) log_{10} copies per mL, but peak viral load did not differ by variant or vaccination status. However, we estimated that peak viral load increases with age (*pp*=0·96 that the slope of peak viral load with log[age] was >0), with an estimated slope of 0·24 (95% CrI –0·02 to 0·49) log_{10} copies per mL per unit change in log(age). This estimate translates to a difference of 0·39 (–0·03 to 0·79) in mean peak log_{10} copies per mL between those aged 10 years and 50 years.

Within-group individual participant estimates of viral load growth rate were positively correlated with peak viral load, with a correlation coefficient estimate of 0·42 (95% CrI 0·13 to 0·65; appendix p 8). Hence, individuals with faster viral load growth tend to have higher peak viral load. The decline rate of viral load was also negatively correlated with viral load growth rate, with a correlation coefficient estimate of –0·44 (95% CrI –0·67 to –0·18), illustrating that individuals with faster viral load growth tend to experience slower viral load decline.

Discussion

Households are the site of most SARS-CoV-2 transmission globally.[19] In our cohort of densely sampled household contacts exposed to the delta variant, SAR was 38% in unvaccinated contacts and 25% in fully vaccinated contacts. This finding is consistent with the known protective effect of COVID-19 vaccination against infection.[8,9] Notwithstanding, these findings indicate continued risk of infection in household contacts despite vaccination. Our estimate of SAR is higher than that reported in fully vaccinated household contacts exposed before the emergence of the delta variant.[1,20,21] The time interval between vaccination and study recruitment was significantly higher in fully vaccinated PCR-positive contacts than fully vaccinated PCR-negative contacts, suggesting that susceptibility to infection increases with time as soon as 2–3 months after vaccination—consistent with waning protective immunity. This potentially important observation is consistent with recent large-scale data and requires further investigation.[17] Household SAR for delta infection, regardless of vaccination status, was 26% (95% CI 20–32), which is higher than estimates of UK national surveillance data (10·8% [10·7–10·9]).[10] However, we sampled contacts daily, regardless of symptomatology, to actively identify infection with high sensitivity. By contrast, symptom-based, single-timepoint surveillance testing probably underestimates the true SAR, and potentially also overestimates vaccine effectiveness against infection.

We identified similar SAR (25%) in household contacts exposed to fully vaccinated index cases as in those exposed to unvaccinated index cases (23%). This finding indicates that breakthrough infections in fully vaccinated people can efficiently transmit infection in the household setting. We identified 12 household transmission events between fully vaccinated index case–contact pairs; for three of these, genomic sequencing confirmed that the index case and

contact were infected by the same delta variant sub-lineage, thus substantiating epidemiological data and temporal relationships of viral load kinetics to provide definitive evidence for secondary transmission. To our knowledge, one other study has reported that transmission of the delta variant between fully vaccinated people was a point-source nosocomial outbreak—a single health-care worker with a particular delta variant sub-lineage in Vietnam.[22]

Daily longitudinal sampling of cases from early (median 4 days) after exposure for up to 20 days allowed us to generate high-resolution trajectories of URT viral load over the course of infection. To date, two studies have sequentially sampled community cases of mild SARS-CoV-2 infection, and these were from highly specific population groups identified through asymptomatic screening programmes (eg, for university staff and students[23] and for professional athletes[24]).

Our most predictive model of viral load kinetics estimated mean peak $\log_{10}$ viral load per mL of 8·14 (95% CrI 7·95–8·32) for adults aged 50 years, which is very similar to the estimate from a 2021 study using routine surveillance data.[25] We found no evidence of variation in peak viral load by variant or vaccination status, but we report some evidence of modest but significant (pp=0·95) increases in peak viral load with age. Previous studies of viral load in children and adults[4,25,26] have not used such dense sequential sampling of viral load and have, therefore, been restricted in their power to resolve age-related differences; the largest such study[25] reported a similar difference between children and adults to the one we estimated. We found the rate of viral load decline was faster for vaccinated individuals with delta infection than all other groups, and was faster for individuals in the alpha and unvaccinated delta groups than those with pre-alpha infection.

For all variant vaccination groups, the variation between participants seen in viral load kinetic parameter estimates was substantially larger than the variation in mean parameters estimated between groups. The modest scale of differences in viral kinetics between fully vaccinated and unvaccinated individuals with delta infection might explain the relatively high rates of transmission seen from vaccinated delta index cases in our study. We found no evidence of lower SARs from fully vaccinated delta index cases than from unvaccinated ones. However, given that index cases were identified through routine symptomatic surveillance, there might have been a selection bias towards identifying untypically symptomatic vaccine breakthrough index cases.

The differences in viral kinetics we found between the pre-alpha, alpha, and delta variant groups suggest some incremental, but potentially adaptive, changes in viral dynamics associated with the evolution of SARS-CoV-2 towards more rapid viral clearance. Our study provides the first evidence that, within each variant or vaccination group, viral growth rate is positively correlated with peak viral load, but is negatively correlated with viral decline rate. This finding suggests that individual infections during which viral replication is initially fastest generate the highest peak viral load and see the slowest viral clearance, with the latter not just being due to the higher peak. Mechanistically, these data suggest that the host and viral factors determining the initial growth rate of SARS-CoV-2 have a fundamental effect on the trajectory throughout infection, with faster replication being more difficult (in terms of both peak viral load and the subsequent decline of viral load) for the immune response to control. Analysis of sequentially sampled immune markers during infection might give insight into the immune correlates of these early differences in infection kinetics. It is also possible that individuals with the fastest viral load growth and highest peaks contribute disproportionately to community transmission, a hypothesis that should be tested in future studies.

Several population-level, single-timepoint sampling studies using routinely available data have found no major differences in cycle threshold values between vaccinated and unvaccinated individuals with delta variant infection.[10,27,28] However, as the timepoint of sampling in the viral trajectory is unknown, this restricts the interpretation of such results. Two other studies longitudinally sampled vaccinated and unvaccinated individuals with delta variant infection.[23,29] A retrospective cohort of hospitalised patients in Singapore[29] also described a faster rate of viral decline in vaccinated versus unvaccinated individuals with delta variant, reporting somewhat larger differences in decline rates than we estimated here. However, this disparity might be accounted for by the higher severity of illness in unvaccinated individuals in the Singaporean study (almost two-thirds having pneumonia, one-third requiring COVID-19 treatment, and a fifth needing oxygen) than in our study, given that longer viral shedding has been reported in patients with more severe illness.[30] A longitudinal sampling study in the USA reported that pre-alpha, alpha, and delta variant infections had similar viral trajectories.[24] The study also compared trajectories in vaccinated and unvaccinated individuals, reporting similar proliferation phases and peak cycle threshold values, but more rapid clearance of virus in vaccinated individuals. However, this study in the USA stratified by vaccination status and variant separately, rather than jointly, meaning vaccinated individuals with delta infection were being compared with, predominantly, unvaccinated individuals with pre-alpha and alpha infection. Moreover, sampling was done as part of a professional sports player occupational health screening programme, making the results not necessarily representative of typical community infections.

Our study has limitations. First, we recruited only contacts of symptomatic index cases as our study recruitment is derived from routine contact-tracing notifications. Second, index cases were defined as the first household member to have a PCR-positive swab, but we cannot exclude the possibility that another household member might already have been infected and transmitted

to the index case. Third, recording of viral load trajectories is subject to left censoring, where the growth phase in prevalent contacts (already PCR-positive at enrolment) was missed for a proportion of participants. However, we captured 29 incident cases and 15 additional cases on the upslope of the viral trajectory, providing valuable, informative data on viral growth rates and peak viral load in a subset of participants. Fourth, owing to the age-stratified rollout of the UK vaccination programme, the age of the unvaccinated, delta variant-infected participants was lower than that of vaccinated participants. Thus, age might be a confounding factor in our results and, as discussed, peak viral load was associated with age. However, it is unlikely that the higher SAR observed in the unvaccinated contacts would have been driven by younger age rather than the absence of vaccination and, to our knowledge, there is no published evidence showing increased susceptibility to SARS-CoV-2 infection with decreasing age.[31] Finally, although we did not perform viral culture here—which is a better proxy for infectiousness than RT-PCR—two other studies[27,32] have shown cultivable virus from around two-thirds of vaccinated individuals infected with the delta variant, consistent with our conclusions that vaccinated individuals still have the potential to infect others, particularly early after infection when viral loads are high and most transmission is thought to occur.[30]

Our findings help to explain how and why the delta variant is being transmitted so effectively in populations with high vaccine coverage. Although current vaccines remain effective at preventing severe disease and deaths from COVID-19, our findings suggest that vaccination alone is not sufficient to prevent all transmission of the delta variant in the household setting, where exposure is close and prolonged. Increasing population immunity via booster programmes and vaccination of teenagers will help to increase the currently limited effect of vaccination on transmission, but our analysis suggests that direct protection of individuals at risk of severe outcomes, via vaccination and non-pharmacological interventions, will remain central to containing the burden of disease caused by the delta variant.

Contributors

AS, JD, MZ, NMF, WB, and ALal conceptualised the study. AS, SH, JD, KJM, AK, JLB, MGW, ND-F, RV, RK, JF, CT, AVK, JC, VQ, EC, JSN, SH, EM, TP, HH, CL, JS, SB, JP, CA, SA, and NMF were responsible for data curation and investigation. AS, SH, KJM, JLB, AC, NMF, and ALal did the formal data analysis. MAC, AB, DJ, SM, JE, PSF, SD, and ALac did the laboratory work. RV, RK, JF, CT, AVK, JC, VQ, EC, JSN, SH, EM, and SE oversaw the project. AS, SH, JD, KJM, JLB, NMF, and ALal accessed and verified the data. JD, MZ, and ALal acquired funding. NMF sourced and oversaw the software. AS and ALal wrote the initial draft of the manuscript. AS, JD, GPT, MZ, NMF, SH, and ALal reviewed and edited the manuscript. The corresponding author had full access to all the data in the study and had final responsibility for the decision to submit for publication.

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Declaration of interests

NMF reports grants from UK Medical Research Council, UK National Institute of Health Research, UK Research and Innovation, Community Jameel, Janssen Pharmaceuticals, the Bill & Melinda Gates Foundation, and Gavi, the Vaccine Alliance; consulting fees from the World Bank; payment or honoraria from the Wellcome Trust; travel expenses from WHO; advisory board participation for Takeda; and is a senior editor of the *eLife* journal. All other authors declare no competing interests.

Data sharing

An anonymised, de-identified version of the dataset can be made available upon request to allow all results to be reproduced. Modelling code will also be made publicly available on the GitHub repository.

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APP 024

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

OAKLAND DIVISION

MARCIANO PLATA, et al., Plaintiffs, **v.** **GAVIN NEWSOM, et al.,** Defendants.	01-cv-01351-JST **SUPPLEMENTAL DECLARATION OF CONNIE GIPSON IN SUPPORT OF DEFENDANTS' REPLY FOR MOTION TO STAY ORDER RE: MANDATORY COVID-19 VACCINATIONS (ECF NO. 3684) PENDING APPEAL** Date: November 17, 2021 Time: 2:00 p.m. Courtroom: 6, 2nd Floor Judge: The Honorable Jon S. Tigar Action Filed: April 5, 2001

I, Connie Gipson, declare:

1. I have personal knowledge regarding the matters stated in this declaration, except for those statements made on information and belief. I am competent to testify to the matters set forth in this declaration and would do so if called upon to testify. I submit this declaration in support of Defendants' reply supporting their motion to stay this Court's vaccine-mandate orders.

2. I have reviewed Plaintiffs' opposition to Defendants motion to stay and the

Declaration of Tammatha Foss in support. In her declaration, Ms. Foss asserts that noncompliance with the CDPH vaccine mandate at CCHCF and CMF as of October 25, 2021, has no bearing of the likelihood of noncompliance with the vaccine-mandate order going forward because the compliance deadline for the CDPH mandate is not until November 24, 2021. (Decl. Tammatha Foss, ECF No. 3738-2, Nov. 8, 2021, at ¶ 3 ("Because the deadline for compliance has not yet been reached, the number of correctional officers at CHCF and CMF who are not yet fully vaccinated is a particularly poor predictor of how many correctional officers will ultimately choose to leave CDCR employment rather than become vaccinated.").) Ms. Foss is wrong. The CDPH deadline for compliance was October 14. As of the morning of October 25, anyone who remained unvaccinated at CHCF or CMF would have understood that they remained noncompliant eleven days past the deadline for compliance. The afternoon of October 25, the Wardens were notified that the deadline for compliance with the CDPH order would be extended to November 24, 2021. It is not clear how long it took for that information to make its way to all correctional staff, but it would have been sometime after the email notification was sent to the Wardens on October 25. Thus, my conclusion that rates of noncompliance with the CDPH order as of October 25 was the best available evidence of likely noncompliance rates going forward was sound.

3. In my previous declaration, I reported that about 8.26% of correctional officers at CHCF and 10.14% of correctional officers at CMF remained noncompliant with the CDPH order as of October 25. Since then, my staff at CHCF and CMF have discovered that CCHCS's vaccine registry showed some correctional officers as noncompliant even though they had actually been vaccinated. Accordingly, my CHCF and CMF staff went through the entire list of noncompliant correctional officers at those two prisons and meticulously confirmed their vaccination status. In doing so, my staff discovered that several different issues resulted in the incorrect noncompliance data from CCHCS's vaccine registry. My team has now provided me with corrected data for those two prisons. As of November 9, 2021, about 5.2% of correctional officers at CHCF and about 2% of correctional officers at CMF remain noncompliant with the CDPH vaccine mandate. My staff attribute most of the discrepancies in the numbers to the incorrect data in CCHCS's

vaccine registry, but the levels of noncompliance have also gone down because some additional correctional officers have been vaccinated or requested religious exemptions since October 25, 2021. CHCF's rate of noncompliance is still concerning to me because if, for example, 5.2% of staff across the prison system were to refuse to comply with the Court's vaccine-mandate order, the impact on prison operations would be severe.

4. The significant errors in the CCHCS vaccine registry are concerning. I have been informed that CDCR has asked CCHCS look into the accuracy of the data, on which the Court relied in its September 27, 2021 vaccine-mandate order. I also believe that Dr. Bick's declaration in support of the Receiver's recommendation for a vaccine mandate and his declaration in support of the Receiver's opposition to Defendants' stay motion heavily cited data from the vaccine registry that was likely incorrect because, as CDCR staff have discovered, the vaccine registry often does not contain accurate information about vaccinations that occurred in the community, and frequently contains incorrect data concerning who works at particular prisons, among other problems.

5. Although CHCF and CMF can serve as barometers for staff noncompliance they are not representative of the levels of staff resistance to vaccination at all prisons. For example prisons like High Desert State Prison and Pelican Bay State Prison, based on their low staff vaccination rates, seem to be far more at risk of losing substantial numbers of staff as a result of the vaccine-mandate order. And they are also prisons where it is especially difficult to recruit staff to fill vacant positions given their remote location.

6. Plaintiffs seem to contend that noncompliant staff will be free to continue working in the prisons indefinitely regardless of their noncompliance. This assumption is wrong. The disciplinary process will begin on the first day after noncompliance with the vaccine-mandate deadline and the hiring authorities have been directed to promptly initiate and expedite the progressive-discipline process for staff who refuse to comply with the vaccine mandate. The course of progressive discipline for individual staff members is variable depending on aggravating and mitigating factors and individual disciplinary history. But on October 4, 2021, CDCR issued a memorandum that provided guidance to address the noncompliance

accountability process for mandatory staff vaccinations under the CDPH order. That memorandum provided the following hypothetical course of discipline, which was based on a progressive discipline approach consistent with CDCR's disciplinary matrix: (1) letter of instruction issued to noncompliant staff the day after the deadline for compliance; (2) if staff continue to remain noncompliant seven to ten days later, a ten percent pay reduction for a set period; (3) if staff continue to refuse to comply seven to ten days later, another ten percent pay reduction for a longer period; (4) if staff continue to refuse to comply within seven to ten days, an unpaid suspension for a set period; and (5) if staff continue to refuse to comply after an unpaid suspension, termination. It is my understanding that the progressive-discipline memorandum for noncompliance with the Court's vaccine mandate will be substantially similar to the October 4 memorandum. Further, under this disciplinary process, noncompliant staff will face salary reductions consistent with the disciplinary matrix within a relatively short period—likely within 2 months after the compliance deadline. Thus, Plaintiffs' assumption that noncompliant staff will simply continue to work in the prisons indefinitely during the progressive discipline process is incorrect.

7. Plaintiffs seem to contend that because Washington's correctional department asserted that it was able to absorb a 4.5% reduction in staff without an impact to prison operations, CDCR should be able to do the same. Plaintiffs' assertion seems to be based on a number of false assumptions, not the least of which is that Washington's prison system and staffing levels are the same as CDCR's prison system and staffing levels. Regardless, based on my knowledge about current staffing levels and my detailed understanding of CDCR's prison operations, I am certain that a statewide 4.5% decrease in prison staff would have a substantial adverse impact on prison operations, and would preclude a number of prisons from offering regular programming.

8. I understand that Plaintiffs have asserted that Defendants' delay in bringing the motion to stay demonstrates that there is no real concern about the harm that the vaccine-mandate order may cause. My concern about staffing issues is real and not less urgent or important because of the timing of Defendants' motion. I have always had concerns that if the Court

mandated staff vaccinations, we might face serious staffing challenges, but as the October 14, 2021 deadline for compliance with the CDPH's order approached, my concerns dramatically increased when I realized that rates of noncompliance with the CDPH order were very high and continued to be relatively high even after that initial deadline passed. And my concerns grew again when I learned that 4.5% of Washington's correctional staff left Washington's Department of Corrections in response to a vaccine mandate. These events unfolded in the weeks *after* the Court's vaccine-mandate order issued. The district court's subsequent order setting a January 12, 2021 compliance deadline has also greatly increased my level of concern because the staffing issues I identified are not likely to be ameliorated before that date.

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9. I understand that Plaintiffs cited a former declaration of mine from last year to support their contention that a prison could get by on severely reduced staffing levels. It is true that essential functions of a prison can be maintained for some limited period of time even in the face of severe staffing shortages. But as I discussed in my October 25 declaration, such severe staffing shortages go hand-in-hand with a number of serious harms, including: (1) adverse impacts on safety, security, and order within the prison; (2) officer fatigue and burnout; (3) more staff injuries and requests for extended leave; (4) suspension of programming so that staff can focus on providing essential services and maintaining critical prison operations; and (5) increases in rates of attrition which can exacerbate staffing problems. Additionally, as I explained in my October 25 declaration, one of the ways to mitigate a serious staffing shortage at a single prison is to redirect staff from other nearby prisons. But if the other nearby prisons are also contending with staffing shortages, this is not an option.

I declare under penalty of perjury that I have read this document, and its contents are true and correct to the best of my knowledge. Executed on November 11, 2021, in Sacramento, California.

/s/ *CONNIE GIPSON*

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

MARCIANO PLATA, et al., **Plaintiffs,** **v.** **GAVIN NEWSOM, et al.,** **Defendants.**	**CASE NO. 01-cv-01351-JST** **SEIU LOCAL 1000's MOTION FOR LEAVE TO FILE AMICUS CURIAE BRIEF AND RESPONSE TO CALIFORNIA CORRECTIONAL PEACE OFFICERS' ASSOCIATION'S MOTION FOR STAY OF SEPTEMBER 27, 2021 ORDER RE: MANDATORY VACCINATIONS & DEFENDANTS' MOTION TO STAY** Hearing Date: November 17, 2021 Time: 2:00 p.m. Judge: Hon. Jon S. Tigar Courtroom: 6

MOTION FOR LEAVE TO FILE AMICUS BRIEF

Movant, SERVICE EMPLOYEES INTERNATIONAL UNION, LOCAL 1000 ("SEIU" or "amicus curiae"), respectfully requests leave to file the attached amicus brief in support of California Correctional Peace Officers' Association's ("CCPOA") Motion For Stay of September 27, 2021 Order Re: Mandatory Vaccinations (ECF No. 3722) ("CCPOA's Motion") and Defendants' Motion to Stay Order Re Mandatory Vaccinations (ECF No. 3715) ("Defendants' Motion"). The Court previously granted SEIU's request to file an Amicus Brief

in response to the underlying Order to Show Cause Re: Receiver's Recommendation on Mandatory Vaccination dated August 9, 2021, and in opposition to the Receiver's recommendation for a mandatory vaccination policy for all California Department of Corrections and Rehabilitation ("CDCR") institutional staff. (ECF No. 3678).

INTEREST OF AMICUS CURIAE

SEIU is the exclusive representative for over 99,000 California state employees across nine bargaining units. Over 12,000 of those SEIU-represented employees work at CDCR institutions. The Ralph C. Dills Act (Cal. Govt. Code §§3512 - 3524) (hereinafter "the Dills Act") provides recognized employee organizations like SEIU with collective bargaining rights on behalf of the employees they represent. SEIU's mission is to protect the rights of the employees that it represents, including those working at CDCR facilities, who would be subject to the mandatory vaccination policy, and be forced to make important irrevocable decisions about their health and their careers while the policy is under appeal if the Stay is not granted. SEIU thus has an organizational interest in protecting the employees it represents from the uncertainties created by not staying the Order while under appeal.

The proposed amicus curiae brief will assist the Court in deciding the matter by highlighting the effects on the employees represented by SEIU of the uncertainty created if the Stay is not granted with respect to state workers' rights and conditions of employment. WHEREFORE, SEIU respectfully requests leave to file the attached brief as amicus curiae.

NO PAYMENT BY ANY PARTY TO PREPARE THIS APPLICATION

This motion and amicus curiae brief was prepared exclusively by SEIU and its counsel. SEIU did not receive any contribution or payment from any party, party's counsel, or any other person or entity, to fund the preparation or submission of this brief.

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

Before The Honorable Jon S. Tigar, Judge

MARCIANO PLATA, ET AL.,	)	
	)	
Plaintiffs,	)	
	)	
VS.	)	**NO. CV 01-01351-JST**
	)	
GAVIN NEWSOM, ET AL.,	)	
	)	
Defendants.	)	
	)	

Oakland, California
Thursday, October 28, 2021

TRANSCRIPT OF PROCEEDINGS

CASE MANAGEMENT CONFERENCE HELD VIA ZOOM

APPEARANCES:

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Reported By: Pamela Batalo-Hebel, CSR No. 3593, RMR, FCRR
Official Reporter

brief disclosure about Dr. Brie Williams, whom all of you know who that is. She's on my advisory board. And there are a couple of items from the Case Management Statement that I just want to acknowledge, really. And then I'll turn it over to you, and you can tell me what else you want to talk about.

As I talk about any of the items I've just mentioned, of course I also will want to hear from you.

That's how I'm going to proceed today so it's just a little bit of a different roadmap.

Let's start with the schedule for responding to the motions to stay. I started by trying to figure out when could I conduct a hearing on this motion. I'm in the midst of my fifth trial right now in seven months so my calendar is more onerous than it normally would be.

The hearing will occur on the afternoon of November 17th. Now, I believe the proposed schedule that the Defendants gave was for oppositions to be filed on the 4th, a reply to be filed on the 9th. Normally I would have that reply due on something like this about a week before the hearing, so there's a day's -- I didn't want to give the Defendants more time than they asked for, but on the other hand, normally I probably would set that reply on the 10th so I will let you tell me what you think I should do there.

And I would like to -- the only other two things I would say before turning it over to you are, first, I want the CCPOA

motion to be on the same schedule, for obvious reasons, and I'm assuming that CCPOA and the Defendants will not respond to each other's motions. What we'll have is on the opposition date, whenever that is, the Receiver and the Plaintiffs can file oppositions to the motions to stay, if they want, and then on the reply date, the Defendants and CCPOA can file reply briefs on their respective motions.

So that's how I'm thinking about that schedule.

Mr. Specter, do you want to weigh in on this?

MR. SPECTER: Sure, Your Honor.

Certainly the 17th is fine for a hearing date. We would just request a few more days for the opposition to be due, given the length of time that Defendants had to prepare their motion, the seriousness of the issue, the factual nature of some of the presentations made by the State, and so we would like the oppositions to be due on November 8th.

THE COURT: It will probably be a little tough for me to stick with that November 9th reply date if I adopt your suggestion. And just as a preview of coming attractions, I will say I'm not going to squeeze myself on the hearing date. So the parties can ask for more time. That's fine. But I'm assuming that you know that I'm going to build in a certain amount of time between the reply brief and the hearing date, and so your request to me about briefing deadlines will include your analysis of the urgency of getting the hearing date. So

that's where we are.

Who wants to speak for the Defendants on this briefing schedule issue? Mr. Mello?

MR. MELLO: I can, Your Honor.

So two things. Number one, that painting is not a Jimi Hendrix painting from the earlier pandemic, number one.

Number two, we have a little bit of concern, and we have concern in light of last night's order about the timing of a potential ruling on a motion to stay and therefore timely filing a motion in the Ninth Circuit in light of the fact that the first doses will be in arms sometime in December, so we have some concern, so I was actually going to suggest that the parties meet and confer about it, but it sounds like your schedule is very rough.

THE COURT: Well, you can certainly -- certainly you can meet and confer. I wasn't surprised by the motion. I was surprised that there was a month between the issuance of my order and the motion. And, you know, I -- the order itself expresses that view. So -- but I'm -- but if you think it makes sense for the parties to meet and confer and then put in competing proposals tomorrow, we could handle it that way.

MR. MELLO: My only concern is that Your Honor has indicated the 17th is the first date. We would actually want an earlier date, and it sounds like that's what is the legal impossible with respect to your calendar, and so that's the

issue. So maybe meeting and conferring doesn't make sense.

I just wanted to bring up the issue that we have that concern that we didn't have before yesterday at 6:00 p.m. when we got the timing with respect to your order. That's it. I'm not solving anything. I'm just identifying a potential issue.

THE COURT: Okay. So if we're not going to meet and confer offline, what should I do right now?

MR. MELLO: I think you should set your schedule. I don't think that Plaintiffs or the Receiver's counsel can come up with a new date on your calendar. It sounds like that's not possible. I'm more concerned about your hearing date, Your Honor, than the parties.

THE COURT: Okay. I'm trying to set a schedule in which an opposition brief is due on a certain date, a reply brief is due on a certain date, and then I have a hearing.

I have a suggestion -- I have a request from Mr. Specter, and are you asking that I accept that suggestion and then -- or consider that suggestion and then issue the briefing schedule that I think is appropriate?

MR. MELLO: I guess --

THE COURT: Besides wanting an earlier hearing than November 17th, which I can't do, it's not clear to me what the Defendants want me to do with the schedule. That's all.

MR. MELLO: Okay. So if the 17th is the earliest hearing date, we will not object to Plaintiffs' request as long

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

OAKLAND DIVISION

MARCIANO PLATA, et al.,

Plaintiffs,

v.

GAVIN NEWSOM, et al.,

Defendants.

CASE NO. 01-1351 JST

Defendants' Supplemental Notice re: Motion to Stay Orders re: Mandatory Vaccinations (ECF No. 3684) Pending Appeal

Re: ECF No. 3715

To the Court, parties, and their counsel of record:

On September 27, 2021, the Court ordered Defendants and the Receiver to file a joint plan implementing the Receiver's recommendation that vaccinations be mandated for all workers entering CDCR's prisons and for certain incarcerated people. (ECF Nos. 3638, 3684.) Defendants appealed that order on October 12, 2021. (ECF No. 3693.)

Defendants then moved to stay the September 27 order pending appeal on October 25, 2021. (ECF No. 3715.) On October 27, 2021, the Court issued an order mandating that full

vaccinations of all persons subject to the September 27 order occur by January 12, 2022. (ECF No. 3721.) The next day, the Court set a briefing schedule for Defendants' stay motion. (ECF No. 3724.)

Defendants' stay motion did not mention the October 27 order because it had not yet been issued, but the grounds on which Defendants moved for a stay of the September 27 order apply equally to the October 27 order. The irreparable harms Defendants described in their stay motion areeven more imminent now given that, per the recent order, all staff must be fully vaccinated by January 12, 2022. (ECF No. 3715-1 at 20.)

For the reasons outlined in Defendants' stay motion (and their anticipated reply), the Court should stay the September 27 and October 27 orders.

Dated: October 30, 2021

HANSON BRIDGETT LLP

/s/ Paul B. Mello
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SAMANTHA D. WOLFF
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DAVID CASARRUBIAS
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Dated: October 30, 2021

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

OAKLAND DIVISION

MARCIANO PLATA, et al., Plaintiffs, **v.** **GAVIN NEWSOM, et al.,** Defendants.	01-cv-01351-JST **AMENDED NOTICE OF APPEAL TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT** Judge: The Honorable Jon S. Tigar

On October 12, 2021, Defendants appealed to the U.S. Court of Appeals for the Ninth Circuit from this Court's order of September 27, 2021 (ECF No. 3693). On October 27, 2021, this Court issued an order that supplemented its September 27 order, which is the subject of the Defendants' pending appeal, by setting a compliance deadline. (ECF No. 3721). Defendants hereby amend their notice of appeal to the U.S. Court of Appeals for the Ninth Circuit to include the order of October 27, 2021 (ECF No. 3721).

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Dated: October 30, 2021

Respectfully submitted,

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Supervising Deputy Attorney General

/s/ Iram Hasan
IRAM HASAN
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Dated: October 30, 2021

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

MARCIANO PLATA, et al.,

Plaintiffs,

v.

GAVIN NEWSOM, et al.,

Defendants.

Case No. 01-cv-01351-JST

ORDER SETTING DEADLINE FOR MANDATORY VACCINATION

On September 27, 2021, the Court ordered mandatory vaccination of certain persons and required Defendants and the Receiver to submit an implementation plan, including a deadline by which all covered persons must be vaccinated, by October 12, 2021. ECF No. 3684. Defendants and the Receiver jointly filed the required plan with a deadline for covered persons to be fully vaccinated by November 29, 2021. ECF No. 3694. Defendants subsequently indicated some confusion over whether the deadline was as stated in the filed plan, explaining that they had requested a December 20, 2021 deadline to which the Receiver did not agree. ECF No. 3703. The Court ordered Defendants to meet and confer to attempt to resolve any dispute that might exist over the implementation deadline. ECF No. 3705.

The Receiver has now requested an order setting a specific implementation deadline. ECF No. 3708. The Court has reviewed the Receiver's and Plaintiffs' filings in support of such an order, and Defendants' and Intervenor California Correctional Peace Officers' Association's filings in opposition. ECF Nos. 3707-08, 3710-13, 3720.

In light of the compelling public health considerations underlying the vaccination order, as well as the significant passage of time – thirty days since the Court issued its order – without any apparent action aside from the October 12 joint filing of an implementation plan, the Court agrees

with the Receiver that it is appropriate to set a specific vaccination deadline at this time.[1] The Court now orders that full vaccination of the persons covered by the September 27, 2021 order occur no later than January 12, 2022.

Without deciding whether Defendants are required to meet and confer with CCPOA and other unions, the Court notes that this deadline allows ample time for such meeting and conferring. Defendants contend that they require 60 days to meet and confer with various unions, *e.g.*, ECF No. 3720-1 at 4, and CCPOA has argued that "a minimum period of six weeks . . . before any mandate takes effect" would be appropriate. ECF No. 3669 at 11. In addition, recent orders of the California Department of Public Health have required full vaccination in ten or eleven weeks from the date the mandates have been announced. ECF No. 3663-1 at 260-61 (August 5, 2021 CDPH order requiring first dose of one-dose regimen or second dose of two-dose regimen by September 30, 2021 – eight weeks later[2]); *id.* at 270 (August 19, 2021 CDPH order requiring first dose of one-dose regimen or second dose of two-dose regimen by October 14, 2021 – again, eight weeks later); CDPH, *Order of the State Public Health Officer re: Adult Care Facilities and Direct Care Worker Vaccine Requirement*, https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Adult-Care-Facilities-and-Direct-Care-Worker-Vaccine-Requirement.aspx (September 28, 2021 CDPH order requiring first dose of one-dose regimen or second dose of two-dose regimen by November 30, 2021 – nine weeks later).

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[1] On October 25, 2021, Defendants filed a motion to stay the Court's September 27, 2021 order. ECF No. 3715. There has yet been no opportunity to oppose the motion, which the Court will consider once it is ripe. The Court will discuss a briefing and hearing schedule on Defendants' motion to stay at tomorrow's case management conference.

[2] A person is considered fully vaccinated two weeks after receiving either of these doses. CDPH, *Order of the State Public Health Officer re: Health Care Worker Protections in High-Risk Settings* (July 26, 2021), https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Unvaccinated-Workers-In-High-Risk-Settings.aspx.

A January 12, 2022 deadline is eleven weeks from the date of this order, and more than fifteen weeks since the Court ordered mandatory vaccination on September 27, 2021.

IT IS SO ORDERED.

Dated: October 27, 2021

JON S. TIGAR
United States District Judge

Local Politics
The Seattle Times

Nearly 1,900 Washington state workers quit or are fired over COVID vaccine mandate

Oct. 19, 2021 at 8:01 pm | *Updated Oct. 20, 2021 at 4:06 am*

A Washington State Patrol trooper stands near a bust of President George Washington in the Legislative Building at the Capitol in Olympia. Nearly 1,900 state workers have left their... (Ted S. Warren / AP) **More**

By Joseph O'Sullivan and Christine Clarridge
Seattle Times staff reporters

OLYMPIA — About 3% of the 63,000 Washington state workers subject to Gov. Jay Inslee's COVID-19 vaccine mandate have left their jobs or were terminated as this week's deadline passed.

So far, 1,887 state employees were terminated or left their positions over the mandate that they be fully vaccinated by Oct. 18 or lose their jobs, according to the Office of Financial Management.

Another roughly 3%, or 1,927 workers, received an accommodation that allows them to work in a less-public role without being vaccinated.

An additional 4.6% of state workers — nearly 2,900 — are still in a state of flux, according to a

statement by OFM Tuesday afternoon.

That means they may have more time to get the vaccine or could be retiring, according to OFM. Others in that group could still be waiting to see if they get an accommodation — and if not, could still lose their jobs. Those outcomes will be determined in the weeks to come.

Of the state workers still employed, more than 92% are verified as vaccinated.

“The high number of state employees who have gotten vaccinated is good news,” wrote Inslee spokesperson Tara Lee in an email. “Good for the workers, their colleagues and the people they serve.

“While we are sorry to see that 3% go and we wish them well, we are pleased that it is not higher,” she added.

The vaccination push came as a fifth COVID-19 wave slammed into the state. It struck the unvaccinated particularly hard, causing a spike in deaths and hospitalizations across rural Washington, where vaccination rates have lagged behind urban areas.

In August, the governor put in place some of the strictest mandates in the nation, requiring state and school employees — as well as hundreds of thousands of health care workers — to get the jabs or lose their jobs.

But with the deep division and politicization over the pandemic and public health measures to curb it, Inslee’s mandates spurred protests, lawsuits and fierce backlash from conservatives.

In a statement Tuesday, conservative Republicans slammed the departure of workers and again decried Inslee’s use of emergency powers since the pandemic began.

“But I don’t think any of us realized it would come to this, and I think many in the state Legislature are having second thoughts today,” said Sen. Jeff Wilson, R-Longview, in prepared remarks. “Other states are requiring vaccinations, but none of them have taken it to the level of mass terminations. When one person makes all the decisions, there can be no question who is at fault.”

As workers protested the mandate, there were concerns that an exodus could hurt the government’s ability to provide services, from prisons and highway patrols to child-abuse investigations.

The high vaccination rates, however, have dampened some of those concerns.

At the Department of Corrections, about 350 workers — roughly 4.5% of the agency workforce — are leaving. But those numbers are spread out across 12 prisons, plus the administrative headquarters and other offices.

“All facilities have adequate staffing for operations,” wrote DOC spokesperson Rachel Ericson in an email.

The employees leaving state service range from a custodian at the Capitol campus to Washington State Patrol troopers around the state and Washington State University football coach — and highest-paid public employee — Nick Rolovich.

Numbers at other large agencies in recent days, according to their spokespeople, included:

● At the Department of Social and Health Services, 92% of 15,670 workers have been verified as vaccinated. About 3% have received an accommodation that allows them to keep working without the vaccine. Another 2% — or roughly 313 workers — have been let go. The remaining workers have a request for accommodation pending or have started the vaccination process.

● At the Washington Department of Transportation, 402 employees are leaving over the mandate, according to that agency. That includes about 130 workers in the ferries division, which alone employs roughly 2,000.

● At the Department of Fish and Wildlife, about 38 staff — or 2% of the agency’s workforce — lost their jobs over the mandate.

● At the Washington State Patrol, 127 individuals had left over the mandate, or nearly 6% of the agency workforce.

Those departures included, according to WSP, 53 civil servants and 74 commissioned officers: 67 troopers, 6 sergeants, and 1 captain.

“We will miss every one of them,” said Chief John R. Batiste in a statement Tuesday morning. “I truly wish that you were staying with us. You have my utmost appreciation for the hard and successful work that you have provided during your valued WSP careers. You will forever have our respect for your courage and your commitment in all you have done on behalf of the agency.”

Later on Tuesday morning, the Spokane County Sheriff's Office — which does not have a vaccine mandate in place — was posting recruiting notices on social media.

In a tweet, the office called out to troopers and other law enforcement subject to mandates.

"Looking for a place where you are appreciated & wanted?" read the tweet, which included a recruitment video featuring Sheriff Ozzie Knezovich. "Please contact a member of our Recruitment Team today."

Staff reporter Mike Lindblom contributed to this report.

More on the COVID-19 pandemic

- Live updates from Seattle, Washington state and the world, Oct. 20
- Nearly 1,900 Washington state workers quit or are fired over COVID vaccine mandate
- Oregon approved state employee religious exemptions at twice the rate Washington did
- White House details plan to vaccinate children age 5-11
- Proof of vaccination will soon be required; here's what you need to know
- Hawaii welcomes travelers again as COVID counts drops
- Full coverage of the coronavirus here and around the world

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

OAKLAND DIVISION

MARCIANO PLATA, et al., Plaintiffs, **v.** **GAVIN NEWSOM, et al.,** Defendants.	01-cv-01351-JST **DECLARATION OF CONNIE GIPSON IN SUPPORT OF DEFENDANTS' MOTION TO STAY ORDER RE: MANDATORY COVID-19 VACCINATIONS (ECF NO. 3684) PENDING APPEAL** Date: December 9, 2021 Time: 2:00 p.m. Courtroom: 6, 2nd Floor Judge: The Honorable Jon S. Tigar Action Filed: April 5, 2001

I, Connie Gipson, declare:

1. I have personal knowledge regarding the matters stated in this declaration, except for those statements made on information and belief. I am competent to testify to the matters set forth in this declaration and would do so if called upon to testify. I submit this declaration in support of Defendants' motion to stay this Court's September 27, 2021 order regarding mandatory COVID-19 vaccinations (ECF No. 3684) pending appeal.

2. I have thirty-three years of experience working for the California Department of Corrections and Rehabilitation (CDCR) and I am currently the Director of CDCR's Division of Adult Institutions. I started my career at CDCR as a medical technical assistant at the California Institution for Women, where I worked from 1988 to 1997. From 1997 to 2008, I held several positions at Wasco State Prison, including captain, business manager and health program coordinator. From 2008 to 2010, I was the Associate Warden at North Kern State Prison. From 2010 to 2013, I served in multiple positions at California State Prison, Corcoran, including as Warden, Acting Warden and Chief Deputy Warden. From 2013 to 2016, I served as the Associate Director of general population male offenders at CDCR's Division of Adult Institutions. From 2016 to 2019, I served as deputy director of facility operations at the Division of Adult Institutions. In 2019, I was promoted to the Acting Director of the Division of Adult Institutions, and was appointed to my current position as the Director in April 2019. I am competent to testify to the matters set forth in this declaration and, if called upon by this Court, would do so. I submit this declaration in support of Defendants' motion to stay the Court's vaccine-mandate order.

3. As the Director of Adult Institutions, I am responsible for monitoring and managing staffing levels of correctional officers in CDCR's prisons. Correctional officers are sworn peace officers responsible for, among many other things, maintaining safety, security, and order in the prisons. Programming for the incarcerated population is not possible without sufficient numbers of correctional officers. I currently oversee about 28,248 correctional officers, sergeants, lieutenants, captains, and counselors. This part of my job is extremely important because sufficient officer staffing levels are required to maintain safety, security, and order throughout the prisons. Prisons cannot operate safely without sufficient numbers of correctional officers. And sufficient officer staffing levels are also required to provide the incarcerated population with essential services—such as medical care and meals—and recreational and rehabilitative programming—such as yard, day room, education, self-improvement, and work programs.

4. My team and I closely track staffing levels and strive continuously to ensure sufficient staffing levels throughout the prisons. My staff regularly prepare detailed projections

of correctional officer staffing levels for each prison. These projections account for incoming cadets, lateral transfers into and out of each prison, planned retirements, and estimated attrition. We use these projections to plan for potential staffing shortages and to manage staffing issues.

5. As the Director of Adult Institutions, I am also responsible for monitoring and managing staffing levels of essential noncustodial workers throughout the prisons, such as culinary staff, electricians, plumbers, carpenters, maintenance mechanics, warehouse workers, and administrative staff. I currently oversee about 8,558 noncustodial workers throughout CDCR's prisons. These workers are also critical to prison operations. If culinary positions are insufficiently staffed it becomes challenging to provide meals for the prison population. If electrician, plumber, and maintenance mechanic positions are insufficiently staffed, work orders for various critical repairs throughout the prisons cannot be timely completed. And if there are insufficient administrative personnel, critical administrative functions that keep the prisons running cannot be timely carried out. The basic functions of each prison depend on these worker classifications.

6. Although different prisons may be impacted differently by officer vacancies, lower levels of officer vacancies usually result in increased voluntary overtime, occasional involuntary overtime for officers, and little to no impact to programs for the incarcerated population. However, as officer vacancies increase, significant operational impacts are likely, including more extensive involuntary overtime for correctional officers and reductions in programming for the incarcerated population, including recreation, day room, rehabilitation, education, and work programs. Officer fatigue, burn out, and injuries tend to increase when vacancies are higher, and continue to increase as vacancy levels rise. High officer vacancies can also have severe impacts on prison operations and security, require drastic cuts in programming, and even basic services, such as phone calls and daily showers for the incarcerated population must be curtailed. Limiting or suspending these programs allows the prison to redirect correctional officers to help ensure the delivery of essential services, such as medical care and meals for the incarcerated population. High vacancy levels also place a high level of stress on correctional officers, who are required to work extensive overtime. As a result, more officers request extended periods of leave, which can

further exacerbate staffing shortages. If the number of vacancies continues to increase, all programming may need to be suspended, and the incarcerated population might be required to remain in cells or dorms for extended periods.

7. Extremely high vacancy rates also create challenges for prisons to maintain safety, security, and order, and the risk of security breaches and violence rises. This is because there may be insufficient staff on hand to adequately respond to serious security breaches and to maintain order. Violent security breaches can lead to physical injuries to staff and incarcerated people, and result in workers compensation claims and lawsuits.

8. What has recently happened at two of CDCR's prisons—California Medical Facility (CMF) in Vacaville and California Health Care Facility (CHCF) in Stockton—affirmed and greatly increased my concerns that a requirement to vaccinate all correctional officers with no testing option will cause a substantial increase in correctional-officer vacancies above current projections. Because CMF and CHCF are both medical prisons, an order issued by the California Department of Public Health (CDPH) in August 2021 already mandates that all staff at CMF and CHCF, including all correctional officers, be vaccinated. The deadline for compliance with that CDPH order was October 14, 2021. I have been closely watching what is happening at CMF and CHCF because they can serve as a barometer for what will happen when all correctional officers at all prisons are required to accept the vaccine as a condition of employment under the vaccine-mandate order. As of October 25, 2021—eleven days past the deadline for mandatory compliance with CDPH's order—78 (8.26%) of CHCF correctional officers, and 72 (10.14%) of CMF correctional officers had neither complied by taking the vaccine nor sought a medical or religious exemption. Although Kern County Superior Court issued a temporary restraining order from the bench in the afternoon on October 13, 2021, prohibiting CDCR from enforcing mandatory vaccinations against the correctional officers covered by the CDPH order, that court ultimately denied the union's request for a preliminary injunction and lifted the temporary restraining order on October 22, 2021. The high levels of noncompliance up through October 25, 2021, indicate that substantial numbers of officers are simply refusing to comply with the CDPH order. If correctional officers at other institutions exhibit similar rates of noncompliance when

the vaccine-mandate order is implemented, the statewide impact will be devastating to CDCR's prison operations.

9. The vigorous pushback from the unions on the CDPH vaccine mandate for healthcare settings is also concerning. The California Correctional Peace Officers Association has sued CDCR in Kern County to block the implementation of the CDPH order; the American Federation of State, County, and Municipal Employees has issued a letter to CDCR and California Correctional Health Care Services (CCHCS) on behalf of psychiatric technicians who work in CDCR's prisons, demanding that CDCR and CCHCS cease and desist from enforcing the CDPH order; and the Service Employees International Union has filed an unfair labor practice charge with California's Public Employment Relations Board against CDCR and CCHCS for implementing the CDPH order.

10. Furthermore, events in another West Coast jurisdiction also forecast that California's prisons will likely experience a significant adverse impact on staffing if the vaccine-mandate order is not stayed. The Seattle Times reported on October 19, 2021, that as a consequence of Washington's vaccine mandate for state workers, the Department of Corrections lost about 4.5% of its prison staff. Although the article stated that a spokesperson for the department asserted that Washington's prisons were still sufficiently staffed to operate, if CDCR were to lose 4.5% of its prison staff across the state, the impact on prison operations would be severe, and normal operations would not be possible in all of CDCR's prisons.

11. It is also noteworthy that as of October 15, 2021, CDCR has received 1,738 religious accommodation requests across multiple classifications of prison workers. About 1,160 of those requests were from custody staff, who are comprised of correctional captains, correctional lieutenants, correctional sergeants, correctional officers and correctional counselors. This too seems to indicate that staff resistance to the vaccine-mandate order will be substantial.

12. If CMF and CHCF's noncompliance rates are consistent across other classifications of workers besides correctional officers throughout the prisons, the impact on operations will be crippling. Prisons simply cannot function without sufficient culinary staff to prepare meals,

sufficient maintenance workers to make critical repairs to electrical, plumbing, and ventilation systems as problems arise, or sufficient administrative staff.

13. If the vaccine-mandate order is implemented, there is also a high risk that a substantial number of highly experienced and skilled officers will simply choose to retire rather than be vaccinated. Difficult and stressful pandemic conditions in the prisons have already resulted in a higher number of retirements than is usual. The resulting staff shortages on top of pandemic conditions required extensive involuntary overtime at some prisons during the pandemic, which resulted in officer injuries, burn out, and increased requests for extended periods of leave. Approximately 729 unvaccinated correctional officers have been employed for over twenty years and are over age 50. This means that they could retire at any time. CDCR normally relies heavily on incoming cadets to help fill positions of officers who have retired, but as discussed below, the cadet resource has been deficient. Consequently, if a significant portion of these officers were to retire in lieu of taking the vaccine, the impact to CDCR's staffing levels and operations would be severe.

14. The likely impact of the vaccine-mandate order will come at a time when CDCR's staffing levels have already been significantly impacted by the COVID-19 pandemic. That is why I was very concerned about the Receiver's recommendation to vaccinate all CDCR staff. Since the pandemic began, staffing levels across the prison system have fallen for a number of reasons, one of which is fewer graduating cadets. CDCR's Correctional Officer Academy has been generating fewer cadets during the pandemic than in previous years. For example, before the pandemic, in fiscal year 2018/19, the Academy graduated 1,608 cadets; in 2019/20, there were 1,316 cadet graduates; and in 2020/21 there were only 892 cadet graduates. So far, only 461 cadets have graduated in fiscal year 2021/22. With fewer cadets graduating, it is difficult for CDCR to timely replace officers who quit or retire. Additionally, significant numbers of current cadets in the academy have not been vaccinated, and I have serious concerns that the vaccine mandate is likely to further reduce the number of graduating cadets who will take positions in CDCR's prisons. Of the cadets that are due to graduate on October 22, 2021, only twenty-four percent are currently vaccinated.

15. Under more normal circumstances, one option for addressing a severe staffing shortage at a single prison is to put together a "strike force" of staff from another nearby prison that is fully staffed to assist the understaffed prison. But this option is not feasible when staffing is stretched thin across many prisons.

16. I am aware that California Correctional Healthcare Services has a number of contracts with healthcare-service providers that allow it to quickly cover vacant healthcare positions that might result from vaccine mandates and avoid negative impacts. There are no similar contracts for correctional officers. Therefore, there is no simple or quick way to address severe shortages of correctional officers, and it could take months or years to fully recover from a substantial loss of correctional officers resulting from the vaccine-mandate order.

I declare under penalty of perjury that I have read this document, and its contents are true and correct to the best of my knowledge. Executed on October 25, 2021, in Sacramento, California.

/S/ *CONNIE GIPSON*

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Director of Adult Institutions
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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

OAKLAND DIVISION

MARCIANO PLATA, et al., Plaintiffs, **v.** **GAVIN NEWSOM, et al.,** Defendants.	01-cv-01351-JST **DECLARATION OF DIANA TOCHE, DDS, IN SUPPORT OF DEFENDANTS' MOTION TO STAY ORDER RE: MANDATORY COVID-19 VACCINATIONS (ECF NO. 3684) PENDING APPEAL** Date: December 9, 2021 Time: 2:00 p.m. Courtroom: 6, 2nd Floor Judge: The Honorable Jon S. Tigar Action Filed: April 5, 2001

I, Diana Toche, DDS, declare:

1. I have personal knowledge regarding the matters stated in this declaration, except for those statements made on information and belief. I am competent to testify to the matters set forth in this declaration and would do so if called upon to testify. I submit this declaration in support of Defendants' motion to stay this Court's September 27, 2021 order regarding mandatory COVID-19 vaccinations pending appeal.

2. I am the Undersecretary of Health Care Services for the California Department of Corrections and Rehabilitation (CDCR). I have served in this role since 2014. I advise the Secretary of CDCR on major policy, program, and organizational issues related to the administration and delivery of health care to CDCR's incarcerated population. I determine and execute health care priorities, plans, policies, and programs consistent with the direction of CDCR, and develop and direct the implementation of initiatives that will be sustainable and improve the efficacy of CDCR's health care system. I formulate and oversee the implementation of priority initiatives that cut across division and program areas including health care, rehabilitative programs, and re-entry. In my current role, I work closely with the court-appointed Receiver who oversees the delivery of medical care to CDCR's incarcerated population. By way of distinction, my role includes oversight of other forms of health care, including mental and dental health care. I have been employed by CDCR since 2009, and previously served as Acting Undersecretary of Administration and Offender Services, Acting Director of the Division of Health Care Services, and Statewide Dental Director. I worked in private practice from 1989 to 2008 before joining CDCR.

3. COVID-19 vaccines first became available in late December 2020. Since that time California Correctional Health Care Services (CCHCS) has provided over 152,500 doses of vaccine to the incarcerated population and over 66,800 doses of vaccine to prison staff. Of CDCR's current incarcerated population (over 99,300 patients), 78,788—about seventy-nine percent—have accepted at least one dose of vaccine. Since the Court issued the order to show cause on August 9, 2021, prison staff vaccination rates have continued to rise. Well over 10,000 doses of vaccine were administered to prison staff from August 9 through October 21, 2021. The number of staff who have received at least one dose of vaccine increased from about fifty-three percent on August 6, 2021, to about sixty-three percent by October 14, 2021. As of October 21, 2021, 35,238 staff had been vaccinated. Broken down by classification, healthcare staff who are fully vaccinated increased from seventy-two percent on August 6, 2021, to eighty-two percent on October 14, 2021; custody staff who are fully vaccinated increased from forty-one percent on August 6, 2021, to fifty-one percent on October 14 2021; and administrative, maintenance, and

operations staff who are fully vaccinated increased from sixty-one percent on August 6, 2021, to sixty-seven percent on October 14, 2021.

4. All unvaccinated prison staff must test for COVID-19 twice weekly, and all prison staff, regardless of vaccination status, must wear either an N95, KN95, or procedure masks, depending on where they are within a prison.

5. As of October 22, 2021, about seventy-nine percent of the incarcerated population has accepted at least one dose of vaccine, compared to approximately seventy-seven percent on August 6, 2021, just before the Court issued the order to show cause. By comparison, as of October 24, 2021, the Centers for Disease Control reports that approximately sixty-six percent of the general public has accepted at least one dose of vaccine (https://covid.cdc.gov/covid-data-tracker/ - vaccinations_vacc-total-admin-rate-total). And consistent with the most current public health guidance, CCHCS issued a policy on August 20, 2021, regarding third booster doses of vaccine—shortly after the Centers for Disease Control and Prevention released its recommendation for administering booster shots—and promptly started offering booster shots to eligible immunocompromised patients. As of October 22, 2021, 7,195 currently eligible patients had already been offered booster shots, and 6,412 had already accepted them. CCHCS continues to offer booster shots to eligible patients.

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6. CCHCS's current vaccination program and other efforts have been very successful at reducing active cases of COVID-19, and have been especially successful at reducing the number of serious illnesses requiring hospitalization. As of October 24, 2021, out of a prison population exceeding 99,300, California Correctional Health Care Services (CCHCS) reported three hospitalization due to serious COVID-19 related illness. By comparison, on January 5, 2021, there were 143 COVID-19 related hospitalizations. As demonstrated by the below graph prepared by CCHCS, around the time when vaccines first became available in late December 2020, there were over 10,000 active cases in the incarcerated population. But since then, CCHCS's efforts to vaccinate the class members, combined with myriad other safety measures implemented by CDCR, have greatly reduced the number of active cases and kept the rate of infection relatively low since March 2021. As of October 24, 2021, CCHCS reported about 187 active cases among a population of over 99,300, and that number has hovered around 200 active cases for the past week.

7. To reduce the risk of serious illness and hospitalizations, CCHCS has also provided infected patients with the newest and most effective therapies where indicated. For example, as of October 14, 2021, CCHCS had administered monoclonal antibody treatments to 483 patients.

8. During the pandemic, the California Department of Public Health (CDPH) entered into contracts with outside healthcare services providers that state agencies—including CCHCS—

can use to satisfy short term medical staffing needs. And CCHCS also has its own contracts with healthcare services providers. Thus, through its own contracts and through the CDPH's contracts, CCHCS has the means to fill vacancies in various healthcare positions that may arise because of people deciding to quit or retire rather than comply with a vaccine mandate. For example, for the period between January 1, 2021 and October 15, 2021 alone, CCHCS deployed clinicians—primarily nurses—from CDPH's contracts 395 times and had 23 additional requests for clinicians pending.

9. The American Federation of State, County, and Municipal Employees has issued a letter to CDCR and CCHCS on behalf of therapists, pharmacists, psychologists, licensed clinical social workers, and physicians assistants who work in CDCR's prisons, demanding that CDCR and CCHCS cease and desist from enforcing the CDPH order.

I declare under penalty of perjury that I have read this document, and its contents are true and correct to the best of my knowledge. Executed on October 25, 2021, in Sacramento, California.

/S/ *DIANA TOCHE*

DIANA TOCHE, DDS
Undersecretary of Health Care Services
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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

OAKLAND DIVISION

MARCIANO PLATA, et al., Plaintiffs, **v.** **GAVIN NEWSOM, et al.,** Defendants.	01-cv-01351-JST **NOTICE OF CDCR AND THE RECEIVER'S SUBMISSION OF A COVID-19 VACCINATION PLAN FOR CERTAIN CDCR WORKERS AND INCARCERATED PEOPLE IN COMPLIANCE WITH THE SEPTEMBER 27, 2021 ORDER** **Re: ECF Nos. 3638, 3684** Judge: Hon. Jon S. Tigar

To the Court and Plaintiffs:

Please take notice that Defendant the California Department of Corrections and Rehabilitation (CDCR) and Receiver J. Clark Kelso (the Receiver) jointly submit the attached plan for implementing a COVID-19 vaccination policy consistent with the Receiver's recommendations (*see* ECF No. 3638), and as required by the Court's September 27, 2021 order (ECF No. 3684).[1]

Dated: October 12, 2021

HANSON BRIDGETT LLP

By: _____

PAUL B. MELLO
SAMANTHA D. WOLFF
LAUREL O'CONNOR
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Attorneys for Defendants

Dated: October 12, 2021

ROB BONTA
Attorney General of California

By: _____

DAMON MCCLAIN
Supervising Deputy Attorney General
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IRAM HASAN
Deputy Attorneys General

Attorneys for Defendants

[1] Defendants do not waive any rights to appeal the Court's September 27, 2021 order by filing this implementation plan or taking steps to implement a COVID-19 vaccination policy pursuant to the order. Nor is submission of the attached plan, as required by the September 27, 2021 order, an admission that the order meets the requirements of the Prison Litigation Reform Act. CDCR continues to have serious reservations about implementing the Receiver's broad mandatory vaccination recommendation due to the impact of implementing this plan on staffing and operations statewide.

Dated: October 12, 2021

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Dated: October 12, 2021

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JOINT IMPLEMENTATION PLAN FOR MANDATORY VACCINATION

CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION (CDCR) AND CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES (CCHCS)

The following joint implementation plan is submitted in order to comply with the *Order Re: Mandatory Vaccinations* issued on September 27, 2021, by the Honorable Jon S. Tigar, District Judge for the United States District Court for the Northern District of California, in the *Plata vs. Newsom* class action lawsuit. (ECF No. 3684.)[1]

APPLICATION OF ORDER RE: MANDATORY VACCINATION

1. Mandatory vaccination shall apply to the following individuals identified as workers:
   - All CDCR/CCHCS and CALPIA employees, retired annuitants, health care registry workers, and contract workers (who work directly with incarcerated persons) who enter CDCR institution grounds for the performance of job duties, including Headquarters and Regional staff who may enter CDCR institution grounds for any purpose including the performance of job duties.
   - All CDCR/CCHCS peace officers, including retired annuitants, who enter CDCR institution grounds for the performance of job duties, regardless of work location.
   - All volunteers who enter CDCR institution grounds to provide services or programming.

   Mandatory vaccination shall apply to the following incarcerated persons identified as workers:
   - All Inmate/Ward Labor Program casual tradespersons, who may work outside their institution.
   - All incarcerated persons who perform job duties outside of a CDCR institution.

2. Mandatory vaccination shall apply to all incarcerated persons who have in-person visitation.

3. Mandatory vaccination does not apply to individuals who may enter CDCR institution grounds for official business and are not identified in 1 above. However, these individuals shall comply with all applicable California Department of Public Health (CDPH) mandates and guidelines that govern high-risk settings, congregate facilities, or correctional facilities and that are in effect at the time of entry into the institution.

[1] This submission is made by CDCR in a good faith effort to comply with the Court's Order (ECF No. 3684). Nothing set forth herein is intended to act as or to indicate forfeiture or voluntary relinquishment by CDCR of any and all issues cognizable in any appeal of the Order. Indeed, CDCR continues to have serious reservations about the impact of implementing this plan on staffing and operations statewide.

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

OAKLAND DIVISION

MARCIANO PLATA, et al.,

Plaintiffs,

v.

GAVIN NEWSOM, et al.,

Defendants.

01-cv-01351-JST

DEFENDANTS' NOTICE OF APPEAL TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

Judge: The Honorable Jon S. Tigar

Defendants Gavin Newsom, Governor of the State of California, and Kathleen Allison, Secretary of the California Department of Corrections and Rehabilitation, appeal to the United States Court of Appeals for the Ninth Circuit from this Court's September 27, 2021 order. (ECF No. 3684.)

Respectfully submitted,

Dated: October 12, 2021

ROB BONTA
Attorney General of California
DAMON G. MCCLAIN
Supervising Deputy Attorney General

/s/ Iram Hasan
IRAM HASAN
Deputy Attorney General
Attorneys for Defendants

Dated: October 12, 2021

HANSON BRIDGETT LLP

/s/ Samantha Wolff
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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

MARCIANO PLATA, et al.,

Plaintiffs,

v.

GAVIN NEWSOM, et al.,

Defendants.

Case No. 01-cv-01351-JST

ORDER RE: MANDATORY VACCINATIONS

Re: ECF No. 3647

Since the COVID-19 pandemic began, over 50,000 incarcerated persons in California's state prisons have been infected by the SARS-CoV-2 virus. At least 240 have died from the disease, many more have been hospitalized, and some of those who have survived continue to suffer long-term effects. Defendants have undertaken significant measures to combat the virus, including the provision of masks, physical distancing, disinfection, testing, quarantine and isolation protocols, restrictions on transfers, reducing the population, and making vaccines available to both incarcerated persons and staff on a voluntary basis. But the virus continues to infect the prison population, including incarcerated persons who have accepted the vaccine – one of whom recently died from the disease – and outbreaks create significant risks of harm beyond the risk of infection. Once the virus enters a facility, it is very difficult to contain, and the dominant route by which it enters a prison is through infected staff.

Facing these facts, the Receiver has recommended, based on his review of the medical and public health science, that a mandatory COVID-19 vaccination policy be implemented for workers entering CDCR institutions and incarcerated persons who choose to work outside of an institution or accept in-person visitation. Now before the Court is an order to show cause as to why the Receiver's recommendations should not be adopted. ECF No. 3647.

The question of mandatory vaccines is complex. In this case, however, the relevant facts are undisputed. No one challenges the serious risks that COVID-19 poses to incarcerated persons. No one disputes that it is difficult to control the virus once it has been introduced into a prison setting. No one contests that staff are the primary vector for introduction. And no one argues that testing, even if done on a daily basis, is an adequate proxy for vaccination to reduce the risk of introduction. While Defendants point to the minority of incarcerated persons who have not yet accepted the vaccine and argue that the best way to protect such individuals is for them to become vaccinated, no one disputes that the risks to the incarcerated population extend to the vaccinated as well as the unvaccinated. All agree that a mandatory staff vaccination policy would lower the risk of preventable death and serious medical consequences among incarcerated persons. And no one has identified any remedy that will produce anything close to the same benefit.

Framed in terms of the Eighth Amendment, under which this case arises, Defendants are aware of a substantial risk of serious harm to incarcerated persons, and, although they have taken many commendable steps during the course of this pandemic, they have nonetheless failed to reasonably abate that risk because they refuse to do what the undisputed evidence requires. Accordingly, the Court will grant the Receiver's request for an order to implement his recommended vaccine mandates.

I. BACKGROUND

Since 2005, the California prison medical care system has been under receivership. COVID-19 is a medical issue that falls within the Receiver's authority, and the Receiver has appropriately taken a leadership role in guiding Defendants' pandemic response. Until the dispute over mandatory vaccination, Defendants have followed the Receiver's recommendations. For example, early in the pandemic, Defendants agreed to implement the Receiver's cohorting guidelines for achieving and maintaining social distancing. Defendants have also implemented many other measures in conjunction with the Receiver or, where appropriate, exercising their own authority. These measures include several early release programs designed to reduce population density, temporary suspension of both intake and visitation, masking and distancing requirements, advanced cleaning protocols, efforts to improve ventilation, and the development of a centralized

command center and multi-disciplinary teams to oversee response efforts to outbreaks.

This is not the first time that this Court, or a companion court, has considered whether to order Defendants to take particular measures in response to the COVID-19 pandemic. Shortly after the pandemic began, Plaintiffs asked the three-judge court convened in this case and *Coleman v. Newsom*, Case No. 2:90-cv-0520 KJM DB (E.D. Cal.), to order a further population reduction in light of the dangers posed by COVID-19. ECF No. 3219. That court concluded that Plaintiffs' request was not properly before the three-judge court and denied Plaintiffs' motion. *Coleman v. Newsom*, 455 F. Supp. 3d 926 (E.D. Cal./N.D. Cal. 2020). Days after the three-judge court denied relief, Plaintiffs moved this Court for:

> an order directing that the population density in the California prison system be reduced so that (1) class members at high risk of serious illness or death from COVID-19 due to their age and/or underlying health conditions are safely housed, and (2) the system can respond to those who become sick and require hospitalization without overloading community health care systems.

ECF No. 3266 at 9. On April 17, 2020, the Court denied Plaintiffs' motion after considering Defendants' early response to the pandemic and concluding that Plaintiffs had not demonstrated an Eighth Amendment violation. *Plata v. Newsom*, 445 F. Supp. 3d 557, 561-69 (N.D. Cal. 2020). The Court also determined that portions of Plaintiffs' relief could only be ordered by a three-judge court. *Id.* at 569-71.

Beginning in April 2020, the Court has conducted regular case management conferences – starting approximately weekly, then biweekly, and then monthly – focused almost exclusively on pandemic management and attended by the parties as well as the California Correctional Peace Officers Association ("CCPOA"). Defendants have continued to cooperate with the Receiver, including by implementing a movement transfer matrix to reduce the risk of transmission caused by movement of incarcerated persons into or within the system, and revising that matrix based on updated information regarding how the virus spreads. Defendants have also complied with orders of this Court. *E.g.*, ECF No. 3353 (regarding staff testing); ECF No. 3455 (setting deadlines to set aside isolation and quarantine space).

Once vaccines became available, Defendants supported efforts to provide the vaccine to

both staff and incarcerated persons – including before many jurisdictions were prioritizing incarcerated persons to receive vaccines. Nearly every incarcerated person has now been offered the vaccine, and those who have not have either been away from the institutions for court proceedings or have newly entered the system. Most recently, Defendants have offered third doses of the vaccine to immunocompromised incarcerated persons in accordance with updated health guidance. Defendants have also been offering the vaccine to staff on-site and have undertaken multiple efforts to encourage both staff and incarcerated persons to be vaccinated. Approximately 75% of both incarcerated persons and health care staff, and approximately 42% of custody staff, have been fully vaccinated to date. Notwithstanding concerted efforts by the Receiver, Defendants, the CCPOA, and many other persons and groups, the overall staff vaccination rate is approximately 55% statewide, with rates in the 30% range at several institutions and a correctional staff rate as low as 18% at one institution.

In February 2021, the Receiver convened a group of experts and decided not to recommend a staff vaccine mandate at that time. However, mandatory vaccination continued to be a topic of conversation, including at the Court's case management conferences. At the July 29, 2021 case management conference, the Receiver reported his conclusion that "all of our efforts to date have been insufficient to achieve the very high rate of staff vaccination that is necessary to further significantly reduce the risk that COVID will be introduced into our prisons," in part due to the threat posed by the more infectious Delta variant. ECF No. 3641 at 18-19. The Receiver recommended "that access by workers to CDCR institutions be limited to those workers who establish proof of vaccination or a religious or medical exemption to vaccination," and that "incarcerated persons who desire to work outside of the institution, for example, fire camps, or to have in-person visitation must be vaccinated or establish a religious or medical exemption." *Id.* at 21. He noted that his discussions with counsel indicated likely opposition to his recommendations, and the Court discussed with the parties and CCPOA a process to resolve the issue.

On August 4, the Receiver filed a report setting forth the public health basis for his recommendations, ECF No. 3638, and the Court subsequently issued an order to show cause as to

why it should not order that those recommendations be implemented, ECF No. 3647. The matter was fully briefed by the parties, the Receiver, and potential intervenor CCPOA,[1] and the Court accepted amicus briefs from the Service Employees International Union, Local 1000 ("SEIU") and a group of mental health professionals. The Court heard argument on September 24, 2021.

Separate from the Receiver's and the Court's consideration of a mandatory vaccination policy, the California Department of Public Health ("CDPH") issued several related orders. First, on July 26, CDPH issued an order requiring full vaccination or testing, either weekly or twice weekly, of staff who work in hospitals, skilled nursing facilities, other health care settings, and high-risk congregate settings, including correctional facilities and homeless centers. CDPH, *Order of the State Public Health Officer re: Health Care Worker Protections in High-Risk Settings* (July 26, 2021), https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Unvaccinated-Workers-In-High-Risk-Settings.aspx. Under this order, CDCR staff must either be fully vaccinated or tested at least once weekly. *Id.* Individuals are considered fully vaccinated "two weeks or more after they have received the second dose in a 2-dose series (Pfizer-BioNTech or Moderna or vaccine authorized by the World Health Organization), or two weeks or more after they have received a single-dose vaccine (Johnson and Johnson [J&J]/Janssen)." *Id.*

CDPH issued another order on August 5 that eliminated the option of testing for workers in certain healthcare settings. ECF No. 3663-1 at 260-63. CDPH concluded that, "[a]s we respond to the dramatic increase in cases, all health care workers must be vaccinated to reduce the chance of transmission to vulnerable populations." *Id.* at 261. The order requires all workers who "provide services or work in" a specified list of health care facilities to "have their first dose of a one-dose regimen or their second dose of a two-dose regimen by September 30, 2021." *Id.* The order defined "worker" as including "all paid and unpaid individuals who work in indoor settings where (1) care is provided to patients, or (2) patients have access for any purpose," and specifically included "security" personnel. *Id.* at 262. CDPH clarified the following day that the

[1] CCPOA's motion to intervene, ECF No. 3665, is noticed for hearing in October and remains pending.

order did not apply to healthcare settings within correctional facilities and that further guidance would be forthcoming.

On August 19, CDPH issued its further guidance in an order that requires the following persons to "have their first dose of a one-dose regimen or their second dose of a two-dose regimen by October 14, 2021": "All paid and unpaid individuals who are regularly assigned to provide health care or health care services to inmates, prisoners, or detainees," and "[a]ll paid and unpaid individuals who are regularly assigned to work within hospitals, skilled nursing facilities, intermediate care facilities, or the equivalent that are integrated into the correctional facility or detention center in areas where health care is provided." ECF No. 3663-1 at 270-71. The latter group "includes workers providing health care to inmates, prisoners, and detainees, as well as persons not directly involved in delivering health care, but who could be exposed to infectious agents that can be transmitted in the health care setting." *Id.* at 271.

Defendants are implementing the August 19 CDPH order by requiring the following individuals to be vaccinated: "all staff at California Health Care Facility (CHCF), California Medical Facility (CMF), and the Skilled Nursing Facility at Central California Women's Facility (CCWF)," and all workers "regularly assigned to work" in certain healthcare areas systemwide, including clinic treatment areas, Correctional Treatment Centers and other licensed beds, hospice beds, and dialysis units. ECF No. 3662-3 at 2-3. The vaccine requirement does "not apply to non-regularly assigned staff, such as relief staff, voluntary overtime, mandatory overtime, swaps, or those who do not work in the area regularly, such as staff making pick-ups or deliveries, conducting maintenance repairs, conducting tours, etc. Additionally, this will not apply to any staff responding to emergencies." *Id.* at 3. "[W]orkers in correctional settings who are not fully vaccinated or who cannot show proof of vaccination [must] submit to twice-weekly testing," which exceeds the requirement in the July 26 CDPH order that such workers be tested weekly. ECF No. 3662 ¶ 18.

II. LEGAL STANDARD

The Prison Litigation Reform Act ("PLRA") allows prospective relief only if it "extend[s] no further than necessary to correct the violation of the Federal right of a particular plaintiff or

plaintiffs." 18 U.S.C. § 3626(a)(1)(A). The federal right at issue in this case is whether Defendants' response to the threat posed by COVID-19 violates the Eighth Amendment. The parties and CCPOA agree on the relevant legal standard. As the Court previously explained:

> To establish an Eighth Amendment violation "based on a failure to prevent harm, the inmate must [first] show that he is incarcerated under conditions posing a substantial risk of serious harm." *Farmer v. Brennan*, 511 U.S. 825, 834 (1994). The Court need not analyze this issue in detail because Defendants have already stated before the Three-Judge Court that they "do not dispute the risk of harm that COVID-19 poses to inmates, as well as the community at large. Nor do Defendants dispute that those who are incarcerated may be at a higher risk for contracting COVID-19 given the circumstances of incarceration, including closer living quarters." ECF No. 3235 at 17. Defendants do not attempt to relitigate the issue here, and the Court finds that this element has been established.[2]
>
> The Court therefore turns to the second prong of the Eighth Amendment analysis: whether Plaintiffs have demonstrated that Defendants "have a 'sufficiently culpable state of mind,'" which in this case requires "'deliberate indifference' to inmate health or safety." *Farmer*, 511 U.S. at 834 (quoting *Wilson v. Seiter*, 501 U.S. 294, 297, 302-03 (1991)). Under this standard, a prison official must "know[] that inmates face a substantial risk of serious harm and disregard[] that risk by failing to take reasonable measures to abate it." *Id.* at 847. "A prison official's duty under the Eighth Amendment is to ensure reasonable safety," and "prison officials who act reasonably cannot be found liable under the Cruel and Unusual Punishments Clause." *Id.* at 844-45 (internal quotation marks and citations omitted). There is no Eighth Amendment violation, for example, where prison officials "did not know of the underlying facts indicating a sufficiently substantial danger and . . . were therefore unaware of a danger," or where "they knew the underlying facts but believed (albeit unsoundly) that the risk to which the facts gave rise was insubstantial or nonexistent." *Id.* at 844. Likewise, "prison officials who actually knew of a substantial risk to inmate health or safety may be found free from liability if they responded reasonably to the risk, even if the harm ultimately was not averted." *Id.* In determining whether officials have been deliberately indifferent, courts must give "due regard for prison officials' 'unenviable task of keeping dangerous men in safe custody under humane conditions,'" *id.* at 845 (quoting *Spain v. Procunier*, 600 F.2d 189, 193 (9th Cir. 1979)), and "consider arguments regarding the realities of prison administration," *Helling v. McKinney*, 509 U.S. 25, 37 (1993).

Plata, 445 F. Supp. 3d at 562 (footnote added).

If the Court finds the violation of a federal right, it may not, under the PLRA, "grant or

[2] Defendants continue to acknowledge that "the COVID-19 pandemic presents a substantial risk of serious harm." ECF No. 3660 at 9.

approve any prospective relief unless the court finds that such relief is narrowly drawn, extends no further than necessary to correct the violation of the Federal right, and is the least intrusive means necessary to correct the violation of the Federal right." 18 U.S.C. § 3626(a)(1)(A). "Narrow tailoring requires a fit between the remedy's ends and the means chosen to accomplish those ends. The scope of the remedy must be proportional to the scope of the violation, and the order must extend no further than necessary to remedy the violation." *Brown v. Plata*, 563 U.S. 493, 531 (2011) (quotation marks, alterations, and citations omitted). "But the precedents do not suggest that a narrow and otherwise proper remedy for a constitutional violation is invalid simply because it will have collateral effects." *Id.* Instead, the PLRA's restrictions on injunctive relief mean "only that the scope of the order must be determined with reference to the constitutional violations established by the specific plaintiffs before the court." *Id.*

III. DISCUSSION

There has been no objection to the Receiver's recommendation "that incarcerated persons who desire to work outside of the institution (e.g., fire camps) or to have in-person visitation must be vaccinated (or establish a religious or medical exemption)." ECF No. 3638 at 27. Accordingly, the Court focuses below on the contested recommendation "that access by workers to CDCR institutions be limited to those workers who establish proof of vaccination (or who have established a religious or medical exemption to vaccination)." *Id.* In particular, the Court examines whether ordering implementation of the Receiver's recommendation is necessary, and is the least restrictive means, to remedy a violation of Plaintiffs' Eighth Amendment rights.

A. Deliberate Indifference

Defendants first argue that a finding of deliberate indifference is precluded by the fact that a portion of the incarcerated population has refused to accept the vaccine they have been offered. However, the cases they rely on are cases seeking individual injunctive relief, rather than the type of systemic relief sought here.[3] *See Pride v. Correa*, 719 F.3d 1130, 1137 (9th Cir. 2013)

[3] *Davis v. Allison*, on which Defendants seek to rely for its conclusion that the plaintiff was unlikely to succeed on the merits of his COVID-related deliberate indifference claim, is distinguishable for the same reason. No. 1:21-cv-00494-HBK, 2021 WL 3761216 (E.D. Cal. Aug. 25, 2021), *report and recommendation adopted*, 2021 WL 4262400 (E.D. Cal. Sept. 20,

("Individual claims for injunctive relief related to medical treatment are discrete from the claims for systemic reform addressed in *Plata*."). More significantly, Defendants fail to consider that it is not only the unvaccinated population that is at substantial risk of serious harm from COVID-19, and that such risk would be present even if the entire incarcerated population were vaccinated. The unrebutted evidence[4] is that, "although vaccination greatly reduces the risk of harm, the Delta variant presents a substantial risk of serious harm even to fully vaccinated patients." ECF No. 3652 ¶ 5. This is because "some fully vaccinated individuals will contract COVID-19. When a fully-vaccinated patient becomes infected this is referred to as a 'breakthrough' infection. Although the exact rate of breakthrough infections is not yet clear, the Delta variant causes breakthrough infections significantly more often than prior COVID-19 variants." *Id.* ¶ 3. The most recent data in the record is that:

> Through September 1, 2021, 385 fully vaccinated patients in CDCR custody have suffered COVID-19 breakthrough infections, and 94 of those patients had a COVID risk score of 3 or higher, indicating a high risk of severe disease. One patient who CCHCS [California Correctional Health Care Services] believes was fully vaccinated has died of COVID-19. Other patients with breakthrough infections have also experienced serious symptoms and there are early indications that some may have long-term symptoms.

ECF No. 3670-1 ¶ 9 (footnotes omitted). Long-term effects of COVID-19 can include "fever, chest pains, shortness of breath, diarrhea, vomiting, sudden onset diabetes and hypertension, mood

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2021) (denying motion for preliminary injunction). In addition, *Davis* is not persuasive because the plaintiff did not raise the issues that are currently before this Court. Instead, Davis more narrowly complained about circumstances in which incarcerated persons are released from quarantine housing and the lack of adequate cleaning supplies. *Id.* at *1. The court determined that "[t]he only disputed fact on this record concerns the inmates' respective access to cleaning supplies for their respective cells," but that the record demonstrated that "inmates *do* have access to cleaning supplies" and that Davis did not "allege that he asked for cleaning supplies for his cell and was denied any supplies." *Id.* at *6 (emphasis in original). The court also noted that Davis had chosen to receive the vaccine and concluded that his "claims of threatened harm are speculative at best." *Id.* at *4. In this case, however, the Receiver and Plaintiffs have presented evidence – unrebutted by Defendants – that the harms faced by vaccinated incarcerated persons are substantial and not speculative, as explained in more detail below.

[4] Aside from the Declaration of James Watt, discussed further below, no medical or public health evidence was submitted in opposition to the Receiver's recommendations. Indeed, Defendants explicitly stated that they "agree with the public health findings regarding the COVID-19 vaccine cited in the Receiver's report." ECF No. 3660 at 24.

disorders, and nervous system disorders. Such long-term symptoms are sometimes experienced by patients who had mild COVID-19 symptoms and the impact may be life-long." ECF No. 3638 at 6-7 (footnotes omitted). Moreover, although much of the recent focus has been on the Delta variant, which "is more than twice as transmissible as the Wuhan strain," the risk is not limited to that variant; instead, "[t]he virus is likely to continue to mutate, potentially creating even more transmissible strains than Delta." ECF No. 3638-1 ¶¶ 29, 33.

In addition, COVID-19 outbreaks pose other serious risks to incarcerated persons beyond the direct impacts of COVID-19 infection. For example, during an outbreak, "non-essential medical services are postponed. Only after 14 days without a new infection in that institution can medium priority healthcare services like preventative care and screenings resume. Routine clinical operations are suspended until 28 days without a new infection." ECF No. 3638 at 18 (footnotes omitted). "An outbreak is defined as three or more related COVID-19 incarcerated person cases within a facility, as determined by a contact investigation, in the past 14 days." ECF No. 3673-1 ¶ 15. "During outbreaks, a large number of people are on quarantine due to exposure. When quarantined for exposure, incarcerated persons experience restricted movement and therefore have limited access to routine healthcare and screenings because they cannot go to the clinic." ECF No. 3652 ¶ 7. And for those incarcerated persons who are able to attend clinic because they are not themselves on quarantine, appointment availability is limited because quarantines "divert clinical staff resources to performing mass testing, medication administration, and rounds on COVID-19 patients rather than providing routine medical care." *Id.* Delays in clinical care are also caused by the "large number of staff in quarantine" – approximately 5,500 in total over the past year – either because they have themselves contracted COVID-19 or because they "are identified as close contacts of an infected individual." *Id.* ¶ 9. The pandemic has led to significant increases in backlog appointments for both primary and specialty care, and the increase in cases due to the Delta variant is expected to lead to further delays. *Id.* ¶¶ 10-11. As of July 2021, there were approximately 5,000 backlogged primary care appointments and 8,000 backlogged specialty appointments. *Id.* at 31, 33. Although mental health care is the subject of the *Coleman* case, the Court notes the undisputed evidence that outbreaks cause "a significant

impediment to the delivery of group therapy" and "complicate the movement of patients for higher level mental health care." ECF No. 3638-1 ¶¶ 9-10; *see also* ECF No. 3658 (brief of amici mental health professionals). In short, "[a]dditional program modifications and the renewed diversion of healthcare resources to address COVID-19 cases from Delta variant outbreaks put patients at a substantial risk of serious harm." ECF No. 3652 ¶ 8.

Defendants also argue that the Court cannot find them deliberately indifferent in light of their multi-faceted response to the COVID-19 pandemic and the Court's April 2020 determination that Defendants were not deliberately indifferent at that time. This argument is unpersuasive. Deliberate indifference "should be determined in light of the prison authorities' *current* attitudes and conduct." *Helling*, 509 U.S. at 36 (emphasis added). While the Court concluded seventeen months ago that Defendants' initial response to the pandemic was not deliberately indifferent, it cannot reach that same conclusion based on the current record. In its prior ruling, the Court explained:

> No bright line divides a reasonable response from one that is deliberately indifferent in violation of the Eighth Amendment. In this case, however, the Court concludes without difficulty that Defendants' response has been reasonable. Plaintiffs identify other steps Defendants might take to provide for greater physical distancing, but they cite no authority for the proposition that Defendants' failure to consider or adopt these potential alternatives constitutes deliberate indifference within the meaning of the Eighth Amendment.

Plata, 445 F. Supp. 3d at 568. The Court reached this conclusion in part because Defendants had already implemented measures to increase physical distancing; Plaintiffs failed to articulate any "standard by which to determine how much physical distance is required to ensure reasonable safety"; Defendants had recently agreed to comply with a cohorting directive from the Receiver designed to increase physical distancing; and "Plaintiffs [did] not argue that housing in compliance with the Receiver's directive would be constitutionally inadequate." *Id.* at 564-68 (quotation marks and citation omitted). As discussed below, such considerations are not present here. At the time of the Court's prior ruling, no vaccine was available. A finding that Defendants were not deliberately indifferent based on a toolbox without a vaccine has little relevance when the same toolbox now includes a vaccine that everyone agrees is one of the most important tools,

if not the most important one, in the fight against COVID-19.

Defendants do not dispute any of the relevant facts, nor do they present any evidence suggesting it would be reasonable not to adopt the Receiver's recommendations. The closest they come is the declaration of Dr. James Watt, a CDPH official, who states that other "measures, when considered in conjunction with the relatively high rate of vaccination among the incarcerated population, will significantly mitigate the spread of the virus," and that "[t]he best way for patients in correctional settings to reduce their risk of severe illness – regardless of location – would be to get vaccinated."[5] ECF No. 3661 ¶¶ 17, 18. But Watt stops short of saying that vaccination, even when in combination with other measures, offers incarcerated persons sufficient protection from COVID-19. Nor could such a conclusion be reconciled with the uncontested evidence regarding the dangers COVID-19 presents to vaccinated incarcerated persons. Likewise, even if other measures "significantly mitigate" the spread of the virus, Watt does not say that they are sufficient to protect Plaintiffs from those harms. Defendants have pointed to no measure or combination of measures that offers the incarcerated population the same level of protection as the vaccine mandates recommended by the Receiver. They do not refute the studies cited by the Receiver that conclude that "COVID-19 spreads far more rapidly inside jails and prisons than in other environments," in part because individuals who live in congregate settings like prisons "have intense, long-duration, close contact." ECF No. 3638 at 10-16. Nor do Defendants dispute the Receiver's conclusion that "[l]imiting the introduction of COVID-19 into prisons is critical to protecting the health of incarcerated people" because:

> prison systems, even those that take important mitigation measures such as masking and social distancing, are not designed and operated to prevent the transmission of a highly contagious virus and cannot be redesigned to do so effectively in the near term. The conditions of confinement and the manner in which the prisons are operated deprive incarcerated people of the same opportunities to protect themselves through social distancing and limiting contact that are available to the public at large.

[5] Defendants also attempt to rely on the December 9, 2020 declaration of Dr. Anne Spaulding. ECF No. 3505. However, Spaulding was opining on Defendants' efforts at that time, prior to the availability of a vaccine, and Defendants have not offered her opinion on the reasonableness of Defendants' efforts under current circumstances.

Id. at 16.

It is also uncontested that "[i]nstitutional staff are primary vectors for introducing COVID-19 into CDCR facilities," *id.* at 7, and that "[i]nstitutions with low staff vaccination rates experience larger and more frequent COVID-19 outbreaks," ECF No. 3652 ¶ 9. For example, half of the 14 outbreaks between May and July 2021 have been traced to staff, and that number could still grow because analysis of the remaining outbreaks is ongoing. ECF No. 3638-1 ¶ 17 & at 9-12. Between July 31 and September 10, 2021, a staggering 48 outbreaks "have been traced back to institutional staff." ECF No. 3670-1 ¶ 6. The record does not include the number of outbreaks overall that occurred during this latter period, but the number of outbreaks traced back to staff alone, over a shorter period of time, indicates that the introduction of the virus into CDCR institutions by staff is increasing. By contrast, "[i]ncarcerated persons who neither work outside of CDCR institutions nor participate in in-person visitation do not present a significant risk of introducing SARS-CoV-2 into CDCR institutions." ECF No. 3638-1 ¶ 13. "Because COVID-19 spreads so easily within prisons and is so disruptive to prison operations once outbreaks begin, it is particularly important that all people going between the community and institutions without quarantining are fully vaccinated to prevent the introduction of COVID-19 to institutions." ECF No. 3670-1 ¶ 4. Defendants themselves acknowledge that "[v]accination in the largest possible numbers, including all incarcerated people, is clearly one of the best available protections against COVID-19." ECF No. 3660 at 25.

Defendants also do not contest the Receiver's analysis regarding the insufficiency of testing as an alternative to vaccination:

> Frequent testing is insufficient to prevent institutional staff who are unaware that they have COVID-19 from spreading the virus. . . . CDCR has indicated that . . . it will test unvaccinated employees twice per week. Tests can detect a positive case only where a certain viral load is present, so a recently infected individual may not test positive for several days after exposure. Results of COVID-19 tests are also typically available only after a wait of a day or longer. An infected staff member might work two or three days before being tested; a newly infected staff member may test negative, continue working and reach a viral load sufficient to transmit the virus before being tested again and finally receiving a positive test result.

> Because as much as 40 percent of transmission is pre-symptomatic, individuals who receive false negative test results or who test too early may be unaware they are contagious throughout this period. As a result, the twice-per-week testing regimen does not effectively prevent asymptomatic staff from introducing COVID-19 to CDCR institutions. Indeed, even daily testing would not do so. Testing is an essential component of any plan, but it is not a substitute for vaccination.

ECF No. 3638 at 8-9 (footnotes omitted). "CDCR staff are vaccinated at far too low a rate to reduce the risk of mass outbreaks in CDCR institutions." ECF No. 3638-1 ¶ 37.

Even in light of all of the above, Defendants argue that their implementation plan for the July 26 and August 19 CDPH orders is sufficient.[6] The uncontradicted public health record before the Court says otherwise. Defendants' plan mandates vaccination at only two institutions in their entirety, and only for staff who are regularly assigned to work in certain designated healthcare settings at the remaining institutions. This partial vaccination requirement is an unreasonable attempt to address the risk of harm to Plaintiffs for several reasons. First, the incarcerated population is not at risk only, and may not even be at the highest risk, in areas that Defendants have designated as healthcare settings. For example, Defendants do not dispute that incarcerated persons do not wear masks when eating or sleeping, and that this increases the chance of transmission.[7] ECF No. 3638 at 13-14. Nor do Defendants dispute the myriad ways in which incarcerated persons come into close contact with staff outside of healthcare settings. *E.g.*, ECF No. 3638-2 ¶ 3 ("Corrections officers have frequent, daily, close contact with incarcerated persons."); ECF No. 3663-2 ¶¶ 12-16 (describing close contact between staff and incarcerated persons with physical disabilities); ECF No. 3663-3 ¶¶ 5-6 (describing close contact between staff

[6] Defendants raise this argument in the context of narrow tailoring, but the issue is properly considered as part of the deliberate indifference analysis because it goes towards the reasonableness of Defendants' response to the risk of harm to Plaintiffs.

[7] Defendants present evidence that there are fewer occupied beds in dormitories now than there were at the beginning of the pandemic. ECF No. 3673-1 ¶ 12. While this might increase the distance between incarcerated persons while they are sleeping, it does not remove the danger of transmission "because the air in any given room is shared with each individual in that room and the length of exposure is so long." ECF No. 3638-3 ¶ 15. Public health experts have concluded, without rebuttal, that "to minimize COVID-19 risk, dorms with a capacity of fifty people should house only three people, and that small dorms with the capacity of six people and cells with capacity of two people should both house only a single person." ECF No. 3638 at 14 (emphasis omitted). Defendants do not contend that they have reduced capacity to such levels.

and incarcerated persons with developmental disabilities). Even healthcare itself can be provided outside designated healthcare settings; for example, during quarantines, "[u]rgent care is provided to patients in their cells or dormitories." ECF No. 3652 ¶ 7. Put most simply, "[i]ncarcerated persons spend the vast majority of their time outside of healthcare settings, where staff with whom they come into contact are vaccinated at much lower rates." ECF No. 3670-1 ¶ 5. Given recent outbreaks, there is no doubt that the limited vaccine requirements adopted by Defendants are insufficient "to ensure reasonable safety." *Farmer*, 511 U.S. at 844 (quotation marks and citation omitted). Of the 48 outbreaks traceable to staff since July 31, only 14, or 29%, were "traced back to a person that the August 19 CDPH order would require to be vaccinated." ECF No. 3670-1 ¶ 6.

Second, and relatedly, requiring vaccination only for workers assigned to designated healthcare settings does not protect vulnerable persons who do not reside in those settings. Defendants acknowledge that patients with COVID-19 risk scores greater than 3 are classified as "medically high-risk."[8] ECF No. 3662 ¶ 5. Throughout the prison system, 17,886 patients have such a score. ECF No. 3670-1 ¶ 8. Of those, "15,246 (85%) live in a space not covered by the August 19 CDPH order," and another "313 live in a medical facility located within an institution that is not fully covered by the order. The August 19 CDPH order does not provide significant protection from outbreaks for either of these two groups," which constitute the overwhelmingly majority of high-risk patients housed in CDCR institutions. *Id.* These patients are housed throughout all of CDCR's adult institutions. ECF No. 3674-1 ¶ 2. In response to the Court's request for information regarding "whether there is any reason for concluding that these individuals are at lower risk than the high-risk individuals housed in the covered institutions or areas," ECF No. 3653 at 3, Defendants offered only that such persons "are likely to have widely variable levels of risk, depending on the institution and the location within the institution of an

[8] "The COVID Weighted Risk Score Factors and their weights in parentheses include: Age 65+ (4), Advanced Liver Disease (2), Persistent Asthma (1), High Risk Cancer (2), Chronic Kidney Disease (CKD) (1), Stage 5 CKD or receiving dialysis (1), Chronic Lung Disease (including Cystic Fibrosis, Pneumoconiosis, or Pulmonary Fibrosis) (1), COPD (2), Diabetes (1), High Risk Diabetes (1), Heart Disease (1), High Risk Heart Disease (1), Hemoglobin Disorder (1), HIV/AIDS (1), Poorly Controlled HIV/AIDS (1), Hypertension (1), Immunocompromised (2), Neurologic Conditions (1), Obesity (1), Other High Risk Chronic Conditions (1), and Pregnancy (1)." ECF No. 3663-1 at 42.

exposure." ECF No. 3661 ¶ 18. The Court cannot conclude from that submission that at-risk patients who reside outside of designated healthcare areas are any less vulnerable than those individuals who live in designated healthcare areas. Defendants also assert that the August 19 order "targets employees who work closely with *particularly* vulnerable patients," ECF No. 3660 at 21 (emphasis in original), but they fail to explain why those patients merit protection only while present in a designated healthcare setting.

Third, transmission of the virus cannot be controlled by requiring vaccination only for staff in limited areas of an institution. Defendants do not dispute that "[p]rison operations require people from throughout the prison to come into contact with each other, making it difficult to isolate an outbreak to only one housing unit or yard." ECF No. 3638 at 13. "Medical facilities and yards often share facilities with the entire institution, such as cafeterias, yards, and programming spaces," which means that incarcerated persons who reside in those areas "have contact with staff and incarcerated persons from other yards." ECF No. 3670-2 ¶ 5. As a consequence, the same person can cause multiple areas to be placed in quarantine, as happened recently when a single staff member exposed four housing units to the virus. ECF No. 3674-1 at 90.

Fourth and finally, even if Defendants had presented evidence that only healthcare areas need be covered by a vaccine requirement, the limitation to only workers who are regularly assigned to such areas would render the requirement ineffective. Defendants have themselves characterized "the flexibility to send custody staff to locations where they are needed, which can change from day to day due to staff illness, leave, emergencies, changes in programming, staffing shortages, promotions, and transfers, among other reasons" as necessary and "even more essential during the current pandemic." ECF No. 3314 at 5-6. "Every day, across all CDCR institutions, there are hundreds of employees working in areas to which they are not regularly assigned," including "relief officers with no permanent post who fill different vacancies from day to day," and "[s]taff are often temporarily assigned to medical facilities." ECF No. 3670-2 ¶¶ 2-3. "Officers working their ordinary shifts are often reassigned to cover higher-need vacant positions. For example, a gym officer may be reassigned for the day to guard a clinic in order to keep the

clinic operating." ECF No. 3638-2 ¶ 4. Thus, workers who are not subject to Defendants' current vaccination requirement regularly work in designated healthcare settings despite not being regularly assigned to those areas. In other words, Defendants plan to regularly send unvaccinated staff into areas they concede are in need of greater protection. For all of the above reasons, Defendants' implementation of the August 19 CDPH order does not constitute a reasonable response to Plaintiffs' risk of harm.

The August 5 CDPH order that applies to non-correctional healthcare settings underscores the unreasonableness of Defendants' position. One of the purposes of that order was "to protect particularly vulnerable populations." ECF No. 3663-1 at 260. It applied to hospitals, skilled nursing facilities, and other healthcare facilities because those facilities were determined to be "particularly high-risk settings where COVID-19 outbreaks can have severe consequences for vulnerable populations including hospitalization, severe illness, and death." *Id.* These settings were also described as "shar[ing] several features. There is frequent exposure to staff and highly vulnerable patients, including elderly, chronically ill, critically ill, medically fragile, and disabled patients. In many of these settings, the patients are at high risk of severe COVID-19 disease due to underlying health conditions, advanced age, or both." *Id.*

These same descriptors concededly apply to California's prisons as a whole, and not only to designated healthcare facilities within those prisons. *See, e.g.*, ECF No. 3638 at 16-18 (noting that incarcerated persons infected with COVID-19 "have worse health outcomes on average than the population as whole," "in part because they have risk factors for COVID-19 at a disproportionate rate compared to the general public" and "are often considered effectively ten years older, physiologically, than their chronological age"). In fact, the July 26 CDPH order described correctional facilities as "residential facilities where the residents have little ability to control the persons with whom they interact. There is frequent exposure to staff and other residents. In many of these settings, the residents are at high risk of severe COVID-19 disease due to underlying health conditions, advanced age, or both." https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Unvaccinated-Workers-In-High-Risk-Settings.aspx. Moreover, one basis for the August 5 order was that "[r]ecent

outbreaks in health care settings have frequently been traced to unvaccinated staff members," which led CDPH to concluded that "all health care workers must be vaccinated to reduce the chance of transmission to vulnerable populations." ECF No. 3663-1 at 261. As discussed above, recent outbreaks in prisons – not only in designated healthcare areas within prisons – have also been traced to staff. Defendants do not explain why it would be reasonable to refuse a similar vaccination requirement to reduce the chance of transmission to the vulnerable population that resides in CDCR's facilities.

Defendants assert that "CDCR has made every effort to implement COVID-19 safety measures based on the latest public health guidance and available resources." ECF No. 3673 at 4. However, to the extent that assertion might have been true before, it is no longer supported by the record. Neither Defendants nor CCPOA disputes that COVID-19 continues to pose a substantial risk of serious harm – including death – to incarcerated persons, regardless of their vaccination status; that, even with mitigation measures in place, the virus spreads quickly in a prison setting; that limiting the introduction of the virus is therefore critical to protecting the health of incarcerated persons; that staff are the primary vector of introducing the virus into a prison; or that testing is ineffective at controlling that vector. In the absence of any evidence suggesting that Defendants' existing mitigation measures reasonably address this risk, the issue is not whether mandatory vaccines are merely a further step Defendants could take, but whether it would be unreasonable not to take it. *See Plata*, 445 F. Supp. 3d at 568 ("[T]he question before the Court is not what it thinks is the best possible solution. Rather, the question is whether Defendants' actions to date are reasonable."). Defendants have disregarded a substantial risk of serious harm "by failing to take reasonable measures to abate it" and are therefore violating Plaintiffs' Eighth Amendment rights.[9] *Farmer*, 511 U.S. at 847.

[9] Defendants state that they "are not aware of any other prison system in the country that has been as innovative or proactive in responding to the COVID-19 pandemic and protecting the health and safety of inmates during these unprecedented times." ECF No. 3660 at 17. While that may be true in some respects, Defendants are not leaders on the question of protecting incarcerated persons against the introduction of the virus by staff, whom Defendants concede are the primary sources of exposure. Unlike California, multiple other jurisdictions – including the Federal Bureau of Prisons; the states of Oregon, Washington, Colorado, Illinois and Massachusetts; and several counties within California, including Orange, San Francisco, Los Angeles, Contra Costa,

B. Narrow Tailoring

Having found an Eighth Amendment violation, the Court now considers whether the Receiver's recommendations present a narrowly tailored remedy. Defendants and CCPOA make several arguments as to why they do not, all of which are unavailing.

First, Defendants suggest that a mandatory staff vaccination policy is not narrowly tailored because the best protection for incarcerated persons would come from a mandatory vaccination policy for incarcerated persons. CCPOA also raises this argument, but with respect to deliberate indifference rather than narrow tailoring. No one has disputed that getting vaccinated provides one of the most effective protections against COVID-19. However, neither the Receiver nor any party has recommended that vaccination be required for all incarcerated persons, and so that question is not before the Court. More importantly, as discussed above, Defendants and CCPOA do not contest the continued risk of harm to *vaccinated* incarcerated persons, nor do they present any evidence that it would be reasonable not to address the introduction of the virus into the prisons. A policy directed towards vaccination of the incarcerated population, aside from those persons covered by the Receiver's uncontested recommendation regarding persons who work outside the institution or receive in-person visitation, would not address these issues and therefore would provide no remedy for the identified harm. Nonetheless, because no one disputes the effectiveness of vaccination as a protective measure, the Court directs the Receiver to consider additional efforts to increase the vaccination rate among the incarcerated population, including whether a mandatory vaccination policy should be implemented.

Second, Defendants and CCPOA argue that Defendants' implementation of the August 19 CDPH order is a lesser intrusive remedy. For the reasons already discussed, that plan is too limited to reasonably address the substantial risks faced by Plaintiffs. By Defendants' own admission, the CDPH order was not intended to address the risk of introduction of the virus by staff into the institutions or even to protect the incarcerated population in anything other than healthcare settings. Instead, the order was intended "to protect particularly vulnerable populations

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and Santa Clara – have adopted mandatory vaccination requirements applicable to correctional staff. ECF No. 3663-1 at 362-431; ECF No. 3674-1 at 256-60.

receiving care in health care settings, and ensure a sufficient, consistent supply of workers in high-risk health care settings." ECF No. 3661 ¶ 12. Thus, although the CDPH order is more narrow and would be less intrusive than the Receiver's recommendation, it was not intended to and does not reasonably abate the risk of serious harm to Plaintiffs.

Third, Defendants and CCPOA argue that existing efforts to increase vaccination among staff are sufficient. However, these efforts "have had minimal success, with the rate of vaccination increasing by just 1% in July (from 52% to 53%) and 2% in August 2021 (from 53% to 55%)." ECF No. 3670-1 ¶ 11. Included as part of the August efforts "was a program of mandatory one-on-one vaccine counseling" through which "5,135 staff members attended a counseling appointment" but only 262 – approximately 5% – agreed to be vaccinated, with 4,385 signing "a formal declination, refusing to become vaccinated." *Id.* That program "has been halted to redirect resources to complying with the August 19 CDPH order." *Id.* Neither Defendants nor CCPOA offer any evidence suggesting that further voluntary efforts will be any more successful, nor do they contest that "CDCR staff are vaccinated at far too low a rate to reduce the risk of mass outbreaks in CDCR institutions." ECF No. 3638-1 ¶ 37.

In short, none of the alternatives suggested by Defendants or CCPOA would correct the violation of Plaintiffs' Eighth Amendment rights identified in this order, and the Court concludes that the Receiver's recommendation "is narrowly drawn, extends no further than necessary to correct the violation of the Federal right, and is the least intrusive means necessary to correct the violation of the Federal right." 18 U.S.C. § 3626(a)(1)(A).

C. Other Considerations

Three other considerations warrant discussion. First, Plaintiffs argued in their initial response that workers who are unvaccinated due to their religious beliefs should not be allowed to enter the prisons. They do not raise this argument in their reply brief, and it is not clear whether they continue to request this relief. In any event, the request is premature, as the manner in which a vaccine mandate might be implemented has not yet been determined – and is something that the Court leaves to the discretion of the Receiver and Defendants in the first instance. Nor does Plaintiffs' brief discussion of the issue establish that the requested relief is proper under the PLRA.

Second, CCPOA asserts that "state unions are entitled to negotiate over the impacts of the CDCR's decision to implement mandatory vaccinations pursuant to the Ralph C. Dills Act, Cal. Gov't Code §§ 3512, et seq." ECF No. 3664 at 12 n.9. Similarly, SEIU argues that "the State . . . has the obligation to negotiate with SEIU over aspects of [a mandatory vaccination] policy that impact matters within the scope of representation before the policy is actually implemented." ECF No. 3656 at 6 (emphasis omitted). Again, the Court leaves the details of implementation to the Receiver and Defendants in the first instance. The Court also notes that CCPOA is already meeting and conferring with CDCR regarding implementation of the August 19 CDPH order, which was issued without prior collective bargaining, and CCPOA does not contend that this timing violates any provision of state law. ECF No. 3669 at 10. If the Receiver or Defendants believe they cannot comply with the Court's order without a waiver of state law, they shall file a motion seeking such a waiver that explains why it is permissible under 18 U.S.C. § 3626(a)(1)(B).

Third, although Plaintiffs suggest that the Court "set a date for full compliance" that is "soon," ECF No. 3674 at 19, the record contains no information on which the Court could base a reasonable compliance deadline, and the Receiver does not request one. Accordingly, the Court does not set a compliance deadline in this order and instead orders the Receiver and Defendants to submit an implementation plan that includes such a deadline.

CONCLUSION

For the foregoing reasons, Defendants and the Receiver shall implement the Receiver's recommendations that (1) access by workers to CDCR institutions be limited to those workers who establish proof of full COVID-19 vaccination or have established a religious or medical exemption to vaccination and (2) incarcerated persons who desire to work outside of the institution or to have in-person visitation must be fully vaccinated against COVID-19 or establish a religious or medical exemption.[10]

Defendants and the Receiver shall submit an implementation plan, including a deadline by which all covered persons must be vaccinated, within 14 days of the date of this order.

[10] Defendants' evidentiary objections to photographs submitted with the Hart Declaration and to one paragraph of the Norman Declaration are overruled. ECF Nos. 3671, 3672.

Additionally, the Receiver shall consider efforts to increase the vaccination rate among the incarcerated population, including whether a mandatory vaccination policy should be implemented.

IT IS SO ORDERED.

Dated: September 27, 2021

JON S. TIGAR
United States District Judge

United States District Court
Northern District of California

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

OAKLAND DIVISION

MARCIANO PLATA, et al., Plaintiffs, **v.** **GAVIN NEWSOM, et al.,** Defendants.	01-cv-01351-JST **DECLARATION OF DIANA TOCHE, DDS** Date: September 24, 2021 Time: 9:30 a.m. Crtrm: 6, 2nd Floor Judge: The Honorable Jon S. Tigar Action Filed: April 5, 2001

I, Diana Toche, DDS, declare:

1. I have personal knowledge regarding the matters stated in this declaration, except for those statements made on information and belief. I am competent to testify to the matters set forth in this declaration, and would do so if called upon to testify. I submit this declaration in support of Defendants' response to the August 4, 2021 order to show cause and the August 20, 2021 order (ECF Nos. 3647 and 3653).

BACKGROUND

2. I am the Undersecretary of Health Care Services for the California Department of Corrections and Rehabilitation (CDCR). I have served in this role since 2014. I advise the Secretary of CDCR on major policy, program, and organizational issues related to the administration and delivery of health care to CDCR's incarcerated population. I determine and execute health care priorities, plans, policies, and programs consistent with the direction of CDCR, and develop and direct the implementation of initiatives that will be sustainable and improve the efficacy of CDCR's health care system. I formulate and oversee the implementation of priority initiatives that cut across division and program areas including health care, rehabilitative programs, and re-entry. In my current role, I work closely with the court-appointed Receiver who oversees the delivery of medical care to CDCR's incarcerated population. By way of distinction, my role includes oversight of other forms of health care, including mental and dental health care. I have been employed by CDCR since 2009, and previously served as Acting Undersecretary of Administration and Offender Services, Acting Director of the Division of Health Care Services, and Statewide Dental Director. I worked in private practice from 1989 to 2008 before joining CDCR.

CDCR'S RESPONSE TO THE COVID-19 PANDEMIC

3. From the outset of the pandemic, CDCR has partnered with the Receiver to address the ever-evolving circumstances presented by the COVID-19 virus, and to protect those who live and work in CDCR's institutions from infection or harmful effects from the virus. I have personally been actively involved in planning and overseeing CDCR's response to the pandemic. Throughout the evolution of the virus, CDCR has partnered with the Receiver to implement measures recommended by the United States Centers for Disease Control and Prevention (CDC) and the California Department of Public Health (CDPH) to mitigate the spread of COVID-19 in CDCR's institutions. These mitigation efforts, along with CDCR's vaccination efforts discussed below, are meant to complement one another as part of a multi-layered approach to reduce the risk of infection and harm from COVID-19.

4. A non-exhaustive list of the steps CDCR has taken in response to the COVID-19 pandemic can be found in the previously-filed declarations of Connie Gipson (ECF Nos. 3240, 3275, and 3508), and on CDCR's website.[1] In addition to these measures, CDCR has undertaken a months-long housing unit ventilation project to upgrade its housing unit ventilation filters, inspect housing unit filters to determine if they are functioning as designed, and identify needed improvements along with proposals for the Secretary's consideration.

5. CDCR implemented additional safety measures for patients classified as "medically high-risk," including those with COVID-19 risk scores greater than 3, and those with scores greater than 6, calculated based on a rubric assigning scores to certain patient traits and health conditions.

6. For example, most recently and consistent with the most up-to-date public health guidance, CDCR will offer a third dose of a COVID-19 vaccine to immunocompromised patients in accordance with public health guidance from the CDC and CDPH. Attached to this declaration as **Exhibit A** is a true and correct copy of an August 20, 2021 memorandum setting forth CDCR and CCHCS's policy and instructions to employees regarding the administration of third doses, and announcing a goal to offer all moderately to severely immunocompromised patients a third dose by September 6, 2021. CDCR will initially focus on its approximately 3,250 patients with organ transplants, HIV, and cancer. As of August 27, 2021, 22 percent of patients who qualify for a booster shot based on their immunocompromised status have already received a third dose.

7. As another example, in October 2020, CDCR started offering medically high-risk patients with COVID-19 risk scores of 3 or greater the option to move into cells. People housed in cells with solid walls and doors that close share airspace with far fewer people than those in dorm settings, and therefore reduces the risk that people housed in them will contract COVID-19. At the same time, CDCR stopped transferring medically high-risk patients to institutions with few or no cells with solid walls and doors. This practice remains in place for unvaccinated patients

[1] Cal. Dep't. Corr. & Rehabilitation, *COVID-19 Response Efforts*, https://www.cdcr.ca.gov/covid19/covid-19-response-efforts/ - Vaccine (last visited Aug. 27, 2021)

with COVID-19 risk scores of 3 or greater.[2]

CDCR'S COVID-19 VACCINATION EFFORTS

8. Based on public health guidance regarding the efficacy of available COVID-19 vaccines,[3] CDCR was an early proponent of providing the COVID-19 vaccine to its staff and incarcerated population as quickly as supplies allowed. Indeed, while vaccines were in limited supply, CDCR partnered with the Receiver to prioritize vaccinating incarcerated people at its institutions as soon as vaccine doses became available in California, and started offering vaccinations to patients earlier than most other states. CDCR administered vaccines to patients and staff in accordance with guidance from CDPH, which addressed the limited access to vaccines by prioritizing certain categories of the population.[4] CDCR offered vaccines to medically high-risk and elderly patients in Phase 1A of the vaccine rollout and then to all incarcerated people in Phase 1B.[5] CDCR began vaccinating front-line staff and patients in long-term facilities, its Skilled Nursing Facility, and similar facilities on December 22, 2020, followed by medically high-risk patients, and later the rest of the incarcerated population.

9. Further, in early 2021, in an effort to administer as many vaccine doses as quickly as possible, CDCR's statewide Dental Director, Dr. Rosenberg, was instrumental in obtaining approval for California dentists to administer vaccines, in addition to doctors and other health care staff authorized to vaccinate patients.[6] This approval undoubtedly sped up administration of the vaccine both within CDCR and in the community outside of CDCR's institutions.

10. CDCR also established a Vaccination Planning and Implementation Committee that

[2] Cal. Corr. Health Care Services, *COVID-19 Screening and Testing Matrix for Patient Movement* 2 (June 18, 2021), https://cchcs.ca.gov/wp-content/uploads/sites/60/COVID19/Appendix13-PatientMovement.pdf.

[3] *See, e.g.,* Ctrs. Disease Cont. & Prevention, *COVID-19 Vaccines and Vaccination*, https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/fully-vaccinated-people.html (last visited Aug. 18, 2021).

[4] Cal. Dep't Pub. Health, *CDPH Allocation Guidelines for COVID-19 Vaccine During Phase 1A: Recommendation* (Dec. 5, 2020), https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/CDPH-Allocation-Guidelines-for-COVID-19-Vaccine-During-Phase-1A-Recommendations.aspx.

[5] Cal. Dep't. Corr. & Rehabilitation, *supra* n.1.

[6] Dr. Rosenberg's discussion of these efforts can be viewed at https://www.cdcr.ca.gov/insidecdcr/2021/02/18/cdcr-dentists-join-covid-19-vaccinationefforts/.

met on a regular basis from January 2021 to May 2021 to monitor vaccine clinic operations and ensure safe and efficient vaccine distribution to staff and patients. This committee successfully took on the challenging task of receiving COVID-19 vaccines allocated to CDCR, evaluating the populations and vaccination rates across each of CDCR's 35 institutions, and distributing vaccine doses to each institution across the state before the vaccine became widely available.

11. As of the date of this declaration, nearly 99 percent of CDCR's incarcerated population has been offered a COVID-19 vaccine at least once. Less than 2 percent of patients have not yet been offered a vaccine, and this is largely because they are either away from the institutions for court proceedings or are new arrivals in a CDCR institution and will be offered a vaccine as a matter of course. With these limited exceptions, any patient who is not vaccinated at this time has chosen not to be.

12. As of August 30, 2021, 78 percent of CDCR's patients have been inoculated against the COVID-19 virus, including the vast majority of people who are considered medically "high-risk:" 93 percent of COVID-naïve people aged 65 and over, 94 percent of COVID-naïve people with COVID-19 risk scores of 6 or more, and 89 percent of COVID-naïve people with risk scores of 3 or more. Health care staff continue to counsel patients who initially refused the vaccine to address their concerns, educate them about the benefits of accepting the vaccine, and encourage them to accept it. Patients who refuse the vaccine are also regularly provided with informational materials to help them decide whether to accept the vaccine. *See*, e.g. The Informed Patient: A San Quentin Newsletter, Issue 58, 3-4 (Aug. 6, 2021), a true and correct copy of which is attached as **Exhibit B.** And CDCR makes the vaccine readily accessible to persons who initially declined it—patients who initially declined need only submit a form or ask a health care staff member for the vaccine.

13. CDCR has also tried to persuade staff to accept the vaccination through the following:

- temporarily being excused from routine COVID-19 surveillance testing
- implementing a supplemental-paid-sick-leave program, which gives eligible staff

up to 80 hours of additional paid sick leave, including for vaccine-related illness;

- the opportunity to win a monetary prize,
- a COVID-19 mitigation advocate program which will focus on peer-to-peer education amongst staff members, and
- expanded vaccine clinics offered for at least five days and at least once per shift during the month of May 2021;

14. At this time, approximately 22 percent of CDCR's incarcerated population and 45 percent of CDCR's staff are not vaccinated against the COVID-19 virus which amounts to roughly 23,000 unvaccinated incarcerated persons and 29,000 unvaccinated staff.

CDCR'S IMPLEMENTATION OF CDPH'S AUGUST 19, 2021 PUBLIC HEALTH ORDER

15. I understand the Court issued an order on August 20, 2021 with questions regarding a public health order issued by CDPH on August 19, 2021. ECF No. 3653 at 3. I have reviewed these questions and can testify regarding CDCR's efforts to implement this public health order.

16. CDPH issued a public health order on August 19, 2021, mandating the COVID-19 vaccine for regularly assigned workers who provide health care and health care services, and workers who are regularly assigned to health care settings within correctional facilities.[7] The order defines the health care settings to which it applies.[8] The order requires these workers to be vaccinated by October 14, 2021.[9] The stated purpose of this order is, primarily, to protect particularly vulnerable populations and, secondarily, ensure a sufficient, consistent supply of workers in high-risk health care settings. *Id.*

17. CDCR promptly started implementing the August 19, 2021 public health order to cover the employees and parts of its institutions covered by the order. Preliminary guidance for

[7] Cal. Dep't. Pub. Health, *State and Local Correctional Facilities and Detention Centers Health Care Worker Vaccination Requirement* (Aug. 19, 2021), https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Correctional-Facilities-and-Detention-Centers-Health-Care-Worker-Vaccination-Order.aspx.

[8] *Id.*

[9] *Id.*

implementing the public health order is set forth in a statement Defendants filed with the Court on August 25, 2021. This statement describes an August 23, 2021 memorandum CDCR issued to its employees. For ease of reference, a true and correct copy of CDCR's memorandum is attached to this declaration as **Exhibit C**.

18. CDCR's August 23, 2021 memorandum also implements a public health order CDPH issued on July 26, 2021 COVID-19 mitigation measure, which requires all workers in correctional settings to either show proof of vaccination against COVID-19 or submit to weekly COVID-19 testing in addition to wearing masks.[10] Ex. C at 3. CDCR exceeds CDPH's order by requiring workers in correctional settings who are not fully vaccinated or who cannot show proof of vaccination to submit to twice-weekly testing. *Id.*

19. I understand the Court asked "how many incarcerated people at higher risk of severe illness or death from COVID-19 are housed outside of the institutions or areas identified by Defendants" in their August 25, 2021 statement. ECF No. 3653 at 3. Approximately 4,250 "higher risk" patients with COVID-19 risk scores of 6 or greater are currently not housed in the health care settings identified in Defendants' August 25, 2021 statement. This number excludes patients at the California Medical Facility, the California Health Care Facility, Community Rehabilitative Program Placements, the Department of State Hospitals, the Correctional Treatment Center, Enhanced Out Patient units, Mental Health Intermediate Care Facilities, Mental Health Crisis Beds, Out-Patient Housing Units, the Psychiatric Inpatient Program, and Psychiatric Services Unit Beds. This number includes patients in Administrative Segregation Units, Debrief Processing Units, Condemned housing, Family Visiting, General Population, Non-Designated Program Facilities, Protective Housing Units, Reception Centers, Restricted Custody General Population, Securing Housing Units, Sensitive Needs Yards, Short Term Restricted Housing, Varied Use, and Work Crew beds. As discussed above, 94 percent of patients with COVID-19 risk scores of 6 or greater and who have not yet contracted COVID-19 are inoculated

[10] Cal. Dep't. Pub. Health, *Health Care Worker Protections in High-Risk Settings* (July 26, 2021), https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Unvaccinated-Workers-In-High-Risk-Settings.aspx.

against the virus.

20. I also understand the Court asked "if Defendants are not requiring vaccines for staff in quarantine and isolation areas, the Court would like to know whether there is any basis for concluding that persons housed in those areas are at lower risk than those housed in covered areas or institutions." ECF No. 3653 at 3. Unlike the health care settings identified in Defendants' August 25, 2021 statement, quarantine and isolation areas are typically located in housing units. Currently, CDCR has some designated spaces set aside for quarantine and isolation purposes that are empty, with no patients or assigned workers.

21. Moreover, each instance requiring quarantine or isolation of patients following a COVID-19 exposure is different, and health care and custody staff collaboratively determine the most appropriate place for quarantine or isolation in each case. For example, in one case, it might be appropriate to quarantine patients in place, and in another, it might be appropriate to quarantine them in a different part of the housing unit than where they live.

22. Additionally, the August 19, 2021 public health order requires workers regularly assigned to provide health care and health care services to be vaccinated,[11] and CDCR requires all workers to wear appropriate personal protective equipment. In isolation areas, appropriate personal protective equipment includes an N95 mask, eye protection, and, when in direct contact with isolation patients, gloves and gowns. These workers may go to quarantine and isolation areas to provide health care or health care services to patients.

23. Finally, to the extent the Court's question is in regards to COVID-19 risk scores of patients in quarantine and isolation areas, it is not possible to know which patients need to be quarantined or isolated until an exposure happens.

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[11] Cal. Dep't. Pub. Health, *supra* n.7.

I declare under penalty of perjury that I have read this document, and its contents are true and correct to the best of my knowledge. Executed on August 30, 2021, in Sacramento, California.

Diana Toche DDS

Diana Toche, DDS
Undersecretary, Health Care Services
California Department of Corrections and Rehabilitation

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

OAKLAND DIVISION

MARCIANO PLATA, et al., Plaintiffs, **v.** **EDMUND G. BROWN, et al.,** Defendants.	01-cv-01351-JST **DECLARATION OF JAMES WATT, MD, MPH** Date: September 24, 2021 Time: 9:30 a.m. Courtroom: 6, 2nd Floor Judge: The Honorable Jon S. Tigar Action Filed: April 5, 2001

I, James Watt, MD, MPH, declare:

1. I have personal knowledge regarding the matters stated in this declaration, except for those statements made on information and belief. I am competent to testify to the matters set forth in this declaration, and would do so if called upon to testify.

BACKGROUND AND EXPERIENCE

2. I am currently employed as the Chief of the Division of Communicable Disease Control of the Center for Infectious Diseases at the California Department of Public Health (CDPH). I held this role from 2010 until 2019, then returned to the role on July 13, 2020, after

serving for six-and-a-half months as CDPH's Acting Deputy Director of the Center for Infectious Diseases and Interim State Epidemiologist.

3. I received my Bachelor of Science degree in Biology and a Bachelor of Arts degree in German Studies at Stanford University. I received my Medical Degree from the University of California, San Diego, and I completed my residency in pediatrics at Oakland Children's Hospital in 1993. I received a Master's Degree in Public Health from the University of California, Berkeley, in 1995. I hold a California medical license and am board certified in pediatrics.

4. In 1996, after completing my formal schooling, I joined the California Department of Health Services (CDHS) as a contract Public Health Medical Officer II. (CDHS was reorganized later and became two agencies, the California Department of Health Care Services (DHCS) and CDPH.) Three years later, I joined the federal Centers for Disease Control and Prevention (CDC) as an Epidemic Intelligence Service Officer in the Respiratory Diseases Branch. I held that role until 2001, when I became an Assistant Scientist in the School of Public Health at Johns Hopkins University. In 2006, I returned to CDPH, where I have been employed since.

5. In addition to my role at CDPH, I am an Associate at the Johns Hopkins University Bloomberg School of Public Health and a Clinical Professor at the University of California, San Francisco, School of Medicine. In these positions, I teach graduate students in public-health schools and medical schools about communicable disease control.

6. During my career, I have published over 60 scientific peer-reviewed papers focused on infectious diseases. As a physician scientist, my research has focused on the diverse challenges that we face in preventing infectious diseases, including emerging infections, and vaccine safety and efficacy. I have provided international consultation to address infectious diseases in many regions of the world. I have served on a variety of advisory panels on communicable disease control, including at the CDC and the World Health Organization (WHO). My professional accomplishments have been recognized through honors and awards including the U.S. Public Health Service Achievement Medal in 2000, the National Center for Infectious Diseases Honor Award in 2001, and Outstanding Achievement Awards from CDPH in 2015 and

2016. My education, professional background, and publications are described in additional detail in my curriculum vitae, attached as Exhibit A.

RECENT PUBLIC HEALTH ORDERS REQUIRING COVID-19 VACCINATION OF HEALTHCARE WORKERS AND JUSTIFICATION FOR THE ORDERS

7. On July 26, 2021, CDPH issued a public health order requiring staff in healthcare settings to either show proof of vaccination against COVID-19 or, in the absence of such proof, submit to regular COVID-19 testing.[1]

8. On August 5, 2021, CDPH issued a public health order requiring health care workers and others who work in facilities providing health care services to be vaccinated with a COVID-19 vaccine by September 30, 2021.[2] The stated public health basis for this order is "to protect particularly vulnerable populations, and ensure a sufficient, consistent supply of workers in high-risk health care settings." The order should achieve this purpose by reducing the spread of the virus in health care settings and by decreasing infections in health care workers generally. In making this order, CDPH recognized that high-risk health care settings are special, and that an order mandating that workers in those settings be vaccinated is warranted. In contrast, CDPH has not mandated that workers in most other workplaces in California be vaccinated or that all California residents must be vaccinated. In fact, the only other workplace where CDPH has mandated vaccination is in schools because children under age 12 are not yet eligible for the vaccine, and less than 47% of youth age 12-17 have been fully vaccinated.

9. As the August 5 order explained, "[h]ospitals, skilled nursing facilities (SNFs), and other health care facility types identified in this order are particularly high-risk settings where COVID-19 outbreaks can have severe consequences for vulnerable populations including hospitalization, severe illness, and death." One reason to mandate vaccination in these types of healthcare settings is because there are often a large number of medically vulnerable patients

[1] Cal. Dep't. Pub. Health, *Health Care Worker Protections in High-Risk Settings* (July 26, 2021), https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Unvaccinated-Workers-In-High-Risk-Settings.aspx.

[2] Cal. Dep't. Pub. Health, *Health Care Worker Vaccine Requirement* (Aug. 5, 2021), https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Health-Care-Worker-Vaccine-Requirement.aspx.

concentrated within them. In addition, many health care facilities in the community are open to children who cannot yet be vaccinated.

10. Another justification for the August 5 order's focus on health care workers is that it will help ensure that the State's critical health care workers are protected from infection so that they can continue to treat patients during the pandemic. Cases among health care workers continue to be reported to CDPH.

11. On August 7, 2021, CDPH published a clarification regarding the applicability of the August 5 order, explaining that the July 26 order, and not the August 5 order, applies to adult and senior care facilities, homeless shelters, and state and local correctional facilities.[3]

12. On August 19, 2021, CDPH issued a public health order specifically addressing health care workers and health care settings in correctional facilities.[4] That order requires all health care workers and other workers who are regularly assigned to work in high risk health care settings within correctional facilities to receive the full course of a COVID-19 vaccine by October 14, 2021. As with the August 5 order, the focus of the August 19 order is health care workers and others working in healthcare settings. Likewise, the underlying purpose of the order—to protect particularly vulnerable populations receiving care in health care settings, and ensure a sufficient, consistent supply of workers in high-risk health care settings—is the same.

13. The public-health basis for the August 19 order is to (1) prevent the spread of infection within health care facilities where vulnerable patients are often concentrated, and (2) protect the health care workers who provide health care services in correctional facilities from infection so that they can continue to treat patients in those facilities. Reducing transmission in health care settings can help ensure a sufficient, consistent supply of workers in those settings by reducing staff absence due to infection or exposure.

[3] Cal. Dep't. Pub. Health, *Public Health Order Questions & Answers: Health Care Worker Vaccine Requirement* (Aug. 20, 2021), https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/FAQ-Health-Care-Worker-Vaccine-Requirement.aspx.

[4] Cal. Dep't. Pub. Health, *State and Local Correctional Facilities and Detention Centers Health Care Worker Vaccination Requirement* (Aug. 19, 2021), https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Correctional-Facilities-and-Detention-Centers-Health-Care-Worker-Vaccination-Order.aspx.

14. Although they are very similar, there are some differences between the orders issued by CDPH on August 5 and August 19. This is because health care settings in correctional facilities are not the same as those in communities, and CDPH endeavors to draft public health orders that are practical and reasonable for the settings in which they will apply. Health care settings integrated into correctional facilities are far more restricted than traditional health care settings in communities. Additionally, the movement in and out of correctional facilities is far more controlled than movement in and out of community health care facilities. The public does not have access to correctional facilities absent prior approval or a security check. And in the context of CDCR's prisons, all those entering the prisons are required to wear masks, and either be vaccinated or have a negative COVID-19 test result within the last 72 hours. It is primarily the correctional facilities' staff who enter and exit the prisons on a daily basis, and they are subject to the requirements of the July 26 public health order in addition to any other screening policies the facility might implement. By contrast, community health care facilities are typically open to the public and visitors. As a result, there is generally much more traffic going in and out of community health care facilities because staff, patients, visitors, and others freely enter and exit community health care facilities on a daily basis.

15. I understand that the Court expressed interest in the reason why the language "or to which patients have access for any purpose," which was included in the August 5 order, was not included in the August 19 order. That language was excluded from the August 19 order because in the correctional context it would be likely to create confusion. In a community hospital, that language would be consistent with CDPH's focus on health care settings where medically high-risk patients are likely to be concentrated. But in the correctional context, that language could be interpreted to include many areas outside of health care settings, such as housing, recreation, and education areas. Such an interpretation is beyond the intended scope of the August 19 order, which is focused on health care settings where medically high-risk patients are likely to be concentrated.

16. I understand that 78% of the incarcerated population within CDCR's correctional facilities are vaccinated. And, using age and the court-appointed Receiver's rubric for classifying

incarcerated people as medically high-risk, I understand that 93% of those over the age of 65 in California's prisons who have not previously contracted COVID-19 are vaccinated, and 94% of those with a COVID-19 risk score of six and above who have not previously contracted COVID-19 are vaccinated. (Decl. Diana Toche Supp. Defs.' Resp. OSC ¶ 12.) This means that the overwhelming majority of medically vulnerable patients in CDCR's prisons are protected by vaccination and are mostly surrounded by a vaccinated incarcerated population.

17. While the August 19 order does not extend the mandatory vaccine mandate to all areas within all prisons, jails, and detention centers statewide, those settings are covered by the July 26 order requiring vaccination or testing in those settings. Additionally, I am aware that the California Department of Corrections and Rehabilitation (CDCR) has implemented other safety measures, such as requiring unvaccinated staff to be tested for COVID-19 twice per week before entering the facilities, mask wearing, and physical distancing. (Decl. Diana Toche Supp. Defs.' Resp. OSC ¶¶ 3-7, 18.) These measures, when considered in conjunction with the relatively high rate of vaccination among the incarcerated population, will significantly mitigate the spread of the virus.

18. I understand the Court has inquired whether a medically high-risk patient in a health care setting would be more at risk of severe illness from an exposure to COVID-19 than if the patient were in some other location in a correctional facility. This is a difficult question to answer because the nature and conditions of two different exposures are never the same. There are two factors to consider when evaluating risk—the likelihood of exposure and the intensity of an exposure if it occurs. The August 19 public health order requires vaccination for all workers regularly assigned to settings in correctional institutions that are most likely to house persons at high risk for more severe disease, namely "hospitals, skilled nursing facilities, intermediate care facilities, or the equivalent." Outside of these settings, incarcerated persons are likely to have widely variable levels of risk, depending on the institution and the location within the institution of an exposure. The August 19 public health order is designed to apply to all correctional facilities in the state, many of which will not have significant numbers of persons at high risk. The best way for patients in correctional settings to reduce their risk of severe illness—regardless

of location—would be to get vaccinated. I understand a COVID-19 vaccine has been offered to virtually all patients in CDCR's correctional facilities, and that it remains available to any patient who requests vaccination. (Decl. Diana Toche Supp. Defs.' Resp. OSC ¶ 11.)

I declare under penalty of perjury that the foregoing is true and correct. Executed on August 29, 2021, in Albany, California.

James Watt

James Watt, MD, MPH
Chief, Division of Communicable Disease Control
Center for Infectious Diseases
California Department of Public Health

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"require for its enforcement the continuous supervision by the federal court over the conduct of [state officers]." *Armstrong v. Brown*, 768 F.3d 975, 983 (9th Cir. 2014). An order that deprives prison administrators of the flexibility to adjust their procedures in response to future needs cannot be considered the least intrusive remedy under the PLRA. *See Westefer v. Neal*, 682 F.3d 679, 684 (7th Cir. 2012) (reversing injunction that "effectively constitutionaliz[ed]" prison officials' own policies and procedures).

Here, the proposed prospective relief at issue—mandatory vaccination of all staff entering CDCR's institutions and only a limited category of incarcerated people—is not narrowly drawn, extends further than necessary, and is not the least intrusive means of protecting the Plaintiff class from COVID-19 for several reasons. First, the order largely ignores the vaccination of class members themselves, and appears designed to protect staff members primarily. It is therefore not narrowly tailored to protect *class members* from severe illness, hospitalization, death from COVID-19. Second, CDCR is already requiring twice-weekly testing of unvaccinated workers and is in the process of implementing a vaccination policy that is far more narrowly tailored than the Receiver's proposal, in that it applies to workers regularly assigned to provide health care or health care services, or who are regularly assigned to work in health care settings, rather than virtually every CDCR worker. *See* ECF No. 3657. Third, additional measures developed in partnership with the Receiver are being implemented to increase acceptance of the vaccine among staff and the incarcerated population. These measures, described further below, are more narrowly drawn and less intrusive than a court order mandating the vaccination of virtually all staff members. Finally, the Receiver's proposed policy would shift focus away from the vaccination of incarcerated people, and instead focus on the vaccination of staff who are largely outside of the Receiver's authority. Because the Receiver's proposed policy at issue would violate the PLRA's strict needs-narrowness-intrusiveness limitations, this Court may not order its implementation.

A. The Receiver's Recommended COVID-19 Vaccination Policy is Not Narrowly Drawn, Extends Further Than Necessary, and is Not the Least Intrusive Means to Achieve the Stated Goal.

The stated goal of the Receiver's proposed policy is to "ensure adequate protection and care for incarcerated persons[.]" ECF no. 3638 at 5. And the CDC advises that vaccination against COVID-19 is a "critical" prevention measure that greatly reduces the risk of infection, serious illness, hospitalization, and death for patients who accept it. *See* Ctrs. Disease Cont. & Prevention, *COVID-19 Vaccines and Vaccination*, https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/fully-vaccinated-people.html (last visited Aug. 30, 2021); *see also* Ctrs. Disease Cont. & Prevention, *Delta Variant: What We Know About the Science*, https://www.cdc.gov/coronavirus/2019-ncov/variants/delta-variant.html (last visited Aug. 30, 2021). But the Receiver's proposed mandatory vaccine policy primarily targets *staff*, not incarcerated people whom the policy is meant to protect.

Defendants are not aware of public health guidance that an unvaccinated person is safer remaining unvaccinated while surrounded by vaccinated people, than he would be if he were fully vaccinated himself. *See id.*; *see also* Decl. Vijayan, ECF No. 3638-3, Decl. Bick, ECF No. 3638-1, and Supp. Decl. Bick, ECF No. 3652. Indeed, fully vaccinated people can still contract the virus and spread it to the unvaccinated. And while the risk of infection, serious illness, and death is not wholly eliminated for vaccinated people who contract the virus, it is greatly reduced. Ctrs. Disease Cont. & Prevention, *Delta Variant: What We Know About the Science*, https://www.cdc.gov/coronavirus/2019-ncov/variants/delta-variant.html (last visited Aug. 30, 2021); Supp. Decl. Bick, ECF No. 3652 at 3.

The CDC warns that unvaccinated people remain the greatest concern, not simply due to transmission concerns, but also because "the Delta variant might cause more severe illness than previous strains in unvaccinated persons." *Id.* Thus, and as the Receiver argues, the benefit of being fully vaccinated is that a vaccinated person will have strong protection against serious illness and death. *Id.*; *see* ECF No. 3638 at 22. In other words, the best form of protection against serious illness and death is for an individual to be vaccinated, and not simply to ensure

that others around the unvaccinated individual are vaccinated. This is why a mandate requiring all those who enter prisons to be vaccinated, even if fully implemented, would not have the intended effect of fully preventing serious illness, hospitalization, and death to the incarcerated population if some within that population remain unvaccinated. And yet, the Receiver's report nonetheless concludes that the best way to keep the incarcerated population safe is to vaccinate staff. ECF No. 3686 at 5. That conclusion notably does not explain why the mandatory vaccination of staff would accomplish this goal better than the mandatory vaccination of incarcerated people themselves.[4]

The type of strategy the Receiver recommends is akin to the CDC's guidance for K-12 schools. Specifically, the CDC encourages using multiple prevention strategies together and consistently to protect children under the age of 12 *who are not eligible* for vaccination at this time. Centers for Disease Control & Prevention, *K-12 Schools*, https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/k-12-guidance.html (last visited Aug. 30, 2021). CDCR similarly implemented layered prevention strategies early in the pandemic before vaccines were available and continues to do so, as discussed above. But the difference here is that, unlike many school-aged children, each class member is eligible for vaccination and, with very limited exception, those who remain unvaccinated remain so by choice. *Id*. at ¶ 11. An injunction requiring that 29,000 staff be vaccinated to protect 23,000 incarcerated people who have chosen not to be vaccinated is not a narrowly tailored remedy.

B. CDCR is Implementing a Staff Vaccination Policy That is Far More Narrowly Tailored Than the Receiver's Recommended Policy.

On August 19, 2021, CDPH issued an order requiring certain workers in the state prison system to be fully vaccinated against COVID-19, absent a religious or qualifying medical exemption. Cal. Dep't. Pub. Health, *State and Local Correctional Facilities and Detention*

[4] Defendants do not object to the portion of the Receiver's policy that calls for the vaccination of incarcerated people who choose to work outside of an institution or who accept in-person visitation, because it would appropriately require the class members themselves to accept an offered medical intervention that would provide them with the best possible protection from COVID-19.

Centers Health Care Worker Vaccination Requirement (Aug. 19, 2021), https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Correctional-Facilities-and-Detention-Centers-Health-Care-Worker-Vaccination-Order.aspx. All other workers must either be vaccinated or test twice weekly. ECF No. 3657 at 3. The underlying purpose of this public health order is the same as the public health order issued on August 5, 2021—to protect particularly vulnerable populations receiving care in health care settings and ensure a consistent supply of health care workers—and is tailored to the unique needs of correctional facilities. Decl. Watt at ¶ 12.

On August 23, 2021, CDCR promptly issued guidance regarding the implementation of the August 19, 2021 public health order. Decl. Toche, Ex. C. Defendants described the implementation process in a statement filed on August 25, 2021. *See* ECF No. 3657. Specifically, every worker at the California Health Care Facility, the California Medical Facility, and the Skilled Nursing Facility at the Central California Women's Facility must be vaccinated by October 14, 2021, absent a religious or medical exemption. *Id*. at 2. Additionally, all regularly assigned workers in health care settings at every CDCR institution, and all workers regularly assigned to provide health care or health care services must be vaccinated by October 14, 2021, absent a religious or medical exemption. *Id*. Workers approved for a religious or medical exemption will undergo mandatory twice-weekly testing. *Id*. at 3. All other workers assigned to non-health care settings must either provide proof of vaccination or undergo twice-weekly testing. *Id*.

CDPH's new public health order, which targets employees who work closely with *particularly* vulnerable patients, is more narrowly tailored and less intrusive than the Receiver's proposal to impose a mandate on every employee who enters CDCR's institutions. The Receiver's more expansive policy does not comply with the PLRA's restrictions on prospective relief.

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

MARCIANO PLATA, et al.,

Plaintiffs,

v.

GAVIN NEWSOM, et al.,

Defendants.

Case No. 01-cv-01351-JST

ORDER MODIFYING SCHEDULE ON AUGUST 9, 2021 ORDER TO SHOW CAUSE

Re: ECF No. 3647

On August 9, 2021, the Court issued an order to show cause as to why it should not order that the Receiver's recommendations regarding mandatory vaccinations be implemented. ECF No. 3647. In that order, the Court observed that, on August 5, 2021, the State Public Health Officer mandated full COVID-19 vaccination for workers in certain health care facilities "to reduce the chance of transmission to vulnerable populations" in "particularly high-risk settings where COVID-19 outbreaks can have severe consequences for vulnerable populations"; that the California Department of Public Health ("CDPH") had so far taken the position that the mandate did not apply to correctional facilities; and that CDPH intended to issue further guidance "that considers the unique circumstances of health care integrated into a congregate setting." *Id.* at 2-3.

On August 19, 2021, the State Public Health Officer issued a "Correctional Facilities and Detention Centers Health Care Worker Vaccination Order." The order provides for mandatory vaccination of:

> a. All paid and unpaid individuals who are regularly assigned to provide health care or health care services to inmates, prisoners, or detainees. This may include nurses, nursing assistants, nurse practitioners, physicians, physician assistants, technicians, therapists, phlebotomists, pharmacists, mental health providers, students and trainees, dietary, and contractual staff not employed by the correctional facility.

b. All paid and unpaid individuals who are regularly assigned to work within hospitals, skilled nursing facilities, intermediate care facilities, or the equivalent that are integrated into the correctional facility or detention center in areas where health care is provided. This includes workers providing health care to inmates, prisoners, and detainees, as well as persons not directly involved in delivering health care, but who could be exposed to infectious agents that can be transmitted in the health care setting (e.g., clerical, dietary, environmental services, laundry, correctional officers, engineering and facilities management, administrative, and volunteer personnel).

CDPH, *Order of the State Public Health Officer Correctional Facilities and Detention Centers Health Care Worker Vaccination Order* (Aug. 19, 2021), https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Correctional-Facilities-and-Detention-Centers-Health-Care-Worker-Vaccination-Order.aspx.[1]

In light of the August 19 CDPH order, the Court modifies the schedule on the order to show cause as follows:

1. By August 25, 2021, Defendants shall file a statement that describes how they will implement the August 19 CDPH order. In particular, they shall identify (a) any institutions at which they will require all staff to be vaccinated and (b) for any remaining institutions, the areas in each institution for which they will require all staff to be vaccinated and the areas in which vaccination for all staff will not be required.

2. The deadline to file written responses to the order to show cause is extended to August 30, 2021.

3. In addition to the information required by the August 9 order, the parties, as well as

[1] A version of the order previously available at this link applied to "[a]ll paid and unpaid individuals who are regularly assigned to work within hospitals, skilled nursing facilities, intermediate care facilities, or the equivalent that are integrated into the correctional facility or detention center in areas where health care is provided *or to which inmate patients have access for any purpose*" (emphasis added). It is not apparent why the italicized phrase was removed, particularly given that the August 5 CDPH order applies to "all paid and unpaid individuals who work in indoor settings where (1) care is provided to patients, or (2) *patients have access for any purpose*." CDPH, *Order of the State Public Health Officer Health Care Worker Vaccine Requirement* (Aug. 5, 2021), https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Health-Care-Worker-Vaccine-Requirement.aspx (emphasis added).

proposed intervenors and CCPOA, if it chooses to file a responsive brief, shall state their position, supported by argument or admissible evidence as appropriate, on whether there is any public health basis for limiting mandatory vaccines to the areas identified by Defendants pursuant to paragraph 1 of this order. For example, the Court would like to learn how many incarcerated persons at higher risk of severe illness or death from COVID-19 are housed outside of the institutions or areas identified by Defendants, and whether there is any reason for concluding that these individuals are at lower risk than the high-risk individuals housed in the covered institutions or areas. Likewise, assuming that Defendants will require vaccines for staff in some but not all areas of one or more institutions, the Court would like to learn whether there is any basis for concluding that incarcerated persons housed in non-covered areas face lower risk in their housing units than they do in the covered areas of those institutions. Similarly, if Defendants are not requiring vaccines for staff in quarantine and isolation areas, the Court would like to know whether there is any basis for concluding that persons housed in those areas are at lower risk than those housed in covered areas or institutions. By providing these examples, the Court does not foreclose discussion of other factors the filing party might deem relevant.

4. The Receiver may file an initial response to the order to show cause by the same August 30 deadline.

5. The reply deadline is continued to September 10, 2021.

6. The hearing is continued to September 24, 2021, at 9:30 a.m. The Court will decide at a later date whether it will require or invite live testimony, or whether the hearing will be limited to oral argument.

IT IS SO ORDERED.

Dated: August 20, 2021

JON S. TIGAR
United States District Judge

United States District Court
Northern District of California

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

MARCIANO PLATA, et al.,

Plaintiffs,

v.

GAVIN NEWSOM, et al.,

Defendants.

Case No. 01-cv-01351-JST

ORDER TO SHOW CAUSE RE: RECEIVER'S RECOMMENDATION ON MANDATORY VACCINATION

Re: ECF No. 3638

The question of whether COVID-19 vaccinations should be mandatory for CDCR staff has been present in this case since at least February 2021. *See* ECF No. 3548 at 4-5. On August 4, 2021, the Receiver filed a report and recommendation concluding that:

> based on the advice of medical and public health professionals, including Dr. Joseph Bick, Director of Healthcare Services, California Correctional Health Care Services (CCHCS), that given the rapid and ongoing spread of the Delta variant in California, *mandatory COVID-19 vaccination for institutional staff is necessary to provide adequate health protection for incarcerated persons*. Once COVID-19 infection has been introduced into a prison, it is virtually impossible to contain, and staff are indisputably a primary vector for introducing into the prison the infection now spreading rapidly in the larger community. Therefore, the only method to ensure adequate protection and care for incarcerated persons is vaccination of all persons who can bring infections into the prison. The Receiver also accepts the view of medical and public health professionals that such a policy protects the health of staff and the surrounding communities.

ECF No. 3638 at 5 (emphasis added). The Receiver recommends "that access by workers to CDCR institutions be limited to those workers who establish proof of vaccination (or have established a religious or medical exemption to vaccination)," and he further recommends "that incarcerated persons who desire to work outside of the institution (e.g., fire camps) or to have in-person visitation must be vaccinated (or establish a religious or medical exemption)." *Id.* at 2.

He has also concluded that "[d]elaying a mandatory vaccination policy until the next wave is upon us will not produce results until it is too late and the worst of the wave is over." *Id.* at 26.

On August 5, 2021, the State Public Health Officer issued an order mandating full COVID-19 vaccination for workers in certain health care facilities, including skilled nursing facilities, dialysis centers, hospice facilities, and clinics and doctor offices. Cal. Dep't of Pub. Health ("CDPH"), *Order of the State Public Health Officer Health Care Worker Vaccine Requirement* (Aug. 5, 2021), https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Health-Care-Worker-Vaccine-Requirement.aspx. The order defines "worker" to include "all paid and unpaid individuals who work in indoor settings where (1) care is provided to patients, or (2) patients have access for any purpose," and to specifically include "persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the health care setting," including "security." *Id.*

The State Public Health Officer explained that vaccination "is the most effective means of preventing infection with the COVID-19 virus, and subsequent transmission and outbreaks"; that "[r]ecent outbreaks in health care settings have frequently been traced to unvaccinated staff members"; and that he was issuing the order "to reduce the chance of transmission to vulnerable populations." *Id.* He also characterized the settings in which vaccines were being mandated as "particularly high-risk settings where COVID-19 outbreaks can have severe consequences for vulnerable populations including hospitalization, severe illness, and death," and explained that "the settings in this order share several features. There is frequent exposure to staff and highly vulnerable patients, including elderly, chronically ill, critically ill, medically fragile, and disabled patients. In many of these settings, the patients are at high risk of severe COVID-19 disease due to underlying health conditions, advanced age, or both." *Id.*

These descriptors would appear to apply equally to CDCR prisons, all of which include clinics, and some of which include other health care facilities specifically identified in the order. Perhaps for that reason, the California Correctional Peace Officers' Association ("CCPOA") has indicated that the order, "if legal, would appear to potentially preempt the Receiver's Recommendation." ECF No. 3644 at 2. However, CDPH has so far taken the position that the

August 5 order does not apply to "State and Local Correctional Facilities" and has stated its intent to issue "forthcoming guidance . . . that considers the unique circumstances of health care integrated into a congregate setting." CDPH, *FAQ – Health Care Worker Vaccine Requirement* (Aug. 5, 2021), https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/FAQ-Health-Care-Worker-Vaccine-Requirement.aspx. Thus, the Receiver's recommendations are not moot.

Accordingly, the Court orders the parties to show cause as to why it should not order that the Receiver's recommendations be implemented.[1] The Court has reviewed the proposed briefing schedules submitted by the parties, the Receiver, and CCPOA, ECF Nos. 3642-45, and now orders as follows:

1. The parties shall file written responses to this order to show cause no later than August 23, 2021. CCPOA may file a response by the same date, with or without seeking intervention.

2. Any requests for intervention or permission to file amicus briefs shall be filed by the same date. Requests for intervention shall be accompanied by the proposed complaint in intervention as well as the proposed brief in response to this order to show cause. Proposed intervenors shall indicate in their request for intervention whether the parties oppose or support intervention. Requests to appear as amicus curiae shall be accompanied by the proposed brief in response to this order to show cause.

3. The parties, CCPOA, and any intervenors whose requests to intervene have been granted may file reply briefs no later than September 3, 2021. The Receiver may file a reply by the same deadline. Unless otherwise ordered, amicus curiae and proposed intervenors whose requests to intervene are denied may not file reply briefs.

4. In addition to making any legal arguments, the parties, CCPOA, and any proposed intervenors must state their opinion on whether they agree or disagree with the public health conclusions described in the Receiver's report. If they disagree, they shall support their position by declarations. They must also state their position, supported by argument or admissible

[1] Nothing in this order precludes the Receiver from implementing his recommendations without a court order if he determines that it is appropriate to do so.

evidence as appropriate, on whether the rationale behind the State Public Health Officer Order of August 5, 2021, applies to some or all of CDCR's employees.

5. The Court tentatively sets this matter for hearing on September 16, 2021, at 2:00 p.m. This date is subject to change if, for example, the Court concludes that an evidentiary hearing is necessary to explore whether there is any public health basis for rejecting the Receiver's recommendations, particularly in light of the State Public Health Officer's August 5, 2021 order.

IT IS SO ORDERED.

Dated: August 9, 2021

JON S. TIGAR
United States District Judge

United States District Court
Northern District of California

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Report of J. Clark Kelso, Receiver

Regarding a Mandatory COVID-19 Vaccination Policy for California Department of Corrections and Rehabilitation Personnel Working within Institutions and for Incarcerated Persons with Outside Contacts

August 4, 2021

MUNGER TOLLES & OLSON LLP

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This report sets forth (a) the public health basis for adopting a mandatory COVID-19 vaccination policy, with medical and religious exemptions, for staff working in or entering California Department of Corrections and Rehabilitation (CDCR) institutions; and (b) the Receiver's recommendation of such a policy as a matter of public health necessity as to workers who enter institutions and as to incarcerated persons who accept employment outside CDCR institutions or receive in-person visits.

The Receiver believes, based on the advice of medical and public health professionals, including Dr. Joseph Bick, Director of Healthcare Services, California Correctional Health Care Services (CCHCS), that given the rapid and ongoing spread of the Delta variant in California, mandatory COVID-19 vaccination for institutional staff is necessary to provide adequate health protection for incarcerated persons. Once COVID-19 infection has been introduced into a prison, it is virtually impossible to contain, and staff are indisputably a primary vector for introducing into the prison the infection now spreading rapidly in the larger community. Therefore, the only method to ensure adequate protection and care for incarcerated persons is vaccination of all persons who can bring infections into the prison. The Receiver also accepts the view of medical and public health professionals that such a policy protects the health of staff and the surrounding communities.

The arrival of the Delta variant poses enormous risks to incarcerated persons and staff and to the ability of the medical system to care for patients. The best available medical science shows that in populations—particularly in congregate settings—with significant unvaccinated populations, the Delta variant *will* cause new outbreaks, increased hospitalizations, and deaths. Efforts short of a mandatory vaccination requirement have not raised the vaccination rate sufficiently to prevent these consequences.

A mandatory vaccination policy is medically necessary for those individuals who regularly go in and out of CDCR facilities—or receive visitors to those facilities—and so cannot be effectively quarantined with each visit. That group includes institutional staff and other CDCR employees who enter institutions, and incarcerated persons who choose to work outside an institution or receive in-person visitation. Given the medical case for mandatory vaccination in the circumstances, the Receiver respectfully recommends that the Court issue an order to show cause why it should not order CDCR and CCHCS to implement such a policy.

I. The ability of COVID-19 to cause great harm – including death – to those incarcerated in CDCR institutions is beyond dispute.

The global COVID-19[1] pandemic has resulted in more than 198 million cases and 4.2 million deaths as of July 2021.[2] Because of unavoidable aspects of prison life, infection rates in California prisons – and in prisons around the world – are dramatically higher than in the free population. In CDCR facilities, 49,580 incarcerated people – 50% of all persons incarcerated by CDCR – have had a confirmed case of COVID-19.[3] To date, 232 incarcerated people have died of COVID-19.[4] By contrast, statewide in California there have been 3.87 million confirmed cases, about 9.5% of the state population, and at least 64,085 deaths.[5] Incarcerated persons are five times as likely to be infected in outbreaks and nearly three times more likely to die.

COVID-19 can cause pneumonia and other severe respiratory symptoms, major organ damage, strokes, blood clots, multisystem inflammatory syndrome, sepsis, and death.[6] Patients who survive COVID-19 often suffer long-term effects including fever, chest pains, shortness of breath, diarrhea, vomiting, sudden onset diabetes and hypertension, mood disorders, and

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[1] Coronavirus disease 2019 (COVID-19) is the disease caused by the coronavirus severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). For ease and clarity, this report will use "COVID-19" throughout to refer both to the virus and the disease it causes.

[2] Johns Hopkins University of Medicine, Coronavirus Resource Center, COVID-19 Dashboard, https://coronavirus.jhu.edu/map.html (accessed Aug. 2, 2021).

[3] California Department of Corrections and Rehabilitation, Population COVID-19 Tracking, https://www.cdcr.ca.gov/covid19/population-status-tracking/ (accessed Aug. 2, 2021).

[4] *Id*.

[5] State of California, Tracking COVID-19 in California, https://covid19.ca.gov/state-dashboard/ (accessed Aug. 2, 2021).

[6] Vijayan Decl. ¶ 4; Mayo Clinic, *COVID-19 (coronavirus): Long-term effects*, https://www.mayoclinic.org/diseases-conditions/coronavirus/in-depth/coronavirus-long-term-effects/art-20490351. *See also* Sapna Bamrah Morris, et al., *Case Series of Multisystem Inflammatory Syndrome in Adults Associated with SARS-CoV-2 Infection – United Kingdom and United States, March-August 2020*, 69 MMWR 1450 (Oct. 9, 2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6940e1.htm; Myoung-Hwa Lee, et al., *Microvascular Injury in the Brains of Patients with COVID-19*, 384 New Eng. J. Med. 481 (Feb. 4, 2021), https://www.nejm.org/doi/10.1056/NEJMc2033369; Alexander E. Merkler, et al., *Risk of Ischemic Stroke in Patients With Coronavirus Disease 2019 (COVID-19) vs Patients With Influenza*, 77 JAMA Neurology 1366 (July 2, 2020), https://jamanetwork.com/journals/jamaneurology/fullarticle/2768098; Tahmineh Mokhtari, et al., *COVID-19 and multiorgan failure: A narrative review on potential mechanisms*, J. Mol. Histol. (Oct. 4, 2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7533045/#; Charles Ochieng' Olwal, et al., *Parallels in Sepsis and COVID-19 Conditions: Implications for Managing Severe COVID-19*, 12 Front. Immunol. (Feb. 3, 2021), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7886971/.

nervous system disorders.[7] Such long-term symptoms are sometimes experienced by patients who had mild COVID-19 symptoms and the impact may be life-long.[8] Approximately one-third of those with severe cases of COVID-19 develop PTSD.[9] Providing adequate care for COVID-19 patients and their long-term conditions presents insuperable challenges for a medical care system already overburdened.

II. Institutional staff are a primary vector for introducing COVID-19 to prisons.

Institutional staff are primary vectors for introducing COVID-19 into CDCR facilities. This is not a criticism, it is simply a fact: "[e]ven when residents rarely leave, these facilities are highly connected to communities through workers and guests."[10] All of CDCR's institutional staff members live outside the prison and regularly come into contact with friends, family, and local service providers in the surrounding community. They bring the risk of these contacts back with them to CDCR institutions. It cannot be otherwise unless staff effectively become prisoners themselves, taking up residence in the prisons and never traveling beyond the walls for the duration of the pandemic.

Incarcerated persons transferred to a new facility may be tested and quarantined with others who arrived on the same day, limiting the risk that any incarcerated persons who are transferred will introduce COVID-19 into the institution at large. But institutional staff come and go from the institution daily and cannot be quarantined with every entrance. When infections rise in the community, visits can be curtailed and limited. Staff ingress, by contrast, is essential to prison operations.

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[7] Angelo Carfi, et al., *Persistent Symptoms in Patients After Acute COVID-19*, 6 JAMA 603 (July 9, 2020), https://jamanetwork.com/journals/jama/fullarticle/2768351. *See also* Vijayan Decl. ¶ 4.

[8] Ani Nalbandian, et al., *Post-acute COVID-19 syndrome*, 27 Nature Med. 601 (March 22, 2021), https://www.nature.com/articles/s41591-021-01283-z; Thomas M. Drake, et al., *Characterisation of in-hospital complications associated with COVID-19 using the ISARIC WHO Clinical Characterisation Protocol UK: a prospective, multicentre cohort study*, 398 The Lancet 223 (July 17, 2021), https://www.thelancet.com/action/showPdf?pii=S0140-6736%2821%2900799-6.

[9] Delfina Janiri, et al., *Posttraumatic Stress Disorder in Patients After Severe COVID-19 Infection*, 78 JAMA Psychiatry 567 (February 18, 2021), https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2776722.

[10] Elizabeth C. Lee, et al., *The engines of SARS-CoV-2 spread*, 370 Science 406 (Oct. 23, 2020), https://science.sciencemag.org/content/370/6515/406 (emphasis added) (identifying prisons and other congregate facilities as particularly vulnerable to COVID).

While staff members are tested, testing is universally recognized as a far imperfect substitute for vaccination. Staff may be infected between tests. And even when tested, COVID-19 is often not detectible by test in its early incubation period.

The factually obvious and inevitable role of staff in bringing infections from the larger community into the prisons has been borne out by the now-long record of COVID-19 in CDCR facilities.[11] Half of all outbreaks in May, June, and July have been confirmed to have originated with staff.[12] Analysis of the remaining outbreaks during that time is ongoing—genomic sequencing takes weeks or months—and those outbreaks, too, may eventually be traced back to staff.[13]

Because of their job responsibilities, institutional staff infected with COVID-19 are virtually certain to come into contact with incarcerated persons and other corrections officers who will, in turn, come into contact with incarcerated persons. Corrections officers have frequent close contact with incarcerated persons, typically working their entire shifts in the spaces in which incarcerated persons live. They have many responsibilities that place them in close contact with incarcerated persons each day, including supervising incarcerated persons as they get their meals and their mail, performing pat-downs for contraband when entering and exiting the yard each day, and handcuffing and escorting incarcerated persons throughout the institution.[14] Corrections officers often move between various parts of a facility over the course of a day based on the needs of the institution, and frequently work overtime in areas of the institution to which they are not permanently assigned. Infected officers are not only likely to infect incarcerated persons, the spread is unlikely to be contained to one part of the facility.[15]

Frequent testing is insufficient to prevent institutional staff who are unaware that they have COVID-19 from spreading the virus. Under the State Public Health Officer Order of July 26, 2021, unvaccinated corrections officers must be tested for COVID-19 once each week.[16] CDCR has indicated that although the COVID-19 safety measures adopted by the State require only weekly testing, it will test unvaccinated employees twice per week.[17] Tests can detect a positive case only where a certain viral load is present, so a recently infected individual may not

[11] Bick Decl. ¶¶ 15-17.
[12] Bick Dec. ¶ 17.
[13] Bick Decl. ¶ 17, Ex. A at 3-4.
[14] Foss Decl. ¶ 3.
[15] Foss Decl. ¶ 4; Vijayan Decl. ¶ 16.
[16] California Department of Public Health, *State Public Health Officer Order of July 26, 2021*, https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Unvaccinated-Workers-In-High-Risk-Settings.aspx#.YQAuOFRMEO4.mailto.
[17] *See* ECF No. 3623 at 7.

test positive for several days after exposure.[18] Results of COVID-19 tests are also typically available only after a wait of a day or longer.[19] An infected staff member might work two or three days before being tested; a newly infected staff member may test negative, continue working and reach a viral load sufficient to transmit the virus before being tested again and finally receiving a positive test result.

Because as much as 40 percent of transmission is pre-symptomatic,[20] individuals who receive false negative test results or who test too early may be unaware they are contagious throughout this period. As a result, the twice-per-week testing regimen does not effectively prevent asymptomatic staff from introducing COVID-19 to CDCR institutions. Indeed, even daily testing would not do so. Testing is an essential component of any plan, but it is not a substitute for vaccination.

The widely recognized link between community outbreaks of COVID-19 and outbreaks in nearby prisons through institutional staff is why the Federal Bureau of Prisons ("BOP") recommended early in the pandemic that staff vaccination be prioritized when the supply of vaccines was limited:

> Vaccinating correctional staff will serve to decrease the possible introduction of SARS-CoV-2 into institutions and thus protect inmates. In the context of limited quantities of vaccine, the BOP recommends offering vaccination *to staff first as the best way to achieve the greatest public health benefit* to inmates, staff, and communities.[21]

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[18] Bick Decl. ¶ 20; Lauren M. Kucirka, et al., *Variation in False-Negative Rate of Reverse Transcriptase Polymerase Chain Reaction-Based SARS-CoV-2 Tests by Time Since Exposure*, 20 Ann. Intern. Med. 1495 (May 13, 2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7240870/#.

[19] Bick Decl. ¶ 20.

[20] Xi He, et al., *Temporal dynamics in viral shedding and transmissibility of COVID-19*, Nature Med. (Apr. 15, 2020), https://www.nature.com/articles/s41591-020-0869-5; Xiang Ren, et al., *Evidence for pre-symptomatic transmission of coronavirus disease 2019 (COVID-19) in China*, 15 Influenza Other Respi. Viruses 19 (January 2021), https://onlinelibrary.wiley.com/doi/full/10.1111/irv.12787. *See also* Vijayan Decl. ¶ 7.

[21] Federal Bureau of Prisons, *COVID-19 Vaccine Guidance: Federal Bureau of Prisons Clinical Guidance* 5 (January 4, 2021), https://www.bop.gov/resources/pdfs/2021_covid19_vaccine.pdf (emphasis added).

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The Receiver and the CDCR medical experts agree: Vaccination of staff is *the best way* to achieve the greatest health benefits for incarcerated persons. There is no other equally effective method.

III. Once introduced, COVID-19 spreads rapidly in prisons.

Studies have repeatedly found that COVID-19 spreads far more rapidly inside jails and prisons than in other environments. The central metric for understanding the spread of COVID-19 is the reproduction rate ("R")—the number of people each infected person, on average, infects over the course of their illness. An R below 1, "subcritical transmission," indicates that each infected person infects less than one other person in turn, on average.[22] If R remains below 1 for a sustained period of time, the disease will disappear.[23] By contrast, when R is above 1, we have "supercritical transmission," and the outbreak will grow.[24]

A project by prominent medical and public health experts to model the reproduction rate of COVID-19 across California estimates that at no time in the pandemic has California's state-wide R exceeded 1.5. Each infected person, on average, infects 1.5 others. The study also estimates that the R has not exceeded 1.5 in any of the six Bay Area counties, nor in Los Angeles or Orange counties, until the arrival of the Delta variant in July 2021.[25]

The transmission rate in prisons is far higher. One modeling study found that, even before the Delta variant, the R of COVID-19 in a large, urban jail in the United States is approximately 8.44.[26] Each infected person infects 8 others. In other words, the reproduction rate in a prison would be expected to be more than 5 times the highest reproduction rate experienced in California and its major metropolitan counties.

The consequence of this greatly elevated rate is inevitable: it produced a staggeringly high incidence of COVID-19 in CDCR facilities and in other jails and prisons. Since the beginning of the pandemic, there have been more than 200 outbreaks of COVID-19 in California jails and

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[22] Lee Worden, et al., *Estimation of COVID-19 transmission rates in California and the U.S. with reporting delays* (May 14, 2020), https://www.medrxiv.org/content/10.1101/2020.05.14.20101162v1.full.pdf.
[23] *Id*.
[24] *Id*.
[25] Lee Worden, et al., *COVID-19 R estimation for California*, https://ca-covid-r.info/ (visited Aug. 2, 2021) (providing updated data to the study at n.22).
[26] Lisa B. Puglisi, et al., *Estimation of COVID-19 basic reproduction ratio in a large urban jail in the United States*, 53 Ann. Epidemiol. 103 (Jan. 2021), https://www.sciencedirect.com/science/article/abs/pii/S1047279720303471?via%3Dihub.

prisons.[27] A study of federal and state prisons in the United States concluded that the mean daily case growth rate was 8.3% per day in prisons as compared to 3.4% in the country as a whole, and that the fatality rate, adjusted for age, was 3 times higher for incarcerated individuals than the population at large.[28] Another study estimated an age- and sex- adjusted COVID-19 mortality rate for incarcerated persons 2.95 times that of the US population at large.[29] This result has been confirmed in detailed regional studies.[30]

COVID-19 spreads so rapidly in prisons because of the design of facilities, the manner in which they must be operated, population density, and the transmission characteristics of the virus. COVID-19 may be transmitted by close contact with an infected individual or by contact with a surface which contains live virus, each of which is difficult to prevent in prisons. The Director of the California Department of Public Health is in agreement, noting that jails and prisons are "residential facilities where the residents have little ability to control the persons with whom they interact. There is frequent exposure to staff and other residents."[31] Institutions were designed long ago with the goal of building a safe security environment in which incarcerated persons could be housed in a cost-effective manner. One aspect of this design is extreme population density. These facilities were not designed to prevent the transmission of COVID-19, and while CDCR and CCHCS have made substantial efforts to limit transmission where possible, experience shows that it is not possible to change many aspects of institutions that cause a high COVID-19 transmission rate. Improvements on this front are vital, but infection rates will remain high, and the benefits of improvements pale in comparison to the benefits of vaccination.

A. Means of Transmission in Prisons

[27] California Department of Public Health, *supra* note 16.
[28] Brendan Saloner, et al., *COVID-19 Cases and Deaths in Federal and State Prisons*, 324(6) JAMA 602 (July 8, 2020), https://jamanetwork.com/journals/jama/fullarticle/2768249?resultClick=1.
[29] Brendan Saloner, et al*., COVID-19 Cases and Deaths in Federal and State Prisons* [published online ahead of print, 2020 Jul 8] 324 *JAMA* 2020, 602–603. doi:10.1001/jama.2020.12528 (as of June 6, 2020), https://pubmed.ncbi.nlm.nih.gov/32639537/.
[30] Monik C. Jimenez, et al., *Epidemiology of COVID-19 Among Incarcerated Individuals and Staff in Massachusetts Jails and Prisons*, JAMA Netw. Open. (August 21, 2020), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2769617?resultClick=1 (documenting in Massachusetts state jails and prisons Massachusetts state prisons an infection rate 2.91 times higher than the state average and 4.80 times the national average).
[31] California Department of Public Health, *supra* note 16.

COVID-19 is transmitted by inhalation of aerosolized particles; deposition of the virus directly on exposed mucus membranes; and fomite transmission, by touching an object on which the virus has been left by someone shedding virus.[32] The greater the amount of virus to which an individual is exposed, and the more prolonged the exposure, the greater the likelihood that the individual will contract COVID-19.[33] Prison conditions put people in sustained close contact, causing exposure to a greater amount of virus for far longer periods of time, and thus a greater likelihood of contraction.[34]

1. *Close Contact Transmission*

COVID-19 spreads much more in congregate facilities such as prisons because "those who live in congregate residences such as prisons, worker dormitories, and long-term care facilities have intense, long-duration, close contact. . . . The confluence of these factors can lead to high infection rates in outbreaks (attack rate); for example, 66% of residents were infected in a homeless shelter, 62% in a nursing home, and 80% in a prison dormitory."[35] The CDC defines close contact as a cumulative fifteen minutes within six feet of an infected individual over a 24 hour period.[36] In congregate facilities in which people remain in the same spaces with each other for many hours, such contact is inevitable and far more common than in the general population.[37] Incarcerated persons share spaces with one another throughout the day: common areas, gyms and recreational spaces, bathrooms, showers, and cafeterias are all typically communal.[38] Sleeping quarters are typically communal as well.[39]

While communal spaces make social distancing challenging under any circumstances, the crowded nature of CDCR institutions leaves insufficient space to make distancing possible.

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[32] Centers for Disease Control and Prevention, SARS-CoV-2 Transmission (May 7, 2021), https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/sars-cov-2-transmission.html.
[33] Bick Decl. ¶ 22.
[34] *Id*.
[35] Elizabeth C. Lee, et al., *The engines of SARS-CoV-2 spread*, 370 Science 406 (Oct. 23, 2020), https://science.sciencemag.org/content/370/6515/406.
[36] Centers for Disease Control and Prevention, Case Investigation & Contract Tracing Guidance, Appendices (updated July 9, 2021), https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/appendix.html.
[37] Bick Decl. ¶¶ 22-23; Vijayan Decl. ¶¶ 9-11, 14.
[38] Foss Decl. ¶ 7.
[39] Foss Decl. ¶ 5.

CDCR's population is currently at 109.3% of its design capacity.[40] These design capacities, even when not exceeded, did not anticipate the need to maintain six feet of distance from others at all times. As a result, the bedrooms, common areas, cafeterias, bathrooms, and other spaces incarcerated persons share are too crowded to allow for consistent social distancing.[41]

Prison operations require people from throughout the prison to come into contact with each other, making it difficult to isolate an outbreak to only one housing unit or yard. For example, prisons often share a single cafeteria.[42] And each individual in a prison, even in quarantine, must be visited by a corrections officer on rounds every day.[43] People from different housing units come in close contact with each other in medication distribution, dining areas, the laundry, telephones, transportation, and in performing work assignments throughout the prison.[44] It is typical for an incarcerated person to be required to come into contact with others throughout the prison multiple times per day.

Masking is also less effective in congregate facilities because incarcerated persons and staff cannot wear a mask at all times. The chance of transmitting the virus is increased by removing a mask, including when that person is eating or sleeping, yet those are necessary exceptions to masking requirements.[45] In CDCR institutions, incarcerated persons are indoors and in close proximity to others while they are eating or sleeping.[46]

While sleeping arrangements vary across CDCR facilities, the most common arrangement is for incarcerated persons to sleep in bunk beds placed within a few feet of each other.[47] This arrangement can allow for transmission between incarcerated persons sharing a bunk bed, and between neighboring beds, particularly because people do not wear masks while sleeping and the very long exposure period of several hours allows for transmission of a large amount of virus.[48] Although individual or small group cells are an improvement over these dormitory conditions, those cells often have one wall that is open with bars or other

[40] California Department of Corrections and Rehabilitation, Three-Judge Court Monthly Update (June 15, 2021), https://www.cdcr.ca.gov/3-judge-court-update/.
[41] Foss Decl. ¶¶ 5, 7, 8, 9, 10.
[42] Foss Decl. ¶ 8; Bick Decl. ¶ 21.
[43] Foss Decl. ¶ 3.
[44] Foss Decl. ¶ 10.
[45] Bick Decl. ¶¶ 25-26.
[46] Foss Decl. ¶¶ 5, 8.
[47] Foss Dec. ¶ 5.
[48] Vijayan Decl. ¶ 15; CDCR CCHCS Memorandum, *Recommended COVID-19 Personal Protective Equipment and Physical Distancing Requirements for Staff and Inmate-Patients Update* (May 10, 2021), ECF No. 3592-1 Ex. A. at 3-4.

perforations rather than a solid door, and are in close proximity to one another,[49] still permitting transmission.

Many individuals sleeping in a single room would be dangerous even with single beds rather than bunk beds and even with six feet between each bed.[50] For example, medical and public health experts from UC Berkeley and UCSF visited the Substance Abuse Treatment Facility and State Prison at Corcoran (SATF) and concluded that, in order to minimize COVID-19 risk, dorms with a capacity of fifty people should house only three people, and that small dorms with a capacity of six people and cells with capacity of two people should both house only a single person.[51] A prison system operating at 109% of design capacity simply cannot meet these idealized conditions.

Thus, CDCR institutions, by their design, current population, and operation, pose a great and ineliminable risk of COVID-19 transmission by close contact, even where rules regarding masking and social distancing are enforced.

Even where greater social distancing is possible, airborne transmission is also a substantial risk in indoor conditions. Indoor conditions, including air conditioning, fans, and heating systems, facilitate transmission by carrying droplets further than six feet – up to 19 to 26 feet away.[52] Particularly in spaces where ventilation uses recycled air with insufficient filtering, these droplets build up over time. The virus can survive for approximately three hours in such droplets suspended in the air. These conditions, in which a person infected with COVID-19 may remain in a single space for a long period of time, make congregate living dangerous even where individuals are further than six feet apart.[53]

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[49] Foss Decl. ¶ 6; Bick Decl. ¶ 27.
[50] Vijayan Decl. ¶ 15.
[51] ECF No. 3566 at 17-21. *See also* ECF No. 3579 at 14-15; ECF No. 3592 at 14-17.
[52] Vijayan Decl. ¶¶ 9-11; Lydia Bourouiba, Images in Clinical Medicine: *A Sneeze*, 375 New Eng. J. Med. e15 (Aug. 25, 2016), https://www.nejm.org/doi/full/10.1056/nejmicm1501197; Francis W. Moses, et al., *COVID-19 outbreak associated with air conditioning in restaurant, Guangzhou, China, 2020*, 26 Emerging Infectious Diseases 2298 (Sept. 2020), https://doi.org/10.3201/eid2609.201749; M. Saiful Islam, et al., *Current knowledge of COVID-19 and infection prevention and control strategies in healthcare settings: A global analysis*, 41 Infection Control & Hospital Epidemiology 1196, 1196–1206 (Oct. 2020), https://doi.org/10.1017/ice.2020.237.
[53] Center for Disease Control and Prevention, *Scientific Brief: SARS-CoV-2 and Potential Airborne Transmission* (Oct. 5, 2020), https://www.cdc.gov/coronavirus/2019-ncov/more/scientific-brief-sars-cov-2.html. *See also* Neeltje van Doremalen, et al., *Aerosol and Surface Stability of*

Indeed, ventilation which uses recirculated air and insufficient filters may spread the virus even to people housed in single-person cells with solid doors.[54] Efforts to install filters to mitigate this condition are ongoing, but are in any event only a small step toward reducing the high risks of infection through repeated and continuous exposure in congregate conditions.[55] Poor circulation is also exacerbated by the lack of openable windows, often making it impossible to comply with CDC guidance that windows be opened to allow air circulation after an infection has been present in a building.[56]

2. *Fomite Transmission*

In congregate spaces such as prisons, fomite transmission is also a much greater risk because many people are in regular contact with the same objects and surfaces. Incarcerated persons share the same tables, chairs, bathroom facilities, and phones, among other items – items used not merely by one or two family members, but by many incarcerated persons.[57] The length of time the virus can survive in a droplet on a surface depends upon the surface material; however, COVID-19 can survive as long as two to three days on plastic or stainless steel.[58] Without nearly constant cleaning, COVID-19 may be transmitted in prisons by contact with surfaces in communal spaces.

B. Facility Design

As noted above, the spaces in which incarcerated persons live are generally too densely populated to allow for social distancing, and inadequate ventilation in CDCR institutions can exacerbate this difficulty.

SARS-CoV-2 as Compared with SARS-CoV-1, 382 New Eng. J. Med. 1564 (Mar. 17, 2020), https://www.nejm.org/doi/10.1056/nejmc2004973.

[54] ECF No. 3566 at 17-21. *See also* ECF No. 3579 at 14-15; ECF No. 3592 at 14-17.

[55] Moreover, while a substantial number of housing units at eleven prisons utilize a MERV-13 filter, eighteen institutions have yet to make this change, with fifteen planning to do so by October. ECF No. 3605 at 10-11.

[56] Centers for Disease Control and Prevention, *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities*, at (Jul. 22, 2020), https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html.

[57] Foss Decl. ¶ 11.

[58] Centers for Disease Control and Prevention, *Science Brief: SARS-CoV-2 and Surface (Fomite) Transmission for Indoor Community Environments* (updated Apr. 5, 2021), https://www.cdc.gov/coronavirus/2019-ncov/more/science-and-research/surface-transmission.html#ref10.

Facilities limitations also make effective quarantining difficult. For those under quarantine in prisons, the CDC recommends that "[i]deally, each quarantined individual should be housed in a single cell with solid walls and a solid door that closes."[59] Throughout the pandemic, CDCR has not had enough solid-door cells at many institutions to follow this guidance.[60]

C. Other Factors

Quarantining in CDCR facilities has also been complicated by some incarcerated persons refusing to leave their cell or dorm despite qualifying for quarantining.[61] While the reasons for such refusal vary, interviews conducted by the *Plata* Plaintiffs suggest that some reasons include fear of social isolation, loss of pay from work, loss of their previous housing and the community networks they have built there, the location of quarantine facilities in a Sensitive Needs Yard where they did not believe they would be safe, and mistrust of custody and medical leadership.[62] CDCR has taken steps to identify and address these issues, including adopting many of the *Plata* Plaintiffs' proposals to ameliorate refusals. But the persistent problem illustrates the complexity of preventing the spread of infection within the prison environment.

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In sum, prison systems, even those that take important mitigation measures such as masking and social distancing, are not designed and operated to prevent the transmission of a highly contagious virus and cannot be redesigned to do so effectively in the near term. The conditions of confinement and the manner in which prisons are operated deprive incarcerated people of the same opportunities to protect themselves through social distancing and limiting contact that are available to the public at large. Limiting the introduction of COVID-19 into prisons is critical to protecting the health of incarcerated people.

IV. Once infected, incarcerated persons with COVID-19 have worse health outcomes than the population at large.

Studies of health outcomes for incarcerated persons with COVID-19 in prison systems confirm that incarcerated persons have worse health outcomes on average than the population

[59] Bick Decl. ¶ 27; Center for Disease Control and Prevention, Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities (June 9, 2021), https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html.
[60] ECF No. 3502 at 2-7. *See also* Foss Decl. ¶¶ 5, 6.
[61] ECF No. 3545 at 27-28.
[62] ECF No. 3548 at 11-15.

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as a whole. One study of patients in Michigan found that this was true even when incarcerated persons were treated in hospitals.[63] The study found incarcerated persons were more likely to be admitted to the intensive care unit (26.9% vs. 18.7%), require respirators (24.1% vs. 9.9%), and require intubation (25.0% vs. 15.2%).[64] Incarcerated persons were also more likely to die in the hospital (29.6% vs. 20.1%) and more likely to die after 30 days (34.3% vs. 24.6%).[65]

Incarcerated persons experience worse health outcomes in part because they have risk factors for COVID-19 at a disproportionate rate compared to the general public. Incarcerated persons have high rates of chronic illnesses including diabetes, heart disease, chronic lung disease, and immunosuppressive illnesses, as well as other risk factors owing to poor access to medical care prior to incarceration or a history of alcohol or drug abuse.[66] For these reasons, incarcerated persons are often considered effectively ten years older, physiologically, than their chronological age,[67] and they experience worse health outcomes accordingly.[68] The more of these risk factors an individual has, the greater the medical care challenges and the greater the risk of a poor health outcome.[69]

Prison conditions also increase the difficulty of securing good patient outcomes. Patients experiencing severe symptoms may need treatment in community medical facilities, such as an area hospital. But many prisons are located in rural areas with poor access to

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[63] Ahmed M. Altibi, et al., *Characteristics and comparative clinical outcomes of prisoner versus non-prisoner populations hospitalized with COVID-19*, Scientific Reports (March 22, 2021), https://www.nature.com/articles/s41598-021-85916-w.

[64] *Id*.

[65] *Id*.

[66] Jennifer Bronson, et al., *Drug Use, Dependence, and Abuse Among State Prisoners and Jail Inmates, 2007-2009*, U.S. Department of Justice, Bureau of Justice Statistics (updated Aug. 10, 2020), https://bjs.ojp.gov/content/pub/pdf/dudaspji0709.pdf (approximately 58% of convicted persons incarcerated in state prisons meet DSM IV criteria for substance use dependence or abuse).

[67] Brie A. Williams, et al., *Aging in Correctional Custody: Setting a Policy Agenda for Older Prisoner Health Care*, 102 Am. J. Pub. Health 1475 (Aug. 2012) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3464842/.

[68] Ingrid A. Binswanger, et al., *Health Disparities and the Criminal Justice System: An Agenda for Further Research and Action*, 89 J. Urban Health 98 (Feb. 2012), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3284594/.

[69] Wei-jie Guan, et al., *Comorbidity and its impact on 1590 patients with COVID-19 in China: a nationwide analysis*, 55 Eur. Respir. J. (May 14, 2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7098485/.

community healthcare, and transportation to a far-away hospital may be necessary.[70] Delays in accessing care for serious COVID-19 cases may be critical.[71]

V. COVID-19 outbreaks exacerbate the healthcare delivery inadequacies that the core mission of the Receivership addresses.

The experience of the pandemic to date has demonstrated beyond dispute the obvious fact that COVID-19 diverts scarce healthcare resources from managing chronic health conditions.[72] CCHCS continues to take precautions against a renewed spread of an even worse variant that will again prevent routine care.[73] When an outbreak is ongoing in an institution, non-essential medical services are postponed. Only after 14 days without a new infection in that institution can medium priority healthcare services like preventative care and screenings resume.[74] Routine clinical operations are suspended until 28 days without a new infection.[75]

Even when there is no recent outbreak in an institution, prevention protocols interfere with the provision of adequate medical services. The risk of COVID-19 requires social distancing in medical clinic waiting areas and the cleaning of holding cells and exam rooms between each appointment, limiting the number of appointments per day.[76] As a result of COVID-19, between January 31, 2020, and March 15, 2021, the backlog of overdue primary care appointments grew from 2,700 to 6,600.[77]

The risk to healthcare providers of contracting COVID-19 at work, the need for the use of excessive overtime, and the stress of providing care in institutions with extraordinarily high

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[70] Bick Decl. ¶ 6.

[71] Jenna S. Silverstein, et al., *Acute Respiratory Decompensation Requiring Intubation in Pregnant Women with SARS-CoV-2 (COVID-19)*, 10 Am. J. Perinatology Rep. e169 (June 4, 2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7272216/; Matthew E. Hartman, et al., *COVID-19 Respiratory Failure: Targeting Inflammation on VV-ECMO Support*, 66 ASAIO Journal 603 (June 2020), https://journals.lww.com/asaiojournal/fulltext/2020/06000/covid_19_respiratory_failure__targeting.4.aspx.

[72] Bick Decl. ¶ 7.

[73] California Department of Corrections and Rehabilitation, Roadmap to Reopening (April 20, 2021), https://www.cdcr.ca.gov/covid19/reopening/roadmap/.

[74] *Id*.

[75] *Id*.

[76] ECF No. 3592 at 17.

[77] *Id*.

COVID-19 caseloads have also made it more difficult to staff healthcare units fully, as the difficult working conditions have reduced the size of the workforce.[78]

VI. The Delta variant will continue to cause additional outbreaks.

The risk now is grave. We cannot afford to be lulled by the decline in infections in CDCR, which mirrored the fall in rates in the larger community. That fall in rates is, unfortunately, already a thing of the past. That fire may be dying, but a new one is starting: As Dr. Tomás J. Aragón, Director of the California Department of Public Health, now reports, "California is currently experiencing the fastest increase in COVID-19 cases during the entire pandemic."[79] As rates rise rapidly, more institutional staff will come to work with COVID-19, unaware they are ill, introducing COVID-19 into CDCR institutions.[80] Indeed, case rates among staff members have increased by more than 500% in recent weeks.[81]

This is not a mere repetition of the early days of the pandemic. This new wave threatens to be worse. The Delta variant is twice as transmissible as the original Wuhan strain.[82] The natural immunity provided by having previously been infected with COVID-19 may not provide robust protection against the Delta variant, both because natural immunity wanes over time, possibly within months,[83] and because the immunity provided by earlier variants may not provide the same level of immunity to the Delta variant.[84] Each of these factors may allow individuals who have previously contracted COVID-19 to be re-infected with the Delta variant.

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[78] Bick Decl. ¶ 12.
[79] California Department of Public Health (July 26, 2021), *supra* note 16.
[80] Bick Decl. ¶¶ 14-18, 20, 30.
[81] Bick Decl. ¶ 30.
[82] Vijayan Decl. ¶ 12; Scientific Pandemic Influenza Group on Modeling, Operational sub-group (SPI-M-O), *Consensus Statement on COVID-19* (June 2, 2021), https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/993321/S1267_SPI-M-O_Consensus_Statement.pdf.
[83] Bick Decl. ¶ 31; Jeffrey Seow, et al., *Longitudinal observation and decline of neutralizing antibody responses in the three months following SARS-CoV-2 infection in humans*, 5 Nature Microbiology 1598 (Oct. 26, 2020), https://www.nature.com/articles/s41564-020-00813-8.
[84] Bick Decl. ¶ 31; Emanuele Andreano & Rino Rappuoli, *SARS-CoV-2 escaped natural immunity, raising questions about vaccines and therapies*, 27 Nature Med. 759 (May 10, 2021), https://www.nature.com/articles/s41591-021-01347-0.

Research results are mixed, but early evidence suggests that health outcomes for those infected with the Delta variant may be worse than for those infected with previous variants, causing hospitalization and death in a greater proportion of cases.[85]

The Delta variant is now the predominant strain of COVID-19 in California, accounting for 82.8% of tested samples in July 2021.[86] Case counts across the state are climbing rapidly. The reproduction rate is the highest it has been in the course of the pandemic. Five counties currently have an R at or above 1.50.[87] This is consistent with past waves, where the reproduction rate was a leading indicator that cases would surge. Positive COVID-19 tests of staff and incarcerated persons in CDCR in July reflect a similarly high percentage of Delta variant infections.[88]

Recognizing the building third wave, public health agencies are now taking action to slow the growth rate of new COVID-19 infections. Two weeks ago, on July 15, 2021, Los Angeles County announced that masks would again be required in indoor public spaces, regardless of vaccination status.[89] The State of California announced on July 26, 2021, that all state employees and employees in certain high-risk environments must provide proof of vaccination or submit to weekly or bi-weekly testing for COVID-19.[90] Following the many hospital systems adopting a mandatory vaccination policy, the Department of Veterans Affairs mandated vaccination for all health care personnel working in or visiting Veterans Health Administration facilities.[91]

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[85] Aziz Sheikh, *SARS-CoV-2 Delta VOC in Scotland: demographics, risk of hospital admission, and vaccine effectiveness*, The Lancet (June 14, 2021), https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)01358-1/fulltext.
[86] California Department of Public Health, Tracking Variants (updated July 22, 2021), https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/COVID-Variants.aspx.
[87] Lee Worden, et al., *supra* note 25 (providing updated data to the study at note 22).
[88] Bick Decl. ¶ 30.
[89] Luke Money & Rong-Gong Lin II, *L.A. County will require masks indoors amid alarming rise in coronavirus cases*, L.A. Times (July 15, 2021), https://www.latimes.com/california/story/2021-07-15/l-a-county-will-require-masks-indoors-amid-covid-19-surge.
[90] California Department of Public Health, *supra* note 16.
[91] U.S. Department of Veterans Affairs, Office of Public and Intergovernmental Affairs, *VA mandates COVID-19 vaccines among its medical employees including VHA facilities staff* (July 26, 2021), https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5696.

Recent large-scale outbreaks demonstrate the risk COVID-19 still presents to prisons. A recent outbreak in Solano sickened 93 incarcerated persons and spread to two of four yards.[92] The vaccination rate for corrections officers at Solano is only 46%.[93]

The virus will continue to mutate, likely generating more transmissible varieties.[94] Variants of Concern (VOC's), such as the Delta variant, have been confirmed to increase transmissibility or virulence, or to decrease the effectiveness of disease prevention measures and treatments.[95] The World Health Organization is also currently tracking four variants currently designated as Variants of Interest (VOI) – variants with genetic changes believed to affect characteristics like transmissibility and disease severity with significant community transmission.[96] Among those Variants of Interest—which may become confirmed Variants of Concern—is the Lambda variant, which may already be driving higher infection rates in South America, and has spread rapidly to other countries, including the United States.[97]

Absent very high levels of vaccination, the Delta variant and other future variants will become more common in California, and there almost certainly will be additional large-scale outbreaks in CDCR facilities.[98] The responsibility to act includes the responsibility to act before it is too late. Now is the time to take decisive steps to minimize this risk.

VII. Vaccination at very high levels is the only effective measure for preventing outbreaks.

The higher reproduction rate from both the Delta variant and the great risk of spread in prison conditions necessitates a resolute effort to block the transmission of the disease into the prison environment.[99] Popular belief notwithstanding, there is no known percentage for achieving so-called "herd immunity" either in the larger community or in prisons. The best way

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[92] Bick Decl., Ex. A at 3.
[93] Bick Decl., Ex B.
[94] Bick Decl. ¶ 33.
[95] World Health Organization, Tracking SARS-CoV-2 variants (accessed Aug. 3, 2021), https://www.who.int/en/activities/tracking-SARS-CoV-2-variants/.
[96] *Id*.
[97] Clive Cookson & Gideon Long, *Lambda Covid variant's 'unusual' mutations puzzle scientists*, Financial Times (July 2, 2021), https://www.ft.com/content/b3ea5177-9312-418b-acb7-af16a3bdcd22; Robert Downen, *Houston Methodist Hospital records first lambda variant as COVID cases double since July 1*, Houston Chronicle (July 19, 2021), https://www.houstonchronicle.com/news/houston-texas/houston/article/Houston-Methodist-Hospital-records-first-lambda-16325190.php.
[98] Bick Decl. ¶¶ 32-33.
[99] Christie Aschwanden, *The false promise of herd immunity for COVID-19*, Nature (October 21, 2020), https://www.nature.com/articles/d41586-020-02948-4.

to protect the health of incarcerated individuals and staff is to achieve as high a level of vaccination as possible.[100]

The Delta variant is well-controlled by existing vaccines.[101] Researchers in Britain have found two doses of the Pfizer vaccine 88% effective against symptomatic disease from the Delta variant.[102] Other studies have replicated this result. A Scottish study found 79% efficacy against symptomatic disease,[103] and a Canadian study found 87% efficacy against symptomatic disease.[104] One study found a more significant decrease in efficacy at preventing symptomatic disease, down to 64%, but that study nevertheless confirmed that the vaccine is 94% effective at preventing hospitalization and death.[105] Some range in studies of efficacy is ordinary and the research overall strongly supports the efficacy of the vaccines at preventing transmission.

Vaccination is far more effective than other measures like masking and social distancing.[106] Even if it were possible in prisons to apply all other methods to reduce transmission, these methods are less effective than vaccination. Social distancing cannot be effectively imposed in current present conditions, but even if it could, it is far less effective in spreading infection than vaccination. Remaining at six feet of distance from others provides some protection against contracting COVID-19, but, particularly in indoor environments, the virus can travel up to 19 to 26 feet away and remain alive in droplets in the air for as much as three hours.[107] It has been a challenge to implement masking requirements. As the Office of

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[100] Bick Decl. ¶¶ 34-37; Vijayan Decl. ¶¶ 17-19.
[101] Bick Decl. ¶¶ 34-35; Vijayan Decl. ¶¶ 18-19.
[102] Jamie Lopez Bernal, et al., *Effectiveness of COVID-19 vaccines against the B.1.617.2 (Delta) Variant*, New Eng. J. Med. (July 21, 2021), https://www.nejm.org/doi/full/10.1056/NEJMoa2108891.
[103] Aziz Sheikh, et al., *SARS-CoV-2 Delta VOC in Scotland: demographics, risk of hospital admission, and vaccine effectiveness* (June 14, 2021), https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)01358-1/fulltext.
[104] Sharifa Nasreen, et al., *Effectiveness of COVID-19 vaccines against variants of concern, Canada* (July 3, 2021), https://www.medrxiv.org/content/10.1101/2021.06.28.21259420v1.
[105] Dov Lieber, *Pfizer Vaccine Less Effective Against Delta Infections but Prevents Sever Illness, Israeli Data Show*, Wall Street J. (July 6, 2021), https://www.wsj.com/articles/pfizers-covid-19-vaccine-is-less-effective-against-delta-variant-israeli-data-show-11625572796.
[106] Bick Decl. ¶ 34.
[107] Lydia Bourouiba, Ph.D., Images in Clinical Medicine: *A Sneeze*, 375 New Eng. J. Med. e15 (Aug. 25, 2016), https://www.nejm.org/doi/full/10.1056/nejmicm1501197; Francis W. Moses, et al., *COVID-19 outbreak associated with air conditioning in restaurant, Guangzhou, China, 2020*, Emerg. Infect. Dis. (Sept. 2020), https://doi.org/10.3201/eid2609.201749; M. Saiful Islam, et al., *Current knowledge of COVID-19 and infection prevention and control strategies in*

the Inspector General's report made clear, masks are not consistently correctly used by incarcerated persons or staff at CDCR institutions.[108] But even when correctly used, "medical masks (surgical masks and even N95 masks) [are] not able to completely block the transmission of virus droplets/aerosols . . . ."[109] As the Director of the California Department of Public Health has noted, "[v]accination against COVID-19 is the most effective means of preventing infection with the COVID-19 virus, and subsequent transmission and outbreaks."[110]

Voluntary efforts have not produced acceptable results, and continuation with a voluntary approach that yields such results must be acknowledged for what it has proven to be – an unacceptable half-way measure. As a result of voluntary programs, only 53% of all staff and only 42% of custodial staff have received at least one dose of the vaccines.[111]

VIII. The vaccination rate for CDCR staff is too low, and it is now evident that voluntary means of encouraging vaccination will not raise rates to acceptable levels.

The vaccination rate for institutional staff is far too low to safeguard the health of CCHCS's patients. Only 40% of corrections officers statewide are fully vaccinated.[112] The proportion is alarmingly lower in some institutions. For example, at High Desert State Prison,

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healthcare settings: A global analysis, 41 Infection Control & Hospital Epidemiology 1196, 1196-1206 (Oct. 2020), https://doi.org/10.1017/ice.2020.237.

[108] Office of the Inspector General, COVID-19 Review Series Part Two (October 2020), https://www.oig.ca.gov/wp-content/uploads/2020/10/OIG-COVID-19-Review-Series-Part-2-%E2%80%93-Face-Coverings-and-PPE.pdf ("[O]ur staff observed that staff and incarcerated persons frequently failed to adhere to those basic safety protocols. . . . The frequent noncompliance by staff and incarcerated persons was likely caused at least in part by the department's supervisors' and managers' lack of enforcement of the requirements. . . . [W]e found that prison management statewide only referred seven of the department's more than 63,000 employees for formal investigations or punitive actions for misconduct related to face covering or physical distancing requirements.").

[109] Hiroshi Ueki, et al., *Effectiveness of Face Masks in Preventing Airborne Transmission of SARCoV-2*, 5 mSphere (Oct. 28, 2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7580955/.

[110] California Department of Public Health, *supra* note 15.

[111] Bick Decl. ¶ 37, Ex. B. The statistics show that virtually all staff who get the first dose get the second. For that reason, unless otherwise indicated, the figures for staff vaccination are for those who have received "at least one dose"; the percentage that have received two doses is slightly less.

[112] *Id*.

just 16% of all corrections officers are fully vaccinated.[113] In six other institutions the complete vaccination rate for corrections officers is at or below 30%.[114] Healthcare staff are fully vaccinated at higher rates, 72% statewide, but that higher rate is still insufficient to provide protection against large outbreaks.[115]

Vaccination rates remain unacceptably low despite widely advertised vaccine clinics for all staff during all shifts, at all facilities in May; offers of up to 80 hours of supplemental paid sick leave; and peer education through the COVID Mitigation Action Program.[116] Recent progress has dwindled. In the four weeks between June 30, 2021, and July 29, 2021, the percentage of staff fully vaccinated and the percentage receiving only one dose each increased by just one percent.[117]

The Receiver is committed to continuing all efforts to increase staff vaccination rates and welcomes all efforts by the State and CCPOA to do the same.[118] Recent experience provides no basis for believing those efforts will find significant success. With rapidly rising case rates, there is no time to delay implementing a policy that will be effective: a mandatory vaccination requirement for staff coming into contact with incarcerated persons.

IX. A mandatory vaccination policy is necessary and reasonable considering historical precedent, the widespread adoption of similar policies, and the public health necessity for doing so.

Because voluntary efforts to raise the vaccination rate to safe levels have proven insufficient, requiring vaccination of institutional staff is the only path likely to provide adequate protection for incarcerated persons. CDCR would not be the first congregate facility to require vaccination for staff against COVID-19. As detailed below, countless other congregate facilities have already chosen to mandate vaccination for staff. Prior to the COVID-19 pandemic, requiring vaccination for other diseases was commonplace. A majority of

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[113] *Id*.
[114] *Id*.
[115] *Id*.
[116] ECF No. 3579 (Apr. 27, 2021) at 7-9.
[117] Bick Decl. ¶ 37; ECF No. 3623 at 6.
[118] Mandatory individual vaccine counseling, scheduled to begin on August 4, 2021, is one such program, as is continuing to pursue peer education through the COVID Mitigation Action Program. Implementing statewide programs of this magnitude takes time, such that any success will take time to manifest. With rapidly rising infection rates, these efforts must proceed alongside implementation of a mandatory program so that their combined impact is not felt only after the next wave has come and gone.

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hospital systems require that staff be vaccinated for the seasonal influenza.[119] Schools and colleges have long required documentation of vaccination for diseases like meningitis.[120]

Mandatory vaccination policies, particularly in congregate settings, are being widely adopted with strong support from the public health community. The American Medical Association and eighty-eight other medical associations have announced their support for mandatory vaccination policies for health care workers.[121] Numerous hospitals have adopted just such a mandatory policy;[122] as have many universities, another type of congregate facility;[123] and the City San Francisco also will require employees in hospitals, nursing homes, and jails, all congregate facilities, whether employed by the city and county or not, to be vaccinated.[124]

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[119] M. Todd Greene, et al., *Changes in Influenza Vaccination Requirements for Health Care Personnel in US Hospitals*, 1 JAMA Network Open e180143 (June 1, 2018), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2682876 (finding that 61.4% of hospitals surveyed had such a requirement).

[120] *See e.g.*, University of California Immunization Requirements & Recommendations (Sept. 25, 2017), https://healthcenter.ucsc.edu/forms/immunization_requirements.pdf.

[121] Ezekiel J. Emanuel, *Joint Statement in Support of COVID-19 Vaccine Mandates for All Workers in Health and Long-Term Care* (July 26, 2021), http://www.ezekielemanuel.com/writing/all-articles/2021/07/26/joint-statement-in-support-of-covid-19-vaccine-mandates-for-all-workers-in-health-and-long-term-care. *See also* Dan Diamond, *Coalition says healthcare workers should be required to get coronavirus vaccine*, Washington Post (July 13, 2021), https://www.washingtonpost.com/health/2021/07/13/vaccine-mandates-health-care-workers/ (reporting that the Society for Healthcare Epidemiology of America, the Infectious Diseases Society of America, and five other public health organizations recently recommend mandatory vaccination for healthcare facilities).

[122] Kelly Gooch and Hannah Mitchell, *Hospitals, health systems mandating vaccines for workers*, Becker's Hospital Review (updated July 15, 2021), https://www.beckershospitalreview.com/workforce/hospitals-health-systems-mandating-vaccines-for-workersjune17.html (listing thirty-two hospital systems which have announced such policies).

[123] Andy Thomason & Brian O'Leary, *Here's a List of Colleges That Will Require Students or Employees to Be Vaccinated Against Covid-19*, Chronicle of Higher Education (July 15, 2021), https://www.chronicle.com/blogs/live-coronavirus-updates/heres-a-list-of-colleges-that-will-require-students-to-be-vaccinated-against-covid-19.

[124] Rong-Gong II, *San Francisco to require staff in hospitals, jails and nursing homes to get COVID-19 vaccine* (June 15, 2021), https://www.latimes.com/california/story/2021-06-15/san-

Every prior measure to limit the spread of COVID-19 in CDCR institutions has been mandatory. Employees have not had the choice of whether to wear a mask, social distance, or take weekly COVID-19 tests.[125] Each is a mandatory requirement of employment. Requiring vaccination, which is far more effective, is consistent with prior actions taken during the COVID-19 pandemic.

Waiting until COVID-19 case counts are higher to mandate vaccination will ensure that protection against COVID-19 is effective only after the next wave has come and gone. The CDC recommends that patients receive the second dose of the Pfizer vaccine three weeks after the first dose, and the second dose of the Moderna vaccine four weeks after the first dose.[126] After the second dose, it takes another two weeks for a patient to receive full benefits of vaccination.[127] Individuals will therefore not be fully vaccinated until at least five to six weeks after their first dose. Any mandatory vaccination program would have to provide a significant amount of additional time for patients to comply. California's two previous waves of COVID-19 infection lasted approximately three months each.[128] Delaying a mandatory vaccination policy until the next wave is upon us will not produce results until it is too late and the worst of the wave is over.

With the rate of vaccination unacceptably low, the voluntary means of raising it ineffective and insufficient, and an urgent need to increase the vaccination rate in the face of the Delta variant, a mandatory vaccination policy is urgently required.

X. The Receiver has determined that a mandatory vaccination policy for workers entering CDCR institutions and incarcerated persons who choose to work outside of an institution or accept in-person visitation is supported by the best medical science and

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francisco-to-require-covid-19-vaccine-for-some-workers?utm_campaign=KHN%3A%20First%20Edition&utm_medium=email&_hsmi=134144726&_hsenc=p2ANqtz-8bEAEUkoHWLC3nfpBI87MguaZQD639q2x_j9_tg1ak_D90-hw1ZiZKcY2XCioY_gGyG3o5QbhsvT8UikNz-YU5DuTwCr6lUcRl5U3E2BWasQ4UqSI&utm_content=134144726&utm_source=hs_email.

[125] California Department of Corrections and Rehabilitation, COVID-19 Response Efforts (accessed July 29, 2021), https://www.cdcr.ca.gov/covid19/covid-19-response-efforts/.

[126] Centers for Disease Control and Prevention, COVID-19 Vaccines That Require 2 Shots (updated June 3, 2021), https://www.cdc.gov/coronavirus/2019-ncov/vaccines/second-shot.html.

[127] *Id*.

[128] State of California, Tracking COVID-19 in California (updated July 15, 2021), https://covid19.ca.gov/state-dashboard/ (showing a spike in infections from mid-June to late-August 2020 and from early-November 2020 to mid-February 2021).

respectfully requests that the Court issue an order to show cause why CDCR and CCHCS should not be ordered to implement such a policy.

Staff and incarcerated persons with contact with the community outside of CDCR institutions cannot be effectively quarantined with each contact and so are most likely to introduce COVID-19 into CDCR institutions. As discussed above, this has been confirmed by more than a year of experience of COVID-19 in CDCR institutions and other jails and prisons. It is particularly critical that those at high risk of being vectors for infection are fully vaccinated to minimize the chance that COVID-19 will be introduced to an institution.

Pursuant to the State Public Health Officer Order of July 26, 2021, all CDCR institutions must verify the vaccine status of all workers. As the Receiver said at the July 29, 2021 Case Management Conference, in addition to this requirement, and the other requirements imposed by that Order, the Receiver recommends that access by workers to CDCR institutions be limited to those workers who establish proof of vaccination (or who have established a religious or medical exemption to vaccination).[129] The Receiver further recommends that incarcerated persons who desire to work outside of the institution (e.g., fire camps) or to have in-person visitation must be vaccinated (or establish a religious or medical exemption). The Receiver has determined that the best available medical science supports this recommendation.

The Receiver respectfully requests that the Court issue an order to show cause why the Court should not order CDCR and CCHCS to implement this recommendation.

[129] *See* 42 U.S.C. § 2000e-2; 42 U.S.C. § 12112.

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

OAKLAND DIVISION

MARCIANO PLATA, et al.,

Plaintiffs,

v.

GAVIN NEWSOM, et al.,

Defendants.

CASE NO. 01-1351 JST

JOINT CASE MANAGEMENT CONFERENCE STATEMENT

Judge: Hon. Jon S. Tigar
Date: June 30, 2021
Time: 2:00 p.m.
Crtrm.: 6, 2nd Floor

hereto as Exhibit A). In essence, staff are the primary vector for coronavirus getting into the prisons, and those who are unvaccinated pose a much higher risk of infecting residents and other staff. In addition, when residents are infected, others, infected or not, are impacted by quarantines, restricted programs, and limited medical care, including postponement of previously scheduled specialty services. Further incentive programs will not substantially increase current staff vaccination rates, based on recent experience and studies of vaccine incentives in similar contexts.

Regarding COVID-19 infections among staff, CDCR recently stopped reporting new staff cases on its "CDCR/CCHCS COVID 19 Employee Status" website. *See* Cal. Dep't of Corr. & Rehab., *CDCR/CCHCS COVID-19 Employee Status*, https://www.cdcr.ca.gov/covid19/cdcr-cchcs-covid-19-status. We asked CDCR and CCHCS about this on June 23. On June 24, CCHCS responded that new COVID-19 staff cases would no longer be reported on the public website, but would be added to CCHCS's internal Roadmap to Reopening registry by mid-July. As we do not have access to that registry, CCHCS also agreed to provide reports of new active staff cases to Plaintiffs' counsel on a weekly basis.

Defendants' Position: CCHCS and CDCR's efforts to vaccinate the incarcerated population have been successful. Defendants are particularly pleased that the vast majority of medically high-risk patients accepted the vaccine. Defendants continue to partner with CCHCS to encourage unvaccinated incarcerated people to accept the vaccine.

Since the last case management conference, 2,946 more staff members have accepted at least one dose of a COVID-19 vaccine, increasing the percentage of staff with at least one dose of a COVID-19 vaccine from 49% to approximately 54%. This trend is encouraging—staff vaccination numbers increased by about 5% between late April and late May,[6] and by another 5% between late May and late June.

[6] (*See* ECF No. 3592 at 9:6-8: between late April and late May, 2,574 staff members accepted at least one dose of a COVID-19 vaccine, increasing the percentage of staff with at least one dose of the vaccine from 44% to 49%)

As reported in the last statement, the Receiver's office and CDCR believe it is necessary to do everything reasonably possible to educate and encourage voluntary vaccine acceptance by staff before determining whether to mandate the vaccine as a condition of employment. Indeed, the Prison Litigation Reform Act requires as much. The Receiver's office reiterated this view in a call with the parties on June 16, 2021, and is moving forward with its plan for medical professionals to have one-to-one, face-to-face consultations with unvaccinated CDCR staff in an effort to address their specific concerns about the vaccine. Going forward, those who continue to decline to vaccinate will be required to participate in training and document their declination. Defendants and the Receiver's office continue to consider additional incentives to encourage staff—particularly those who work in the prisons—to voluntarily accept the vaccine.

In a May 21, 2021 email, the Receiver encouraged the parties to discuss their views regarding a mandatory COVID-19 policy for staff in the May 25, 2021 case management conference statement. Defendants did this (*See* ECF No. 3592 at 8:10-11:1), and are considering Plaintiffs' views as set forth in their June 14, 2021 letter. In light of the additional measures the Receiver's office is implementing, the continuing low number of confirmed active COVID-19 cases in custody (and around the State), the high vaccination rate among incarcerated persons, and because a mandatory staff vaccination policy would have implications for a variety of congregate and other settings across the state, and not just CDCR facilities, Defendants believe it is premature to mandate the COVID-19 vaccination as a condition of employment at this time.

II. POPULATION REDUCTION

Plaintiffs' Position: CDCR's population continues to slowly increase. As of June 25, per the CCHCS Vaccine Registry, 98,500 were incarcerated, an increase of approximately 1,500 from May 21. We acknowledge the current population is more than 20,000 fewer than pre-pandemic levels in March 2020, but remain concerned that the population now continues to steadily increase.

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

OAKLAND DIVISION

MARCIANO PLATA, et al.,

Plaintiffs,

v.

GAVIN NEWSOM, et al.,

Defendants.

CASE NO. 01-1351 JST

DECLARATION OF CONNIE GIPSON IN SUPPORT OF DEFENDANTS' OPPOSITION TO PLAINTIFFS' POSITION ON QUARANTINE IN HOUSING UNITS WITH SHARED AIR SPACE

Judge: Hon. Jon S. Tigar

I, Connie Gipson, declare:

1. I am the Director of the California Department of Corrections and Rehabilitation's (CDCR) Division of Adult Institutions. In 2019, I was promoted to the Acting Director of the Division of Adult Institutions, and was officially appointed to my current position as the Director in April 2019. I am competent to testify to the matters set forth in this declaration and, if called upon by this Court, would do so. I submit this declaration in support of Defendants' Opposition to Plaintiffs' Position on Quarantine in Housing Units with Shared Air Space.

2. I understand that Plaintiffs assert that CDCR has been deliberately indifferent to the

COVID-19 pandemic. Considering the fact that thousands of CDCR employees for many months have worked tirelessly on a daily basis to fight the spread of this unprecedented pandemic and struggle every day to make the best decisions for the welfare of inmates and staff in the prisons, it is difficult for me to understand Plaintiffs' allegations of deliberate indifference. In this declaration, I have tried to capture a number of the significant efforts CDCR, CCHCS, and their employees have made to address this pandemic, but it is not possible to identify all efforts to date aimed at combating this unprecedented public health crisis.

3. I have submitted two previous declarations this year that discussed CDCR's efforts to flatten the curve of the COVID-19 pandemic and to manage this crisis. The first declaration was filed on March 31, 2020, and can be found at ECF No. 3240. Below is a list summarizing some of the actions taken and measures implemented in response to the pandemic that I described in much more detail in that declaration:

- California Correctional Healthcare Services (CCHCS) and CDCR's establishment of a multi-disciplinary team, chaired by a public health physician, to take all feasible steps to prevent a COVID-19 outbreak in CDCR's institutions and to develop a thorough and solid response action plan for dealing with outbreaks;
- CDCR's activation of the Department Operations Center (DOC)—a centrally-located command center where CDCR and CCHCS experts monitor information, prepare for known and unknown events, and exchange information centrally in order to make decisions and provide guidance quickly in the event of outbreaks;
- CDCR's development of Pandemic Operational Guidelines;
- The suspension of public visiting in the prisons;
- The suspension of intake from the county jails (intake has since resumed on a limited and intermittent basis, but it is currently suspended);
- CDCR's implementation of symptom screening for individuals entering the prison system;
- CDCR's efforts to educate staff and inmates about the need for taking precautions such as physical distancing and hygiene;

- CDCR's efforts to reduce the populations in dorms by transferring significant numbers of inmates out of dorms to other housing throughout the system;
- CDCR's implementation of enhanced cleaning efforts throughout the prisons and the wide distribution of hand soap and hand sanitizer dispensers; and
- CDCR's implementation of quarantines for exposed patients;

4. I submitted another declaration on April 13, 2020, in which I described some of CDCR's additional efforts to respond to the pandemic. That declaration is located at ECF No. 3275. Below is a list summarizing some of the actions taken and measures implemented that I described in more detail in that declaration:

- CDCR's implementation of an expedited release plan to quickly reduce the system's population by nearly 3,500 inmates;
- The implementation of a modified program to manage and restrict inmate movement throughout the system and to provide guidance on physical distancing and efforts to cohort inmates in their housing units;
- CDCR's placement of physical-distancing markings throughout the prisons to encourage physical distancing;
- CDCR's ongoing efforts to reduce dorm populations by transferring inmates out of particular dorm settings;
- CDCR's development of plans to convert certain areas in prisons, such as gyms, chapels and visiting areas, into additional housing for the purpose of allowing greater physical distancing in housing units;
- The California Prison Industry Authority's efforts to manufacture cloth face masks and hand sanitizer for inmates and staff throughout the system;
- The creation of physical-distancing cohorts within dorm settings; and
- The placement of restrictions on inmate transfers and the implementation of requirements to obtain approval for transfers from the Health Care Placement Oversight Program and the CCHCS's public health team.

5. A host of additional measures that CDCR has implemented in response to the

pandemic can be found on CDCR's website at: https://www.cdcr.ca.gov/covid19/covid-19-response-efforts/; https://www.cdcr.ca.gov/covid19/san-quentin-state-prison-response/; and https://www.cdcr.ca.gov/covid19/memos-guidelines-messaging/.

6. Beginning in July 2020, CDCR implemented several plans to expedite the release of additional inmates to further reduce the prison population. Those measures resulted in the early release of an additional 7,060 inmates from the 35 institutions and camps (including California City Correctional Facility) during the period from July 1 through December 3, 2020. Combined with the previous early release efforts, natural releases, and restrictions on intake from the counties, CDCR has reduced its population by over 23,000 inmates since the beginning of the pandemic. The press release concerning the early-release measures implemented in July 2020 provides additional details and can be found at https://www.cdcr.ca.gov/news/2020/07/10/cdcr-announces-additional-actions-to-reduce-population-and-maximize-space-systemwide-to-address-covid-19/.

7. To ensure that transfers of inmates between institutions are conducted safely, CCHCS developed the Movement Matrix. The current version of this document is attached as Exhibit A to this declaration, and a new draft version is attached as Exhibit B. By carefully complying with the requirements of the Movement Matrix, CDCR has been able to safely transfer inmates throughout the system for a number of important reasons, including moving medically high-risk patients into safer settings and reducing the population in particular housing units to make them safer. CDCR takes the Movement Matrix requirements seriously, and has turned away intake busses from counties that have not complied with transfer requirements.

8. CCHCS conducts a robust COVID-19 surveillance-testing program for CDCR staff and patients in the prisons. In addition to sending tests to labs for results, every prison now also has the ability to conduct point-of-care tests that usually provide results in about fifteen minutes. Furthermore, wastewater monitoring has commenced at two prisons and may be expanded to others to assess its feasibility and effectiveness for early detection of outbreaks.

9. Because of testing fatigue among the incarcerated population and staff, CCHCS has started testing using anterior nasal swabs, which are less invasive and more comfortable than the

nasopharyngeal swabs previously used. This change was made to encourage a high rate of testing compliance.

10. CDCR and CCHCS are also collaborating on an effort to move medically high-risk patients out of dorms and into cells. On October 21, 2020, the Receiver issued a memorandum entitled "Transferring COVID-19 High-Risk Patients to Safer Housing," which requires CDCR to offer each person with a COVID-weighted risk score of three or higher a single cell with a solid door. A copy of the Receiver's memorandum is attached to this declaration as Exhibit C. The Receiver has also restricted the transfer of medially high-risk patients to a specific group of prisons that do not have the ability to house them in cells with solid doors. As a result of these decisions, CDCR is now prioritizing movement of medically high-risk patients who have not contracted COVID-19 in the last three months from congregate living spaces to cells with solid doors. CDCR and CCHCS are working on a process for mandating the transfer of patients who do not voluntarily move to cells. The implementation of the plan to move medically high-risk patients has already commenced at San Quentin, and plans for three other institutions are being developed.

11. Since April 2020, CDCR has been providing cloth face masks to inmates and staff and providing guidance and directives on mask use. CDCR currently requires mask wearing in the prisons and provides all staff with surgical face masks. As an additional mitigation effort during serious outbreaks at particular prisons, CDCR has issued N95 masks to all inmates and staff to help stop the virus's spread. To date, this type of prison-wide N95 measure has been implemented at Folsom State Prison, San Quentin State Prison, and Avenal State Prison. And at other prisons experiencing outbreaks, CDCR required the use of N95 masks by staff and inmates who work or reside in the areas experiencing the outbreaks.

12. CDCR has implemented other measures to protect inmates at prisons experiencing serious outbreaks, such as transferring medically high-risk patients out of dorms and into cells, and the implementation of increased testing rates.

13. In July 2020, CDCR began working on setting aside and reserving quarantine and isolation space at all prisons based on guidance developed by CCHCS and various public health

experts, including input from the parties' experts. This public-health workgroup devised a method for determining the amount of space that each prison should reserve for quarantine and isolation purposes in the event of an outbreak. The methodology was based on the number of inmates residing in the largest congregate living space in each prison. The workgroup's report on the methodology is attached to this declaration as Exhibit D.

14. Attempting to reserve the recommended isolation and quarantine space for each prison was a massive undertaking that presented the logistical challenge of transferring hundreds inmates to different housing units and prisons, This effort was made more challenging because it was necessary to ensure that reserved spaces satisfied the needs of the plaintiffs in the class actions *Armstrong v. Newsom* and *Coleman v. Newsom.* It took months of work to achieve the current reserves and CDCR continues to meet and confer with Plaintiffs and the parties to the other class actions concerning the subject of reserved spaces, and work on these issues continued through November 2020.

15. CDCR's reserved space has capacity to house approximately 7,809 patients in cells if they are mostly double celled, and up to about 4,228 patients if they are single celled. CDCR has also formally reserved about 1,195 beds that are in congregate living spaces, such as dorms, tents, gyms, and other converted spaces for isolation and quarantine.

16. Attached as Exhibit E is a chart that describes the reserved space at each of the prisons. The formally reserved spaces and beds are reflected in the second and third columns of Exhibit E. The third column also indicates the space reserves recommended by the public-health workgroup. As reflected in Exhibit E, many of the prisons reserved more space than was recommend by the public-health workgroup, and some prisons exceeded the recommendations by a large quantity (e.g., California City Correctional Facility (CAC), California Institution for Women (CIW), and California State Prison-Sacramento (SAC)). Several prisons, however, could not come close to reserving the recommended amount of quarantine and isolation space because of their designs (e.g., San Quentin (SQ), Folsom (FOL), California Rehabilitation Center (CRC)). The public-health working group recognized that these prisons would not be able to reserve the recommended space because of their designs, and acknowledged that they would require unique

solutions.

17. Because of CDCR's reduced population, a number of prisons currently have abundant additional space—beyond the reserved space—that could be used for quarantine and isolation if needed. Those spaces are described in the fourth and fifth columns of Exhibit E. In total, the additional cell space is sufficient to house about 2,620 patients if they are mostly double celled, and about 1,347 patients if they are single celled. And there are about 1,999 additional beds in congregate settings that are also currently available for quarantine or isolation use.

18. Because some of the prisons were unable to reserve the recommended space for isolation and quarantine, and because their facility designs are likely to present challenges in the event of an outbreak, they have developed plans for how to deal with a surge of COVID-19 cases. San Quentin, Folsom, California Rehabilitation Center, California Health Care Facility, and Avenal State Prison have developed such plans, which are based on experience gained during past serious outbreaks, such as the outbreak at San Quentin.

19. I understand that Plaintiffs have complained that reserved isolation and quarantine space might sometimes be used for precautionary quarantines associated with inmate transfers. I have not yet fully investigated whether or to what extent this is happening, but even if this does happen at some prisons, it should not cause much of an impact on availability of quarantine and isolation space when there is an outbreak. When there is an outbreak of three or more patients at a prison, that prison closes to transfers. This means that almost all transfers to or from that prison, with the possible exception of intake from reception centers, cease once there are three positive cases of COVID-19. If there are no more transfers to or from a prison, then there is no need for precautionary quarantine. To the extent there is a reduced number of transfers at closed prisons, as I explained above, most prisons have already reserved more quarantine and isolation space than the public-health workgroup recommended, and many prisons have abundant additional space beyond the reserved space. And finally, anticipated modifications to the precautionary quarantine protocols that are reflected in the new draft Movement Matrix (see Exhibit B) should further mitigate any issue in this area, if one exists, because there will be fewer precautionary quarantines taking place. Regardless, I would welcome the opportunity to dig further into this issue and

discuss it with the Receiver and the Plaintiffs to determine whether there is a problem that needs to be addressed, and if so, work on a plan to remedy it.

20. Quarantine cohorts have occurred in some instances even when reserved quarantine space is available at a prison, and I understand that Plaintiffs have complained about this issue. The Receiver has provided the parties with data that shows that most inmates on quarantine are housed alone or with only one other inmate. But that data also confirms that significant numbers of inmates are quarantined in cohorts of various sizes. Some of these situations are the result of the reserved quarantine spaces being filled at a particular prison during an outbreak. The management of outbreaks in prison settings is extremely complex. To the extent officials have decided to use quarantine cohorts when there is still reserved space available for quarantine, there could be good reasons for those decisions based on the circumstances of a particular outbreak at a particular prison. And those good reasons might not be readily apparent to those who are not on the ground in that facility during the outbreak. On the other hand, it is possible that less than optimal decisions have been made in some circumstances. I understand that on December 1, 2020, Plaintiffs asked the Receiver to look into some specific quarantines related to this issue, but I do not believe the Receiver has yet completed his investigation or responded to that inquiry. I believe this issue warrants further investigation and I welcome the opportunity to work on it with the Receiver and Plaintiffs to ensure that the best available options for quarantine are utilized first.

21. I expect that the Receiver will want to discuss these quarantine issues with the parties very soon because on December 4, 2020, he sent new guidance to the parties concerning quarantine for patients who have been exposed to COVID-19. The new guidance states that the first choice for post-exposure quarantine housing should be solid-door cells occupied by only one person, and that quarantine cohorting is to be used with no more than two persons per shared airspace. The Receiver's new guidance, however, recognized that at certain prisons this quarantine standard is not achievable. At those institutions, CDCR should make all efforts to find satisfactory quarantine alternatives. For two institutions—California Medical Facility and California Health Care Facility—the Receiver committed decisions concerning post-exposure quarantine to the discretion of medical leadership in light of the unique missions and operations at

those prisons. This new guidance will be a challenge to implement, but I look forward to working with the Receiver to determine whether it is feasible and to explore possible options for implementing it.

22. CDCR makes a concerted effort to learn from past outbreaks how to better respond to new outbreaks. A good example of this was the handling of the outbreak at Folsom from August through October 2020. Based on our experience with the outbreak at San Quentin, and because we knew that Folsom faced many of the same challenges that made outbreak management at San Quentin difficult, at the beginning of the Folsom outbreak, we immediately took a number of steps that resulted in a far better outcome. Those steps included the early installation of tents to provide additional capacity for quarantine, isolation, and medical treatment, the preparation of Folsom's limited cell capacity to help manage the outbreak, the removal of medically high-risk patients to cells, close monitoring of staffing needs and the implementation of plans to ensure sufficient staffing for the duration of the outbreak, the implementation of a mandatory prison-wide N95 mask policy for staff and inmates, and greatly increased testing rates. Through all of these efforts, we were able to prevent an outcome similar to the outbreak at San Quentin even though Folsom and San Quentin faced many of the same challenges based on their age and design.

23. Another good example of CDCR's improving ability to effectively respond to outbreaks in challenging settings is the outbreak that occurred at California Rehabilitation Center. This prison has no cells available for quarantining patients, and yet it was able to get a large outbreak under control and prevent the loss of life from COVID-19. The reduction in California Rehabilitation Center's population allowed it to utilize several large dorms for quarantine space, and the installation of climate-controlled tents increased the housing capacity. Furthermore, additional climate-controlled tents were installed for the specific purpose of housing medically high-risk patients away from the general population, and dedicated staff were assigned to essentially cohort with those high-risk patients during the outbreak to further limit their potential exposure to the virus. The medically high-risk areas contained full services, including bathrooms and showers, dedicated to those patients so they would not have to visit areas where the general population resided. The tents were designed to house ten people, but only four medically high-

risk people were assigned to each tent, which allowed for greater physical distancing.

24. I am aware that CCHCS and CDCR are actively communicating with the California Department of Public Health to ensure that inmates and staff are provided the opportunity to be vaccinated in accordance with public health guidelines for vaccine distribution. CDCR is optimistic and hopeful that vaccines will be distributed and administered quickly, but we will continue to work night and day with the goal of protecting the incarcerated and staff for the duration of this ever changing and challenging pandemic.

I declare under penalty of perjury that I have read this document, and its contents are true and correct to the best of my knowledge. Executed on December 9, 2020, in Sacramento, California.

/s/ *Connie Gipson*
Connie Gipson,

Exhibit A

COVID-19 SCREENING AND TESTING MATRIX FOR PATIENT MOVEMENT
August 19, 2020

1. ***To reduce the likelihood of COVID-19 spreading from one location to another, movement shall be limited to that which is necessary for clinical care, medical isolation or quarantine, reduction of overcrowding, and serious custody concerns.***
2. ***If transfer from one institution to another must take place, pre and post transfer quarantine and COVID-19 testing shall be performed.***
3. ***Inmates and transportation staff shall wear N95 masks during transfer. Transportation vehicles shall be disinfected after each trip. Transportation staff shall be tested as per the staff testing policy.***
4. ***Every effort shall be made to avoid layovers during transportation.***
5. ***Inmates who were previously infected with COVID and have been moved to the resolved status are considered to be immune from re-infection for at least twelve weeks, and shall not be required to re-test for movement purposes during that time frame.***
6. ***Inmates moving into higher level of care (HLOC) beds (medical CTC, OHU, MHCB, PIP) shall be quarantined in the HLOC***

TYPE OF MOVEMENT	COVID TESTING STRATEGY	HOUSING	WHAT TO DO IF PATIENT REFUSES COVID TEST
From jail to reception center	All inmates and transportation staff shall wear an N 95 respirator during transfer Quarantine all new arrivals for 14 days after arrival in cell based housing. Screen all new arrivals for COVID-19 symptoms upon arrival and then daily while in quarantine. Test all new arrivals for COVID-19 within 24 hours, again on day 7 and again prior to release from quarantine (no sooner than day 12). Place any inmate who tests positive in isolation. May release inmates from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative.	Quarantine in cell based housing.	Inmate to remain in pre-transfer quarantine for at least 21 days and receive daily symptom screening. Disposition to be determined in consultation with CME and public health.
From jail directly to Specialized Medical Beds (SMB)	Advance authorization required by the Director, Health Care Services and Director, Health Care Operations. All inmates and transportation staff shall wear an N 95 respirator during transfer. Quarantine all new arrivals for 14 days after arrival in cell based housing. Screen all new arrivals for COVID-19 symptoms upon arrival and then daily while in quarantine. Test all new arrivals for COVID-19 within 24 hours, again on day 7 and again prior to release from quarantine (no sooner than day 12). Place any inmate who tests positive in isolation.		Inmate to remain in pre-transfer quarantine for at least 21 days and receive daily symptom screening. Disposition to be determined in consultation with CME and public health. .

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	May release inmates from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative.		
From reception center to institution	Screen all inmates for COVID-19 symptoms and then test for COVID-19 just prior to transfer utilizing a methodology that allows for no more than 48 hours turnaround time for results. If inmate tests negative and patient is asymptomatic, transfer as soon as possible but no more than 72 hours after test was obtained. All inmates and transportation staff shall wear an N 95 respirator during transfer.		Inmate to remain in pre-transfer quarantine for at least 21 days and receive daily symptom screening. Disposition to be determined in consultation with CME and public health.
Institution intake from reception center	Quarantine all new arrivals for 14 days in cell based housing. Facilities which by design have no cell based housing shall house newly arriving inmates in cohorts of no more than 10 in a dorm or small tent solely dedicated to the cohorts who arrive on the same day. Screen all new arrivals for COVID-19 symptoms upon arrival and then daily while in quarantine. Test all new arrivals for COVID-19 within 24 hours, on day 7 and prior to release from quarantine (no sooner than day 12). Place any inmate who tests positive in isolation. May release inmates from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative.	Quarantine in celled housing, with minor exceptions as noted.	Inmate to remain in quarantine for at least 21 days. Disposition to be determined in consultation with CME and public health.
General population movement from one institution to another, including to camp hubs	**Sending institution** Quarantine all inmates prior to transfer in cell based housing. Facilities which by design have no cell based housing shall house inmates in cohorts of no more than 10 in a dorm or small tent solely dedicated to the cohorts who will depart on the same day. Screen all inmates for COVID-19 symptoms initially and then daily while in quarantine. Test symptomatic patients. Place any inmate who tests positive in isolation. Test for COVID after 14 days in quarantine utilizing a methodology that allows for no more than 48 hours turnaround time for results. If inmate tests negative, transfer as soon as possible but no more than 72 hours after test was obtained. All inmates and transportation staff shall wear an N 95 respirator during transfer. **Receiving institution** Quarantine all new arrivals for 14 days in cell based housing. Facilities which by design have no cell based housing shall house newly arriving inmates in cohorts of no more than 10 in a dorm or small tent solely dedicated to the cohorts who arrive	Quarantine in celled housing, with minor exceptions as noted.	Inmate to remain in quarantine for at least 21 days. Disposition to be determined in consultation with CME and public health.

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	on the same day. Screen all new arrivals for COVID-19 symptoms upon arrival and then daily while in quarantine. Test all new arrivals for COVID-19 on day 12 of quarantine. May release inmates from quarantine after 14 days if asymptomatic and COVID-19 test- is negative. Place any inmate who tests positive in isolation.		
Movement from one institution to another for specialized medical bed placement	**Sending institution** Movement that is not considered clinically urgent or emergent: • Quarantine all inmates prior to transfer in cell based housing. Screen all inmates for COVID-19 symptoms initially and then daily while in quarantine. • Test symptomatic patients. • Place any inmate who tests positive in isolation. • Test for COVID after 14 days in quarantine utilizing a methodology that allows for no more than 48 hours turnaround time for results. • If inmate tests negative, transfer as soon as possible but no more than 72 hours after test was obtained. • All inmates and transportation staff shall wear an N 95 respirator during transfer. Movement that is considered clinically urgent or emergent: • Perform rapid testing for COVID-19 prior to movement. • Communicate results to receiving facility. • All inmates and transportation staff shall wear an N 95 respirator during transfer. **Receiving institution** House appropriately at receiving institution (isolation vs quarantine) depending upon the results of the rapid test. New arrivals who tested positive at sending institution shall be housed in isolation at receiving institution and managed per CCHCS guidelines. New arrivals who tested negative at sending institution shall be quarantined for 14 days in cell based housing. These inmates shall be screened for COVID-19 symptoms upon arrival and then daily while in quarantine. Test these inmates for COVID-19 on day 12 of quarantine. May release inmates from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative.		Inmate to remain in quarantine for at least 21 days. Disposition to be determined in consultation with CME and public health.

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	Place any inmate who tests positive in isolation.		
Movement within same institution • **Release from STRH, LTRH, ASU, SHU** • **PIP / MHCB admission or discharge** • **CTC, OHU, hospice admission or discharge** • **Mental health level of care change** • **DPP moves** • **DDP moves** • **All other routine movement**	No screening or testing if remains at current institution UNLESS Moving from a COVID-19 outbreak unit to a non-outbreak unit: • All such movement should be avoided. • If movement from a COVID-19 outbreak unit to a non-outbreak unit is essential, inmate shall be quarantined in new unit and screened/tested as if coming from a different institution. (See "General population movement from one institution to another, including to camp hubs"). Moving into a large dorm (50 or more residents): • Perform COVID-19 symptom screening and COVID-19 rapid testing of the inmate prior to this move.	No COVID-19 related housing restrictions EXCEPT inmates moving from a COVID-19 outbreak unit to a non-outbreak unit shall be quarantined in a cell in the new unit and tested prior to release.	Inmate to remain in quarantine for at least 21 days, unless placement in quarantine is impossible (e.g.: MSF), in which case the inmate will not be moved. Disposition to be determined in consultation with CME and public health.
Movement from one institution to another for MHCB or PIP placement	MH Regional required to receive approval from the Deputy Director, Health Care Services, to move patient who declines testing. **Sending institution** Perform rapid testing for COVID-19 prior to movement. Communicate results to receiving facility. All inmates and transportation staff shall wear an N 95 respirator during transfer. **Receiving institution** House appropriately at receiving institution (isolation vs quarantine) depending upon the results of the rapid test. New arrivals who tested positive at sending institution shall be housed in isolation at receiving institution and managed per CCHCS guidelines. New arrivals who tested negative at sending institution shall be quarantined for 14 days in cell based housing. These inmates shall be screened for COVID-19 symptoms upon arrival and then daily while in quarantine. Test these inmates for COVID-19 on day 12 of quarantine. May release inmates from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative. Place any inmate who tests positive in isolation.	Quarantine in celled housing.	Inmate to remain in quarantine for at least 21 days. Disposition to be determined in consultation with CME and public health.
Admission to DSH from CDCR	Quarantine all inmates prior to transfer in cell based housing. Screen all inmates for COVID-19 symptoms initially and then	As per DSH protocols upon arrival to DSH	Inmate to remain in quarantine for at least 21 days.

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	daily while in quarantine. Test symptomatic patients. Place any inmate who tests positive in isolation. Test for COVID after 14 days in quarantine utilizing a methodology that allows for no more than 48 hours turnaround time for results. If inmate tests negative, transfer as soon as possible but no more than 72 hours after test was obtained. All inmates and transportation staff shall wear an N 95 respirator during transfer.		Disposition to be determined in consultation with the Deputy Director, Mental Health and public health.
DSH discharge to CDCR	**Sending DSH institution** Quarantine all inmates prior to transfer in cell based housing. Screen all inmates for COVID-19 symptoms initially and then daily while in quarantine. Test for COVID after 14 days in quarantine utilizing a methodology that allows for no more than 48 hours turnaround time for results. If inmate tests negative, transfer as soon as possible but no more than 72 hours after test was obtained. All inmates and transportation staff shall wear an N 95 respirator during transfer. **Receiving CDCR institution** Quarantine all new arrivals for 14 days in cell based housing. Screen all new arrivals for COVID-19 symptoms upon arrival and then daily while in quarantine. Test all new arrivals for COVID-19 on day 12 of quarantine. May release inmates from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative Place any inmate who tests positive in isolation**.**	Quarantine in celled housing.	Inmate to remain in quarantine for at least 21 days. Disposition to be determined in consultation with the Deputy Director, Mental Health and public health.
To MCCF, ACP, CCTRP, MCRP, fire camp	Quarantine all inmates prior to transfer in cell based housing. Facilities which by design have no cell based housing shall house newly arriving inmates in cohorts of no more than 10 in a dorm or small tent solely dedicated to the cohorts who arrive on the same day. Screen all inmates for COVID-19 symptoms initially and then daily while in quarantine. Test symptomatic patients. Place any inmate who tests positive in isolation. Test for COVID after 14 days in quarantine utilizing a methodology that allows for no more than 48 hours turnaround time for results. If inmate tests negative, transfer as soon as possible but no	Quarantine in celled housing, with minor exceptions as noted.	Do not transfer.

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	more than 72 hours after test was obtained. All inmates and transportation staff shall wear an N 95 respirator during transfer.		
From MCCF, ACP, CCTRP, MCRP, fire camp to an institution	All inmates and transportation staff shall wear an N 95 respirator during transfer. Screen all new arrivals for COVID-19 symptoms upon arrival and then daily while in quarantine. Test all new arrivals for COVID-19 on day 12 of quarantine. May release inmates from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative Place any inmate who tests positive in isolation.	Quarantine in celled housing.	
Parole, medical parole, PRCS release	All inmates shall be screened for COVID-19 symptoms and then tested for COVID one week prior to transfer. Results of testing shall be communicated to parole agent or probation officer and local public health officer in county of release. If inmate tests positive, immediately consult with HQ public health unit re transportation and placement All inmates and transportation staff shall wear an N 95 respirator during transfer.		Inmates cannot be held beyond their parole date regardless of whether they agree to test or if the test is positive.
Out to court, same day return	All inmates and transportation staff shall wear an N 95 respirator during transfer. Use videoconferencing to avoid out to court travel in all cases unless court refuses to do so. Perform daily COVID screening for 14 days upon return. Place symptomatic returns in single cell quarantine while awaiting testing.	No housing restrictions.	.
Out to court, overnight stay.	**Manage like an intake from jail to reception center** All inmates and transportation staff shall wear an N 95 respirator during transfer. Use video conferencing to avoid out to court travel in all cases unless court refuses to do so. Quarantine all new arrivals for 14 days after arrival in cell based housing. Facilities which by design have no cell based housing shall house newly arriving inmates in cohorts of no more than 10 in a dorm or small tent solely dedicated to the cohorts who arrive on the same day. Screen all new arrivals for COVID-19 symptoms upon arrival and then daily while in quarantine. Test all new arrivals for COVID-19 within 24 hours, again on day 7 and again prior to release from quarantine (no sooner than	Quarantine in celled housing, with minor exceptions as noted.	Inmate to remain in quarantine for at least 21 days. Disposition to be determined in consultation with CME and public health.

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	day 12). Place any inmate who tests positive in isolation. May release inmates from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative.		
Out for clinical appointment, same day return	All inmates and transportation staff shall wear an N 95 respirator during transfer. Use "e-consult" and telemedicine whenever possible to avoid unnecessary offsite transportation. Perform daily COVID screening for 14 days upon return. Place symptomatic returns in single cell quarantine while awaiting testing.	No housing restrictions.	
Return from outside hospitalizations and emergency department visits	**Manage like an intake from jail to reception center** All inmates and transportation staff shall wear an N 95 respirator during transfer. Quarantine all new arrivals for 14 days after arrival in cell based housing. Facilities which by design have no cell based housing shall house newly arriving inmates in cohorts of no more than 10 in a dorm or small tent solely dedicated to the cohorts who arrive on the same day. Screen all new arrivals for COVID-19 symptoms upon arrival and then daily while in quarantine. Test all new arrivals for COVID-19 within 24 hours, on day 7 and prior to release from quarantine (no sooner than day 12). Place any inmate who tests positive in isolation. May release inmates from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative.	Quarantine in celled housing, with minor exceptions as noted.	Inmate to remain in quarantine for at least 21 days. Disposition to be determined in consultation with CME and public health.

DEFINITIONS

Patients placed in isolation or quarantine shall not move outside of the isolation or quarantine housing unless approved by clinical staff. Medical care and meals shall be provided/served within the isolation/quarantine space. Isolated and quarantined patients shall shower and toilet separately from other patients, and the showers/toilets shall be disinfected prior to use by others. All group activities shall be canceled.

1. **ISOLATION**
    a. **Persons who are CONFIRMED to have COVID-19:**
        i. Isolation is necessary.

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August 19, 2020

ii. For individual cases, the preference is for isolation in a negative pressure room.
iii. The second choice is isolation in a private room with a solid, closed door.
iv. Multiple confirmed COVID-19 positive cases can be housed together.
v. Confirmed positive patients shall not be housed in the same unit with those who are not known to have COVID-19.
vi. If there are no other options and these patients must be housed in the same building with non-infected patients, they must be physically separated from patients who do not have COVID-19. Physical separation requires solid walls and solid doors.
vii. Patients confirmed to have COVID-19 shall not be housed in dorms with those who are not confirmed to have COVID-19.
viii. Daily healthcare monitoring shall be conducted for patients diagnosed with COVID-19.
ix. All staff interacting with confirmed positive patients shall wear appropriate PPE including N 95 respirators.
x. To the extent possible, staff who are working in housing units with COVID-19 infected patients shall be cohorted such that they are not interacting with patients who are not known to be infected.

2. QUARANTINE

a. Persons who have been exposed to COVID-19

i. Quarantine is necessary.
ii. These patients are at risk of being infected as a result of their exposure. Thus, they shall be separated from both the confirmed cases and from the symptomatic but not yet confirmed cases to avoid re-exposure.
iii. For individual cases, the preference is for quarantine in a private room with a solid, closed door.
iv. Exposed persons shall not be housed in dorms with those who are not known to be exposed.
v. If private rooms are not available, exposed persons can be quarantined together as a cohort.
vi. If cohorting is essential, quarantine cohorts shall be as small as possible (1-10 persons) to minimize spread.
vii. Cohorts with different exposure dates shall not be housed together.
viii. Cohorts with different types of exposures shall also be separated, including those coming in from jails.
ix. Daily healthcare monitoring shall be conducted for patients who are under quarantine.
x. Serial testing and healthcare surveillance is used to identify those infected so that they can be moved to isolation.

b. Precautionary Quarantine for persons who are not know to be exposed

i. Quarantine is necessary.
ii. Each facility shall maintain sufficient quarantine space to accommodate its historical average volume of transfers
iii. For individual cases, the preference is for quarantine in a private room with a solid, closed door.
iv. If private rooms are not available, exposed persons can be quarantined together as a cohort.
v. If cohorting is essential, quarantine cohorts shall be as small as possible (1-10 persons) to minimize spread.
vi. Cohorts with different movement dates shall be separated. Cohorts with different types of movement shall also be separated, including those coming in from jails or transferring between institutions.
vii. Serial testing and healthcare surveillance is used to identify those infected so that they can be moved to isolation.

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viii. Patients arriving to an institution shall not be released from quarantine until they have completed quarantine and tested negative for COVID-19.

Exhibit B

COVID-19 SCREENING AND TESTING MATRIX FOR PATIENT MOVEMENT

DRAFT VERSION 11.24.20

1. *To reduce the likelihood of COVID-19 spreading from one location to another, movement shall be limited to that which is necessary for clinical care, medical isolation or quarantine, reduction of overcrowding, and serious custody concerns.*
2. *Institutions and facilities/yards within institutions may be closed for movement in and/or out due to a COVID outbreak. Movement in and out of locations that are "closed" due to COVID activity may occur on a case by case basis and shall require prior approval from the Director, Health Care Services or designee. Close coordination shall take place between sending and referring institutions.*
3. *COVID-19 screening consists of a verbal symptom questionnaire and temperature screening.*
4. *All COVID-19 testing shall be by Polymerase Chain Reaction (PCR) unless specifically stated otherwise.*
5. *Inmates and transportation staff shall wear N95 masks during transfer. Transportation vehicles shall be operated with reduced occupancy and shall be disinfected after each trip.*
6. *Every effort shall be made to avoid layovers during transportation. If a layover is essential, this shall be preapproved by the Directors of DAI and Health Care Services or their designees and coordinated in advance with the receiving facilities.*
7. *Whenever possible, precautionary transfer quarantine shall take place in celled housing with a solid door. Facilities which by design have no cell based housing shall conduct precautionary transfer quarantine in cohorts of no more than 4 in a dorm or small tent solely dedicated to a cohort that arrived on the same day.*
8. *Symptomatic inmates shall be isolated alone in celled housing with a solid door and tested for COVID-19.*
9. *Inmates with a PCR-confirmed diagnosis of COVID-19 may be housed together as a cohort on isolation status.*
10. *Inmates who were previously infected with COVID and were subsequently moved to the resolved status are considered by the CDC to be immune from re-infection for 90 days from the date of first symptoms or first positive test, whichever came first. All movement of "resolved" patients within this 90 day window shall be coordinated by HCPOP in consultation with the CCHCS Public Health Unit.*
11. *Inmates who have a COVID Risk Score of three or more who are transferred shall only be housed in cells with solid front doors. Inmates with COVID risk scores of three or more shall not transfer to SQ, FSP, ASP, CVSP, CRC, or CIM FAC-A and D.*

TYPE OF MOVEMENT	COVID SCREENING AND TESTING STRATEGY	WHAT TO DO IF PATIENT REFUSES COVID TEST
From jail to reception center	**Sending jail:** Do not transfer inmates who are currently isolated or quarantined due to exposure. Test by PCR five days prior to scheduled transfer. If PCR negative and COVID screen negative, transfer within 5 days of PCR test collection. Inmates who are symptomatic and/or test positive during pre-transfer testing shall not be transferred. All inmates and transportation staff shall wear an N 95 respirator during transfer. **Receiving reception center:** Quarantine all new arrivals for 14 days. Screen all new arrivals for COVID-19 upon arrival and then daily while in quarantine. Test all new arrivals for COVID-19 within 24 hours, again on day 7 and again prior to release from quarantine (day 12-14). May release inmates from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative. Inmates who are symptomatic and/or test positive during pre-transfer testing shall be isolated as per interim guidance.	Inmate to remain in quarantine for at least 21 days and receive daily symptom screening. Disposition to be determined in consultation with the Deputy Director, Medical Services or designee.
From jail directly to Specialized Medical Beds (SMB)	Advance authorization required by the Director, Health Care Services or designee. The Intake Control Unit and HCPOP shall coordinate these moves and shall inform the receiving CEO and CME in advance. All inmates and transportation staff shall wear an N 95 respirator during transfer. Quarantine all new arrivals for 14 days. Screen all new arrivals for COVID-19 upon arrival and then daily while in quarantine. Test all new arrivals for COVID-19 within 24 hours, again on day 7 and again prior to release from quarantine (day 12-14). . May release inmates from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative. Inmates who are symptomatic and/or test positive during pre-transfer testing shall be isolated as per interim guidance.	Inmate to remain in quarantine for at least 21 days and receive daily symptom screening. Disposition to be determined in consultation with the Deputy Director, Medical Services or designee.

From reception center to institution	Do not transfer inmates who are currently isolated or quarantined due to exposure. Pre-transfer precautionary quarantine not required unless inmate refuses testing or receiving institution unable to quarantine as described above. Test by PCR five days prior to scheduled transfer. If PCR negative, screen for COVID and obtain rapid test on day of scheduled transfer. If PCR negative, screen negative, and rapid test negative, transfer within 5 days of PCR test collection and one day of rapid test collection. Inmates who are symptomatic and/or test positive during pre-transfer testing shall not be transferred and shall be isolated as per interim guidance. All inmates and transportation staff shall wear an N 95 respirator during transfer.	Inmate to be placed in quarantine for at least 21 days and receive daily symptom screening. Disposition to be determined in consultation with the Deputy Director, Medical Services or designee.
Institution intake from reception center	Quarantine patients for 14 days. . Screen for COVID-19 upon arrival and then daily while in quarantine. Test for COVID-19 on day 5 and then again on day 12-14 of quarantine. May release inmates from quarantine after 14 days if asymptomatic and COVID-19 test is negative. Inmates who are symptomatic and/or test positive shall be isolated as per interim guidance.	Inmate to remain in quarantine for at least 21 days. Disposition to be determined in consultation with the Deputy Director, Medical Services or designee.
General population movement from one institution to another, including to camp hubs; movement from ASU / STRH / LTRH / SHU to another facility; movement to facilitate out to court appearance	Sending institution Do not transfer inmates who are currently isolated or quarantined due to exposure. Pre-transfer precautionary quarantine not required unless inmate refuses testing or receiving institution unable to quarantine as described above. Test by PCR five days prior to scheduled transfer. If PCR negative, screen for COVID and obtain rapid test on day of scheduled transfer. If PCR negative, screen negative, and rapid test negative, transfer within 5 days of PCR test collection and one day of rapid test collection. Inmates who are symptomatic and/or test positive during pre-transfer testing shall not be transferred and shall be isolated as per interim guidance. All inmates and transportation staff shall wear an N 95 respirator during transfer. Receiving institution Quarantine patients for 14 days. Screen for COVID-19 upon arrival and then daily while in quarantine. Test for COVID-19 on day 5 and then again on day 12-14 of quarantine.	Sending and receiving institutions: Inmate to be placed in quarantine for at least 21 days. Disposition to be determined in consultation with the Deputy Director, Medical Services or designee.

	May release inmates from quarantine after 14 days if asymptomatic and COVID- 19 test is negative. Inmates who are symptomatic and/or test positive shall be isolated as per interim guidance.	
Movement from one institution to another for OHU, CTC, or Hospice placement	Sending institution Movement that clinicians have determined to not be urgent or emergent: Pre-transfer precautionary quarantine not required unless inmate refuses testing or receiving institution unable to quarantine as described above. Test by PCR five days prior to scheduled transfer. If PCR negative, screen negative, and rapid test negative, transfer within 5 days of PCR test collection and one day of rapid test collection. Inmates who are symptomatic and/or test positive during pre-transfer testing shall not be transferred and shall be isolated as per interim guidance. Movement that clinicians have determined to be urgent or emergent: Perform rapid testing for COVID-19 on day of transfer. Transfer patient regardless of the results of the COVID-19 test. Communicate results to receiving facility. All inmates and transportation staff shall wear an N 95 respirator during transfer. Receiving institution New arrivals who tested positive at sending institution: Isolate as per interim guidance. New arrivals who tested negative at sending institution: Quarantine for 14 days. Screen for COVID-19 upon arrival and then daily while in quarantine. Test for COVID-19 on day 5 and then again on day 12-14 of quarantine. May release inmates from quarantine after 14 days if asymptomatic and COVID- 19 test is negative. Inmates who are symptomatic and/or test positive shall be isolated as per interim guidance.	Sending and receiving institutions: Inmate to be placed in quarantine for at least 21 days. Disposition to be determined in consultation with the Deputy Director, Medical Services or designee.
Movement within same institution • Release from STRH, LTRH, ASU, SHU • PIP / MHCB admission or	Patients shall not be moved to or from an outbreak unit at the same institution. No quarantine or testing required for movement within the same institution unless the patient will be moving into a large dorm (50 or more residents). If so, perform COVID screening and COVID-19 testing of the inmate prior to this move. Only move the patient if the COVID screen and test are negative. If movement is considered urgent or emergent, perform a rapid test and transfer within a day if COVID screen and test are negative.	Inmate to be placed in quarantine for at least 21 days, unless placement in quarantine is impossible (e.g., MSF), in which case the inmate will not be moved. Disposition to be determined in consultation with the Deputy

discharge • CTC, OHU, hospice admission or discharge • Mental health level of care change • DPP moves • DDP moves • All other routine movement		Director, Medical Services or designee.
Admission to MHCB or PIP at another institution	**Sending institution** Perform rapid testing for COVID-19 on day of transfer. Transfer patient regardless of the results of the COVID-19 test. Communicate results to receiving facility. All inmates and transportation staff shall wear an N 95 respirator during transfer. **Receiving institution** <u>New arrivals who tested positive at sending institution:</u> Isolate as per interim guidance. <u>New arrivals who tested negative at sending institution:</u> Quarantine for 14 days. Screen for COVID-19 upon arrival and then daily while in quarantine. Test for COVID-19 on day 5 and then again on day 12-14 of quarantine. May release inmates from quarantine after 14 days if asymptomatic and COVID- 19 test is negative. Inmates who are symptomatic and/or test positive shall be isolated as per interim guidance.	Receiving institution: Inmate to be placed in quarantine for at least 21 days. Disposition to be determined in consultation with the Deputy Director, Medical Services or designee.
Discharge from MHCB or PIP to another institution	**Sending institution** Do not transfer inmates who are currently isolated or quarantined due to exposure. Pre-transfer precautionary quarantine not required unless inmate refuses testing or receiving institution unable to quarantine as described above. Test by PCR five days prior to scheduled transfer. If PCR negative, screen for COVID and obtain rapid test on day of scheduled transfer.	Sending and receiving institutions: Inmate to be placed in quarantine for at least 21 days. Disposition to be determined in consultation with the Deputy Director, Medical Services or designee.

	If PCR negative, screen negative, and rapid test negative, transfer within 5 days of PCR test collection and one day of rapid test collection. Inmates who are symptomatic and/or test positive during pre-transfer testing shall not be transferred and shall be isolated as per interim guidance. **Receiving institution** Quarantine patient for 14 days. Screen for COVID-19 upon arrival and then daily while in quarantine. Test for COVID- 19 on day 5 and then again on day 12-14 of quarantine. May release inmates from quarantine after 14 days if asymptomatic and COVID-19 test is negative. Inmates who are symptomatic and/or test positive shall be isolated as per interim guidance.	
Transfer to DSH from CDCR	Screen inmate and test for COVID 19. If inmate is asymptomatic and tests negative, transfer as soon as possible but no more than 5 days after test was administered. If the patient tests positive, further conversation shall take place between the sending and receiving clinicians to determine if the patient will transfer immediately or complete isolation within the CDCR. All inmates and transportation staff shall wear an N 95 respirator during transfer.	Disposition to be determined in consultation with Deputy Director Mental Health or designee and DSH.
OMDH paroles to DSH	Screen inmate and test for COVID 19. Communicate results to DSH prior to inmate parole. Transport inmate on the day of their parole to DSH. All inmates and transportation staff shall wear an N 95 respirator during transfer.	Communicate information to DSH and transport the inmate on their date of parole.
DSH discharge to CDCR	**Sending DSH institution** Do not transfer inmates who are currently isolated or quarantined due to exposure. Screen and test for COVID prior to transfer. If inmate is asymptomatic and tests negative, transfer as soon as possible but no more than 5 days after test was administered. All inmates and transportation staff shall wear an N 95 respirator during transfer. **Receiving CDCR institution** Quarantine inmate for 14 days. Screen for COVID-19 upon arrival and then daily while in quarantine. Test for COVID-19 on day 5 and then again on day 12-14 of quarantine. May release inmates from quarantine after 14 days if asymptomatic and COVID-19 test is negative Inmates who are symptomatic and/or test positive shall be isolated as per	DSH: disposition to be determined in consultation with Deputy Director Mental Health or designee, DSH, the Deputy Director, Medical Services or designee. Receiving CDCR institution: Inmate to be placed in quarantine for at least 21 days. Disposition to be determined in consultation with the Deputy Director, Medical Services or designee.

	interim guidance.	
To MCCF, ACP, CCTRP, MCRP, fire camp (unable to quarantine new arrivals)	Do not transfer inmates who are currently quarantined due to exposure. Quarantine inmate prior to transfer. Screen for COVID-19 initially and then daily while in quarantine. Test for COVID on day 12-14 of quarantine. Inmate to remain in quarantine while awaiting results. If inmate tests negative, transfer as soon as possible but no more than 5 days after test was administered. All inmates and transportation staff shall wear an N 95 respirator during transfer. Inmates who are symptomatic and/or test positive shall be isolated as per interim guidance.	Do not transfer.
From MCCF, ACP, CCTRP, MCRP, or fire camp to an institution (unable to quarantine prior to transport)	All inmates and transportation staff shall wear an N 95 respirator during transfer. Receiving CDCR institution Screen for COVID-19 upon arrival and then daily while in quarantine. Test for COVID-19 on day 5 and then again on day 12-14 of quarantine. May release inmates from quarantine after 14 days if asymptomatic and COVID-19 test is negative. Inmates who are symptomatic and/or test positive shall be isolated as per interim guidance. Inmates returning to an institution for urgent/emergent dental treatment Perform rapid COVID test immediately upon arrival prior to dental treatment. If the inmate tests negative, dental care will be rendered as appropriate. If the inmate tests positive, the inmate shall be isolated and dental treatment will proceed pursuant to dental program policy for COVID-19 positive patients.	Inmate to be placed in quarantine for at least 21 days. Disposition to be determined in consultation with the Deputy Director, Medical Services or designee.
From one fire camp to another fire camp	Perform symptom screening. If screens negative, may transfer to new camp without testing. If screens positive, transport to closest prison for COVID testing and either isolation or quarantine depending upon the results. Inmate and staff shall wear N95 during transportation.	NA
From fire camp to emergency room for treatment of minor injuries/conditions prior to release to fire camp.	Inmate and staff shall wear N95 during transportation and while in the emergency department.	NA
From fire camp to hospital	When released, inmate shall be transported back to a prison for	NA

for admission or other more serious condition	appropriate housing/quarantine/testing All inmates and transportation staff shall wear an N 95 respirator during transfer.	
Parole, medical parole, PRCS release	All inmates shall be screened for COVID-19 symptoms and then tested for COVID within one week of release. Results of testing shall be communicated to parole agent or probation officer and local public health officer in county of release. If inmate tests positive, manage as detailed in the COVID interim guidance. . All inmates and transportation staff shall wear an N 95 respirator during transfer.	Inmates cannot be held beyond their parole date regardless of whether they agree to test or if the test is positive.
Out to court, same day return	Use videoconferencing to avoid out to court travel in all cases unless court refuses to do so. If inmate remained in the custody of the transportation officer at all times, and if the inmate wore a face covering at all times, quarantine upon return shall not be required. All inmates and transportation staff shall wear an N 95 respirator during transfer.	NA
Out to court, at least one overnight stay in a jail or another prison.	Sending institution Do not transfer inmates who are currently isolated or quarantined due to exposure. Screen for COVID symptoms and perform rapid test on the day of departure. If COVID screen and test are negative, patient can be transported. Inmates who are symptomatic and/or test positive shall be isolated as per interim guidance. All inmates and transportation staff shall wear an N95 respirator during transfer. Receiving CDCR Institution Manage like an intake from jail to reception center. All inmates and transportation staff shall wear an N 95 respirator during transfer. Quarantine all new arrivals for 14 days after arrival. Screen all new arrivals for COVID-19 upon arrival and then daily while in quarantine. Test all new arrivals for COVID-19 within 24 hours, again on day 7 and again prior to release from quarantine (day 12-14). May release inmate from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative. Inmates who are symptomatic and/or test positive shall be isolated as per interim guidance.	Sending institution: Refusals to test prior to OTC appointments should be communicated to the courts. If approved, asymptomatic inmates who have completed quarantine may be transferred. Inmate to remain in quarantine for at least 21 days. Disposition to be determined in consultation with the Deputy Director, Medical Services or designee. . Receiving institution: Inmate to be placed in quarantine for at least 21 days. Disposition to be determined in consultation with the Deputy Director, Medical Services or designee.
Out for clinical appointment,	Use "e-consult" and telemedicine whenever possible to avoid unnecessary offsite transportation.	NA

same day return	All inmates and transportation staff shall wear an N 95 respirator during transfer. Perform daily COVID screening for 14 days upon return. Symptomatic inmates shall be isolated shall be isolated and tested as per interim guidance.	
Return from outside hospitalizations and emergency department visits	Manage like an intake from jail to reception center All inmates and transportation staff shall wear an N 95 respirator during transfer. Quarantine for 14 days. Screen for COVID-19 upon arrival and then daily while in quarantine. Test for COVID-19 at 24 hours, again at day 7, and on day 12-14 of quarantine. May release inmates from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative. Inmates who are symptomatic and/or test positive shall be isolated as per interim guidance.	Inmate to be placed in quarantine for at least 21 days. Disposition to be determined in consultation with the Deputy Director, Medical Services or designee. .

ISOLATION: GENERAL PRINCIPLES

Patients who are in isolation shall:

- Remain in their isolation location unless approved by clinical staff to move elsewhere
- Be medicated and fed in their isolation location
- Shall receive clinical care in their isolation location
- Shall not share showers or toilets with those who are not infected

ISOLATION OF INFECTED PATIENTS AND PRECAUTIONARY ISOLATION OF SYMPTOMATIC PATIENTS WHO ARE AWAITING TESTING

1. Isolation of patients who are infected with COVID-19
    a. All infected patients are to be isolated.
    b. Patients who were diagnosed solely based upon a rapid point of case test (POC) shall not be housed with other infected patients unless the POC test is confirmed by a PCR test.
    c. Infected patients shall not be housed with patients who are not confirmed to have COVID-19.
    d. Infected patients can be housed in congregate living sites with other COVID-19 infected patients.
    e. Twice daily health care monitoring shall be conducted for patients diagnosed with COVID-19.
    f. All staff interacting with COVID-19 infected patients shall wear an N 95 respirator, eye protection, and when in direct contact gloves and gowns.
2. Precautionary isolation of symptomatic patients who are being evaluated for COVID-19 infection
    a. Symptomatic patients who have not yet been confirmed to have COVID-19 shall be isolated separately from confirmed COVID-19 patients and separately from those who are not symptomatic.
    b. Daily health care monitoring shall be conducted for symptomatic patients who are awaiting diagnosis.
    c. All staff interacting with symptomatic isolated patients shall wear an N 95 respirator, eye protection, and when in direct contact gloves and gowns. .

QUARANTINE OF PATIENTS WHO HAVE BEEN EXPOSED TO COVID-19 AND PRECAUTIONARY QUARANTINE PRE OR POST TRANSFER

1. Quarantine of Patients who have been Exposed to COVID-19
    a. These patients are at risk of being infected as a result of their exposure. Thus, they shall be separated from both the confirmed cases and from the symptomatic but not yet confirmed cases.
    b. For individual cases, the preference is for quarantine in a private room with a solid, closed door.
    c. Exposed persons shall not be housed in dorms with those who are not know to be exposed.
    d. If private rooms are not available, persons with the same exposure can be quarantined together as a cohort.
    e. If cohorting is essential, quarantine cohorts shall be as small as possible (2-4 persons).

f. Daily healthcare monitoring shall be conducted for patients who are under quarantine.
g. Serial testing and healthcare surveillance is used to identify those who are infected so that they can be moved to isolation.
h. Patients shall not be released from quarantine until they have completed quarantine and tested negative for COVID-19 by PCR.
i. Any inmate who develops symptoms shall be placed in isolation alone and tested for COVID-19.

2. Precautionary quarantine for persons who are post transfer
   a. Each facility shall maintain sufficient quarantine space to accommodate its historical average volume of transfers.
   b. For individual cases, the preference is for quarantine in a private room with a solid, closed door.
   c. If private rooms are not available, persons can be quarantined together as a cohort.
   d. If cohorting is essential, quarantine cohorts shall be as small as possible (2-4 persons).
   e. Cohorts with different movement dates shall be separated.
   f. Cohorts with different types of movement shall also be separated, including those coming in from jails or transferring between institutions.
   g. Patients arriving to an institution shall not be released from quarantine until they have completed quarantine and tested negative for COVID-19 by PCR.
   h. Any inmate who develops symptoms should be placed in isolation alone and tested for COVID-19.

Exhibit C

Report on Risks of COVID to High-Risk Patients
Draft October 14, 2020

Introduction

We are now into the eighth month of the COVID-19 pandemic. Responding to the pandemic remains the highest priority for both the California Department of Corrections and Rehabilitation ("CDCR") and California Correctional Health Care Services ("CCHCS"). Since early 2020, we have implemented unprecedented organizational changes to respond to COVID-19 while also facing global Personal Protective Equipment ("PPE") shortages and testing delays. Over the course of the last several months, CDCR and CCHCS, in collaboration and after regularly consulting with public health experts including the California Department of Public Health ("CDPH"), have revised operational practices, implemented regular statewide testing of staff and patients, taken initial steps to de-populate dorms, provided educational programs for staff, implemented gate screening, mandated use of face coverings, aggressively distributed and required use of PPE, provided cleaning supplies and hand sanitizer, and created complex movement guidelines to minimize the risk of spread. Additional information can be found on the COVID-19 Preparedness website (https://www.cdcr.ca.gov/covid19/) and in the Receiver's Forty-fifth Tri-Annual Report filed with the Court on October 1, 2020 (https://cchcs.ca.gov/wp-content/uploads/sites/60/TR/T45_20201001_TriAnnualReport.pdf).

From a systemwide perspective, CDCR's population has experienced a COVID-19 positive case rate and death rate that is similar to what other prisons around the country have experienced. But we can do better. Because of the risk of greater morbidity and mortality to patients with certain defined COVID-19 risk factors (most importantly, age), throughout the pandemic, we have paid special attention to measures to reduce risks to this population. We now have actual data based on CDCR's own experience with COVID-19, and that data, combined with the recent determination by the Centers for Disease Control and Prevention ("CDC") that COVID-19 can spread by aerosolization, strongly points to a single conclusion:

> Dorm and open-cell-front housing poses particularly high risks of morbidity and mortality to our patients with COVID-19 risk-factors.

This conclusion drives an urgent search for additional steps that would reduce or eliminate those particularly high risks to those patients. We recommend that CDCR extend an offer to the over 8,200 patients with COVID-19 risk scores of 3 and above who are currently housed in dorms or open-cell-front housing the opportunity to transfer into closed-front cells either at their existing institution or at another institution.[1]

[1] Based upon our data and CDC guidelines, we developed a tool for assigning each patient a "COVID-19 risk score" which represents that individual's risk for having serious illness or death if they become infected with COVID-19.

Status Report on CDCR's COVID-19 Cases and Deaths

Prisons and jails have not been designed, built or operated with consideration of the risks posed by communicable diseases. As noted over a decade ago by CCHCS's Statewide Medical Executive, Dr. Joseph Bick, "most jails and prisons were constructed to maximize public safety, not to minimize the transmission of disease or to efficiently deliver health care." Joseph A. Bick, M.D., "Infection Control in Jails and Prisons," 45 Clinical Infectious Diseases 1047-1055 (Oxford Academic 2007).

Faced with the COVID-19 pandemic, a particularly dangerous and rapidly spreading infectious disease, prisons have struggled to protect their patients. CDCR's experience with COVID-19 is similar to the experience of prisons and other congregate living environments around the country (e.g., skilled nursing facilities, shelters, and cruise ships). Focusing on the federal prison system and the ten largest state prison systems, CDCR has had a larger number of cases per capita than most, but a lower number of deaths per capita than most. The following two tables are based on data reported by The Marshall Project's "State by State Look at Coronavirus in Prisons" as of October 10, 2020 (https://www.themarshallproject.org/2020/05/01/a-state-by-state-look-at-coronavirus-in-prisons):[2]

State (numeric ranking of largest prison systems)	Cases	Per 10,000
Florida (#3)	16428	1942
Texas (#1)	23065	1904
Michigan (#10)	5572	1612
California (#2)	**14870**	**1528**
Ohio (#5)	6499	1443
Federal Prisons	16012	1086
Arizona (#9)	2599	659
Illinois (#8)	1846	591
Georgia (#4)	1917	385
New York (#6)	791	213
Pennsylvania (#7)	469	109

Table 1. Cases in Federal and Top Ten State Prisons

[2] The per capita calculations for California in these tables is based upon an assumed population of 97,317. According to the Project's website, its population numbers were updated as of July 28, 2020. In California, there had, by that time, been a substantial reduction in CDCR's population. During the early months of the pandemic, CDCR's population was much larger (e.g., its population in March was over 120,000). Because of the difference between the population number used by the Project and CDCR's generally higher population numbers during much of the pandemic, the per capita rates for California listed in Tables 1 and 2 are slightly overstated.

State (numeric ranking of largest prison systems)	Deaths	Per 10,000
Ohio (#5)	100	22
Michigan (#10)	73	21
Florida (#3)	141	17
Georgia (#4)	69	14
Texas (#1)	161	13
Federal Prisons	134	9
California (#2)	**69**	**7**
Arizona (#9)	28	7
New York (#6)	17	5
Pennsylvania (#7)	11	3
Illinois (#8)	22	n/a

Table 2. Deaths in Federal and Top Ten State Prisons

It is much more difficult to compare cases and deaths in prisons with how COVID-19 has affected the general public in California, the United States or any other possibly relevant geographic unit. One of many methodological challenges in making such comparisons is that the number of cases and deaths in the prisons tends to be much more precise than the number of cases and deaths reported in the free world. For example, it is generally agreed that the number of reported COVID-19 confirmed cases in the United States substantially undercounts the number of actual COVID-19 cases. This is because, among other things, testing for COVID-19 has not been as widespread as it would need to be to count the actual number of cases. For example, according to CDCR's COVID-19 Tracker, there have been 340.2 tests per 1,000 persons in the United States. This means that two-thirds of the population in the United States has not had a COVID-19 test. By contrast, CDCR has tested 800.3 per 1,000 of its patients, making CDCR's count of cases much closer to the true number. A number of studies have concluded that it is likely there are *at least* 6 times more COVID-19 cases in the United States than have been reported (the range of underreporting goes from 6 to 24 times). *See, e.g.*, "Seroprevalence of Antibodies to SARS-CoV-2 in 10 Sites in the United States, March 23 – May 12, 2020," JAMA Internal Med. (July 21, 2020) (doi:10.1001/jamainternmed.2020.4130). The State of California has done a little more testing per 1,000 persons than the United States, but its testing rate of 395.4 per 1,000 also suggests that its reported count of COVID-19 cases is likely to be low.

The following table, Table 3, depicts the COVID-19 case rate for CDCR, the United States, California and Los Angeles. To account for the likely undercount of cases in the United States, California and Los Angeles County, the second column reports an unadjusted case rate based on the cases being currently reported, and the third column reports a case rate adjusted by

multiplying the case rate in the second column by 6, the lowest multiplier suggested by the undercount studies cited above:[3]

	Case Rate (unadj) per 100,000	Case Rate (6x adj) per 100,000
CDCR	13,944	Not Applicable
United States	2,344	14,063
California	2,133	12,798
Los Angeles County	2,710	16,264

Table 3. Case Rates in CDCR, the United States, California and Los Angeles.

A similar problem exists with respect to the reported number of deaths from COVID-19. Because CDCR's population is so much smaller than the United States or California, and because we actually monitor the condition of each patient in CDCR, the number of deaths CDCR reports from COVID-19 is likely to be more accurate than the death rates reported for the United States and California. The magnitude of the undercount in free world reports is not as well studied as the undercount in cases, making it nearly impossible to adjust free world death rates to account for the likely undercount.

There is a second methodological problem in trying to compare CDCR COVID-19 death rates with free world COVID-19 death rates. The rate of COVID-19 deaths is highly dependent upon age with well over 70% of deaths occurring in persons age 65 and older, and the age distribution of patients within CDCR does not match the age distribution of free world populations. In general, CDCR's population is slightly younger. Absent an adjustment to match the age distribution of CDCR's population to the age distribution of free world populations, the effective rate of CDCR COVID-19 deaths will be lower than if an age adjustment is made.

A third methodological problem is that it is generally recognized that persons who live for lengthy periods of time in prison tend, in terms of their health, to age more quickly than persons who are not in prison. A person who has been living in prison for decades and who has reached age 50 and above is likely to have an effective age anywhere from 5 to 10 years higher than their actual age. Whether this general tendency applies to the risk of death from COVID-19 is unknown at this time.

Given the uncertainties described above, Table 4 depicts the COVID-19 death rate for CDCR, the United States, California and Los Angeles County without making any adjustment for actual or effective age, or for the likely undercount of free world deaths. Because of the methodological challenges in comparing CDCR's death rate with free world death rates, the numbers in Table 4 should be viewed with extreme caution:

[3] The rates reported in Tables 3, 4, and 5 are calculated using a CDCR population number of 108,387 which is equal to the average of the monthly population during the pandemic.

	Death Rate per 100,000
CDCR	64
United States	65
California	42
Los Angeles County	65

Table 4. Death Rates in CDCR, the United States, California and Los Angeles.

It is not surprising that CDCR's case and death rates would be somewhat similar to the rates experienced in the state and in the country. Prisons are not hermetically sealed. Tens of thousands of employees and contractors enter CDCR institutions from their communities every day, hundreds of patients are transferred from one institution to another each week, and scores of patients are sent out to or return from court and local hospitals every month. CDCR's prisons are part of the community for COVID-19 purposes.

Discussion of COVID-19 in Dorms and Open-Cell-Front Housing

The data above is based on the cumulative number of cases and deaths throughout the CDCR system. However, we have more granular data for each institution which shows that dorm housing used at institutions throughout CDCR and open-cell-front housing used at San Quentin State Prison and Folsom State Prison pose a significantly higher risk to our patients than closed-cell-front housing.[4] The disparity in risk is so great that it demands focus on the housing assignments for our COVID-19 high-risk patients.

As of October 10, 2020, 69 patients in CDCR custody have died from COVID-19-associated illnesses. Eighty-four percent (84%) of those 69 deaths had a COVID-19 risk score of 3 or above at the time of death, and there has been only one patient with a risk score of 0 who has died from COVID-19. Table 5 depicts the number of deaths and death rates by COVID-19 risk score:

COVID-19 Risk Score	Deaths	Patient Count with Score	Death Rate per 1,000
0	1	43987	0.023
1	3	25817	0.116
2	7	11779	0.594
3	10	5954	1.679
4	4	3145	1.272

[4] There actually are a number of different dorm designs used within CDCR that are likely to have materially different COVID-19 spread risks: e.g., 270 Dorms, E-Dorms, Cross-Top Dorms, and Small 6-8 Man Dorms with Closed Doors. Further analysis and discussion may conclude that closed-door, small dorms are an appropriate alternative to residing in a large dorm with shared air space. However, for purposes of this paper, all dorm types have been grouped together in a single "dorm" category.

5	6	1962	3.058
6	7	1628	4.300
7	6	1322	4.539
8	10	1025	9.756
9	5	637	7.849
10 to 17	10	1097	9.116
Grand Total	69	98353	0.702

Table 5. Deaths and Death Rates by COVID-19 Risk Score.

For purposes of further analysis, "COVID-19 high-risk patients" refers to all patients with a COVID-19 risk score of 3 and above. This threshold has been chosen primarily because, as depicted in Table 5, there is a substantial increase in the death rate from risk score 2 to risk score 3, and the death rate beginning at risk score 3 and above is higher than the overall death rate for the entire population

An analysis of the housing location of all COVID-19 patients who have died highlights dorm and open-cell-front housing as being particularly problematic to our COVID-19 high-risk patients. Eighty-one percent (81%) of the 69 deaths acquired COVID-19 while living in a dorm or open-cell-front housing unit.

Dorms and open-cell-front housing are more dangerous than closed-door cells because, as very recently confirmed by the CDC, transmission of COVID-19 occurs both through droplets and through aerosolization. Early on in the pandemic, it was believed that transmission occurred only through droplets which supported putting the social distancing requirement at 6 feet (since droplets can only rarely travel more than 6 feet from the source) and not being as concerned about situations where aerosol spread might occur. In response to that understanding, CDCR made efforts to depopulate enough dorm space so that there was 6-feet of distance between groups of 8.

As the world's experience with the pandemic progressed, it increasingly became clearer that some transmission was occurring through aerosolization in addition to droplet spread. Pathogens that spread via aerosolization can travel in air currents over greater distances and remain in the air for longer periods of time as opposed to large droplets which rapidly fall to the ground within approximately six feet. As a result, aerosolized organisms result in an increased risk of transmission in closed rooms and spaces where the virus can infect people who are more than 6 feet from an original source.

The fact of spread by aerosolization makes dorms and open-cell-front housing within CDCR substantially more problematic in terms of the speed and extent of COVID-19 spread among our patients than closed-cell-front housing. Accordingly, COVID-19 high-risk patients, who are at a much higher risk of morbidity and mortality from COVID-19, should not be housed in dorms or open-cell-front housing.

Table 6 depicts the distribution of COVID-19 high-risk patients (i.e., those with COVID-19 risk scores of 3 and above) in dorm, open-cell-front and closed-cell-front housing:

Housing Type	Number of Patients with COVID-19 Risk Score of 3 and Above
Dorm	6,916
Open-cell-front	1,357
Closed-cell-front	8,420
Total	16,693

Table 6. Housing of COVID-19 High-Risk Patients

In summary, about fifty percent (50%) of the COVID-19 high-risk population remain in the most problematic housing for the transmission of COVID-19. Strategies for reducing these risks include:

- Consideration for release from CDCR of COVID-19 high-risk patients in problematic housing;
- Inter-institution transfer of COVID-19 high-risk patients from dorms and open-cell-front housing to closed-cell-front housing;
- Intra-institution transfer of COVID-19 high-risk patients from dorms and open-cell-front housing to closed-cell-front housing; and,
- Adding housing capacity at select prisons in the form of small tents to further depopulate dorms and open-cell-front housing (certainly not as effective as closed-cell-front housing, but better than large dorms and large open-cell-front housing).

CDCR has already reviewed and considered for release thousands of COVID-19 high-risk patients; a small number of those patients have been released. Consideration for release of COVID-19 high-risk patients in high-risk housing should continue.

If all of the COVID-19 high-risk patients currently in dorms and open-cell-front housing were moved into small tents, it would require some 800 10-person tents to be installed throughout the CDCR system. This number of tents would pose substantial resource and operational challenges, even if that number of tents was readily available. At select institutions, however, installation of 10-person tents may result in a marginal improvement in risk, but this should be a last resort employed only if no other solution is possible because small tents are certainly not as effective as closed-cell-front housing.

The transfer of COVID-19 high-risk patients from dorms and open-cell-front housing to closed-cell-front housing, either by intra-institution transfer or inter-institution transfer, may be feasible on a large enough scale to significantly reduce the risk of COVID-19 to our high-risk patients.

Transferring large numbers of patients within institutions or, particularly, between institutions is not a risk-free endeavor. Much more stringent movement requirements were adopted after the failed movement of high-risk patients from CIM to Corcoran and San Quentin in May (e.g., pre-transfer quarantine and testing, and post-transfer quarantine and testing). However, no matter what protections are placed around inter-institution transfers, there is a risk that the transfer of large numbers of patients between institutions might itself trigger further COVID-19 spread,

particularly at the receiving institution. On the other hand, CDCR is currently transferring hundreds of patients per week between institutions, so the risks associated with transfer already exist within CDCR's system, and the marginal increase in risk of transfers associated with a program to transfer patients from dorms and open-cell-front housing to close-cell-front housing appears to be outweighed by the benefit to patients of offering such a move.

CDCR has already offered intra-institution transfers to several hundred COVID-19 high-risk patients with COVID-19 risk scores of 11 and above, so we have some experience with this type of program. Where it has been tried, a significant percentage of patients has refused the transfer offer. For example, of the 123 patients recently offered such a move, only 19 accepted the offer, an acceptance rate of fifteen percent (15%). Because these moves are intended primarily to benefit the patient, we have respected the patients' decisions to remain in their existing housing.

Conclusion

Based on the above analysis, we conclude that CDCR should offer to every patient with a COVID-19 risk score of 3 and above who is currently housed in a dorm setting or in open-cell-front housing, the option of being transferred to closed-cell-front housing either at their existing institution or at some other institution.

Exhibit D

CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

ORDER TO SET ASIDE ISOLATION AND QUARANTINE SPACE
Public Health Workgroup Recommendations

Background

The *Order to Set Aside Isolation and Quarantine Space* (case number 01-cv-01351-JST) issued on July 22, 2020 requires the California Department of Corrections (CDCR) and California Correctional Health Care Services (CCHCS) to identify, and keep vacated or reserved, at least 100 beds to be used for isolation and quarantine housing in the event of a COVID-19 outbreak for a period of at least 180 days.

The *Order* also requires assessment of whether additional space is required at each institution for isolation and quarantine purposes and, if so, whether that will be obtained by vacating additional housing units or through other means. Assessments shall be guided by health considerations, without regard to whether sufficient space can be reserved at the institution without further reduction in the population.

The purpose of the remainder of this document is to summarize the public health workgroup's deliberations and recommendations regarding additional space needs that occurred during three separate meetings on July 28th, July 31st and August 4th, 2020. On August 7th and 12th, the workgroup's draft recommendations were discussed with each institution's leadership, court representatives and other stakeholders. The focus of the discussions was to determine what types of space must be created at each institution to isolate and quarantine different subpopulations including, but is not limited to, persons with disabilities, mental health and/or other special/restricted housing needs.

Workgroup Deliberations

Representatives from CDCR and CCHCS met with the parties' health experts to devise a method for determining whether additional bed space above the ordered 100 beds per institution is required to protect residents from COVID-19 infection and if additional space is required, how much space is needed at each institution. It is expected that if an outbreak were to occur that has the potential of infecting significant numbers of residents it would likely start and spread within congregate living spaces such as dormitories or cells with open bars or porous doors.

During the deliberations, the workgroup reviewed space information provided by CDCR and CCHCS staff that showed, at the end of July, approximately two-thirds of residents live in existing celled housing settings that usually are comprised of solid walls and doors and have a two person occupancy. Also noted was that many large dorm settings had already been de-densified leaving significant vacancies in these large dorms at most institutions.

While additional dedicated space will be a mixture of isolation and quarantine spaces, each will serve a different purpose. Isolation space is used to house patients who are confirmed or suspected to be infected with COVID-19. Suspected cases must be housed separate from each other, and unlike patients with confirmed infection who can be housed together in larger cohorts within dorm-like settings, patients suspected to have COVID-19 infection must be separated from each other in single cells with solid doors, with minimal exceptions noted.

Currently there are four institutions where the proportion of residents infected with COVID-19 ranges from approximately one-third to nearly two-thirds involving almost 1,000 to 2,000 individuals at those prisons. What this means from a housing perspective is that dorm housing or cells with open bars or porous doors can be used to cohort the significant numbers of residents with confirmed infection at these prisons, depending on other factors which may impact the type of housing and patients who can be cohorted together in isolation.

On the other hand, at most of the remaining institutions, either no cases have been identified among residents or smaller numbers of persons have been infected. Therefore quarantine spaces will be required for the majority of space rather than isolation space, and these should be configured as equivalent to *single cells with solid doors.* Quarantine space is the most restrictive because it's used to house residents who have been exposed to COVID-19 but have not tested positive for the virus. Under optimal circumstances, residents, in quarantine, should be housed individually, in a setting that has solid walls and doors, to ensure that if an exposed person tests positive the risk of transmission to others is significantly reduced.

Workgroup Recommendations

General Space and Other Recommendations

Although these recommendations focus on space considerations for isolation and quarantine for incarcerated persons, it is assumed that the following basic measures and resources in sufficient amounts are in effect and available respectively in order to prevent and contain COVID-19, which include but are not limited to: restricted movement, timely testing for residents and staff, assignment of staff in cohorts that do not mix, and utilization of face coverings, personal protective equipment and environmental controls.

The general space recommendations noted below apply to all institutions and focus on the quality or types of space that need to exist at all institutions rather than the quantity of space per se. The general recommendations include:

- Individuals confirmed to have active COVID-19 infection can be isolated together in congregate living spaces but must be not share air apace with any of the other groups (except resolved cases; see below).
- Individuals suspected of COVID-19 infection should be housed in the equivalent of single cells with solid doors.
- Individuals who have been exposed should be quarantined in the equivalent of single cells with solid doors.
- Individuals who have not been infected and have not been exposed should be housed in sparsely populated spaces that allow for as much physical distancing as possible and in the smallest cohorts as possible.
- Individuals who have resolved COVID-19 infection can be housed with most other individuals noted above except for suspected cases. This assumes that individuals who have resolved their infection are not contagious and do not get re-infected within at least three months of the initial infection.

Specific Institution Space Recommendations

Based on the above concepts and general recommendations, it was determined that a sound method to ensure sufficient quantity of space to house infected and exposed individuals who require isolation and quarantine respectively would be to base it on each institution's largest congregate living spaces because the risk of transmission of infection to large numbers of residents is greatest in these equivalent dorm-like settings that include, at some institutions, celled housing with open bars and porous doors.

Information in Attachment A, which was prepared by Quality Management staff, provides the numbers of isolation and quarantine beds required at each institution based on the method of reserving enough space to equal the *combined occupancy in each institution's two largest congregate housing units.* Also shown in Attachment A are numbers of persons with disabilities, patients in the Enhanced Outpatient Program level of mental health services and patients with a COVID-19 risk score of 4 or more as well as other data.

Given the recommendations and application of the method, it appears that nearly all institutions already had reserved or vacated enough suitable bed space for isolation and quarantine. However there were notable exceptions in terms of either institutions requiring significantly more space than other institutions such as Folsom State Prison or the space that had been identified is not adequate because it's dorm space or cells with porous doors. It should be noted that San Quentin also required significantly more space than others but since so many of the residents have already been infected the actual isolation and quarantine space that needs to be set aside is less than calculated once those patients have been excluded.

Although the quantity and quality of bed space identified appears adequate for isolation and quarantine purposes at most prisons, there were concerns raised by plaintiffs' representatives regarding whether there needs to be specific numbers of beds set aside for isolation versus quarantine, both in general and for patients with disabilities or in the mental health program, and whether patients in isolation and quarantine need to be in different housing units even if all occupants are in cells with solid doors with physical distancing among individuals and face coverings/masking are required and environmental controls are aggressively implemented. Regarding the concerns, the point of the method proposed by the public health experts is to identify and respond to an outbreak at the earliest onset which means most of the space will be for quarantine and if the space is single cells with solid doors and all public health measures are enforced along with the de-densification that has already occurred, the proposed space plan, though imperfect, is a reasoned and supportable approach that protects residents and staff.

Conclusion:

Through the extensive process described above, CCHCS has provided a summary of conclusions reached in terms of assessing whether additional space is required beyond what was identified by CDCR. This summary is provided as Attachment B. However, public health experts have opined that ideal quarantine space is single-cell based housing. Attachment C reflects the identified bed needs if the CDCR identified spaces were converted to single-cell housing. There are a number of issues that have arisen in the course of the discussions with public health experts, plaintiffs, and prison leadership. While Judge Tigar's order is quite specific, it is difficult to address all 35 prisons with the same approach. Such exceptions are noted below:

- There are multiple institutions where the recommendations of CCHCS and public health experts is difficult, if not impossible: San Quentin State Prison (SQP), Folsom State Prison (FSP), and the California Rehabilitation Center (CRC). SQP and FSP have entirely too large of a congregate living area and require unique solutions (as are occurring now) to address an outbreak. CRC has zero cells on the entire property and will require a multitude of vacant dorms (already accomplished) and a unique strategy on quarantining patients.

Also in the course of the discussions described above, it is anticipated that plaintiffs' counsel and court monitors will express concerns with CDCR's identified space or current policies regarding the housing of isolation and quarantine patients. These concerns are noted below:

- Many institutions have vacated the identified space(s) in accordance with Judge Tigar's order, but were utilizing less-desirable locations for quarantine/isolation. During the meetings with prison leadership, they were directed to begin utilizing the space.
- In multiple instances, institutions were housing isolation and quarantine patients in the same building. When asked, they clearly articulated how they were maintaining maximum distancing between quarantine and isolation.
- The identified space(s) is intended to be utilized by inmates from differing levels and differing programs. Plaintiffs and court monitors expressed concern about the ability to effectively program in the same building. Examples: EOP inmates with Non-EOP inmates, SNY inmates with GP inmates, Level II with Level IV, etc.
- Many of the spaces identified did not have adequate housing for Armstrong class members according to the Armstrong Court Expert and plaintiffs.
- How to address inmates who refuse to move to the designated locations.
- When tents were mentioned for isolation cases, plaintiffs expressed concerns about accessibility and public health requirements.
- For institutions with Arizona (perforated steel) doors (CEN, CAL, LAC), plaintiffs expressed a need for lexan to placed on cell fronts. At CAL, all doors already have lexan installed in the identified building. At LAC, some of the cells have lexan installed in the identified building. At CEN, none of the cell doors have lexan installed.
- While the public health experts have opined that single cells are ideal for quarantine space, it is entirely appropriate for space identified for isolation to be in dorms or tents as the patients have already been identified as positive for Covid.

Lastly, from the perspective of CCHCS, many institutions have excess capacity, beyond what was identified for purposed of Judge Tigar's order, and could quickly identify additional buildings for use as quarantine and/or isolation space.

ATTACHMENT A

Institution	Total Population	Patients In Two Largest Air Spaces		COVID Resolved and Active				Instit
				Institution		2 Largest Air Spaces		
		#	%	#	%	#	%	#
ASP	3,804	248	7%	1,353	36%	95	38%	2,451
CAC	2,138	4	0%	1	0%	0	0%	2,137
CAL	2,926	180	6%	16	1%	0	0%	2,910
CCC	2,151	48	2%	512	24%	46	96%	1,639
CCI	3,426	235	7%	495	14%	124	53%	2,931
CCWF	2,130	16	1%	16	1%	0	0%	2,114
CEN	3,191	193	6%	38	1%	0	0%	3,153
CHCF	2,567	277	11%	3	0%	0	0%	2,564
CIM	2,521	188	7%	832	33%	8	4%	1,689
CIW	1,187	4	0%	310	26%	0	0%	877
CMC	3,425	143	4%	94	3%	0	0%	3,331
CMF	2,197	162	7%	5	0%	0	0%	2,192
COR	3,387	46	1%	195	6%	0	0%	3,192
CRC	2,690	187	7%	358	13%	16	9%	2,332
CTF	4,529	127	3%	3	0%	0	0%	4,526
CVSP	2,090	91	4%	983	47%	5	5%	1,107
DVI	1,473	66	4%	0	0%	0	0%	1,473
FSP	2,626	1,380	53%	5	0%	1	0%	2,621
HDSP	3,414	71	2%	3	0%	1	1%	3,411
ISP	3,004	63	2%	53	2%	0	0%	2,951
KVSP	3,546	66	2%	5	0%	0	0%	3,541
LAC	3,040	210	7%	128	4%	2	1%	2,912
MCSP	3,878	29	1%	20	1%	20	69%	3,858
NKSP	1,698	78	5%	9	1%	0	0%	1,689
PBSP	2,389	49	2%	0	0%	0	0%	2,389
PVSP	2,933	78	3%	1	0%	0	0%	2,932
RJD	3,635	39	1%	5	0%	1	3%	3,630
SAC	2,281	11	0%	4	0%	0	0%	2,277
SATF	4,627	16	0%	8	0%	0	0%	4,619
SCC	2,416	63	3%	0	0%	0	0%	2,416
SOL	3,553	211	6%	1	0%	0	0%	3,552
SQ	3,138	1,550	49%	1,983	63%	1,246	80%	1,155
SVSP	2,804	78	3%	3	0%	0	0%	2,801
VSP	2,896	16	1%	0	0%	0	0%	2,896
WSP	2,179	152	7%	123	6%	1	1%	2,056

ATTACHMENT A

COVID Naïve			COVID Naïve High Risk				COVID Hig	
ution	2 Largest Air Spaces		Institution		2 Largest Air Spaces		Institution	
%	#	%	#	%	#	%	#	%
64%	153	62%	16	0%	0	0%	25	1%
100%	4	100%	5	0%	0	0%	5	0%
99%	180	100%	7	0%	0	0%	7	0%
76%	2	4%	16	1%	0	0%	16	1%
86%	111	47%	40	1%	1	0%	55	2%
99%	16	100%	127	6%	1	6%	127	6%
99%	193	100%	9	0%	0	0%	9	0%
100%	277	100%	879	34%	87	31%	881	34%
67%	180	96%	380	15%	4	2%	684	27%
74%	4	100%	83	7%	0	0%	102	9%
97%	143	100%	449	13%	22	15%	457	13%
100%	162	100%	493	22%	62	38%	494	22%
94%	46	100%	106	3%	0	0%	116	3%
87%	171	91%	34	1%	1	1%	37	1%
100%	127	100%	253	6%	7	6%	253	6%
53%	86	95%	27	1%	0	0%	62	3%
100%	66	100%	31	2%	3	5%	31	2%
100%	1,379	100%	160	6%	114	8%	160	6%
100%	70	99%	20	1%	0	0%	20	1%
98%	63	100%	13	0%	0	0%	16	1%
100%	66	100%	53	1%	0	0%	53	1%
96%	208	99%	205	7%	10	5%	216	7%
99%	9	31%	846	22%	0	0%	848	22%
99%	78	100%	28	2%	0	0%	28	2%
100%	49	100%	35	1%	0	0%	35	1%
100%	78	100%	2	0%	1	1%	2	0%
100%	38	97%	537	15%	0	0%	539	15%
100%	11	100%	53	2%	0	0%	53	2%
100%	16	100%	266	6%	6	38%	266	6%
100%	63	100%	39	2%	1	2%	39	2%
100%	211	100%	491	14%	51	24%	492	14%
37%	304	20%	113	4%	41	3%	582	19%
100%	78	100%	77	3%	1	1%	77	3%
100%	16	100%	268	9%	3	19%	268	9%
94%	151	99%	26	1%	3	2%	26	1%

ATTACHMENT A

h Risk (4+)		ADA (Impacting Placement, Overall)				ADA Mobility Impacting Place		
2 Largest Air Spaces		Institution		2 Largest Air Spaces		Institution		2 Largest
#	%	#	%	#	%	#	%	#
0	0%	1	0%	0	0%	0	0%	0
0	0%	0	0%	0	0%	0	0%	0
0	0%	3	0%	0	0%	3	0%	0
0	0%	0	0%	0	0%	0	0%	0
6	3%	0	0%	0	0%	0	0%	0
1	6%	130	6%	4	25%	124	6%	4
0	0%	5	0%	0	0%	5	0%	0
87	31%	885	34%	72	26%	856	33%	66
5	3%	155	6%	2	1%	139	6%	2
0	0%	11	1%	0	0%	11	1%	0
22	15%	6	0%	0	0%	6	0%	0
62	38%	545	25%	48	30%	489	22%	43
0	0%	48	1%	0	0%	48	1%	0
1	1%	2	0%	0	0%	2	0%	0
7	6%	11	0%	0	0%	11	0%	0
0	0%	1	0%	0	0%	0	0%	0
3	5%	33	2%	8	12%	31	2%	8
114	8%	6	0%	2	0%	5	0%	2
0	0%	46	1%	1	1%	39	1%	1
0	0%	7	0%	0	0%	5	0%	0
0	0%	89	3%	5	8%	89	3%	5
10	5%	172	6%	12	6%	163	5%	11
2	7%	216	6%	0	0%	206	5%	0
0	0%	23	1%	0	0%	22	1%	0
0	0%	1	0%	0	0%	1	0%	0
1	1%	22	1%	5	6%	22	1%	5
0	0%	705	19%	0	0%	677	19%	0
0	0%	9	0%	0	0%	8	0%	0
6	38%	474	10%	11	69%	379	8%	10
1	2%	4	0%	1	2%	4	0%	1
51	24%	11	0%	0	0%	11	0%	0
367	24%	52	2%	4	0%	40	1%	0
1	1%	176	6%	5	6%	167	6%	5
3	19%	357	12%	7	44%	357	12%	7
3	2%	20	1%	6	4%	19	1%	5

ement	ADA Non-Mobility				EOP And ADA			
Air Spaces	Institution		2 Largest Air Spaces		Institution		2 Largest Air Spaces	
%	#	%	#	%	#	%	#	%
0%	1	0%	0	0%	0	0%	0	0%
0%	0	0%	0	0%	0	0%	0	0%
0%	0	0%	0	0%	0	0%	0	0%
0%	0	0%	0	0%	0	0%	0	0%
0%	0	0%	0	0%	0	0%	0	0%
25%	6	0%	0	0%	5	0%	0	0%
0%	0	0%	0	0%	0	0%	0	0%
24%	29	1%	6	2%	113	4%	0	0%
1%	16	1%	0	0%	0	0%	0	0%
0%	0	0%	0	0%	2	0%	0	0%
0%	0	0%	0	0%	0	0%	0	0%
27%	56	3%	5	3%	74	3%	0	0%
0%	0	0%	0	0%	11	0%	0	0%
0%	0	0%	0	0%	0	0%	0	0%
0%	0	0%	0	0%	0	0%	0	0%
0%	1	0%	0	0%	0	0%	0	0%
12%	2	0%	0	0%	0	0%	0	0%
0%	1	0%	0	0%	0	0%	0	0%
1%	7	0%	0	0%	0	0%	0	0%
0%	2	0%	0	0%	0	0%	0	0%
8%	0	0%	0	0%	11	0%	0	0%
5%	9	0%	1	0%	12	0%	0	0%
0%	10	0%	0	0%	17	0%	0	0%
0%	1	0%	0	0%	0	0%	0	0%
0%	0	0%	0	0%	0	0%	0	0%
6%	0	0%	0	0%	0	0%	0	0%
0%	28	1%	0	0%	117	3%	0	0%
0%	1	0%	0	0%	1	0%	0	0%
63%	95	2%	1	6%	22	0%	0	0%
2%	0	0%	0	0%	0	0%	0	0%
0%	0	0%	0	0%	0	0%	0	0%
0%	12	0%	4	0%	7	0%	0	0%
6%	9	0%	0	0%	46	2%	0	0%
44%	0	0%	0	0%	9	0%	0	0%
3%	1	0%	1	1%	1	0%	0	0%

ATTACHMENT A

EOP No ADA				Facilities with Two Largest Air Spaces
Institution		2 Largest Air Spaces		
#	%	#	%	
7	0%	0	0%	C 320 1, B 220 1
0	0%	0	0%	C 002C1, C 002C2
1	0%	0	0%	D 002 2, C 005 2
0	0%	0	0%	A34, A12
14	0%	1	0%	E BH 1, D 00251
88	4%	0	0%	C 510 1, C 511 1
0	0%	0	0%	B 001 2, B 002 2
459	18%	0	0%	E304, E302
34	1%	27	14%	BH, SH
47	4%	0	0%	A EMUA1, A EMUA1
572	17%	0	0%	G 026 1, G 025 1
408	19%	0	0%	S COV 1, B DC 1
252	7%	0	0%	M 005 1, M 003 1
1	0%	0	0%	D 402 3, D 404 2
8	0%	0	0%	B TD 1, D 004 1
0	0%	0	0%	M 001 1, M 002 1
1	0%	0	0%	AEH
6	0%	2	0%	BldgU1, BldgU3
16	0%	0	0%	M 002 1, M 001 1
0	0%	0	0%	M 002 1, M 001 1
119	3%	0	0%	M 002 1, M 001 1
521	17%	0	0%	Z 001 1, B 003 1
629	16%	0	0%	M 002G1, C GYM 1
16	1%	0	0%	M 002 1, C 001 2
5	0%	0	0%	M 002 2, M 002 1
7	0%	0	0%	M 001 1, M 002 1
674	19%	0	0%	M 022 2, M 022 1
721	32%	0	0%	M 001F1, M 002J1
454	10%	0	0%	B 003 1, A 002 1
1	0%	0	0%	B 001D1, B 001E2
4	0%	0	0%	C 016 1, C 017 1
228	7%	34	2%	NBlock, WBlock
319	11%	0	0%	M 002 1, M 001 1
280	10%	0	0%	B 001 1, B 003 1
22	1%	0	0%	H 003 1, H 004 1

Rooms of Two Largest Air Spaces	Bed Type in Two Largest Air Spaces	Notes from Institution
ASP C 320 1000, ASP B 220 1000	Dorm	-
C 002C1, C 002C2	Cell	-
D 002 2, C 005 2	270 Cell	-
A34, A12	Dorm	-
CCI E BH 1000, CCI D 00251000	Dorm	-
CCWF C 510 1008, CCWF C 511 1030	Dorm	-
B 001 2, B 002 2	270 Cell	-
E304, E302	Dorm	-
BH, SH	Cell	RC Housing Unit pending conversion to NDPF Level II
A EMUA1, A EMUA1	Cell	-
CMC G 026 1000, CMC G 025 1000	Dorm	
CMF S COV 1000, CMF B DC 1000	Dorm	-
COR M 005 1000, COR M 003 1000	Dorm	-
CRC D 402 3000, CRC D 404 2000	Dorm	-
CTF B TD 1000, CTF D 004 1000	Dorm	
CVSP M 001 1000, CVSP M 002 1000	Dorm	-
AEH	Cell	Tiered Open Air
BldgU1, BldgU3	Cell	Tiered Open Air
HDSP M 002 1000, HDSP M 001 1000	Dorm	-
ISP M 002 1000, ISP M 001 1000	Dorm	-
KVSP M 002 1000, KVSP M 001 1000	Dorm	-
Z 001 1, B 003 1	Cell	-
MCSP M 002G1000, MCSP C GYM 1000	Dorm	-
NKSP M 002 1000, NKSP C 001 2000	Dorm	-
PBSP M 002 2000, PBSP M 002 1000	Dorm	-
PVSP M 001 1000, PVSP M 002 1000	Dorm	-
RJD M 022 2000, RJD M 022 1000	Dorm	-
SAC M 001F1000, SAC M 002J1000	Dorm	-
SATF B 003 1004, SATF A 002 1006	Dorm	-
SCC B 001D1050, SCC B 001E2051	Dorm	-
SOL C 016 1000, SOL C 017 1000	Dorm	-
NBlock, WBlock	Cell	Tiered Open Air
SVSP M 002 1000, SVSP M 001 1000	Dorm	-
VSP B 001 1001, VSP B 003 1008	Dorm	-
WSP H 003 1000, WSP H 004 1000	Dorm	-

ATTACHMENT B

Institution	Total Population	Patients In Two Largest Air Spaces		CDCR IDENTIFIED BEDS	CDCR IDENTIFIED SPACE(S)	ADDITIONAL SPACE REQUIRED	COMMENTS	Rooms of Two Largest Air Spaces	Bed Type in Two Largest Air Spaces	Door Type in Identifed Beds
		#	%							
ASP	3,804	248	7%	191	A-120	(57)	Only 1 celled 270 housing unit at ASP.	ASP C 320 1000, ASP B 220 1000	Dorm	N/A
CAC	2,138	4	0%	168	A-2, A and B Pod			C 002C1, C 002C2	Cell	Solid
CAL	2,926	180	6%	198	A-5		Old ASU unit. Has lexan installed over Arizona doors	D 002 2, C 005 2	270 Cell	Perforated
CCC	2,151	48	2%	200	C-3			A34, A12	Dorm	Solid
CCI	3,426	235	7%	148	E-Clark Dorm D-9	(87)	Plaintiffs offered reasonable alternatives to identified spaces.	CCI E BH 1000, CCI D 00251000	Dorm	N/A & Solid
CCWF	2,130	16	1%	200	A-503			CCWF C 510 1008, CCWF C 511 1030	Dorm	Solid
CEN	3,191	193	6%	192	A-5	(1)		B 001 2, B 002 2	270 Cell	Perforated
CHCF	2,567	277	11%	192	E-Yard Tent (100) 92 negative pressure rooms	(85)		E304, E302	Dorm	N/A & Solid
CIM	2,521	188	7%	102	B-1 (Cypress)	(86)		BH, SH	Cell	Solid
CIW	1,187	4	0%	220	H-12		Incorrect space listed on chart. CIW identifed H-12 as space.	A EMUA1, A EMUA1	Cell	Solid
CMC	3,425	143	4%	300	C-5			CMC G 026 1000, CMC G 025 1000	Dorm	Solid
CMF	2,197	162	7%		W-1, W-2, S-3	(162)	CDCR acknowledged that submitted plan needs to be completely redone.	CMF S COV 1000, CMF B DC 1000	Dorm	Solid
COR	3,387	46	1%	200	3B02			COR M 005 1000, COR M 003 1000	Dorm	Solid
CRC	2,690	187	7%	155	D-410, D-311		Unique solution required for CRC due to the institution be 100% dorms.	CRC D 402 3000, CRC D 404 2000	Dorm	N/A
CTF	4,529	127	3%	178	Central Y-Wing			CTF B TD 1000, CTF D 004 1000	Dorm	Solid
CVSP	2,090	91	4%	192	D-11		CDCR will revise CVSP's plan to revert current ASU to identified quarantine unit.	CVSP M 001 1000, CVSP M 002 1000	Dorm	N/A
DVI	1,473	66	4%	264	G-Wing			AEH	Cell	Solid
FSP	2,626	1,380	53%	286	Tents - 40 A-IV: 88 A dorm Pods 3/4 MSF 500/600		Unique solution required for FSP due to enormous single, congregate living areas.	BldgU1, BldgU3	Cell	Open Bar & N/A
HDSP	3,414	71	2%	128	C-1		Had an additional space identifed and ready to house additional quarantine.	HDSP M 002 1000, HDSP M 001 1000	Dorm	Solid
ISP	3,004	63	2%	200	C-1			ISP M 002 1000, ISP M 001 1000	Dorm	Solid
KVSP	3,546	66	2%	128	D-6			KVSP M 002 1000, KVSP M 001 1000	Dorm	Solid
LAC	3,040	210	7%	200	C-5	(10)		Z 001 1, B 003 1	Cell	Perforated
MCSP	3,878	29	1%	200	A-2			MCSP M 002G1000, MCSP C GYM 1000	Dorm	Solid
NKSP	1,698	78	5%	200	D-3			NKSP M 002 1000, NKSP C 001 2000	Dorm	Solid
PBSP	2,389	49	2%	128	A-1			PBSP M 002 2000, PBSP M 002 1000	Dorm	Solid
PVSP	2,933	78	3%	200	D-5			PVSP M 001 1000, PVSP M 002 1000	Dorm	Solid
RJD	3,635	39	1%	200	D-20			RJD M 022 2000, RJD M 022 1000	Dorm	Solid
SAC	2,281	11	0%	196	A-2 B-1 C-8			SAC M 001F1000, SAC M 002J1000	Dorm	Solid
SATF	4,627	16	0%	200	E-2			SATF B 003 1004, SATF A 002 1006	Dorm	Solid
SCC	2,416	63	3%	100	Fac C Gym		CDCR acknowledged that submitted plan needs to be completely redone as SCC identifed 100 beds in a gym.	SCC B 001D1050, SCC B 001E2051	Dorm	N/A
SOL	3,553	211	6%	200	B-7	(11)		SOL C 016 1000, SOL C 017 1000	Dorm	Solid
SQ	3,138	1,550	49%	258	Gym - 108 Tents - 150		Unique solution required due to enormous single, congregate living areas.	NBlock, WBlock	Cell	N/A
SVSP	2,804	78	3%	128	C-7			SVSP M 002 1000, SVSP M 001 1000	Dorm	Solid
VSP	2,896	16	1%	344	A-4 B-4			VSP B 001 1001, VSP B 003 1008	Dorm	Solid & N/A
WSP	2,179	152	7%	200	B-1			WSP H 003 1000, WSP H 004 1000	Dorm	Solid
					Total	(499)	Excludes CRC, FSP, & SQ			

ATTACHMENT C

Institution	Total Population	Patients In Two Largest Air Spaces		CDCR IDENTIFIED BEDS	CDCR SINGLE CELL BEDS	CDCR IDENTIFIED SPACE(S)	ADDITIONAL SPACE REQUIRED	COMMENTS	Rooms of Two Largest Air Spaces	Bed Type in Two Largest Air Spaces	Door Type in Identifed Beds
		#	%								
ASP	3,804	248	7%	191	0	A-120	(248)	Only 1 celled 270 housing unit at ASP.	ASP C 320 1000, ASP B 220 1000	Dorm	N/A
CAC	2,138	4	0%	168	84	A-2, A and B Pod			C 002C1, C 002C2	Cell	Solid
CAL	2,926	180	6%	198	100	A-5	(80)	Old ASU unit. Has lexan installed over Arizona doors	D 002 2, C 005 2	270 Cell	Perforated
CCC	2,151	48	2%	200	100	C-3			A34, A12	Dorm	Solid
CCI	3,426	235	7%	148	12	E-Clark Dorm D-9	(223)	Plaintiffs offered reasonable alternatives to identified spaces.	CCI E BH 1000, CCI D 00251000	Dorm	N/A & Solid
CCWF	2,130	16	1%	200	100	A-503			CCWF C 510 1008, CCWF C 511 1030	Dorm	Solid
CEN	3,191	193	6%	192	100	A-5	(93)		B 001 2, B 002 2	270 Cell	Perforated
CHCF	2,567	277	11%	192	92	E-Yard Tent (100) 92 negative pressure rooms	(185)		E304, E302	Dorm	N/A & Solid
CIM	2,521	188	7%	102	51	B-1 (Cypress)	(137)		BH, SH	Cell	Solid
CIW	1,187	4	0%	220	110	H-12		Incorrect space listed on chart. CIW identifed H-12 as space.	A EMUA1, A EMUA1	Cell	Solid
CMC	3,425	143	4%	300	300	C-5			CMC G 026 1000, CMC G 025 1000	Dorm	Solid
CMF	2,197	162	7%			W-1, W-2, S-3		CDCR acknowledged that submitted plan needs to be completely redone.	CMF S COV 1000, CMF B DC 1000	Dorm	Solid
COR	3,387	46	1%	200	100	3B02			COR M 005 1000, COR M 003 1000	Dorm	Solid
CRC	2,690	187	7%	155	0	D-410, D-311		Unique solution required for CRC due to the institution be 100% dorms.	CRC D 402 3000, CRC D 404 2000	Dorm	N/A
CTF	4,529	127	3%	178	129	Central Y-Wing			CTF B TD 1000, CTF D 004 1000	Dorm	Solid
CVSP	2,090	91	4%	192	0	D-11	(91)	CDCR will revise CVSP's plan to revert current ASU to identified quarantine unit.	CVSP M 001 1000, CVSP M 002 1000	Dorm	N/A
DVI	1,473	66	4%	264	132	G-Wing			AEH	Cell	Solid
FSP	2,626	1,380	53%	286	0	Tents - 40 A-IV: 88 A dorm Pods 3/4 MSF 500/600		Unique solution required for FSP due to enormous single, congregate living areas.	BldgU1, BldgU3	Cell	Open Bar & N/A
HDSP	3,414	71	2%	128	64	C-1	(7)	Had an additional space identifed and ready to house additional quarantine.	HDSP M 002 1000, HDSP M 001 1000	Dorm	Solid
ISP	3,004	63	2%	200	100	C-1			ISP M 002 1000, ISP M 001 1000	Dorm	Solid
KVSP	3,546	66	2%	128	64	D-6	(2)		KVSP M 002 1000, KVSP M 001 1000	Dorm	Solid
LAC	3,040	210	7%	200	100	C-5	(110)		Z 001 1, B 003 1	Cell	Perforated
MCSP	3,878	29	1%	200	100	A-2			MCSP M 002G1000, MCSP C GYM 1000	Dorm	Solid
NKSP	1,698	78	5%	200	102	D-3			NKSP M 002 1000, NKSP C 001 2000	Dorm	Solid
PBSP	2,389	49	2%	128	64	A-1			PBSP M 002 2000, PBSP M 002 1000	Dorm	Solid
PVSP	2,933	78	3%	200	100	D-5			PVSP M 001 1000, PVSP M 002 1000	Dorm	Solid
RJD	3,635	39	1%	200	100	D-20			RJD M 022 2000, RJD M 022 1000	Dorm	Solid
SAC	2,281	11	0%	196	108	A-2 B-1 C-8			SAC M 001F1000, SAC M 002J1000	Dorm	Solid
SATF	4,627	16	0%	200	100	E-2			SATF B 003 1004, SATF A 002 1006	Dorm	Solid
SCC	2,416	63	3%	100	0	Fac C Gym	(63)	CDCR acknowledged that submitted plan needs to be completely redone as SCC identifed 100 beds in a gym.	SCC B 001D1050, SCC B 001E2051	Dorm	N/A
SOL	3,553	211	6%	200	100	B-7	(111)		SOL C 016 1000, SOL C 017 1000	Dorm	Solid
SQ	3,138	1,550	49%	258	0	Gym - 108 Tents - 150		Unique solution required due to enormous single, congregate living areas.	NBlock, WBlock	Cell	N/A
SVSP	2,804	78	3%	128	64	C-7	(14)		SVSP M 002 1000, SVSP M 001 1000	Dorm	Solid
VSP	2,896	16	1%	344	44	A-4 B-4			VSP B 001 1001, VSP B 003 1008	Dorm	Solid & N/A
WSP	2,179	152	7%	200	100	B-1			WSP H 003 1000, WSP H 004 1000	Dorm	Solid
						Total	(1364)	Excludes CRC, FSP, & SQ			

Exhibit E

Institution	Original Plata Reserved Space	Number of Original Reserved Beds	Additional Available Space	Additional Available Beds
ASP	Facility C, Housing Unit 330 (192 Dorm Beds) Facility A, Housing Unit 140 (200 Cell Beds)	Dorm Beds - 192 Cell Beds - 200 double or 100 single CCHCS QM Recommendation - 248	None	N/A
CAC	Facility A, Building 2, A and B Pod - (168 Cell Beds)	Cell Beds - 168 double or 84 single CCHCS QM Recommendation - 4	Facility A, Building 2, C Pod	Cell Beds (88 double or 44 single)
CAL	Facility A, Building 5 (200 Cell Beds); Facility B, Building 5 (200 Cell Beds)	Cell Beds - 400 double or 200 single CCHCS QM Recommendation - 180	Facility C, Building 2	Cell Beds (200 double or 100 single)
CCC	Facility C, Building 3 (200 Cell Beds)	Cell Beds - 200 double or 100 single CCHCS QM Recommendation - 48	Facility A Dorms 6, 7, 13 - Isolation Facility A Dorms 1, 2, 12 - Quarantine Facility B Dorms 67, 75, 76 - Isolation Facility B Dorms 62, 69, 70 - Quarantine Facility C Gym Isolation	60 Dorm Beds 30 Dorm Beds 30 Dorm Beds 60 Dorm Beds 98 Dorm Beds
CCI	Facility A, Housing Unit 8 (124 Cell Beds) Facility C Housing, Unit 1 (200 Cell Beds) Facility E, Davis Hall (94 Dorm Beds) Facility D, Housing Unit 9 (48 Cell Beds) Facility D Gym (60 beds)	Dorm/Gym Beds - 154 Cell Beds - 248 double or 124 single CCHCS QM Recommendation - 235	None	None
CCWF	Facility A, Building 503 (200 Cell Beds)	Cell Beds - 200 double or 100 single CCHCS QM Recommendation - 16	Facility A, Building 502 B, C and D Wings - Isolation Facility B, Building 508- D-wing - Quarantine EOP Facility A, Building 502, A-wing - Isolation EOP	192 Cell Beds (Solid door 8 person cells) 64 Cell Beds (Solid door 8 person cells) 64 Cell Beds (Solid door 8 person cells)
CEN	Facility A, Building 5 (200 Cell Beds) Facility D, Building 5 (200 Cell Beds)	Cell Beds - 400 double or 200 single CCHCS QM Recommendation - 193	Facility B, Building 4 (200 Cell Beds) Facility A, Building 3 (200 Cell Beds)	Cell Beds (400 double or 200 single)
CHCF	Facility E, Main Yard Tents (100 beds) Facilities A, B, C and D Negative Pressure Rooms (NPR) (92 NPR beds)	NPR Beds - 92 Tent Beds - 100 CCHCS QM Recommendation - 277	None	N/A
CIM	Facility B, Birch Hall (102 single Cell Beds) Facility C, Del Norte (200 Cell Beds)	Single Cell Beds - 102 Cell Beds - 200 double or 100 single CCHCS QM Recommendation - 188	Facility A 10 DPW beds in Tent #9	10 DPW beds (Tent #9)
CIW	Housing Unit A RCU (220 Cell Beds)	Cell Beds - 220 double or 110 single CCHCS QM Recommendation - 4	None	N/A
CMC	Facility C, Building 5 (300 single Cell Beds)	Single Cell Beds - 300 CCHCS QM Recommendation - 143	None	N/A
Institution	Original Plata Reserved Space	Number of Original Reserved Beds	Additional Available Space	Additional Available Beds
CMF	S-3 Housing Unit (18 Cell Beds) W-1 Housing Unit (41 Cell Beds) W-3 Housing Unit (42 Cell Beds) H-1 Housing Unit (21 Cell Beds, 26 Dorm Beds) I-1 Housing Unit (10 Dorm Beds, 36 Cell Beds)	Single Cell Beds - 158 Dorm Beds - 36 CCHCS QM Recommendation - 162	None	N/A
COR	Facility 3B, Building 02 (200 Cell Beds)	Cell Beds - 200 double or 100 single CCHCS QM Recommendation - 46	Facility 3C, Building 03 - Quarantine 4A1L C-Section - Isolation A1L A-Section - Isolation EOP 4B4R C-Section - Quarantine 4B4L - Isolation 4A2L B-Section - Quaranteen	Cell Beds (200 double or 100 single) Cell Beds (48 double or 24 single) Cell Beds (40 double or 20 single) Cell Beds (48 double or 24 single) Cell Beds (128 double or 64 single) Cell Beds (40 double or 20 single)
CRC	Facility D, Dorm 410 (78 Dorm Beds) Facility D, Dorm 311 (77 Dorm Beds)	Dorm Beds - 155 Gym Beds - 78 CHCS QM Recommendation - 187	Dorms 407 - Isolation Dorm 408 - Quarantine Dorm 411 - Quarantine Dorm 214 - Isolation	72 Dorm Beds 72 Dorm Beds 12 Dorm Beds 200 Dorm Beds
CTF	Central Facility, Y wing (258 Cell Beds)	Cell Beds - 258 double or 129 single CCHCS QM Recommendation - 127	Central Gym - Isolation South Gym - Isolation Fremont Dorm - Isolation Central Chapels 1 & 2 - Isolation	56 Dorm Beds 54 Dorm Beds 200 Dorm Beds 24 Dorm Beds
CVSP	Facility D, Building 11 (192 Dorm Beds) Facility A, Building 3 (200 Cell Beds)	Cell Beds - 200 double or 100 single Dorm Beds - 192 CCHCS QM Recommendation - 91	None	N/A
DVI	Facility A, G-wing (264 Cell Beds)	Cell Beds - 264 double or 132 single CCHCS QM Recommendation - 66	L-1 - Isolation	Cell Beds (96 double or 48 single)
FOL	Facility A, Unit IV, Tier 2, A & B side cells (88 Cell Beds); MSF Dorm 500 (10 Dorm Beds) MSF 600 (18 Dorm Beds)	Cell Beds - 92 double or 44 single Dorm Beds - 10 Dorm Beds - 18 CCHCS QM Recommendation - 1380	Facility A, Unit IV, Tier 3 A & B side cells - Quarantine Facility B, FWF, B Dorm (Male Beds) - Isolation Facility B, FWF A Dorm DRP Mod (Female Beds) - Isolation Facility B, FWF A Dorm Pod 2 - Quarantine	Cell Beds (92 double or 46 single) 282 Dorm Beds 20 Dorm Beds 9 single Cell Beds
HDSP	Facility C, Building 1 (128 Cell Beds); Facility A, Building 4 (200 Cell Beds)	Cell Beds - 328 double or 164 single CCHCS QM Recommendation - 71	None	N/A
ISP	Facility C, Building 1 (200 Cell Beds);	Cell Beds - 200 double or 100 single; CCHCS QM Recommendation - 63	Facility C, Building 2 - Isolation	(200 double or 100 single)
KVSP	Facility D, Building 6 (128 Cell Beds); Facility A, Building 1, Section B (20 Cell Beds)	Cell Beds - 148 double or 74 single CCHCS QM Recommendation - 66	Facility D, Building 7, B Section - Flex space (empty) Facility B, Building 1 B/C section - Isolation	Cell Beds (40 double or 20 single) 80 Cell Beds (80 double or 40 single)
Institution	Original Plata Reserved Space	Number of Original Reserved Beds	Additional Available Space	Additional Available Beds
LAC	Facility C, Building 5 (200 Cell Beds) Facility B, Building 2 (200 Cell Beds) Facility B Gym (24 beds)	Cell Beds - 400 double or 200 single Gym Beds - 24 CCHCS QM Recommendation - 210	None	N/A

MCSP	Facility A, Building 2 (200 Cell Beds)	Cell Beds - 200 double or 100 single; CCHCS QM Recommendation - 29	Facility A Gym - Isolation Facility B Gym - Isolation Facility C Gym - Isolation Facilty D, Building 18 -Quarantine (2 six men cells)	100 Dorm Beds 100 Dorm Beds 100 Dorm Beds 12 Cell Beds (Solid door 6 person cells)
NKSP	Facility D, Building 3 (198 Cell Beds)	Cell Beds - 198 double or 99 single CCHCS QM Recommendation - 78	Facility B, Building 4	Cell Beds (198 double or 99 single)
PBSP	Facility A, Building 1 (128 Cell Beds)	Cell Beds - 128 double or 64 single CCHCS QM Recommendation - 49	None	N/A
PVSP	Facility D-5 Building (200 Cell Beds)	Cell Beds - 200 double or 100 single CCHCS QM Recommendation - 78	Facility D, Building 3 - Isolation	Cell Beds (200 double or 100 single)
RJD	Facility D, Housing Unit 20 (200 Cell Beds)	Cell Beds - 200 double or 100 single CCHCS QM Recommendation - 39	Facility C Gym - Isolation	24 Dorm Beds
SAC	Facility A, Building 2 (20 Cell Beds); Facility B, Building 1 (48 Cell Beds); Facility C, Building 8 (128 Cell Beds)	Cell Beds - 196 double or 98 single CCHCS QM Recommendation - 11	None	N/A
SATF	Facility E, Building 2 (200 Cell Beds); Facility C, Building 4 sec. B and C (88 Cell Beds) Facility C Building 3 (128 Cell Beds) Facility F, Housing Unit F1, A-section- 11 pods (88 Dorm Beds)	Cell Beds - 200 double or 100 single CCHCS QM Recommendation - 260	Facility A Gym - Isolation Facility B Gym - Isolation Facility F/G Gym - Isolation Facility C, Building 4 - Isolation	46 Dorm Beds 46 Dorm Beds 40 Dorm Beds Cell Beds (256 double or 128 single)
SCC	Facility C, Building 3 (200 Cell Beds) Facility C gym (100 beds)	Cell Beds - 200 double or 100 single CCHCS QM Recommendation - 63	None	N/A
SOL	Facility B, Building 7 (200 Cell Beds) Facility B, Building 9 (200 Cell Beds) Facility B Gym (150 Dorm Beds)	Cell Beds - 400 double or 200 single Gym Beds - 128 CCHCS QM Recommendation - 211	Facility C Gym - Isolation	150 Dorm Beds
SQ	Gym (108 beds)	Gym Beds - 108 CCHCS QM Recommendation - 1550	Adjustment Center 1st tier North - Isolation Adjustment Center 1st tier South - Quarantine Adjustment Center 2nd tier North - Isolation Adjustment Center 2nd tier South - Quarantine (Sections will be emptied as needed). Chapel A, Quarantine Chapel B, Quarantine Chapel C Quarantine	17 Single Cell Beds 11 Single Cell Beds 17 Single Cell Beds 18 Single Cell Beds 10 Dorm Beds 10 Dorm Beds 10 Dorm Beds
SVSP	Facility C, Building 7 (182 Cell Beds); Facility D, Building 6, Section B (40 Cell Beds)	Cell Beds - 222 double or 111 single CCHCS QM Recommendation - 78	Facility C Gym - Flex space (empty) Facility D, Building 6, C Section - Flex space (empty) EOP Family Visiting - Flex space (empty)	1 Dorm Bed Cell Beds (48 double or 24 single) 2 Dorm Beds
VSP	Facility A, Building 4 (88 Cell Beds) Facility A, Building 3 (199 Cell Beds)	Cell Beds - 287 double or 143 single CCHCS QM Recommendation - 16	Main Yard Gym - Isolation Facility B, Building 4 - Isolation	80 Single Beds 256 Cell Beds (8 man Rooms)
WSP	Facility B, Building 1 (200 Cell Beds); Facility B, Building 5 (200 Cell Beds)	Cell Beds - 400 double or 200 single CCHCS QM Recommendation - 152	None	N/A

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

MARCIANO PLATA, et al.,

Plaintiffs,

v.

ARNOLD SCHWARZENEGGER, et al.,

Defendants.

NO. C01-1351 TEH

CLASS ACTION

ORDER APPOINTING RECEIVER

On October 3, 2005, this Court issued its written Findings of Fact and Conclusions of Law in support of its June 30, 2005 decision to establish a Receivership to take control of the delivery of medical services to California state prisoners confined by the California Department of Corrections and Rehabilitation ("CDCR").[1] In its written ruling, the Court explained that it was undertaking a national search to find a Receiver with the leadership ability, experience, and vision to take on the monumental and critical task of bringing the

[1] As the October 3, 2005 ruling notes, Pelican Bay State Prison is exempted from this action and instead falls under this Court's jurisdiction in the separate case of *Madrid v. Woodford*, C90-3094 TEH.

level of medical care provided to California's 166,000 inmates up to federal constitutional standards. Having undergone a thorough and successful search process, the Court HEREBY APPOINTS Mr. Robert Sillen to serve as the Receiver in this case, at the pleasure of the Court, effective Monday, April 17, 2006. A copy of the Receiver's curriculum vitae is attached to this Order.

In furtherance of the Receivership, the Court sets forth the Receiver's duties and powers as follows:

I. DUTIES OF THE RECEIVER

A. Executive Management

The Receiver shall provide leadership and executive management of the California prison medical health care delivery system with the goals of restructuring day-to-day operations and developing, implementing, and validating a new, sustainable system that provides constitutionally adequate medical care to all class members as soon as practicable. To this end, the Receiver shall have the duty to control, oversee, supervise, and direct all administrative, personnel, financial, accounting, contractual, legal, and other operational functions of the medical delivery component of the CDCR.

B. Plan of Action

The Receiver shall, within 180 - 210 calendar days of the effective date of appointment, develop a detailed Plan of Action designed to effectuate the restructuring and development of a constitutionally adequate medical health care delivery system. This Plan shall include recommendations to the Court of which provisions of the (1) June 13, 2002 Stipulation for Injunctive Relief, and (2) September 17, 2004 Stipulated Order re Quality of Patient Care and Staffing Order and Injunction (and/or policies or procedures required thereby), should be carried forward and which, if any, should be modified or discontinued due to changed circumstances. The Plan of Action shall also include a proposed time line for

all actions and a set of metrics by which to evaluate the Receiver's progress and success. The Receiver shall update and/or modify this Plan as necessary throughout the Receivership.

Pending development of the Plan of Action, the Receiver shall undertake immediate and/or short term measures designed to improve medical care and begin the process of restructuring and development of a constitutionally adequate medical health care delivery system.

C. Budgeting and Accounting

The Receiver shall determine the annual CDCR medical health care budgets consistent with his duties and implement an accounting system that meets professional standards. The Receiver shall develop a system for periodically reporting on the status of the CDCR's medical health care budget and shall establish relations with the California Office of Inspector General to ensure the transparency and accountability of budget operations.

D. Reporting

The Receiver shall provide the Court with bimonthly progress reports. These reports shall address: (a) all tasks and metrics contained in the Plan and subsequent reports, with degree of completion and date of anticipated completion for each task and metric, (b) particular problems being faced by the Receiver, including any specific obstacles presented by institutions or individuals, (c) particular successes achieved by the Receiver, (d) an accounting of expenditures for the relevant period, and (e) all other matters deemed appropriate for judicial review.

The Receiver shall meet with the Court on a bimonthly basis shortly following the issuance of each report and shall remain in contact with the Court throughout the Receivership on an informal, as needed, basis.

II. POWERS AND AUTHORITY OF THE RECEIVER

The Receiver shall have all powers necessary to fulfill the above duties under this Order, including, but not limited to:

A. General Powers

The Receiver shall exercise all powers vested by law in the Secretary of the CDCR as they relate to the administration, control, management, operation, and financing of the California prison medical health care system. The Secretary's exercise of the above powers is suspended for the duration of the Receivership; it is expected, however, that the Secretary shall work closely with the Receiver to facilitate the accomplishment of his duties under this Order.

B. Personnel

The Receiver shall have the power to hire, fire, suspend, supervise, promote, transfer, discipline, and take all other personnel actions regarding CDCR employees or contract employees who perform services related to the delivery of medical health care to class members. The Receiver shall have the power to establish personnel policies and to create, abolish, or transfer positions related to the delivery of medical health care to class members. The Receiver also shall be empowered to negotiate new contracts and to renegotiate existing contracts, including contracts with labor unions, in the event that such action is necessary for the Receiver to fulfill his duties under this Order.

C. Property

The Receiver shall have the power to acquire, dispose of, modernize, repair, and lease property, equipment, and other tangible goods as necessary to carry out his duties under this Order, including but not limited to information technology and tele-medicine technology.

D. Governing State Laws, Regulations, and Contracts

The Receiver shall make all reasonable efforts to exercise his powers, as described in this Order, in a manner consistent with California state laws, regulations, and contracts, including labor contracts. In the event, however, that the Receiver finds that a state law, regulation, contract, or other state action or inaction is clearly preventing the Receiver from developing or implementing a constitutionally adequate medical health care system, or otherwise clearly preventing the Receiver from carrying out his duties as set forth in this Order, and that other alternatives are inadequate, the Receiver shall request the Court to waive the state or contractual requirement that is causing the impediment. Upon receipt of any such request, the Court shall determine the appropriate procedures for addressing such request on a case-by-case basis.

E. Access

The Receiver shall have unlimited access to all records and files (paper or electronic) maintained by the CDCR, including but not limited to all institutional, personnel, financial, and prisoner records, as deemed necessary by the Receiver to carry out his duties under this Order.

The Receiver shall have unlimited access to all CDCR facilities, as deemed necessary by the Receiver, to carry out his duties under this Order. Ordinarily, the Receiver shall attempt to provide reasonable notice when scheduling such visits, but this shall not preclude the Receiver from making unannounced visits to facilities or offices as the Receiver deems necessary to carry out his duties under this Order.

The Receiver shall have unlimited access to prisoners and to line and managerial staff, including the authority to conduct confidential interviews with staff and prisoners.

F. Immunity and Indemnification

The Receiver and his staff shall have the status of officers and agents of this Court, and as such shall be vested with the same immunities as vest with this Court.

Additionally, Defendants shall indemnify the Receiver and members of his staff to the same extent as Defendants are obligated to indemnify the Secretary of the CDCR.

III. OFFICE OF THE RECEIVER

A. The Receiver shall be paid a reasonable compensation for his services in an amount to be approved by this Court.

B. The Receiver shall establish an Office of the Receiver in a location to be determined in consultation with the Court, with staffing necessary to fully carry out his duties as set forth in this Order. Upon approval from the Court, the Receiver shall set reasonable compensation and terms of service for each member of his staff, (including employees and/or consultants) and shall be authorized to enter into contracts with the employees or consultants of the Office.

C. Because time is of the essence, and in order to begin operations immediately, Defendants shall, within 30 days of the date of this Order, establish an initial operating fund with the Court in the amount of $750,000. The Receiver shall submit monthly requests for payment from this fund to the Court. Further funds for the Office of the Receiver shall be deposited to the Receiver's Office Fund Account set forth in paragraph F below.

D. Throughout the Receivership, the Receiver shall submit to the Court a monthly accounting of all receipts and expenditures of the Office of the Receiver and shall arrange for an independent financial audit of the Receiver's Office Fund Account on an annual basis.

E. Within 45 calendar days from the date of effective appointment, the Receiver shall establish an interest-bearing account, with respect to which he shall be the signatory and fiduciary. This account shall be designated as the Receiver's Office Fund Account and shall be maintained solely for the reasonable and necessary expenses associated with the operation of the Office of the Receiver, including but not limited to salaries, consulting fees, and the

costs of supplies, equipment, office space, transportation,[2] and the like. The Receiver shall arrange with Defendants a system for regularly replenishing the Receiver's Office Fund Account.

F. Within 75 calendar days of the date of effective appointment, the Receiver shall establish a budget for the Office of the Receiver's first year of operation. The Receiver shall also establish a budget for the Office of Receiver for each subsequent year of operation, with each such budget due 90 days in advance of each budget year.

IV. COSTS

All costs incurred in the implementation of the policies, plans, and decisions of the Receiver relating to the fulfillment of his duties under this Order shall be borne by Defendants. Defendants shall also bear all costs of establishing and maintaining the Office of Receiver, including the compensation of the Receiver and his staff.

V. LENGTH OF RECEIVERSHIP

The Receivership shall remain in place no longer than the conditions which justify it make necessary, and shall cease as soon as the Court is satisfied, and so finds in consultation with the Receiver, that Defendants have the will, capacity, and leadership to maintain a system of providing constitutionally adequate medical health care services to class members. The Court expects that as the Receivership progresses, the Receiver will attempt to engage Defendants in assuming responsibility over portions of the system that are within Defendants' demonstrated ability to perform, so that the ultimate transfer of power back to the State will be transitional.

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[2]When engaged in travel, the Receiver and his staff shall use their best efforts to contain direct expenses in a cost-effective fashion. For example, when engaged in necessary travel, the Receiver and his staff shall, when possible, utilize advanced-purchase economy airfares and reasonably priced accommodations.

Prior to the cessation of the Receivership, the Receiver shall develop a Plan for Post-Receivership Governance of the system, which shall include consideration of its structure, funding, and governmental responsibility for its long-term operation. The Receiver shall present this plan to the Court for approval and adoption as an order.

VI. COOPERATION

A. All Defendants, and all agents, or persons within the employ, of any Defendant in this action (including contract employees), and all persons in concert and participation with them, and all counsel in this action, shall *fully* cooperate with the Receiver in the discharge of his duties under this Order, and shall promptly respond to all inquiries and requests related to compliance with the Court's orders in this case. Any such person who interferes with the Receiver's access, as set forth in section II.E., or otherwise thwarts or delays the Receiver's performance of his duties under this Order, shall be subject to contempt proceedings before this Court.

B. Counsel for Defendants shall ensure that the following state agencies are given prompt notice of the substance of this paragraph: the Department of Personnel Administration, the Department of Finance, the Department of General Services, the State Personnel Board, and any other state agencies that Defendants deem should be notified. Defendants shall notify the Court in writing of their compliance with this paragraph within 30 days of the date of this Order.

C. The Secretary of the CDCR shall ensure that all of the CDCR's employees and agents (including contract employees) are given prompt notice of the substance of this paragraph. Defendants shall notify the Court in writing of their compliance with this paragraph within 30 days of the date of this Order.

VII. ADVISORY BOARD

The Court, in consultation with the Receiver, shall appoint an Advisory Board of no more than five members to assist and advise the Court and the Receiver with respect to achieving the goals of the Receivership.

VIII. MODIFICATION

Given that this Receivership is unprecedented in scope and dimension, this Court finds that flexibility will be an important element in ensuring its effectiveness. Accordingly, this Order may be modified as necessary from time to time to assure the success of this Receivership and the eventual return of the operation of the CDCR's medical health care delivery system to the State of California.

IT IS SO ORDERED.

Dated: February 14, 2006

THELTON E. HENDERSON
UNITED STATES DISTRICT JUDGE

ADRMOP,APPEAL,E−Filing,PROTO,ProSe,REFDIS,REFSET−EDL,RELATE

U.S. District Court
California Northern District (Oakland)
CIVIL DOCKET FOR CASE #: 4:01−cv−01351−JST

Plata et al v. Newsom et al
Assigned to: Judge Jon S. Tigar
Relate Case Cases: 3:05−cv−05214−TEH
4:20−cv−00731−JST
4:20−cv−07065−JST
4:20−cv−08289−JST
Case in other court: 07−16383
07−17008
Ninth Circuit, 07−17284
08−15063
08−16553
United States Court of Appeals for the Ninth Circ, 08−16682
08−16717
08−16858
08−17362
09−15864
09−17154
09−17314
09−17315
11−17208
13−15466
13−17506
Ninth Circuit Court of Appeals, 21−16696
Ninth Circuit Court of Appeals, 21−16816
Cause: 42:1983 Prisoner Civil Rights

Date Filed: 04/05/2001
Jury Demand: None
Nature of Suit: 440 Civil Rights: Other
Jurisdiction: Federal Question

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Date Filed	#	Docket Text
11/16/2021	3751	**ORDER GRANTING ADMINISTRATIVE MOTION FOR LEAVE TO FILE SURREPLY TO DEFENDANTS' MOTION TO STAY SEPTEMBER 27, 2021 ORDER RE; MANDATORY VACCINATIONS PENDING APPEAL by Judge Jon S. Tigar granting 3748 Administrative Motion. (mll, COURT STAFF) (Filed on 11/16/2021) (Entered: 11/16/2021)**
11/16/2021	3750	TRANSCRIPT ORDER for proceedings held on 10/28/2021 before Judge Jon S. Tigar by California Correctional Peace Officers Association, for Court Reporter Pam Batalo. (Adam, Gregg) (Filed on 11/16/2021) (Entered: 11/16/2021)
11/16/2021	3749	TRANSCRIPT ORDER for proceedings held on 08/12/2020; 09/17/2020; 12/23/2020; 03/04/2021 before Judge Jon S. Tigar by California Correctional Peace Officers Association, for Court Reporter Raynee Mercado. (Adam, Gregg) (Filed on 11/16/2021) (Entered: 11/16/2021)
11/16/2021	3748	UNOPPOSED ADMINISTRATIVE MOTION FOR LEAVE TO FILE SURREPLY TO DEFENDANTS MOTION TO STAY SEPTEMBER 27, 2021 ORDER RE; MANDATORY VACCINATIONS PENDING APPEAL ECF NO. 3719 filed by J. Clark Kelso. Responses due by 11/22/2021. (Attachments: # 1 Declaration of Jacob Kreilkamp, # 2 Proposed Order Regarding Administrative Motion for Leave to File Surreply, # 3 Surreply to Defendants' Motion to Stay, # 4 Declaration of Dr. Joseph Bick)(Brian, Brad) (Filed on 11/16/2021) Modified on 11/16/2021 (cjl, COURT STAFF). (Entered: 11/16/2021)
11/15/2021	3747	Defendants' November 2021 Status Report by Gavin Newsom. (Attachments: # 1 Exhibit A, # 2 Exhibit B)(Hasan, Iram) (Filed on 11/15/2021) Modified on 11/16/2021 (cjl, COURT STAFF). (Entered:

		11/15/2021)
11/15/2021	3745	**ORDER re 3735 Opposition/Response to Motion, filed by Service Employees International Union, Local 1000. Signed by Judge Jon S. Tigar on November 15, 2021. (mll, COURT STAFF) (Filed on 11/15/2021) (Entered: 11/15/2021)**
11/12/2021	3746	FILED IN ERROR. Returned motion 3746 by mail to pro se inmate Gonzalez at California State Prison Lancaster County, citing Order Re: Pro Se Inmate Filings 2348 . Declaration of Ex Parte Communication by filed by Mario Gonzalez. (cjl, COURT STAFF) (Filed on 11/12/2021) Modified on 11/15/2021 (cjl, COURT STAFF). (Entered: 11/15/2021)
11/12/2021	3744	Transcript Designation Form before Judge Jon S. Tigar, *re 3693 , 3697 , 3730* (Hasan, Iram) (Filed on 11/12/2021) (Entered: 11/12/2021)
11/11/2021	3743	REPLY IN SUPPORT OF 3722 CALIFORNIA CORRECTIONAL PEACE OFFICERS ASSOCIATIONS MOTION FOR STAY OF SEPTEMBER 27, 2021 AND OCTOBER 27, 2021 ORDERS RE: MANDATORY VACCINATIONS filed by California Correctional Peace Officers Association. (Attachments: # 1 Declaration of Gregg McLean Adam in Support)(Adam, Gregg) (Filed on 11/11/2021) Modified on 11/12/2021 (cjl, COURT STAFF). (Entered: 11/11/2021)
11/11/2021	3742	Request for Judicial Notice in Support of Defendants Reply for Motion to Stay Order re: Mandatory Vaccinations ECF No. 3684 Pending Appeal filed by Gavin Newsom. (Attachments: # 1 Exhibit A, # 2 Exhibit B)(Related document(s) 3741) (Wolff, Samantha) (Filed on 11/11/2021) Modified on 11/12/2021 (cjl, COURT STAFF). (Entered: 11/11/2021)
11/11/2021	3741	DEFENDANTS REPLY IN SUPPORT OF MOTION TO STAY SEPTEMBER 27, 2021 ORDER RE: MANDATORY VACCINATIONS ECF NO. 3684 PENDING APPEAL, AND ORDERS ISSUED IN FURTHERANCE OF SEPTEMBER 27 ORDER filed by Gavin Newsom. (Attachments: # 1 Declaration Supplemental Declaration of Connie Gipson In Support of Defendants Reply for Motion to Stay Order)(Wolff, Samantha) (Filed on 11/11/2021) Modified on 11/12/2021 (cjl, COURT STAFF). (Entered: 11/11/2021)
11/10/2021	3740	**ORDER GRANTING PAYMENT FOR COURT APPOINTED EXPERTS. Ms. LaMarre in the amount of $1,550.00, Dr. Goldenson in the amount of $275.00. Signed by Judge Jon S. Tigar on November 10, 2021. (mll, COURT STAFF) (Filed on 11/10/2021) (Entered: 11/10/2021)**
11/08/2021	3739	OPPOSITION/RESPONSE (re 3722 MOTION to Stay *September 27, 2021 Order Re: Mandatory Vaccinations*, 3715 MOTION to Stay re 3684 Order) filed byMarciano Plata. (Attachments: # 1 Declaration of Laura Bixby)(Hart, Sophie) (Filed on 11/8/2021) (Entered: 11/08/2021)
11/08/2021	3738	OPPOSITION/RESPONSE (re 3722 MOTION to Stay *September 27, 2021 Order Re: Mandatory Vaccinations*, 3715 MOTION to Stay re 3684 Order) filed byJ. Clark Kelso. (Attachments: # 1 Declaration of Jacob Kreilkamp, # 2 Declaration of Tammatha Foss)(Bowen, Robert) (Filed on 11/8/2021) (Entered: 11/08/2021)
11/08/2021	3737	INTERVENOR CALIFORNIA CORRECTIONAL PEACE OFFICERS ASSOCIATIONS SUPPLEMENTAL NOTICE RE: MOTION FOR STAY OF ORDERS RE: MANDATORY VACCINATIONS (ECF No. 3684) PENDING APPEAL by California Correctional Peace Officers Association. (Adam, Gregg) (Filed on 11/8/2021) Modified on 11/9/2021 (cjl, COURT STAFF). (Entered: 11/08/2021)
11/08/2021	3736	AMENDED NOTICE OF APPEAL to the 9th Circuit Court of Appeals filed by California Correctional Peace Officers Association. Appeal of Notice of Appeal to the Ninth Circuit 3714 (Pay.gov Agency Tracking ID ACANDC−16538373.) (Adam, Gregg) (Filed on 11/8/2021) Modified on 11/9/2021 (cjl, COURT STAFF). (Entered: 11/08/2021)
11/08/2021	3735	SEIU LOCAL 1000s MOTION FOR LEAVE TO FILE AMICUS CURIAE BRIEF AND RESPONSE TO CALIFORNIA CORRECTIONAL PEACE OFFICERS ASSOCIATIONS MOTION FOR STAY OF SEPTEMBER 27, 2021 ORDER RE: MANDATORY VACCINATIONS & DEFENDANTS MOTION TO STAY filed by Service Employees International Union, Local 1000. (Attachments: # 1 Proposed Order)(Witherspoon, Theresa) (Filed on 11/8/2021) Modified on 11/9/2021 (cjl, COURT STAFF). (Entered: 11/08/2021)
11/05/2021	3734	TRANSCRIPT ORDER for proceedings held on 10/28/21 before Judge Jon S. Tigar by Ralph Coleman, for Court Reporter Pam Batalo. (Xu, Amy) (Filed on 11/5/2021) (Entered: 11/05/2021)

11/04/2021	3733	Transcript of Proceedings held on 10/28/2021, before Judge Tigar. Court Reporter Pamela Batalo Hebel, telephone number 626−688−7509; pamela_batalo−hebel@cand.uscourts.gov. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerk's Office public terminal or may be purchased through the Court Reporter/Transcriber until the deadline for the Release of Transcript Restriction. After that date it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this filing. (Re 3726 Transcript Order) Redaction Request due 11/26/2021. Redacted Transcript Deadline set for 12/6/2021. Release of Transcript Restriction set for 2/2/2022. (Related documents(s) 3726) (Batalo, Pam) (Filed on 11/4/2021) (Entered: 11/04/2021)
11/02/2021	3732	NOTICE of Substitution of Counsel by Iram Hasan (Hasan, Iram) (Filed on 11/2/2021) (Entered: 11/02/2021)
10/30/2021	3731	Defendants' Supplemental Notice re: Motion to Stay Orders re: Mandatory Vaccinations (ECF No. 3684) re 3715 MOTION to Stay re 3684 Order, 3721 Order Pending Appeal by Gavin Newsom. (Hasan, Iram) (Filed on 10/30/2021) Modified on 11/1/2021 (cjl, COURT STAFF). (Entered: 10/30/2021)
10/30/2021	3730	AMENDED NOTICE OF APPEAL by Gavin Newsom . (Hasan, Iram) (Filed on 10/30/2021) (Entered: 10/30/2021)
10/29/2021	3729	**AMENDED RECEIVERSHIP TRANSITION PLAN ORDER. Signed by Judge Jon S. Tigar on October 29, 2021. (mll, COURT STAFF) (Filed on 10/29/2021) (Entered: 10/29/2021)**
10/29/2021	3728	**ORDER MODIFYING MARCH 10, 2015 TRANSITION PLAN ORDER. Signed by Judge Jon S. Tigar on October 29, 2021. (mll, COURT STAFF) (Filed on 10/29/2021) (Entered: 10/29/2021)**
10/29/2021	3727	Transcript of Proceedings held on October 14, 2021, before Judge Jon S. Tigar. Court Reporter Raynee H. Mercado, CSR, telephone number 510−565−7228, cacsr8258@gmail.com. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerk's Office public terminal or may be purchased through the Court Reporter until the deadline for the Release of Transcript Restriction. After that date it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this filing. (Re 3699 Transcript Order) Release of Transcript Restriction set for 1/18/2022. (Related document(s) 3699) (Mercado, Raynee) (Filed on 10/29/2021) (Entered: 10/29/2021)
10/28/2021	3726	TRANSCRIPT ORDER for proceedings held on 10/28/2021 before Judge Jon S. Tigar by Gavin Newsom, for Court Reporter Pam Batalo. (Hasan, Iram) (Filed on 10/28/2021) (Entered: 10/28/2021)
10/28/2021	3725	USCA Case Number 21−16816 Ninth Circuit Court of Appeals for 3714 Notice of Appeal to the Ninth Circuit filed by California Correctional Peace Officers Association. (cjl, COURT STAFF) (Filed on 10/28/2021) (Entered: 10/28/2021)
10/28/2021	3724	**Minute Entry for proceedings held before Judge Jon S. Tigar: Further Case Management Conference held on 10/28/2021.Further Case Management Conference held on 10/28/2021. Hearing held via Zoom videoconference. Briefing schedule set regarding pending motions to stay. The Court addressed the parties regarding Advisory Board member Dr. Brie Williams. Further case management conference set. Case Management Statement due by 12/14/2021 by Noon. Further Case Management Conference set for 12/16/2021 02:00 PM in Oakland, − Videoconference Only. Responses due by 11/8/2021. Replies due by 11/11/2021. Motion Hearing set for 11/17/2021 02:00 PM in Oakland, − Videoconference Only before Judge Jon S. Tigar. This proceeding will be held via a Zoom webinar.** **Webinar Access:** All counsel, members of the public, and media may access the webinar information at https://www.cand.uscourts.gov/jst **General Order 58 .** Persons granted access to court proceedings held by telephone or videoconference are reminded that photographing, recording, and rebroadcasting of court proceedings, including screenshots or other visual copying of a hearing, is absolutely prohibited. **Zoom Guidance and Setup:** https://www.cand.uscourts.gov/zoom/. **; terminating 3719 Motion to Shorten Time Case Management Statement due by 12/14/2021. Further Case Management Conference set for 12/16/2021 02:00 PM in Oakland, − Videoconference Only. Responses due by 11/8/2021. Replies due by 11/11/2021. Motion Hearing set for 11/17/2021 02:00 PM in Oakland, − Videoconference Only before Judge Jon S. Tigar.Total Time in Court: 35 minutes. Court Reporter: Pamela Hebel. Plaintiff Attorney: Donald Specter, Steven Fama, Sophie Hart, Laura Bixby. Defendant Attorney: Paul Mello, Samantha Wolff,**

		Damon McClain, Iram Hasan. Interpreter: Counsel for Intervenors: David Sanders, Gregg Adam. ***(This is a text−only entry generated by the court. There is no document associated with this entry.)*** **(mll, COURT STAFF) (Date Filed: 10/28/2021) (Entered: 10/28/2021)**
10/27/2021	3723	NOTICE OF ERRATA REGARDING DECLARATION OF MIGDALIA SIACA IN SUPPORT OF RECEIVERS REPLY REGARDING REPORT OF MEET AND CONFER by J. Clark Kelso. (Attachments: # 1 Errata Declaration of Migdalia Siaca)(Forster, Katherine) (Filed on 10/27/2021) Modified on 10/28/2021 (cjl, COURT STAFF). (Entered: 10/27/2021)
10/27/2021	3722	MOTION to Stay *September 27, 2021 Order Re: Mandatory Vaccinations* filed by California Correctional Peace Officers Association. Motion Hearing set for 12/9/2021 02:00 PM in Oakland, Courtroom 6, 2nd Floor before Judge Jon S. Tigar. Responses due by 11/10/2021. Replies due by 11/17/2021. (Adam, Gregg) (Filed on 10/27/2021) (Entered: 10/27/2021)
10/27/2021	3721	**ORDER SETTING DEADLINE FOR MANDATORY VACCINATION. Signed by Judge Jon S. Tigar on October 27, 2021. (jstlc3, COURT STAFF) (Filed on 10/27/2021) (Entered: 10/27/2021)**
10/27/2021	3720	RESPONSE *to Parties' Response to Report of Meet and Confer* by J. Clark Kelso. (Attachments: # 1 Declaration of Katherine Forster, # 2 Declaration of Migdalia Siaca)(Forster, Katherine) (Filed on 10/27/2021) (Entered: 10/27/2021)
10/26/2021	3719	Defendants Motion to Shorten Time to Brief and Hear Motion to Stay September 27, 2021 Order re: Mandatory Vaccinations (ECF No. 3684) Pending Appeal filed by Gavin Newsom. (Attachments: # 1 Declaration Declaration of Paul Mello, # 2 Proposed Order Proposed Order)(Wolff, Samantha) (Filed on 10/26/2021) Modified on 10/27/2021 (cjl, COURT STAFF). (Entered: 10/26/2021)
10/26/2021	3718	CASE MANAGEMENT STATEMENT *Amicus Curiae* filed by Service Employees International Union, Local 1000. (Witherspoon, Theresa) (Filed on 10/26/2021) (Entered: 10/26/2021)
10/26/2021	3717	JOINT CASE MANAGEMENT STATEMENT filed by Marciano Plata, Gavin Newsom. (Attachments: # 1 Exhibit 1, # 2 Exhibit 2, # 3 Exhibit 3)(Hart, Sophie) (Filed on 10/26/2021) Modified on 10/27/2021 (cjl, COURT STAFF). (Entered: 10/26/2021)
10/26/2021	3716	Intervenor COMPLAINT *Limited Intervention*. Filed byCalifornia Correctional Peace Officers Association. (Adam, Gregg) (Filed on 10/26/2021) (Entered: 10/26/2021)
10/25/2021	3715	MOTION to Stay re 3684 Order filed by Gavin Newsom. Motion Hearing set for 12/9/2021 02:00 PM before Judge Jon S. Tigar. Responses due by 11/8/2021. Replies due by 11/15/2021. (Attachments: # 1 Memorandum of Points and Authorities, # 2 Declaration of Diana Toche, # 3 Declaration of Connie Gipson, # 4 Request for Judicial Notice w/ Exhibit A, # 5 Proposed Order)(McClain, Damon) (Filed on 10/25/2021) (Entered: 10/25/2021)
10/25/2021	3714	NOTICE OF APPEAL to the 9th Circuit Court of Appeals filed by California Correctional Peace Officers Association. (Appeal fee of $505 receipt number ACANDC−16538373 paid.) (Adam, Gregg) (Filed on 10/25/2021) (Entered: 10/25/2021)
10/25/2021	3713	RESPONSE *to Receiver's Report of Meet and Confer* re 3707 Notice (Other) by Marciano Plata. (Hardy, Alison) (Filed on 10/25/2021) Modified on 10/26/2021 (jml, COURT STAFF). (Entered: 10/25/2021)
10/25/2021	3712	RESPONSE *to Receivers Proposed Order Regarding Mandatory Vaccination* by California Correctional Peace Officers Association. (Adam, Gregg) (Filed on 10/25/2021) (Entered: 10/25/2021)
10/25/2021	3711	Declaration of Samantha Wolff in Support of 3710 Response (Non Motion), *DEFENDANTS RESPONSE TO RECEIVERS REPORT OF MEET AND CONFER ON IMPLEMENTATION PLAN* filed byGavin Newsom. (Related document(s) 3710) (Wolff, Samantha) (Filed on 10/25/2021) Modified on 10/26/2021 (jml, COURT STAFF). (Entered: 10/25/2021)
10/25/2021	3710	RESPONSE *TO RECEIVERS REPORT OF MEET AND CONFER ON IMPLEMENTATION PLAN* by Gavin Newsom. (Attachments: # 1 Declaration of D. Toche ISO of Defs Response to Receivers Report on Meet nd Confer re Plan Implementation)(Wolff, Samantha) (Filed on 10/25/2021) Modified on 10/26/2021 (jml, COURT STAFF). (Entered: 10/25/2021)
10/20/2021	3709	**ORDER RE: RECEIVER'S PROPOSED ORDER REGARDING MANDATORY VACCINATION re 3708 Notice (Other) filed by J. Clark Kelso, 3707 Notice (Other) filed by J. Clark Kelso. Responses due by 10/25/2021 by Noon. Replies due by 10/27/2021 by Noon. Signed by Judge Jon S. Tigar on October 20, 2021. (mllS, COURT STAFF) (Filed on 10/20/2021) (Entered: 10/20/2021)**

10/20/2021	3708	NOTICE of Lodging of Proposed Order by J. Clark Kelso. (Forster, Katherine) (Filed on 10/20/2021) Modified on 10/21/2021 (cjlS, COURT STAFF). (Entered: 10/20/2021)
10/20/2021	3707	NOTICE of Report of Meet and Confer on Implementation Plan by J. Clark Kelso. (Attachments: # 1 Declaration of Katherine M. Forster)(Forster, Katherine) (Filed on 10/20/2021) Modified on 10/21/2021 (cjlS, COURT STAFF). (Entered: 10/20/2021)
10/19/2021	3706	**ORDER GRANTING PAYMENT FOR COURT APPOINTED EXPERTS. Ms. LaMarre in the amount of $1,700.00, Dr. Goldenson in the amount of $$893.75, and Dr. Puisis in the amount of $1,100.00. Signed by Judge Jon S. Tigar on October 19, 2021. (mllS, COURT STAFF) (Filed on 10/19/2021) (Entered: 10/19/2021)**
10/15/2021	3705	**ORDER RE: DEFENDANTS' REQUEST FOR CLARIFICATION re 3703 Response (Non Motion) filed by Gavin Newsom. Signed by Judge Jon S. Tigar on October 15, 2021. (mllS, COURT STAFF) (Filed on 10/15/2021) (Entered: 10/15/2021)**
10/15/2021	3704	Defendants' October 2021 Status Report by Gavin Newsom. (Attachments: # 1 Exhibit A−B)(Gille, Ryan) (Filed on 10/15/2021) Modified on 10/18/2021 (cjlS, COURT STAFF). (Entered: 10/15/2021)
10/15/2021	3703	Defendants Notice of Recent Decision and Request for Clarification re 3684 Order by Gavin Newsom. (Wolff, Samantha) (Filed on 10/15/2021) Modified on 10/18/2021 (cjlS, COURT STAFF). (Entered: 10/15/2021)
10/15/2021	3702	TRANSCRIPT ORDER for proceedings held on 10/14/2021 before Judge Jon S. Tigar by California Correctional Peace Officers Association, for Court Reporter Raynee Mercado. (Adam, Gregg) (Filed on 10/15/2021) (Entered: 10/15/2021)
10/14/2021	3701	TRANSCRIPT ORDER for proceedings held on 10/14/2021 before Judge Jon S. Tigar by Gavin Newsom, for Court Reporter Raynee Mercado. (Hasan, Iram) (Filed on 10/14/2021) (Entered: 10/14/2021)
10/14/2021	3700	TRANSCRIPT ORDER for proceedings held on 10/14/21 before Judge Jon S. Tigar by Ralph Coleman, for Court Reporter Raynee Mercado. (Trapani, Cara) (Filed on 10/14/2021) (Entered: 10/14/2021)
10/14/2021	3699	TRANSCRIPT ORDER for proceedings held on 10/14/2021 before Judge Jon S. Tigar by J. Clark Kelso, for Court Reporter Raynee Mercado. (Bowen, Robert) (Filed on 10/14/2021) (Entered: 10/14/2021)
10/14/2021	3698	**Minute Entry for proceedings held before Judge Jon S. Tigar: Motion Hearing held via Zoom videoconference on 10/14/2021 re 3665 MOTION to Intervene filed by California Correctional Peace Officers Association. Argument heard from parties. The Court GRANTS 3665 MOTION to Intervene filed by California Correctional Peace Officers Association. No written order will issue. The transcript of the hearing shall serve as the Court's order. Total Time in Court: 20 minutes. Court Reporter: Raynee Mercado. Plaintiff Attorney: Donald Specter, Steven Fama, Laura Bixby. Defendant Attorney: Iram Hasan, Samantha Wolff, Damon McClain. Interpreter: Counsel for Intervenors: David Sanders, Gregg Adam. Receiver: Clark KelsoOutside Counsel for Receiver: Jamie Dupree, Brad Brian, Robert Bowen *(This is a text−only entry generated by the court. There is no document associated with this entry.)* (mllS, COURT STAFF) (Date Filed: 10/14/2021) (Entered: 10/14/2021)**
10/14/2021	3697	USCA Case Number 21−16696 Ninth Circuit Court of Appeals for 3693 Notice of Appeal to the Ninth Circuit filed by Gavin Newsom. (cjlS, COURT STAFF) (Filed on 10/14/2021) (Entered: 10/14/2021)
10/13/2021	3696	Notice of Appeal FEE PAID (Filing fee$505,receipt number 0971−16491861). (Hasan, Iram) (Filed on 10/13/2021) (Entered: 10/13/2021)
10/13/2021	3695	Mailed request for payment of docket fee to appellant (cc to USCA). (cjlS, COURT STAFF) (Filed on 10/13/2021) (Entered: 10/13/2021)
10/12/2021	3694	RESPONSE re 3684 Order *NOTICE OF CDCR AND THE RECEIVER'S SUBMISSION OF A COVID−19 VACCINATION PLAN FOR CERTAIN CDCR WORKERS AND INCARCERATED PEOPLE IN COMPLIANCE WITH THE SEPTEMBER 27, 2021 ORDER* by Gavin Newsom. (Wolff, Samantha) (Filed on 10/12/2021) (Entered: 10/12/2021)
10/12/2021	3693	NOTICE OF APPEAL to the 9th Circuit Court of Appeals filed by Gavin Newsom. Appeal of Order 3684 (Appeal fee FEE NOT PAID.) (Hasan, Iram) (Filed on 10/12/2021) (Entered: 10/12/2021)
10/12/2021	3692	CLERKS NOTICE SETTING ZOOM HEARING. Motion Hearing set for 10/14/2021 02:00 PM in Oakland, − Videoconference Only before Judge Jon S. Tigar. This proceeding will be held via a Zoom

		webinar. **Webinar Access:** All counsel, members of the public, and media may access the webinar information at https://www.cand.uscourts.gov/jst **General Order 58.** Persons granted access to court proceedings held by telephon e or videoconference are reminded that photographing, recording, and rebroadcasting of court proceedings, including screenshots or other visual copying of a hearing, is absolutely prohibited. **Zoom Guidance and Setup:** https://www.cand.uscourts.gov/zoom/. , Set/Reset Deadlines as to 3665 MOTION to Intervene . Motion Hearing set for 10/14/2021 02:00 PM in Oakland, − Videoconference Only before Judge Jon S. Tigar. *(This is a text−only entry generated by the court. There is no document associated with this entry.)* (mllS, COURT STAFF) (Filed on 10/12/2021) (Entered: 10/12/2021)
10/08/2021	3691	**ORDER FOR COLLECTION OF UNDISPUTED ATTORNEYS' FEES AND COSTS FOR SECOND QUARTER OF 2021 by Judge Jon S. Tigar granting 3690 Stipulation.(mllS, COURT STAFF) (Filed on 10/8/2021) (Entered: 10/08/2021)**
10/07/2021	3690	STIPULATION WITH PROPOSED ORDER RE COLLECTION OF SECOND QUARTER FEES filed by Marciano Plata, Gavin Newsom. (Hardy, Alison) (Filed on 10/7/2021) Modified on 10/8/2021 (cjlS, COURT STAFF). (Entered: 10/07/2021)
10/05/2021	3689	TRANSCRIPT ORDER for proceedings held on 9/24/2021 before Judge Jon S. Tigar for Court Reporter Pam Batalo. (oh, COURT STAFF) (Filed on 10/5/2021) (Entered: 10/05/2021)
10/01/2021	3688	NOTICE of Filing of Receiver's 48th Tri−Annual Report by J. Clark Kelso. (Dupree, Jamie) (Filed on 10/1/2021) Modified on 10/4/2021 (cjlS, COURT STAFF). (Entered: 10/01/2021)
09/29/2021	3687	DEFENDANTS NOTICE OF ERRATA re: STATUS REPORTS IN RESPONSE TO FEBRUARY 10, 2014 ORDER re 3676 Status Report, 3650 Status Report, 3616 Status Report by Gavin Newsom. (Gille, Ryan) (Filed on 9/29/2021) Modified on 9/30/2021 (cjlS, COURT STAFF). (Entered: 09/29/2021)
09/29/2021	3686	Transcript of Proceedings (corrected) held on 09/24/2021, before Judge Tigar. Court Reporter Pamela Batalo Hebel, telephone number 626−688−7509; pamela_batalo−hebel@cand.uscourts.gov. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerk's Office public terminal or may be purchased through the Court Reporter/Transcriber until the deadline for the Release of Transcript Restriction. After that date it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this filing. (Re 3683 Transcript Order, 3680 Transcript Order) Redaction Request due 10/20/2021. Redacted Transcript Deadline set for 11/1/2021. Release of Transcript Restriction set for 12/28/2021. (Related documents(s) 3683 , 3680) (Batalo, Pam) (Filed on 9/29/2021) (Entered: 09/29/2021)
09/29/2021	3685	***Please see 3686 for corrected entry.*** Transcript of Proceedings held on 09/24/2021, before Judge Tigar. Court Reporter Pamela Batalo Hebel, telephone number 626−688−7509; pamela_batalo−hebel@cand.uscourts.gov. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerk's Office public terminal or may be purchased through the Court Reporter/Transcriber until the deadline for the Release of Transcript Restriction. After that date it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this filing. (Re 3683 Transcript Order, 3680 Transcript Order) Redaction Request due 10/20/2021. Redacted Transcript Deadline set for 11/1/2021. Release of Transcript Restriction set for 12/28/2021. (Related documents(s) 3683 , 3680) (Batalo, Pam) (Filed on 9/29/2021) Modified on 9/29/2021 (ddkS, COURT STAFF). (Entered: 09/29/2021)
09/27/2021	3684	**ORDER RE: MANDATORY VACCINATIONS. Signed by Judge Jon S. Tigar on September 27, 2021. (mllS, COURT STAFF) (Filed on 9/27/2021) (Entered: 09/27/2021)**
09/24/2021	3683	TRANSCRIPT ORDER for proceedings held on 9/24/2021 before Judge Jon S. Tigar by J. Clark Kelso, for Court Reporter Pam Batalo. (Bowen, Robert) (Filed on 9/24/2021) (Entered: 09/24/2021)
09/24/2021	3682	TRANSCRIPT ORDER for proceedings held on 09/24/21 before Judge Jon S. Tigar by Ralph Coleman, for Court Reporter Pam Batalo. (Xu, Amy) (Filed on 9/24/2021) (Entered: 09/24/2021)
09/24/2021	3681	TRANSCRIPT ORDER for proceedings held on 09/24/2021 before Judge Jon S. Tigar by California Correctional Peace Officers Association, for Court Reporter Pam Batalo. (Adam, Gregg) (Filed on 9/24/2021) (Entered: 09/24/2021)

09/24/2021	3680	TRANSCRIPT ORDER for proceedings held on 09/24/2021 before Judge Jon S. Tigar by Gavin Newsom, for Court Reporter Pam Batalo. (Gille, Ryan) (Filed on 9/24/2021) (Entered: 09/24/2021)
09/24/2021	3679	**Minute Entry for proceedings held before Judge Jon S. Tigar: Show Cause Hearing held on 9/24/2021. Hearing held via Zoom videoconference. Arguments heard from all parties. Issue taken under submission. Total Time in Court: 58 minutes. Court Reporter: Pamela Hebel. Plaintiff Attorney: Donald Specter, Steven Fama, Sophie Hart, Laura Bixby, Rita Lomio. Defendant Attorney: Paul Mello, Samantha Wolff, Damon McClain, Ryan Gille, Iram Hasan. Counsel for Intervenors: David Sanders, Gregg Adam. Receiver: Clark Kelso Outside Counsel for Receiver: Jamie Dupree, Brad Brian, Katherine Forster, Robert Bowen *(This is a text−only entry generated by the court. There is no document associated with this entry.)* (mllS, COURT STAFF) (Date Filed: 9/24/2021) (Entered: 09/24/2021)**
09/22/2021	3678	**ORDER re 3656 Amicus Curiae Appearance, filed by Service Employees International Union, Local 1000. Signed by Judge Jon S. Tigar on September 22, 2021. (mllS, COURT STAFF) (Filed on 9/22/2021) (Entered: 09/22/2021)**
09/20/2021	3677	REPLY (re 3665 MOTION to Intervene) filed byCalifornia Correctional Peace Officers Association. (Attachments: # 1 Declaration Gregg McLean Adam)(Adam, Gregg) (Filed on 9/20/2021) (Entered: 09/20/2021)
09/15/2021	3676	DEFENDANTS SEPTEMBER 2021 STATUS REPORT IN RESPONSE TO FEBRUARY 10, 2014 ORDER by Gavin Newsom. (Attachments: # 1 Exhibit A−B)(Gille, Ryan) (Filed on 9/15/2021) Modified on 9/16/2021 (cjlS, COURT STAFF). (Entered: 09/15/2021)
09/13/2021	3675	Plaintiffs' Opposition to 3665 California Correctional Peace Officers Association's Motion to Intervene filed by Marciano Plata. (Bixby, Laura) (Filed on 9/13/2021) Modified on 9/14/2021 (cjlS, COURT STAFF). (Entered: 09/13/2021)
09/10/2021	3674	Reply to Responses to OSC re: Receiver's Recommendation on Mandatory Vaccination by Marciano Plata. (Attachments: # 1 Declaration of Sophie Hart)(Lomio, Rita) (Filed on 9/10/2021) Modified on 9/13/2021 (cjlS, COURT STAFF). (Entered: 09/10/2021)
09/10/2021	3673	Defendants Reply In Support Of Their Response To The Order To Show Cause Regarding The Receivers Mandatory Covid−19 Vaccine Policy by Gavin Newsom. (Attachments: # 1 Declaration of Connie Gipson In Support of Defendants' Reply to Responses to Order to Show Cause Re: Receiver's Recommendation on Mandatory Vaccination)(Wolff, Samantha) (Filed on 9/10/2021) Modified on 9/13/2021 (cjlS, COURT STAFF). (Entered: 09/10/2021)
09/10/2021	3672	OBJECTIONS to 3663 Defendants' Objection to the Declaration of Sara Norman In Support of Plaintiffs' Response to Order to Show Cause re Receiver's Recommendation on Mandatory Vaccination by Gavin Newsom. (Wolff, Samantha) (Filed on 9/10/2021) Modified on 9/13/2021 (cjlS, COURT STAFF). (Entered: 09/10/2021)
09/10/2021	3671	OBJECTIONS to *Defendants' Objection to the Declaration of Sophie Hart In Support of Plaintiffs' Response to Order to Show Cause re Receiver's Recommendation on Mandatory Vaccination* by Gavin Newsom. (Wolff, Samantha) (Filed on 9/10/2021) (Entered: 09/10/2021)
09/10/2021	3670	RECEIVERS REPLY TO PARTIES RESPONSE TO ORDER TO SHOW CAUSE REGARDING RECEIVERS RECOMMENDATION ON MANDATORY VACCINATION (ECF NO. 3647) by J. Clark Kelso. (Attachments: # 1 Declaration Reply Declaration of Dr. Joseph Bick, # 2 Declaration Reply Declaration of Tammatha Foss)(Brian, Brad) (Filed on 9/10/2021) Modified on 9/13/2021 (cjlS, COURT STAFF). (Entered: 09/10/2021)
09/10/2021	3669	INTERVENOR CALIFORNIA CORRECTIONAL PEACE OFFICERS ASSOCIATIONS REPLY TO RESPONSES TO ORDER TO SHOW CAUSE RE: RECEIVERS RECOMMENDATION ON MANDATORY VACCINATION by California Correctional Peace Officers Association. (Adam, Gregg) (Filed on 9/10/2021) Modified on 9/13/2021 (cjlS, COURT STAFF). (Entered: 09/10/2021)
09/09/2021	3668	CLERK'S NOTICE CONTINUING CASE MANAGEMENT CONFERENCE. *(This is a text−only entry generated by the court. There is no document associated with this entry.)*,. The Case Management Conference set for 9/20/2021 is CONTINUED. Case Management Statement due by 10/26/2021 by 3:00 PM. Further Case Management Conference set for 10/28/2021 02:00 PM in Oakland, − Videoconference Only. This proceeding will be held via a Zoom webinar. **Webinar Access:** All counsel, members of the public, and media may access the webinar information at https://www.cand.uscourts.gov/jst

		General Order 58. Persons granted access to court proceedings held by telepho ne or videoconference are reminded that photographing, recording, and rebroadcasting of court proceedings, including screenshots or other visual copying of a hearing, is absolutely prohibited. **Zoom Guidance and Setup:** https://www.cand.uscourts.gov/zoom/. Case Management Statement due by 10/26/2021. Further Case Management Conference set for 10/28/2021 02:00 PM in Oakland, − Videoconference Only. (mllS, COURT ST AFF) (Filed on 9/9/2021) (Entered: 09/09/2021)
09/09/2021	3667	Receipt #34611156012 for $525.00 with receipt date 09/07/2021 from State of California (palsS, COURT STAFF) (Filed on 9/9/2021) (Entered: 09/09/2021)
09/07/2021	3666	**ORDER re 3658 Amicus Curiae Appearance, filed by Paul Good, Craig Haney, Terry Kupers, Pablo Stewart. Signed by Judge Jon S. Tigar on September 7, 2021. (mllS, COURT STAFF) (Filed on 9/7/2021) (Entered: 09/07/2021)**
08/30/2021	3665	MOTION to Intervene filed by California Correctional Peace Officers Association. Motion Hearing set for 10/14/2021 02:00 PM in Oakland, Courtroom 6, 2nd Floor before Judge Jon S. Tigar. Responses due by 9/13/2021. Replies due by 9/20/2021. (Attachments: # 1 Declaration Gregg McLean Adam, # 2 Declaration Suzanne L. Jimenez)(Adam, Gregg) (Filed on 8/30/2021) (Entered: 08/30/2021)
08/30/2021	3664	RESPONSE TO ORDER TO SHOW CAUSE by California Correctional Peace Officers Association . (Attachments: # 1 Declaration Gregg McLean Adam)(Adam, Gregg) (Filed on 8/30/2021) (Entered: 08/30/2021)
08/30/2021	3663	RESPONSE TO ORDER TO SHOW CAUSE by Marciano Plata . (Attachments: # 1 Declaration of Sophie Hart, # 2 Declaration of Rita Lomio, # 3 Declaration of Sara Norman)(Lomio, Rita) (Filed on 8/30/2021) (Entered: 08/30/2021)
08/30/2021	3662	Declaration of Diana Toche in Support of 3660 Response to Order to Show Cause filed byGavin Newsom. (Attachments: # 1 Exhibit A, # 2 Exhibit B, # 3 Exhibit C)(Related document(s) 3660) (Wolff, Samantha) (Filed on 8/30/2021) (Entered: 08/30/2021)
08/30/2021	3661	Declaration of James Watt in Support of 3660 Response to Order to Show Cause filed byGavin Newsom. (Related document(s) 3660) (Wolff, Samantha) (Filed on 8/30/2021) (Entered: 08/30/2021)
08/30/2021	3660	RESPONSE TO ORDER TO SHOW CAUSE by Gavin Newsom . (Wolff, Samantha) (Filed on 8/30/2021) (Entered: 08/30/2021)
08/30/2021	3659	NOTICE of Appearance by Rita Katherine Lomio *for Plaintiffs* (Lomio, Rita) (Filed on 8/30/2021) (Entered: 08/30/2021)
08/30/2021	3658	Amicus Curiae APPEARANCE entered by Cara Elizabeth Trapani on behalf of Craig Haney, Paul Good, Pablo Stewart, Terry Kupers. (Attachments: # 1 Proposed Order Granting Brief of Amici Curiae Mental Health Professionals In Support of Vaccine Mandate)(Trapani, Cara) (Filed on 8/30/2021) (Entered: 08/30/2021)
08/25/2021	3657	Response to Order to Show Cause 3653 Order,, Set Deadlines/Hearings, *Defendants' Response to August 20, 2021 Order (ECF No. 3653)* byGavin Newsom. (Attachments: # 1 Declaration of Diana Toche, DDS in Support of Defendants' Response to August 20, 2021 Order (ECF No. 3653) with Exhibit A)(Hasan, Iram) (Filed on 8/25/2021) (Entered: 08/25/2021)
08/23/2021	3656	Amicus Curiae APPEARANCE entered by Theresa Clare Witherspoon on behalf of Service Employees International Union, Local 1000. (Attachments: # 1 Exhibit A, # 2Exhibit B, # 3 Proposed Order)(Witherspoon, Theresa) (Filed on 8/23/2021) Modified on 8/24/2021 (bnsS, COURT STAFF). (Entered: 08/23/2021)
08/23/2021	3655	Receipt #34611155826 for $275.00 with receipt date 08/20/2021 from State of California. (rghS, COURT STAFF) (Filed on 8/23/2021) (Entered: 08/23/2021)
08/20/2021	3654	CLERKS NOTICE SETTING ZOOM HEARING. Order to Show Cause Hearing set for 9/24/2021 09:30 AM. This proceeding will be held via a Zoom webinar. **Webinar Access:** All counsel, members of the public, and media may access the webinar information at https://www.cand.uscourts.gov/jst

		General Order 58. Persons granted access to court proceedings held by telephone or videoconference are reminded that photograph ing, recording, and rebroadcasting of court proceedings, including screenshots or other visual copying of a hearing, is absolutely prohibited. **Zoom Guidance and Setup:** https:/ /www.cand.uscourts.gov/zoom/. Order to Show Cause Hearing set for 9/24/2021 09:30 AM. *(This is a text−only entry generated by the court. There is no document associated with this entry.)* (mllS, COURT STAFF) (Filed on 8/20/2021) (Entered: 08/20/2021)
08/20/2021	3653	**ORDER MODIFYING SCHEDULE ON 3647 AUGUST 9, 2021 ORDER TO SHOW CAUSE. Show Cause Responses due by 8/30/2021. Replies due by 9/10/2021. Order to Show Cause Hearing set for 9/24/2021 at 9:30 AM. Signed by Judge Jon S. Tigar on August 20, 2021. (jstlc3, COURT STAFF) (Filed on 8/20/2021) (Entered: 08/20/2021)**
08/20/2021	3652	Declaration of Dr. Joseph Bick in Support of 3638 Notice (Other), filed byJ. Clark Kelso. (Related document(s) 3638) (Brian, Brad) (Filed on 8/20/2021) (Entered: 08/20/2021)
08/18/2021	3651	TRANSCRIPT ORDER for proceedings held on 06/30/2021 before Judge Jon S. Tigar by California Correctional Peace Officers Association, for Court Reporter Diane Skillman. (Adam, Gregg) (Filed on 8/18/2021) (Entered: 08/18/2021)
08/16/2021	3650	*Defendants' August 2021 Status Report* by Gavin Newsom. (Attachments: # 1 Exhibit A−B)(Gille, Ryan) (Filed on 8/16/2021) Modified on 8/17/2021 (jmlS, COURT STAFF). (Entered: 08/16/2021)
08/11/2021	3649	**ORDER GRANTING MOTION TO APPROVE AMENDMENTS TO PHYSICIAN CLINICAL COMPETENCY POLICY by Judge Jon S. Tigar granting 3613 Motion. (mllS, COURT STAFF) (Filed on 8/11/2021) (Entered: 08/11/2021)**
08/10/2021	3648	STIPULATION WITH PROPOSED ORDER *Re Motion to Approve Amendments to Physician Clinical Competency Policy* re 3637 Order, Set Deadlines/Hearings filed by J. Clark Kelso, Marciano Plata and Gavin Newsom. (Dupree, Jamie) (Filed on 8/10/2021) Modified on 8/11/2021 (jmlS, COURT STAFF). (Entered: 08/10/2021)
08/09/2021	3647	**ORDER TO SHOW CAUSE RE: RECEIVER'S RECOMMENDATION ON MANDATORY VACCINATION. Order to Show Cause Hearing set for 9/16/2021 02:00 PM. Show Cause Response due by 8/23/2021. Signed by Judge Jon S. Tigar on August 9, 2021. (mllS, COURT STAFF) (Filed on 8/9/2021) (Entered: 08/09/2021)**
08/09/2021	3646	Declaration of GREGG McLEAN ADAM in Support of 3644 Notice (Other) *AMENDED AS TO EXHIBIT B ONLY* filed byCalifornia Correctional Peace Officers Association. (Related document(s) 3644) (Adam, Gregg) (Filed on 8/9/2021) (Entered: 08/09/2021)
08/06/2021	3645	*Receiver's Proposed Briefing Schedule* by J. Clark Kelso (Brian, Brad) (Filed on 8/6/2021) Modified on 8/9/2021 (jmlS, COURT STAFF). (Entered: 08/06/2021)
08/06/2021	3644	*CCPOA's Position on Briefing Schedule* by California Correctional Peace Officers Association (Attachments: # 1 Declaration of Gregg McLean Adam in Support)(Adam, Gregg) (Filed on 8/6/2021) Modified on 8/9/2021 (jmlS, COURT STAFF). (Entered: 08/06/2021)
08/06/2021	3643	*Defendants' Proposed Briefing Schedule* by Gavin Newsom (Gille, Ryan) (Filed on 8/6/2021) Modified on 8/9/2021 (jmlS, COURT STAFF). (Entered: 08/06/2021)
08/06/2021	3642	*Plaintiffs Proposed Briefing Schedule* by Marciano Plata (Specter, Donald) (Filed on 8/6/2021) Modified on 8/9/2021 (jmlS, COURT STAFF). (Entered: 08/06/2021)
08/06/2021	3641	Transcript of Proceedings held on July 29, 2021, before Judge Jon S. Tigar. Court Reporter Raynee H. Mercado, CSR, telephone number 510−565−7228, cacsr8258@gmail.com. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerk's Office public terminal or may be purchased through the Court Reporter until the deadline for the Release of Transcript Restriction. After that date it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this filing. (Re 3636 Transcript Order), TRANSCRIPT COPY DELIVERED re 3634 Transcript Order, 3633 Transcript Order, 3632 Transcript Order Release of Transcript Restriction set for 11/4/2021. (Related document(s) 3636 , 3634 , 3633 , 3632) (rhm) (Filed on 8/6/2021) (Entered: 08/06/2021)
08/05/2021	3640	JOINT NOTICE *Regarding Resolution of Discovery Dispute* by Gavin Newsom and Marciano Plata re 3630 Case Management Conference − Further Set Deadlines/Hearings, Util − Teleconference Zoom,

		(Gille, Ryan) (Filed on 8/5/2021) Modified on 8/6/2021 (jmlS, COURT STAFF). (Entered: 08/05/2021)
08/05/2021	3639	**ORDER GRANTING PAYMENT FOR COURT APPOINTED EXPERTS. Ms. LaMarre in the amount of $250.00; Dr. Goldenson in the amount of $275.00. Signed by Judge Jon S.Tigar on August 5, 2021. (mllS, COURT STAFF) (Filed on 8/5/2021) (Entered: 08/05/2021)**
08/04/2021	3638	NOTICE *OF FILING OF REPORT* by J. Clark Kelso (Attachments: # 1 Declaration Declaration of Dr. Joseph Bick, # 2 Declaration Declaration of Ms. Tammatha Foss, # 3 Declaration Declaration of Dr. Tara Vijayan)(Brian, Brad) (Filed on 8/4/2021) Modified on 8/5/2021 (jmlS, COURT STAFF). (Entered: 08/04/2021)
08/03/2021	3637	**ORDER RE: MOTION TO APPROVE AMENDMENTS TO PHYSICIAN CLINICAL COMPETENCY POLICY; ORDER VACATING HEARING. Joint or Competing Proposals due by 8/11/2021. Signed by Judge Jon S. Tigar on August 3, 2021. (mllS, COURT STAFF) (Filed on 8/3/2021) (Entered: 08/03/2021)**
08/02/2021	3636	TRANSCRIPT ORDER for proceedings held on 07/29/2021 before Judge Jon S. Tigar by J. Clark Kelso, for Court Reporter Raynee Mercado. (Dupree, Jamie) (Filed on 8/2/2021) (Entered: 08/02/2021)
07/30/2021		Electronic filing error. Incorrect event used. [err101] The correct event is Statement of Non−Opposition. The correct event can be found at: Civil Events > Motions and Relate d Filings > Other Supporting Documents > Statement of Non−Opposition. **Corrected by Clerk's Office. No further action is necessary.** Re: 3635 Statement, filed by Gavin Newsom (jmlS, COURT STAFF) (Filed on 7/30/2021) (Entered: 07/30/2021)
07/30/2021	3635	Statement of Non−Opposition *To Motion To Approve Receiver's Proposed Amendments To A Portion of Court−Approved Policy Regarding Physician Clinical Competency Due to Changed Circumstances, As Modified by Supplemental Filing* by Gavin Newsom. (Wolff, Samantha) (Filed on 7/30/2021) Modified on 7/30/2021 (jmlS, COURT STAFF). (Entered: 07/30/2021)
07/30/2021	3634	TRANSCRIPT ORDER for proceedings held on 07/29/21 before Judge Jon S. Tigar by Ralph Coleman, for Court Reporter Raynee Mercado. (Xu, Amy) (Filed on 7/30/2021) (Entered: 07/30/2021)
07/29/2021	3633	TRANSCRIPT ORDER for proceedings held on 7/29/2021 before Judge Jon S. Tigar by Gavin Newsom, for Court Reporter Raynee Mercado. (Gille, Ryan) (Filed on 7/29/2021) (Entered: 07/29/2021)
07/29/2021	3632	TRANSCRIPT ORDER for proceedings held on 07/29/2021 before Judge Jon S. Tigar by California Correctional Peace Officers Association, for Court Reporter Raynee Mercado. (Adam, Gregg) (Filed on 7/29/2021) (Entered: 07/29/2021)
07/29/2021	3631	TRANSCRIPT ORDER for proceedings held on 07/29/2021 before Judge Jon S. Tigar by California Correctional Peace Officers Association, for Court Reporter Diane Skillman. (Adam, Gregg) (Filed on 7/29/2021) (Entered: 07/29/2021)
07/29/2021	3630	**Minute Entry for proceedings held before Judge Jon S. Tigar: Further Case Management Conference held via Zoom videoconference on 7/29/2021. Vaccination discussed. Statement made by Receiver regarding recommended policy implementation. The Receiver will file a status report and recommendation by 8/4/2021. The parties are ordered to meet and confer about, and make a joint proposal regarding, briefing schedule in response to the Receivers report. The parties are also ordered to meet and confer about, and file a joint or competing letter brief as discussed at the conference. If the parties are unable to agree, they must submit competing proposals. In the latter event, the Court will endeavor to choose, in all respects, the single proposal it concludes is most reasonable. Further case management conference set. Receiver's Status Report due by 8/4/2021. Joint Letter Brief due by 8/5/2021. Proposals re Briefing Schedule due by 8/6/2021. Case Management Statement due by 9/17/2021. Further Case Management Conference set for 9/20/2021 02:00 PM in Oakland, − Videoconference Only. This proceeding will be held via a Zoom webinar.** **Webinar Access:** All counsel, members of the public, and media may access the webinar information at https://www.cand.uscourts.gov/jst **General Order 58.** Persons granted access to court proceedings held by telephone or videoconference are reminded that phot ographing, recording, and rebroadcasting of court proceedings, including screenshots or other visual copying of a hearing, is absolutely prohibited. **Zoom Guidance and Setup:** h ttps://www.cand.uscourts.gov/zoom/.

		Case Management Statement due by 9/17/2021. Joint Proposed Discovery due by 8/5/2021. Show Cause Response due by 8/6/2021. Status Report due by 8/4/2021. Further Case Management Conference set for 9/20/2021 02:00 PM in Oakland, − Videoconference Only.Total Time in Court: 52 minutes. Court Reporter: Raynee Mercado. Plaintiff Attorney: Donald Specter, Alison Hardy, Sophie Hart. Defendant Attorney: Samantha Wolff, Damon McClain, Ryan Gille, Iram Hasan. Intervenors: David Sanders, Gregg Adam. Receiver: Clark Kelso Outside Counsel for Receiver: Jamie Dupree ***(This is a text−only entry generated by the court. There is no document associated with this entry.)*** **(mllS, COURT STAFF) (Date Filed: 7/29/2021) (Entered: 07/29/2021)**
07/29/2021	3629	**ORDER FOR COLLECTION OF UNDISPUTED ATTORNEYS' FEES AND COSTS FOR FIRST QUARTER 2021 by Judge Jon S. Tigar granting 3625 Stipulation.(mllS, COURT STAFF) (Filed on 7/29/2021) (Entered: 07/29/2021)**
07/28/2021		Electronic filing error. **NOTICE TO COUNSEL:** Jacob S. Kreilkamp. The docket shows a different address from what is appearing on the document (dkt. #: 3628 Notice of Appearan ce filed by J. Clark Kelso). Please update your personal profile on ECF. (jmlS, COURT STAFF) (Filed on 7/28/2021) (Entered: 07/28/2021)
07/28/2021	3628	NOTICE of Appearance by Jacob Samuel Kreilkamp (Kreilkamp, Jacob) (Filed on 7/28/2021) (Entered: 07/28/2021)
07/28/2021	3627	NOTICE of Appearance by Katherine M. Forster (Forster, Katherine) (Filed on 7/28/2021) Modified on 7/28/2021 (jmlS, COURT STAFF). (Entered: 07/28/2021)
07/28/2021	3626	NOTICE of Appearance by Robert Emmett Bowen (Bowen, Robert) (Filed on 7/28/2021) (Entered: 07/28/2021)
07/28/2021	3625	STIPULATION WITH PROPOSED ORDER *FOR COLLECTION OF UNDISPUTED ATTORNEYS' FEES AND COSTS FOR FIRST QUARTER 2021* filed by Marciano Plata and Gavin Newsom. (Hardy, Alison) (Filed on 7/28/2021) Modified on 7/28/2021 (jmlS, COURT STAFF). (Entered: 07/28/2021)
07/27/2021	3624	NOTICE of Appearance by Brad Dennis Brian (Brian, Brad) (Filed on 7/27/2021) (Entered: 07/27/2021)
07/27/2021	3623	JOINT CASE MANAGEMENT STATEMENT filed by Marciano Plata and Gavin C. Newsom. (Attachments: # 1 Exhibit A)(Hart, Sophie) (Filed on 7/27/2021) Modified on 7/28/2021 (jmlS, COURT STAFF). (Entered: 07/27/2021)
07/27/2021	3622	Statement of Non−Opposition re 3621 Supplemental Brief, filed byMarciano Plata. (Related document(s) 3621) (Norman, Sara) (Filed on 7/27/2021) (Entered: 07/27/2021)
07/27/2021	3621	Supplemental Brief re 3613 MOTION for Hearing *TO APPROVE RECEIVER'S PROPOSED AMENDMENTS TO A PORTION OF COURT−APPROVED POLICY REGARDING PHYSICIAN CLINICAL COMPETENCY DUE TO CHANGED CIRCUMSTANCES* filed byJ. Clark Kelso. (Related document(s) 3613) (Dupree, Jamie) (Filed on 7/27/2021) (Entered: 07/27/2021)
07/27/2021	3620	*CCPOA Submission for July 29, 2021 CMC* filed by California Correctional Peace Officers Association. (Adam, Gregg) (Filed on 7/27/2021) Modified on 7/27/2021 (jmlS, COURT STAFF). (Entered: 07/27/2021)
07/23/2021	3619	**ORDER TO EXTEND TIME. Set/Reset Deadlines as to 3613 MOTION for Hearing *TO APPROVE RECEIVER'S PROPOSED AMENDMENTS TO A PORTION OF COURT−APPROVED POLICY REGARDING PHYSICIAN CLINICAL COMPETENCY DUE TO CHANGED CIRCUMSTANCES*., Motions terminated: 3617 STIPULATION WITH PROPOSED ORDER filed by Marciano Plata, J. Clark Kelso, Gavin Newsom. Responses due by 7/27/2021. Replies due by 8/3/2021. Signed by Judge Jon S. Tigar on July 23, 2021. (mllS, COURT STAFF) (Filed on 7/23/2021) (Entered: 07/23/2021)**
07/21/2021		Electronic filing error. Incorrect event used. [err101] The correct event is Statement of Non−Opposition. The correct event can be found at: Civil Events > Motions and Related Filings > Other Supporting Documents > Statement of Non−Opposition. **Corrected by Clerk's Office. No further action is necessary.** Re: 3618 Statement, filed by Gavin Newsom (jmlS, COURT STAFF) (Filed on 7/21/2021) (Entered: 07/22/2021)
07/21/2021	3618	Statement of Non−Opposition *To Motion To Approve Receiver's Proposed Amendments To A Portion of Court−Approved Policy Regarding Physician Clinical Competency Due to Changed Circumstances* by Gavin Newsom. (Wolff, Samantha) (Filed on 7/21/2021) Modified on 7/22/2021 (jmlS, COURT STAFF). (Entered: 07/21/2021)

07/21/2021	3617	STIPULATION WITH PROPOSED ORDER *to Extend Time for Response to Receiver's Motion* filed by Marciano Plata, Gavin Newsom and J. Clark Kelso . (Norman, Sara) (Filed on 7/21/2021) Modified on 7/21/2021 (jmlS, COURT STAFF). (Entered: 07/21/2021)
07/15/2021	3616	STATUS REPORT *Defendants' July 2021 Status Report in Response to February 10, 2014 Order* by Gavin Newsom. (Attachments: # 1 Exhibit A−B)(Gille, Ryan) (Filed on 7/15/2021) (Entered: 07/15/2021)
07/14/2021	3615	**ORDER GRANTING PAYMENT FOR COURT APPOINTED EXPERTS. Dr. Goldenson in the amount of $275.00. Signed by Judge Jon S. Tigar on July 14, 2021. (mllS, COURT STAFF) (Filed on 7/14/2021) (Entered: 07/14/2021)**
07/07/2021	3614	CLERK'S NOTICE Continuing Motion Hearing. The motion noticed for 8/12/2021 is CONTINUED due to being set on a date that is closed to further settings. *(This is a text−only entry generated by the court. There is no document associated with this entry.)*, Set/Reset Deadlines as to 3613 MOTION for Hearing *TO APPROVE RECEIVER'S PROPOSED AMENDMENTS TO A PORTION OF COURT−APPROVED POLICY REGARDING PHYSICIAN CLINICAL COMPETENCY DUE TO CHANGED CIRCUMSTANCES*.,. Responses due by 7/21/2021. Replies due by 7/28/2021. Motion Hearing set for 8/26/2021 02:00 PM in Oakland, − Videoconference Only before Judge Jon S. Tigar. This proceeding will be held via a Zoom webinar. **Webinar Access:** All counsel, members of the public, and media may access the webinar information at https://www.cand.uscourts.gov/jst **General Order 58.** Persons granted access to court proceedings held by telephone or videoconference are reminded that photographing, recording, and rebroadcasting of court proceedings, including screenshots or other visual copying of a hearing, is absolutely prohibited. **Zoom Guidance and Setup:** https://www.cand.uscourts.gov/zoom/. Responses due by 7/21/2021. Replies due by 7/28/2021. Motion Hearing set for 8/26/2021 02:00 PM in Oakland, − Videoconference Only before Judge Jon S. Tigar. (Related documents(s) 3613)(mllS, COURT STAFF) (Filed on 7/7/2021) (Entered: 07/07/2021)
07/07/2021	3613	MOTION for Hearing *TO APPROVE RECEIVER'S PROPOSED AMENDMENTS TO A PORTION OF COURT−APPROVED POLICY REGARDING PHYSICIAN CLINICAL COMPETENCY DUE TO CHANGED CIRCUMSTANCES* filed by J. Clark Kelso. (Attachments: # 1 Declaration OF JORGE A. LEON IN SUPPORT OF MOTION TO APPROVE RECEIVER'S PROPOSED AMENDMENTS TO A PORTION OF COURT−APPROVED POLICY RE PHYSICIAN CLINICAL COMPETENCY DUR TO CHANGED CIRCUMSTANCES, # 2 Exhibit EXH 1 TO DEC OF JORGE A. LEON, # 3 Declaration OF JAMIE L. DUPREE IN SUPPORT OF MOTION TO APPROVE RECEIVER'S PROPOSED AMENDMENTS TO A PORTION OF COURT−APPROVED POLICY RE PHYSICIAN CLINICAL COMPETENCY DUR TO CHANGED CIRCUMSTANCES, # 4 Exhibit EXH 2 & 3 TO JAMIE L. DUPREE DECLARATION, # 5 Proposed Order OF JORGE A. LGRANTING MOTION TO APPROVE RECEIVER'S PROPOSED AMENDMENTS TO A PORTION OF COURT−APPROVED POLICY RE PHYSICIAN CLINICAL COMPETENCY DUR TO CHANGED CIRCUMSTANCES)(Dupree, Jamie) (Filed on 7/7/2021) (Entered: 07/07/2021)
07/01/2021	3612	TRANSCRIPT ORDER for proceedings held on 6/30/2021 before Judge Jon S. Tigar by J. Clark Kelso, for Court Reporter Diane Skillman. (Dupree, Jamie) (Filed on 7/1/2021) (Entered: 07/01/2021)
07/01/2021	3611	TRANSCRIPT ORDER for proceedings held on 06/30/21 before Judge Jon S. Tigar by Ralph Coleman, for Court Reporter Diane Skillman. (Xu, Amy) (Filed on 7/1/2021) (Entered: 07/01/2021)
07/01/2021	3610	**ORDER RE: ADVISORY BOARD MEMBERSHIP. Signed by Judge Jon S. Tigar on June 30, 2021. (mllS, COURT STAFF) (Filed on 7/1/2021) (Entered: 07/01/2021)**
06/30/2021	3609	Transcript of Proceedings held on June 30, 2021, before Judge Jon S. Tigar. Court Reporter Diane E. Skillman, telephone number 925−899−2912, Diane_Skillman@cand.uscourts.gov. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerk's Office public terminal or may be purchased through the Court Reporter until the deadline for the Release of Transcript Restriction. After that date it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this filing. (Re 3607 Transcript Order) Release of Transcript Restriction set for 9/28/2021. (Related documents(s) 3607) (Skillman, Diane) (Filed on 6/30/2021) (Entered: 06/30/2021)

06/30/2021	3608	CLERK'S NOTICE SETTING ZOOM HEARING. *(This is a text−only entry generated by the court. There is no document associated with this entry.)*,. Case Management Statement due by 7/27/2021 by 5:00 p.m. Further Case Management Conference set for 7/29/2021 10:00 AM in Oakland, − Videoconference Only. This proceeding will be held via a Zoom webinar. **Webinar Access:** All counsel, members of the public, and media may access the webinar information at https://www.cand.uscourts.gov/jst **General Order 58.** Persons granted access to court proceedings held by telephone or videoconference are reminded that photographing, recording, and rebroadcast ing of court proceedings, including screenshots or other visual copying of a hearing, is absolutely prohibited. **Zoom Guidance and Setup:** https://www.cand.uscourts.gov/zoom/. Case Management Statement due by 7/27/2021. Further Case Management Conference set for 7/29/2021 10:00 AM in Oakland, − Videoconference Only. (mllS, COURT STAFF) (Filed on 6/30/2021) (Entered: 06/30/2021)
06/30/2021	3607	TRANSCRIPT ORDER for proceedings held on 6/30/21 before Judge Jon S. Tigar by Gavin Newsom, for Court Reporter Diane Skillman. (Gille, Ryan) (Filed on 6/30/2021) (Entered: 06/30/2021)
06/30/2021	3606	**Minute Entry for proceedings held before Judge Jon S. Tigar: Further Case Management Conference held on 6/30/2021. Hearing held via Zoom videoconference. Topics in the case management statement discussed. Parties are directed to meet and confer about a suitable new case management conference date and contact the courtroom deputy by July 2, 2021.Total Time in Court: 36 minutes. Court Reporter: Diane Skillman. Plaintiff Attorney: Donald Specter, Steven Fama, Sophie Hart. Defendant Attorney: Paul Mello, Samantha Wolff, Damon McClain, Ryan Gille. Counsel for Intervenors: David Sanders, Gregg Adam.Receiver: Clark Kelso. Outside Counsel for Receiver: Jamie Dupree *(This is a text−only entry generated by the court. There is no document associated with this entry.)* (mllS, COURT STAFF) (Date Filed: 6/30/2021) (Entered: 06/30/2021)**
06/25/2021	3605	JOINT CASE MANAGEMENT STATEMENT filed by Gavin Newsom and Marciano Plata. (Attachments: # 1 Exhibit A−C)(Gille, Ryan) (Filed on 6/25/2021) Modified on 6/28/2021 (jmlS, COURT STAFF). (Entered: 06/25/2021)
06/15/2021	3604	STATUS REPORT −− *Defendants' June 2021 Status Report in Response to February 10, 2014 Order* by Gavin Newsom. (Attachments: # 1 Exhibit A to Defs' June 2021 Status Report, # 2 Exhibit B to Defs' June 2021 Status Report)(Gille, Ryan) (Filed on 6/15/2021) (Entered: 06/15/2021)
06/10/2021	3603	TRANSCRIPT ORDER for proceedings held on 05/27/2021 before Judge Jon S. Tigar by Gavin Newsom, for Court Reporter Pam Batalo. (Gille, Ryan) (Filed on 6/10/2021) (Entered: 06/10/2021)
06/10/2021	3602	Receipt #34611154794 for $275.00 with receipt date 06/10/2021 from State of California(rghS, COURT STAFF) (Filed on 6/10/2021) (Entered: 06/10/2021)
06/09/2021	3601	**Order by Judge Jon S. Tigar granting 3600 Stipulation Modifying Court Order (ECF No. 3492) re Staff Non−Compliance.(mllS, COURT STAFF) (Filed on 6/9/2021) (Entered: 06/09/2021)**
06/09/2021	3600	STIPULATION WITH PROPOSED ORDER *Modifying Court Order (ECF No. 3492) re Staff Non−Compliance* re 3492 Order filed by Gavin Newsom and Marciano Plata. (Gille, Ryan) (Filed on 6/9/2021) Modified on 6/9/2021 (jmlS, COURT STAFF). (Entered: 06/09/2021)
06/08/2021	3599	**ORDER GRANTING PAYMENT FOR COURT APPOINTED EXPERTS. Dr. Goldenson in the amount of $550.00. Signed by Judge Jon S. Tigar on June 8, 2021. (mllS, COURT STAFF) (Filed on 6/8/2021) (Entered: 06/08/2021)**
06/04/2021	3598	Transcript of Proceedings held on 05/27/2021, before Judge Tigar. Court Reporter Pamela Batalo Hebel, telephone number 626−688−7509; pamela_batalo−hebel@cand.uscourts.gov. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerk's Office public terminal or may be purchased through the Court Reporter/Transcriber until the deadline for the Release of Transcript Restriction. After that date it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this filing. (Re 3595 Transcript Order) Redaction Request due 6/25/2021. Redacted Transcript Deadline set for 7/6/2021. Release of Transcript Restriction set for 9/2/2021. (Related documents(s) 3595) (Batalo, Pam) (Filed on 6/4/2021) (Entered: 06/04/2021)

06/01/2021	3597	NOTICE *of Filing of Receiver's 47th Tri−Annual Report* by J. Clark Kelso (Dupree, Jamie) (Filed on 6/1/2021) Modified on 6/1/2021 (jmlS, COURT STAFF). (Entered: 06/01/2021)
05/28/2021	3596	**ORDER** Pursuant to the parties' agreement, the next joint case management shall be filed by June 25, 2021, at 5:00 p.m. Signed by Judge Jon S. Tigar on May 28, 2021. *(This is a text−only entry generated by the court. There is no document associated with this entry.)* (jstlc3, COURT STAFF) (Filed on 5/28/2021) (Entered: 05/28/2021)
05/28/2021	3595	TRANSCRIPT ORDER for proceedings held on 05/27/21 before Judge Jon S. Tigar by Ralph Coleman, for Court Reporter Pam Batalo. (Xu, Amy) (Filed on 5/28/2021) (Entered: 05/28/2021)
05/27/2021	3594	**Minute Entry for proceedings held before Judge Jon S. Tigar: Further Case Management Conference held on 5/27/2021. Hearing held via AT&T teleconference. The Court disclosed to parties that it visited Kern Valley State Prison on May 3, 2021. Further case management conference set. The parties are directed to file an updated case management statement at their convenience but no later than 5/28/2021.Parties will inform the Law Clerk assigned to the case when a case management statement will be filed. Further Case Management Conference set for 6/30/2021 02:00 PM in Oakland, − Videoconference Only. This proceeding will be held via a Zoom webinar.** **Webinar Access:** All counsel, members of the public, and media may access the webinar information at https://www.cand.uscourts.gov/jst **General Order 58.** Persons granted access to court proceedings held by telephone or videoconference are reminded that photographing, recording, and rebroadcasting of court proceedings, including screenshots or other visual copying of a hearing, is absolutely prohibited. **Zoom Guidance and Setup:** https://www.cand.uscourts.gov/zoom/. **Further Case Management Conference set for 6/30/2021 02:00 PM in Oakland, − Videoconference Only.Total Time in Court: 1 hour. Court Reporter: Pamela Hebel. Plaintiff Attorney: Donald Specter, Steven Fama, Alison Hardy, Sophie Hart.. Defendant Attorney: Samantha Wolff, Damon McClain, Ryan Gille, Iram Hasan. Intervenors: David Sanders, Gregg Adam.** **Receiver: Clark Kelso** **Outside Counsel for Receiver: Jamie Dupree *(This is a text−only entry generated by the court. There is no document associated with this entry.)* (mllS, COURT STAFF) (Date Filed: 5/27/2021) (Entered: 05/27/2021)**
05/27/2021	3593	CLERKS NOTICE SETTING TELEPHONIC HEARING. **Due to technical difficulties with the Zoom platform the Further Case Management Conference set for 5/27/2021 02:00 PM will be held via AT&T conference line. Please use the information below to access the hearing.** Further Case Management Conference set for 5/27/2021 02:00 PM in Oakland, − Telephonic Only. This proceeding will be held by AT&T Conference Line. The court circulates the following conference number to allow the equivalent of a public hearing by telephone. For conference line information, see: https://apps.cand.uscourts.gov/telhrg/ All counsel, members of the public and press please use the following dial−in information below to access the conference line: Dial In: 1(877) 336−1831 Access Code: 6116340 The Court may be in session with proceedings in progress when you connect to the conference line. Therefore, mute your phone if possible and wait for the Court to address you before speaking on the line. For call clarity, parties shall NOT use speaker phone or earpieces for these calls, and where at all possible, parties shall use landlines. PLEASE NOTE: Persons granted access to court proceedings held by telephone or videoconference are reminded that photographing, recording, and rebroadcasting of court proceedings, including screenshots or other visual copying of a hearing, is absolutely prohibited. See General Order 58 at Paragraph III.

		Further Case Management Conference set for 5/27/2021 02:00 PM in Oakland, − Telephonic Only. *(This is a text−only entry generated by the court. There is no document associated with this entry.)* (mllS, COURT STAFF) (Filed on 5/27/2021) (Entered: 05/27/2021)
05/25/2021	3592	Joint CASE MANAGEMENT STATEMENT filed by Gavin Newsom and Marciano Plata. (Attachments: # 1 Exhibit A−B)(Hasan, Iram) (Filed on 5/25/2021) Modified on 5/26/2021 (jmlS, COURT STAFF). (Entered: 05/25/2021)
05/24/2021	3591	STATUS REPORT *Preliminary Submission Regarding Mandatory Vaccinations* by California Correctional Peace Officers Association. (Adam, Gregg) (Filed on 5/24/2021) (Entered: 05/24/2021)
05/20/2021	3589	Receipt #34611154426 for $756.25 with receipt date 05/19/2021 from State of California. (rghS, COURT STAFF) (Filed on 5/20/2021) (Entered: 05/20/2021)
05/17/2021	3588	Defendants' May 2021 Status Report in Response to February 10, 2014 Order by Gavin Newsom. (Attachments: # 1 Exhibit A−B)(Gille, Ryan) (Filed on 5/17/2021) Modified on 5/18/2021 (bnsS, COURT STAFF). (Entered: 05/17/2021)
05/14/2021	3590	SUBMISSION OF STATEMENTS, FACTS AND DECLARATION in Support of Class Members Opposition to the Joint Case Management Statements Submitted by C.D.C.R., filed by Brian T. Hill. (Attachments: # 1 Envelope)(jlmS, COURT STAFF) (Filed on 5/14/2021) (Entered: 05/20/2021)
05/12/2021	3587	**ORDER GRANTING PAYMENT FOR COURT APPOINTED EXPERTS. Dr. Goldenson in the amount of $275.00. Signed by Judge Jon S. Tigar on May 12, 2021. (mllS, COURT STAFF) (Filed on 5/12/2021) (Entered: 05/12/2021)**
05/04/2021	3586	CLERK'S NOTICE DETERMINING THAT NO CASES ARE RELATED re MOTION to Relate Case 3578 . (mllS, COURT STAFF) (Filed on 5/4/2021) (Entered: 05/04/2021)
05/03/2021	3585	Transcript of Proceedings held on 04/29/2021, before Judge Tigar. Court Reporter Pamela Batalo Hebel, telephone number 626−688−7509; pamela_batalo−hebel@cand.uscourts.gov. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerk's Office public terminal or may be purchased through the Court Reporter/Transcriber until the deadline for the Release of Transcript Restriction. After that date it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this filing. (Re 3582 Transcript Order) Redaction Request due 5/24/2021. Redacted Transcript Deadline set for 6/3/2021. Release of Transcript Restriction set for 8/2/2021. (Related documents(s) 3582) (Batalo, Pam) (Filed on 5/3/2021) (Entered: 05/03/2021)
04/29/2021	3584	TRANSCRIPT ORDER for proceedings held on 04/29/2021 before Judge Jon S. Tigar by California Correctional Peace Officers Association, for Court Reporter Pam Batalo. (Adam, Gregg) (Filed on 4/29/2021) (Entered: 04/29/2021)
04/29/2021	3583	TRANSCRIPT ORDER for proceedings held on 04/29/21 before Judge Jon S. Tigar by Ralph Coleman, for Court Reporter Pam Batalo. (Xu, Amy) (Filed on 4/29/2021) (Entered: 04/29/2021)
04/29/2021	3582	TRANSCRIPT ORDER for proceedings held on 4/29/2021 before Judge Jon S. Tigar by Gavin Newsom, for Court Reporter Pam Batalo. (Gille, Ryan) (Filed on 4/29/2021) (Entered: 04/29/2021)
04/29/2021	3581	**Minute Entry for proceedings held before Judge Jon S. Tigar: Further Case Management Conference held on 4/29/2021. Hearing held via Zoom videoconference. Further case management conference set. Case Management Statement due by 5/25/2021 by 3:00 p.m. Further Case Management Conference set for 5/27/2021 02:00 PM in Oakland, − Videoconference Only. This proceeding will be held via a Zoom webinar.** **Webinar Access:** All counsel, members of the public, and media may access the webinar information at https://www.cand.uscourts.gov/jst **General Order 58.** Persons granted access to court proceedings held by telephone or videoconference are reminded that pho tographing, recording, and rebroadcasting of court proceedings, including screenshots or other visual copying of a hearing, is absolutely prohibited. **Zoom Guidance and Setup:** https://www.cand.uscourts.gov/zoom/. **Case Management Statement due by 5/25/2021. Further Case Management Conference set for 5/27/2021 02:00 PM in Oakland, − Videoconference Only.Total Time in Court: 53 minutes. Court Reporter: Pamela Hebel. Plaintiff Attorney: Donald Specter, Steven Fama, Alison Hardy, Sophie Hart. Defendant Attorney: Paul Mello, Samantha Wolff, Damon McClain, Ryan Gille, Iram**

		Hasan. Counsel for Intervenors: Gregg Adam, David Sanders. Receiver: Clark KelsoOutside Counsel for Receiver: Jamie Dupree. ***(This is a text−only entry generated by the court. There is no document associated with this entry.)*** **(mllS, COURT STAFF) (Date Filed: 4/29/2021) (Entered: 04/29/2021)**
04/27/2021	3580	CASE MANAGEMENT STATEMENT *Update on COVID−19 Mitigation Efforts* filed by California Correctional Peace Officers Association. (Adam, Gregg) (Filed on 4/27/2021) (Entered: 04/27/2021)
04/27/2021	3579	JOINT CASE MANAGEMENT STATEMENT filed by Marciano Plata and Gavin Newsom. (Attachments: # 1 Exhibit A, # 2 Exhibit B, # 3 Exhibit C)(Bixby, Laura) (Filed on 4/27/2021) Modified on 4/28/2021 (jmlS, COURT STAFF). (Entered: 04/27/2021)
04/27/2021	3578	MOTION to Relate Case filed by Daniel Ruiz, Daniel Ruiz, Jr, Fernando Vera, Vanessa Robinson, Santos Ruiz, Angelina Chavez. (Attachments: # 1 Declaration, # 2 Exhibit)(Haddad, Michael) (Filed on 4/27/2021) (Entered: 04/27/2021)
04/22/2021	3577	**ORDER GRANTING PAYMENT FOR COURT APPOINTED EXPERTS. Dr. Goldenson in the amount of $756.25. Signed by Judge Jon S. Tigar on April 22, 2021. (mllS, COURT STAFF) (Filed on 4/22/2021) (Entered: 04/22/2021)**
04/15/2021	3576	*Defendants' April 2021 Status Report in Response to February 10, 2014 Order* by Gavin Newsom. (Attachments: # 1 Exhibit A−B)(Gille, Ryan) (Filed on 4/15/2021) Modified on 4/16/2021 (jmlS, COURT STAFF). (Entered: 04/15/2021)
04/02/2021	3575	**ORDER FOR COLLECTION OF UNDISPUTED ATTORNEYS' FEES AND COSTS FOR FOURTH QUARTER OF 2020 by Judge Jon S. Tigar granting 3574 Stipulation.(mllS, COURT STAFF) (Filed on 4/2/2021) (Entered: 04/02/2021)**
04/01/2021	3574	STIPULATION WITH PROPOSED ORDER *FOR COLLECTION OF UNDISPUTED ATTORNEYS' FEES AND COSTS FOR FOURTH QUARTER 2020* filed by Marciano Plata and Gavin Newsom. (Hardy, Alison) (Filed on 4/1/2021) Modified on 4/2/2021 (jmlS, COURT STAFF). (Entered: 04/01/2021)
04/01/2021	3573	Transcript of Proceedings held on March 26, 2021, before Judge Jon S. Tigar. Court Reporter Diane E. Skillman, telephone number 925−899−2912, Diane_Skillman@cand.uscourts.gov. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerk's Office public terminal or may be purchased through the Court Reporter until the deadline for the Release of Transcript Restriction. After that date it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this filing. (Re 3569 Transcript Order) Release of Transcript Restriction set for 6/30/2021. (Related documents(s) 3569) (Skillman, Diane) (Filed on 4/1/2021) (Entered: 04/01/2021)
03/29/2021	3572	TRANSCRIPT ORDER for proceedings held on 03/26/2021 before Judge Jon S. Tigar by Gavin Newsom, for Court Reporter Diane Skillman. (Gille, Ryan) (Filed on 3/29/2021) (Entered: 03/29/2021)
03/29/2021	3571	TRANSCRIPT ORDER for proceedings held on 03/26/2021 before Judge Jon S. Tigar by California Correctional Peace Officers Association, for Court Reporter Diane Skillman. (Adam, Gregg) (Filed on 3/29/2021) (Entered: 03/29/2021)
03/29/2021	3570	**ORDER REGARDING MONITORING BY THE OFFICE OF THE INSPECTOR GENERAL. Signed by Judge Jon S. Tigar on March 29, 2021. (mllS, COURT STAFF) (Filed on 3/29/2021) (Entered: 03/29/2021)**
03/26/2021	3569	TRANSCRIPT ORDER for proceedings held on 03/26/21 before Judge Jon S. Tigar by Ralph Coleman, for Court Reporter Diane Skillman. (Shinn−Krantz, Marc) (Filed on 3/26/2021) (Entered: 03/26/2021)
03/26/2021	3568	**Minute Entry for proceedings held before Judge Jon S. Tigar: Further Case Management Conference held on 3/26/2021.Hearing held via Zoom videoconference. Joint Case Management Statement discussed. CDCR Representative, Charles Callahan, attended and addressed the Court's questions. Further case management conference set. Case Management Statement due by 4/27/2021. Further Case Management Conference set for 4/29/2021 09:00 AM in Oakland, − Videoconference Only. This proceeding will be held via a Zoom webinar.** **Webinar Access:** All counsel, members of the public, and media may access the webinar information at https://www.cand.uscourts.gov/jst **Gene ral Order 58.** Persons granted access to court proceedings held by telephone or videoconference are reminded that photographing, recording, and rebroadcasting of court proceedings, including

		screenshots or other visual copying of a hearing, is absolutely prohibited. **Zoom Guidance and Setup:** https://www.cand.uscourts.gov/zoom/. **Case Management Statement due by 4/27/2021. Further Case Management Conference set f or 4/29/2021 09:00 AM in Oakland, − Videoconference Only.Total Time in Court: 1 hour. Court Reporter: Diane Skillman. Plaintiff Attorney: Sophie Hart, Steve Fama, Sara Norman. Defendant Attorney: Paul Mello, Samantha Wolff, Damon McClain, Ryan Gille. Counsel for Intervenors: Gregg Adam, David Sanders.Outside Counsel for Receiver: Jamie DupreeReceiver: Clark Kelso** ***(This is a text−only entry generated by the court. There is no document associated with this entry.)*** **(mllS, COURT STAFF) (Date Filed: 3/26/2021) (Entered: 03/26/2021)**
03/25/2021	3567	STATUS REPORT *from CCPOA on COVID−19 Mitigation Efforts* by California Correctional Peace Officers Association. (Adam, Gregg) (Filed on 3/25/2021) (Entered: 03/25/2021)
03/24/2021	3566	CASE MANAGEMENT STATEMENT *Joint Case Management Conference Statement* filed by Gavin Newsom. (Attachments: # 1 Exhibit A−B)(Gille, Ryan) (Filed on 3/24/2021) (Entered: 03/24/2021)
03/15/2021	3564	*Defendants' March 2021 Status Report in Response to February 10, 2014 Order* by Gavin Newsom. (Attachments: # 1 Exhibit A−B)(Gille, Ryan) (Filed on 3/15/2021) Modified on 3/15/2021 (jmlS, COURT STAFF). (Entered: 03/15/2021)
03/09/2021	3563	Receipt #34611153374 for $1,500 received on 03/09/2021 from State of California. (rghS, COURT STAFF) (Filed on 3/9/2021) (Entered: 03/09/2021)
03/04/2021	3562	TRANSCRIPT ORDER for proceedings held on 03/04/21 before Judge Jon S. Tigar by Ralph Coleman, for Court Reporter Raynee Mercado. (Xu, Amy) (Filed on 3/4/2021) (Entered: 03/04/2021)
03/04/2021	3561	AMENDED Minute Entry for proceedings held before Judge Jon S. Tigar: Further Case Management Conference held on 3/4/2021. Hearing held via Zoom videoconference. Further case management conference set. Case Management Statement due by 3/24/2021 by 3:00 p.m. Further Case Management Conference set for 3/26/2021 02:30 PM in Oakland, − Videoconference Only. This proceeding will be held via a Zoom webinar. **Webinar Access:** All counsel, members of the public, and media may access the webinar information at https://www.cand.uscourts.gov/jst **General Order 58.** Persons granted access to court proceedings held by telephone or videoconference are reminded that photographing, recording, and rebroadcasting of court proceedings, including screenshots or other visual copying of a hearing, is absolutely prohibited. **Zoom Guidance and Setup:** https://www.cand.uscourts.gov/zoom/. Case Management Statement due by 3/24/2021. Further Case Management Conference set for 3/26/2021 02:30 PM in Oakland, − Videoconference Only. Total Time in Court: 1 hour. Court Reporter: Raynee Mercado. Plaintiff Attorney: Donald Specter, Steven Fama, Alison Hardy, Sophie Hart. Defendant Attorney: Paul Mello, Samantha Wolff, Damon McClain, Ryan Gille, Iram Hasan. Counsel for Intervenors: Gregg Adam, David Sanders. Receiver: Clark KelsoOutside Counsel for Receiver: Jamie Dupree(mllS, COURT STAFF) (Filed on 3/4/2021) (Entered: 03/04/2021)
03/04/2021	3560	TRANSCRIPT ORDER for proceedings held on 3/4/2021 before Judge Jon S. Tigar by Gavin Newsom, for Court Reporter Raynee Mercado. (Gille, Ryan) (Filed on 3/4/2021) (Entered: 03/04/2021)
03/04/2021	3559	*******ENTERED IN ERROR. SEE CORRECTED ENTRY AT ECF. 3561.****** Minute Entry for proceedings held before Judge Jon S. Tigar: Further Case Management Conference held on 3/26/2021. Hearing held via Zoom videoconference. Further case management conference set. This proceeding will be held via a Zoom webinar. **Webinar Access:** All counsel, members of the public, and media may access the webinar information at https://www.cand.uscourts.gov/jst **General Order 58.** Persons granted access to court proceedings held by telephone or videoconference are reminded that photographing, recording, and rebroadcasting of court proceedings, including screenshots or other visual copying of a hearing, is absolutely prohibited.

		Zoom Guidance and Setup: https://www.cand.uscourts.gov/zoom/. Total Time in Court: 1 hour. Court Reporter: Raynee Mercado. Plaintiff Attorney: Donald Specter, Steven Fama, Alison Hardy, Sophie Hart. Defendant Attorney: Paul Mello, Samantha Wolff, Damon McClain, Ryan Gille, Iram Hasan. Counsel for Intervenors: Gregg Adam, David Sanders. Receiver: Clark KelsoOutside Counsel for Receiver: Jamie Dupree *(This is a text−only entry generated by the court. There is no document associated with this entry.)* (mllS, COURT STAFF) (Date Filed: 3/4/2021) Modified on 3/4/2021 (mllS, COURT STAFF). Modified on 3/4/2021 (mllS, COURT STAFF). (Entered: 03/04/2021)
03/02/2021	3558	JOINT CASE MANAGEMENT STATEMENT filed by Marciano Plata and Gavin Newsom. (Attachments: # 1 Exhibit A, # 2 Exhibit B)(Hart, Sophie) (Filed on 3/2/2021) Modified on 3/3/2021 (jmlS, COURT STAFF). (Entered: 03/02/2021)
03/02/2021	3557	TRANSCRIPT ORDER for proceedings held on 2/16/2021 before Judge Jon S. Tigar by Gavin Newsom, for Court Reporter Diane Skillman. (Gille, Ryan) (Filed on 3/2/2021) (Entered: 03/02/2021)
03/02/2021	3556	STATUS REPORT *Update from CCPOA on COVID−19 Mitigation Efforts* by California Correctional Peace Officers Association. (Adam, Gregg) (Filed on 3/2/2021) (Entered: 03/02/2021)
03/01/2021	3555	NOTICE of Change In Counsel by Gregg McLean Adam, Esq (Adam, Gregg) (Filed on 3/1/2021) (Entered: 03/01/2021)
02/18/2021	3554	**ORDER GRANTING PAYMENT FOR COURT APPOINTED EXPERTS. Ms. LaMarre in the amount of $400.00, Dr. Goldenson in the amount of $1,100.00. Signed by Judge Jon S. Tigar on February 18, 2021. (mllS, COURT STAFF) (Filed on 2/18/2021) (Entered: 02/18/2021)**
02/17/2021	3553	Transcript of Proceedings held on February 16, 2021, before Judge Jon S. Tigar. Court Reporter Diane E. Skillman, telephone number 925−899−2912, Diane_Skillman@cand.uscourts.gov. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerk's Office public terminal or may be purchased through the Court Reporter until the deadline for the Release of Transcript Restriction. After that date it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this filing. (Re 3551 Transcript Order) Release of Transcript Restriction set for 5/18/2021. (Related documents(s) 3551) (Skillman, Diane) (Filed on 2/17/2021) (Entered: 02/17/2021)
02/16/2021	3552	*Defendants' February 2021 Status Report in Response to February 10, 2014 Order* by Gavin Newsom. (Attachments: # 1 Exhibit A−B)(Gille, Ryan) (Filed on 2/16/2021) Modified on 2/17/2021 (jmlS, COURT STAFF). (Entered: 02/16/2021)
02/16/2021	3551	TRANSCRIPT ORDER for proceedings held on 02/16/21 before Judge Jon S. Tigar by Ralph Coleman, for Court Reporter Diane Skillman. (Xu, Amy) (Filed on 2/16/2021) (Entered: 02/16/2021)
02/16/2021	3550	**Minute Entry for proceedings held before Judge Jon S. Tigar: Further Case Management Conference held on 2/16/2021. Hearing held via Zoom videoconference. Case management statement discussed. Further case management conference set. Case Management Statement due by 3/2/2021 by 3:00 p.m. Further Case Management Conference set for 3/4/2021 10:00 AM in Oakland, − Videoconference Only. This proceeding will be held via a Zoom webinar.** **Webinar Access:** All counsel, members of the public, and media may access the webinar information at https://www.cand.uscourts.gov/jst **General Order 58.** Persons granted access to court proceedings held by telephone or vi deoconference are reminded that photographing, recording, and rebroadcasting of court proceedings, including screenshots or other visual copying of a hearing, is absolutely prohibited. **Zoom Guidance and Setup:** https://www.cand.uscourts.gov/zoom/. **Case Management Statement due by 3/2/2021. Further Case Management Conference set for 3/4/2021 10:00 AM in Oakland, − Videoconference Only.Total Time in Court: 1 hour 6 minutes. Court Reporter: Diane Skillman.** Attorneys for Plaintiffs: Donald Specter, Steven Fama, Alison Hardy, Sophie Hart Attorneys for Defendants: Paul Mello, Samantha Wolff, Damon McClain, Ryan Gille, Iram Hasan Counsel for Intervenors: Gregg Adam, David Sanders Receiver: Clark Kelso Outside Counsel for Receiver: Jamie Dupree

		(This is a text−only entry generated by the court. There is no document associated with this entry.) (mllS, COURT STAFF) (Date Filed: 2/16/2021) (Entered: 02/16/2021)
02/12/2021	3549	Receipt in the amount of $756.25 from State of California. Received on 02/11/2021. Receipt #34611153012 (rghS, COURT STAFF) (Filed on 2/12/2021) (Entered: 02/12/2021)
02/12/2021	3548	CASE MANAGEMENT STATEMENT filed by Gavin Newsom and Marciano Plata. (Attachments: # 1 Exhibit A)(Wolff, Samantha) (Filed on 2/12/2021) Modified on 2/12/2021 (jmlS, COURT STAFF). (Entered: 02/12/2021)
02/02/2021	3547	**ORDER APPOINTING ADVISORY BOARD MEMBER. Signed by Judge Jon S. Tigar on February 2, 2021. (mllS, COURT STAFF) (Filed on 2/2/2021) (Entered: 02/02/2021)**
02/01/2021	3546	NOTICE *of Filing of Receiver's 46th Tri−Annual Report* by J. Clark Kelso (Dupree, Jamie) (Filed on 2/1/2021) Modified on 2/1/2021 (jmlS, COURT STAFF). (Entered: 02/01/2021)
01/28/2021	3545	Transcript of Proceedings held on 01/28/2021, before Judge Tigar. Court Reporter Pamela Batalo Hebel, telephone number 626−688−7509; pamela_batalo−hebel@cand.uscourts.gov. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerk's Office public terminal or may be purchased through the Court Reporter/Transcriber until the deadline for the Release of Transcript Restriction. After that date it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this filing. (Re 3542 Transcript Order) Redaction Request due 2/18/2021. Redacted Transcript Deadline set for 3/1/2021. Release of Transcript Restriction set for 4/28/2021. (Related documents(s) 3542) (Batalo, Pam) (Filed on 1/28/2021) (Entered: 01/28/2021)
01/28/2021	3544	TRANSCRIPT ORDER for proceedings held on 01/28/2021 before Judge Jon S. Tigar by California Correctional Peace Officers Association, for Court Reporter Pam Batalo. (Adam, Gregg) (Filed on 1/28/2021) (Entered: 01/28/2021)
01/28/2021	3543	TRANSCRIPT ORDER for proceedings held on 01/28/21 before Judge Jon S. Tigar by Ralph Coleman, for Court Reporter Pam Batalo. (Xu, Amy) (Filed on 1/28/2021) (Entered: 01/28/2021)
01/28/2021	3542	TRANSCRIPT ORDER for proceedings held on January 28, 2021 before Judge Jon S. Tigar by Gavin Newsom, for Court Reporter Pam Batalo. (Wolff, Samantha) (Filed on 1/28/2021) (Entered: 01/28/2021)
01/28/2021	3541	**Minute Entry for proceedings held before Judge Jon S. Tigar: Further Case Management Conference held on 1/28/2021. Hearing held via Zoom videoconference. Case management statement discussed. Case Management Statement due by 2/12/2021 by 3:00 p.m. Further Case Management Conference set for 2/16/2021 10:00 AM in Oakland, − Videoconference Only. This proceeding will be held via a Zoom webinar.** **Webinar Access:** All counsel, members of the public, and media may access the webinar information at https://www.cand.uscourts.gov/jst **General Order 58.** Persons granted access to court proceedings held by telephone or videoconference are reminded that photog raphing, recording, and rebroadcasting of court proceedings, including screenshots or other visual copying of a hearing, is absolutely prohibited. **Zoom Guidance and Setup:** htt ps://www.cand.uscourts.gov/zoom/. **Case Management Statement due by 2/12/2021. Further Case Management Conference set for 2/16/2021 10:00 AM in Oakland, − Videoconference Only.Total Time in Court: 1 hour 27 minutes. Court Reporter: Pamela Hebel.** Attorneys for Plaintiffs: Donald Specter, Steven Fama, Alison Hardy, Sophie Hart Attorneys for Defendants: Paul Mello, Samantha Wolff, Damon McClain, Ryan Gille, Iram Hasan Counsel for Intervenors: Gregg Adam, David Sanders Receiver: Clark Kelso Outside Counsel for Receiver: Jamie Dupree *(This is a text−only entry generated by the court. There is no document associated with this entry.)* (mllS, COURT STAFF) (Date Filed: 1/28/2021) (Entered: 01/28/2021)
01/27/2021	3540	AMICUS CURIAE CALIFORNIA CORRECTIONAL PEACE OFFICERS ASSOCIATIONS UPDATE REGARDING MASK WEARING AND CUSTODY STAFF by California Correctional Peace Officers Association. (Adam, Gregg) (Filed on 1/27/2021) Modified on 1/28/2021 (cjlS, COURT STAFF). (Entered: 01/27/2021)

01/26/2021	3539	JOINT CASE MANAGEMENT STATEMENT filed by Marciano Plata and Gavin Newsom. (Hart, Sophie) (Filed on 1/26/2021) Modified on 1/27/2021 (jmlS, COURT STAFF). (Entered: 01/26/2021)
01/16/2021	3538	Transcript of Proceedings held on January 14, 2021, before Judge Jon S. Tigar. Court Reporter Diane E. Skillman, telephone number 925−899−2912, Diane_Skillman@cand.uscourts.gov. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerk's Office public terminal or may be purchased through the Court Reporter until the deadline for the Release of Transcript Restriction. After that date it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this filing. (Re 3534 Transcript Order) Release of Transcript Restriction set for 4/16/2021. (Related documents(s) 3534) (Skillman, Diane) (Filed on 1/16/2021) (Entered: 01/16/2021)
01/15/2021	3537	*Defendants' January 2021 Status Report in Response to February 10, 2014 Order* by Gavin Newsom. (Attachments: # 1 Exhibit A−B)(Gille, Ryan) (Filed on 1/15/2021) Modified on 1/19/2021 (jmlS, COURT STAFF). (Entered: 01/15/2021)
01/15/2021	3536	NOTICE *of Parties' Filing Schedule for January 28,2021 Case Management Conference* by Gavin Newsom and Marciano Plata. (Wolff, Samantha) (Filed on 1/15/2021) Modified on 1/19/2021 (jmlS, COURT STAFF). (Entered: 01/15/2021)
01/15/2021	3535	TRANSCRIPT ORDER for proceedings held on 01/14/21 before Judge Jon S. Tigar by Ralph Coleman, for Court Reporter Diane Skillman. (Xu, Amy) (Filed on 1/15/2021) (Entered: 01/15/2021)
01/14/2021	3534	TRANSCRIPT ORDER for proceedings held on 1/14/2021 before Judge Jon S. Tigar by Gavin Newsom, for Court Reporter Diane Skillman. (Gille, Ryan) (Filed on 1/14/2021) (Entered: 01/14/2021)
01/14/2021	3533	Receipt in the amount of $1,018.75 from State of California. Received on 01/14/2021. Receipt #34611152577(rghS, COURT STAFF) (Filed on 1/14/2021) (Entered: 01/14/2021)
01/14/2021	3532	**Minute Entry for proceedings held before Judge Jon S. Tigar: Further Case Management Conference held on 1/14/2021. Hearing held via Zoom videoconference. Parties are to meet and confer and submit a joint schedule detailing when information will be exchanged between the parties. Joint Information Sharing Schedule due 1/15/2021 by 5:00 p.m. Case Management Statement due by 1/26/2021 by 3:00 p.m. Further Case Management Conference set for 1/28/2021 10:00 AM in Oakland, − Videoconference Only. This proceeding will be held via a Zoom webinar.** **Webinar Access:** All counsel, members of the public, and media may access the webinar information at https://www.cand.uscour ts.gov/jst **General Order 58.** Persons granted access to court proceedings held by telephone or videoconference are reminded that photographing, recording, and rebroadcasting of court proceedings, including screenshots or other visual copying of a hearing, is absolutely prohibited. **Zoom Guidance and Setup:** https://www.cand.uscourts.gov/zoom/. **Case Management Statement due by 1/26/2021. Status Repo rt due by 1/15/2021. Further Case Management Conference set for 1/28/2021 10:00 AM in Oakland, − Videoconference Only.Total Time in Court: 2 hours 2 minutes. Court Reporter: Diane Skillman.** Attorneys for Plaintiffs: Donald Specter, Steven Fama, Alison Hardy, Sophie Hart, Sara Norman Attorneys for Defendants: Paul Mello,Samantha Wolff, Damon McClain, Ryan Gille Counsel for Intervenors: Gregg Adam, David Sanders Receiver: Clark Kelso Outside Counsel for Receiver: Martin Dodd, Jamie Dupree *(This is a text−only entry generated by the court. There is no document associated with this entry.)* (mllS, COURT STAFF) (Date Filed: 1/14/2021) (Entered: 01/14/2021)
01/13/2021	3531	Proposed Order *on Quarantine Space* by Marciano Plata. (Norman, Sara) (Filed on 1/13/2021) (Entered: 01/13/2021)
01/13/2021	3530	JOINT CASE MANAGEMENT STATEMENT filed by Gavin Newsom and Marciano Plata. (Attachments: # 1 Exhibit 1 and 2, # 2 Declaration of Connie Gipson, # 3 Exhibit F and G to Declaration of Connie Gipson)(Gille, Ryan) (Filed on 1/13/2021) Modified on 1/14/2021 (jmlS, COURT STAFF). (Entered: 01/13/2021)
01/13/2021	3529	Letter from Amicus Curiae CCPOA *re Vaccinations*. (Adam, Gregg) (Filed on 1/13/2021) (Entered: 01/13/2021)

01/12/2021	3528	**ORDER GRANTING PAYMENT FOR COURT APPOINTED EXPERTS. Dr. Goldenson in the amount of $756.25. Signed by Judge Jon S. Tigar on January 12, 2021. (mllS, COURT STAFF) (Filed on 1/12/2021) (Entered: 01/12/2021)**
01/07/2021	3527	**ORDER by Judge Jon S. Tigar Granting 3525 STIPULATION FOR COLLECTION OF UNDISPUTED ATTORNEYS' FEES AND COSTS FOR THIRD QUARTER OF 2020.(amgS, COURT STAFF) (Filed on 1/7/2021) (Entered: 01/07/2021)**
01/06/2021		Electronic filing error. Incorrect event used. [err101] The correct event is Stipulation and Proposed Order. The correct event can be found at: Civil Events > Motions and Rela ted Filings > Stipulations > Stipulation and Proposed Order. **Corrected by Clerk's Office. No further action is necessary.** Re: 3525 Proposed Order filed by Marciano Plata (jmlS, COURT STAFF) (Filed on 1/6/2021) (Entered: 01/07/2021)
01/06/2021	3525	STIPULATION WITH PROPOSED ORDER *FOR COLLECTION OF UNDISPUTED ATTORNEYS' FEES AND COSTS FOR THIRD QUARTER OF 2020* by Marciano Plata and Gavin Newsom. (Hardy, Alison) (Filed on 1/6/2021) Modified on 1/7/2021 (jmlS, COURT STAFF). (Entered: 01/06/2021)
01/04/2021	3524	TRANSCRIPT ORDER for proceedings held on 12/23/2020 before Judge Jon S. Tigar by Gavin Newsom, for Court Reporter Raynee Mercado. (Gille, Ryan) (Filed on 1/4/2021) (Entered: 01/04/2021)
12/23/2020	3523	**ORDER RE: QUARANTINE SPACE. Signed by Judge Jon S. Tigar on December 23, 2020. (mllS, COURT STAFF) (Filed on 12/23/2020) (Entered: 12/23/2020)**
12/23/2020	3522	TRANSCRIPT ORDER for proceedings held on 12/23/20 before Judge Jon S. Tigar by Ralph Coleman, for Court Reporter Raynee Mercado. (Xu, Amy) (Filed on 12/23/2020) (Entered: 12/23/2020)
12/23/2020	3521	**Minute Entry for proceedings held before Judge Jon S. Tigar: Further Case Management Conference held on 12/23/2020. Hearing held via Zoom videoconference. The Court informed parties of ex parte contact with Professor Elizabeth Linos. Argument heard from parties regarding 3502 MOTION Joint Brief on Quarantine. Motion taken under submission. Written order to issue.** Attorneys for Plaintiffs:Donald Specter,Steven Fama,Alison Hardy,Sophie Hart,Sara Norman Attorneys for Defendants:Paul Mello,Samantha Wolff,Damon McClain,Ryan Gille,Iram Hasan Counsel for Intervenors:Gregg Adam,David Sanders Receiver:Clark Kelso Outside Counsel for Receiver:Martin Dodd,Jamie Dupree Total Time in Court: 1 hour 50 minutes. Court Reporter: Raynee Mercado. *(This is a text−only entry generated by the court. There is no document associated with this entry.)* (mllS, COURT STAFF) (Date Filed: 12/23/2020) (Entered: 12/23/2020)
12/22/2020	3520	JOINT CASE MANAGEMENT STATEMENT filed by Marciano Plata and Gavin Newsom. (Attachments: # 1 Exhibit A)(Hart, Sophie) (Filed on 12/22/2020) Modified on 12/23/2020 (jmlS, COURT STAFF). (Entered: 12/22/2020)
12/17/2020	3519	Receipt in the amount of $756.25 from State of California FBO Gray Davis; Date receipt issued on 12/15/2020 with receipt # 34611152119 (rghS, COURT STAFF) (Filed on 12/17/2020) (Entered: 12/17/2020)
12/15/2020	3518	*Defendants' December 2020 Status Report in Response to February 10, 2014 Order* by Gavin Newsom. (Attachments: # 1 Exhibit A, # 2 Exhibit B)(Gille, Ryan) (Filed on 12/15/2020) Modified on 12/16/2020 (jmlS, COURT STAFF). (Entered: 12/15/2020)
12/15/2020	3517	**ORDER GRANTING PAYMENT FOR COURT APPOINTED EXPERTS. Ms. LaMarre in the amount of $400.00, Dr. Goldenson in the amount of $618.75. Signed by Judge Jon S. Tigar on December 15, 2020. (mllS, COURT STAFF) (Filed on 12/15/2020) (Entered: 12/15/2020)**
12/14/2020	3516	NOTICE of Appearance by Iram Hasan (Hasan, Iram) (Filed on 12/14/2020) (Entered: 12/14/2020)
12/11/2020	3515	Transcript of Proceedings held on 12/10/2020, before Judge Tigar. Court Reporter Pamela Batalo Hebel, telephone number 626−688−7509; pamela_batalo−hebel@cand.uscourts.gov. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerk's Office public terminal or may be purchased through the Court Reporter/Transcriber until the deadline for the Release of Transcript Restriction. After that date it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this filing. (Re 3513 Transcript Order) Redaction Request due 1/4/2021. Redacted Transcript Deadline set for 1/11/2021. Release of Transcript Restriction set for 3/11/2021. (Related documents(s) 3513) (Batalo, Pam) (Filed

		on 12/11/2020) (Entered: 12/11/2020)
12/10/2020	3514	TRANSCRIPT ORDER for proceedings held on 12/10/2020 before Judge Jon S. Tigar by Gavin Newsom, for Court Reporter Pam Batalo. (Gille, Ryan) (Filed on 12/10/2020) (Entered: 12/10/2020)
12/10/2020	3513	TRANSCRIPT ORDER for proceedings held on 12/10/20 before Judge Jon S. Tigar by Ralph Coleman, for Court Reporter Pam Batalo. (Xu, Amy) (Filed on 12/10/2020) (Entered: 12/10/2020)
12/10/2020	3512	**Minute Entry for proceedings held before Judge Jon S. Tigar: Further Case Management Conference held on 12/10/2020.Total Time in Court: 40 minutes. Court Reporter: Pamela Hebel. Attachment: minute order. (mllS, COURT STAFF) (Date Filed: 12/10/2020) (Entered: 12/10/2020)**
12/10/2020	3511	**ORDER RELATING CASE 20−cv−08289−YGR to 01−cv−01351−JST. Signed by Judge Jon S. Tigar on December 10, 2020. (mllS, COURT STAFF) (Filed on 12/10/2020)** **Any non−CM/ECF Participants have been served by First Class Mail to the addresses of record listed on the Notice of Electronic Filing (NEF)** **(Entered: 12/10/2020)**
12/10/2020	3510	CLERKS NOTICE SETTING ZOOM HEARING. The motion hearing scheduled for 12/23/2020 at 2:00 p.m. is advanced and rescheduled to coincide with the motion hearing and case management conference set by ECF. 3488. Motion Hearing set for 12/23/2020 **10:00 AM** in Oakland, − Videoconference Only before Judge Jon S. Tigar. This proceeding will be held via a Zoom webinar. **Webinar Access:** All counsel, members of the public, and media may access the webinar information at https://www.cand.uscourts.gov/jst **11General Order 58.** Persons granted access to court proceedings held by telephone or videoconference are reminded that photographing, recording, and rebroadcasting of court proceedings, including screenshots or other visual copying of a hearing, is absolutely prohibited. **Zoom Guidance and Setup:** https://www.cand.uscourts.gov/zoom/. , Set/Reset Deadlines as to 3502 MOTION Joint Brief on Quarantine . Motion Hearing set for 12/23/2020 10:00 AM in Oakland, − Videoconference Only before Judge Jon S. Tigar. *(This is a text−only entry generated by the court. There is no document associated with this entry.)* (mllS, COURT STAFF) (Filed on 12/10/2020) Modified on 12/10/2020 (mllS, COURT STAFF). (Entered: 12/10/2020)
12/09/2020		Electronic filing error. Incorrect event used. [err101] The correct event is Brief. The correct event can be found at: Civil Events > Motions and Related Filings > Other Sup porting Documents > Brief. **Corrected by Clerk's Office. No further action is necessary.** Re: 3502 MOTION Joint Brief on Quarantine filed by Marciano Plata (jmlS, COURT STAFF) (Filed on 12/9/2020) (Entered: 12/10/2020)
12/09/2020	3509	Proposed Order re 3502 MOTION Joint Brief on Quarantine by Gavin Newsom. (Mello, Paul) (Filed on 12/9/2020) (Entered: 12/09/2020)
12/09/2020	3508	DECLARATION of Connie Gipson in Opposition to 3502 MOTION Joint Brief on Quarantine filed byGavin Newsom. (Attachments: # 1 Exhibit A A to the Declaration of Connie Gipson In Support of Defendants' Opposition to Plaintiffs' Posiiton On Quarantine In Housing Units with Shared Air Space, # 2 Exhibit B to the Declaration of Connie Gipson In Support of Defendants' Opposition to Plaintiffs' Posiiton On Quarantine In Housing Units with Shared Air Space, # 3 Exhibit C to the Declaration of Connie Gipson In Support of Defendants' Opposition to Plaintiffs' Posiiton On Quarantine In Housing Units with Shared Air Space, # 4 Exhibit D to the Declaration of Connie Gipson In Support of Defendants' Opposition to Plaintiffs' Posiiton On Quarantine In Housing Units with Shared Air Space, # 5 Exhibit E to the Declaration of Connie Gipson In Support of Defendants' Opposition to Plaintiffs' Posiiton On Quarantine In Housing Units with Shared Air Space)(Related document(s) 3502) (Mello, Paul) (Filed on 12/9/2020) (Entered: 12/09/2020)
12/09/2020	3507	OBJECTIONS to re 3504 Declaration in Support *DEFENDANTS' OBJECTIONS TO THE DECLARATION OF ADAM LAURING M.D., Ph.D., IN SUPPORT OF PLAINTIFFS' POSITION ON QUARANTINE IN HOUSING UNITS WITH COMMON AIR SPACE* by Gavin Newsom. (Wolff, Samantha) (Filed on 12/9/2020) (Entered: 12/09/2020)
12/09/2020	3506	DECLARATION of Ryan Gille in Opposition to 3502 MOTION Joint Brief on Quarantine filed byGavin Newsom. (Attachments: # 1 Exhibit A, # 2 Errata B, # 3 Exhibit C)(Related document(s) 3502) (Wolff, Samantha) (Filed on 12/9/2020) (Entered: 12/09/2020)