XAVIER BECERRA
Attorney General of California
MONICA N. ANDERSON
Senior Assistant Attorney General
DAMON MCCLAIN (209508)
Supervising Deputy Attorney General
JOHN WALTERS (216427)
RYAN GILLE (262105)
IRAM HASAN (320802)
Deputy Attorneys General
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 703-5500
Facsimile: (415) 703-58443
Email: Ryan.Gille@doj.ca.gov

HANSON BRIDGETT LLP
PAUL B. MELLO - 179755
SAMANTHA D. WOLFF - 240280
425 Market Street, 26th Floor
San Francisco, California 94105
Telephone: (415) 777--3200
Facsimile: (415) 541-9366
pmello@hansonbridgett.com

Attorneys for Defendants

PRISON LAW OFFICE
DONALD SPECTER (83925)
STEVEN FAMA (99641)
ALISON HARDY (135966)
SARA NORMAN (189536)
RANA ANABTAWI (267073)
SOPHIE HART (321663)
1917 Fifth Street
Berkeley, California 94710
Telephone: (510) 280-2621
Fax: (510) 280-2704
dspecter@prisonlaw.com

Attorneys for Plaintiffs

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA, OAKLAND DIVISION

MARCIANO PLATA, et al.,

Plaintiffs,

v.

GAVIN NEWSOM, et al.,

Defendants.

CASE NO. 01-1351 JST

JOINT CASE MANAGEMENT CONFERENCE STATEMENT

Judge: Hon. Jon S. Tigar
Date: November 5, 2020
Time: 1:30 p.m.
Crtrm.: 6, 2nd Floor

The parties submit the following joint statement in advance of the November 5, 2020 Case Management Conference.

I. POPULATION REDUCTION

Plaintiffs' Position: Further population reductions are necessary to minimize the risk of harm from COVID-19, particularly at prisons with primarily open-air, congregate living spaces, and among those at increased risk of harm if infected. As Defendants have acknowledged, reduced population contributes to fewer infections and deaths. *See* ECF No. 3469 at 3-4.

Unfortunately, as previously explained (*see* ECF No. 3417 at 2:14-3:2), the overall CDCR population reduction since March, while certainly helped by early release programs, has primarily resulted from natural releases and the suspension and limitation of intake.[1] Defendants have now stopped two of the three population reduction programs announced in July. As intake increases, and the number of early releases dwindles, CDCR's total population will increase.

Indeed, CDCR's population is already beginning to increase: the population totals for CDCR's Prisons and Camps on October 21 and 28 were, respectively, 7 and 75 people greater than the week before.[2] Significantly, these week-to-week net increases were the first reported since the initial CDCR COVID-19 patient was diagnosed in late March.[3]

---

[1] The subsidiary role of early releases in population reduction is further illustrated by Defendants' recently provided data. They report that between July 1 and October 14, approximately 6,200 were released early, while a far greater number -- approximately 8,500 -- were released via their natural release date (ECF No. 3469 at 2:9-13), and at the same time, intake was prohibited until late August and since then has been, until the last three weeks, greatly limited.

[2] *See* "Institutions/Camps" totals (subpart A.I.1) at https://www.cdcr.ca.gov/research/wp-content/uploads/sites/174/2020/10/Tpop1d201021.pdf [October 21] and https://www.cdcr.ca.gov/research/wp-content/uploads/sites/174/2020/10/Tpop1d201028.pdf [October 28].

[3] *See* "Institutions/Camps" totals (subpart A.I.1) in 2020 Weekly Total Population

Given the large number of people in county jail awaiting transport to CDCR,[4] this dangerous increasing of population will likely continue unless the State re-starts early release programs.

We continue to be extremely disappointed that the State ended the early release program focused on those most vulnerable to severe complications or death if infected by COVID-19, and that so very few – less than 50 out of almost 6,600 eligible[5] – were released by that program when it was in effect. We are similarly disappointed the State excluded people from its COVID-19 high risk early release consideration if medical conditions changed such that they were no longer considered high risk, but refused to include people newly determined to be high risk based on pre-existing medical conditions that public health officials in July announced were serious risk factors for hospitalization or death from COVID-19. We are finally disappointed that the State has not released anyone from San Quentin since the October 20 state appellate decision requiring that prion's population to be substantially reduced due to the risk of harm from COVID-19.

Our disappointment with the State's very limited releases of those most at risk is deepened given what appears to be the inevitable next wave of COVID-19 infections. The

---

Reports at https://www.cdcr.ca.gov/research/weekly-total-population-report-archive-2020/.

[4] CDCR on September 29 stated that nearly 8,000 people in county jails were awaiting transport to its reception centers (see ECF No. 3460 at 10:8-20), and surely many additional people were sentenced to state prison in the counties since then. For the most recent three weeks, *i.e.*, those starting October 19, October 26, and November 2, CDCR told us that it authorized intake of, respectively, 610, 428, and 680 people.

[5] *See* ECF No. 3460 at 4:9-6:6 (Defendants report that of 6,599 eligible for early release consideration under COVID-19 high-risk program, 45 determinately sentenced people were approved for release, and 12 indeterminately sentenced people were referred to the Governor for executive clemency consideration). We are not aware of the Governor granting any person in prison clemency since these referrals were made. Even if all referred were released, the main point would remain: surpassingly few of those most at risk of harm from COVID-19 were released by the State's program specifically enacted to release those people.

Governor warned of this next wave a month ago.[6] The United States as a whole is experiencing record-breaking numbers of infections, with no state reporting decreased numbers of infections.[7] California, as of the end of October, had an almost 20 percent increase in infections over the previous week.[8]

Defendants' Position: As of October 28, 2020, CDCR has experienced a population reduction of 23,049, representing a nearly 20 percent decrease in the size of the population, since the start of the COVID-19 public health crisis.[9] Between July 1 and October 28, 2020, 6,391 people were released from institutions and camps as a result of the COVID-19 early-release programs Defendants announced on July 10.[10] This represents 206 more early releases than those reported in the October 20 case management statement.[11] An additional 9,089 were released in accordance with their natural release dates during this

---

[6] *See* Amy Graff, SFGATE, *Newsom warns second COVID-19 wave in other countries could hit California* (Oct. 5, 2020), https://www.sfgate.com/news/editorspicks/article/COVID-19-coronavirus-second-wave-California-fall-15623027.php.

[7] *See* New York Times, *The U.S. breaks its record, tallying over 99,000 new cases in a day* (Oct. 31, 2020), https://www.nytimes.com/live/2020/10/30/world/covid-19-coronavirus-updates#the-us-breaks-its-record-tallying-over-99000-new-cases-in-a-day (reporting that "nearly two dozen states are reporting their worst weeks for new cases — and none are recording improvements").

[8] *See* California Department of Public Health, COVID-19 Cases, California Cases, at https://public.tableau.com/views/COVID-19CasesDashboard_15931020425010/Cases?%3Aembed=y&%3AshowVizHome=no (last accessed Oct. 31, 2020) (showing as of October 31 an 18.4% "Weekly % Change" aka "Week-Over-Week % Change of New Cases").

[9] This figure is calculated by taking the difference between the total population in institutions and camps on February 26, 2020 and October 14, 2020. Weekly population reports can be found at https://www.cdcr.ca.gov/research/weekly-total-population-report-archive-2020/.

[10] *See* ECF No. 3389 at 2:4-5:4 and https://www.cdcr.ca.gov/covid19/expedited-releases/ for details regarding CDCR's COVID-19 early-release program announced on July 10, 2020.

[11] *See* ECF No. 3469 at 3:9-3:12.

period. As of October 28, CDCR's institutions and camps have a population of 94,293, CDCR's lowest population in three decades.[12]https://word-edit.officeapps.live.com/we/wordeditorframe.aspx?ui=en-US&rs=en-US&hid=vCe5%2Bp3Mrkefw96kzKDndA.0&wopisrc=https%3A%2F%2Fwopi.onedrive.com%2Fwopi%2Ffiles%2FEFAD5F4D2302DFAD!1633&wde=docx&sc=host%3D%26qt%3DFolders&mscc=1&wdp=2&uih=OneDrive&jsapi=1&jsapiver=v2&corrid=de8d08f3-df71-4e33-908c-37031bfc25a6&usid=de8d08f3-df71-4e33-908c-37031bfc25a6&newsession=1&sftc=1&wdorigin=Unknown&instantedit=1&wopicomplete=1&wdredirectionreason=Unified_SingleFlush - _ftn1https://word-edit.officeapps.live.com/we/wordeditorframe.aspx?ui=en-US&rs=en-US&hid=vCe5%2Bp3Mrkefw96kzKDndA.0&wopisrc=https%3A%2F%2Fwopi.onedrive.com%2Fwopi%2Ffiles%2FEFAD5F4D2302DFAD!1633&wde=docx&sc=host%3D%26qt%3DFolders&mscc=1&wdp=2&uih=OneDrive&jsapi=1&jsapiver=v2&corrid=de8d08f3-df71-4e33-908c-37031bfc25a6&usid=de8d08f3-df71-4e33-908c-37031bfc25a6&newsession=1&sftc=1&wdorigin=Unknown&instantedit=1&wopicomplete=1&wdredirectionreason=Unified_SingleFlush - _ftn2https://word-edit.officeapps.live.com/we/wordeditorframe.aspx?ui=en-US&rs=en-US&hid=vCe5%2Bp3Mrkefw96kzKDndA.0&wopisrc=https%3A%2F%2Fwopi.onedrive.com%2Fwopi%2Ffiles%2FEFAD5F4D2302DFAD!1633&wde=docx&sc=host%3D%26qt%3DFolders&mscc=1&wdp=2&uih=OneDrive&jsapi=1&jsapiver=v2&corrid=de8d08f3-df71-4e33-908c-37031bfc25a6&usid=de8d08f3-df71-4e33-908c-37031bfc25a6&newsession=1&sftc=1&wdorigin=Unknown&instantedit=1&wopicomplete=1&wdredirectionreason=Unified_SingleFlush - _ftn3https://word-edit.officeapps.live.com/we/wordeditorframe.aspx?ui=en-US&rs=en-US&hid=vCe5%2Bp3Mrkefw96kzKDndA.0&wopisrc=https%3A%2F%2Fwopi.onedrive.com%2

---

[12] *See* October 28, 2020 population report at https://www.cdcr.ca.gov/research/wp-content/uploads/sites/174/2020/10/Tpop1d201028.pdf.

Fwopi%2Ffiles%2FEFAD5F4D2302DFAD!1633&wde=docx&sc=host%3D%26qt%3DFolders&mscc=1&wdp=2&uih=OneDrive&jsapi=1&jsapiver=v2&corrid=de8d08f3-df71-4e33-908c-37031bfc25a6&usid=de8d08f3-df71-4e33-908c-37031bfc25a6&newsession=1&sftc=1&wdorigin=Unknown&instantedit=1&wopicomplete=1&wdredirectionreason=Unified_SingleFlush - _ftn4

CDCR continues to process early releases on a rolling basis through the 180-day early-release program announced on July 10, which has accounted for the vast majority of all early releases since then. This discretionary early-release program was implemented as an added safety measure at a time when more comprehensive COVID-19 related policies were still being developed. Since then, CDCR adopted additional significant safety measures to reduce the spread of COVID-19, including, as described below, a drastic reduction in intake from county jails, comprehensive testing, quarantine, isolation, and movement protocols, policies regarding personal protective equipment, and plans for COVID-19 testing of staff and incarcerated persons. CDCR continues to evaluate, improve, and update these policies in close coordination with the Receiver.

CDCR has regularly provided early-release data to Plaintiffs' counsel and the public after announcing the July 10 programs. The data shows that CDCR's early-release programs are not merely subsidiary: between July 1 and October 28, 2020, early releases accounted for over 41 percent of all releases from CDCR's institutions and camps during that period.[13] Defendants have also been transparent about the fact that the early releases are one of many safety measures CDCR implemented in response to COVID-19, and note that Plaintiffs' list of disappointments (*see supra* pp. 2-3) lacks recognition of the logistics of release and post-release processes and the impact on public safety.

---

[13] As reported above and according to data compiled by CDCR's Office of Research, 6,391 people were released from CDCR's institutions and camps through its COVID-19 early-release programs between July 1 and October 28. 9,089 additional people were released in accordance with their natural release dates. A total of 15,480 people were released during this period.

Plaintiffs' counsel receives several updates regarding intake and its mechanics each week through email and phone conferences, and they are aware of the planning, testing, quarantine, isolation, communication, and movement protocols involved in the intake process. Plaintiffs continue to disapprove of CDCR's efforts to provide relief to overpopulated county jails by restarting intake, but fail to acknowledge the impact on jails, courts, and local communities CDCR's intake policies have. At the October 21, 2020 case management conference, Plaintiffs' counsel had no response when the Court attempted to seek clarity on their conflicting positions on this issue (Tr. at 13:11-12), and appear to offer no further clarity on their position in this statement.

Additionally, Plaintiffs' commentary on the State's compliance with court directives in *In re Ivan Von Staich*, No. A160122, 2020 WL 6144780 (Cal. Ct. App. Oct. 20, 2020) is unhelpful and inappropriate. *In re Von Staich* is a separate, state court matter that currently remains pending. Defendants will not substantively comment on that litigation here except to note that, on its own motion, the California Supreme Court opened a case for appeal of this matter and extended its time for ordering review to and including February 17, 2020. Thus, the *In re Von Staich* order does not become enforceable until either the court denies a petition for review or the period expires for California Supreme Court review (on February 17, 2020), whichever occurs first.

Plaintiffs' counsel continue to omit mention of safety measures that have been created, executed, and improved over the past eight months or the beneficial impact they have had. Indeed, Plaintiffs have actively contributed to the development of safety protocols implemented by the Receiver and monitored CDCR's compliance with these protocols, many of which are mentioned on page four above and in sections below. These include, but are not limited to, aggressive testing strategies in each of CDCR's 35 institutions, contact tracing conducted by healthcare staff, quarantine and isolation protocols that surpass some Centers for Disease Control recommendations, a movement matrix that controls all movement of incarcerated people across the state, staff testing, protective-equipment guidance, and an ongoing collaboration between CDCR and the

counties regarding compliance with these standards in advance of intake.

Finally, Plaintiffs comment on the current size of CDCR's population. Although CDCR's population has increased by 82 people in the past two weeks since the last case management conference, it has reduced by nearly 20 percent since the beginning of March and still remains the lowest it has been in three decades.

II. TESTING AND TRANSFER PROTOCOLS

Plaintiffs' Position: CDCR continues to transfer large numbers of patients between prisons. Over the last several weeks, there have been on average approximately 500 such transfers per week. Testing and quarantining of those transferred, to reduce the risk of COVID-19 transmission, remain governed by CCHCS's August 19 "Movement Matrix."

We are not able at present to adequately monitor compliance with the Movement Matrix's testing and quarantine requirements. The best we can do is spot check individual patient records, and it is not possible to gain a systemic view of compliance doing that given the large numbers of people transferred. We also ask CCHCS regularly if it is aware of any COVID-19 transmission events associated with transfers; it says it is not aware of any such events. And while CCHCS says it believes prison staff are complying with the Matrix requirements, we believe it necessary—again remembering the San Quentin disaster resulting from transfers of positive patients into that prison, and the failure to properly quarantine them once they arrived—that objective information document compliance.

In this regard, CCHCS says its Transfer Registry, which we are told will comprehensively display compliance with Movement Matrix requirements for each transferred person, will be made available to us when "fully operational" or "completed." As of October 30, no date for this could be provided by CCHCS. We are not able to square this information with previous reports that the Transfer Registry had been implemented.

CCHCS also previously stated that it would modify an existing form in its Electronic Health Records System (EHRS) so that nurses before a transfer can document

that they checked that Movement Matrix requirements had been followed at the sending prison. On October 30, CCHCS said it wanted to complete work on this project and implement the revised form as soon as possible, but could not provide a date by which that would happen.

Defendants' Position: Since the current iteration of the movement matrix went into effect on August 21, 2020, DAI, CCHCS, and leadership teams at all institutions have held meetings, conference calls, and training sessions to help staff understand and implement the matrix. As directed by the matrix, movement is limited and controlled, and must be pre-approved by CDCR headquarters, which is working in collaboration with CCHCS (including Mr. Cullen and Dr. Bick). Additionally, there is continued enforcement of the safety protocols requiring all county staff and incarcerated people arriving at CDCR on intake buses to wear N95 masks. Further, CDCR and CCHCS continue to utilize measures to track patient information for transfers. Staff at each prison have procedures and processes in place to follow the requirements of the matrix. Further, on October 6, 2020, CCHCS implemented an online registry to track all transfer information for incarcerated persons. The registry is easily accessible, updateable, and contains comprehensive information that allows staff to review medical and other important data before, during, and after transfers. Finally, the prisons continue to offer comprehensive COVID-19 testing for incarcerated people, and the specific protocols for each prison are outlined for Plaintiffs during routine calls with CCHCS staff.

III. INTAKE

Plaintiffs' Position: CDCR doubled intake this week: from 338 the week of October 25, to 680 the week of November 1. As noted above, the State has at the same time ended two of the three early release programs announced in July. If the State continues intake at this pace, without conducting additional early releases, the population reduction achieved in recent months will be slowly reversed.

Defendants' Position: CDCR accepted 445 incarcerated persons into custody from county jail intake the week of October 18, and 338 incarcerated persons the week of

October 25, as follows:

Week of:	Number of Incarcerated Persons	Sending County	Receiving Institution
October 18	26	Humboldt	NKSP
October 18	28	Shasta	NKSP
October 18	41	Butte	NKSP
October 18	10	Plumas	NKSP
October 18	5	Modoc	NKSP
October 18	30	Napa	NKSP
October 18	22	Contra Costa	NKSP
October 18	40	Sutter	NKSP
October 18	74	Los Angeles	WSP
October 18	130	San Bernardino	WSP
October 18	39	Orange	CCWF
Total Week of October 18:	445		
October 25	44	El Dorado	NKSP
October 25	23	Shasta	NKSP
October 25	15	Colusa	NKSP
October 25	32	Yuba	NKSP
October 25	105	Tulare	WSP
October 25	52	San Luis Obispo	WSP
October 25	35	Los Angeles	CCWF
October 25	10	Kings	NKSP
Total Week of October 25:	338		

Each week, CDCR headquarters staff meet with leadership at the three reception centers (NKSP, WSP, and CCWF) and CCHCS to evaluate current available space, determine whether the institutions should permit intake the following week, and if so, how much space is available to accommodate social distancing of newly arriving incarcerated persons during the initial quarantine period.

For the week of November 1, CDCR has authorized intake as follows:

Number of Incarcerated Persons	Sending County	Receiving Institution
100	San Joaquin	NKSP
50	Madera	NKSP
40	Mendocino	NKSP
100	Riverside	NKSP
50	Sacramento	NKSP
25	Sacramento	WSP
100	Fresno	WSP
100	Merced	WSP
50	Sonoma	WSP
25	Sacramento	WSP
40	San Diego	CCWF
Total Week of November 1:	680	

As Defendants have reported in previous Case Management Statements, CDCR is working tirelessly to ensure that sending counties are complying with all intake protocols, including testing of incarcerated persons in advance of transport and wearing of N95 masks by both incarcerated persons and transportation staff at all times during transport. CDCR requires strict compliance with its protocol and has refused buses at intake on this basis, two of which were refused this week.

CDCR also coordinates intake with the sending counties to ensure that it is spread

across multiple days within the week to better enable staff at the receiving institution to ensure social distancing during the intake process.

CDCR remains in communication each week with the California State Sheriffs' Association to determine which counties have the greatest need and are able to comply with CDCR's strict transfer protocol, and establishes priority for intake accordingly.

IV. QUARANTINE AND ISOLATION

Plaintiffs' Position:

A. Set Aside of Quarantine and Isolation Space

Plaintiffs continue to contest the adequacy of the quarantine and isolation space identified by Defendants at each prison in response to the Court order of July 22, ECF No. 3401 at 3-4. We raised our concerns with CCHCS on September 16, as described in several past Joint Case Management Conference Statements, based on (a) the plan to use congregate living environments with shared airspace for quarantine purposes, when experience has proven that such environments serve as incubators for uncontrolled viral spread, and (b) the plan to move patients to housing environments that many consider will render them susceptible to attack from other incarcerated people.

On October 27, we asked the Receiver to consider an additional question: whether the set-aside spaces at each prison include provisions for people who are about to be transferred or have been recently transferred (known as precautionary quarantine). This question has gained urgency as inter-prison transfers have steadily increased, averaging approximately 500 per week in recent weeks, and intake has climbed as well, with a planned 680 to enter CDCR from county jails the week of November 2.

CCHCS's own COVID-19 Screening and Testing Matrix for Patient Movement of August 19, 2020, requires people to be placed in precautionary quarantine pre- and post-transfer in celled housing (except for those prisons that have no cells). Each prison "shall maintain sufficient quarantine space to accommodate its historical average volume of transfers." (Definitions at 2.b.ii.) Plaintiffs asked whether such quarantine space has been set aside in accordance with this directive, and if so, whether it is considered included in

the set-aside space for outbreaks.

B. Development of Policies Related to Quarantine and Isolation

As reported at prior Case Management Conferences, Plaintiffs have asked the Receiver to consider developing three policies related to quarantine and isolation: (a) guidance regarding when people should be quarantined or isolated in a space other than the set-aside space, (b) procedures and time-frames for placing patients in isolation or quarantine once positive test results are received or information is received regarding an exposure, and (c) a directive to ensure that those placed in isolation due to symptoms who are pending a COVID-19 test results are kept separate from those who are lab-confirmed to have COVID-19. *See* ECF No. 3469 at 12. On October 30, CCHCS updated its policy regarding the preferential use of set aside space for isolation and quarantine, and stated that isolation of positive patients should happen immediately. No specific procedures for ensuring that were mandated. CCHCS on October 30 said that is developing a report that will measure compliance with key quarantine and isolation requirements. We hope this includes timeliness of placement. CCHCS also says that directives regarding separate isolation placement for symptomatic patients who are pending test results have been provided verbally to the prisons, and will be included in the next revision of the isolation guidelines set forth in the Movement Matrix.

C. Monitoring Use of Quarantine and Isolation Space

CCHCS provided us with the Outbreak Management Tool (OMT) for 10 prisons, as requested, and late last week provided access to a portal at which it says all prisons' OMTs will be accessible. We have engaged in productive discussions with CCHCS regarding best practices and our suggestions for OMT improvements. In our view, the OMTs should permit managers and executives to determine whether fundamental CCHCS public health directives regarding medical isolation and quarantine are being followed at the prisons, and

provide information from which we can monitor such compliance.[14] We have at CCHCS's invitation suggested revisions to the OMTs so they might better present this key information.

Defendants' Position: As discussed in the last joint statement, CDCR has completed its initial effort to set aside large amounts of previously identified isolation and quarantine space at the prisons. CDCR has continued to work with Plaintiffs, the Receiver, the *Coleman* Special Master, and the *Armstrong* Court Expert to ensure that appropriate isolation and quarantine space is reserved for class members of all three class actions and to modify reserved spaces and plans for quarantine and isolation as needed across the system.

On October 27, 2020, representatives from all three class actions met again to discuss isolation and quarantine space needs, with a focus on the needs of *Coleman* enhanced-outpatient class members. The *Plata* Receiver and the *Coleman* Special Master requested another follow-up meeting to take place on November 10. Similar efforts are underway through the *Armstrong* case to ensure that the potential needs of *Armstrong* class members are adequately covered.

V. SAFELY HOUSING MEDICALLY VULNERABLE PEOPLE

Plaintiffs' Position: People who live in open airspace congregate living areas in CDCR prisons are at higher risk of contracting COVID-19 than those housed in cells, and thousands of people living in those spaces currently are at heightened risk of severe illness or death from the virus, due to their age and/or medical condition. Since we filed our last Statement, the Receiver finalized his report entitled "Transferring COVID-19 High-Risk

---

[14] CCHCS's public health directives are set forth in its web-based COVID-19 "Interim Guidance" (https://cchcs.ca.gov/covid-19-interim-guidance/), including in particular the "Definitions" section at the end of Appendix 13, the "COVID-19 Screening and Testing Matrix for Patient Movement" (revised August 19, 2020, and also known as the Movement Matrix).

Patients to Safer Housing" in which he addresses concerns about the medically vulnerable in open airspace living units. The Safer Housing Report recommends that CDCR "extend an offer to the over 8,200 patients with COVID-19 risk scores of 3 and above the opportunity to transfer into closed-front cells either at their existing institution or at another institution."

Plaintiffs support this recommendation, and Defendants have not objected to it. *See* ECF No. 3475 at 21. Indeed, Defendants have repeatedly affirmed that they are "committed to working with the Receiver to facilitate movements of medically high-risk patients from dorms to cells" to ensure safe housing "when such movement is recommended and approved by the appropriate public health and corrections experts." ECF No. 3469 at 15; *see also* ECF No. 3460 at 17, ECF No. 3448 at 16.

Unfortunately, progress towards implementing this recommendation has been limited. During our meeting with the Receiver's staff and Defendants on October 22, Mr. Kelso stated that his staff and Defendants would form a Working Group to plan for and to implement offering celled housing to medically vulnerable people, consistent with his Report. He indicated that this process would be undertaken "quickly," and that he was identifying CDCR custody and mental health staff to participate in this process. However, Plaintiffs learned on October 30 that the Working Group has not yet been formed. According to Vince Cullen, Director of Health Care Operations and Corrections Services, CCHCS is still assessing all prisons to ensure they have accurate information about the living spaces available. He reported that this process will not take months, but will also "not be ready next week."

Providing safer housing to those who are at highest risk of serious illness or death if they contract COVID-19 must be a priority, and the Plaintiffs urge Defendants and the Receiver to expedite this process. There will be, as the parties and the Court have recognized, challenges to implementation that include, but are not limited to, a reluctance on the part of many who have earned the right to live in less restrictive dorm housing to

move to a more restrictive cell.[15] Plaintiffs believe that there may be ways to incentivize movement to safer housing, and will welcome the opportunity to work with the Receiver and Defendants to develop and deploy strategies to make safer housing appealing to those who would benefit most from a move. As noted above, the next wave of infections is building now, and expediting the process is critical.

Defendants' Position: The Receiver has provided the parties with a final report on October 21, 2020 that proposes that CDCR should offer over 8,000 high risk medical patients living in dorms the opportunity to move into a single cell. The Defendants remain committed to working with the Receiver to facilitate movements of medically high-risk patients from dorms to cells, or any other movements, to safely house medically high-risk patients when such movement is recommended and approved by the appropriate public health and corrections experts.

VI. COVID-19 TESTING

Plaintiffs' Position:

A. Staff Testing

As previously reported, CCHCS took over authority for the staff testing program in August. On October 30, CCHCS distributed a revised "Employee Testing Guidance" to the parties. We are reviewing the revised Guidance and will send any concerns to CCHCS. Preliminarily, the revised Guidance appears to have increased the frequency of testing for employees at CHCF, CMF, and CCWF, and in medical inpatient units, from monthly to at least every two weeks (and weekly during an outbreak). It also increases the frequency of testing for transportation and hospital custody staff, from monthly to weekly, which we support. We are reviewing whether the revised Guidance's testing requirements are adequate for staff who work at jobs areas, such as kitchens and factories, that require

[15] As noted in our previous Case Management Conference Statement, Plaintiffs have distributed over 120 surveys to people who have been offered, and have declined, transfer to a cell, based on their elevated COVID risk factors. We have started to receive responses and are in the process of reviewing and compiling that information.

high levels of contact with incarcerated people and have been the source of a number of major outbreaks.

Regarding staffing for this program, CCHCS reports that as of October 5, it had assigned employee health RNs to each prison to conduct contact tracing onsite (this was previously done at Headquarters). CCHCS also reports that it will hire nurses to conduct the testing at each prison, and has stated it plans to have these nurses in place by the end of December. In the meantime, vendors continue to conduct employee testing.

Regarding Plaintiffs' monitoring, we still do not have access to employee testing data. The last update we received was in the July 27 Joint Case Management Conference Statement. *See* ECF No. 3405 at 8-10. CCHCS has said it is working on a reporting system for this data, and that reports for three prisons where some of the most vulnerable patients are incarcerated—CHCF, CMF, and CCWF—would be sent to us this week.

We support these developments and appreciate the steps CCHCS has taken to improve the staff testing program. But, seven months into this pandemic, we are disappointed that a comprehensive staff testing plan has yet to be fully implemented. Most significantly, CCHCS has reported that testing employees with symptoms of COVID-19—something we have been requesting since July, *see* ECF No. 3370, including in our motion, *see* ECF No. 3402 at 4-6—will not happen until CCHCS nurses are hired and trained to conduct onsite testing, which it estimates will not be completed until the end of December.

B. Incarcerated Population Testing

1. Patient Testing Policies

We have since June asked CCHCS to revise certain COVID-19 clinical guidelines regarding patient testing so that instead of language indicating a discretionary suggestion (e.g., "should"), words (e.g., "shall") be used that denote a directive mandate. We specifically were concerned about provisions related to serial re-testing of those quarantined who initially tested negative, and regular testing of those who work in areas with high levels of contact with staff or other incarcerated people.

With regard to serial re-testing, it appears the requested change will be made.[16] With regard to testing of essential workers who have high levels of contact with staff and others, no changes were made to the clinical guidelines, and there continues to be no mandated testing of these people despite multiple major COVID-19 outbreaks being directly attributable to such contact. On October 30, we again raised these concerns in relation to the most recent such outbreak, involving kitchen and factory workers at the California State Prison and Substance Abuse Treatment Facility (SATF). According to CCHCS, these workers were infected by staff and then seeded infections in multiple housing units, with approximately 400 people testing positive over the last 14 days. We believe CCHCS must require that prisons at specified intervals test workers who have high levels of contact with staff. On October 30, the Receiver said the issue would be considered.

2. Notification to Patients of Test Results

In early July we first raised concerns about inadequate patient notification and education regarding COVID-19 test results. CCHCS continues to work on implementing standardized templates that will notify patients of negative, inconclusive, or negative COVID-19 test results, and provide educational information. On October 30, CCHCS indicated it hoped to implement use of these templates by Thanksgiving. Meanwhile, and unfortunately, late, limited, and otherwise inadequate written notification of and education regarding test results continues.

Defendants' Position: Defendants note that Plaintiffs have raised issues in this section that appear to be directed to the Receiver's office and CCHCS. Defendants will not attempt to respond on their behalf, but remain committed to working with them in

---

[16] On November 2, CCHCS's Chief Counsel wrote, as we understand it, that discretionary language ("should") would be replaced with mandatory language ("shall") in the Interim Guidance's "Testing for COVID-19 and Other Respiratory Pathogens" provision that currently reads "[s]erial retesting of housing unit inmates and others who are at potential exposure risk, who are quarantined, and initially test negative should be performed every 3-7 days until no new cases are identified."

addressing Plaintiffs' concerns.

VII. OIG Report on the Use of Face Coverings in CDCR

Plaintiffs' Position: On October 26, the Office of the Inspector General (OIG) released its second report in its review of CDCR's response to the COVID-19 pandemic. *See* Office of the Inspector General, *COVID-19 Review Series, Part Two: The California Department of Corrections and Rehabilitation Distributed and Mandated the Use of Personal Protective Equipment and Cloth Face Coverings; However, Its Lax Enforcement Led to Inadequate Adherence to Basic Safety Protocols* (Oct. 2020), available at: https://www.oig.ca.gov/wp-content/uploads/2020/10/OIG-COVID-19-Review-Series-Part-2-%E2%80%93-Face-Coverings-and-PPE.pdf. This report reviews CDCR's distribution and use of personal protective equipment (PPE). The OIG found that, although CDCR had provided PPE and communicated face covering and physical distancing requirements to staff and incarcerated persons, in practice, both frequently failed to adhere to mask-wearing requirements. *Id*. at 2. OIG staff directly observed this during their monitoring visits, *id.* at 22-30, and significant noncompliance was also reported by prison staff surveyed by the OIG, *id*. at 31.

Most troubling, the OIG concluded that the failure to follow face covering and physical distancing requirements "was likely caused at least in part by the department's supervisors' and managers' lax enforcement of the requirements." *Id*. at 2. The OIG noted that CDCR has referred only 7 employees (out of more than 63,000) for formal investigation or punitive actions for misconduct relating to face covering and physical distancing requirements since February 1, 2020. *Id.* at 2-3, 35. Even lower levels of progressive discipline were infrequent: "A sample of five prisons that employ a total of 10,382 staff showed that from February 1, 2020, to September 2, 2020, prison supervisors and managers had taken just 29 disciplinary actions—in a period spanning seven months—for noncompliance with the department's face covering or physical distancing requirements." *Id.* at 20-21. Of those 29, "almost all the actions taken were the lowest levels of the progressive discipline process: namely, verbal warnings and instances of

written counseling." *Id*. at 34. California Institution for Men, with 1,413 COVID-confirmed cases and 27 COVID-related deaths among the incarcerated population, "provided no documentation of any disciplinary actions." *Id.* at 2, 34. San Quentin, with 2,240 COVID-confirmed cases and 28 COVID-related deaths, "provided documentation of just one action." *Id*. at 2, 34-35.

The OIG also faulted CDCR and CCHCS for loosening face covering requirements in June 2020. *Id*. at 3, 36. Two memos released in June allowed staff and incarcerated persons to remove their face coverings when they were outside and able to maintain a distance of at least six feet from other individuals. *Id*. at 36-37.

Plaintiffs were deeply troubled by this report. In response to the OIG's recommendations, on October 27, CDCR and CCHCS issued a memorandum requiring staff to wear face coverings "at all times," with two exceptions: (1) when a staff member is alone in a hard-walled office, tower, or control booth, and (2) when a staff members is in the performance of their duties and is actively responding to an incident. In the latter incident, the staff member is permitted to remove their face covering while jogging/running to respond to an incident. The memorandum also provides that "corrective action shall be taken" whenever managers or supervisors observe noncompliance, and that managers and supervisors "shall document" the noncompliance in a tracking log. Finally, the memo calls for unannounced compliance visits to each prison.

We support these efforts, but remain concerned, as self-monitoring of compliance with the face covering and physical distancing policies has proven to be extremely difficult. We have previously sent reports to CDCR and CCHCS of staff not adhering to these policies; each time, we have been told that CDCR or CCHCS conducted audits and found no or limited issues. We believe that the OIG should conduct another review of CDCR's compliance with the mandatory mask requirement in the near future, given the likelihood of another wave of COVID-19 infections hitting the prisons in the near future. The Inspector General has informed us that upon request from the Court he would conduct a follow-up review in a few months in order to determine whether there is increased

compliance by staff with the mask wearing requirements.

Defendants' Position: On October 26, 2020, the OIG released a report focused on CDCR's distribution of personal protective equipment (PPE) to its staff and incarcerated persons during the COVID 19 pandemic. The report states that OIG monitored CDCR institutions between May 19, 2020 and July 29, 2020 and that it conducted state-wide staff surveys.

The report found that, despite early shortages, CDCR was generally able to procure and maintain PPE supplies. Indeed, by April 9, CDCR delivered more than half of the 752,000 cloth face coverings it had purchased to its institutions. However, the report further found that CDCR's enforcement of face covering and social distancing guidelines was too lax and that not enough disciplinary action was employed, resulting in noncompliance by staff and incarcerated persons.

On October 27, CDCR issued a memorandum updating the requirements regarding the use of facial coverings and physical distancing, including strict enforcement protocols and regular unannounced compliance audits to each institution. The memorandum reminds "[a]ll departmental supervisors and managers [that they] are responsible for ensuring subordinate staff consistently wear approved face coverings correctly and practice physical distancing," and that failure to do so will result in corrective action. This memorandum is attached as **Exhibit A**. Further, on October 28, CCHCS issued an amended memorandum outlining enhanced entrance screening procedures that detail the screening process, screener training, guidance for employees who are sick or denied entrance to an institution, and regular submission of a proof of practice report to ensure compliance with screening procedures, attached as **Exhibit B**.

In addition, Regional Healthcare Executives conducted random, surprise spot checks at several institutions the week of November 2. Progressive discipline was initiated for instances of noncompliance, in accordance with CDCR's October 27 memorandum. Further, Secretary Allison and Mr. Kelso are jointly hosting a call with all wardens, CEOs, and their management teams on Friday, November 6 to further reiterate the importance of

the mask wearing mandate and related discipline for noncompliance. Secretary Allison and Mr. Kelso are also in the process of creating a video with additional speakers which will stress the importance of mask wearing to staff. Thus, while CDCR is disappointed and concerned by the OIG's findings based upon monitoring that occurred before the end of July, it is taking every effort to ensure staff compliance with mask-wearing mandates and enhance policies to further safeguard the institution population as well as staff against the spread of COVID-19.

VIII. Prison-Specific Updates

Plaintiffs' Position: We continue to have weekly conferences with Regional Health Care Chief Executive Officers (CEOs) and their supervisor regarding COVID-related matters at individual prisons. We very much appreciate these discussions, including because we learn of positive initiatives, raise concerns about problems, and suggest opportunities for improvement.

Based on information received at the October 16 conference with the CEOs, we on October 20 reported to the Court that CIM would begin serial weekly testing of never-positive patients, as is being done at San Quentin, and the California Rehabilitation Center (CRC). *See* ECF No. 3469 at 17:16-22. We also reported that CIM had arranged for approximately 20 additional nurses, to implement such testing. *Id*.

On October 23, the Regional CEO said serial retesting did not start at CIM and that 20 additional nurses were not obtained there; CCHCS then said it would review the matter. On October 30, it was again stated that serial retesting of never-positive patients prison-wide, is not occurring at CIM, could not occur until additional nurses were hired, and that an experienced physician had been sent to the prison to determine those staffing needs.

That incorrect information was provided about serial weekly testing at CIM is unfortunate. That such retesting has not started is unacceptable. Serial retesting of never-positive patients occurs at San Quentin, CRC, and, we believe, Avenal. The COVID-19 outbreak at CIM is about to enter its eighth month. Almost 1,500 at the prison have been infected with the virus, resulting in 161 hospitalized (the largest such total among CDCR

prisons) and 27 deaths (sadly, the second highest among the state prisons). CIM has a very large number of medically vulnerable patients: only the California Health Care Facility (CHCF) and the California Medical Facility (CMF) have greater percentages of high risk medical patients.[17] CIM's number of medically vulnerable patients, and the continuing consequences from COVID-19 suffered by those at the prison (the two most recent deaths occurred in the last week), require that weekly retesting of never-positive patients start immediately.[18]

Defendants' Position: Defendants note that Plaintiffs have raised issues in this section that appear to be directed to the Receiver's office and CCHCS. Defendants will not attempt to respond on their behalf, but remain committed to working with them in addressing Plaintiffs' concerns.

IX. Updates on Medical Care Matters Not Directly Related to COVID-19

Plaintiffs' Position: A conference with CCHCS has been scheduled for November 6 to discuss in more detail what is being done about the thousands of delayed (many for months) Addiction Medicine physician appointments for patients with substance use disorders referred for Medication Assisted Treatment (MAT). *See* ECF No. 3469 at 19. We appreciate the opportunity to further discuss this important issue. In the last two weeks we have for the first time learned, via CCHCS responses to queries about particular patients, that a part of the problem is that some Addiction Medicine physicians, both at a local prison and headquarters, have reached their current patient load limit set by federal licensing requirements and thus cannot prescribe MAT for additional patients.

---

[17] The most recent data provided by CCHCS, dated August 2020, shows that 65% of CHCF's population is designated medical high risk. At CMF and CIM, respectively, 53.9% and 49.6% of the population is so designated. Because CIM houses more people than CMF, the number of medical high risk patients housed there is greater than at CMF.

[18] We support the serial retesting program at CRC, but it is puzzling that CCHCS does it there but not at CIM. CCHCS data shows that only 4.6% of CRC's population is designated medical high risk, 23 patients have been hospitalized due to COVID-19 and, fortunately, none have died.

Defendants' Position: Defendants note that Plaintiffs have raised issues in this section that appear to be directed to the Receiver's office and CCHCS. Defendants will not attempt to respond on their behalf, but remain committed to working with them in addressing Plaintiffs' concerns.

DATED: November 4, 2020

HANSON BRIDGETT LLP

By: */s/ Paul B. Mello*
PAUL B. MELLO
SAMANTHA D. WOLFF
Attorneys for Defendants

DATED: November 4, 2020

XAVIER BECERRA
Attorney General of California

By: */s/ Ryan Gille*
DAMON MCCLAIN
Supervising Deputy Attorney General
RYAN GILLE
IRAM HASAN
Deputy Attorney General
Attorneys for Defendants

DATED: November 4, 2020

PRISON LAW OFFICE

By: */s/ Steven Fama*
STEVEN FAMA
ALISON HARDY
SARA NORMAN
SOPHIE HART
Attorneys for Plaintiffs

EXHIBIT A

CALIFORNIA DEPARTMENT of CORRECTIONS AND REHABILITATION

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

MEMORANDUM

Date: October 27, 2020

To: California Department of Corrections and Rehabilitation All Staff
California Correctional Health Care Services All Staff
Division of Juvenile Justice All Staff

From:

K. Allison

KATHLEEN ALLISON
Secretary
California Department of Corrections and Rehabilitation

J. Clark Kelso

J. CLARK KELSO
Receiver

Subject: **STAFF WEARING FACIAL COVERINGS AND PHYSICAL DISTANCING REQUIREMENTS IN INSTITUTIONS AND FACILITIES**

This memorandum updates expectations and requirements outlined in the June 11, 2020, and July 1, 2020, memoranda regarding the wearing of facial coverings and practicing physical distancing at California Department of Corrections and Rehabilitation (CDCR) and Division of Juvenile Justice (DJJ) institutions and facilities. The Department takes the health and safety of all those who live and work in our state prisons very seriously and remains dedicated to enforcing protocols in response to the novel Coronavirus disease (COVID-19) pandemic.

All staff working or performing duties on CDCR or DJJ grounds, indoors and outdoors, shall correctly wear approved face coverings at all times. Properly worn face coverings shall cover the nose, mouth, and chin. The exceptions to this requirement are (1) when a staff member is alone in a hard-walled office, tower, or control booth or (2) when a staff member in the performance of their duties is actively responding to an incident. In this instance, the staff member is permitted to remove their face covering while jogging/running. However, immediately upon arrival to the incident, the face covering shall be replaced properly over the nose, mouth, and chin.

Staff unable to wear an approved face covering due to a medical, mental health, or developmental disability shall notify their supervisor and Return-to-Work Coordinator to engage

in the interactive Reasonable Accommodation process. Staff requesting a religious accommodation shall contact their local Equal Employment Opportunity Coordinator.

Requirements for Supervisors and Managers and Employee Relations Officers/Health Care Employee Relations Officers

All departmental supervisors and managers are responsible for ensuring subordinate staff consistently wear approved face coverings correctly and practice physical distancing. Whenever managers or supervisors observe a subordinate employee fail to adhere to face covering or physical distancing directives, corrective action shall be taken in accordance with Department Operations Manual, Article 22, Employee Discipline, section 33030.8, Causes for Corrective Action. Additionally, supervisors and managers shall document each instance of non-compliance with any directives contained within this memorandum on face coverings and physical distancing to track repeat offenses and take corrective and adverse actions, as appropriate. With information provided by each supervisor and manager, the attached Non-Compliance Tracking log shall be maintained by the Employee Relations Officers/Health Care Employee Relations Officers until further notice and will be requested for unannounced as well as regularly scheduled audits or reviews.

Any supervisors and managers who fail to enforce these directives shall be subject to progressive discipline including:

- Verbal Counseling
- Employee Counseling Record (CDC Form 1123)
- Letter of Instruction
- Adverse Action or Rejection During Probation, dependent on the employee's tenure

As a reminder, your assigned Employee Relations Officer/Health Care Employee Relations Officer is available to provide assistance throughout the progressive discipline process.

Requirements for Associate Directors and Regional Health Care Executives

Associate Directors and Regional Health Care Executives, CDCR, or designees, shall prepare a schedule to conduct unannounced compliance visits to each assigned institution within 30 days of issuance of this memorandum and shall establish a regular, ongoing schedule on a 120-day interval thereafter. Compliance or non-compliance shall be recorded on the attached Facial Coverings Compliance Checklist and shall be maintained until further notice and will be requested for unannounced as well as regularly scheduled audits or reviews.

Non-Compliance Tracking for Staff Failure to Wear Face Covering or Not Properly Worn Face Covering

(Insert Name of Institution)

Institution	**Unit**	**Employee's Name** (Last, First Name)	**Classification**	**Date of Failure** (Face Covering Mandate)	**Repeat Offense** (Yes/No)	**Type of Corrective Action Taken** (Verbal Counseling; ECR, LOI)	**Corrective Action Issuance Date**	**ECR/LOI Date of 30-Day Follow-up Discussion with Employee**	**Date 989 Request Submitted to Hiring Authority** (if applicable)	**Comments**

CONFIDENTIAL

Non-Compliance Tracking for Staff Failure to Wear Face Covering or Not Properly Worn Face Covering

(Insert Name of Institution)

Institution	**Unit**	**Employee's Name** (Last, First Name)	**Classification**	**Date of Failure** (Face Covering Mandate)	**Repeat Offense** (Yes/No)	**Type of Corrective Action Taken** (Verbal Counseling; ECR, LOI)	**Corrective Action Issuance Date**	**ECR/LOI Date of 30-Day Follow-up Discussion with Employee**	**Date 989 Request Submitted to Hiring Authority** (if applicable)	**Comments**

FACE COVERING COMPLIANCE CHECKLIST

The following checklist shall be completed to verify compliance related to the October 27, 2020, memorandum entitled Staff Wearing Facial Coverings and Physical Distancing Requirements in Institutions and Facilities. Regional Health Care Executives and Associate Directors, or designees, shall conduct compliance visits at their respective sites within 30-days of issuance of the October 27, 2020, memo and on a 120-day interval thereafter. Compliance Checklists shall be maintained until further notice and will be requested for audit or review purposes.

Recreational Yard	Compliance	Non-compliance	Comments
Staff Mask			
Inmate Mask			
Social Distancing			

Program Office	Compliance	Non-compliance	Comments
Staff Mask			
Inmate Mask			
Social Distancing			

Clinic	Compliance	Non-compliance	Comments
Staff Mask			
Inmate Mask			
Social Distancing			

Laundry	Compliance	Non-compliance	Comments
Staff Mask			
Inmate Mask			
Social Distancing			

Canteen	Compliance	Non-compliance	Comments
Staff Mask			
Inmate Mask			
Social Distancing			

Dining Hall	Compliance	Non-compliance	Comments
Staff Mask			
Inmate Mask			
Social Distancing			

Housing Units/Dorms	Compliance	Non-compliance	Comments
Staff Mask			
Inmate Mask			
Social Distancing			

Work Change	Compliance	Non-compliance	Comments
Staff Mask			
Inmate Mask			
Social Distancing			

Gym	Compliance	Non-compliance	Comments
Staff Mask			
Inmate Mask			
Social Distancing			

Dayroom	Compliance	Non-compliance	Comments
Staff Mask			
Inmate Mask			
Social Distancing			

Institution: _____

Print Name and Title: _____

Signature/Date: _____/_____

EXHIBIT B

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

MEMORANDUM

Date: October 28, 2020

To: California Department of Corrections and Rehabilitation All Staff
California Correctional Health Care Services All Staff
Division of Juvenile Justice All Staff

From:

Connie Gipson
Director
Division of Adult Institutions

DocuSigned by:
Joseph Bick
347167202A8A404...
Joseph Bick, M.D., CCHP
Director
Health Care Services

Heather Bowlds
Director
Division of Juvenile Justice

Subject: **NOVEL CORONAVIRUS DISEASE 2019 (COVID-19) INSTITUTION ENTRANCE SCREENING PROCEDURES REVISED OCTOBER 8, 2020 - AMENDED**

This memorandum updates expectations related to Novel Coronavirus Disease 2019 (COVID-19) entrance screening procedures at California Department of Corrections and Rehabilitation (CDCR) and Division of Juvenile Justice (DJJ) institutions and youth facilities. Symptom screening is an essential step the Department can take to lower the chance of COVID-19 transmission in the workplace. All institutions and youth facilities shall implement and abide by the procedures outlined in this memorandum to improve the consistency and effectiveness of the entrance screening process.

Screening Process

All institutions shall conduct entrance screening for all staff, vendors, volunteers, contractors and visitors each time that they enter an institution. The screening shall take place at either the parking lot entrance gate, while individuals are in their vehicles or at a designated screening location (e.g., the institution's first pedestrian access point). Designated screening locations shall be approved by the Regional Health Care Executive (RHCE), California Correctional Health Care Services, and Associate Director (AD), CDCR, or Deputy Director (DD), DJJ, and Chief Physician and Surgeon (CP&S), DJJ. Institutions shall submit their proposed screening plans to their respective RHCE and AD for CDCR or DD and CP&S for DJJ by **November 2, 2020**.

MEMORANDUM

The COVID-19 entrance screening consists of the following two-step process:

Step 1: Symptom and Exposure Risk Screening

Symptom questions shall be answered verbally by all individuals prior to being permitted to enter an institution.

1) *Do you have any **new or worsening symptoms not caused by an underlying health care condition:***
   - *Fever of 100.4 or greater or chills?*
   - *Cough?*
   - *Shortness of breath or difficulty breathing?*
   - *Unexplained or unusual fatigue?*
   - *Muscle or body aches?*
   - *Headache?*
   - *Loss of taste or smell?*
   - *Sore throat?*
   - *Congestion or a runny nose?*
   - *Nausea or vomiting?*
   - *Diarrhea (3 or more loose stools within 24 hours)?*

2) *Within the past 14 days, have you while not wearing appropriate personal protective equipment been in close physical contact **(within 6 feet or closer for a cumulative total of 15 minutes or more over a 24-hour period)** with a person who is known to have laboratory-confirmed COVID-19 or with anyone who has any symptoms consistent with COVID-19?*

Step 2: Temperature Measurement

Temperature measurements shall be taken for each individual with a non-contact, infrared, digital thermometer by screening staff.

Determining Entrance into the Institution

- Individuals who respond "no" to all screening questions and have a temperature measured less than 100.4 degrees Fahrenheit shall be granted entry into the institution.
- Individuals who respond "yes" to any screening questions or have a temperature measured equal to or greater than 100.4 degrees Fahrenheit shall be denied entry into the institution. Individuals with temperatures of 100.4 degrees Fahrenheit or above are considered symptomatic for COVID-19 even if no other symptoms are present.
- Individuals who respond "yes" to any screening questions, which may be related to underlying health care conditions, shall have further triage with a licensed nurse. Based on the clinical judgment of the nurse, the individual may be allowed entry into the institution. Employees providing medical substantiation of an underlying health care condition consistent with COVID-19 symptoms will not need additional triage. Medical substantiation shall be kept by the employee and shown to screening staff each day and shall include the specific COVID-19 like symptom(s) from the list in Step 1 or 2 above and a date the symptom(s) are expected to resolve or if the symptom(s) are permanent.

- Individuals who respond "no" to any of the screening questions but have symptoms observed by the screening staff shall have additional triage conducted by a licensed nurse. Based on the clinical judgment of the nurse, the individual may be denied entry into the institution.

Guidance for Employees who are Sick or Denied Entrance to an Institution

In an effort to prevent and reduce transmission of illness, the Centers for Disease Control and Prevention recommends that employees should stay home when sick with influenza-like illness including COVID-19. Employees shall self-screen prior to reporting for work and if experiencing any COVID-19 symptoms the employee shall:

- Not report to work,
- Immediately follow existing procedures for calling in sick, and
- Consult with their personal health care provider for additional guidance.

CDCR is developing a process to provide prompt COVID-19 testing for all staff denied entrance to an institution following the screening process. Until that testing process is finalized and implemented, adherence to the following guidelines is required:

- Employees denied entrance to an institution or who develop any COVID-19 symptoms while at work shall immediately notify their supervisor by telephone or email and shall consult with their personal health care provider for additional guidance. State employees can receive COVID-19 testing through their personal health care provider, state run testing sites such as Verily or Optum Serve, or other locally sponsored testing sites. The link to testing sites is at https://covid19.ca.gov/testing-and-treatment/.

- Employees who test positive for COVID-19 (with or without symptoms), or who test negative **or refuse to test** but have symptoms shall not return to work until:
  - ✓ At least 10 calendar days have passed *since symptoms first appeared* or *first positive diagnostic viral test result, if asymptomatic* **and**
  - ✓ At least 24 hours have passed *since last* fever of 100.4 or greater without the use of fever-reducing medications **and**
  - ✓ Symptoms (e.g., cough, shortness of breath) have improved.

All ATO and leave usage questions related to staff COVID can be found by viewing the CDCR and CCHCS decision trees:

https://www.cdcr.ca.gov/covid19/wp-content/uploads/sites/197/2020/10/ATO-Essential-Non-Essential- Employee-Decision-Tree-2.pdf

https://www.cdcr.ca.gov/covid19/wp-content/uploads/sites/197/2020/10/Essential-Non-Essential- Employee-Decision-Tree-3.pdf

MEMORANDUM

Screener Training

Excluding Bargaining Unit 06 rank and file staff, screening staff shall be comprised of trained non-health care or health care staff. **Bargaining Unit 06 Supervisors may be permitted to conduct screening on first watch during traffic times and on an emergent basis on second and third watch. Institution Chief Executive Officers and Wardens shall coordinate and ensure appropriate coverage is available on each watch to conduct entrance screening for all staff, vendors, volunteers, contractors and visitors.**

Institutions shall ensure all staff assigned to conduct screenings are trained in taking a temperature, asking **all individuals including staff to read and respond to each symptom screening question** and referring individuals to a licensed nurse, as needed. All screeners shall be provided On-the-Job Training (OJT) to cover the mandated symptom screening questions; proficiency in thermometer use including proper thermometer calibration and battery replacement; and how to handle screening refusals and denying entrance to symptomatic individuals. Institutions shall submit proof of practice regarding OJT for currently assigned screeners to their respective RHCE and AD for CDCR or DD and CP&S for DJJ by **November 2, 2020**, and OJT shall be documented and maintained for each screener assigned in the future.

Equipment and Supplies

Institutions shall ensure all screening locations maintain an adequate supply of functioning thermometers for temperature screenings and a three-month supply of batteries. Thermometers utilized for COVID-19 temperature screenings shall be non-contact, infrared, and digital. The Chief Support Executive (CSE) for CDCR or Senior Registered Nurse for DJJ, at each institution shall conduct routine inspections, at least quarterly, and testing of new thermometers prior to use. Institutions shall develop a process for reporting and replacing malfunctioning or broken thermometers. Additionally, as noted above, screeners shall be trained on proper thermometer calibration and battery replacement according to manufacturer guidelines.

Ongoing Screening Compliance and Monitoring

To ensure ongoing compliance with institution entrance screening procedures, each institution shall submit a monthly proof of practice, to the institution's respective RHCE and AD for CDCR or DD and CP&S for DJJ by the fifth of every month for the preceding month. This proof of practice will certify that a manager, not lower than the level of Associate Warden and CSE or designee, personally observed the entrance screening process and conducted random checks of staff screening compliance.

Thank you for your continued dedication and commitment to reducing the spread of COVID-19 and protecting the health and safety of our inmates, wards, staff, and the public. If you have any questions regarding implementation of this memorandum, please contact the institution's RHCE or AD for CDCR or DD or CP&S for DJJ.