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17  
18 **UNITED STATES DISTRICT COURT**  
19 **NORTHERN DISTRICT OF CALIFORNIA**  
20 **OAKLAND DIVISION**

21 MARCIANO PLATA, et al.,

22  
23 Plaintiffs,

24 v.

25 GAVIN NEWSOM, et al.,

26 Defendants.  
27

CASE NO. 01-1351 JST

**JOINT CASE MANAGEMENT  
CONFERENCE STATEMENT**

Judge: Hon. Jon S. Tigar

Date: October 28, 2021

Time: 2:00 p.m.

Crtrm.: 6, 2nd Floor

1 The parties submit the following joint statement in advance of the October 28, 2021  
2 Case Management Conference.

3 **I. COVID-19 VACCINE**

4 **A. Patients**

5 *Plaintiffs' Position:* As of October 26, 99% of CDCR's 99,345 incarcerated people  
6 had been offered vaccination against COVID-19, per the CCHCS Vaccine Registry.<sup>1</sup>  
7 76,934, or 77% of the population, were fully vaccinated, and another 2,009, or 2%, had  
8 received a first dose. 19,328, or 20% of residents, had refused the vaccine.

9 CCHCS has also, as of October 22, identified approximately 14,000 patients  
10 eligible for a third or booster dose under current federal guidelines. These include  
11 approximately 3,200 immunocompromised patients who received two doses of an mRNA  
12 vaccine more than six months ago, and for whom a third dose was recommended in  
13 August. Essentially all these patients were offered a booster by mid-September; as of  
14 October 1 approximately 91% had accepted and received it. The remaining approximately  
15 11,000 patients received two doses of the Pfizer vaccine more than six months ago, and  
16 thus are eligible for a booster pursuant to late September federal recommendations. Last  
17 week, it said it planned to offer a booster to all eligible Pfizer-vaccinated patients by  
18 October 31; as of October 22, CCHCS data indicated that more than 4,000 had been  
19 offered a booster.<sup>2</sup> We very much appreciate CCHCS's efforts.

20 *Defendants' Position:* Consistent with the most current public health guidance,  
21 CDCR/CCHCS issued a policy on August 20, 2021, regarding third booster doses of  
22 vaccine—just two days after the Centers for Disease Control and Prevention released its  
23 recommendation for administering booster shots. CDCR and CCHCS promptly started  
24 offering booster shots to eligible immunocompromised patients. CDCR and CCHCS have

25 \_\_\_\_\_  
26 <sup>1</sup> Those not yet offered are almost entirely either out-to-court (and thus housed in  
27 county jails) or new arrivals to CDCR Reception Centers.

28 <sup>2</sup> We anticipate that additional patients will be identified as eligible for, and offered, a  
booster given that on October 20 federal guidelines called for a booster for those who  
received the Moderna or Janssen vaccine.

1 since expanded booster-shot-eligibility criteria to include all non-immunocompromised  
2 patients who have received two doses of the Pfizer vaccine. According to data received  
3 from CCHCS on October 22, 7,195 currently eligible patients have been offered a booster  
4 shot, and 6,412 have accepted it.

5 Further, at the conclusion of the hearing on CCPOA's motion to intervene, counsel  
6 for the Receiver indicated that "we are developing a plan that we think effectively will  
7 require that all incarcerated persons becoming vaccinated, subject to religious and – and  
8 medical exemptions. That plan is still in development, but we will submit a plan to the  
9 court." (Oct. 14, 2021 Tr. at 15:24-16:3.) Defendants look forward to reviewing that plan  
10 with CCHCS prior to its submission to this Court.

#### 11 **B. Staff**

12 *Plaintiffs' Position:* As of October 14, only 59% of prison staff statewide are fully  
13 vaccinated against COVID-19 (62% have received at least one dose). *See* Exhibit A to  
14 October 20, 2021 CCHCS Memorandum, attached hereto as Exhibit 1. The rates for  
15 custody staff are substantially lower: only 51% are fully vaccinated, with 52% having  
16 received at least one dose. *Id.*<sup>3</sup> Custody staff rates at a number of prisons are substantially  
17 lower than that. For example, at High Desert State Prison, a shockingly paltry 25% are  
18 fully vaccinated (27% have received a first dose); similarly, at Pelican Bay State Prison  
19 those rates are, respectively, 28% and 29%. *Id.*

20 On September 27, the Court ordered that Defendants implement the Receiver's  
21 recommendation requiring vaccination for all prison staff and certain incarcerated persons.  
22 Neither Defendants nor CCPOA, in opposing the order, disputed its public health basis,  
23 including that staff are the primary vector of infection, vaccination reduces the risk of  
24 infecting others, testing is an imperfect means to stop transmission, incarcerated people  
25 including the fully vaccinated remain at risk from COVID, and the August California

26 \_\_\_\_\_  
27 <sup>3</sup> That same document shows the fully / at least one dose vaccination rates for  
28 healthcare staff are 82%/85%; for administrative, maintenance and operations staff  
67%/60%; and for contractor staff 37%/41%.

1 Department of Public Health vaccination requirement for certain prison staff leaves tens of  
2 thousands of the incarcerated at risk for exposure to infection from staff not required to be  
3 vaccinated.

4 The Court's order required the Receiver and Defendants to file a joint  
5 implementation plan by October 12. That plan as filed requires full vaccination by  
6 November 29. *See* ECF No. 3694 at 5. However, the Plan remains unimplemented. On  
7 October 20, the Receiver reported to the Court that Defendants have since refused to  
8 commit to the joint implementation plan, or to any date for implementation of the  
9 vaccination requirement, and requested the Court order the joint implementation plan  
10 (modified slightly to account for a delay in beginning implementation) be adopted. *See*  
11 ECF No. 3707. The Court has asked the parties to respond. We fully support the  
12 Receiver's request.

13 Defendants have filed a notice of appeal of the September 27 order, ECF No. 3693,  
14 and a motion to stay the order, ECF No. 3715.

15 As stated above, the California Department of Public Health (CDPH) in August  
16 mandated that all staff at two prisons and certain staff at other prisons be fully vaccinated  
17 against COVID-19 by October 14, 2021. On October 21, CCHCS last week said this  
18 mandate applied to 20,229 staff. However, it did not provide the total number of such staff  
19 fully vaccinated, including because a then-existing state court order had temporarily  
20 restrained the CDPH mandate for California Correctional Peace Officer Association  
21 (CCPOA) members. The restraining order expired on October 22 and on that same date  
22 the state court denied a request by CCPOA members for a preliminary injunction enjoining  
23 the CDPH mandate. CCHCS also informed us that staff subject to the CDPH mandate  
24 who are not fully vaccinated are required to wear N95 masks at all times when on prison  
25 grounds. We plan to ask how such staff will be identified each day and how the N95 mask  
26 requirement will be monitored.

27 *Defendants' Position:* Staff vaccination rates continue to improve. As of October  
28

1 26, 65% of staff have at least one dose of the COVID-19 vaccine.

2 Plaintiffs are correct that Defendants did not dispute the Receiver’s public health  
3 findings submitted in support of the August 4, 2021 Receiver’s Report, however, the  
4 public health findings did *not* determine that “the August California Department of Public  
5 Health vaccination requirement for certain prison staff leaves tens of thousands of the  
6 incarcerated at risk for exposure to infection from staff not required to be vaccinated,” as  
7 Plaintiffs misstate above. Nor could they, since the Receiver’s Report, filed on August 4,  
8 2021, predated the California Department of Public Health’s (CDPH) orders pertaining to  
9 mandatory vaccination for prison staff. (*See* ECF No. 3657.) And, while Defendants  
10 agreed with the public health findings regarding COVID-19 that were included in the  
11 Receiver’s report, Defendants were clear that they “do not agree with the conclusions the  
12 Receiver drew from these findings, namely, that the ‘only method to ensure adequate  
13 protection and care for incarcerated persons is’ to vaccinate all prison staff.” (ECF No.  
14 3660 at 19:23-20:2, *citing* ECF No. 3638 at 5.)

15 Moreover, as Defendants indicated in their Reply to the Order to Show Cause Re:  
16 Receiver’s COVID-19 Vaccine Policy and at the September 24, 2021 hearing, neither  
17 Plaintiffs nor the Receiver submitted *any* evidence establishing that it is safer for an  
18 unvaccinated patient to be surrounded by vaccinated persons, rather than for that patient  
19 himself to be vaccinated; this fact has not and cannot be disputed. (*See* Defs. Reply re:  
20 Order to Show Cause re: Receiver’s COVID-19 Vaccine Pol’y (“Defs.’ Reply”), ECF No.  
21 3673, at 12:23-28 (“the public health findings cited in the Receiver’s report fail to support  
22 Plaintiffs’ position that vaccinating *staff* is the *only* way to keep the incarcerated  
23 population safe from the threat of COVID-19 ... Plaintiffs’ position ignores not only the  
24 numerous layered safety measures that CDCR has implemented and enforces, but also the  
25 most direct means available of ensuring adequate safety of the incarcerated population—  
26 vaccinating all incarcerated people”), 13:20-22 (“Neither Plaintiffs nor the Receiver cite  
27 any public health guidance that identifies or supports such a strategy [of vaccinating those  
28

1 who work near incarcerated persons] as providing more protection than the vaccination of  
2 all incarcerated people.”); ECF No. 3686 (Sept. 24, 2021 Tr.) at 26:23-27:1 (“I don’t think  
3 that there is any public health finding that says that a person who is unvaccinated is more  
4 safe if everybody around them is vaccinated than if he or she were vaccinated”), 29:22-  
5 30:1 (“the State is not disputing those public health findings. They are disputing the  
6 conclusion that the only way to protect ... vaccinated and unvaccinated residents -- is to  
7 mandate vaccines for 40,000 employees on the record in front of it”).)

8 Plaintiffs parrot the Receiver’s improper and incomplete assertions in his October  
9 20 filing, including that “Defendants have since refused to commit to the joint  
10 implementation plan, or to any date for implementation of the vaccination requirement.”  
11 This statement omits half the story. Defendants already advised the Court on October 15  
12 that “the deadlines set forth in the October 12, 2021 plan are no longer achievable and  
13 Defendants request clarification from this Court as to what deadlines, if any, now apply.”  
14 (ECF No. 3703 at 3.) Moreover, and prior to the Receiver’s October 20 filing, a Kern  
15 County Superior Court had specifically restrained the State from implementing a portion of  
16 its plan. (*See* Defendants’ Request for Clarification, ECF No. 3703.) In response, the  
17 Court ordered Defendants and the Receiver to meet and confer over the timeframe for  
18 implementing the Court’s September 27, 2021 order, and gave them 13 days to do so. The  
19 Court requested an update on those efforts at the next case management conference on  
20 October 28, 2021. (ECF No. 3705.) Defendants were in the process of meeting and  
21 conferring with counsel for the Receiver on implementation dates as instructed when the  
22 Receiver unilaterally terminated the discussions and filed a one-sided proposed order.  
23 (ECF No. 3708.)

24 Since that time, the Kern County Superior Court’s temporary restraining order  
25 preventing implementation of the plan with respect to Bargaining Unit 6 employees  
26 specified in the August 19 CDPH Order has terminated, and the court subsequently denied  
27 CCPOA’s request for a preliminary injunction. (*See* ECF No. 3710 at 4:20-25.) And as  
28

1 stated in Defendants' Response to the Receiver's Report of Meet and Confer on  
2 Implementation Plan ("Defendants' Response"), Defendants explained to the Receiver's  
3 counsel that, in the absence of a court order mandating implementation of the vaccine plan  
4 by a date certain, the State could not unilaterally implement the plan and ignore the notice  
5 provisions and bargaining requirements set forth in applicable contracts between CDCR  
6 and the affected unions. (ECF No. 3710 at 3:18-24.) CDCR is therefore presently  
7 required to meet and confer with the affected unions per the terms of their contracts. (*Id.*  
8 at 3:21-22.) While the Receiver's unilateral termination of the meet-and-confer process  
9 unnecessarily halted implementation efforts, Defendants are prepared to proceed with  
10 implementation while complying with their bargaining obligations under state law prior to  
11 implementation. (ECF No. 3710 at 13-17.) Defendants and the Receiver restarted  
12 discussions on October 25, and Defendants remain hopeful that they will work out an  
13 implementation timeline that takes into account the reality of Defendants' obligations to its  
14 employees. With CCPOA's October 25, 2021 filing, however, the union contends that  
15 there must be meaningful time for bargaining over the effects of the plan before the plan  
16 may be implemented. (ECF No. 3712 at 3.) This position complicates Defendants' and  
17 the Receiver's efforts to reach agreement as to implementation deadlines, but counsel for  
18 the Defendants and Receiver are continuing to meet and confer.

## 19 **II. VENTILATION**

20 *Plaintiffs' Position:* The Receiver told a legislature committee in February, "If the  
21 coronavirus were designing its ideal home it would build a prison." See ECF No. 3548 at  
22 7:10-12. One reason that's so is because the virus spreads by airborne aerosols and almost  
23 everyone in prison lives in crowded and poorly ventilated common air space housing units  
24 in which masks cannot be and are not worn for hours at a time, such as during hours of  
25 sleep. Most housing units have very little if any natural ventilation (if there are windows  
26 they almost always do not open). The electric mechanical ventilation systems at almost all  
27 prisons are designed to, in the heating mode, recirculate some portion of the air back to and  
28

1 through each housing unit. Further, as described below, a good number of these  
2 ventilation systems do not work as designed, and need repair.

3 In sum, those who live and work in the units face significant risk of airborne  
4 transmission of COVID-19. A March 2021 report by independent experts CalPROTECT,<sup>4</sup>  
5 regarding a December 2020 review at the California Substance Abuse Treatment Facility  
6 and State Prison (SATF), identified “ventilation and air circulation” as a “key vulnerability  
7 related to COVID-19 control.” Substance Abuse and Treatment Facility (SATF) Corcoran  
8 Site Visit Report, March 5, 2021, attached hereto as Exhibit 2, at 22. The report  
9 documented several concerns: wildly varying but generally relatively low air exchange  
10 rates between housing units; the use of inadequate filters; and the lack of routine  
11 maintenance (resulting in, among other things, inoperative exhausts, variable airflows, and  
12 unintended pressurizations leading to what it termed potential infection scenarios). *Id.* at  
13 24-30.

14 Months ago, Defendants acknowledged that housing unit ventilation “plays a role in  
15 the health” of those incarcerated or who work in CDCR prisons. ECF No. 3566 at 19.  
16 CDCR thus at the end of 2020 undertook a project to install, where possible, MERV-13  
17 filters for recirculated air in housing units, which as stated above is used during cold  
18 weather months. According to October 15 information from CDCR, all prison housing  
19 units Air Handling Units (AHUs) now have MERV-13 filters installed except for: (1) six  
20 prisons at which AHUs do not recirculate air; (2) two prisons which cannot accommodate  
21 MERV-13 filters due to system design (MERV-11 filters have been installed in one and  
22 are on order for the other); (3) two prisons at which the estimated installation of MERV-13  
23 filters is said to be, respectively, October and November, 2021; and two (of 24) housing  
24 units at one prison, with the status of installation in those units not stated. The MERV-13

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25  
26 <sup>4</sup> CalPROTECT is a multidisciplinary team of experts in public health,  
27 medicine and infectious disease, behavioral science, environmental engineering, and  
28 economics from AMEND at UC San Francisco and UC Berkeley Schools of Public Health  
and Public Policy. See <https://amend.us/calprotect>.

1 filters must be promptly installed at the prisons and housing units that can use them.  
2 CDCR and CCHCS must monitor to determine whether the filters reduce the risk of  
3 airborne transmission during cold weather months.

4 CDCR also undertook in March a project to inspect and evaluate all housing unit  
5 ventilation systems, “focusing on whether the airflow is working the way it is supposed  
6 to.” ECF No. 3566 at 20:2-4. An Executive Summary of the inspections and evaluations,  
7 and a “Summary of Performance Measures” were finally provided on August 31, and are  
8 attached as Exhibit 3. Shortly thereafter, CDCR provided additional data, and last month  
9 arranged an hour meeting with its headquarters person in overall charge of the project.<sup>5</sup>

10 CDCR, per the information provided, inspected and took measurements of all  
11 housing unit Air Handling Units (AHUs) and a small subset of cell and dorm air supply  
12 vents. Many serious problems were identified. The “Summary of Performance Measures”  
13 shows that the airflow of nearly one-third of AHUs was below 90% of design  
14 specifications.<sup>6</sup> At six prisons, nearly three-quarter or more of the AHUs failed to meet  
15 that standard, including two at which more than 90% failed to meet that mark. The data  
16 further shows that at four prisons, well under 20% of the airflow measurements taken at  
17 cells or dorms were at least 90% of design specifications, and at six other prisons only  
18 50% to approximately 70% of measurements met that standard. In sum, CDCR’s  
19 inspections and evaluations showed a need for repair or replacement of many housing  
20 AHUs and ventilation systems.

21 Despite these findings, CDCR has no overall program to repair or replace  
22 substandard AHUs or other ventilation system problems. The Executive Summary merely  
23 states that headquarters staff will assist in “prioritizing” repairs, but it was made clear  
24 during a October 5 discussion that any decision as to whether and when to make any repair

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25 <sup>5</sup> The CDCR Director of Division of Facility Planning, Construction and  
26 Management.

27 <sup>6</sup> The data shows a total of 1,042 AHUs with airflow at least 90% of design were said  
28 to have airflow of at least 90% of design specifications and 490 which do not; 104 AHUs  
were pending airflow measurement.

1 has been left to each individual prison. While CDCR Facility Planning, Construction and  
2 Management Division (FPCM) have made visits to some of the prisons “to review repair  
3 procedures and priorities,” there is no requirement that any repair be made, by any date.  
4 There are no plans to even ask if repairs have been completed, let alone a plan for post-  
5 repair inspections, airflow measurements, and evaluation.

6 We continue to believe that CDCR must assess not only whether AHUs are  
7 functioning as designed, but whether residents are safe from airborne spread of COVID-19  
8 at current population levels (and, if not, what population each housing unit could safely  
9 support), so that CDCR can be better prepared in the event of a vaccine-evading variant or  
10 emergence of a similar airborne disease. *See* ECF No. 3592 at 15-17. In August, CCHCS  
11 said that CalPROTECT had completed visits and reviews, including we believe regarding  
12 housing unit ventilation, at 11 additional prisons in the first six months of this year.  
13 CCHCS said that CalPROTECT would provide a report regarding its site visits at the end  
14 of this year. We are hopeful this review will provide a more comprehensive assessment of  
15 the risk of airborne spread in CDCR’s housing units.

16 *Defendants’ Position:* CDCR has undertaken a significant effort to install MERV-  
17 13 filters in all appropriate housing units. As of October 15, 2021, Defendants have  
18 installed higher efficiency MERV-13 air filters in 602 housing units; only 29 others are  
19 still awaiting replacement. Eighty-nine additional housing units are served by AHUs that  
20 do not recirculate any interior air, so MERV-13 filters are unnecessary in those units. And  
21 33 other housing units are served by AHUs that did not operate properly with MERV-13  
22 filters installed, and required a lower efficiency filter such as a MERV-11.

23 Plaintiffs note above that “[t]he ‘Summary of Performance Measures’ shows that  
24 the airflow of nearly one-third of AHUs was below 90% of design specifications, and  
25 suggest that “CDCR’s inspections and evaluations showed a need for repair or replacement  
26 of many housing AHUs and ventilation systems.” It is important to understand, however,  
27 that there are two primary factors that determine the design specifications for a housing  
28

1 unit AHU: (1) code requirements for minimum airflow (based on the floor area of the  
2 building and the number of occupants), and (2) the volume of airflow necessary to  
3 maintain the building's interior air temperature (normally driven by the type of AHU, the  
4 volume of exhausted air, and the exterior temperatures at the location). The volume of  
5 airflow needed to maintain interior temperatures is always larger than the code  
6 requirements for airflow. While the calculation will vary based on the building size and  
7 the AHU, an example from a 270-design cell housing unit at SATF indicates that  
8 approximately 2,000 Cubic Feet per Minute (CFM) of airflow is required by code and the  
9 AHUs serving that building are designed to produce 24,000 CFM of airflow. Due to the  
10 code required airflow being a smaller amount than the airflow needed to maintain  
11 temperature, an AHU that is performing below design specifications is likely still meeting  
12 code requirements but may be having difficulty in maintaining indoor air temperature  
13 during peak hot or cold weather events.

14 AHUs performing below the 90% level are one indicator that the institutions should  
15 perform preventive and reparative maintenance for these units. A poor performing AHU  
16 may not be maintaining appropriate interior temperature; repair requests for AHUs are  
17 normally generated by the building's inhabitants due to the interior temperature being too  
18 hot or too cold. Prison housing unit AHUs are operating 24/7 and in some extreme  
19 climatic zones within California. Given these operating conditions and the age of many of  
20 the AHUs, it is not surprising that repairs (or in extreme cases, replacement) are necessary  
21 in some instances.

22 Plaintiffs are mistaken that "CDCR has no overall program to repair or replace  
23 substandard AHUs or other ventilation system problems." CDCR's program for AHU  
24 repair or replacement is not a separate program but is a component of the larger  
25 maintenance program at each prison. AHU repairs are conducted by Plant Operations  
26 throughout the year based on either notification from the building's occupants that it is too  
27 hot or too cold, or based upon conditions identified during preventive maintenance. If  
28

1 conditions are such that repair is not feasible or unlikely to improve the AHU's operation,  
2 prisons will utilize their facility maintenance budget for replacement of the AHU.

3 While Plaintiffs are correct that decisions as to whether and when to make repairs is  
4 within each institution's discretion, CDCR headquarters is heavily involved with setting  
5 expectations and providing assistance. The Division of Adult Institutions (DAI) discussed  
6 the inspection results at a Warden's meeting on September 1, 2021, emphasizing the need  
7 to address AHU performance issues. DAI will continue to emphasize these repairs at  
8 subsequent Warden's Meetings and during mid-year fiscal reviews. Facility Planning,  
9 Construction and Management Division (FPCM) staff have conducted conference calls  
10 with prison Plant Operations' staff dating back to July 2021 discussing inspection results  
11 and repair priorities. Beginning in September 2021, FPCM staff have been performing site  
12 visits specifically regarding ventilation to review repair procedures and priorities with  
13 Plant Operations staff. As of October 23, 2021, 17 of these site visits have occurred.

### 14 **III. COVID-19 MONITORING**

15 *Plaintiffs' Position:* Earlier this month we received information that at Wasco State  
16 Prison wheelchair users not known to have or to have been exposed to COVID-19 were  
17 being brought for showers into a unit housing those on quarantine due to exposure to  
18 others with active COVID-19, and, even more concerning, into an isolation unit housing  
19 those known have active COVID-19. On October 13, we asked CCHCS and CDCR  
20 whether this was true, and if so, to stop the practice because it wrongly risked infection of  
21 the people concerned. On October 20, CDCR responded, acknowledging that those not  
22 known to have been exposed to COVID-19 were brought into a quarantine unit for  
23 showers, but not addressing the question about people being brought into the isolation unit.  
24 We again asked for a response to that question. On October 21, CDCR replied, refusing to  
25 acknowledge whether disabled people had been brought into an isolation unit to shower,  
26 but stating that effective October 14 – the day after our initial query – the disabled people  
27 in the unit we said had been being brought to a COVID-19 isolation unit for showers were  
28

1 brought to an entirely different building to shower. That CDCR staff, more than 18  
2 months into the pandemic, could expose vulnerable people to the risk of COVID-19  
3 infection in the way that occurred at Wasco bespeaks indifference to, or an inability to  
4 understand and implement, the most basic safeguards necessary when housing known  
5 active or suspected COVID-19 patients.

6 *Defendants' Position:* On October 13, 2021, Plaintiffs indicated they had received  
7 reports of wheelchair-using patients not on quarantine or isolation at Wasco being brought  
8 into quarantine and isolation spaces to use wheelchair-accessible showers. They  
9 referenced reports of wheelchair-using patients housed in Buildings B1 and B6, A-side,  
10 being brought to the B-side (quarantine in B1, and isolation in B6) for showers. Plaintiffs  
11 asked: "Can WSP confirm whether wheelchair-using patients are being brought into  
12 isolation and quarantine spaces in order to use wheelchair-accessible showers? If so, is  
13 this practice permitted by current policies on quarantine and isolation? Rather than  
14 unnecessarily exposing these patients by bringing them to isolation and quarantine spaces,  
15 are there alternative wheelchair-accessible showers that can be used? Or can these patients  
16 be moved elsewhere in the institution to more safely and easily access wheelchair-  
17 accessible showers?"

18 Defendants responded on October 20, 2021, and stated the following, in part:

19 The B-side of FBB1, is currently used as intake for inmates as well as  
20 overflow for inmates with Americans with Disabilities Act (ADA)  
21 requirements, but is not a designated quarantine unit. We do not have cells  
22 for permanent wheelchair users (DPW) on the A-Side of any of our  
23 buildings. As a result, this inquiry is specifically related to intermittent  
24 wheelchair users (DPO).

25 Upon review, it was discovered that the B-side of FBB1 was utilized last  
26 week to accommodate contact quarantine overflow when our designated  
27 quarantine building (Facility B Building #5) was at capacity. However, as of  
28 October 14, 2021, the remaining contact quarantine inmates were moved  
back into the designated quarantine building as space became available. Prior  
to last week, it was the practice of WSP-RC staff to bring DPO designated  
inmates from FBB1, A-side to FBB1, B-side to shower in order to ensure  
access to architectural accommodations including a shower ramp, shower

1 chair, grab bars and a shower hose with shower wand. After the contact  
2 quarantine inmates were placed on the B-side of FBB1, staff continued to  
3 provide showers in this manner but cleaned and disinfected the showers in  
4 between each use. DPO-designated inmates are no longer brought into  
5 quarantine spaces to shower.

6 Plaintiffs' counsel responded the evening of October 20, 2021, and advised that the  
7 above response did not address their questions about Building 6, and asked further follow  
8 up questions related to the institution's practices relating to showering for wheelchair-  
9 bound patients in Building 6. Defendants responded the next day and advised "[t]here was  
10 a clerical error that occurred and the last response from WSP was missing." Defendants  
11 further explained:

12 Per the direction of the Facility B Captain, effective Thursday, October 14,  
13 2021, all DPO inmates housed in FBB6, A-side were to be escorted to FBB4,  
14 B-Side for showers. This direction was in effect until Monday, October 18,  
15 2021, when contact quarantine inmates housed in FBB1, B-Side came off of  
16 quarantine and were re-housed elsewhere. Once FBB1, B-Side was emptied  
17 and sanitized, all DPO/DPW/DPM inmates housed in FBB6, A-Side were  
18 moved to FBB1, B-Side.

19 FBB1, B-Side is currently used as intake for inmates as well as overflow for  
20 inmates with Americans with Disabilities Act (ADA) requirements, but is  
21 not a designated quarantine unit.

22 Per Warden (A) Shirley, effective Monday, October 18, 2021, all Reception  
23 Center DPO/DPW/DPM inmates, will be housed in FBB1, B-Side, where  
24 there are 4 DPW cells and the building is designated for ADA. Once the  
25 DPO/DPW/DPM inmates are released from the 14 day quarantine, any who  
26 can be housed in dorms will be moved to dorms. Any who are not dorm  
27 qualified will remain in FBB1, B-Side until transferred.

28 It should be noted FBB4, A-Side shower has been retrofitted with hand rails  
and a wheelchair ramp in order to house DPO/DPW/DPM inmates, however,  
WSP-RC is still awaiting approval from Plaintiff Attorneys in order to utilize  
this housing unit for ADA housing.

Thus, contrary to Plaintiffs' assertions above, Defendants did not refuse to answer any  
question. Moreover, Plaintiffs' accusations of "indifference to, or an inability to  
understand and implement, the most basic safeguards necessary" are unhelpful and

1 inaccurate. Mistakes can occur in a system the size of CDCR's, but to accuse Defendants  
2 of deliberate indifference for correcting a mistake immediately upon discovery does not  
3 demonstrate a reckless disregard.

#### 4 **IV. INTEGRATED SUBSTANCE USE DISORDER TREATMENT (ISUDT)**

5 *Plaintiffs' Position:* As recently reported by the Receiver (*see* ECF 3668 at 10<sup>7</sup>),  
6 more than 12,000 incarcerated persons now receive Medication Assisted Treatment (MAT)  
7 for substance use disorders, typically opioid addiction. This number represents an  
8 approximately five-fold increase since the pandemic began in March 2020. We very much  
9 appreciate the efforts of CCHCS over the last 18 months to make MAT more widely  
10 available. We continue to believe the ISUDT program including MAT is necessary for  
11 adequate care, reduces morbidity and mortality, and changes many lives for the better.

12 For the Court's information, we have three main concerns regarding ISUDT which  
13 we have recently raised with CCHCS. First, there continues to be a large backlog of  
14 patients pending an initial addiction medicine provider appointment, which is necessary to  
15 begin MAT. As of 9/27/21, approximately 4,000 initial appointments were pending, with  
16 approximately 3,000 of those overdue, including about 600 ordered more than six months  
17 ago. CCHCS has implemented strategies to reduce this backlog, but "anticipates" it will  
18 not be "sufficiently addressed" until July 2022, perhaps sooner at some prisons. We  
19 continue to monitor these efforts, and when appropriate ask CCHCS to consider starting  
20 treatment immediately for particularly at-risk patients with pending initial appointments.

21 Second, group counseling and other non-MAT interventions continue to be  
22 unavailable for many ISUDT patients, including because of COVID-related precautions  
23 and restrictions. Data recently provided by CCHCS data shows that only about 60% of  
24 MAT-prescribed patients receive in-person groups or what is called "packet programming"  
25 (written handouts). Further, it was reported that more than 500 patients who had been  
26 receiving in-person groups or handouts were not able to get it due to COVID-related

27 \_\_\_\_\_  
28 <sup>7</sup> The page reference here is to the ECF pagination.

1 quarantines. More broadly, we are concerned whether sufficient space and staff can be  
2 marshaled to provide in-person groups for the 12,000 current ISUDT patients then the  
3 16,000 or more who eventually will be enrolled in the program. We will follow-up with  
4 CCHCS regarding these matters.

5 Finally, we are concerned about efforts to link MAT patients with MAT care in the  
6 community after parole or release. The Receiver recently reported (*see* ECF 3668 at 12)  
7 that just over 600 MAT-prescribed patients had been successfully linked to community  
8 providers upon release. That is greatly appreciated and important, but information received  
9 from CCHCS last week stated that nearly 450 such patients during this same period were  
10 released without being linked to a community provider. We will follow-up with CCHCS  
11 regarding the latter patients, including what might be done to increase the number of  
12 released patients with community providers.<sup>8</sup>

13 *Defendants' Position:* Defendants will continue to work closely with CCHCS in  
14 providing this critical and life-saving treatment to the incarcerated population and defer to  
15 CCHCS regarding its response to Plaintiffs' inquiries above.

## 16 **V. PLAINTIFFS' RECENT SITE VISITS**

### 17 **A. Salinas Valley State Prison (SVSP) and California Medical Facility 18 (CMF) Psychiatric Inpatient Programs**

19 *Plaintiffs' Position:* On September 27, we wrote the Receiver and CCHCS  
20 regarding medical care in the Psychiatric Inpatient Programs (PIPs), based largely on site  
21 visits to those programs at Salinas Valley State Prison and California Medical Facility  
22 conducted, respectively, in June and July. As we explained, we believe there are major  
23 problems with medical care in those programs, including: inconsistent scheduling  
24 practices; no use of sick-call slips and a lack of standardized nurse triage practices; lack of  
25

---

26 <sup>8</sup> CCHCS also confirmed last week that its policies provide for all MAT-prescribed  
27 patients to receive a 30-day supply of medication when paroling or released to community  
28 supervision, unless they are receiving Methadone, in which case they are referred to a  
Narcotics Treatment Program in the county in which they are released.

1 clear guidelines for follow-up with chronic care patients, many of whom could go months  
2 without provider encounters; and a lack of follow-up for patients said to have refused  
3 medical services.

4 We understand CCHCS is in the process of instituting a pilot program – the  
5 Specialized Beds Complete Care Model – to address certain deficiencies it identified in  
6 PIP care. The primary feature of the pilot is a daily group huddle between medical, mental  
7 health, and custody staff, and more communication between staff on different shifts. We  
8 appreciate this pilot, but as designed, it does not appear to address all deficiencies we  
9 reported.

10 As explained in our letter to the Receiver and CCHCS, we believe PIPs should be  
11 considered outpatient settings for purposes of medical care. This would mean medical  
12 staff in those units would be required to follow the same timeframes regarding  
13 appointments and care as their outpatient counterparts. This would, in our view, promote  
14 better continuity of care, and reduce the chance of patients not being seen by medical staff  
15 or receiving necessary care for months. As an alternative, we suggested the development  
16 of a Patient Registry for the PIPs that would track and require medical encounters take  
17 place for every patient in the PIP within a minimum time frame, e.g. every 30 days for  
18 chronic care patients and every 90 days for all other patients, or more often as needed.

19 We look forward to discussing our report and findings with CCHCS.

20 *Defendants' Position:* Defendants defer to CCHCS and its determination as to how  
21 best to address the issues Plaintiffs identify above. In addition, Defendants note that CMF  
22 has an ongoing initiative to ensure that PIP patients are seen timely for episodic and  
23 chronic care. CMF leadership is monitoring and actively engaging with PIP line staff in  
24 ensuring that PIP patient follow-ups are timely and scheduled in CERNER.

25 **B. Substance Abuse Treatment Facility and State Prison, Corcoran (SATF)**

26 *Plaintiffs' Position:* In August, Plaintiffs' counsel conducted a remote site visit,  
27 including phone interviews with patients and a video meeting with staff, at SATF. We  
28 requested this visit due to our growing concerns about staff misconduct at SATF. In May,

1 Plaintiffs' counsel in *Armstrong* sent CDCR and CCHCS a letter documenting deeply  
2 concerning social media posts by SATF medical staff, celebrating the brutal killings of  
3 disabled incarcerated people there. *See* ECF No. 3266 at 16, 75-78, Joint Case Status  
4 Statement, *Armstrong v. Newsom*, Case No. 4:94-cv-02307-CW (N.D. Cal. May 17, 2021).  
5 During a May 2021 *Armstrong* monitoring visit, counsel also heard and shared with CDCR  
6 and CCHCS reports of medical staff belittling patients and dismissing their concerns.

7       Unfortunately, the accounts we received during our interviews in August were  
8 consistent with those concerns. We heard numerous reports of dismissive and  
9 unprofessional behavior from nursing staff when people came to the clinic to obtain  
10 medications, request incontinence supplies, or otherwise seek help. For example, we heard  
11 reports of nurses telling patients to "get out of here" when they came to the clinic to  
12 request incontinence supplies, taunting patients when they requested medical grievances,  
13 giving patients too-small incontinence briefs and condom catheters and dismissing them  
14 when they asked for the appropriate size, and so frequently dismissing patients who  
15 requested hearing aid batteries that patients had begun severely restricting use of their  
16 hearing aids. We were also told by multiple patients that nurses will frequently  
17 inappropriately threaten people with or directly issue unwarranted Rule Violation Reports  
18 (RVRs). When we raised the issue with medical leadership at SATF during the site visit,  
19 they reported that they were not aware of any RVRs being issued by medical staff.  
20 However, according to documents produced by Defendants after the remote visit, medical  
21 staff at SATF issued 61 RVRs to patients between January 1, 2021 and August 17, 2021.  
22 All were issued by nursing staff, and four specific nurses were responsible for issuing 46  
23 out of the 61 RVRs.

24       We raised these concerns with medical staff during a call on August 13, 2021, after  
25 our interviews, and in a written report on October 8, 2021. We appreciate the stated  
26 commitment of CCHCS Headquarters staff, the Regional Healthcare Executive, and the  
27 SATF CEO to addressing these issues. During our call on August 13, we were told: (1) the  
28

1 CEO was following up personally with patients who had been the subject of advocacy  
2 letters from our office; (2) the nurses who had been identified as the authors of the social  
3 media posts had been placed on leave; (3) supervising registered nurses (SRN) had been  
4 directed to attend all IAC meetings; and (4) medical leadership had reiterated expectations  
5 of professionalism to clinic staff.

6 We appreciate these efforts, and hope to see substantial improvements at SATF at  
7 our next visit. Given the scope of the problems at SATF, however, we believe SATF will  
8 need to do more to create sustainable change. We encouraged leadership to identify a  
9 strong SRN and assign that person to the yard we identified as most problematic, and to  
10 require all SRNs spend more time in the medical clinics, supervising and modeling  
11 positive interactions with patients. We also encouraged leadership to proactively seek out  
12 confidential feedback from patients, especially those who have frequent interactions with  
13 medical staff. Finally, we requested CDCR and CCHCS review each of the 61 RVRs  
14 issued by medical staff at SATF, to determine whether any should be rescinded, and to  
15 specifically investigate the four nurses responsible for issuing 75% of the RVRs for misuse  
16 of the disciplinary process.

17 We plan to conduct another site visit to SATF soon to assess CDCR and CCHCS's  
18 efforts to address these problems.

19 *Defendants' Position:* Defendants are informed by CCHCS that SATF nursing  
20 leadership has addressed the SRN leadership functions and is implementing a plan to  
21 address leadership issues. The SATF CEO reviewed the 61 RVR's referenced by Plaintiffs  
22 and determined that all were appropriate and none should be rescinded. The nurses listed  
23 in the RVRs did submit their written findings (variance reports) of patient behaviors to  
24 custody, the custody review process for RVRs was followed at SATF, and the patient  
25 RVRs were subsequently issued through the custody RVR process. But as an additional  
26 precaution, the SATF Chief Nursing Executive is reviewing the nurses with the most  
27 frequent variance reports to custody. Additionally, SATF is continuing to conduct weekly  
28

1 tours on all three watches and interacting with incarcerated persons in an effort to receive  
2 additional feedback.

3 DATED: October 26, 2021

HANSON BRIDGETT LLP

4  
5  
6 By: /s/ Samantha Wolff

PAUL B. MELLO  
7 SAMANTHA D. WOLFF  
8 LAUREL O'CONNOR  
9 DAVID C. CASARRUBIAS  
Attorneys for Defendants

10 DATED: October 26, 2021

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Deputy Attorneys General  
17 Attorneys for Defendants

18  
19 DATED: October 26, 2021

PRISON LAW OFFICE

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Attorneys for Plaintiffs

28

# Exhibit 1



# CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES



## MEMORANDUM

Date : October 20, 2021

To : Steven Fama, Prison Law Office

Subject : **PRISON LAW OFFICE NON-PARAGRAPH 7 CONCERN RELATING TO  
UPDATED TABLE SHOWING CDCR STAFF INSTITUTION-SPECIFIC  
COVID-19 VACCINATION NUMBERS AND PERCENTAGES**

California Correctional Health Care Services (CCHCS) is providing the italicized information below in response to your e-mail inquiry dated October 13, 2021.

1. Could you please send us an updated/current table showing California Department of Corrections and Rehabilitation (CDCR) staff prison-specific vaccination numbers and percentages for staff (overall, for healthcare, and for custody), of the kind filed with the Court on September 10, 2021, as an exhibit to a Declaration by Dr. Joseph Bick? When you provide the table, please let us know the date the table's data reflects.

*Refer to Attachment A for the updated table showing the number and percentage of CDCR staff at each institution who received COVID-19 vaccinations as of October 14, 2021.*

Thank you.

cc: Clark Kelso, Receiver  
Directors, CCHCS  
CCHCS Office of Legal Affairs  
Office of Legal Affairs, CDCR  
Office of the Attorney General  
Hanson Bridgett, LLP  
Jackie Clark, Deputy Director (A), Institution Operations, CCHCS  
DeAnna Gouldy, Deputy Director, Policy and Risk Management Services, CCHCS  
Renee Kanan, MD, Deputy Director, Quality Management, CCHCS  
Erin Hoppin, Associate Director, Risk Management Branch, CCHCS  
Regional Deputy Medical Executive, Regions I-IV, CCHCS  
Regional Health Care Executive, Regions I-IV, CCHCS  
Regional Nursing Executive, Regions I-IV, CCHCS

as of October 14, 2021

Institution	ALL						Healthcare						Custody						Administrative, Maintenance & Operations Services						Contractor Staff					
	Total number of staff	Completely Vaccinated		Vaccinated with at Least 1 Dose		Total number of staff	Completely Vaccinated		Vaccinated with at Least 1 Dose		Total number of staff	Completely Vaccinated		Vaccinated with at Least 1 Dose		Total number of staff	Completely Vaccinated		Vaccinated with at Least 1 Dose		Total number of staff	Completely Vaccinated		Vaccinated with at Least 1 Dose						
		#	%	#	%		#	%	#	%		#	%	#	%		#	%	#	%		#	%	#	%	#	%			
SW	55754	32784	59%	34587	62%	10685	8814	82%	9101	85%	26440	13412	51%	14315	54%	12084	8154	67%	8463	70%	6541	2401	37%	2705	41%					
ASP	1400	771	55%	824	59%	174	125	72%	130	75%	721	367	51%	400	55%	401	236	59%	250	62%	103	43	42%	44	43%					
CAC	742	377	51%	399	54%	111	97	87%	99	89%	380	139	37%	149	39%	153	98	64%	103	67%	98	43	44%	48	49%					
CAL	1302	887	68%	946	73%	147	112	76%	117	80%	722	486	67%	519	72%	324	241	74%	249	77%	109	48	44%	61	56%					
CCC	1035	418	40%	439	42%	96	80	83%	80	83%	582	196	34%	210	36%	256	109	43%	113	44%	101	33	33%	36	36%					
CCI	1671	753	45%	820	49%	213	163	77%	178	84%	960	355	37%	384	40%	340	186	55%	192	56%	158	49	31%	66	42%					
CCWF	1336	810	61%	864	65%	296	240	81%	249	84%	529	247	47%	273	52%	384	267	70%	278	72%	127	56	44%	64	50%					
CEN	1328	972	73%	1028	77%	152	120	79%	123	81%	739	546	74%	582	79%	343	270	79%	278	81%	94	36	38%	45	48%					
CHCF	4002	2971	74%	3126	78%	1720	1509	88%	1543	90%	1063	748	70%	797	75%	612	462	75%	488	80%	607	252	42%	298	49%					
CIM	1852	1175	63%	1235	67%	363	311	86%	316	87%	847	475	56%	510	60%	416	296	71%	305	73%	226	93	41%	104	46%					
CIW	1381	875	63%	921	67%	362	299	83%	309	85%	484	306	63%	322	67%	278	216	78%	224	81%	257	54	21%	66	26%					
CMC	1947	1209	62%	1265	65%	400	340	85%	355	89%	882	446	51%	464	53%	468	357	76%	365	78%	197	66	34%	81	41%					
CMF	2807	1939	69%	1993	71%	813	727	89%	736	91%	870	636	73%	660	76%	404	341	84%	351	87%	720	235	33%	246	34%					
COR	2194	1168	53%	1247	57%	377	310	82%	320	85%	1140	492	43%	540	47%	429	280	65%	290	68%	247	85	34%	96	39%					
CRC	1322	788	60%	823	62%	178	152	85%	157	88%	741	388	52%	410	55%	285	209	73%	214	75%	118	39	33%	42	36%					
CTF	1426	1015	71%	1066	75%	204	187	92%	190	93%	682	419	61%	443	65%	397	301	76%	314	79%	143	108	76%	119	83%					
CVSP	901	522	58%	552	61%	115	91	79%	98	85%	432	230	53%	247	57%	278	178	64%	183	66%	76	23	30%	24	32%					
DVI	70	44	63%	46	66%	18	15	83%	16	89%	4	2	50%	2	50%	17	11	65%	12	71%	31	16	52%	16	52%					
FSP	1220	723	59%	747	61%	170	147	86%	152	89%	599	330	55%	344	57%	320	209	65%	212	66%	131	37	28%	39	30%					
HDSP	1300	449	35%	488	38%	187	126	67%	132	71%	719	180	25%	194	27%	295	122	41%	138	47%	99	21	21%	24	24%					
ISP	1361	747	55%	795	58%	131	90	69%	93	71%	685	356	52%	382	56%	300	191	64%	198	66%	245	110	45%	122	50%					
KVSP	1627	925	57%	991	61%	238	194	82%	201	84%	975	463	47%	508	52%	362	237	65%	249	69%	52	31	60%	33	63%					
LAC	1695	974	57%	1057	62%	347	269	78%	280	81%	809	395	49%	428	53%	337	217	64%	226	67%	201	92	46%	122	61%					
MCSP	1794	1015	57%	1063	59%	384	310	81%	324	84%	861	349	41%	371	43%	457	302	66%	308	67%	92	54	59%	60	65%					
NKSP	1482	847	57%	898	61%	259	201	78%	213	82%	772	389	50%	410	53%	338	219	65%	229	68%	113	38	34%	46	41%					
PBSP	1347	516	38%	539	40%	136	83	61%	85	63%	853	240	28%	251	29%	299	165	55%	173	58%	59	28	47%	30	51%					
PVSP	1313	664	51%	708	54%	170	127	75%	134	79%	763	323	42%	349	46%	305	185	61%	192	63%	75	29	39%	33	44%					
RUD	2286	1440	63%	1513	66%	485	417	86%	430	89%	1047	598	57%	646	62%	385	306	79%	312	81%	368	118	32%	124	34%					
SAC	1927	1098	57%	1151	60%	389	323	83%	331	85%	892	450	50%	482	54%	339	239	71%	246	73%	307	86	28%	92	30%					
SATF	1983	1041	52%	1110	56%	383	276	72%	288	75%	988	430	44%	467	47%	455	273	60%	285	63%	157	62	39%	70	45%					
SCC	1191	566	48%	594	50%	135	107	79%	108	80%	657	257	39%	275	42%	309	167	54%	173	56%	90	35	39%	38	42%					
SOL	1484	836	56%	872	59%	217	188	87%	190	88%	723	343	47%	364	50%	378	254	67%	266	70%	166	51	31%	52	31%					
SQ	2148	1313	61%	1392	65%	348	290	83%	301	86%	995	631	63%	676	68%	341	270	79%	278	82%	464	122	26%	137	30%					
SVSP	2022	1277	63%	1338	66%	400	345	86%	358	90%	968	541	56%	573	59%	411	284	69%	295	72%	243	107	44%	112	46%					
VSP	1203	791	66%	815	68%	258	215	83%	220	85%	538	307	57%	315	59%	311	230	74%	236	76%	96	39	41%	44	46%					
WSP	1655	868	52%	922	56%	309	228	74%	245	79%	818	352	43%	368	45%	357	226	63%	238	67%	171	62	36%	71	42%					

# Exhibit 2

# Substance Abuse and Treatment Facility (SATF) Corcoran Site Visit Report March 5, 2021

Berkeley

Public  
Health



AMEND  
CHANGING CORRECTIONAL CULTURE

David Sears\*<sup>§</sup>, Stefano M. Bertozzi\*<sup>§</sup>, Rachel Sklar\*, Brittany Imwalle\*, Ada T. Kwan,  
Sandra I. McCoy, Robert Schell, Helena Archer, Chakriya Srey, Brie Williams

\* Attended in-person site visit  
§ Corresponding authors

# Agenda

- ❖ Context
- ❖ Overview of observations
- ❖ Recommendations
- ❖ Discussion

# CalPROTECT (California Prison Roadmap for Targeting Efforts to Address the Ecosystem of COVID Transmission)

CalPROTECT is an initiative comprised of a multidisciplinary team of experts in public health, medicine and infectious disease, behavioral science, environmental engineering, and economics from **AMEND at UC San Francisco** and **UC Berkeley Schools of Public Health and Public Policy**.

On December 13 & 14, 2020, CalPROTECT visited the Substance Abuse and Treatment Facility, Corcoran State Prison (SATF-CSP) to evaluate ongoing transmission of COVID-19.

Today's presentation summarizes our key findings and recommendations. We have opted to minimize our description of the background of the prison to optimize time for Q&A.

Dr. McCoy and Dr. Sklar will lead today's presentation, followed by Dr. Bertozzi who will highlight key points prior to the Q&A.

# 1. Purpose of this Assessment

Our goal is to describe and recommend policies that may protect and promote physical and mental health among people who are incarcerated, including the prevention and control of COVID-19.

For our team's December 2020 site visit to SATF, we were guided by the following questions:

1. *What were characteristics of the 2020 COVID-19 outbreak at SATF-CSP?*
  - a. *What are the factors that contributed to the outbreak and/or its containment?*
  - b. *How did COVID-19 spread in different housing units?*
  - c. *What factors might contribute to mitigation of future outbreaks at SATF-CSP?*
  - d. *In which areas does SATF-CSP remain vulnerable to future COVID-19 outbreaks?*
2. *What lessons might be transferable to other settings, and how are these lessons translated to policy?*

## 2. Methodology

### Onsite Data Collection

- Interviews and conversations with key stakeholders (e.g., leadership staff, medical leadership, inmate councils)
- Group discussions (e.g., inmate councils)
- Space/place observation during facility visit
- Indoor air quality assessments
  - CO<sub>2</sub> and airflow

### Public data sources

- CDCR, Kings County Department of Public Health, California Government Open Data Portal, CCHS

# 3.1 Findings

## Outbreak Characterization

# Overview of SATF Population and Outbreak

Population	Size	Active Cases	Total Confirmed
As of January 19th, 2021			
Staff	1,555 (Q3)	74 (48 per 1000)	513 (330 per 1000)
Incarcerated (Capacity)	4,314 (3,424)	16 (3 per 1000)	3,004 (696 per 1000)

As of 1/19/2021:

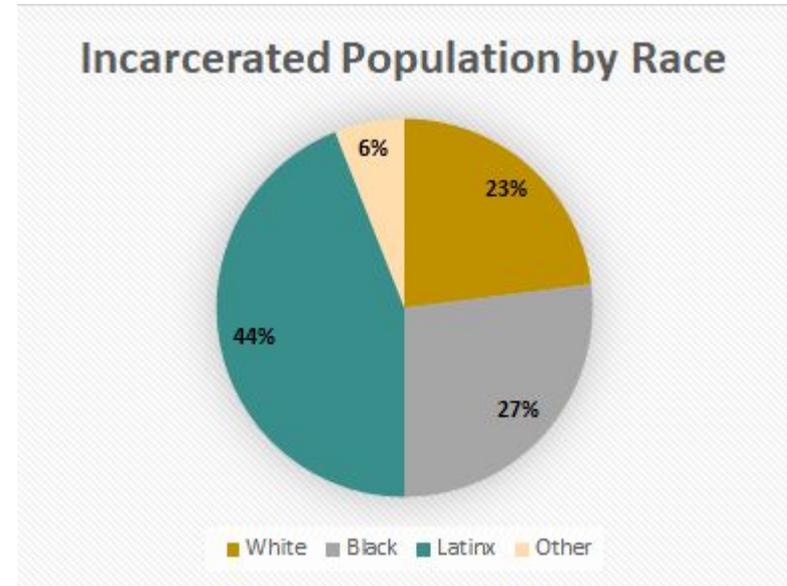
Active cases in CDCR = 37 per 1000

Confirmed cases in CDCR = 471 per 1000

# Demographic Breakdown of SATF Population

Risk Level	SATF	CDCR Facility Avg
As of October 2020		
High Risk I	5%	7%
High Risk II	8%	10%
Medium Risk	54%	34%
Low Risk	33%	49%

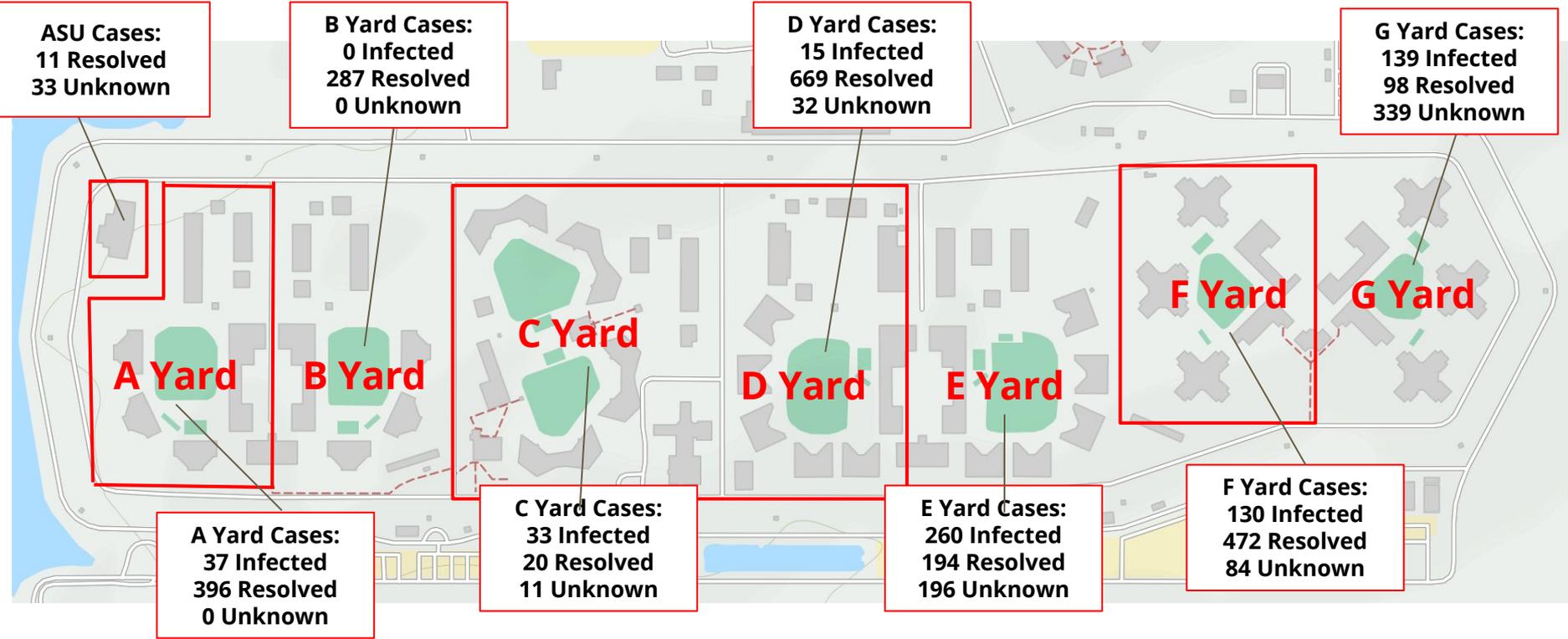
Notes: High risk selection criteria include i) diagnoses/conditions associated with current or future risk for adverse health event, ii) multiple higher level of care events in past 12 months, iii) prolonged medical bed stays, iv) patients on 10 or more medications, v) two or more high risk specialty consultations in past 6 months, vi) 65 years or older, vii) any comorbid medium risk diagnoses/conditions that may increase risks for future adverse health events; Chronic conditions constitute any that do not meet the selection criteria for high risk, including patients enrolled in mental health services delivery system and patients with permanent disabilities (ADA) affecting placement.



**29% of population aged 50+**

**17.2% have at least one ADA-Classified Disability**

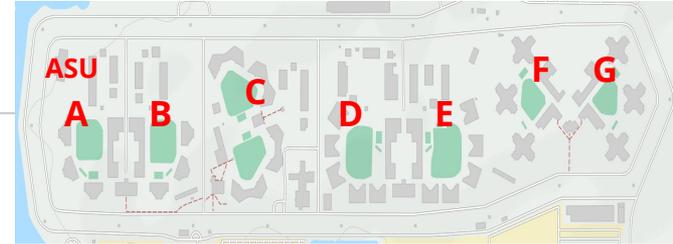
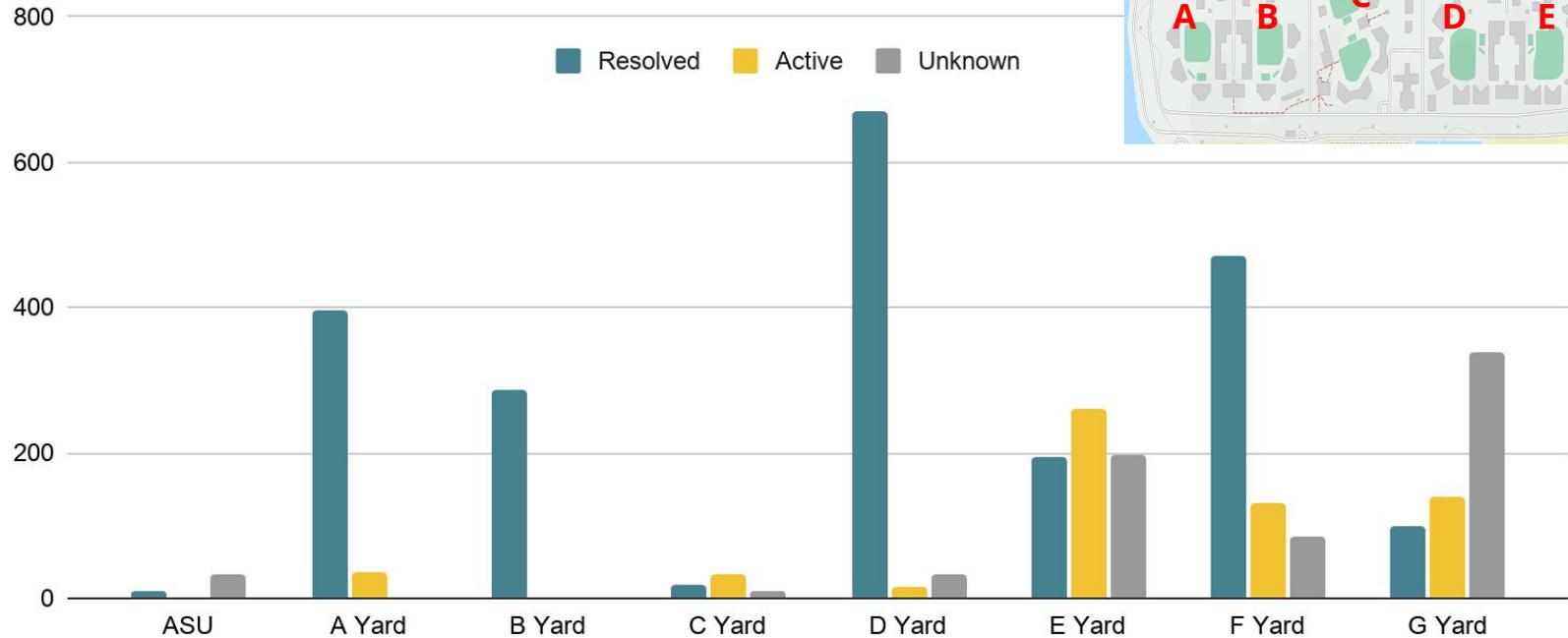
# Landscape of Cases on Visit Day: Dec. 13th, 2020



1. All values as of December 13th, 2020
2. Bolded red squares indicate site visit and ventilation testing locations

# COVID-19 was detected in nearly all housing units

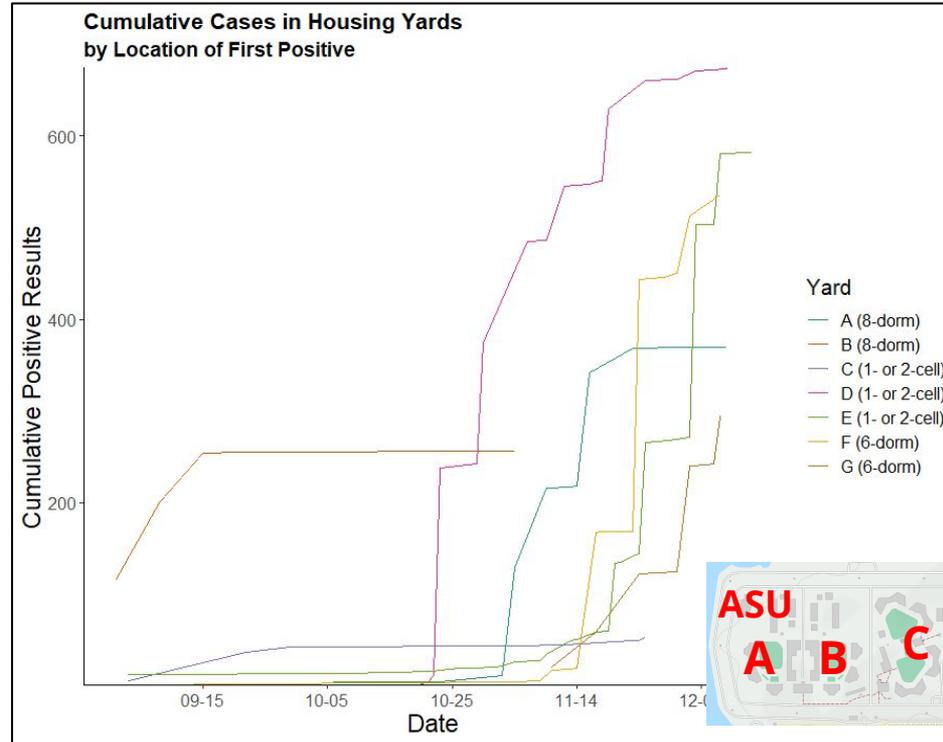
Cases by Yard, SATF-CSP on December 13, 2020



# Cases increased across all housing types in fall

**This graph displays cumulative COVID-19 cases across housing units at SATF over time:**

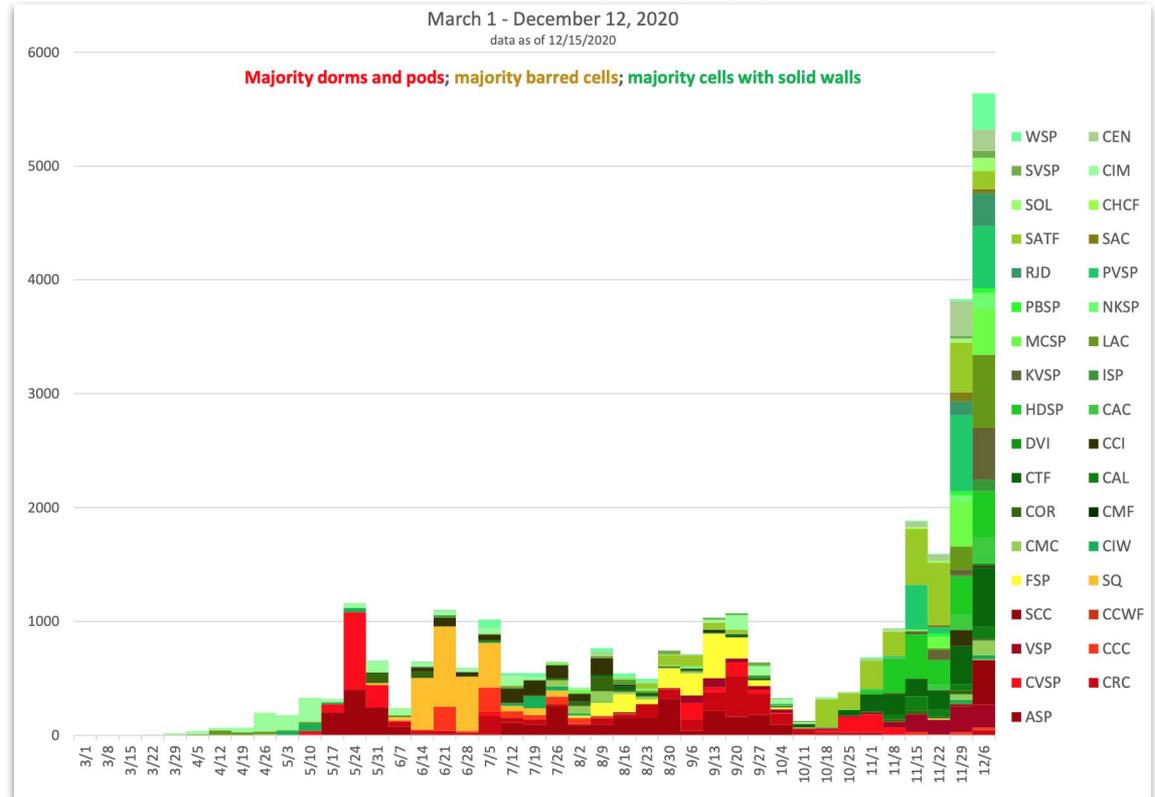
- "Stepwise" appearance due to periodic mass testing starting in late October
- Housing yard indicates location of first positive result, not where exposure occurred
- Many cases occurred in dedicated quarantine units/areas, where patients were moved
- Widespread testing began after outbreak was underway



# Cases by institution housing type changed significantly in late fall

This graph displays CCHCS statewide COVID-19 Cases (N = 30,571) by institution and housing type

- Across CDCR, COVID-19 outbreaks in summer 2020 predominantly occurred in facilities that were mostly dorms and pods.
- However, this pattern has changed beginning in mid-October, with outbreaks occurring in facilities with majority solid-walled cells.
- This may be due to the onset of cooler weather and the use of recirculated, heated air.



Note: Figure provided to CalPROTECT by Dr. Heidi Bauer from CDCR (December 2020)

# View of risk by housing status, Summer 2020

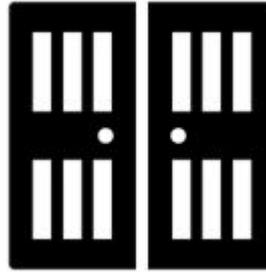
Within jails and prisons, density in the form of close, prolonged contact is a critical risk factor for COVID-19 transmission, which is primarily influenced by *population density, shared air space, and unit type*. While all units pose some level of risk for COVID-19 transmission, particular types of units have higher transmission risk than others.



Single or double occupancy cells with solid doors which are located on solid-floor tiers



Single or double occupancy cells with grilled doors and windows, which are located on solid-floor tiers



Single or double occupancy cells with grilled doors and no windows, located on solid-floor tiers



Small dorms (<20 individuals)



Large dorms (>20 individuals)

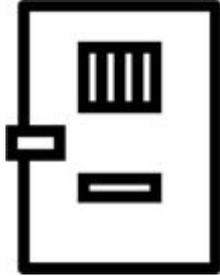


**Relative likelihood of onward COVID-19 transmission within the unit**

Source: [CalPROTECT Evaluation of the April-May 2020 COVID-19 Outbreak at California Men's Colony, July 2020](#)

# View of risk by housing status, Fall 2020 - Winter 2021

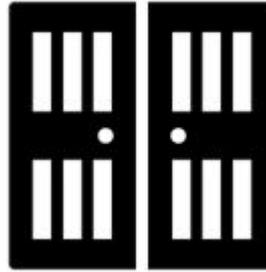
*The initial outbreak in Yard D, which has single and double occupancy cells with solid doors and allowed little time out of cells, suggests risk is more complicated...*



Single or double occupancy cells with solid doors which are located on solid-floor tiers



Single or double occupancy cells with grilled doors and windows, which are located on solid-floor tiers



Single or double occupancy cells with grilled doors and no windows, located on solid-floor tiers



Small dorms (<20 individuals)

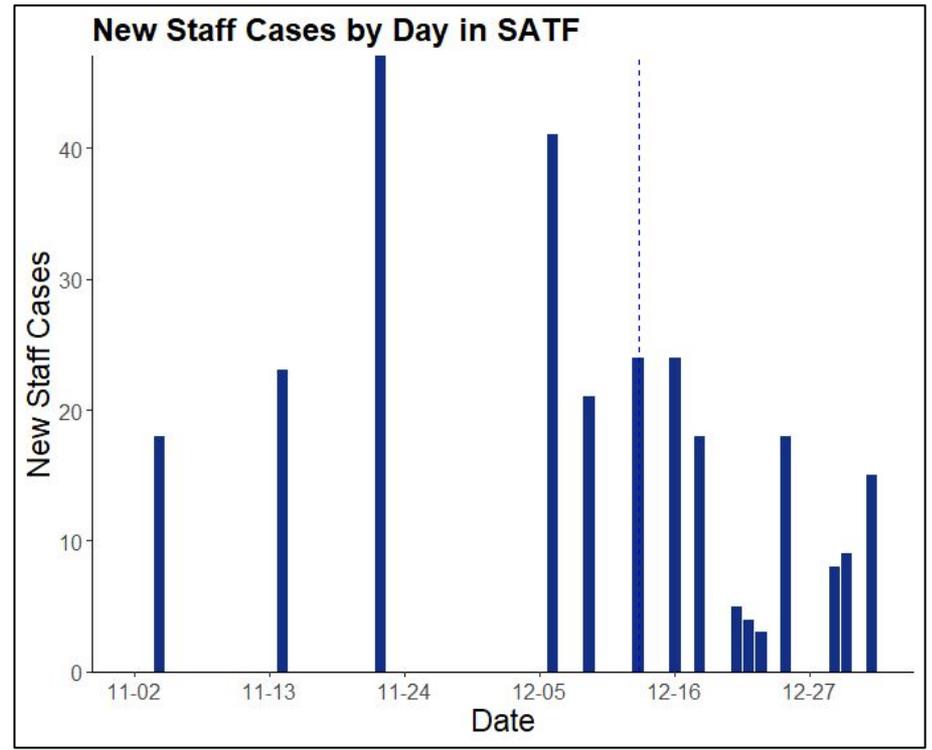
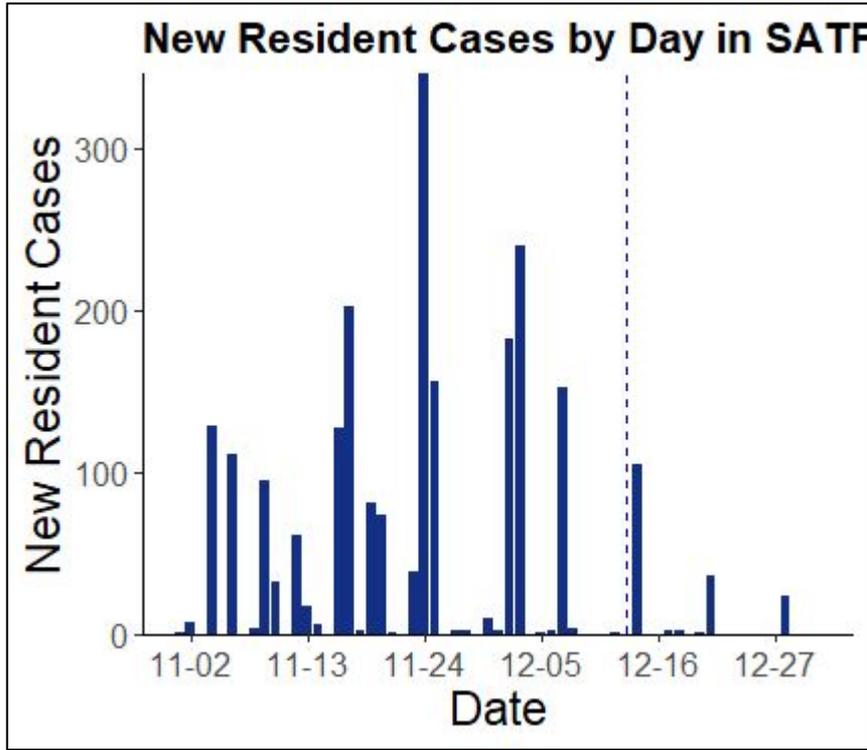


Large dorms (>20 individuals)

**Relative likelihood of onward COVID-19 transmission within the unit**

Source: [CalPROTECT Evaluation of the April-May 2020 COVID-19 Outbreak at California Men's Colony, July 2020](#)

# Outbreak Characterization: Epi Curves



**NOTE: Date is of first positive test result**

----- CalPROTECT Team Visit Date (12/13-12/14)

# Notes on Outbreak Characterization

There was a small outbreak in September but the situation turned much more dire in late October and peaked in early December - current case rate far below average but after 3,000+ inmates already had COVID-19

There is still a sizable population that has not yet had the virus but certain yards contain no uninfected inmates

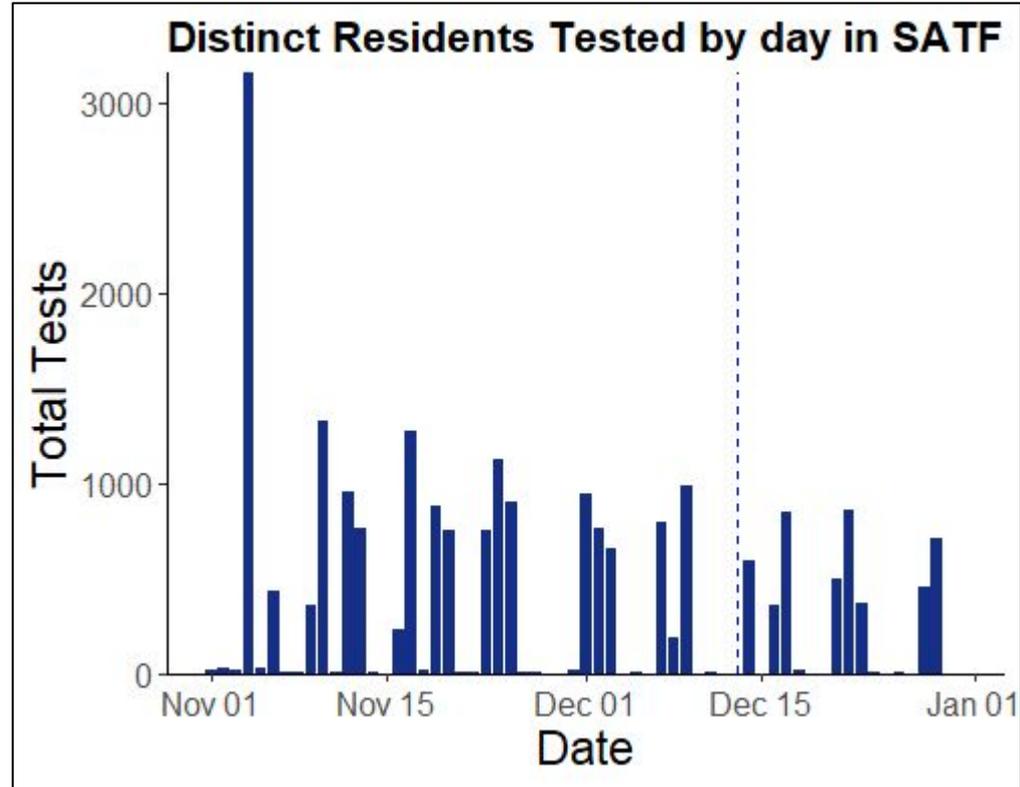
Note: The odd flat areas here are the result of several days without reporting information from Dec 4-6, Dec 10, Dec 12-14, Dec 16, Dec 25-27, Jan 2-4

The staff epi curve suggests that the timing of the most significant outbreak coincides with that of the inmates, with a peak at mid-December

# Overview of Testing at SATF

## Features of Testing Program:

- Inmate testing began in June '20
- Rapid testing rolled out on 9/23/20
- Approximately 25 Sofia 2 tests/day and 5 BD Veritor tests/day
- Weekly testing of staff
- Limited rapid testing for clinical use
- Most of the data on right is RT-PCR Tests, which face significant turnaround time at SATF (3-4 days)



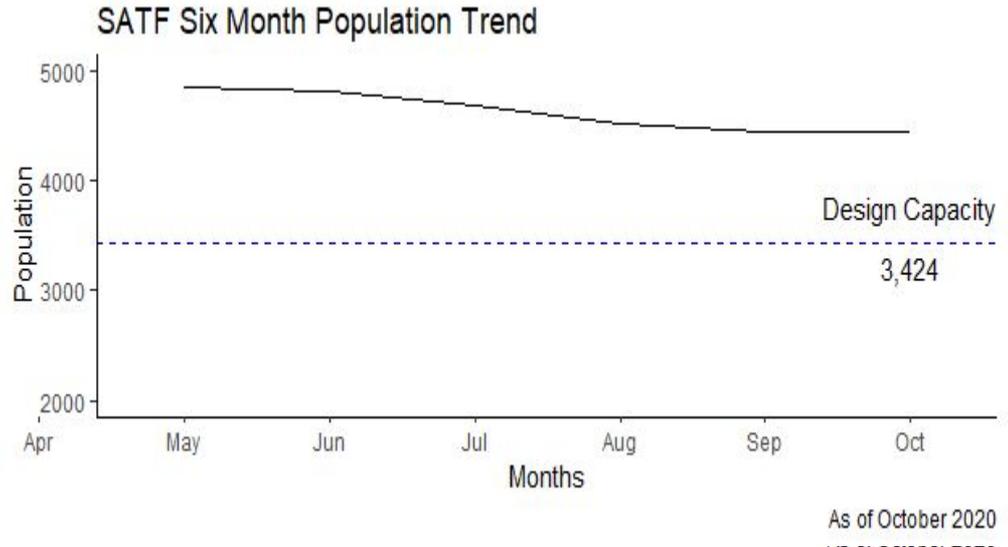
## 3.2 Findings

# Evaluation of Outbreak Mitigation and Control

# Gaps in adherence to recommended control measures limit effectiveness

Although CDC guidelines emphasize the public health importance of reducing population density, **decarceration occurred early on in the outbreak but not in recent months.**

- Population decreased from 4587 to 4450 before outbreak
- Staff interviews describe critical staffing & space shortages for an outbreak setting
- Ventilation may be designed for stated capacity, rather than current population.



Note: While crucial for mitigating outbreaks, rated capacity is simply the number of inmates intended to be housed in the facility according to the BJS and does not have a meaningful public health interpretation

Measures/Most Relevant Guidance	Current State
<p><b>Transfer Guidance:</b></p> <p>Minimize interactions between incarcerated/detained persons living in different housing units, to prevent transmission from one unit to another.</p>	<p>Within-facility transfer policies at present do not include an evaluation of the location-specific risk for transmission of the areas in question. <b>All but essential transfers were frozen on 3/23/20, and all transfers prohibited from 11/23/20.</b></p> <p><b>No restrictions on staff movement, cohorting, or changes to vanpooling policies at present.</b></p>
<p><b>Personal protective equipment (PPE):</b></p> <p>Ensure all individuals with risk of infection have correct PPE available, are properly trained to use it, and are adherent to guidelines.</p>	<p>Early distribution of masks; good compliance observed, but some feedback on fatigue. Interviews indicate a desire for further education.</p>
<p><b>Testing procedures:</b></p> <p>Testing is recommended for all close contacts; periodic testing for staff and cohorts should be considered. Encourage collaboration with local health authorities for planning.</p>	<p>Testing turnaround for staff around 2d, for residents around 3-4d, which hamper mitigation. At present, only use rapid tests for symptomatic patients, not for exposures or screening; additionally, rapid testing only available to residents at present.</p> <p><b>Testing for symptomatic patients was slow in the initial outbreak phase, which dramatically delayed the response.</b></p>

Measures/Most Relevant Guidance	Current State
<p><b>Quarantine/ isolation procedures:</b></p> <p>Individuals with symptoms should be isolated as soon as recognized, and movement kept to a minimum. Established hierarchy of quarantine space for multiple individuals.</p>	<p><b>Widespread movement of residents, prolonged testing turnaround time, and delayed outbreak recognition accelerated COVID-19 spread between housing units.</b></p> <p>Concerns about the movement of residents in isolation or quarantine seeding outbreaks in other parts of the prison, likely due to some combination of <b>poor air exchange, recirculation, and unbalanced ventilation/pressurization</b>, and shared staff between isolation/ quarantine area and housing units without cases in these yards.</p> <p>Quarantine and isolation units exist within housing yards. Inmates testing positive are rehoused in dedicated isolation unit, with cell and pod-mates in quarantine. Uninfected, "High Risk Medical patients" as defined by CDCR, were removed from dorm style living and rehoused in 2 person cells.</p>
<p><b>Physical mitigation measures</b></p> <p>Implement distancing strategies, regardless of symptoms, and minimize mixing of individuals from different housing units. If group activities detained, other activities to support mental health should occur.</p>	<p>Residents are now nearly all housed based on uninfected/resolved/infected status. <b>Delays from testing and ventilation issues may have contributed to spread</b> in spite of this. Since resolved patients are nearly all housed together, they could be given more privileges with little risk (such as more yard, return to jobs, etc). Dorms faced nearly 100% spread, making it difficult to implement recommended quarantine/isolation guidance within these buildings.</p>

***"To list all movement would be astronomical." - Associate Warden***

# Strengths and Vulnerabilities Related to COVID-19 Control

Key Strengths	Key Vulnerabilities
<ul style="list-style-type: none"><li>• Dedicated medical and custody staff and leadership</li><li>• Engaged inmate council willing to model and support vaccination rollout</li><li>• Virtual video visits to promote morale and well-being of patients starting in November '20</li><li>• Masking compliance was well-noted</li></ul>	<ul style="list-style-type: none"><li>• Medical staff shortages increased fatigue, required adjustment of services provided, and led to more staff movement throughout facility</li><li>• Although formal sharing of staff across institutions was discontinued in response to COVID-19, staff interviews suggest it may have continued with Corcoran SP</li><li>• Long testing turnaround times (3-4 days) and limited use of rapid tests delayed decisions, thereby limiting effective response and mitigation</li><li>• By following well-intentioned, central office guidelines about movement of residents throughout the facility for quarantine and medical isolation, healthcare staff noted that frequent movement may have driven spread</li><li>• Aspects of outbreak managed separately for the three groups (medical/custody/residents), rather than as a coordinated effort.</li><li>• Data collection systems are slow and require a large amount of time from medical staff</li><li>• <b>Ventilation and air recirculation</b></li></ul>

## 3.3 Findings

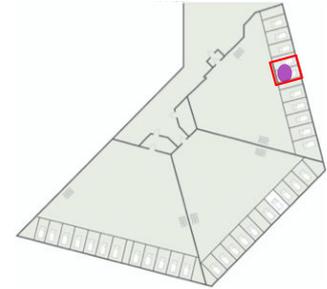
# Environmental Observations

# Air changes were estimated using measured CO2 levels in four buildings at SATF

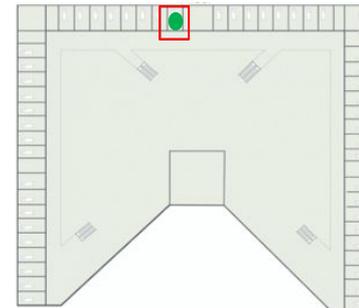
Yard	Room Type	Observed Occupants	Air Changes per Hour (ACH)
A	Dorm	48	0.7
C	Cell	2	3.2
D	Cell	2	5.7
F	Dorm	6	2.6



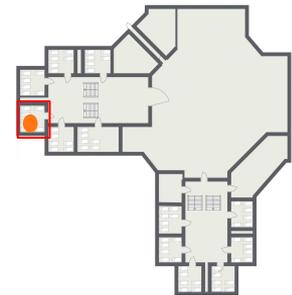
Yard A



Yard C

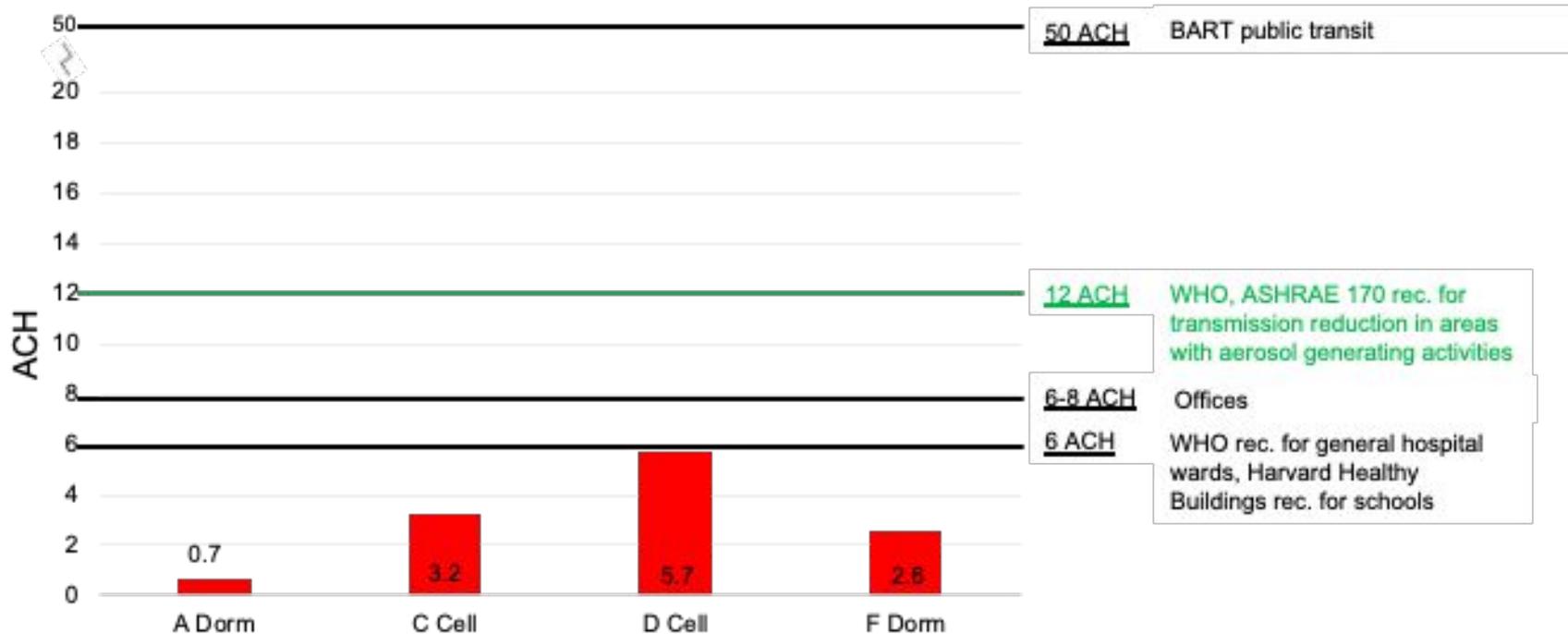


Yard D



Yard F

# Air change rates in four SATF buildings are lower than recommended minimum for infection control

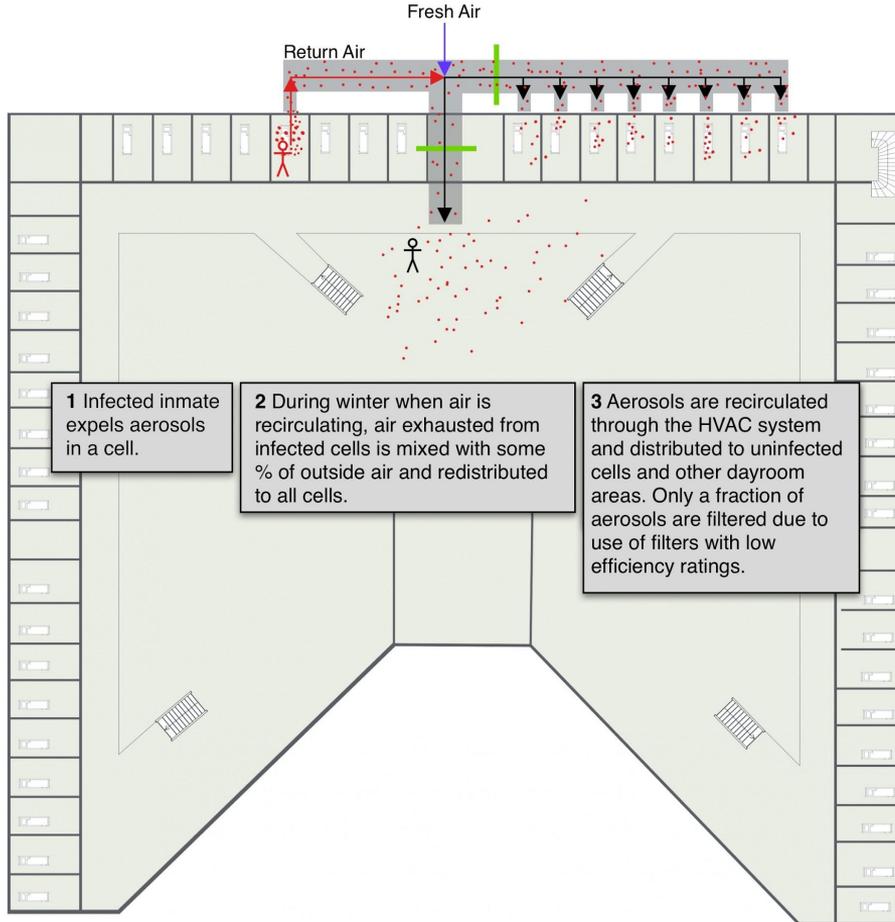


Measurements for SATF Yards

# Other Environmental Observations

- **Movement of infected patients to rooms with poorly functioning ventilation systems**
  - Inoperative exhausts and variable air velocities measured in cells indicate unbalanced system
  - Unintended pressurization differences between rooms promote the escape of virus laden air from enclosed cells or spaces
- **Use of filters below minimum efficiency ratings**
  - MERV 13 (or higher) recommended by CDC and ASHRAE for viral capture
  - MERV 8,10 used at SATF
- **Lack of routine maintenance compromising overall indoor air quality**
  - Need for filter replacements indicated by:
    - Accumulation of dirt/debris around vents
    - Inmates use hair nets to block black smoke and dust from coming from supply
  - Uncomfortable/uncontrolled flows suggest need for damper replacement & rebalancing

# Potential infection scenario: air recirculation in cell blocks



Infected droplets,  $> 5 \mu\text{m}$  in size, settle on floors and surfaces quickly, but aerosols can travel in air currents potentially for hours.



Infected aerosols,  $< 5 \mu\text{m}$  in size, can travel in air currents within a room, and remain suspended in air for hours.



Air filter. At SATF, filter MERV 8 and MERV 10 filters are used. A MERV 10 or less filter has no effect on particulates in the  $0.3 - 1 \mu\text{m}$



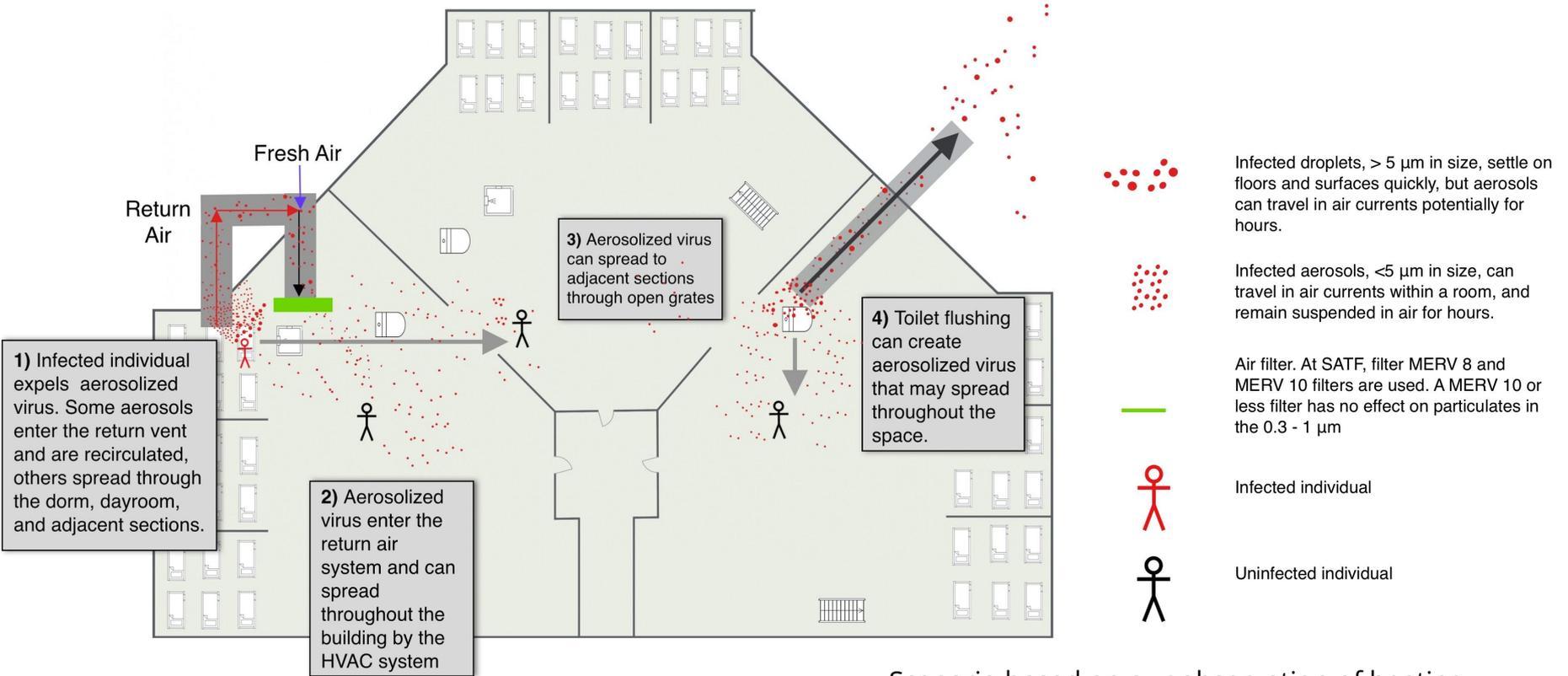
Infected individual



Uninfected individual

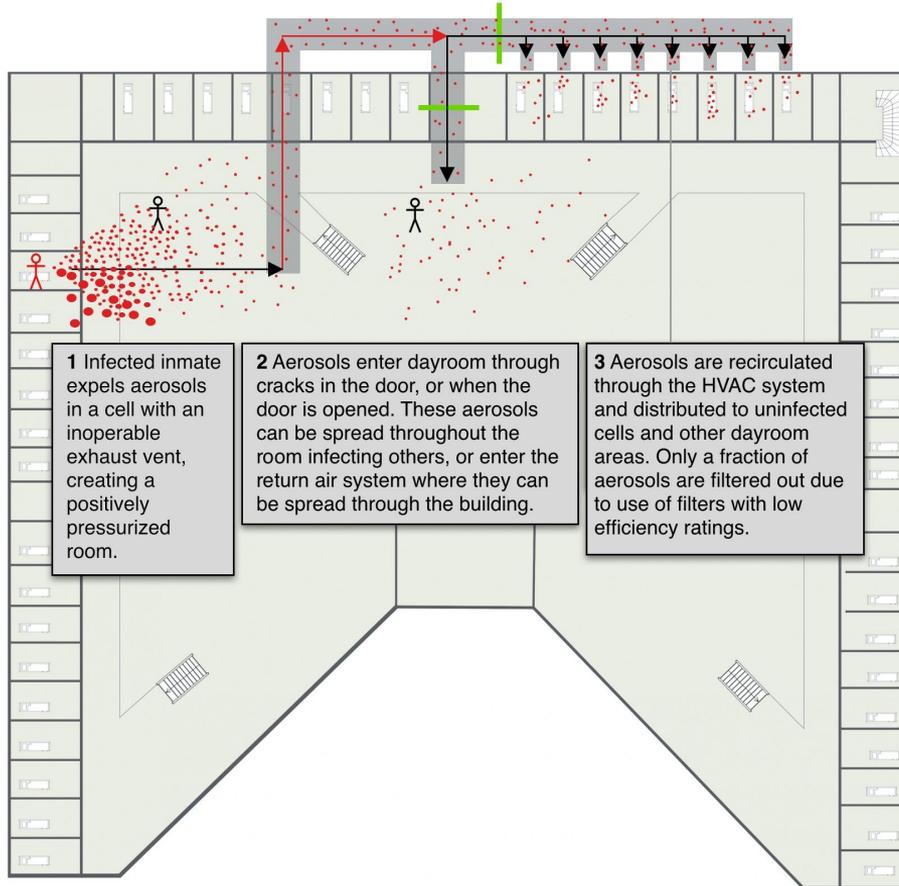
Scenario based on our observation of heating and recirculation system.

# Potential infection scenario: air recirculation in dormitory buildings



Scenario based on our observation of heating and recirculation system.

# Potential infection scenario. Inoperative exhaust vent in cells, positively pressurized cell



Infected droplets,  $> 5 \mu\text{m}$  in size, settle on floors and surfaces quickly, but aerosols can travel in air currents potentially for hours.



Infected aerosols,  $< 5 \mu\text{m}$  in size, can travel in air currents within a room, and remain suspended in air for hours.



Air filter. At SATF, filter MERV 8 and MERV 10 filters are used. A MERV 10 or less filter has no effect on particulates in the  $0.3 - 1 \mu\text{m}$



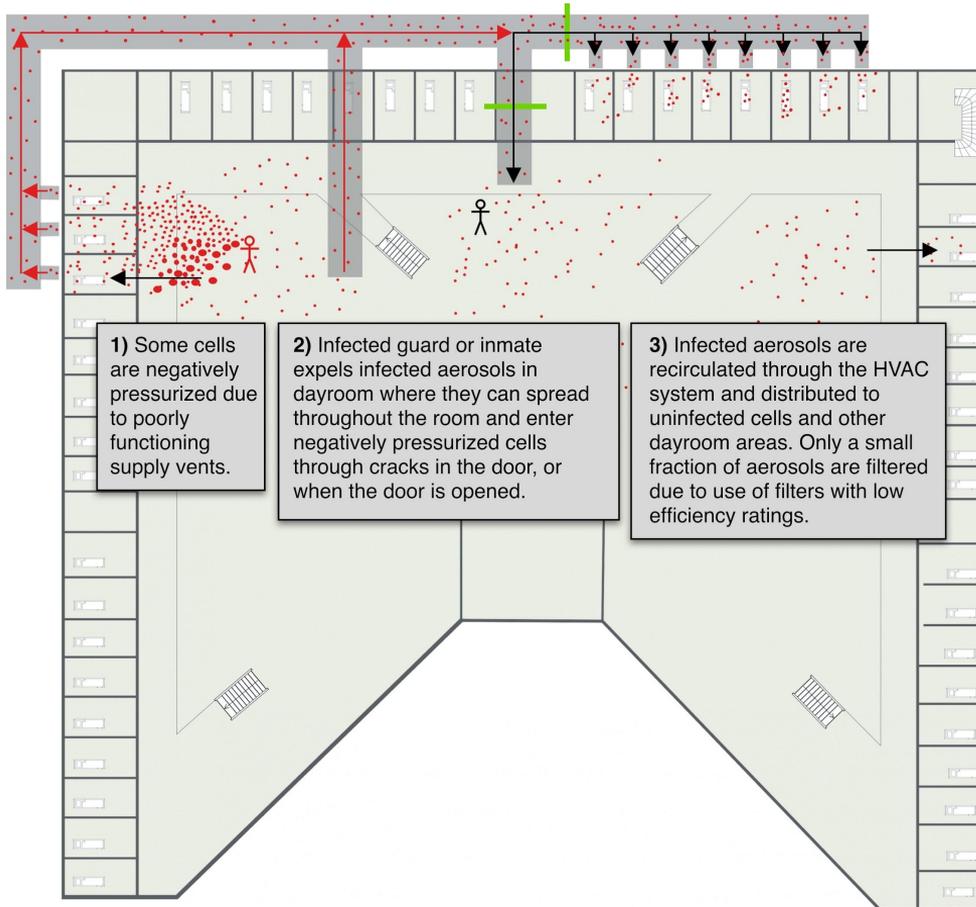
Infected individual



Uninfected individual

Scenario based on our observation of inoperative exhaust vents in D Yard cells.

# Potential infection scenario: Inoperative supply in cells, negatively pressurized cells



## negatively pressurized cells



Infected droplets,  $> 5 \mu\text{m}$  in size, settle on floors and surfaces quickly, but aerosols can travel in air currents potentially for hours.



Infected aerosols,  $< 5 \mu\text{m}$  in size, can travel in air currents within a room, and remain suspended in air for hours.



Air filter. At SATF, filter MERV 8 and MERV 10 filters are used. A MERV 10 or less filter has no effect on particulates in the  $0.3 - 1 \mu\text{m}$



Infected individual



Uninfected individual

Scenario based on our observation of inoperable supply vents in D Yard cells.

# Common strategies to reduce indoor air concentrations of virus and inhalation dose have NOT been available at SATF

“The dose makes the poison”

Dose = Concentration x Respiration rate x Time in infected space x Fraction deposited in lungs

- **Concentration:** properly functioning ventilation systems, supplementary air cleaners/single zone filters
- **Respiration rate:** Separation of high respiration activities to outdoors versus sedentary activities indoors
- **Time in infected space:** Ventilating the space while occupants are away from room

# 4. Recommendations

# Recommendations overview

1. **Decarcerate:** Occupancy reduction is the single most effective method to prevent and reduce COVID-19 transmission.  
*All further recommendations are dependent on the implementation of effective decarceration.*
2. **Ventilate:** Urgently hire an HVAC specialist to evaluate and rebalance SATF's ventilation system; Install supplemental air cleaners and open building windows to reduce airborne transmission.
3. **Test smartly:** Scale up testing for early detection and reduce testing turnaround time to 24 hours or less. Testing approach may differ for institutions that have an outbreak vs. without an outbreak
4. **Prepare:** Improve outbreak/emergency planning, communication, and response through including surge planning, testing plans and strengthened data systems.
5. **Communicate:** Develop and disseminate plans to create stable community cohorts that include medical staff, custody staff, and residents.
6. **Foster Wellness:** Continue to promote a culture that encourages learning, participation in public health measures, and promotes health and wellness.

# Recommendations:

## Strategy #1: Occupancy reduction is the single most effective method to prevent and reduce COVID-19 transmission.

**Why is this strategy important?** Both population density and overcrowding influence the feasibility and effectiveness of every preparation, prevention, and management recommendation from CDC. Specifically:

- SATF experienced a rapidly spreading, large-scale outbreak despite have a high proportion of single and double occupancy cells with solid doors and walls
- SATF is already well over design capacity which is in itself too crowded to ensure safe quarantine and isolation and protection of medically vulnerable residents given observed outbreaks in most units.
- The rate of onward SARS-CoV-2 transmission is directly related to the number of people exposed.
- Emergent evidence from other facilities suggests that other prevention and control methods may reduce transmission but ultimately are insufficient to fully control spread without decarceration.

**Specific steps and tactics to implement this strategy:** Urgently decarcerate the SATF and CDCR population through releases (not high-risk transfers) with support for re-entry. This may involve collaboration with local university dorms, hotels, etc. for quarantine prior to release, and coordination with community partners for reentry support.

Several subsequent recommendations rely on decarceration for successful implementation and management.

## Recommendations:

### Strategy #2: Urgently hire an HVAC specialist to evaluate and rebalance SATF's ventilation system and prevent/reduce airborne transmission.

**Why is this strategy important?** COVID-19 attack rates across SATF housing units are so high that transmission through close contact *alone* is highly unlikely.

#### **Specific steps and tactics to implement this strategy (recognizing that expert support is URGENTLY needed):**

- Maximize outdoor air and **avoid recirculation** in HVAC systems. If recirculation is unavoidable, increase filter ratings to MERV 13+
- Hire external ventilation specialists to rebalance HVAC system
- Establish an updated understanding of relative room pressure relationships and areas vulnerable to infiltration/exfiltration of infected aerosols
- Introduce natural ventilation where possible (e.g., guard quarters in front of cell blocks)
- Separate isolation/quarantine into different buildings to avoid contamination of fresh air intakes
- Install lids on toilet seats to reduce any potential transmission through infected fecal aerosols, especially in dorms
- **Instate a regular ventilation maintenance schedule including rebalancing, filter changes, damper replacements and duct cleaning**

# Recommendations:

## Strategy #3: Scale up testing for early detection and reduce testing turnaround time (TAT) to 24 hours or less.

**Why is this strategy important?** Lab turnaround times >24 hours create immense vulnerabilities given the lack of safe spaces for quarantine, isolation, and protection of medically vulnerable residents. On *average*, an infected patient is able to transmit the virus for 2d prior to the onset of symptoms, followed by another 5d from the onset of symptoms with most transmission likely occurring at the beginning of this time frame. A 3.5d TAT means that isolation is commencing well after a person is most infectious. Ultimately, this meant that SATF identified the outbreak and implemented mass screening too late.

### **Specific steps and tactics to implement this strategy:**

- Immediately undertake an analysis of bottlenecks and potential solutions to reduce testing TAT to <24 hours (e.g., more staff).
- Make quarantine and medical isolation decisions based on PCR tests with a 24-hour turnaround time or rapid antigen testing. Notably, speed of reporting can be more important than test sensitivity when screening asymptomatic individuals ([Larremore, 2021](#))
- If bottlenecks persist, prioritize increasing testing frequency in housing units/yards with expanding outbreaks (at the expense of those without)
- Use rapid tests more frequently for people with known exposures and/or high-risk activities (kitchen workers, staff working in units with active infections, etc.) who are not currently isolated.
- Expand close contact definition for testing from roommate to fellow residents in shared air spaces (e.g., 47 rather than 8 close contacts in A yard) to avoid missing new infections.

# Recommendations:

## Strategy #4: Improve outbreak/emergency planning, communication, and response.

**Why is this strategy important?** Well-intentioned movement of residents as part of outbreak control efforts likely inadvertently spread SARS-CoV-2 throughout and between housing units. Transmission was likely accelerated by the use of recirculated air. Unlike in the summer, celled housing may carry comparable risks to dormitory housing when coupled with the onset of winter necessitating the use of unfiltered, recirculated heated air.

### **Specific steps and tactics to implement this strategy:**

- **Conduct surge planning to identify locations** to house a significant proportion of the population in separate medical isolation and quarantine beds should an outbreak occur
  - Identify high medical risk patients to support releases, well-planned transfers, isolation and quarantine.
  - Assess of housing types, capacity, resident health risk, ventilation and other relevant characteristics to inform selection of isolation and quarantine areas
- Use rapid testing for screening of staff and residents to support decision making and case detection.
- Prepare outdoor facilities with adequate air exchange for testing and treatment with low transmission risk.
- Establish a data collection system that allows for automation and reduces the demand on medical staff for data entry activities.
- **Prioritize full-site outbreak planning that identifies site-specific risks and vulnerabilities and coordination across all groups at risk (medical, correctional, residential).**

## Recommendations:

### Strategy #5: Develop and disseminate plans to create stable community cohorts that include medical staff, custody staff, and residents.

**Why is this strategy important?** Use of cohorts reduces risk of transmission within facilities, facilitates more effective contact tracing and testing programs, and limits need for within-facility movement.

#### **Specific steps and tactics to implement this strategy:**

- Create stable community cohorts that include medical staff, custody staff, and residents with movement restricted to those areas. The cohort should include housing units, activity units, kitchens, etc., and allocates an adequate number of staff to support both standard and outbreak activities.
- Prohibit vanpooling and carpooling, particularly with staff from neighboring correctional facilities. Subsidize transportation costs for staff to avoid vanpooling (and use rapid tests on these individuals weekly).
- Restrict within-facility movement of high-risk residents unless absolutely necessary, and only in cases where facility can confirm they are being moved into housing with closed cells and no shared or recirculated air. Utilize daily rapid testing for staff and residents who cross cohorts.

**Cohorting of close contacts of a case should only be practiced when there are no other options. Individual isolation is always preferable, and may be facilitated through decarceration or depopulation.**

## Recommendations:

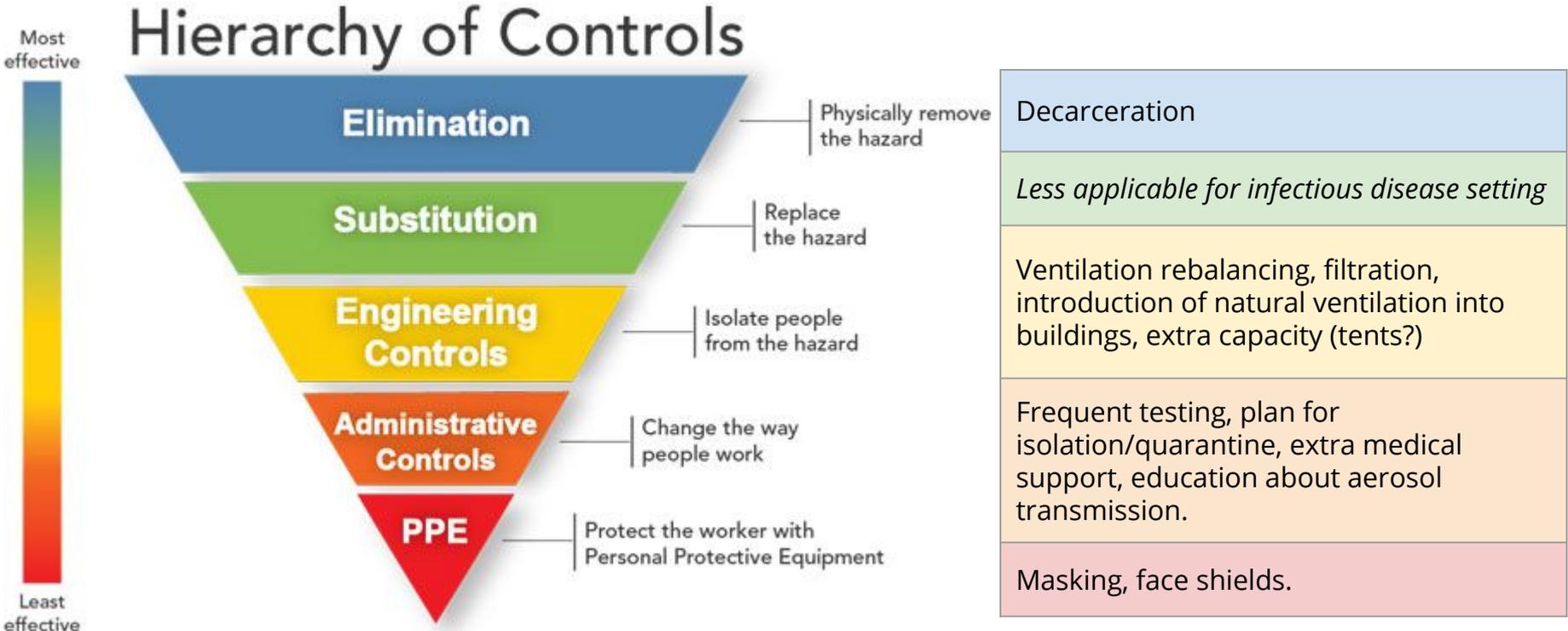
### Strategy #6: Continue to promote a culture that encourages learning, participation in public health measures, and promotes health and wellness.

**Why is this strategy important?** Promoting mental health and social well-being is an essential function of healthcare in the prison system, and should be considered both within outbreak response situations, with reintroduction of activities in non-mass-outbreak situations.

#### **Specific steps and tactics to implement this strategy:**

- Increase yard time for residents who have recovered from illness and those who have been vaccinated. Within cohorts, allocate yard time instead of strictly limiting ability to go outside.
- Continue to offer video visitations to improve inmate and family mental health, in addition to other activities to promote mental and social health within each setting.
- Strengthen education and dissemination of information for staff and residents around COVID-19 transmission, proper social distancing and mitigation efforts, importance of early reporting of symptoms, and vaccination FAQ. Additionally, develop plans for clearly disseminating new evidence and new guidance appropriate for the facility.
- Collect patient and staff questions about vaccination safety, answer and disseminate responses as FAQs
- Financial and other incentives can support staff morale, particularly when surge capacity needed.
- Offer COVID-19 specific sick days in addition to regular time to address staff concerns around vaccination

# Further Consideration for Implementing Recommendations



# At current occupancy levels it is impossible to control infection in dorms

Yard	Room Type	Observed Occupants	Measured Air Changes per Hour (ACH)	Occupancy Needed to Meet WHO Standards
A	Dorm	48	0.7	3
C	Cell	2	3.2	1
D	Cell	2	5.7	1
F	Dorm	6	2.6	1

**Note: Above chart shows occupancy reduction needed to meet WHO minimum standard for containing airborne infections. Chart shows the effect of reducing occupancy alone. However, a mix of interventions including ventilation maintenance, addition of air cleaning units, UVGI can be used to provide additional air changes to meet standards**

# Acknowledgments

Ms. Theresa Cisneros, SATF Chief Deputy Warden

Mr. Jason Collins, SATF Associate Warden

Mr. Raul Morales, SATF Associate Warden

Mr. Bob Edwards, SATF CEO

Mr. Wayne Motle, SATF Chief Engineer

SATF inmate councils

SATF Medical and Custody leadership

And all others involved in coordinating the visit and providing information for the report.

Receiver Mr. Clark Kelso

Dr. Joseph Bick

Ms. Jackie Clark

Ms. Chakriya Srey

Dr. Amy Lerman

Ms. Karalyn Lacey

# Exhibit 3

**HOUSING UNIT AIR HANDLING UNIT INSPECTIONS**Executive Summary

The California Department of Corrections and Rehabilitation (CDCR) directed adult institutions to conduct an inspection of housing unit Air Handling Units (AHUs). The inspection was to include physical inspections of AHUs, ducts and vents, as well as airflow measurements at both the AHU and at supply vents within the housing unit.

An initial review of the submitted inspection data indicated that the task of performing the airflow measurements in the ventilation systems was complex and not evenly understood or implemented. In some instances, the measurements provided for the AHU airflow and resulting housing unit vent airflow seemed contradictory. In other instances, the airflow measurements were based upon fewer individual measurements than had been indicated in the instructions, leading to incomplete measurements. CDCR's Facility Planning, Construction and Management Division (FPCM) staff will be conducting site visits beginning in September to work with individual institutions to review their data collection practices, identify data anomalies, perform additional airflow measurements (if warranted) and assist in prioritizing repairs for underperforming AHUs.

While AHU performance and overall ventilation within a housing unit was the focus of the inspections, the installation of MERV-13 filters in housing unit AHUs that have the capability of recirculating interior air is anticipated to improve filtration of the recirculated air and assist in the reduction of airborne viruses. Prisons were directed in December 2020 to install MERV-13 filters, which provide more effective filtration for smaller particles, such as aerosols and viruses. Currently, 21 institutions have switched to these higher-efficiency filters. The remaining 11 institutions that have AHUs with the capability of recirculating interior air are anticipated to have MERV-13 filters installed by the end of October 2021, when these AHUs switch from cooling to heating mode.

Background

There is a large variety of ventilation system designs within CDCR's institutions. Some housing units have no AHU (i.e. rely on natural ventilation) and provide radiant heat. Other systems use 100% outside air as the intake to their AHUs (there are no fans or ducts to recirculate interior air back through the AHU). However, most AHUs operate with a mix of outside air and recirculated air. Typically, during warmer weather, a large number of AHUs use nearly 100% outside air. During cooler weather, most systems use a higher amount of recirculated air.

For celled housing units built within the last 40 years, a common feature for ventilation is that the cells are under positive air pressure: the air supply to the cell (120 cubic feet per minute) is greater than the volume of air exhausted directly from the cell to outside the housing unit through the exhaust fan (55 cubic feet per minute). Therefore, per design, there is a net flow of air from the cell to the dayroom.

Institutional Plant Operations staff are responsible for the day-to-day maintenance and management of an institution's infrastructure systems, including ventilation systems in the housing units. In addition to performing routine inspections, preventive maintenance and replacing AHU filters, they are called on to investigate, mitigate, and repair AHUs and ventilation systems that are reported to them by the incarcerated population or staff as not operating properly.

**HOUSING UNIT AIR HANDLING UNIT INSPECTIONS**Inspection of Housing Unit Ventilation Systems

On March 30, 2021, CDCR headquarters directed adult institutions to have Plant Operations staff at each adult institution perform an inspection of each housing unit's ventilation system. This effort was to identify needed ventilation system repairs for optimal system operation. To that end, Plant Operations staff performed physical inspections of AHUs, ducts and vents, as well as airflow measurements at the supply duct leading from the AHU and a representative sample of supply vents in cells or dormitory areas. Measuring airflow at the supply duct leading from the AHU level is to review if the AHU is supplying air in accordance with its specification. Low airflow measurements could indicate a need for maintenance or repair on the AHU. Measurements at supply vents in cells or dormitory areas are intended to identify potential issues within the air distribution ducting or with blocked vents.

To assist the institutions with this task, CDCR headquarters' staff developed a training tool that specified the methodology to use when measuring airflow, and identified measuring equipment the institutions would need to use to perform these measurements. Additional information provided included instructions, inspection forms, a listing of AHUs specific to the individual sites, and forms to record the measured results. Two statewide training conference calls were also held to provide instruction to the institutions.

Data Analysis, Quality and Follow-Up Actions

Institutions uploaded documentation of the inspection activities on a shared data platform. Overall, Plant Operations staff inspected approximately 1,800 AHUs and performed air sampling measurements at more than 10,000 cell and dormitory supply vents. A "Summary of Performance Measurements" chart has been prepared to summarize information for each prison. The yellow-shaded columns under the "AHU Performance" heading reflect measurements at the supply duct leading from the AHU, and the green-shaded columns under the "Airflow Performance within Living Space" heading reflect measurements taken at supply vents in cells or dormitory areas. The measurements were compared to 90% of the design specification airflow, which is an industry standard developed by the American Society of Heating, Refrigerating and Air Conditioning Engineers (ASHRAE). The chart also indicates that additional review is ongoing at identified prisons, often related to identifying the design specifications for older AHUs.

An initial review by FPCM staff of the data submitted from the inspections effort indicated a varying level of expertise across the Plant Operations personnel who performed the inspections and varying levels of completeness of the collected data. While Plant Operations staff are skilled at performing maintenance tasks and otherwise maintaining the variety of infrastructure systems that are needed to operate 24-hour institutions, performing the airflow measurements in the ventilation system proved to be a complex task that was unevenly understood and implemented. In some instances, the measurements provided for the AHU airflow and resulting housing unit vent airflow seemed contradictory, which may indicate that measurements were not taken correctly. In other instances, the airflow measurements were based on fewer individual measurements than had been indicated in the instructions, leading to incomplete measurements.

**HOUSING UNIT AIR HANDLING UNIT INSPECTIONS**

FPCM staff held subsequent conference calls with each institution to discuss the AHU inspection data. FPCM is working with each prison to prioritize maintenance and repair activities such as re-inspecting any AHU that was identified as underperforming (when airflow measurements were less than 90% of the design specification), correcting any deficiencies noted in the re-inspection, and then re-measuring airflow to determine if the repairs were sufficient to restore airflow to within design parameters. FPCM staff will be conducting site visits in September/October 2021 to work with individual institutions to review and improve their data collection practices, identify data anomalies, perform additional airflow measurements (if warranted) and assist in prioritizing repairs for underperforming AHUs.

**MERV-13 Filter Installation**

Due to the complexity of ventilation and air circulation patterns within a housing unit, CDCR is following the recommendation of ASHRAE to install MERV-13 filters in housing unit AHUs that have the capability of recirculating interior air based on their effectiveness in capturing particles of a size similar to the COVID-19 virus. Prisons were directed in December 2020 to replace existing filters (mostly were of the MERV-8 level of efficiency) with MERV-13 filters, which provide more effective filtration for smaller particles, such as aerosols and viruses. If MERV-13 filters caused a significant decrease in airflow, institutions were directed to instead install MERV-11 filters. In addition, it was reiterated that institutions should maximize outside air intake and minimize recirculated air.

Since that time, FPCM has been monitoring the institutions' progress in installing MERV-13 filters. Many institutions found that obtaining MERV-13 filters was difficult because of shortages in the supply chain. Currently, 21 institutions have switched to these higher-efficiency filters. The remaining 11 institutions that have AHUs with the capability of recirculating interior air are anticipated to have MERV-13 filters installed by the end of October 2021, when these AHUs switch from cooling to heating mode and the volume of recirculated air will increase.

## Housing Unit Air Handling Unit Inspections

## - Summary of Performance Measurements -

Institution	AHU Performance				Airflow Performance within Living Space	
	Total Number of AHUs	Number of AHUs with Airflow at Least 90% of Design Specifications	Number of AHUs with Airflow Below 90% of Design Specifications	Number of AHUs Pending Airflow Measurement	Number of Cell/Dorm Level Airflow Measurements	Percentage of Airflow Measurements Taken at Cell/Dorm Level with Airflow at Least 90% of Design Specifications
ASP <sup>1</sup>	66	----	----	66	----	----
CAC	120	30	90	----	420	14%
CAL	70	44	26	----	664	67%
CCC <sup>2</sup>	53	48	3	2	812	91%
CCI	44	31	13	----	362	93%
CCWF	62	49	13	----	118	89%
CEN	68	61	7	----	227	96%
CHCF <sup>3</sup>	62	----	----	----	----	----
CIM <sup>4</sup>	50	6	28	16	1176	15%
CIW	25	25	0	----	75	96%
CMC <sup>4</sup>	64	5	59	----	212	Additional Review Necessary
CMF <sup>4</sup>	21	12	5	4	42	95%
COR	57	55	2	----	330	91%
CRC	16	16	0	----	64	13%
CTF	15	7	8	----	117	60%
CVSP <sup>5</sup>	25	15	10	----	147	96%
FSP <sup>4</sup>	27	16	7	4	167	50%

<sup>1</sup> Due to inconsistencies in the procedures used for the original measurements, re-measurements are underway.

<sup>2</sup> Two AHUs at this prison have inaccessible ductwork and were not available for staff to measure airflow from the AHU.

<sup>3</sup> CHCF was constructed with a Building Management System that automatically controls airflow based on established parameters and field sensor communications. Because the system automatically varies airflow as required, it does not lend itself to the AHU inspection measurements.

<sup>4</sup> AHU and/or Living Unit airflow design specifications require additional review for certain AHU/Living Units at these prisons.

<sup>5</sup> These rows exclude newly-installed AHUs from the ISP/CVSP HVAC replacement project. These AHUs are under warranty by the General Contractor.

## Housing Unit Air Handling Unit Inspections

## - Summary of Performance Measurements -

Institution	AHU Performance				Airflow Performance within Living Space	
	Total Number of AHUs	Number of AHUs with Airflow at Least 90% of Design Specifications	Number of AHUs with Airflow Below 90% of Design Specifications	Number of AHUs Pending Airflow Measurement	Number of Cell/Dorm Level Airflow Measurements	Percentage of Airflow Measurements Taken at Cell/Dorm Level with Airflow at Least 90% of Design Specifications
HDSP	46	44	2	----	267	63%
ISP <sup>5</sup>	27	1	26	----	246	100%
KVSP	26	21	5	----	816	92%
LAC	68	68	0	----	204	100%
MCSP	63	19	44	----	348	79%
NKSP	54	54	0	----	162	100%
PBSP	60	49	11	----	652	90%
PVSP	66	29	37	----	528	95%
RJD	74	71	3	----	444	91%
SAC <sup>4</sup>	18	12	4	2	308	0%
SATF	80	80	0	----	432	100%
SCC <sup>1</sup>	75	----	----	----	----	----
SOL	67	50	17	----	620	97%
SQ <sup>4</sup>	20	10	0	10	57	Additional Review Necessary
SVSP	62	16	46	----	132	71%
VSP	77	54	23	----	486	69%
WSP	60	59	1	----	142	98%

<sup>1</sup> Due to inconsistencies in the procedures used for the original measurements, re-measurements are underway.

<sup>2</sup> Two AHUs at this prison have inaccessible ductwork and were not available for staff to measure airflow from the AHU.

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