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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' RESPONSE TO ORDER TO SHOW CAUSE REGARDING RECEIVER'S MANDATORY COVID-19 VACCINE POLICY** Date: September 24, 2021 Time: 9:30 a.m. Crtrm: 6, 2nd Floor Judge: The Honorable Jon S. Tigar Action Filed: April 5, 2001

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INTRODUCTION

Since the beginning of the COVID-19 pandemic, California state officials, including Defendants, have been national leaders in sounding the alarm about the harmful effects of COVID-19, focusing attention on the undisputed public health guidance that vaccination is the most powerful protection against it, and organizing some of the most successful efforts in the nation to vaccinate the population, incarcerated and otherwise. Indeed, under the leadership of Governor Newsom, the Secretary of CDCR, and the Receiver, Defendants led the nation in prioritizing the early vaccination of incarcerated people with the most effective COVID-19 vaccines in the world. Their determination to protect the health and safety of incarcerated people has yielded impressive results. To date, virtually every incarcerated person has been offered this simple and effective medical treatment that greatly reduces the risk of infection, serious illness, hospitalization, and death.[1] Unlike other state prison systems that de-prioritized their incarcerated population for vaccination when vaccines were scarce, CDCR started these efforts at the earliest possible time after the vaccine became available, has continuously advised incarcerated people of the benefits of vaccination and the dangers of remaining unvaccinated, and continues to encourage those who initially refused the vaccine to accept it. Yet, despite these efforts, and the determined efforts of the attorneys representing them in this 20-year-long class-action litigation, about 22 percent of the incarcerated population remains unvaccinated today. And, with very limited exception, it is because those incarcerated people have chosen not to heed undisputed public health guidance, the advice of the Receiver and medical staff at the prisons, and the advice of their own attorneys.

The Prison Litigation Reform Act (PLRA) mandates that any prospective relief must be necessary to correct a constitutional violation. The Court must make these findings before it can enter the relief it is presently contemplating—an order mandating the vaccination of all who work in the State's prisons. Specifically, the Court must find that the State's efforts to address the

[1] Those who have not been offered the vaccine are almost entirely either out-to-court and thus not physically present in a CDCR institution, or are new arrivals at a Reception Center and are pending a vaccine offer. Declaration of Diana Toche (Decl. Toche) at ¶ 11.

COVID-19 pandemic, including the offer of vaccination against the virus to virtually every incarcerated person and extensive efforts to persuade hesitant patients for their own safety, have fallen short of constitutional requirements, and that the State has been deliberately indifferent to the objective threat posed by the virus. Neither the Court's Order to Show Cause nor the Receiver's proposed policy present such a finding. Nor can they, because an incarcerated person's choice to refuse an effective medical treatment that would protect them from the virus does not amount to deliberate indifference on the part of the State. Nor do Defendants' monumental, nation-leading efforts to develop and implement myriad evidence-based COVID-19 mitigation strategies in partnership with the Receiver to keep the incarcerated population safe.[2] And because Defendants are anything but deliberately indifferent to the threat of COVID-19, there is no constitutional violation to be remedied; therefore, the contemplated relief is not appropriate. Accordingly, the PLRA precludes the Court from ordering CDCR to implement the Receiver's proposed mandatory vaccination policy.

The PLRA also precludes the Court from ordering the implementation of the proposed policy because it is not narrowly drawn, extends further than necessary, and is not the least intrusive means to achieve its stated goal. Here, the Receiver's report in support of the proposed policy entirely omits the undisputed fact that the best protection for class members against COVID-19 is for those class members themselves to get vaccinated. (Declaration of JamesWatt, MD, MPH (Decl. Watt) at ¶ 18.) But despite the clear protection against COVID-19 that being vaccinated provides to an inmate, 22 percent of the inmate population have at this point declined to follow this important healthcare measure. The Receiver's proposed solution for protecting incarcerated people—forcing the vaccination of those who work near them rather than ensuring that they are all vaccinated—is not narrowly drawn, extends further than necessary, and is not the least intrusive means of achieving his stated goal. In short, the proposed policy ignores the most

[2] Defendants' patient-vaccination efforts are in addition to myriad safety measures that were previously implemented or that remain in place, including, for example, mask mandates for staff and incarcerated people, social distancing requirements, quarantine and isolation protocols, stringent transfer and movement protocols, reduced county jail intake, and a 22 percent reduction in population.

effective and direct means of protecting incarcerated people. Accordingly, this Court lacks authority to order the implementation of the Receiver's proposed policy.

RELEVANT PROCEDURAL HISTORY

On August 4, 2021, the Receiver filed a report recommending that access to CDCR's institutions be limited only to staff who provide proof of vaccination, or who have established a religious or medical exemption from vaccination. ECF No. 3638. The report also recommends that incarcerated people who choose to work outside institutions or accept in-person visits must be vaccinated or establish a religious or medical exemption. *Id.* On August 9, 2021, this Court issued an order to show cause as to why it should not order CDCR to implement the Receiver's recommended policy. ECF No. 3647. On August 20, 2021, the Court issued an order modifying its August 9, 2021 order to show cause. ECF No. 3653. On August 25, 2021, in accordance with the August 20, 2021 order, Defendants filed a statement explaining how CDCR will implement the California Department of Public Health's (CDPH) August 19, 2021 public health order. ECF No. 3657.

To date, Plaintiffs have filed no motions requesting the relief the Court is contemplating. Nor have Plaintiffs ever sought formal court intervention to mandate vaccination of inmates who refuse vaccination, despite repeatedly emphasizing that "[v]accination against COVID-19, especially for those at heightened risk of serious complications or death if infected, is essential." ECF No. 3530 at 3. Moreover, this Court has not made the requisite findings that Defendants' response to the COVID-19 pandemic violates federal law or that the Receiver's recommended policy satisfies the Prison Litigation Reform Act's needs-narrowness-intrusiveness requirement.

ARGUMENT

I. THIS COURT LACKS THE AUTHORITY UNDER THE PRISON LITIGATION REFORM ACT TO ORDER PROSPECTIVE RELIEF BECAUSE DEFENDANTS' RESPONSE TO THE COVID-19 PANDEMIC IS REASONABLE AND DOES NOT VIOLATE CLASS MEMBERS' RIGHTS.

A court may only order prospective relief with respect to prison conditions when "necessary to correct the violation of the Federal right of a particular plaintiff or plaintiffs."

Prison Litigation Reform Act, 18 U.S.C. § 3626(a)(1)(A). To demonstrate a violation, Plaintiffs must prove that Defendants' response to the COVID-19 pandemic amounts to "deliberate indifference to serious medical needs." *Estelle v. Gamble*, 429 U.S. 97, 104 (1976). The Eighth Amendment analysis requires both objective proof that incarcerated people face a substantial risk of serious harm, and evidence of the defendants' state of mind about that substantial deprivation. *Farmer v. Brennan*, 511 U.S. 825, 837 (1994). A prison official acts with deliberate indifference when he is "aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference." *Id*. When officials respond reasonably to a risk of harm, there is no Eighth Amendment violation even if the harm is not averted. *Id*. at 844.

Precisely because the COVID-19 pandemic presents a substantial risk of serious harm, Defendants have responded by implementing the extensive safety measures discussed below, continuing to enforce many of those measures to date, and developing new measures as needed and as called for by evolving public health guidance. Under the second, subjective prong of the deliberate indifference analysis, prison officials must know of and disregard "an excessive risk to inmate health or safety" for the court to find a violation of a federal right. *Farmer*, 511 U.S. at 837. The state of mind required for deliberate indifference equates to the *mens rea* element for criminal recklessness. *Id*. at 839-40. Accordingly, courts must "focus[] on what a defendant's mental attitude actually was (or is), rather than what it should have been (or should be)." *Id*. at 839. This standard is exacting, and courts have rejected attempts to dilute it. *See Estelle*, 429 U.S. at 106-08 ("insufficient treatment, malpractice, or negligence does not amount to a constitutional violation."). This exacting standard cannot be satisfied on the record before the Court. And in the absence of a finding that Defendants' response to the COVID-19 pandemic violated class members' rights, this Court lacks the authority to order prospective relief under the PLRA. 18 U.S.C. § 3626(a)(1).

A. Defendants Cannot Be Deliberately Indifferent Because a Portion of the Incarcerated Population Refuses the Safe and Effective Vaccines that CDCR Offered to Them.

Deliberate indifference may result from a prison official's denial, delay, or intentional interference with medical treatment. *Hutchinson v. U.S.*, 838 F.2d 390, 394 (9th Cir. 1988) (citing *Estelle*, 429 U.S. at 104-05). But an incarcerated person's refusal to accept, comply with, or participate in medical treatment does not demonstrate deliberate indifference on the part of the prison's medical providers. *See Zatko v. Rowland*, 835 F. Supp. 1174, 1170 (N.D. Cal. 1993) (no deliberate indifference where the patient refused medical treatment, was noncompliant, and impeded his own recovery); *Smith v. Warden, Belmont Corr. Inst.,* No. 2:20-CV-5830, 2021 WL 2689613, at *3 (S.D. Ohio June 8, 2021), report and recommendation adopted, No. 2:20-CV-5830, 2021 WL 2688602 (S.D. Ohio June 30, 2021) (no deliberate indifference to the risks of COVID-19 where patient was offered vaccine); *Olson v. Finley, et al*., No. 1:21-CV-387, 2021 WL 3083495, at *9 (M.D. Pa. Apr. 27, 2021), *report and recommendation adopted sub nom. Olson v. Finley*, No. 1:21-CV-387, 2021 WL 3077548 (M.D. Pa. July 21, 2021) (no deliberate indifference to COVID-19 where patient refused to cooperate with vaccination efforts).

Defendants partnered with the Receiver to prioritize CDCR's incarcerated population to receive COVID-19 vaccines as soon as they became available in California, and started offering vaccinations to incarcerated people earlier than most other states. Declaration of Diana Toche, DDS (Decl. Toche) at ¶ 8. The most vulnerable incarcerated people were prioritized initially. Now virtually every incarcerated person in CDCR's institutions has been offered a COVID-19 vaccine at least once. *Id*. at ¶ 11. Vaccines are now readily available, even to those who initially refused. *Id*. at ¶¶ at 8, 11. To date, 78 percent of CDCR's incarcerated population has accepted the vaccine, including 94 percent of COVID naïve medically high-risk patients and 93 percent COVID naïve patients age 65 or older. *Id*. at ¶ 12. Medical staff, as well as patients' own attorneys here, continue to consult with and educate patients who initially declined the vaccine. *Id*. With very limited exception, those who are not vaccinated today have chosen not to be. *Id*. at ¶ 11. Yet, despite the fact that vaccination provides significant protection against a serious

COVID-19 infection for patients who accept it, the requested relief completely ignores most unvaccinated patients and instead seeks an order requiring vaccination of virtually all *staff*. *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).

Any order requiring the State to implement the Receiver's policy must be preceded by a finding that Defendants are deliberately indifferent to COVID-19. But the Court cannot make such a finding where class members refuse to accept the best measure to prevent serious illness, hospitalization, and death from COVID-19. *See Zatko*, 835 F. Supp. 1174, 1178 (N.D. Cal. 1993) (incarcerated person's refusal to accept medical care did not amount to a denial or delay of medical care or harm by prison officials) (citing *Estelle*, 429 U.S. at 104-05 (1977)). Indeed, as a federal court in Pennsylvania recently determined, an incarcerated person who refused the COVID-19 vaccine could not later state a claim against prison officials for deliberate indifference to COVID-19 after rejecting "a simple measure that could largely ensure his well-being during the current pandemic." *See Olson v. Finley, et al*., No. 1:21-CV-387, 2021 WL 3083495, at *9 (M.D. Pa. Apr. 27, 2021), *report and recommendation adopted sub nom. Olson v. Finley*, No. 1:21-CV-387, 2021 WL 3077548 (M.D. Pa. July 21, 2021). The court in *Olson* was clear—an incarcerated person "cannot refuse medical care and then cite the lack of such care as an Eighth Amendment violation[.]" *Id*. Accordingly, here, class members' refusal to follow the guidance of the Receiver and medical staff, and their own attorneys' requests to be vaccinated does not amount to deliberate indifference by Defendants.

A similar Eighth Amendment claim failed where prison officials reasonably responded to the risk of harm from COVID-19 by offering the vaccine to over 90 percent of the incarcerated population, including the plaintiff. *Smith v. Warden, Belmont Corr. Inst.,* No. 2:20-CV-5830, 2021 WL 2689613, at *3 (S.D. Ohio June 8, 2021), report and recommendation adopted, No.

2:20-CV-5830, 2021 WL 2688602 (S.D. Ohio June 30, 2021). Likewise, here, any claim that Defendants' conduct in response to the pandemic violated the Eighth Amendment cannot succeed when 99 percent of CDCR's patients have been offered a COVID-19 vaccine at least once and the efforts of the Receiver, medical staff and Plaintiffs' own attorneys to encourage those who initially declined the vaccine continue. On these facts, the Court cannot find that Defendants have acted with deliberate indifference.

Because the Court can only order prospective relief if it finds that Defendants responded to the COVID-19 pandemic with deliberate indifference to Plaintiffs' health and safety, this Court lacks the authority to issue an order requiring the vaccination of all staff entering CDCR's institutions. 18 U.S.C. § 3626(a)(1).

B. Defendants Have Implemented Comprehensive, Layered Safety Measures Since the Start of the Pandemic, and Continue to Do so Consistent with Constantly Evolving Public Health Guidance.

When officials "undertake[] to act in areas fraught with medical and scientific uncertainties," their latitude "must be especially broad." *Marshall v. United States*, 414 U.S. 417, 427 (1974). COVID-19 is a novel and constantly evolving virus that is unquestionably fraught with uncertainties. Defendants address this reality by continually modifying mitigation measures to keep up with the changing circumstances and evolving public health guidance. Securing COVID-19 vaccine supplies for CDCR's patients is only one aspect of Defendants' efforts to ensure class members' safety. Since the start of the pandemic, Defendants have diligently coordinated with the Receiver and CCHCS to implement nearly all CDC recommendations for congregate living facilities. Decl. Toche at ¶ 3. In other words, they have acted to "ensure reasonable safety." *Farmer*, 511 U.S. at 844 (quoting *Hellen v. McKinney*, 509 U.S. 25, 33 (1993)). A finding of deliberate indifference simply cannot be reconciled with the sheer magnitude of Defendants' efforts over the past year and a half.

As discussed in response to Plaintiffs' previous challenges to Defendants' COVID-19 mitigation efforts, Defendants implemented numerous measures to reduce the risk of harm to the incarcerated population. As has been the case since the beginning of the pandemic, Defendants

and the Receiver continue to adjust their approach in responding to the COVID-19 pandemic as more is learned about the virus and in response to constantly-evolving public health guidance. The following list includes examples of mitigation measures implemented at the start of the pandemic in March and April 2020:

- CCHCS and CDCR established 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 plan for dealing with outbreaks;
- CDCR activated the Department Operations Center—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 developed Pandemic Operational Guidelines;
- CDCR suspended public visiting in the prisons;
- CDCR suspended intake from the county jails;
- CDCR implemented symptom screening for all individuals entering the prisons;
- CDCR initiated efforts to educate staff and inmates about the need for taking precautions such as physical distancing and hygiene;
- CDCR initiated efforts to reduce the population in dorms by transferring significant numbers of inmates from dorms to other housing throughout the system;
- CDCR implemented enhanced cleaning efforts throughout the prisons and widely distributed hand soap and hand sanitizer;
- CDCR implemented quarantines for exposed patients;
- CDCR implemented an expedited release plan to quickly reduce the system's population by nearly 3,500 incarcerated people;
- CDCR implemented a modified program to manage and restrict the movement of incarcerated people throughout the system and to provide guidance on physical

distancing and efforts to cohort incarcerated people in their housing units;

- CDCR placed physical-distancing markings throughout the prisons to encourage physical distancing;
- CDCR developed 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 initiated efforts to manufacture cloth face masks and hand sanitizer for inmates and staff throughout the system;
- CDCR created physical-distancing cohorts within dorm settings; and
- CDCR placed restrictions on transfers and implemented requirements to obtain approval for transfers from the Health Care Placement Oversight Program and CCHCS's public health team.

ECF 3508, Decl. Gipson Supp. Defs' Position, Joint Brief on Quarantine ¶¶ 3-4; *see also* ECF Nos. 3240 and 3275.

Following these actions, CDCR continued to supplement and modify its COVID-19 mitigation efforts throughout the pandemic in coordination with its health care partners:

- CDCR implemented plans to expedite the release of incarcerated people in July 2020 while additional mitigation measures were being developed, resulting in over 10,000 expedited releases, *see* Cal. Dep't. Corr. & Rehabilitation, *CDCR Announces Additional Actions to Reduce Population and Maximize Space Systemwide to Address COVID-19* (July 10, 2020), https://www.cdcr.ca.gov/news/2020/07/10/cdcr-announces-additional-actions-to-reduce-population-and-maximize-space-systemwide-to-address-covid-19/; *see also* ECF No. 3623 at 5;
- CDCR identified and reserved space dedicated to quarantine and isolation at all institutions based on guidance developed by CCHCS in July 2020;
- CCHCS developed, and CDCR and CCHCS implemented a movement matrix with stringent testing, quarantine, and personal protective equipment protocols to ensure the

safety of incarcerated people moving within and between institutions, and continue to modify the matrix and its implementation based on evolving public health guidance *see* Cal. Corr. Health Care Services, *COVID-19 Screening and Testing Matrix for Patient Movement*, https://cchcs.ca.gov/wp-content/uploads/sites/60/COVID19/Appendix13-PatientMovement.pdf (last visited Aug. 30, 2021);

- CCHCS initiated a robust COVID-19 surveillance testing program for staff and incarcerated people in CDCR's institutions and more frequent testing during outbreaks;
- CCHCS started using more comfortable nasal swabs to ease testing fatigue;
- CCCHS and CDCR moved medically high-risk incarcerated people from dorms to cells;
- CDCR mandated mask wearing at all prisons and issued N95 masks to all incarcerated people and staff at institutions with serious outbreaks;
- CDCR and CCHCS ceased intake at institutions with three or more positive COVID-19 cases;
- CDCR and CCHCS implemented procedures and lessons learned from previous COVID-19 outbreaks, enabling staff to respond quickly to contain the size of outbreaks; and
- CDCR and CCHCS implemented strategic safety measures in accordance with institution-specific needs, like installing tents to provide quarantine and isolation space for medically high risk patients during an outbreak at the California Rehabilitation Center, an institution with no cells.

Id. at ¶¶ 5-23.

Additionally, CDCR's institutions activated incident command posts staffed by both CDCR and CCHCS staff to manage outbreaks from a central point in the institution including, but not limited to, coordinating staff, quarantine and isolation efforts, and aid from outside agencies. *See*

ECF No. 3405 at 10-14. CDCR is also in the midst of a months-long housing unit ventilation project, in which it is upgrading housing unit ventilation filters, evaluating whether ventilation units are functioning as designed, and identifying solutions for any needed repairs. Decl. Toche at ¶ 4. And significantly, CDCR and CCHCS are now offering third doses of COVID-19 vaccines to immunocompromised incarcerated people in accordance with newly-issued CDC guidance. *Id*. at ¶ 6. CDCR continues to implement additional safety measures in accordance with the Receiver's policies and in partnership with CCHCS.[3] These include ongoing incentives to promote COVID-19 vaccine acceptance amongst patients and staff, as discussed in section II below. *Id*. at ¶¶ 12-13.

The Receiver's report in support of his proposed policy characterizes some of these mitigation efforts—for example, frequent testing, mask-wearing, and physical distancing—as ineffective in preventing the transmission of COVID-19. ECF No. 3686 at 11-16. Notably, the report discusses the efficacy of these measures when implemented in isolation, but omits discussion of their efficacy when implemented in conjunction with other measures. Defendants never intended these measures to act alone—they were always meant to complement one another. Decl. Toche at ¶ 3. In response to Plaintiffs' most recent challenge to Defendants' response to COVID-19, Defendants' public health expert, Dr. Spaulding, opined that implementing a multipronged application of evidence-based strategies can dramatically reduce the risk of harm from COVID-19. Decl. Spaulding Supp. Defs.' Position on Quarantine and Isolation Space (Decl. Spaulding), ECF No. 3505 at 3, 8, 11, 19. *See also* Margaret A. Honein, et al., *Summary of Guidance for Public Health Strategies to Address High Levels of Community Transmission of SARS-CoV-2 and Related Deaths*, vol. 69, Ctrs. Disease Cont. & Prevention Morbidity & Mortality Weekly Rep. (Dec. 4, 2020), https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6949e2-H.pdf. Ultimately, Dr. Spaulding

[3] Additional details regarding CDCR's COVID-19 response efforts can be found at on CDCR's website at https://www.cdcr.ca.gov/covid19/covid-19-response-efforts/, https://www.cdcr.ca.gov/covid19/memos-guidelines-messaging/, https://www.cdcr.ca.gov/covid19/updates/, and https://www.cdcr.ca.gov/covid19/san-quentin-state-prison- response/.

opined, CDCR was making reasonable efforts to satisfy the CDC's public health guidelines for correctional institutions and CCHCS's health care policy. Decl. Spaulding, ECF No. 3505 at 19.

Even if the Court and Plaintiffs believe safety measures could have been implemented differently, neither this Court nor Plaintiffs may substitute their judgment for that of state experts and officials. *Jacobson v. Commonwealth of Massachusetts*, 197 U.S. 11, 30 (1905) ("It is no part of the function of a court or a jury to determine which of two modes was likely to be the most effective for the protection of the public against disease"). This Court acknowledged the same early in the pandemic when evaluating Plaintiffs' then-challenge to Defendants' response efforts: "the 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." *Plata*, 445 F.Supp.3d 557, 567 (N.D. Cal. 2020). The record before the Court in April 2020 included a fraction of the safety measures that have since been implemented in CDCR's institutions, and yet it "conclude[d] without difficulty that Defendants' response has been reasonable." *Id*. Now, with 78 percent of CDCR's incarcerated population vaccinated in addition to the implementation of myriad other safety measures, this Court must once again conclude that Defendants' response has been reasonable. Indeed, Defendants 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.

II. AN ORDER IMPLEMENTING THE RECEIVER'S RECOMMENDED COVID-19 VACCINATION POLICY WOULD VIOLATE THE PLRA'S RESTRICTIONS ON PROSPECTIVE RELIEF.

Any prospective relief ordered under the Prison Litigation Reform Act must not only be necessary to correct a constitutional violation, but also be narrowly drawn, extend no further than necessary, and be the least intrusive means to correct that violation. 18 U.S.C. § 3626(a)(1)(A). A "court shall not grant or approve any prospective relief unless the court finds that such relief" meets these requirements. *Id*. Courts must be sensitive to "the need for deference to experienced and expert prison administrators." *Brown v. Plata*, 563 U.S. 493, 511 (2011). Thus, a district court may not "attempt to 'micro manage'" prison administration, or order relief that would

"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.

C. A Mandatory Vaccination Policy for Staff is Not Narrowly Drawn, Extends Further Than Necessary, and is Not the Least Intrusive Means to Ensure the Wellbeing of Class Members When Other Less Intrusive Measures Are Underway.

An order to implement the Receiver's proposed policy cannot yet be considered the least intrusive means of promoting the wellbeing of class members when other relatively new and less intrusive measures are being implemented and tested. The State's current efforts to increase voluntary vaccine acceptance among CDCR and CCHCS staff include:

- Implementation of CDPH's August 19, 2021 vaccination order for employees working in correctional health care settings, discussed in section II.B. above;
- Thirty-minute, one-on-one consultations with health care professionals for unvaccinated incarcerated people and staff members starting on August 2, 2021 to address any concerns they have related to the vaccine, and to assist them in making an informed decision, ECF No. 3623 at 6;
- The Governor's July 26, 2021 announcement of a new COVID-19 safety measure that requires state employees to show proof of vaccination by August 2, 2021 or, in the absence of such proof, submit to weekly COVID-19 testing. This policy took effect for correctional settings like CDCR on August 9, 2021. CDCR is testing its unvaccinated or unverified employees twice per week, exceeding the Governor's order, ECF No. 3623 at 7; Office Gov. Gavin Newsom, *Governor Newsom Announces Historic "Vax for the Win" Program to Get More Californians Vaccinated by June 15* (May 27, 2021), https://www.gov.ca.gov/2021/05/27/governor-newsom-announces-historic-vax-for-the-win-program-to-get-more-californians-vaccinated-by-june-15/;
- CDPH's July 26, 2021 public health order requiring that workers in health care and high-risk congregate settings show proof of vaccination or, in the absence of such proof, submit to regular COVID-19 testing, 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;

- Creation of a COVID-19 Mitigation Advocate Program through which each CDCR institution forms a COVID-19 Mitigation Team comprised of trained staff volunteers to educate staff at the peer level on the importance of compliance with COVID-19 mitigation measures, CDCR and CCHCS's COVID-19 policies, the vaccination program, and precautions that should be taken outside of work, ECF No. 3579 at 8; and
- A supplemental paid-sick-leave program through which full-time employees receive up to 80 hours of additional sick leave at their regular rate of pay for reasons including time needed to obtain a COVID-19 vaccine or recover from any side-effects following administration of the vaccine, ECF No. 3592 at 9 n.11.

These extensive measures demonstrate CDCR's ongoing efforts to increase vaccine acceptance rates. And notably, the first four measures had not been fully implemented when the Receiver announced his proposed policy on August 4. While Plaintiffs and the Receiver remain dubious of any effort short of mandatory vaccination (*see* ECF Nos. 3605 at 5, 3686 at 22), both fail to acknowledge that CDCR's previous efforts to incentivize staff vaccinations increased vaccine acceptance by five percent in May 2021, ECF No. 3605 at 5, the month during which widely advertised vaccine clinics were held for all staff during all shifts, ECF No. 3592 at 7, and increased by another five percent in June 2021, ECF No. 3605 at 5, the month during which vaccinated Californians were eligible for cash prize drawings. *See* Office of Governor Gavin Newsom, *Governor Newsom Announces Historic "Vax for the Win" Program to Get More Californians Vaccinated by June 15* (May 27, 2021), https://www.gov.ca.gov/2021/05/27/governor-newsom-announces-historic-vax-for-the-win-program-to-get-more-californians-vaccinated-by-june-15/. The PLRA's mandate that only prospective relief that is narrowly drawn, extends no further than necessary, and is the least intrusive means to correct a constitutional violation may be ordered cannot be disregarded. Here, there is no constitutional violation to be corrected, and even if there was, the above-listed

measures must be given a chance to succeed. Accordingly, this Court lacks the authority to order the Receiver's proposed relief.

D. The Receiver's Recommended COVID-19 Vaccination Policy Improperly Focuses on Staff, Over Whom He Largely Has No Authority.

The Receivership was established to ensure the delivery of constitutionally adequate medical care to class members. Order Appointing Receiver, ECF No. 473. The Receiver's authority therefore includes introducing medical treatments like the vaccination of all class members. However, with respect to CDCR staff, the Receiver's authority only extends over "CDCR employees or contract employees who perform services related to the delivery of medical health care to class members." *Id*. at 4. The Receiver's report, however, does not discuss the vaccination of incarcerated people, a medical treatment which the Receiver has the authority to implement, and instead extends to categories of employees far broader than the staff over which the Receiver has authority. Indeed, the Receiver's policy seeks a requirement that *every single* CDCR employee who enters its institutions be vaccinated, or else be denied access to the institutions. ECF No. 3638 at 5. The requested relief is not narrowly drawn because it does not attempt to narrow its scope, for example, by targeting employees who work in health care settings with high concentrations of particularly vulnerable patients, employees who work with medically high-risk incarcerated people specifically, employees who generally work more closely with incarcerated people, or simply the employees over whom the Receiver has authority.[5]

III. DEFENDANTS AGREE WITH THE RECEIVER'S PUBLIC HEALTH FINDINGS, BUT REGARDLESS, THE COURT LACKS THE AUTHORITY TO ORDER CDCR TO IMPLEMENT THE RECEIVER'S RECOMMENDED COVID-19 VACCINE POLICY.

The Court ordered the parties to state their opinions regarding whether they agree or disagree with the Receiver's public health findings. ECF No. 3647 at 3. Defendants agree with the public health findings regarding the COVID-19 vaccine cited in the Receiver's report. However, Defendants do not agree with the conclusion the Receiver drew from these findings,

[5] This is, in part, why the Receiver cannot simply implement his recommended policy as the Court suggests. *See* Order to Show Cause, ECF No. 3647 at 3 n1. Nor may the Receiver implement the policy because, as an officer of this Court, he too must abide by the dictates of the PLRA. *See* Order Appointing Receiver, ECF No.473 at 6:2-3.

namely, that the "only method to ensure adequate protection and care for incarcerated persons is" to vaccinate all prison staff. ECF No. 3638 at 5. Vaccination in the largest possible numbers, including all incarcerated people, is clearly one of the best available protections against COVID-19. Indeed, Defendants have long communicated their support for vaccination against COVID-19 as one of the most powerful safety measures available. *See, e.g.*, Joint Case Mgmt. Stmts., ECF Nos. 3520, 3530, 3539, 3548, 3558, 3566, 3579, 3592, 3592, 3623. Accordingly, Defendants have partnered with the Receiver and CCHCS in their efforts to mitigate the risks of COVID-19 since the start of the pandemic, including through vaccination of CDCR's staff and incarcerated population since COVID-19 vaccines first became available. *Id*.

But the salient question in this litigation is whether this Court has the authority under the PLRA to order CDCR and CCHCS to implement the Receiver's recommended policy—which it does not. Defendants have discussed the Receiver's public health conclusions in subsection II of the argument section above to the extent they are relevant to the issue of the Court's authority to order prospective relief.

IV. THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH ISSUED ORDERS ON AUGUST 5, 2021 AND AUGUST 19, 2021 TO ACHIEVE THE SAME GOAL IN DIFFERENT SETTINGS.

The Court ordered the parties to state their position on whether the rationale behind CDPH's August 5, 2021 order applies to some or all of CDCR's employees. ECF No. 3647 at 3. As the Court's order indicates, CDPH issued guidance for interpreting its August 5 order. *Id*. at 2; Cal. Dep't Pub. Health, *Public Health Order Questions & Answers: Health Care Worker Vaccine Requirement* (August 20, 2021), https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/FAQ-Health-Care-Worker-Vaccine-Requirement.aspx. The guidance clarifies that the August 5 order does not apply to state and local correctional facilities and indicates additional guidance will be issued regarding health care in congregate settings, taking into consideration "the unique circumstances of health care integrated into a congregate setting." *Id*. According to this guidance, the July 26, 2021 order requiring state employees to either show proof of vaccination or submit to regular COVID-19

testing applies to correctional facilities. *Id.* CDPH's August 5 order, in contrast, does not apply to employees who work in CDCR's institutions. However, CPDH issued an order on August 19, 2021 that *does* apply to certain CDCR employees, as discussed in section II.B. above. *See* Cal. Dep't. Public Health, *State Public Health Officer Order of August 19, 2021* (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.

The Court later ordered the parties to provide responses to several questions the Court posed regarding CDPH's August 19, 2021 public health order. ECF No. 3653 at 3. First, the Court asked whether there is a public health basis for limiting mandatory vaccines to the areas identified in Defendants' August 25, 2021 statement. Defendants' August 25, 2021 statement describes CDCR's implementation of a state public health order, the purpose of which is primarily "to protect *particularly* vulnerable populations," and secondarily to "ensure a sufficient, consistent supply of workers in high-risk health care settings." Decl. Toche at ¶ 16-17; Decl. Watt at ¶ 12. The basis for limiting mandatory vaccines to the areas described in Defendants' August 25, 2021 statement, therefore, is to achieve the stated goal of the State's August 19, 2021 public health order in a manner consistent with CDPH's statutory authority.

Second, 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 in Defendants' August 25, 2021 statement. ECF No. 3653 at 3. As of August 30, 2021, this number is approximately 4,250. Decl. Toche at ¶ 19.

Third, the Court asks whether there is any basis for concluding that "persons at a higher risk of severe illness or death" housed outside the health care settings listed in Defendants' August 25, 2021 statement: (1) "are at a lower risk than the high-risk individuals housed in the covered institutions or areas[,]" and (2) "face a lower risk in their housing units than they do in the covered areas of those institutions." ECF No. 3653 at 3. Defendants are implementing vaccination requirements for workers consistent with the August 19, 2021 public health order

which, as stated above, seeks to cover *particularly* vulnerable patients in *high-risk health care settings* as defined by the public health order. Just as the August 5, 2021 public health order does not cover environments outside particular high-risk health care settings it defines, the August 19, 2021 order does not either.

Finally, the Court asks "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. The August 19, 2021 public health order requires workers regularly assigned to provide health care or health care services to be vaccinated. Decl. Toche at ¶ 16, Ex. C. These workers may visit quarantine and isolation areas to provide health care or health care services. Moreover, quarantine and isolation areas are not health care settings as defined by the public health order, and those persons temporarily housed in quarantine or isolation are not necessarily at a higher risk of experiencing serious illness, hospitalization or death simply by virtue of their housing location. Notably, when designated quarantine and isolation areas house no patients, workers are not assigned to those areas, so the public health order does not apply. Decl. Toche at ¶ 20. Quarantine and isolation areas are not static. Health care and non-health care workers collaboratively determine where to quarantine incarcerated people on a case-by-case basis. *Id*. at ¶ 21. For example, it may be appropriate to quarantine in place in one case, and move to a different part of a housing unit or institution in another. *Id*.

Additionally, assuming the Court's question is in regards to the risk of serious illness from infection in a quarantine and isolation area versus an area listed in Defendants' August 25, 2021 filing, the following are some of the factors that apply to this question. Until an exposure happens, it is not possible to know which incarcerated people might require quarantine or isolation. Decl. Toche at ¶ 23. As discussed above, Defendants have myriad, layered mitigation measures in place to address the risks posed by COVID-19 that are designed to limit the spread of infection, including requiring staff to wear appropriate personal protective equipment. *Id*. at ¶ 22.

V. IMPLEMENTATION OF THE RECEIVER'S RECOMMENDED COVID-19 VACCINE POLICY.

At the July 29, 2021 case management conference, the Court asked the parties to address the question of how the Receiver's policy would be implemented. Neither the Court nor the Receiver possess the authority to implement this policy under the PLRA. But as discussed in section II.B above and in the statement Defendants filed on August 25, 2021, CDCR is implementing CDPH's August 19, 2021 mandatory COVID-19 vaccine policy, which applies to certain CDCR workers.

CONCLUSION

An order requiring CDCR to implement the Receiver's mandatory COVID-19 vaccination policy would run afoul of the PLRA's restrictions on prospective relief. Prospective relief must be necessary to correct a violation of Plaintiffs' constitutional rights. Here, in light of the comprehensive and effective safety measures that Defendants have implemented—including offering vaccination to virtually every incarcerated person, requiring vaccination of all health care workers and workers in the highest risk health care settings, and requiring either vaccination or testing of every single worker—there is no such violation. Further, even if this Court were to determine that Defendants had acted with deliberate indifference, the Receiver's proposed policy is not narrowly drawn to correct the purported violation, extends further than necessary, and is not the least intrusive form of relief. This Court therefore lacks authority to order the prospective relief contemplated by its August 9, 2021 order to show cause.

Dated: August 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.** **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

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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

CA2001CS0001

EXHIBIT A

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

MEMORANDUM

Date:	August 20, 2021
To:	Institutional, Headquarters, and Regional Healthcare Staff
From:	Quality Management Unit
Subject:	Patient COVID Vaccine Registry Update: Incorporation of Third Dose Recommendation for Immunocompromised Patients

On August 12, the Federal Drug Administration revised the Emergency Use Authorizations for the Pfizer-BioNtech and Moderna mRNA COVID-19 vaccines recommending a third dose of the vaccine for patients who are considered moderately to severely immunocompromised. At this time, this recommendation does not apply to patients who received the single dose Janssen COVID-19 vaccine.

The third dose recommendation means that any moderately to severely immunocompromised patient who has received their second dose of the mRNA vaccine more than 28 days ago should receive a third dose as soon as possible. Additionally, going forward any immunocompromised patient should be vaccinated with a total of three mRNA doses, with the third dose administered 28 days after receiving the second dose. Administering, three total doses to people who are immunocompromised is essential to protect this vulnerable population from hospitalization or death from COVID-19.

With the heightened concerns of the Delta variant of COVID-19, **California Correctional Health Care Services (CCHCS) has set a goal to offer all moderately to severely immunocompromised patients this recommended third dose by Labor Day (September 6, 2021**). This short time frame is necessary to ensure this vulnerable population is protected from serious outcomes from COVID-19.

To assist institutions in this endeavor, the Patient COVID Vaccine Registry has been enhanced to help identify and track this group of individuals. Below you will find an overview of the changes to the registry and instructions on how to identify this population within the COVID-19 Patient Vaccine Registry.

It is also important to note that if any patient is identified as moderately to severely immunocompromised by their primary care provider, regardless of being flagged on the COVID-19 Patient Vaccine Registry as needing a third dose, ***do not hesitate to offer a third dose to that patient*.**

MEMORANDUM

WHAT YOU NEED TO KNOW

- The CDC have put out general guidance for patients who should get a third dose of an mRNA vaccine, which include patients who have:
  - Been receiving active cancer treatment for tumors or cancers of the blood
  - Received an organ transplant and are taking medicine to suppress the immune system
  - Received a stem cell transplant within the last 2 years or are taking medicine to suppress the immune system
  - Moderate or severe primary Immunodeficiency
  - Advanced or untreated HIV infection
  - Active treatment with high-dose corticosteroids or other drugs that may suppress your immune response
- CCHCS is identifying patients as Moderately to Severely Immunocompromised Patients in close alignment with CDC's guidelines, using components of the following CCHCS Chronic Condition Specifications:
  - Cancer, excluding most skin cancers and 'history of' diagnoses.
  - HIV (all patients are included)
  - Other Chronic Conditions, subsets Immunocompromised and Organ Transplant

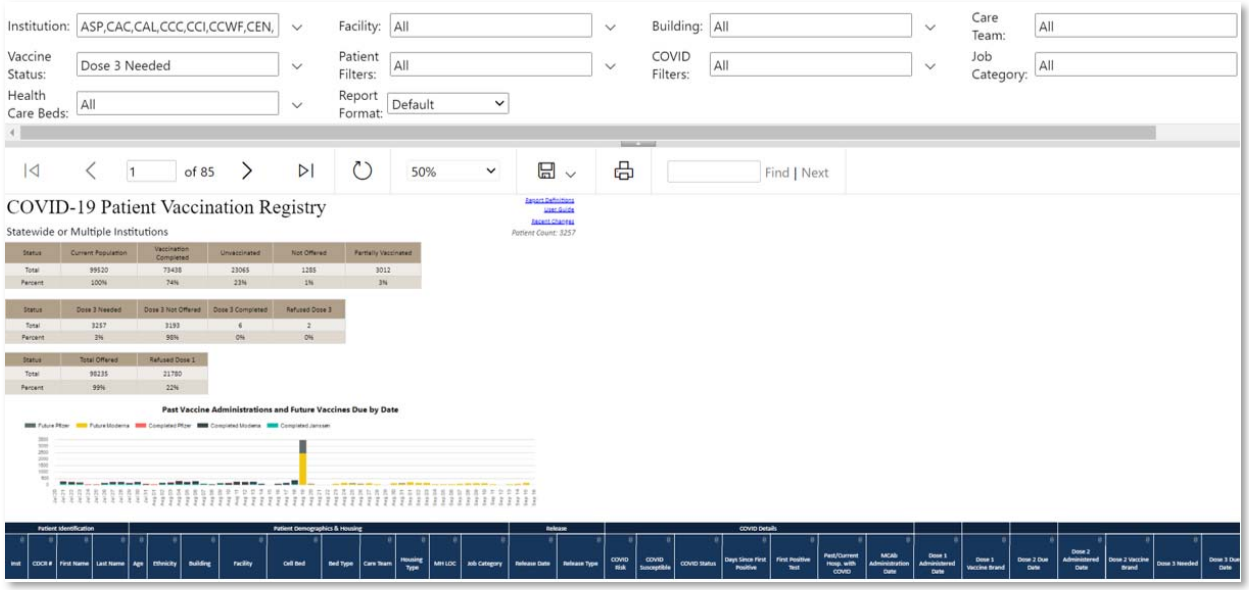
  CCHCS rules may miss some moderately to severely immunocompromised patients, including patients actively being treated offsite with infusion therapies (e.g. chemotherapy or anti-rheumatologic agents) and radiation therapy. Please check with your local institution's Offsite Specialty Services coordinators to ensure such patients are offered the third dose of the mRNA vaccine, as they may not be flagged in the registry.
- Reception Centers should be thoughtful of newly arriving patients for who are recommended a third dose of an mRNA vaccine and offer it when clinically appropriate to do, as registry data may not yet be updated with information on these new patients' immunocompromising conditions.
- While the recommendations from the CDC are to provide the vaccine brand for the third dose that is consistent with the first two doses, if possible, offering a third dose of either mRNA vaccine brand should not be delayed if the same brand is not readily available.

MEMORANDUM

HOW TO USE THE COVID-19 PATIENT VACCINE REGISTRY

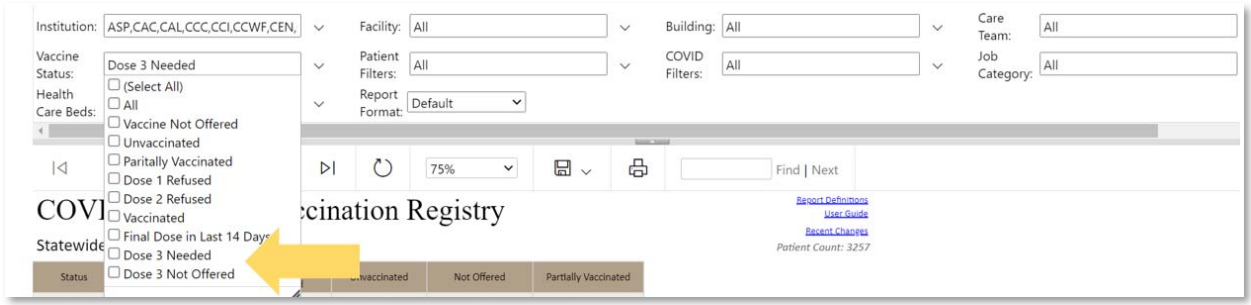
ACCESSING THE COVID-19 PATIENT VACCINE REGISTRY

The COVID-19 Patient Vaccine Registry can be found on CCHCS's intranet, on the QM portal, under All Operational Tools Tab, in the COVID-19 Tools section. Click the link to be go to QM All Operational Tools page: Quality Management - All Operational Tools or click here to go directly to the registry: COVID-19 Patient Vaccine Registry



NEW REGISTRY FILTERING OPTIONS

The 'Vaccine Status' Menu drop down has two new options added, as shown below in the screenshot.



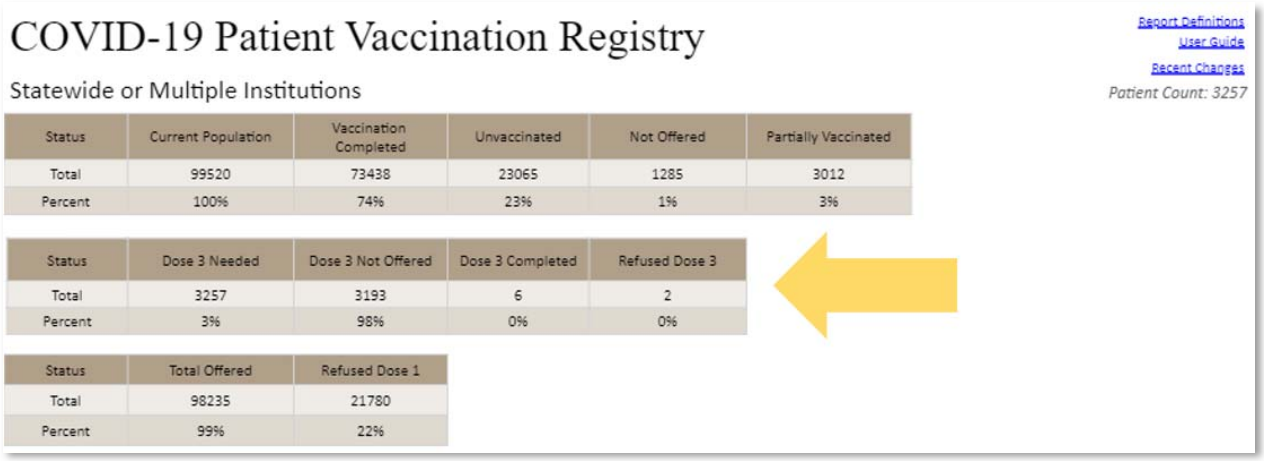
1. **Dose 3 Needed:** Select this option to obtain a list of patients eligible to receive the third dose of an mRNA vaccine.

2. **Dose 3 Not Offered:** Select this option to obtain a list of patients who are eligible to receive the third dose and who do not have a documented receipt or refusal in EHRS for the third dose of the mRNA vaccine.

Some immunocompromised patients have a) received the single dose Janssen COVID-19 vaccine or b) have not received a second mRNA COVID-19 vaccine dose. These patients will not appear as needing a third dose in the registry.

THIRD DOSE TRACKING AND PERFORMANCE MONITORING

The COVID-19 Patient Vaccination Registry includes specific third dose performance monitoring, showing number of patients offered the third dose, patients who've received the third dose, and patients who've refused the third dose of the identified eligible population recommended to receive the third dose.



COVID-19 Patient Vaccination Registry

Statewide or Multiple Institutions

Report Definitions
User Guide
Recent Changes
Patient Count: 3257

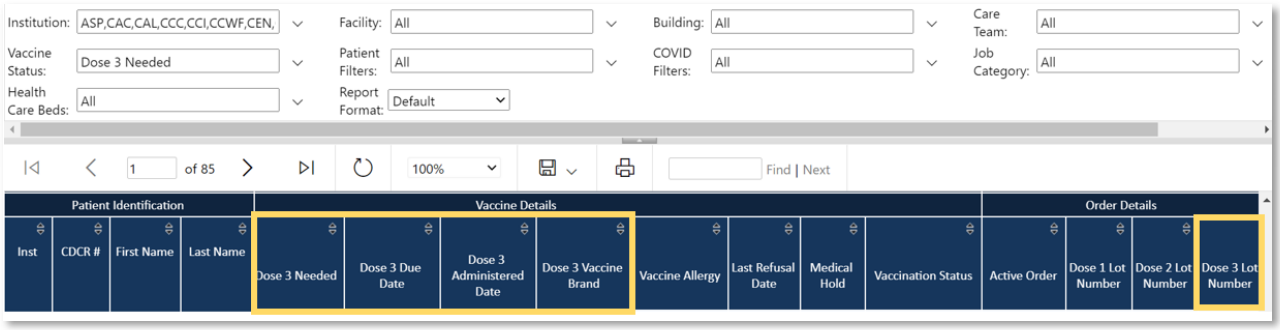
Status	Current Population	Vaccination Completed	Unvaccinated	Not Offered	Partially Vaccinated
Total	99520	73438	23065	1285	3012
Percent	100%	74%	23%	1%	3%

Status	Dose 3 Needed	Dose 3 Not Offered	Dose 3 Completed	Refused Dose 3
Total	3257	3193	6	2
Percent	3%	98%	0%	0%

Status	Total Offered	Refused Dose 1
Total	98235	21780
Percent	99%	22%

NEW THIRD DOSE DETAILS ADDED TO THE REGISTRY

For patient specific details in the registry, there are new columns added under Vaccine Details and Order Details, as shown below.



Institution: ASP,CAC,CAL,CCC,CCI,CCWF,CEN, | Facility: All | Building: All | Care Team: All

Vaccine Status: Dose 3 Needed | Patient Filters: All | COVID Filters: All | Job Category: All

Health Care Beds: All | Report Format: Default

1 of 85 | 100% | Find | Next

Patient Identification				Vaccine Details								Order Details			
Inst	CDCR #	First Name	Last Name	Dose 3 Needed	Dose 3 Due Date	Dose 3 Administered Date	Dose 3 Vaccine Brand	Vaccine Allergy	Last Refusal Date	Medical Hold	Vaccination Status	Active Order	Dose 1 Lot Number	Dose 2 Lot Number	Dose 3 Lot Number

1. **Third Dose Need:** A checkmark will appear indicating the patient meets one or more of the condition specifications of Cancer, HIV, Immunocompromised, and Organ Transplant.

Clicking on the checkmark in this column will open the patient's clinical risk profile for the specific details.

2. **Dose 3 Due Date:** The date the third dose was due (i.e. 28 days after the second dose is administered) is shown. If this date is in the past, it will be highlighted in red.
3. **Dose 3 Administered Date:** The documented date the third dose was administered is shown.
4. **Dose 3 Vaccine Brand:** The brand of the mRNA vaccine administered as the third dose is shown.
5. **Dose 3 Lot Number:** The vaccine lot number of the third dose is shown.

QUESTIONS?

CCHCS wants to hear from you if you have suggestions for ways to make this tool more useful or are having any difficulties using this tool, particularly if data does not match what you are seeing in patient records, which may indicate problem with data feeds that impacts all institutions. If you have any questions or concerns, please contact QM at QMStaff@cdcr.ca.gov.

If you have questions about whether a patient should be offered a third dose or the timing of the third dose in relation to current known or potential immunosuppressing treatments, please send your questions to: **m_MSDCOVID19Vaccine@cdcr.ca.gov**

Also, please join us on Wednesday 8/25/2021 from 1-3p for the QM Weekly Webinar for a live demonstration and review of the COVID-19 Patient Vaccine Registry and ask questions directly to QM staff. To add this webinar to your calendar, please click here: QM Weekly Webinar - Aug 25, 2021.

Your continued efforts to provide our patients with the best possible outcomes possible are deeply appreciated.

Thank you.

EXHIBIT B

AUGUST 6, 2021 ISSUE 58

THE INFORMED PATIENT:
A SAN QUENTIN NEWSLETTER

IN THIS ISSUE:

PLEASE NOTE: *The information contained in each issue is subject to change. Researchers continue to learn more about COVID-19 every day, and the new information may correct something we used to think was true. For example, in the beginning of the pandemic, researchers didn't think wearing masks would protect people from spreading the virus; more recent research shows that masks do protect people. As we receive new information, we will share it with you here, including any impacts on programming.*

About this Issue

As you know, we're here to inform you about things that impact you. It's always nice when we have good news to share, but we want to be just as upfront about stuff we know you don't necessarily want to hear. In this issue, we'll share some unwelcome information about the suspension of the expedited release program.

We also want to share information about breakthrough infections of COVID-19. There's been a lot of buzz in the media about these cases, and we want you to fully understand what they are and how to best protect yourself.

Finally, we'll give you some program updates from the Mental Health department, including information about the upcoming 2021 Mental Wellness Week.

AUGUST 6, 2021 ISSUE 58

EXPEDITED RELEASE PROGRAM

On suspended status

Many of you know people who have gotten sentence reductions through the **expedited (early) release** program. This is an initiative that was started to help quickly, safely, and drastically reduce the CDCR population during the COVID-19 pandemic so that we could more easily practice infection control precautions, such as social distancing. However, CDCR has now announced that, at the end of July, it will suspend the expedited releases of eligible incarcerated people with 180-days or less remaining on their sentences.

The expedited releases of eligible individuals began with a small cohort in April 2020 and then on a rolling basis in July 2020. These releases allowed CDCR to create more physical space throughout the institutions, an effort that was vital to mitigating the spread of COVID-19. These releases, along with all of our efforts to practice physical distancing, masking, and be vaccinated, have resulted in the continued decline of COVID-19 cases in our institutions. As of July 22, 2021, there were 18 cases in our institutions, when at the height of the pandemic more than 10,000 CDCR residents had active cases of COVID.

The last list of potentially eligible people was created on July 29, 2021. Release Program Studies and law enforcement notifications of people actually scheduled for expedited release will be provided as required by law through CDCR's normal processes. Some individuals may not be immediately eligible for release (as matters such as COVID-19 tests or Offender with a Mental Health Disorder screenings may delay release). While these individuals will still be processed for release once cleared, no more eligibility lists will be created. Only people who appear on the final list will be eligible for expedited release.

That might not sound promising if you think you're eligible for expedited release but haven't yet been identified. But keep in mind that, for now, the program is suspended, not terminated. If, at some point, it appears that expedited releases are a tool that needs to be brought back to help fight the spread of COVID-19, it may be reactivated at that time.

AUGUST 6, 2021 ISSUE 58

BREAKTHROUGH CASES

What it means, and what to know

There's been a lot of recent attention in the media on **breakthrough cases** of COVID. A breakthrough case refers to someone who tests positive for COVID even after they have been vaccinated and enough time should have elapsed for the vaccine to be fully established in their system.

The COVID-19 Delta variant seems to produce more breakthrough cases than other versions of the virus — in other words, more vaccinated people are getting infected with the Delta variant than with other strains of COVID-19. We always knew that the vaccines were not 100% effective, meaning that some breakthrough cases have been expected since the beginning, but recent data show that the vaccines are somewhat less effective against the Delta variant than the others. However, being vaccinated still makes a TREMENDOUS difference. Recent data from the Centers for Disease Control and Prevention (CDC) show that:

1. **Risk of infection is reduced 3-fold in vaccinated patients:** meaning that if you are fully vaccinated and exposed to the Delta variant of COVID-19, you are two-thirds less likely to end up infected with the virus than someone who is not vaccinated.
2. **If you do get infected with the Delta variant, risk of severe disease or death is reduced 10-fold or greater if you are fully vaccinated:** in other words, if you are vaccinated and get infected, we expect you to have a much milder case of COVID-19 than someone who is not vaccinated. The risk of you needing to be hospitalized or dying is at least 90% less than the risk for a person who is not vaccinated.

That's the good news. There's also some pretty bad news:

1. **Transmissibility:** it appears that when vaccinated people get COVID-19, they are just as contagious (their COVID-19 infections are just as **transmissible**) as people who are unvaccinated. Even when vaccinated people have no symptoms at all, they may be just as likely to pass the disease to somebody else as someone who is unvaccinated.
2. **Severity:** so far, the Delta variant does appear to cause more severe disease in unvaccinated persons than other strains.

CONT'D ON PAGE 4

BREAKTHROUGH CASES cont'd

The bottom line: The best way to protect yourself and others from bad outcomes from the Delta variant is to be vaccinated. Even when vaccinated, continue to wear your mask, wash your hands regularly, and keep your distance when you can. If you are unvaccinated, please consider getting vaccinated, and please get tested when your health care team asks you to. All of these measures are life-saving.

THE INFORMED LOVED ONE

Make sure your people know when you're severely ill

If you want to ensure your loved ones can be contacted if your health is in danger, you can complete an Authorization for Release of Information form (CDCR Form 7385). This form need to be updated annually. We will ensure forms are available in the units, if they are not already. Patients can select up to two loved ones to receive health status updates in the event that they have a serious worsening of their medical condition.

PROGRAM UPDATES

Mental Wellness Week 2021

Mental Wellness Week is tentatively scheduled for the week of August 30 through September 3 this year and will feature speakers, prizes, and activities.

If you would like to participate, please reach out to our new Suicide Prevention Coordinator, Dr. E. Anderson, by sending a communication in a U-Save envelope to the Warden's Office, c/o *The Informed Patient*. We are looking for artists, poets, musicians, and comedians to participate and help make the week meaningful for all. All submissions will be considered and may be subject to editing. Thank you in advance for your participation.

Also from Mental Health: Moving forward, hand-crank radios will now resume being issued only to those in ASU.

Feedback, Questions, and Comments

We want to answer any questions you have. If you have questions not addressed in this issue, please send a U-SAVE envelope to the Warden's Office, addressed to:

The Informed Patient: A SQ Newsletter.

EXHIBIT C

CALIFORNIA DEPARTMENT of CORRECTIONS AND REHABILITATION

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

MEMORANDUM

Date	:	August 23, 2021
To	:	Wardens Chief Executive Officers Superintendents
From	:	DocuSigned by: Diana Toche D7A487A8AEC64C4... KATHLEEN ALLISON, Secretary, CDCR DocuSigned by: Clark Kelso 2E3708FD02AF4DC... CLARK KELSO, Receiver
Subject	:	**MANDATORY COVID-19 VACCINES AND TESTING FOR INSTITUTION STAFF**

The purpose of this memorandum is to address two Public Health Orders issued by the California Department of Public Health (CDPH):

- State and Local Correctional Facilities and Detention Centers Health Care Worker Vaccination Order, issued August 19, 2021, and
- Health Care Worker Protections in High-Risk Settings, issued July 26, 2021.

In this memorandum, direction will be provided to all California Department of Corrections and Rehabilitation (CDCR), California Correctional Health Care Services (CCHCS), and Division of Juvenile Justice (DJJ) staff statewide regarding the requirements and expectations pursuant to these Orders.

AUGUST 19, 2021, PUBLIC HEALTH ORDER: FULL VACCINATION REQUIREMENT FOR STAFF

The August 19, 2021, CDPH Public Health Order requires workers in specified correctional health care facilities to show evidence of full vaccination for COVID-19 by October 14, 2021, or to obtain approval for a reasonable medical or religious accommodation precluding them from the mandatory full vaccination. Staff for whom this requirement applies cannot opt out of vaccination or routinely test in lieu of vaccination.

The Order's requirement for full vaccination applies to all staff at California Health Care Facility (CHCF), California Medical Facility (CMF), and the Skilled Nursing Facility at Central California Women's Facility (CCWF). In addition, it applies to those workers regularly assigned to work in the following health care areas or posts within institutions system-wide.

1. All Correctional Treatment Centers (CTC) and similar locations, including:
    a. Medical CTC beds
    b. Licensed and Unlicensed Psychiatric In-Patient Program housing
    c. Licensed and Unlicensed Mental Health Crisis housing
2. All Out-Patient Housing Units (OHUs)
3. Medical, Specialty, Mental Health, and Dental clinic treatment areas
4. Hospice beds
5. Dialysis units

6. Triage and Treatment Areas (TTAs)
7. Staff identified on the Master Assignment Roster as assigned to transportation or medical guarding in the community
8. All DJJ staff assigned to the Mental Health Residential Units, Intensive Behavioral Treatment Program Units, and Sexual Behavior Treatment Program Units
9. All staff assigned to the Medical Wings within DJJ facilities
10. All staff assigned to the Program Center at N.A. Chaderjian Youth Correctional Facility

All paid and unpaid regularly assigned workers/volunteers subject to the Order's vaccination requirement include but are not limited to the following: clinicians, nurses/nursing assistants, technicians, therapists, phlebotomists, pharmacists, dietary staff, janitorial and laundry staff, administrative staff, registry staff, contract staff, volunteers, custody staff, health facility maintenance workers, and inmate workers. The Order's vaccination requirement shall apply to all five-day-a-week posts and regular-day-off posts. Currently, this requirement will 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.

Local Hiring Authority Responsibilities: Each local hiring authority shall be responsible for identifying staff who are regularly assigned to the listed areas and notifying the employees that they are covered by and must comply with the August 19, 2021, order. The Staff Vaccine Registry shall be utilized to determine staff who are vaccinated, partially vaccinated, and unvaccinated. Staff who have not already done so may submit vaccination records. For complete instructions, refer to the May 19, 2021 memorandum, "Submission of COVID-19 Vaccination Record Cards."

Qualifying Accommodations to Vaccination Requirement

1. *Medical Reasonable Accommodation*
   Staff unable to be fully vaccinated due to a qualifying medical reason shall notify their supervisor and Return-to-Work Coordinator of their request for a reasonable accommodation. Reasonable accommodation requests shall be submitted on the CDCR Form 855, Request for Reasonable Accommodation, and require a written statement signed by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician stating that the individual qualifies for the accommodation (but the statement should not describe the underlying medical condition or disability) and the probable duration of an individual's inability to receive the vaccine (or if the duration is unknown or permanent, so indicate).
2. *Religious Accommodation*
   Staff unable to be fully vaccinated due to a sincerely held religious belief shall notify their supervisor and local Equal Employment Opportunity Coordinator of their request for religious accommodation. Religious accommodation requests shall require a statement indicating that the individual has a sincerely held religious belief that precludes them from obtaining any COVID-19 vaccine.
3. Requests for medical/religious reasonable accommodation shall be submitted by September 14, 2021. The Department shall engage in the interactive process with staff to ensure that the appropriate determination is made. Staff who have submitted a request for reasonable medical or religious accommodation may request permission to remain off work, using leave credits or an unpaid leave of absence pending a determination on the request. Staff who are approved for a reasonable medical or religious accommodation shall be subjected to mandatory twice-weekly testing as required by the August 5, 2021 California Department of Public Health Public Health

Order and the All Facilities Letter (AFL) 21-28 until such Order and AFL are rescinded or otherwise no longer in effect.

Further direction will be forthcoming regarding staff regularly assigned to the identified institutions or health care areas who are not vaccinated or do not have an approved reasonable medical or religious reasonable accommodation secured by October 14, 2021.

CDCR and CCHCS Labor Relations will be working with labor organizations to inform them of this Order.

JULY 26, 2021, PUBLIC HEALTH ORDER: HEALTH CARE WORKER PROTECTIONS IN HIGH-RISK SETTINGS
The August 19, 2021 order **supplements and does not supplant** the CDPH's Public Health Order issued on July 26, 2021. The CDPH's July 26, 2021, Public Health Order requires all unvaccinated and partially vaccinated workers in High-Risk Congregate Settings, including state and local correctional facilities, to undergo screening and testing for COVID-19. In other words, staff to whom the August 19, 2021, requirement does not apply remain subject to the requirements of the July 26, 2021, Order.

Therefore, pursuant to this Order and effective August 23, 2021, all staff who work in correctional settings who are unvaccinated, partially vaccinated, or have not provided a record of full vaccination shall undergo **twice-weekly COVID testing** with at least 72 hours between each test.

If you are testing outside of the CDCR testing program, you will need to submit proof of testing. See attachment for instructions on how to submit this information.

Refusal to get tested on a twice-weekly basis may result in corrective or disciplinary action in accordance with Department Operations Manual, Article 22, Employee Discipline, Section 33030.8, Causes for Corrective Action, and 33030.9, Causes for Adverse Action.

QUESTIONS/CONCERNS
If you have any questions or concerns about the directives contained in this memorandum, inquiries should be directed as follows:

- For Wardens: Contact your mission's Associate Director, Division of Adult Institutions (DAI)
- For Chief Executive Officers: Contact your respective Regional Health Care Executive
- For DJJ: Contact either Deputy Director
- For staff with reasonable accommodation-related questions: Contact the local Return-to-Work Coordinator for medical accommodations and their local EEO Coordinator for religious accommodations.

CDCR/CCHCS is committed to providing additional information as soon as available.

Attachment

cc: CDCR_CCHCS Extended Executive Staff
Regional Health Care Executives
Associate Directors, DAI

ATTACHMENT

The Environmental Health and Safety module within the Business Information Systems (BIS) platform is used to capture testing data for all California Department of Corrections and Rehabilitation (CDCR) and California Correction Health Care Services (CCHCS) staff. Using the DocuSign PowerForm will securely submit staff's documentation of ***Non-CDCR/CCHCS COVID-19 Test Result*** directly to the Employee Health Program team. The PowerForm can be used only if staff has an email account where they can verify their submittal. For the best user experience, staff shall use their @CDCR.CA.GOV email account.

Staff shall submit documentation of COVID-19 test result only if they have tested outside of CDCR/CCHCS (e.g. Kaiser, Sutter, CVS, Walgreens, etc.). Tests completed within CDCR/CCHCS will automatically be recorded in BIS. Documentation of test results must include the following:

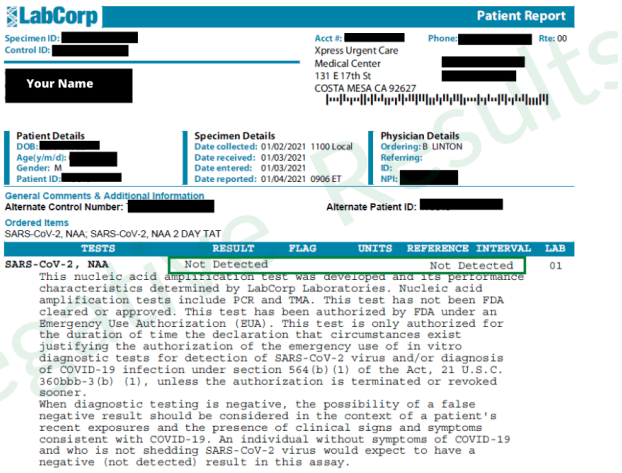
1. Name of the company that conducted the test
2. Name and date-of-birth of the employee
3. The test result

DIRECTIONS FOR USING THE POWERFORM

1. A confirmation code will be sent to the email address provided while initiating the PowerForm.
2. Once confirmed via the email account provided, the ***Non-CDCR/CCHCS COVID-19 Test Result PowerForm*** will launch for staff to fill out.
3. Enter all required information into the form.
4. Attach the documentation of ***Non-CDCR/CCHCS COVID-19 Test Result***.
5. Click Finish once all required information are entered and the documentation of ***Non-CDCR/CCHCS COVID-19 Test Result*** is attached.

Name:
Date:
PERNR:
Date of Birth:
Attach documentation of ***Non-CDCR/CCHCS COVID-19 Test Result*** (as shown in Example).

Example:


LabCorp Patient Report

Specimen ID: [redacted]
Control ID: [redacted]

Your Name

Acct #: [redacted] Phone: [redacted] Rte: 00
Xpress Urgent Care
Medical Center
131 E 17th St
COSTA MESA CA 92627

Patient Details
DOB: [redacted]
Age(y/m/d): [redacted]
Gender: M
Patient ID: [redacted]

Specimen Details
Date collected: 01/02/2021 1100 Local
Date received: 01/03/2021
Date entered: 01/03/2021
Date reported: 01/04/2021 0906 ET

Physician Details
Ordering: B LINTON
Referring:
ID:
NPI: [redacted]

General Comments & Additional Information
Alternate Control Number: [redacted]
Alternate Patient ID: [redacted]

Ordered Items
SARS-CoV-2, NAA; SARS-CoV-2, NAA 2 DAY TAT

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
SARS-CoV-2, NAA	Not Detected			Not Detected	01

This nucleic acid amplification test was developed and its performance characteristics determined by LabCorp Laboratories. Nucleic acid amplification tests include PCR and TMA. This test has not been FDA cleared or approved. This test has been authorized by FDA under an Emergency Use Authorization (EUA). This test is only authorized for the duration of time the declaration that circumstances exist justifying the authorization of the emergency use of in vitro diagnostic tests for detection of SARS-CoV-2 virus and/or diagnosis of COVID-19 infection under section 564(b)(1) of the Act, 21 U.S.C. 360bbb-3(b)(1), unless the authorization is terminated or revoked sooner.
When diagnostic testing is negative, the possibility of a false negative result should be considered in the context of a patient's recent exposures and the presence of clinical signs and symptoms consistent with COVID-19. An individual without symptoms of COVID-19 and who is not shedding SARS-CoV-2 virus would expect to have a negative (not detected) result in this assay.

Although DocuSign is the preferred method, staff may also mail-in their documentation of test results to the following address:

California Correctional Health Care Services
Attn: Employee Health Program, E-1
PO Box 588500
Elk Grove, CA 95758