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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

OAKLAND DIVISION

MARCIANO PLATA, et al.,

Plaintiffs,

v.

GAVIN NEWSOM, et al.,

Defendants.

CASE NO. 01-1351 JST

JOINT CASE MANAGEMENT CONFERENCE STATEMENT

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

The parties submit the following joint statement in advance of the June 30, 2021 Case Management Conference.

I. VACCINES

As of June 25, 2021, approximately 98% of the California Department of Corrections and Rehabilitation's (CDCR) incarcerated population has been offered at least one dose of the vaccine, and approximately 73% of those offered have accepted it. (Those not offered vaccine are almost entirely either out-to-court and thus not physically present in a CDCR prison, or are Reception Center new arrivals pending a vaccine offer.) This amounts to 73% percent of the incarcerated population having received at least one dose of the vaccine, and 71% of the population being *fully* vaccinated. Vaccination rates of medically high-risk incarcerated people are as follows: over 99% of all COVID-19-naïve patients aged 65 or older have been offered the vaccine, 90% of patients in this category are fully vaccinated, and another 1% of await the second dose of the vaccine; over 99% of all COVID-19-naïve patients with a COVID-19 weighted risk score of 6 or higher have been offered the vaccine, 91% of patients in this category are fully vaccinated, and another 1% await the second dose of the vaccine; and 99% of COVID-19-naïve patients with a COVID-19 weighted risk score of 3 or higher have been offered the vaccine, 84% of patients in this category are fully vaccinated, and another 2% await the second dose of the vaccine. Additionally, as of June 15, 2021, at least[1] 52% of staff who work in CDCR's institutions have been given at least one dose of the COVID-19 vaccine. Employees and incarcerated people are still required to wear personal protective equipment and practice physical distancing even after receiving the vaccine.[2]

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[1] This percentage includes those for whom CDCR and CCHCS, working with the Department of Public Health, have determined have been vaccinated outside CDCR's system. Because individuals may decline to share their medical information, it may not be possible to reflect every vaccinated staff member in this percentage.

Defendants' section on this topic states that the percentage of vaccinated staff is 54%, based on internal data collected on June 25, 2021.

[2] The Receiver's office and CDCR lifted the mask-wearing requirement for those

Plaintiffs' Position:

Patients

We continue to be pleased with CCHCS's efforts to vaccinate incarcerated people against COVID-19. As of June 25, CCHCS's Vaccine Registry shows that 98% of the 98,500 people in CDCR custody have been offered a vaccine.[3] It also shows that 71% of the population is fully vaccinated, and another 2% have received one dose of a two-dose regimen, so will be fully vaccinated in no more than 30 days. .

The Registry also shows that the COVID vaccine refusal rate among the CDCR population is now 26%.[4] We appreciate that CCHCS continues to re-offer vaccine to patients, that they continue to plan an outreach event at Salinas Valley State Prison to promote the vaccine to people who have thus far refused it (two of that prison's four main yards have relatively high refusal rates among residents), and is sending its Corrections Services Director to four prisons with relatively high refusal rates in an attempt to identify what might work to increase vaccine acceptance.

CCHCS on June 16 said it anticipates an EHRS upgrade will be implemented this month which will auto-populate a patient's vaccine status directly to the medical provider at the time of an appointment. CCHCS also said it will update its guidance to providers to require that the vaccine be discussed and offered at any appointment with a patient who is unvaccinated.

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who are outdoors and at least six feet away from others. And as of June 15, 2021, the State no longer requires fully vaccinated people to wear masks in most circumstances, but still requires mask-wearing by fully vaccinated people who live or work in correctional facilities, consistent with public health guidance.

[3] As indicated above, those not offered vaccine are almost entirely either not physically present in a CDCR prison, or are Reception Center new arrivals pending a vaccine offer.

[4] As of June 11, there were ten CDCR "yards" (as sub-facilities within each prison are commonly called) with populations of greater than 500 at which between approximately 45% to just over 50% had refused a vaccine offer. There are also about three dozen small units or yards, most housing less than 100 people, with refusal rates of 45% or higher.

While the number of active COVID cases statewide remain low, outbreaks have occurred at a handful of prisons in the last 30 days. These outbreaks show the continuing risk of COVID infection in the prisons, including even to the vaccinated, especially in prisons with relatively large vaccination refusal rates among the patient population and/or staff. The largest recent outbreak, at California State Prison, Solano, occurred on a yard with a relatively high patient vaccine refusal rate (approximately 50% at the time of the first positive cases in late May), and all but a few of the approximately 85 recently positive patients were unvaccinated. In contrast, an outbreak at Mule Creek State Prison, Facility C, which has relatively low vaccine refusal rate among the patient population (just over 10%), was limited to fewer than 20 patients, about half of whom were unvaccinated.

CCHCS on June 16 reported that since approximately late May, two CDCR patients had been hospitalized for COVID-related conditions. This too shows the continuing risk of COVID-19 to the incarcerated.

Staff

CCHCS data shows that the statewide institutional staff vaccination rate (at least one dose received) is only 52% as of June 15, 2021. The rate for custody staff is 41% overall, and among correctional officers – the job classification which has the most direct contact with residents – the rate is only 36% statewide. The vaccination rate for officers at some prisons is far lower. For example, only 16% of officers are vaccinated at High Desert State Prison. There are also large numbers of unvaccinated staff among certain medical job classifications.[5]

We continue to believe that vaccination against COVID-19 should be mandated for all CDCR and CCHCS staff in the prisons. As requested by the Receiver, we recently provided a detailed statement of our position to the Receiver, Defendants, and CCPOA. *See* Letter from Donald Specter to J. Clark Kelso, Receiver (June 15, 2021) (attached

[5] For example, data provided by CCHCS shows that 73% of Registered Nurses, 68% of Certified Nurse Assistants, 58% of Licensed Vocational Nurses, and 52% of Medical Assistants are vaccinated.

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

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

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

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

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

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

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

II. POPULATION REDUCTION

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

As of mid-June, according to information received in the *Coleman* case, approximately 5,000 people in county jails were pending transportation to CDCR. CDCR Reception Centers were receiving approximately 900 new arrivals per week.

CDCR continues the early release program, begun approximately a year ago, applicable to some who have 180 days or less to serve. In recent months, this program has resulted on average in approximately 85 people each week paroling or being released to community supervision earlier than they otherwise would have.[7]

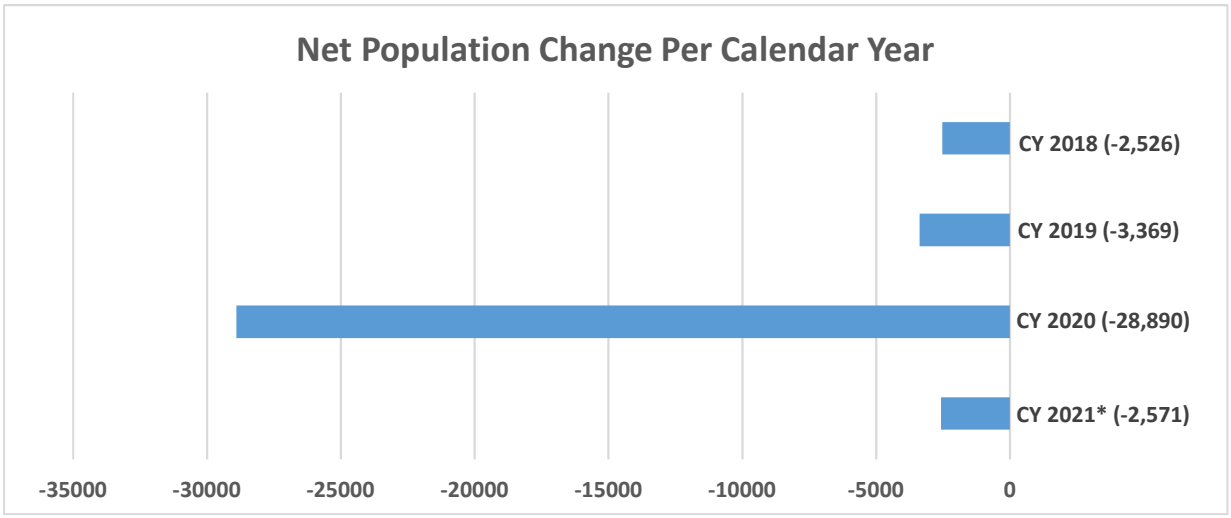
We continue to believe that efforts to reduce population remain necessary given the risk from COVID-19. *See* ECF No. 3579 at 9:21-11:1. We appreciate that these efforts now include new credit rules implemented on May 1, which permit some incarcerated persons to receive increased good conduct and other credits. Unfortunately, those new rules mean that some people designated minimum custody—including fire-fighters—will serve more time in prison, because the rules change how credits are calculated for that group.

Defendants' Position: As Plaintiffs acknowledge, CDCR reduced its population as an emergency measure in response to the COVID-19 pandemic. In addition to people who were released in accordance with their natural release dates, approximately 9,586 people have been released early through CDCR's COVID-19 early-release programs since July 2020. The extent of CDCR's significant population reduction efforts in response to the pandemic, and its current population as compared to historical levels, is most clearly demonstrated in the following graphic:[8, 9]

[7] Average determined based on total statewide releases under the program as of May 15, 2021 (the most recent date for which data is available), compared to the number of such releases as of December 30, 2020.

[8] The source of this data comes from CDCR's Division of Correctional Policy Research and Internal Oversight, Office of Research, June 9, 2021.

[9] *CY 2021 includes all admissions and releases through May 2021.



With a robust COVID-19 mitigation framework in place, including quarantine, testing, and transfer protocols, CDCR is focusing on alleviating the backlog of people currently awaiting transfer in county jails to CDCR custody. As a result, CDCR is experiencing a slow and modest population increase. CDCR continues to release incarcerated people through the 180-day early-release program, which has resulted in approximately 8,942 early releases since July 2020.

III. OIG SENTINEL CASE REPORT NO. 21-01

Plaintiffs' Position: Last December, we informed the Court that we had forwarded CDCR a log kept by a San Quentin resident detailing numerous instances of staff not wearing face-coverings at the prison, and that the Warden had said the allegations would be investigated via the prison's "inquiry" process. *See* ECF No. 3520 at 15:2-16:4. Defendants acknowledged that the matter would be reviewed, and emphasized that "the complaining party is not entitled to the details of the outcome of an investigation into allegations of employee misconduct." *Id*. at 17:10-23.

Earlier this month, the Office of Inspector General (OIG) issued a lengthy report regarding the CDCR's inquiry. *See* OIG Sentinel Case 21-01 (June 3, 2021) (attached hereto as Exhibit B). The report concludes that prison investigators conducted a biased and inadequate inquiry into the allegations, and that the investigator's determination that the allegations were not sustained was meritless and without basis. *Id*. at 3, 8. With regard

to the latter conclusion, the OIG commented:

> What we find most troubling, however, is the conclusion that there was "no evidence" to prove staff members did not comply with the facecovering order. This is not true. The incarcerated person who submitted the letter spelled out 19 specific incidents of staff members not wearing face coverings and noted the specific places and times of those incidents. ***That is evidence.***

Id. at 8 (emphasis in original). According to the OIG, "the prison investigators conducted a woefully inadequate and biased inquiry and made incorrect findings," and "the inquiry was not conducted in order to gather information relevant to the allegations made, but . . . was conducted in such a way as to reach a conclusion that the allegations were not true." *Id*. at 9. The OIG further reports that its efforts to have departmental executives and an undersecretary take different action were futile. *Id*.

In a letter, the CDCR Secretary took issue with several matters in the report, including the key conclusion that the investigation was woefully inadequate. *Id*. at 10-12. The OIG's reply to the Secretary's assertions on this latter point, is, we believe, compelling and entirely persuasive. *Id*. at 17.

As a result of orders entered by Judge Wilken in the *Armstrong* case, CDCR is revamping its "inquiry" investigations. The OIG's Sentinel Case report shows that these changes cannot come soon enough, and the CDCR's dismissive response to the report shows well why court orders were necessary.

The CDCR's unwillingness to accept the word of an incarcerated person[10] suggests it will never be able to fully enforce face-covering mandates, even though such are an

[10] The OIG concluded the incarcerated person's letter should have been sufficient to establish "reasonable belief" that misconduct occurred, and the matter thus should have been referred to the Office of Internal Affairs for investigation. *See* OIG Sentinel Case 21-01 (June 3, 2021) at 3 (attached hereto as Exhibit B). In her letter responding to the OIG's report, the CDCR Secretary stated: "The complaint did include dates and times; however providing dates and times in and of itself is not always sufficient evidence to open an internal affairs investigation. While the letter is evidence and the details add credibility to the incarcerated person's statement, treating any single accusation as the only source required to establish reasonable belief is not appropriate." *See id.* at 11.

effective means to reduce COVID-19 transmission. The inability to fully enforce face-covering mandates ultimately supports a requirement that all staff be vaccinated against the virus.

Defendants' Position: Consistent with the Secretary's response to the OIG's June 2021 sentinel report, CDCR continues to stand by the investigation. CDCR takes allegations of rules violations seriously and, contrary to Plaintiffs' assertion that it is "[unwilling] to accept the word of an incarcerated person[,]" CDCR launched an investigation in response to the incarcerated person's allegations, interviewed a number of incarcerated people and supervising officers, and produced a detailed report with its findings. The allegations were properly investigated by CDCR, as opposed to the Office of Internal Affairs, because the consequence for noncompliance with the mask-wearing policy was corrective action, and not adverse action. *See* Exhibit B at 13. CDCR properly initiated a local inquiry because the allegations were not submitted through the grievance process. *Id*. CDCR continues to prioritize the safety of those who reside and work in its institutions during the COVID-19 pandemic and, as the OIG noted, even though the incarcerated person's claims were not substantiated, San Quentin State Prison's Warden nonetheless issued a policy ordering that letters of instruction would be issued to any staff member observed not wearing a face covering. *Id*. at 9. Separately, the parties in the *Armstrong* class action have been meeting and conferring regarding the *Armstrong* remedial plan since October 2020. As part of these ongoing meet-and-confer sessions, the parties are working collaboratively with the help of the *Armstrong* court-appointed expert to create a new investigation process that complies with the court's remedial-plan order.

IV. HOUSING UNIT VENTILATION

Plaintiffs' Position: On June 24, CDCR counsel provided an update regarding MERV-13 filter installation in prison housing units, of the kind included by us in the most recent Case Management Statement. *See* ECF No. 3592 at 15:12-25. According to information provided, three additional prisons completed the filter installations since last

month, meaning 11 of 34 prisons slated to incarcerate people next winter now have them.[11] CDCR further reported that four other prisons' housing units do not recirculate indoor air, so MERV-13 filters will not be installed,[12] and that filters cannot be installed in another prison's housing units because the ventilation system design does not allow for it.[13] MERV-13 filter installation is estimated to occur variously between July and October at 15 of the 18 remaining prisons, with an estimated installation date still to be determined for the three others.

We also on June 10 asked for a list of which prisons have completed and submitted ventilation system inspections, the schedule for completing any that remain, and a copy of completed inspection results. These inspections are a key part of CDCR's plan to evaluate and improve housing unit ventilation. *See* ECF No. 3566 at 19:5-20:12 and ECF No. 3592 at 4-11. On June 25, CDCR counsel responded. Unfortunately, no update was provided as to the status of inspections, other than a statement that CDCR is working diligently to upload results to an internal website, and that once that was completed, a high-level summary would be prepared, "probably not until late July," for the Receiver and CDCR Secretary. CDCR counsel said this summary could be shared with Plaintiffs' counsel at that time. No completed inspection results were provided. No reason was given for not providing an update as to the status of inspections at each prison, or completed inspection results. We replied on June 25, again asking for the information. We will inform the Court if we are unable to resolve this apparent dispute.

Defendants' Position: Defendants continue to provide Plaintiffs with updates regarding CDCR's ongoing efforts to inspect prison ventilation systems. CDCR is making good progress with this project. Currently, approximately 42% of the housing units in CDCR's institutions use MERV-13 filters or filters with higher efficiency. This is an

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[11] Deuel Vocational Institution is scheduled to close this fall.

[12] Those prisons are California Institution for Women, California Rehabilitation Center, California Training Facility, and San Quentin.

[13] That prison is Sierra Conservation Center.

increase since Defendants' report in the previous CMC statement, when approximately one third of housing units were using MERV-13 or higher-efficiency filters. Approximately 48% of housing units use 100% outside air. MERV-13 or higher-efficiency filters will not be installed in certain housing units at the California Institution for Women, California Rehabilitation Center, Correctional Training Facility, and San Quentin State Prison where interior air is not recirculated. The MERV-13 filter installation schedule set forth in Plaintiffs' position above is consistent with Defendants' records.

V. RESUMPTION OF SERVICES

Plaintiffs' Position: CCHCS now posts information on the re-opening phase of each prison facility, via a tab on the "CDCR Population COVID Tracking" webpage.[14] Information about a facility's re-opening phase is enormously useful, but we have learned that programs—including healthcare services—can be restricted for substantial numbers even if the facility is designated "Phase 3" (which means "normal," per the CCHCS website). This is because a "Phase 3" facility can still have many patients on quarantine for exposure to COVID-19 (with an infected staff person commonly the vector, as we understand it), and thus for at least two weeks greatly restrict movement and services available for that particular set of patients. For example, although as of June 15, Facilities C, D, and E at the California Health Care Facility (CHCF) were all designated "Phase 3," there were, according to CCHCS data, 230 people in those facilities quarantined due to COVID exposure on that same date.

The most recent data from CCHCS shows that the previously reported backlogs of more than 6,000 primary care and more than 9,000 specialty service orders statewide (see ECF No. 3592 at 17:18-25) have been only very modestly reduced. We understand it will take time for these overdue appointments to be provided, given that thousands of not yet overdue orders must also be addressed. With regard to specialty services, we asked

[14] *See* Cal. Dep't of Corr. & Rehab., *Population COVID-19 Tracking*, https://www.cdcr.ca.gov/covid19/population-status-tracking/.

CCHCS about efforts to provide cancer screening ultrasounds for approximately 1,000 end-stage liver disease patients who as of May were overdue for such imaging.[15] CCHCS explained that in May it provided lists of overdue patients to each prison, that a vendor provided additional staff to help with the backlog, and that updated lists of overdue ESLD patient ultrasounds are being generated for each prison.

We have scheduled site visits at Salinas Valley State Prison (June 29), CHCF (July 1), California State Prison, Solano (July 7-8), and California Medical Facility (July 13-14). Among other things, we hope during these visits to observe and gain other on-the-ground information regarding re-opened medical services. The visits to Salinas Valley and CMF, as well as CHCF if the current outbreak there permits it, will also focus on medical care in the Psychiatric Inpatient Programs.

Defendants' Position: Now that COVID-19 case numbers are relatively low and a large percentage of the incarcerated population is vaccinated, CDCR is focusing on resuming pre-pandemic programming to the extent possible. Even while resuming programming, quarantine may be necessary in the event of an exposure to COVID-19 to protect those exposed and prevent an outbreak. CDCR recognizes that quarantine impairs incarcerated people's ability to program, and therefore carefully evaluates the need for quarantine in consultation with CCHCS before instituting a quarantine.

CCHCS and CDCR revised the "COVID-19 Screening and Testing Matrix for Patient Movement" on June 18, 2021. A copy of the updated Matrix is attached as Exhibit C. The key changes are:

- clarification that neither pre- nor post-transfer quarantine is required for fully vaccinated patients who are moving from one location to another;
- clarification that pre- and post-transfer symptom screening and COVID testing

[15] Timely liver ultrasounds can detect early treatable cancer in these patients. In 2016, after five liver cancer deaths of ESLD patients were identified in which ultrasound screening guidelines were not followed, CCHCS established tracking mechanisms and took other steps to increase timely ultrasounds.

applies to all new intakes, regardless of vaccination status;

- addition of overnight offsite sleep study in the "Out for clinical appointment, same day return" category when screening and testing; and
- clarification that twice weekly testing is sufficient for patients with multiple off-site appointments with same day return within a week (e.g. chemotherapy or radiotherapy.)

Additionally, as Plaintiffs note, CCHCS is addressing the backlog of specialty services that has resulted from the pandemic. CDCR is committed to working closely with CCHCS to do its part in facilitating these specialty encounters.

Finally, Defendants look forward to resuming site visits, a major step towards returning to the process of delegating healthcare services back to the State.

DATED: June 25, 2021

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EXHIBIT A

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VIA EMAIL ONLY

June 14, 2021

J. Clark Kelso
Receiver

RE: COVID-19 Staff Vaccination Mandate

Dear Clark:

We write in response to your May 21 request for our view on "on the legality of, pros and cons of, and evidentiary basis for or against requiring CDCR staff – both health care and custody" to be vaccinated.

Over the last fifteen months, more than 69,000 people who live and work in California prisons have been infected by the novel coronavirus, at least 250 have died, and an untold number are suffering and will continue to suffer debilitating, long-term effects from the disease. Staff remain the primary vector for COVID-19 infections in the prison system, where four prisons are experiencing outbreaks. Although safe and effective vaccines have been widely available to staff in all prisons since January 2021, only about half have chosen to be vaccinated. The remainder continue to work in direct physical proximity to incarcerated people and each other and expose them to an unacceptably high risk of serious harm and death. At some prisons, the number of staff who are unvaccinated is shockingly high; at High Desert State Prison, for example, 75% of staff are unvaccinated.

To protect the incarcerated population as well as the staff, including the many who are immunocompromised and the many incarcerated individuals who, because of their disabilities or medical conditions, must come in frequent, direct contact with staff, you must direct that all staff who work in the prisons be vaccinated immediately, subject to the usual exemptions and accommodations required under state and federal law.

The public health basis and the life-saving benefits of such action are beyond dispute.[1] That is why employers, including at least 43 California colleges and universities, large healthcare

[1] *See, e.g.*, Eric Reinhart & Daniel L. Chen, Carceral-Community Epidemiology, Structural Racism, and COVID-19 Disparities, Proceedings of the Nat'l Academy of Sciences, Vol. 118 (May 2021) ("[Carceral] facilities function as disease incubators, providing sites for easy viral and bacterial replication with a ready supply of tightly packed bodies that are rendered even more vulnerable by inadequate healthcare, poor living conditions, and

providers, meat-packing plants, the Prison Law Office, and other law firms, already have required, or very soon will require, that employees be vaccinated.[2]

Some employers may have the luxury of waiting to enact a vaccination mandate. You do not. There are no telework, social distancing, or other strategies that alone or in combination adequately reduce the substantial risk of serious harm and death to the almost 100,000 people confined in state prisons, not to mention the over 65,000 staff who work in the prisons and live in the outside community. The essential work of CCHCS and CDCR institution staff to operate the prison and run programming simply cannot be done over Zoom.

There is no time to monitor "trends." Delay cannot be justified based on current, relatively low case counts. By the time the virus strikes again, it will be too late, as we have seen time and time again during the pandemic. And there is evidence throughout the world that the virus will strike again. Moscow is now on lockdown and the United Kingdom has postponed its reopening because of new outbreaks of a more contagious variant. Pockets of infection have been discovered in California, including Marin County. It takes only one infected staff person to seed an outbreak and/or cause a large-scale shutdown of prison operations. Indeed, many of the new staff infections have been identified as variants, which may have higher transmissibility. You cannot vaccinate yourself out of an active outbreak; the virus spreads too rapidly, and the prisons

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associated comorbidities"); CDC, COVID-19 Vaccine FAQs in Correctional and Detention Centers (June 1, 2021) ("Outbreaks in correctional and detention facilities are often challenging to control" and may "lead to community transmission outside of the facility").

[2] This includes the Los Angeles Unified School District, Sunrise Senior Living, University of Pennsylvania Health System, Houston Methodist Hospital, Boys & Girls Clubs of the SF Peninsula, California College of the Arts, California Lutheran University, California Polytechnic State University (San Luis Obispo and Pomona), California State University (Bakersfield, Chico, Fresno, Fullerton, Long Beach, Los Angeles, Northridge, Sacramento, San Bernardino, San Marcos, Maritime Academy, Channel Islands, Dominguez Hills, East Bay, Monterey Bay, Stanislaus), Harvey Mudd College, Humboldt State University, Samuel Merritt University, San Diego State University, San Francisco State University, San Jose State University, Sonoma State University, Southwestern College, Stanford University, University of California (Berkeley, Davis, Irvine, Los Angeles, Merced, Riverside, San Diego, San Francisco, Santa Barbara, Santa Cruz), University of La Verne, University of San Francisco, University of Southern California, Whittier College, JB USA Holdings, Inc. (meat packing), Lastique International Corp. (plastics distributor), Davis Wright Tremaine LLP, and Sanford Heisler Sharp LLP. Other employers require new hires to be vaccinated, including United Airlines, Delta Airlines, employees of the Doña Ana Detention Center, and senior living operators ALG Senior, Altria Senior Living, Civitas Senior Living, and Juniper Communities, Silverado.

function as "disease multipliers" and "epidemiological pumps."[3] As you stated earlier this year, if the coronavirus were building its ideal home, it would build a prison. Firm leadership and swift action are urgently needed.

EFFICACY OF INCENTIVES AND VOLUNTARY VACCINATION PROGRAMS

The CCPOA asks, "*at this point in time*," that this matter be delayed indefinitely and counsels that "[m]ore time" be given to wait and see if over 30,400 staff will change their minds.[4] But we cannot continue to inch along under a danger of this magnitude. We are long past the wait-and-see-and-hope-for-the-best approach. There are no data-driven guideposts or projections for whether or when incentives will result in full staff vaccination. Indeed, no metrics for efficacy have ever been offered. The data we do have, both in CDCR and in the larger community, however, indicates that a voluntary program will not achieve the full vaccination needed.

Put simply, measures to encourage voluntary vaccination have not increased staff vaccinations on the scale, or with the speed, necessary to protect our clients or the surrounding communities. Incentives of some form have been in place since December 2020. Even with them, vaccination rates remain low. Between May 14 and June 4, 2021, the number of institution staff who received a first dose of a vaccine went up by only 2%.[5] Assuming that rate remains constant, which is doubtful as remaining unvaccinated staff likely are more resistant to being vaccinated, all staff at High Desert will have received a first dose of the vaccine by **July 2023**, over two years from now.[6] At CHCF and CMF, which have close to the highest rates of partially or fully vaccinated staff (63% and 62%, respectively), it would take until **July 2022**. And this does not address whether staff will voluntarily keep up to date on any necessary booster shots.

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3 *See* Eric Reinhart & Daniel L. Chen, Carceral-Community Epidemiology, Structural Racism, and COVID-19 Disparities, Proceedings of the Nat'l Academy of Sciences, Vol. 118 (May 2021); *see also* Eric Reinhart & Daniel L. Chen, Incarceration and Its Disseminations: COVID-19 Pandemic Lessons From Chicago's Cook County Jail, Health Affairs Vol. 39, No. 8 (June 2020) ("Existing conditions in jails and penitentiaries make infection control particularly difficult, putting inmates at unconscionable and perhaps unconstitutional risk.").

4 *See* ECF 3591 at 4 (emphasis in original).

5 *See* Email from Suzanne Benavidez, Special Assistant to Director Joseph Bick, M.D., California Correctional Health Care Services, PLO Covid Data Summary for 06/04/21 (June 4, 2021).

6 This is calculated based on the staff vaccination rates set forth in CDCR's online Vaccination Tracker as of June 10, 2021. It does not include people who were vaccinated by a community healthcare provider and did not report their vaccination status.

The mitigation efforts cited by the CCPOA have been in place for months. This includes CCPOA's admirable public service videos, released in January 2021; supplemental paid sick leave, enacted by the legislature in March 2021; COVID Mitigation Advocacy Program, finalized in April 2021; temporary relief from routine COVID-19 testing, in effect in May and June 2021; and additional vaccine clinics at each institution, in effect in May 2021.[7]

The CCPOA's only new suggestions, one-time bonuses and counseling from a medical professional, likely would not result in the number of staff vaccinations needed without needless delay and, in any event, could be done in tandem with a mandatory program.[8] Extensive information on the safety and efficacy of the vaccines from medical professionals has been widely available, and staff would be offered individual consultations under a mandatory vaccination program.[9] And, on May 18, 2021, all staff were informed of cash prizes that people who have been vaccinated, or who sign a declination form, are eligible for.[10] This is in addition to the state's $116.5 million Vax for the Win program, "which includes $50 incentive cards to newly vaccinated residents and cash prize drawings for all who have received at least one dose."[11]

The low efficacy of incentives to date is not unexpected. Medical researchers believe that "[i]ncentives alone are unlikely to deliver the population immunity that will end the pandemic."[12] As a result, they recommend that "organizations that take care of patients," such as prisons, "mandate Covid vaccination for their employees":

> No intervention strategy is more effective than requiring vaccination, and our institution, Penn Medicine, recently announced that all health

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7 *See* ECF 3591 at 2, 5-6.

8 *See* ECF 3591 at 8-9.

9 *See, e.g.*, ECF 3539, Joint CMC Statement at 4-5 (Jan. 26, 2021) (Defendants' Position); ECF 3548, Joint CMC Statement at 5-6 (Feb. 12, 2021) (Defendants' Position).

10 *See* Email from CDCR CCHCS COVID-19, Vaccine rewards program (May 18, 2021). Bonuses, unfortunately, may have unintended consequences. This is because "booster shots will probably be required down the line," and "[o]ffering incentives now may set a costly and undesirable precedent, causing people to expect—and wait for—an incentive the next time around." *See* Kevin G. Volpp & Carolyn C. Cannuscio, Incentives for Immunity—Strategies for Increasing Covid-19 Vaccine Uptake, New England Journal of Medicine (May 26, 2021).

11 Office of Governor Newsom, Governor Newsom Draws First 15 Winners in California's Vax for the Win Giveaway (June 4, 2021), https://www.gov.ca.gov/2021/06/04/governor-newsom-draws-first-15-winners-in-californias-vax-for-the-win-giveaway/.

12 Kevin G. Volpp & Carolyn C. Cannuscio, Incentives for Immunity—Strategies for Increasing Covid-19 Vaccine Uptake, New England Journal of Medicine (May 26, 2021).

> system employees will be required to be vaccinated. U.S. health care workers are declining Covid-19 vaccination at alarming rates. In one nursing home, although 90% of the residents had been vaccinated, only half of the employees had followed suit; one of the unvaccinated employees infected multiple residents, and one vaccinated and two unvaccinated residents died. Such preventable lapses in safety should be unacceptable to anyone in the health care profession. Vaccination mandates in schools and workplaces—**especially in high-contact settings such as meat-packing plants and prisons**—could substantially reduce the future toll of Covid-19 in the United States.[13]

That recommendation is consistent with studies of influenza vaccination strategies, which have found mandatory vaccination programs to be "more effective at increasing coverage levels than any voluntary strategy."[14] "The best available evidence suggests that even when health care organizations implement aggressive, labor-intensive voluntary influenza vaccination programs for their employees, they are rarely able to achieve vaccination rates higher than 70%."[15]

One study found that years of "extensive publicity, incentives and educational programs" at a large healthcare organization with approximately 26,000 employees resulted in an influenza vaccination rate below the target goal of 80%.[16] After influenza vaccination was made a condition of employment for all employees, 98.4% were vaccinated.[17] An additional 0.35% received a

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13 *Id.* (emphasis added).

14 *See* Alexandra M. Stewart & Marisa A. Cox, State Law and Influenza Vaccination of Health Care Personnel, Vaccine, Vol. 31, 827-832, 829-830 (2013) ("Health care employers have adopted various strategies to encourage HCP to voluntarily receive influenza vaccination. However, these measures have failed to achieve 90% coverage levels. As a result, beginning in 2004, medical care facilities and local health departments began to require designated HCP to receive influenza vaccination as a condition of employment. Today, hundreds of facilities throughout the country have developed and implemented similar policies. Mandatory vaccination programs have been endorsed by professional and nonprofit, state health, and public health entities. These programs have been more effective at increasing coverage levels than any voluntary strategy, with some health systems reporting coverage levels up to 99.3%." (internal footnotes omitted)).

15 Abigale L. Ottenberg *et al.*, Vaccinating Health Care Workers Against Influenza, Am. J. of Public Health, Vol. 101, 212-16, 212-13 (Feb. 2011).

16 Hilary M. Babcock *et al.*, Mandatory Influenza Vaccination of Health Care Workers, Clinical Infectious Diseases, Vol. 50, 459-464, 460 (Feb. 2010).

17 *Id.* at 460-62.

religious exemption, 1.24% received a medical exemption, and only eight people, or 0.03% of staff, were terminated for noncompliance.[18]

The study results are consistent with CCPOA's belief that "few employees not near retirement will resign" if COVID-19 vaccines are mandated.[19] It also is consistent with the experience of Houston Methodist Hospital, which required that its employees be vaccinated against COVID-19 by June 7, 2021. Only about 0.7% (or 178) of the over 26,000 employees have been suspended for failure to comply with the policy.[20]

LEGAL BASIS AND REQUIRED EXEMPTIONS AND ACCOMMODATIONS

A staff vaccination mandate is well supported by state and federal law. The recent decision of the Superior Court for the County of Alameda in *Kiel v. The Regents of the University of California*, No. HG20-072843 (Super. Ct. Dec. 4, 2020), is instructive. There, the Court considered the lawfulness of an Executive Order issued by the President of the University of California conditioning access to University property on flu vaccination.[21] The Court denied plaintiffs' motion for a preliminary injunction.[22] The Court observed that the U.S. Supreme Court held over a century ago in *Jacobson v. Commonwealth of Massachusetts*, 197 U.S. 11 (1905), "that a state's mandatory vaccination statute was a lawful exercise of the state's police power to protect the public health and safety."[23] And, "[s]ince *Jacobson*, courts have repeatedly cited *Jacobson* and upheld mandatory vaccination laws over challenges predicated on the First Amendment, the Equal Protection Clause, the Due Process Clause, the Fourth Amendment, education rights, parental rights, and privacy rights."[24] In fact, the Court noted that it "is unaware of any case in which a court has struck down a mandatory immunization imposed as a condition . . . of access to property for the purpose of employment."[25]

The same analysis applies here. In fact, the goal of the Executive Order considered in *Kiel* is almost identical to the one that would animate a COVID-19 vaccination mandate in California prisons: "to reduce the likelihood of severe disease . . . and in turn reduce the likelihood that our

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18 *Id.* at 461.

19 *See* ECF 3591 at 12.

20 Bill Chappell, The Clock's Ticking for 178 Hospital Workers Suspended for Not Getting Vaccinated, NPR (June 10, 2021).

21 *Kiel v. The Regents of the Univ. of Cal.*, No. HG20-072843 at 2 (Super. Ct. Dec. 4, 2020).

22 *Id.* at 7-8.

23 *Id.* at 8.

24 *Id.* at 9 (collecting cases, including *Zucht v. King*, 260 U.S. 174, 175-77 (1922) ("it is within the police power of a state to provide for compulsory vaccination")).

25 *Id.* at 14.

health system will be overwhelmed (in more in [sic] than just hospital bed capacity)."[26] The Court also found that the evidence "amply supports that requiring flu vaccination is more likely to reduce transmission of the flu on UC property than proceeding under looser rules," including mask-wearing—something that certainly is true of existing COVID-19 vaccinations.[27]

That the vaccines are authorized by the FDA for emergency use under 21 U.S.C. § 360bbb-3 does not change the analysis. Indeed, a federal court recently rejected a legal challenge on that basis and upheld Houston Methodist Hospital's COVID-19 vaccination policy, noting that "Methodist is trying to do their business of saving lives without giving them the COVID-19 virus. It is a choice made to keep staff, patients, and their families safer."[28] The California Department of Public Health has recognized that "COVID-19 vaccines have gone through extensive clinical trials and the most intensive safety review in U.S. history," and are "highly effective" at preventing serious illness from COVID-19.[29]

As with the Executive Order reviewed in *Kiel*, the COVID-19 vaccination mandate should be subject to medical exemptions and religious and disability accommodations required under state and federal law. That is consistent with recent guidance from the U.S. Equal Employment Opportunity Commission (EEOC).[30] The CCPOA attempts to make a straightforward mandate

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26 *Id.* at 12.

27 *Id.* at 11. Indeed, over four months ago, Defendants represented that they would reevaluate their position on a vaccination mandate based, among other things, on "the outcome of ongoing scientific studies regarding how effectively the vaccine reduces not just viral infection, but viral transmission." ECF 3548, Joint CMC Statement at 5 (Feb. 12, 2021). The Centers for Disease Control and Prevention now recognize that "[a] growing body of evidence indicates that people fully vaccinated with an mRNA vaccine (Pfizer-BioNTech and Moderna) are less likely to have asymptomatic infection or to transmit SARS-CoV-2 to others." CDC, Science Brief: COVID-19 Vaccines and Vaccination (May 27, 2021).

28 *Bridges v. Houston Methodist Hospital*, No. H-21-1774 at 2-4 (S.D. Tex. June 12, 2021) (rejecting argument that "no one can be mandated to receive 'unapproved' medicines in emergencies, and . . . no currently-available vaccines have been fully approved by the Food and Drug Administration").

29 Cal. Dep't of Public Health, Vaccinate All 58, Let's Get to Immunity (last visited June 11, 2021), https://www.vaccinateall58.com/.

30 EEOC, What You Should Know About COVID-19 and the ADA, the Rehabilitation Act, and Other EEO Laws (May 28, 2021), https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws ("The federal EEO laws do not prevent an employer from requiring all employees physically entering the workplace to be vaccinated for COVID-19, subject to the reasonable accommodation provisions of Title VII and the ADA and other EEO considerations"). State law imposes similar requirements. *See* California for All, Vaccines (June 11, 2021),

unpalatable by grafting unnecessary and time-consuming bureaucratic measures to it in the name of implementing antidiscrimination laws.[31] But that is nothing more than scare tactics. The state already has processes in place to evaluate requests for accommodations and exemptions under the same state and federal laws. Those existing processes can be used here.

Finally, the suggestion, as CCPOA has made and others may, to delay a needed mandate for "several months" of bargaining also is misplaced.[32] As the CCPOA acknowledges, "[t]he Dills Act permits the State to act first and bargain later in a bona fide emergency."[33] The COVID-19 pandemic certainly qualifies as "an act of God, natural disaster, or other emergency or calamity affecting the state, and which is beyond the control of the employer or recognized employee organization" under both state and federal law.[34] In any event, the prospect of drawn-out negotiations militates in favor of quick action, not further delay.

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https://covid19.ca.gov/vaccines/ ("**May an employer require COVID-19 vaccination for all employees entering the workplace?** Yes, if certain requirements are met. Under the ADA, an employer may require all employees to meet a qualification standard that is job-related and consistent with business necessity, such as a safety-related standard requiring COVID-19 vaccination. However, if a particular employee cannot meet such a safety-related qualification standard because of a disability, the employer may not require compliance for that employee unless the employer can demonstrate that the individual would pose a 'direct threat' to the health or safety of the employee or others in the workplace." (citing to EEOC, What You Should Know About COVID-19 and the ADA, the Rehabilitation Act, and Other EEO Laws)).

31 ECF 3591 at 12-14.

32 *Id.* at 11.

33 *Id.* at 12 (citing Gov't Code § 3516.5 ("In cases of emergency when the employer determines that a law, rule, resolution, or regulation must be adopted immediately without prior notice . . . the administrative officials . . . shall provide such notice and opportunity to meet and confer in good faith at the earliest practical time following the adoption of such law, rule, resolution, or regulation.").

34 Gov't Code § 3523(d); *see, e.g.*, Exec. Dep't, State of California, Proclamation of a State of Emergency (Mar. 4, 2020); U.S. Dep't of Health & Human Services, Office of the secretary, Determination of Public Health Emergency (Feb. 7, 2020) ("[P]ursuant to section 564 of the FD&C Act, I determined that there is a public health emergency that has a significant potential to affect national security or the health and security of United States citizens living abroad and that involves a novel (new) coronavirus (nCoV) first detected in Wuhan City, Hubei Province, China in 2019 (2019-nCoV)."); FDA, Emergency Use Authorization for Vaccines Explained (Nov. 20, 2020),https://www.fda.gov/vaccines-blood-biologics/vaccines/emergency-use-authorization-vaccines-explained ("FDA recognizes the gravity of the current public health emergency and the importance of

In our view, the Eighth Amendment, requires you "to take adequate steps to curb the spread of disease within the prison system."[35] As the last year and a quarter has demonstrated the vaccine is the most effective and safe way to prevent the spread of infection and to mitigate disease caused by COVID-19 in prisons. We do not now know whether those who live and work in CDCR will be assaulted by another surge, perhaps caused by a more infectious variant. What we do know for a fact is that mandating the vaccine for staff will help enormously in reducing the risk of further disease and death.[36] Therefore, we urge you to adopt a policy requiring all staff to be vaccinated absent medical exemptions and the need for religious and disability accommodations.

If you would like to discuss this issue or need any further information, we expect that you will let us know.

Sincerely,

/s/

Donald Specter
Rita Lomio

cc: Counsel in *Plata*, *Armstrong*, *Coleman*, and *Clark*
Armstrong Court Expert
Coleman Special Master
Counsel for CCPOA

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facilitating availability, as soon as possible, of vaccines to prevent COVID-19—vaccines that the public will trust and have confidence in receiving.").

35 *Coleman v. Newsom*, 455 F. Supp. 3d 926, 932 (E.D. Cal./N.D. Cal. 2020). "Indeed, disease control is one of the areas in which the *Plata* court previously concluded that Defendants fell short." *Id.*

36 *Helling v. McKinney*, 509 U.S. 25, 33 (1993) ("We have great difficulty agreeing that prison authorities may not be deliberately indifferent to an inmate's current health problems but may ignore a condition of confinement that is sure or very likely to cause serious illness and needless suffering the next week or month or year.")

EXHIBIT B

OIG | OFFICE of the INSPECTOR GENERAL

Roy W. Wesley
Inspector General
Bryan B. Beyer
Chief Deputy
Inspector General
Independent
Prison Oversight

OIG Nº 21–01 | SENTINEL CASE | JUNE 3, 2021

California Department of Corrections and Rehabilitation Prison Investigators Conducted an Inadequate Inquiry Into Allegations Staff Members Failed to Wear Face Coverings and, Despite a Reasonable Belief That Staff Misconduct Occurred, the Warden Failed to Refer the Case to the Office of Internal Affairs for an Investigation

The Office of the Inspector General (OIG) is responsible for, among other things, monitoring the California Department of Corrections and Rehabilitation's (the department) staff complaint process, internal investigations, and employee disciplinary process. Pursuant to California Penal Code sections 6126 and 6133, the OIG reports annually on the staff complaint process and semiannually on its monitoring of internal investigations and the employee disciplinary process. However, in some cases, where there are compelling reasons, the OIG may issue a separate public report regarding our monitoring; we call these *Sentinel Cases*. The OIG may issue a Sentinel Case when it has determined that the department's handling of a case was unusually poor and involved serious errors, even after the department had a chance to repair the damage. This Sentinel Case, No. 21-01, involves an incident in which an incarcerated person alleged the misconduct of several staff members, providing detailed information concerning the offenses, after which departmental staff conducted a substandard inquiry into the misconduct allegations, disregarded departmental policy for handling incarcerated persons' allegations of staff misconduct, and ultimately took no action against the staff members accused of committing the alleged misconduct.

In correspondence dated November 29, 2020, an incarcerated person at a prison in northern California sent a letter to the department, California Correctional Health Care Services, the Prison Law Office,[1] and the OIG concerning allegations that staff members in a unit where the incarcerated person was housed failed to wear face coverings as required by departmental policy. The department requires staff members to wear face coverings at all times while performing duties on prison grounds, per written order signed by the Secretary.

On October 27, 2020, the Secretary of the department and the federal receiver issued a memorandum to all employees ordering all staff performing duties on departmental grounds to correctly wear approved face coverings at all times, with the exception being when an employee is alone in a hard-walled office, tower, or control booth, or when an employee in the performance of their duties is running or jogging while actively responding to an incident.

On November 19, 2020, the Secretary of the department and the federal receiver issued a memorandum to all employees updating previous memoranda related to face coverings stating that effective November 23, 2020, all staff performing duties on departmental grounds were required to wear polypropylene procedure masks or surgical masks while performing duties on institutional grounds, except in the following circumstances:

1. While eating or drinking, if a minimum of six feet of physical distance is maintained from all other individuals.
2. When alone in an office with the door closed.
3. When alone in a tower or enclosed control booth with no other individuals present.

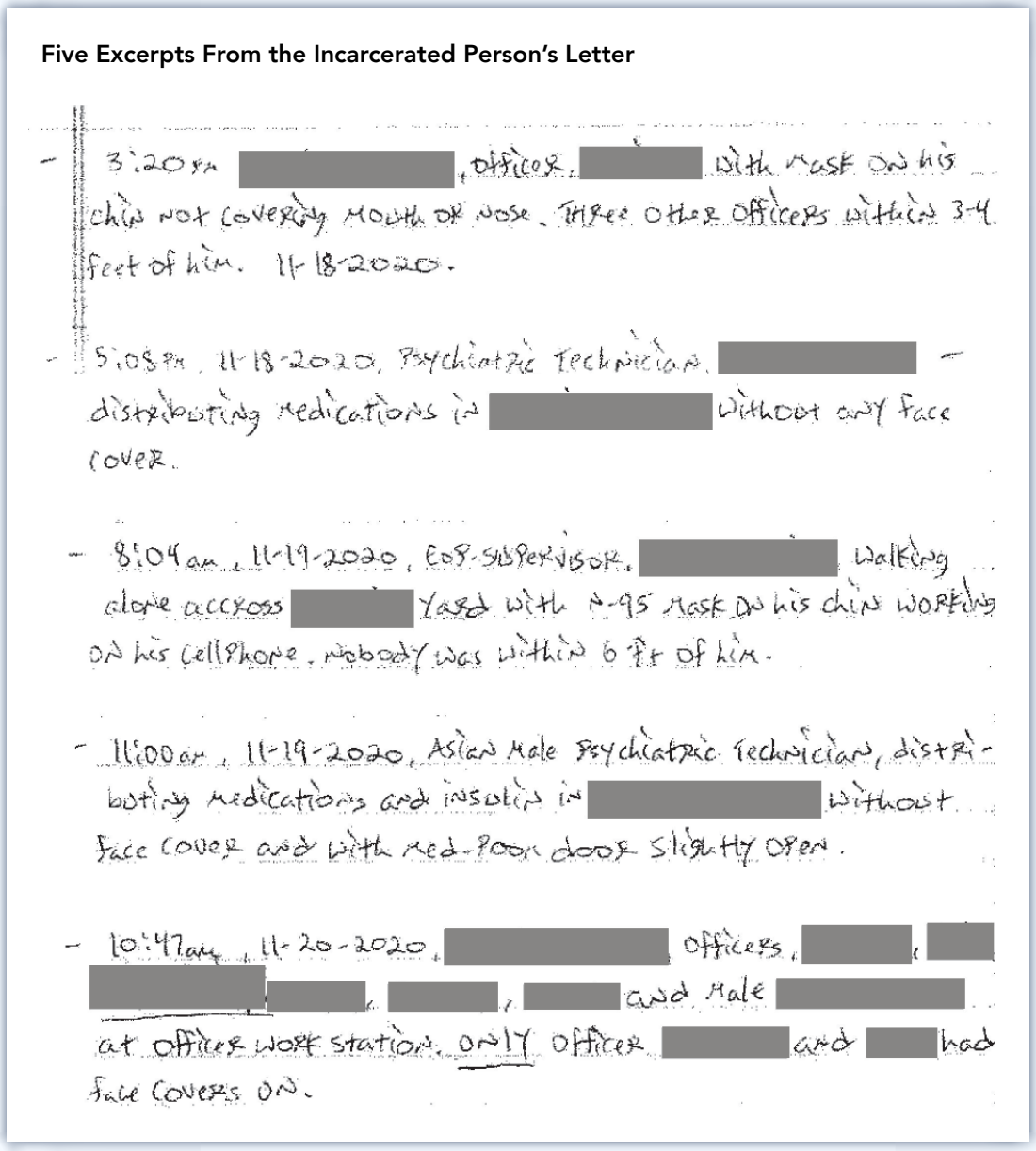
1. The Prison Law Office is a law firm based in Berkeley, California that represents incarcerated persons in litigation related to the conditions of incarceration in State prisons and county jails, among other things.

10111 Old Placerville Road, Suite 110, Sacramento, California 95827 ❋ Telephone: (916) 255-1102 ❋ www.oig.ca.gov

In his letter, the incarcerated person documented specific dates and times he observed various staff members failing to wear face coverings, named 17 separate staff members in those incidents, and provided brief descriptions of what the staff members were doing at the time of the policy violation. Below, we present excerpts from the letter in which the incarcerated person included the following observations (we have redacted the names of staff members and housing units).

The incarcerated person documented a total of 19 instances, including the five reproduced here (excerpts, see right), in which he observed staff members not properly wearing face coverings between November 18, 2020, and November 29, 2020. The incarcerated person also described a 20th incident in which a sergeant and an officer alerted staff members or incarcerated persons to put on face coverings because the warden was walking around the prison. In every instance, the incarcerated person included either the name and classification of the offending staff member or a physical description of the staff member. Also, the incarcerated person alleged that, even though departmental executives had designated a particular dormitory as housing for incarcerated persons on medical quarantine, on November 3, 2020, officers assigned to that particular dormitory visited officers in other dormitories before an outbreak of the novel coronavirus could be determined not to exist. Furthermore, the incarcerated person who wrote the letter also identified 10 staff members and a group of clinicians who were "always careful to properly wear face covers."

Five Excerpts From the Incarcerated Person's Letter



- 3:20 PM [redacted], Officer [redacted] with mask on his chin not covering mouth or nose. Three other officers within 3-4 feet of him. 11-18-2020.

- 5:08 PM, 11-18-2020, Psychiatric Technician [redacted] distributing medications in [redacted] without any face cover.

- 8:04 am, 11-19-2020, EOP Supervisor [redacted] walking alone accross [redacted] Yard with N-95 mask on his chin working on his cellphone. Nobody was within 6 ft of him.

- 11:00 am, 11-19-2020, Asian Male Psychiatric Technician, distributing medications and insulin in [redacted] without face cover and with med-room door slightly open.

- 10:47 am, 11-20-2020, [redacted] officers, [redacted], [redacted], [redacted], [redacted], and Male [redacted] at officer work station. Only officer [redacted] and [redacted] had face covers on.

Prison Investigators Conducted a Biased and Inadequate Inquiry Into the Allegations Raised by the Incarcerated Person

The incarcerated person raised specific allegations of misconduct against several staff members at the prison. If the warden had determined there was a reasonable belief that misconduct occurred which would result in adverse action, he would have been required to immediately refer the matter to the Office of Internal Affairs. If the warden had not yet established a reasonable belief, then he would have been required to refer the matter to the Allegation Inquiry Management Section. In response to the letter, the warden did neither and instead directed the prison's investigative services unit to conduct an inquiry. Based on the information provided, the warden should have immediately referred the matter to the Office of Internal Affairs because there was a reasonable belief misconduct occurred.

The incarcerated person set forth sufficient information in his letter to establish a reasonable belief that misconduct occurred by providing detailed information regarding 19 separate incidents involving 17 named staff members over an approximate two-week period. Despite there being sufficient information to forward the matter to the Office of Internal Affairs, the warden instructed an investigative services unit lieutenant and a sergeant at the prison (prison investigators) to conduct an inquiry, and the investigative services unit lieutenant produced an inquiry report. The OIG reviewed the inquiry report and supporting exhibits, including interview recordings, and found the inquiry to be biased and woefully inadequate.

The inquiry report reflected that the prison investigators reviewed attendance records related to 18 of the 20 alleged incidents and confirmed that every staff member who had been identified by name in the incarcerated person's letter as failing to wear a face covering at a specific place and time was, in fact, working in that particular area during the specified time frame. However, the inquiry report did not reflect that prison investigators reviewed attendance records pertaining to the remaining two incidents, namely an incident on November 24, 2020, and an incident alleging that a sergeant and an officer warned others of the warden walking around the prison on November 26, 2020.

The inquiry report reflected that prison investigators also gathered written reports from some staff members and conducted unrecorded interviews with some supervisors. Moreover, the inquiry report reflected that prison investigators conducted and recorded interviews of 16 incarcerated persons, including the incarcerated person who submitted the letter. However, the interviews were deficient. Investigators did not adequately address the incidents described by the incarcerated person in his letter; instead, they asked mostly general questions about how staff were doing and were focused on gathering information to exonerate staff members. In the OIG's opinion, the closest the investigators came to asking about any specific incident occurred during the December 7, 2020, interview with the incarcerated person who wrote the letter. The exchange occurred after a discussion about how medical and mental health staff were doing recently.

One prison investigator asked the incarcerated person whether staff were wearing their face coverings at the medication pass on the morning of the interview and over the weekend prior to the interview. The incarcerated person said the person distributing medications wore his mask the night before the interview, but that he did catch him not wearing a face covering a week prior. A prison investigator asked for this staff member's name, but the incarcerated person did not know it. The investigator asked was this person an "Asian," referring to the incarcerated person's letter in which he identified an "Asian male psychiatric technician." The incarcerated person said it was a "Black guy." The incarcerated person said he

caught the staff member not wearing a mask a couple of times while at the podium.

One investigator then noted that the medications were passed through a window from inside an office. The incarcerated person pointed out that the window was open and that they were not in a "sealed-in office." The incarcerated person then referenced an incident when an "Asian male" had the door cracked open. The investigator did not follow up to ask when these two incidents happened, if they were incidents described in the incarcerated person's letter, or if there were any other witnesses to these incidents. Instead, the investigator changed the subject to an irrelevant issue and asked how the incarcerated persons were doing with wearing their masks.

Rather than addressing every allegation the incarcerated person made with specific questions, the prison investigators asked him mostly general questions about how staff were doing recently, spent an unnecessary amount of time discussing issues unrelated to his specific allegations, and asked questions geared toward eliciting exonerating evidence. While impartial investigators should attempt to gather all evidence that could tend to exonerate those accused of misconduct, the investigators in this case focused more on gathering information to exonerate staff in general than they did on gathering evidence that could prove the allegations. For example, at the beginning of the interview of the incarcerated person who submitted the letter, the following exchange ends with the first question the prison investigator asked:

> The reason that we are here today is because we received the allegation you are making regarding all the staff members not wearing their mask [sic], and I just wanted to get some clarifications regarding your observations. So you identified on multiple occasions that these staff members were not wearing their masks. At times were they eating or drinking?

Instead of asking the incarcerated person for specific details about any of the incidents he described, the prison investigators opened the interview with a question attempting to elicit exonerating evidence. One prison investigator also asked the incarcerated person what his feelings were concerning incarcerated persons manipulating appeals to receive monetary compensation. The prison investigators asked the incarcerated person if he had received a "writeup" (discipline) and why he had received it. A prison investigator also asked the incarcerated person what was his motivation for bringing the allegations to light.

The prison investigator proceeded to ask the incarcerated person a series of questions about how staff members were doing generally with the face-covering order. Later in the interview, the prison investigator posited to the incarcerated person that it was "ten times better" at the prison than it was in March 2020, and asked if the incarcerated person thought it was getting better. The incarcerated person asked if she meant the department was doing better. The prison investigator continued to argue that the number of incarcerated persons testing positive "increasingly dropping to almost like no inmates" showed that the prison was doing better and asked the incarcerated person if the improved numbers spoke to how people were taking "it" more seriously, and that the face coverings were effective. The prison investigator then asked,

> Because imagine if staff would not be wearing their masks on a constant basis, then I think we would have more of an infection, right? [*sic*]

The incarcerated person responded,

> Well, it's possible. I think there's too much that people don't know about this virus yet.

In short, during the interview with the incarcerated person who wrote the letter, the prison investigator attempted to offer excuses for staff members and argued as to why the prison was doing better. However, the prison investigator failed to adequately address the specific allegations raised by the incarcerated person in his letter.

During interviews with other incarcerated persons, the prison investigators did not inform incarcerated persons they were doing an inquiry into allegations against staff and did not ask any incarcerated persons about any of the allegations raised by the incarcerated person who submitted the letter, whether it be dates, locations, or times of an incident, or the staff member who was involved in the incident. Instead, the prison investigators again focused on asking general questions about how staff were doing with wearing face coverings.

Nevertheless, some of the incarcerated persons provided evidence that corroborated the information provided by the incarcerated person who submitted the letter. For example, one incarcerated person told the prison investigators that sometimes staff members at the podium, also known as the officer's work station, in the building did not wear face coverings. The prison investigator asked the incarcerated person if he could identify the involved staff members in a photo lineup, to which the incarcerated person answered he could. However, there is no record the prison investigators actually followed up and asked the incarcerated person to review photographs and identify the staff members who did not wear face coverings while situated at the podium in the building.

The prison investigator asked this same incarcerated person when was the last time he saw someone not wear a face covering, and he responded it was a couple of days ago. She asked what time of day, and he said "third watch." The prison investigator asked if there was one staff member who did it more than others, and the incarcerated person identified an officer by name who did not wear a face covering at "the podium." The incarcerated person who submitted the letter had previously indicated the same officer did not properly wear a face covering while standing at the "officer work station" on four occasions, along with a fifth occasion for which the incarcerated person did not specify the location.[2]

Furthermore, one of the prison investigators asked the incarcerated person whether the officer who was not wearing a face covering at the podium was eating or drinking at the time. The incarcerated person responded he did not look long enough to see whether the officer was eating or drinking. In another interview, a third incarcerated person told one of the prison investigators that sometimes staff members did not wear face coverings. When asked where the incarcerated person observed officers not wearing face coverings, the individual responded, "the podium," corroborating the allegation of the incarcerated person who submitted the complaint that on several occasions officers were not properly wearing face coverings at the officer's work station or "podium."

In the letter, the incarcerated person documented 19 incidents of staff members not properly wearing face coverings. These incidents included observations concerning a staff member walking without wearing a face covering, or officers gathering and conversing in front of a dormitory without wearing face coverings. However, the most common location cited for staff members failing to properly wear a mask was the officer's work station, or podium. The incarcerated person

2. When summarizing the allegations identified in the letter, in the inquiry report, the prison investigator referred to the "officer work station" as "the Officer's work station," "the Officer station," and "the Officers podium." It appears based on the inquiry report that the term "work station" refers to the "podium."

identified nine separate incidents in which multiple staff members—sometimes as many as seven—congregated at the officers' work station while at least one of those staff members was not properly wearing a face covering. The incarcerated person identified a 10th incident in which a staff member working at the officer's work station was not properly wearing a mask, but did not indicate any other staff members were in the area.

Furthermore, during the interviews, the prison investigators continually asked incarcerated persons if officers pulled down their face coverings to eat or drink. However, the prison investigators did not ask the other incarcerated persons about the specific incidents in the letter and whether staff members were eating or drinking during those incidents. Also, nowhere in the letter did the incarcerated person mention the officers were eating or drinking. In fact, the incarcerated person wrote,

> It's also important to note that in every instance that I documented, none of the staff members was [*sic*] eating, drinking or making any effort to social distance. Either way, it's not possible to social distance in [housing unit] Officer work stations.

When one of the prison investigators asked the incarcerated person who wrote the letter whether any staff members were eating or drinking on any of the occasions he identified, the incarcerated person replied as follows:

> No they weren't. Most of the times that I identified, I was paying attention to..., I was paying attention to that, to whether they were eating or drinking, and I saw that they weren't. Maybe once or twice. I wanna say one officer that was in front of [dormitory], he had a soda or something in his hand. But other than that, no I was actually paying attention to that, and they weren't.

Contrary to the incarcerated person's statement, the prison investigator noted in her summary of this interview that the incarcerated person said he observed staff drinking soda on a couple of occasions. The following is the prison investigator's summary of that exchange:

> [Incarcerated person] stated that staff was not eating and or drinking when they had their mask off. He recanted and said it had only happened on a couple of occasions where he had observed staff drinking soda.

The prison investigator did not ask questions to identify which incident this was, whether the officer was merely holding the soda or drinking from it, whether there were other staff members around and whether they were socially distanced, or whether there were any other incidents in which an officer was holding or drinking a soda.

According to departmental policy, staff members may remove their face coverings while eating or drinking "if a minimum of six feet of physical distance is maintained from all other individuals." The inquiry report did not reflect that prison investigators conducted an analysis or attempted to ascertain the following:

1. Whether the staff members claimed they were, in fact, eating or drinking on the dates and at the locations specified;
2. Where the staff members typically ate their meals while on duty; and
3. Whether it is impossible to socially distance at the podium as the incarcerated person alleged.

During many interviews of incarcerated persons, one of the prison investigators was assigned a dual

role, creating a potential conflict of interest. In eight of the interviews, the investigative services unit lieutenant introduced a sergeant as a "staff assistant" for incarcerated persons and noted on the record in six of those interviews that the interviewee was in the mental health delivery system at the enhanced outpatient program (EOP) level of care.[3] Although the report does not address this assignment, it can be reasonably inferred that the investigative services unit assigned the sergeant as the staff assistant to these incarcerated persons because they were designated as EOP.

In these interviews, the investigative services unit lieutenant introduced the sergeant as the interviewee's "staff assistant" in case he did not understand something, or if the investigative services unit lieutenant spoke too fast. However, the investigative services unit lieutenant also introduced the sergeant as her "partner" in one of those interviews. In addition, the sergeant introduced himself as an "investigator" in some interviews and as "with investigations" in others. He performed investigatory tasks during the inquiry, including asking questions in interviews.

The prison investigators compounded the problem of bias when they failed to assign a staff assistant to the incarcerated person who wrote the letter, even though the investigative services unit lieutenant referred to him during the interview as a "very high functioning EOP inmate."

The blending of the two roles of "staff assistant" and investigator is a poor practice, and if the department is going to assign a "staff assistant" to assist incarcerated persons in interviews, it should assign someone who is not already assigned to conduct the investigation, so as to remove the implication of bias. Furthermore, the department should treat complainants and other witnesses equally and fairly when assigning a staff assistant.

In addition to interviewing the incarcerated persons, the prison investigators gathered reports from nine staff members who may have been present during some of the alleged violations. Eight of the staff members documented that they did not remember or could not recall anyone not properly wearing face coverings on a specific date in question, with a couple making statements that they only witnessed staff remove their face coverings to eat or drink. Only one of the nine staff members did not qualify their memorandum as the other eight had and wrote that they did not observe any staff members not wearing or incorrectly wearing face coverings.

Three of the officers who submitted reports were officers who were accused of failing to properly wear a mask. However, their reports did not address the allegations against them and only contained statements concerning their observations on a day they had not been accused of misconduct. The prison investigator did not document any interviews with any of these nine staff members.

There is also no documentation showing prison investigators interviewed any of the staff members suspected of not wearing a face covering. The inquiry report only reflects that the prison investigators conducted unrecorded interviews of six supervisors who, with a couple of exceptions, stated staff members complied with the face-covering policy.

Regarding the allegation that officers from [housing unit] were visiting officers from other dormitories before a possible novel coronavirus (COVID-19) outbreak in [housing unit] could be ruled out, the prison investigator merely noted in her report there was documentation that the unit was not placed on quarantine status until November 4, 2020—not November 3, 2020, as the incarcerated person had alleged. However, the investigators did not ask the incarcerated person any specific questions about the allegation, including on what days and where he alleged the officers visited other officers.

3. The enhanced outpatient program is an outpatient mental care program at the department for those incarcerated persons requiring a more enhanced treatment plan with mental health staff.

The Prison Investigator's Conclusion That the Allegations Were Not Sustained Was Meritless and Without Basis

At the end of the inquiry report, the investigative services unit lieutenant concluded, in part, the following:

> At this time from the information provided the allegations brought forth by Inmate [redacted] were NOT SUSTAINED. Although Inmate [redacted]'s account of staff being on duty on specific times and dates, were extremely accurate there was no evidence to prove or disprove they were not in compliance with the masking order. The vast majority of witnesses interviewed, including staff and inmates provided information refuting [redacted] claims. The balance of the evidence is overwhelmingly indicative of staff being in compliance with the masking order as outlined in the June 11, 2020 memorandum. Therefore the allegations are deemed not sustained at this time.

The investigative services unit lieutenant's conclusion was meritless and without basis. The investigative services unit lieutenant asserted that the "vast majority of witnesses interviewed" refuted the incarcerated person's claims. However, although most of the incarcerated persons indicated staff members were generally doing well complying with face-covering requirements, the prison investigators did not ask any of them about the specific incidents identified by the incarcerated person who submitted the letter. For example, prison investigators did not ask any of the incarcerated persons about the specific allegation that, on November 20, 2020, at 10:47 a.m., specifically named officers gathered at an officer's work station without face coverings, nor did they ask if they recalled any similar incidents in the previous weeks.

Furthermore, contrary to the investigative services unit lieutenant's conclusion, staff members did not refute the incarcerated person's specific claims. Eight of the nine staff members who submitted reports wrote that, on one specific date, they did not recall anyone in violation of the department's face-covering policy. Failing to recall anyone not properly wearing a face covering is not the same as refuting specific allegations about specific officers failing to properly wear a face covering at a specific place and at a specific time.

What we find most troubling, however, is the conclusion that there was "no evidence" to prove staff members did not comply with the face-covering order. This is not true. The incarcerated person who submitted the letter spelled out 19 specific incidents of staff members not wearing face coverings and noted the specific places and times of those incidents. ***That is evidence.***

Interestingly enough, the investigative services unit lieutenant herself noted in the inquiry report that the incarcerated person was "extremely accurate" about the specific dates and times staff members were on duty. Furthermore, two other incarcerated persons corroborated the allegations made by the incarcerated person who submitted the letter, noting they observed officers at the podium without face coverings. One of those other incarcerated persons also identified an officer

who more frequently failed to properly wear a face covering; the incarcerated person who wrote the letter identified the same officer as not wearing a face covering on five occasions. ***The statements of the other incarcerated persons are also evidence.***

Despite the corroborating evidence provided by incarcerated persons and the lack of refutation concerning the specific allegations, the investigative services unit lieutenant inexplicably determined the allegations to be not sustained. Subsequently, the warden approved the findings of the investigative services unit lieutenant and did not refer the matter to the Office of Internal Affairs for an investigation. The OIG previously identified as a concern that wardens found staff violated policy in only 1.7 percent of cases resolved between June 1, 2020, and August 31, 2020.[4] The warden's findings in this case along with the manner in which this inquiry was conducted provides further evidence supporting our concern that the exoneration rate of more than 98 percent demonstrates a lack of fairness in the process.

In the OIG's opinion, the prison investigators conducted a woefully inadequate and biased inquiry and made incorrect findings. The manner in which the interviews were conducted and the way questions were posed to incarcerated persons leads us to conclude that the investigators did not believe the allegations made by the incarcerated person from the outset and that the inquiry was not conducted in order to gather information relevant to the allegations made, but that it was conducted in such a way so as to reach a conclusion that the allegations were not true.

Despite the inadequate inquiry, there was sufficient evidence to determine that there was a reasonable belief that misconduct occurred. However, the hiring authority did not refer the matter to the Office of Internal Affairs for investigation, and the department issued no disciplinary action or corrective action to any of the staff members who were specifically identified as having violated departmental policy concerning face coverings, as well as a direct order from the Secretary of the department.

We elevated the decision that had been made to not take any further action to a departmental executive, an undersecretary, and voiced our strong disagreement with the department's decision to not take any action despite specific evidence of staff misconduct. Nevertheless, the undersecretary confirmed the decision to not take any action against the staff members who committed misconduct. Interestingly, following the inquiry, the warden instituted a policy ordering that for any staff member observed not wearing a face covering, management would immediately issue a letter of instruction. A letter of instruction is a form of corrective action, not disciplinary action.

THE OIG HAS PUBLISHED VARIOUS REPORTS detailing the department's failure to seriously investigate allegations of staff misconduct proffered by incarcerated persons within the last two years (e.g., also see **our 2019 report on Salinas Valley State Prison**, **our inaugural Sentinel Case, No. 20–01**, and our **special review cited herein as footnote 4**). In the OIG's opinion, this case is yet another example of the department failing to seriously investigate allegations of staff misconduct made by incarcerated persons and also of prison investigators conducting severely inadequate inquiries and investigations into alleged staff misconduct. OIG

4. *The California Department of Corrections and Rehabilitation: Its Recent Steps Meant to Improve the Handling of Incarcerated Persons' Allegations of Staff Misconduct Failed to Achieve Two Fundamental Objectives: Independence and Fairness; Despite Revising Its Regulatory Framework and Being Awarded Approximately $10 Million of Annual Funding, Its Process Remains Broken* (Sacramento: State of California, the Office of the Inspector General, 2021).

STATE OF CALIFORNIA — DEPARTMENT OF CORRECTIONS AND REHABILITATION GAVIN NEWSOM, GOVERNOR

OFFICE OF THE SECRETARY
P.O. Box 942883
Sacramento, CA 94283-0001

May 14, 2021

Mr. Roy Wesley
Office of the Inspector General
10111 Old Placerville Road, Suite 110
Sacramento, CA 95827

Dear Mr. Wesley:

The California Department of Corrections and Rehabilitation (Department) submits this letter in response to the Office of the Inspector General's (OIG) draft Sentinel Report 21-01 titled *California Department of Corrections and Rehabilitation Prison Investigators Conducted an Inadequate Inquiry Into Allegations Staff Members Failed to Wear Face Coverings and, Despite a Reasonable Belief That Staff Misconduct Occurred, the Warden Failed to Refer the Case to the Office of Internal Affairs for an Investigation*. In this report, the OIG notes that an incarcerated person sent correspondence to the Department, California Correctional Health Care Services, the Prison Law Office, and the OIG concerning allegations that staff members failed to wear face coverings in a unit where incarcerated persons are housed. The Department has reviewed the draft report and has the following comments:

Sentinel Report 21-01, page 3: *Based on the information provided, the warden should have immediately referred the matter to the Office of Internal Affairs because there was a reasonable belief misconduct occurred.*

Response: Under the current policy, the allegations in this letter would be considered staff complaints rather than allegations of staff misconduct because even if true, these allegations are not likely to result in adverse disciplinary action. As outlined in the October 27, 2020, memorandum titled *STAFF WEARING FACIAL COVERINGS AND PHYSICAL DISTANCING REQUIREMENTS IN INSTITUTIONS AND FACILITIES*, "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 Departmental Operations Manual, Article 22, Employee Discipline, section 33030.8, Causes for Corrective Action." If this inquiry had established proof of masking violations, the hiring authority would have appropriately taken corrective action to change the employee's behavior. Adverse action, on the other hand, would be utilized only after corrective action had already been taken and the employee continually failed to adhere to policy. Because the consequence for non-compliance was corrective action, not adverse action, under current policy and procedure, the allegations should not have been referred to the Office of Internal Affairs as the OIG suggests. Lastly, the allegations were reviewed by the hiring authority who appropriately initiated a local inquiry as the allegations were not submitted via the grievance process. 1

The OIG's comments begin on page 13.

Sentinel Report 21-01, page 3: *The incarcerated person set forth sufficient information in his letter to establish a reasonable belief that misconduct occurred by providing detailed information regarding 19 separate incidents involving 17 named staff members over an approximate two-week period.*

Response: The complaint did include dates and times; however providing dates and times in and of itself is not always sufficient evidence to open an internal affairs investigation. While the letter is evidence and the details add credibility to the incarcerated person's statement, treating any single accusation as the only source required to establish reasonable belief is not appropriate. 2

Sentinel Report 21-01, page 3: *A prison investigator asked for this staff member's name, but the incarcerated person did not know it. The investigator asked was this person an "Asian," referring to the incarcerated person's letter in which he identified an "Asian male psychiatric technician." The incarcerated person said it was a "Black guy."*

Response: During the interview, the claimant was not always able to identify the staff he alleges were in violation of the face mask policy. At one point, the claimant noted the allegation was against an "Asian guy" and later it was a "Black guy". Inconsistencies such as these make it difficult to positively identify any staff member, and calls in question the reliability of the information being provided. 3

Sentinel Report 21-01, page 5: *During interviews with other incarcerated persons, the prison investigators did not inform incarcerated persons they were doing an inquiry into allegations against staff, and did not ask any incarcerated persons about any of the allegations raised by the incarcerated person who submitted the letter, whether it be dates, locations, or times of an incident, or the staff member who was involved in the incident. Instead, the prison investigators again focused on asking general questions about how staff were doing with wearing face coverings.*

Response: The Investigative Services Unit (ISU) staff have been specifically trained not to ask leading questions in order to elicit an unbiased response from the person being interviewed. In addition, the ISU staff take great care not to divulge too much information that could put the safety of any person, including the person who originally submitted the complaint, in jeopardy. 4

Sentinel Report 21-01, page 9: *In the OIG's opinion, the prison investigators conducted a woefully inadequate and biased inquiry and made incorrect findings. The manner in which the interviews were conducted and the way questions were posed to incarcerated persons leads us to conclude that the investigators did not believe the allegations made by the incarcerated person from the outset and that the inquiry was not conducted in order to gather information relevant to the allegations made, but that it was conducted in such a way so as to reach a conclusion that the allegations were not true.*

Response: As previously noted, ISU asks general questions to elicit an original answer without unintentionally leading the person into a response. Furthermore, while the department and the OIG may disagree on the outcome of the inquiry, to describe an inquiry that resulted in a 21-page report and that included the review of attendance reports, interviews with supervisors, written reports from staff, and interviews with 16 incarcerated individuals, as "woefully inadequate" is disingenuous and misleading. 5

Thank you for the opportunity to review and comment on the draft report. If you have further questions, please contact me at (916) 323-6001.

Sincerely,

DocuSigned by:
Kathleen Allison
066FFF332C694AB...

KATHLEEN ALLISON
Secretary

COMMENTS

OFFICE OF THE INSPECTOR GENERAL'S COMMENTS ON THE RESPONSE FROM THE DEPARTMENT OF CORRECTIONS AND REHABILITATION

To provide clarity and perspective, we are commenting on the California Department of Corrections and Rehabilitation's (hereinafter referred to as the department) response to our Sentinel Case No. 21-01. The numbers below correspond with the numbers we have placed in the margin of the department's response.

1. The department's response minimizes the allegations made by the incarcerated person in his letter. The incarcerated person's letter did not refer to an isolated incident of an employee failing to a wear a mask, nor was this an instance of a supervisor observing a staff member failing to wear a mask on a single occasion. The incarcerated person's letter paints a picture of widespread and pervasive failures by staff to wear face coverings in and around a dormitory unit over a 12-day period from November 18 through November 29, 2020. The incarcerated population, as well as staff, suffered greatly as a result of the COVID-19 outbreak earlier in the year, making the failures even more egregious.

   The incarcerated person identified two officers who failed to properly wear a face covering on five occasions over a 12-day period and another officer who failed to do so on four occasions. A total of nine employees were identified, including eight officers, who failed to properly wear a mask multiple times during this time period. The incarcerated person documented these violations in his letter, providing specific names, dates, times, and locations. The incarcerated person also noted incidents in which supervisors and officers were properly wearing a mask, but were present when staff members failed to properly wear a mask. There is no record in the inquiry report that any of these staff members reported the failure of staff to properly wear a mask. The incarcerated person identified incidents in which multiple staff members congregated without socially distancing and failed to wear face coverings in violation of a clear policy meant to protect incarcerated persons and staff members alike. The incidents described clearly amounted to potential misconduct, and the hiring authority should have referred these allegations to the Office of Internal Affairs or the Allegation Inquiry Management Section.

Incidents Reported by the Incarcerated Person Concerning Staff Members Who Failed to Wear Masks

		November 2020 (Dates and times are listed in next row)																	
Staff Member	No. of Incidents	18 1520 hrs	18 1708 hrs	19 804 hrs	19 1100 hrs	20 1047 hrs	21 903 hrs	21 1402 hrs	22 1526 hrs	24 1057 hrs	24 1545 hrs	25 1420 hrs	26 2nd watch	27 230 hrs	27 1430 hrs	28 1315 hrs	28 1706 hrs	29 822 hrs	29 940 hrs	29 1000 hrs
Officer 1	2	X										X								
Psychiatric Technician 1	2		X					X												
Doctor 1	1			X																
Psychiatric Technician: Asian Male (unnamed)	1				X															
Officer 2	2					X	X													
Officer 3	5					X	X		X							X				X
Officer 4	5					X	X								X	X		X		
Officer 5	1					X														
Officer 6	2					Y			Y											
Officer 7	1					X														
Counselor, Male (unnamed)	1					Y														
Sergeant, Female (unnamed)	1						Y													
Officer 8	2						X									X				
Officer 9	1								X											
Officer 10	2								X	X										
Officer (unnamed)	1									X										
Psychiatric Technician: Black Male (unnamed)	1										X									
Officer 11	3											X	X		X					
Officer 12	4												X					X	X	X
Officer 13	1													X						
Sergeant, Tall Male (unnamed)	1													Y						
Psychiatric Technician: Asian Male (unnamed)	1																X			
Officer (unnamed)	1																	Y		
Officer 14	1																		X	
Officer 15	1																		X	
Lieutenant 1	1																			Y
Sergeant 1	1																			X

Key

X = Failed to wear a mask properly

Y = Wore a mask properly, but was present when other staff failed to wear a mask properly

Note: All staff members listed with a number were identified by name by the incarcerated complainant, but their names have been redacted. If the incarcerated person did not name the staff member, but otherwise described them, they are referred to as *unnamed*.

2. Even if the department determined that the letter alone was not sufficient to establish a reasonable belief that misconduct occurred, it should have immediately referred the matter to the Allegation Inquiry Management Section as required by departmental policy. The hiring authority did not refer the matter to either the Office of Internal Affairs or the Allegation Inquiry Management Section. Instead, the investigative services unit conducted an inadequate inquiry and failed to ask all the necessary questions to corroborate or contradict the allegations made by the incarcerated person. The incarcerated person detailed 19 separate incidents that took place over a 12-day period, and prison investigators failed to adequately investigate any of them. The OIG dismisses the department's contention it could not establish a reasonable belief that misconduct occurred based on the incarcerated person's letter because the department decided to conduct a local inquiry and failed to adequately address whether there was a reasonable belief that misconduct occurred in any of the incidents raised in the letter.

3. The department responded the incarcerated person noted that one allegation was against an "Asian guy," then later that it was against a "Black guy," and that these statements were inconsistent. This contention is not accurate, as the incarcerated person never accused an "Asian guy" and a "Black guy" of the same specific misconduct as we will explain below.

   The incarcerated person described in his letter three instances in which he observed psychiatric technicians failing to properly wear face coverings, but he did not name those individuals. He described those instances as follows:

   a. "11:00 a.m., 11-19-20, Asian male psychiatric technician, distributing medications and insulin (redacted) without face cover and with med-room door slightly open."

   b. "3:45 p.m., 11-24-2020, Black male psychiatric technician who worked (redacted) at officer work station wearing face cover on his chin with mouth and nose exposed."

   c. "5:06 p.m., 11-28-2020, Asian male psychiatric technician issued me medications in (redacted) without face covering."

   The letter never indicates that any one of the psychiatric technicians involved in these instances was the same person.

During the interview, the investigators asked the incarcerated person if the staff were wearing masks during medication pass on the day of the interview (December 7, 2020) and over the weekend prior to the interview. The incarcerated person said the person distributing medication the night before had his mask on, but that he did catch him not wearing a mask about a week prior to the interview. The investigator asked if he was "Asian." The incarcerated person said he was a "Black guy" and that the incarcerated person had caught him not wearing a mask a couple of times at the podium. The incarcerated person did not state in the interview that he was an "Asian guy" as the department claims in its reply. Furthermore, the incarcerated person's statement was consistent with his letter in which he identified a Black male psychiatric technician who failed to properly wear a face covering while at the workstation, or podium.

The department contends the incarcerated person was inconsistent and calls into question the reliability of the information being provided. This is simply not true.

As we pointed out in our report, the investigators failed to ask during the interview if the incidents discussed were the same as those described in the incarcerated person's letter, or if there were any other witnesses to these incidents. The department's inadequate inquiry failed to establish that the incarcerated person was being inconsistent.

Finally, the department replied that the inconsistency makes it difficult to positively identify any staff member. However, the department ignores that the investigator was able to identify psychiatric technicians who were on duty at the time of these incidents. The investigator did not ask the incarcerated person if he could identify by photograph any of the psychiatric technicians as being the person who failed to wear a mask. As we noted in our report, investigators asked a second incarcerated person if he would be able to identify by photograph staff members who failed to properly wear a face covering at the podium. The incarcerated person said he could. There is no record the prison investigators actually followed up and asked the incarcerated person to review photographs and identify the staff members who did not wear face coverings. It is difficult to identify staff members involved in misconduct when investigators fail to take obvious and reasonable steps to follow up on readily available information.

4. The department contends it is unable to ask incarcerated persons about specific allegations without asking leading questions. A leading question is one in which the question prompts, implies, or encourages the respondent to give the desired answer. There are many ways to ask witnesses about allegations regarding a specific incident without asking leading questions, and the OIG observes investigators with the Office of Internal Affairs do so in almost every investigation.

   Furthermore, the investigators failed to ask the incarcerated complainant about the allegations he raised in his letter. The department's concerns about safety are not relevant to the investigators' failure to ask specific questions of this incarcerated complainant.

5. The department contends our opinion that the inquiry was woefully inadequate is disingenuous because the investigator wrote a 21-page report, conducted 16 recorded interviews of incarcerated persons (11 of which were fewer than three minutes long), conducted unrecorded interviews of some supervisors, and reviewed attendance records. The OIG disagrees with the department that this work amounts to an adequate inquiry.

   While we disagreed with the outcome of the inquiry, that is not why we described it as woefully inadequate. As we pointed out in our report, investigators failed to sufficiently ask questions concerning the incidents described in the letter written by the incarcerated person. Furthermore, they failed to follow up with the incarcerated person who said he could identify by photograph those staff members who failed to properly wear a face covering while at the podium. The investigators failed to interview the accused staff members about the allegations against them. In addition, the investigators failed to determine whether it was possible for staff members to congregate at the podium without masks and safely socially distance while eating. For these reasons and for the remainder set forth in this Sentinel Case, we have properly concluded that the inquiry was woefully inadequate.

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EXHIBIT C

COVID-19 SCREENING AND TESTING MATRIX FOR PATIENT MOVEMENT

1. *To reduce the likelihood of COVID-19 spreading from one location to another, movement shall be limited to that which is necessary for clinical care, medical isolation or quarantine, reduction of overcrowding, and serious custody concerns.*

   Necessary movement includes but is not limited to:

   a) *movement of MHSDS patients as required by the Program Guide,*
   b) *transfers in and out of restricted housing units,*
   c) *transfers for medical inpatient (CTC, OHU, SMB) placement or to facilitate access to specialty services,*
   d) *transfers of people with disabilities impacting placement (including DPP and DDP individuals),*
   e) *transfers to address personal safety concerns, and*
   f) *transfers for placement in camps and community-based facilities.*

2. *Transfer-related COVID-19 screening consists of a verbal symptom questionnaire and temperature screening.*
3. *All COVID-19 testing shall be by Polymerase Chain Reaction (PCR) unless specifically stated otherwise.*
4. *When rapid point of care (POC) testing is utilized, one positive rapid POC will preclude movement. Isolate the patient in a solid door single cell and obtain a PCR test as soon as possible, preferably within 24 hours. A negative PCR test and no evidence for active COVID on clinical assessment will be required before movement is allowed.*
5. *Patients and transportation staff shall wear N95 masks during transfer. Masks shall cover the nose, mouth, and chin. Transportation vehicles shall be operated at no more than 75% occupancy and shall be disinfected after each trip.*
6. *Every effort shall be made to avoid layovers during transportation. If a layover is essential, patients shall layover in cell-based housing and only be housed with others coming from the same location at the same time.*
7. *Precautionary quarantine shall be utilized for all unvaccinated patients transferring from one institution to another location. Precautionary quarantine of unvaccinated patients shall take place post-transfer in the receiving institution, except in limited circumstances when patients are instead placed on pre- transfer precautionary quarantine. Pre-transfer precautionary quarantine is not required for fully vaccinated patients transferring to MCCF, ACP, CCTRP, MCRP, or a fire camp.*
8. *Precautionary post-transfer quarantine of unvaccinated patients shall take place in celled housing with a solid door. Facilities which by design have no cell-based housing (SQ, FSP, ASP, CVSP, CRC, CMC-West, or CIM FAC-A and D) shall conduct precautionary post-transfer quarantine of unvaccinated patients in cohorts of no more than 20 patients in a dorm solely dedicated to a cohort that arrived on the same day from the same location to the same unoccupied dorm at the receiving institution.*

9. *Vaccinated patients are those who are at least 14 days post receiving the last recommended dose of the COVID-19 vaccine series.*
10. *Unvaccinated patients are those who have:*
    a) *received no COVID vaccine, or*
    b) *received a partial vaccine series, or*
    c) *completed a vaccine series but are <14 days post completing the series.*
11. *Symptomatic patients shall be isolated alone in celled housing with a solid door and tested for COVID-19.*
12. *Patients with a PCR-confirmed diagnosis of COVID-19 may be housed together as a cohort on isolation status.*
13. *Movement of unvaccinated COVID-resolved patients shall be subject to the same testing and quarantine requirements as unvaccinated COVID naïve patients.*
14. *Patients with COVID risk scores of three or more who have not completed the COVID vaccine shall only be housed in cells with solid front doors, shall not be moved to dorm settings and shall not transfer to SQ, FSP, ASP, CVSP, CRC, CMC-West, or CIM FAC-A and D.*
15. *Patients who have completed the COVID vaccination may be housed in dorm settings and may be housed at SQ, FSP, ASP, CVSP, CRC, CMC-West, or CIM FAC-A and D, regardless of COVID risk score.*

TYPE OF MOVEMENT	COVID SCREENING AND TESTING STRATEGY	WHAT TO DO IF PATIENT REFUSES COVID TEST
From jail to reception center	**Sending jail:** • Do not transfer patients who are isolated due to active infection or quarantined due to exposure. • Perform COVID screening and viral testing by either PCR within 5 days of scheduled transfer or POC testing within 24 hours of departure. • If viral testing is negative and COVID screen negative, transfer within 5 days of PCR test collection or 24 hours of the negative rapid POC test. • Patients who are symptomatic and/or test positive during pre-transfer testing shall not be transferred, regardless of vaccination status. • All patients and transportation staff shall wear an N95 mask during transfer. **Receiving reception center:** • Quarantine all new arrivals for 14 days. • Screen all new arrivals for COVID-19 upon arrival and then daily while in quarantine. • Test all new arrivals for COVID-19 within 24 hours, and again prior to release from quarantine (day 12-14). • May release patients from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative. • Patients who are symptomatic and/or test positive shall be isolated as per interim guidance.	Sending jail: Patients who refuse to test prior to transfer to reception center shall not be transported with other patients. Special arrangements shall be made between the sending jail and the receiving reception center to move these patients individually and place them directly in quarantine upon arrival. Receiving reception center: Patients who arrive from jail and then refuse to test during reception center quarantine shall remain in quarantine at the reception center for at least 21 days and receive daily symptom screening prior to being released.
From jail directly to Specialized Medical Beds (SMB)	• Advance authorization is required by the Director, Health Care Services or designee. • The Intake Control Unit and HCPOP shall coordinate these moves and shall inform the receiving CEO and CME in advance. • All patients and transportation staff shall wear an N95 mask during transfer. • Quarantine all new arrivals for 14 days. • Screen all new arrivals for COVID-19 upon arrival and then daily while in quarantine. • Test all new arrivals for COVID-19 within 24 hours, again on day 5 and again prior to release from quarantine (day 12-14). • May release patients from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative. • Patients who are symptomatic and/or test positive shall be isolated as per interim guidance.	Patient to remain in quarantine at the receiving institution for at least 21 days and receive daily symptom screening.

TYPE OF MOVEMENT	COVID SCREENING AND TESTING STRATEGY	WHAT TO DO IF PATIENT REFUSES COVID TEST
From reception center to institution	• Do not transfer patients who are isolated due to active infection or quarantined due to exposure. • Pre-transfer precautionary quarantine not to be used unless transferring to MCCF, ACP, CCTRP, MCRP, or a fire camp. • Perform COVID screening and test by PCR within 5 days of scheduled transfer. • If PCR negative, screen for COVID and obtain rapid test within 24 hours of scheduled transfer. • If PCR negative, screen negative, and rapid test negative, transfer within 5 days of PCR test collection and within 24 hours of rapid test collection. • Patients who are symptomatic and/or test positive during pre-transfer testing shall not be transferred and shall be isolated as per interim guidance. • All patients and transportation staff shall wear an N95 mask during transfer.	Patient to be placed in quarantine for at least 21 days and receive daily symptom screening.
Institution intake from reception center	• Screen all patients for COVID-19 upon arrival. • Quarantine unvaccinated patients for 14 days. • Screen unvaccinated patients daily while in quarantine. • Test all new arrivals for COVID-19 on day 5 and then again on day 12-14. • May release patients from quarantine after 14 days if asymptomatic and COVID-19 tests are negative. • Patients who are symptomatic and/or test positive shall be isolated as per interim guidance.	Patient to remain in quarantine for at least 21 days.
General population movement from one institution to another, including to camp hubs; movement from ASU / STRH / LTRH / SHU to another facility	Sending institution • Do not transfer patients who are isolated due to active infection or quarantined due to exposure. • Perform COVID screening and test by PCR within 5 days of scheduled transfer. • If PCR negative, screen for COVID and obtain rapid test within 24 hours of scheduled transfer. • If PCR negative, screen negative, and rapid test negative, transfer within 5 days of PCR test collection and within 24 hours of rapid test collection. • Patients who are symptomatic and/or test positive during pre-transfer testing shall not be transferred and shall be isolated as per interim guidance. • All patients and transportation staff shall wear an N95 mask during transfer. Receiving institution • Screen all patients for COVID-19 upon arrival. • Quarantine unvaccinated patients for 14 days. • Screen unvaccinated patients daily while in quarantine. • Test all new arrivals for COVID-19 on day 5 and then again on day 12-14. • May release patients from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative. • Patients who are symptomatic and/or test positive shall be isolated as per interim guidance.	Sending and receiving institutions: Patient to be placed in quarantine for at least 21 days.

TYPE OF MOVEMENT	COVID SCREENING AND TESTING STRATEGY	WHAT TO DO IF PATIENT REFUSES COVID TEST
Movement from one institution to another for OHU, CTC, SNF, or Hospice placement	**Sending institution** Movement that clinicians have determined to be urgent or emergent: • Perform rapid testing for COVID-19 within 24 hours of transfer. • Transfer patient regardless of the results of the COVID-19 test. • Communicate results to receiving facility. • All patients and transportation staff shall wear an N95 mask during transfer. • Perform post-transfer precautionary quarantine and testing at receiving institution. Movement that clinicians have determined to not be urgent or emergent: • Perform COVID screening and test by PCR 5 days prior to scheduled transfer. • If PCR negative, screen for COVID and obtain rapid test within 24 hours of scheduled transfer. • If PCR negative, COVID screen negative, and rapid test negative, transfer within 5 days of PCR test collection and within 24 hours of rapid test collection. • Patients who are symptomatic and/or test positive during pre-transfer testing shall not be transferred and shall be isolated as per interim guidance. **Receiving institution** New arrivals who tested positive at sending institution: • Isolate as per interim guidance. New arrivals who tested negative at sending institution: • Screen all patients for COVID-19 upon arrival. • Quarantine unvaccinated patients for 14 days. • Screen unvaccinated patients daily while in quarantine. • Test all new arrivals for COVID-19 on day 5 and then again on day 12-14. • May release patients from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative. • Patients who are symptomatic and/or test positive shall not be transferred and shall be isolated as per interim guidance.	Sending and receiving institutions: Patient to be placed in quarantine for at least 21 days.

TYPE OF MOVEMENT	COVID SCREENING AND TESTING STRATEGY	WHAT TO DO IF PATIENT REFUSES COVID TEST
Movement within same institution: • Release or move into STRH, LTRH, ASU, SHU • CTC, OHU, Hospice admission or discharge • Mental health level of care change • DPP moves • DDP moves • All other routine mvmt	• Patients shall not be moved to or from an outbreak area at the same institution unless it is for purposes of isolation or quarantine. • No quarantine or testing required for movement within the same institution unless an unvaccinated patient will be moving into a large dorm (20 or more residents). If so, perform COVID screening and COVID-19 testing of the patient within 5 days prior to this move. Only move the patient if the COVID screen and test are negative. • If movement is considered urgent or emergent, perform a rapid test and transfer within 24 hours if COVID screen and rapid test are negative. • Patients who are symptomatic and/or test positive shall not be transferred and shall be isolated as per interim guidance.	Patient to be placed in quarantine for at least 21 days, unless placement in quarantine is impossible (e.g., MSF), in which case the patient will not be moved.
Admission to MHCB or PIP	**Sending institution** • Perform COVID screening and rapid testing for COVID-19 within 24 hours of transfer. • Transfer patient regardless of the results of the COVID-19 test. • Communicate results to receiving facility. • All patients and transportation staff shall wear an N95 mask during transfer. **Receiving institution** <u>New arrivals who screened or tested positive at sending institution:</u> • Isolate as per interim guidance. <u>New arrivals who tested negative at sending institution:</u> • Screen all patients for COVID-19 upon arrival. • Quarantine unvaccinated patients for 14 days. • Screen unvaccinated patients daily while in quarantine. • Test all new arrivals for COVID-19 on day 5 and then again on day 12-14. • May release patients from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative. • Patients who are symptomatic and/or test positive shall be isolated as per interim guidance.	Receiving institution: Patient to be placed in quarantine for at least 21 days.

TYPE OF MOVEMENT	COVID SCREENING AND TESTING STRATEGY	WHAT TO DO IF PATIENT REFUSES COVID TEST
Discharge from CTC, OHU, MHCB or PIP to another institution	**Sending institution** Movement that clinicians have determined to be urgent, including discharges that are necessary to free up a bed for a pending admission: • Do not transfer patients who are isolated due to active infection or quarantined due to exposure. • Perform COVID screening and rapid viral testing for COVID-19 within 24 hours of transfer. • If COVID screen and rapid test negative, transfer within 24 hours of rapid test collection. • Patients who are symptomatic and/or test positive during pre-transfer testing shall not be transferred and shall be isolated as per interim guidance. • All patients and transportation staff shall wear an N95 mask during transfer. • Patients who are being moved as urgent discharges shall be transported individually. Movement that clinicians have determined to be routine: • Do not transfer patients who are isolated due to active infection or quarantined due to exposure. • COVID screening and test by PCR within 5 days of scheduled transfer. • If PCR negative, screen for COVID and obtain rapid test within 24 hours of transfer. • If PCR negative, screen negative, and rapid test negative, transfer within 5 days of PCR test collection and within 24 hours of rapid test collection. • Patients who are symptomatic and/or test positive during pre-transfer testing shall not be transferred and shall be isolated as per interim guidance. • All patients and transportation staff shall wear an N95 mask during transfer. **Receiving institution** • Screen all patients for COVID-19 upon arrival. • Quarantine unvaccinated patients for 14 days. • Screen unvaccinated patients daily while in quarantine. • Test all new arrivals for COVID-19 on day 5 and then again on day 12-14. • May release patients from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative. • Patients who are symptomatic and/or test positive shall be isolated as per interim guidance.	Receiving institutions: Patient to be placed in quarantine for at least 21 days.
Transfer to DSH from CDCR	• Perform COVID screening and test by PCR within 5 days of scheduled transfer. • If patient is asymptomatic and tests negative, transfer as soon as possible but no more than 5 days after test was administered. If the patient tests positive, further conversation shall take place between the sending and receiving clinicians to determine if the patient will transfer immediately or complete isolation within the CDCR institution. • All patients and transportation staff shall wear an N95 mask during transfer.	Disposition to be determined in consultation with CME and CMH at sending institution and DSH.

TYPE OF MOVEMENT	COVID SCREENING AND TESTING STRATEGY	WHAT TO DO IF PATIENT REFUSES COVID TEST
OMDH paroles to DSH	• Screen patient and test for COVID 19 within 5 days of parole date. • Communicate results to DSH prior to patient's parole. • Transport patient on the day of their parole to DSH. • All patients and transportation staff shall wear an N95 mask during transfer.	Communicate information to DSH and transport the patient on their date of parole.
DSH discharge to CDCR	**Sending DSH institution** • Do not transfer patients who are isolated due to active infection or quarantined due to exposure. • Screen and test for COVID-19 prior to transfer. • If patient is asymptomatic and tests negative, transfer as soon as possible but no more than 5 days after test was administered. • All patients and transportation staff shall wear an N95 mask during transfer. **Receiving CDCR institution** • Screen all patients for COVID-19 upon arrival. • Quarantine unvaccinated patients for 14 days. • Screen unvaccinated patients daily while in quarantine. • Test all new arrivals for COVID-19 on day 5 and then again on day 12-14. • May release patients from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative • Patients who are symptomatic and/or test positive shall be isolated as per interim guidance.	DSH: Disposition to be determined in consultation with the CME and CMH at the receiving institution and DSH. Receiving CDCR institution: Patient to be placed in quarantine for at least 21 days.
To MCCF, ACP, CCTRP, MCRP, fire camp (unable to quarantine new arrivals)	• Do not transfer patients who are isolated due to active infection or currently quarantined due to exposure. • Quarantine unvaccinated patients prior to transfer (pre-transfer precautionary quarantine). • Screen patients for COVID-19 initially and then daily for 14 days. • Test all new arrivals for COVID on day 12-14 of quarantine. • Patients to remain in quarantine while awaiting results. • If patient tests negative, transfer as soon as possible but no more than 5 days after test was administered. • All patients and transportation staff shall wear an N95 mask during transfer. • Patients who are symptomatic and/or test positive shall be isolated as per interim guidance.	Do not transfer.

TYPE OF MOVEMENT	COVID SCREENING AND TESTING STRATEGY	WHAT TO DO IF PATIENT REFUSES COVID TEST
From MCCF, ACP, CCTRP, MCRP, CPMP, or fire camp to an institution (unable to quarantine prior to transport)	All patients and transportation staff shall wear an N95 mask during transfer. **Receiving CDCR institution** • Screen all patients for COVID-19 upon arrival. • Quarantine unvaccinated patients for 14 days. • Screen unvaccinated patients daily while in quarantine. • Test all new arrivals for COVID-19 on day 5 and then again on day 12-14. • May release patients from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative. May release unvaccinated patients from quarantine after 14 days if asymptomatic and COVID-19 test is negative. • Patients who are symptomatic and/or test positive shall be isolated as per interim guidance. Patients returning to an institution for urgent/emergent dental treatment: • Perform rapid COVID test immediately upon arrival prior to dental treatment. If the patient tests negative, dental care will be rendered as appropriate. If the patient tests positive, the patient shall be isolated and dental treatment will proceed pursuant to dental program policy for COVID-19 positive patients.	Receiving Institution: Patient to be placed in quarantine for at least 21 days.
From one fire camp to another fire camp	• Perform symptom screening. • If screens negative, may transfer to new camp without testing. • If screens positive, transport to closest prison for COVID testing and either isolation or quarantine depending upon the results. • Patient and staff shall wear an N95 mask during transportation.	N/A
From fire camp to emergency room for <24 hours of treatment of minor injuries/conditions prior to release to fire camp.	• Patient and staff shall wear an N95 mask during transportation and while in the emergency department.	N/A
From fire camp to hospital for admission or more serious condition	• When released, patient shall be transported back to a prison for appropriate housing/ quarantine/testing. • All patients and transportation staff shall wear an N95 mask during transfer.	N/A
Parole, medical parole, PRCS release	• All patients shall be screened for COVID-19 symptoms and then tested for COVID within one week of release. • Results of testing shall be communicated to parole agent or probation officer and local public health officer in county of release. • If patient tests positive, manage as detailed in the COVID-19 interim guidance. • All patients and transportation staff shall wear an N95 mask during transfer.	Patients cannot be held beyond their parole date regardless of whether they agree to test or if the test is positive.

TYPE OF MOVEMENT	COVID SCREENING AND TESTING STRATEGY	WHAT TO DO IF PATIENT REFUSES COVID TEST
Out to court, same day return	Use videoconferencing to avoid out-to-court travel in all cases unless court refuses. • Notify court and county public health in advance regarding any patients who are currently isolated or quarantined due to exposure. Plan will be determined in consultation with the court. • For all other patients: POC test within 24 hours before every court appearance. If POC test is positive, isolate the patient and notify the court. • If patient remained in the custody of the transportation officer at all times, and if the patient wore a face covering at all times, quarantine upon return shall not be required. • Screen for COVID-19 symptoms upon return. • Perform rapid and PCR COVID tests on day 5 after return. • All patients and transportation staff shall wear an N95 mask during transfer.	If patient refuses testing, notify the court. Plan will be determined in consultation with the court.
Out to court, at least one overnight stay in a jail or another prison.	Sending institution • Notify court in advance regarding any patients who are currently isolated or quarantined due to exposure. Plan will be determined in consultation with the court. • For all other patients, screen for COVID symptoms and perform rapid test within 24 hours of departure. • If COVID screen and test are negative, patient can be transported. • Patients who are symptomatic and/or test positive shall be isolated as per interim guidance and the court shall be notified. • All patients and transportation staff shall wear an N95 mask during transfer. Receiving CDCR Institution • All patients and transportation staff shall wear an N95 mask during transfer. • Screen all patients for COVID-19 upon arrival. • Quarantine unvaccinated patients for 14 days. • Screen unvaccinated patients daily while in quarantine. • Test all new arrivals for COVID-19 on day 5 and then again on day 12-14. • May release patients from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative. • Patients who are symptomatic and/or test positive shall be isolated as per interim guidance.	Sending institution: Refusals to test prior to OTC appointments should be communicated to the courts. Patient to be placed in pre-transfer quarantine for at least 21 days. Disposition to be determined by CME at sending institution in consultation with the court. Receiving institution: Patient to be placed in quarantine for at least 21 days.
Out for clinical appointment, same day return; sleep studies	• Use "e-consult" and telemedicine whenever possible to avoid unnecessary offsite transportation. • All patients and transportation staff shall wear an N95 mask during transfer. • Screen for COVID symptoms upon return. • Perform rapid and PCR COVID tests on day 5 after return. • If patients have multiple off site appointments with same day return within a week (for example for chemotherapy or radiotherapy) twice weekly testing is sufficient	Patient to be placed in quarantine for at least 21 days.

TYPE OF MOVEMENT	COVID SCREENING AND TESTING STRATEGY	WHAT TO DO IF PATIENT REFUSES COVID TEST
Return from outside hospitalizations and emergency department visits	• All patients and transportation staff shall wear an N95 mask during transfer. • Screen all patients for COVID-19 upon arrival. • Quarantine unvaccinated patients for 14 days. • Screen unvaccinated patients daily while in quarantine. • Test all new arrivals for COVID-19 on day 5 and then again on day 12-14. • May release patients from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative • Patients who are symptomatic and/or test positive shall be isolated as per interim guidance.	Patient to be placed in quarantine for at least 21 days. Disposition to be determined by CME at the institution.

ISOLATION AND QUARANTINE GENERAL PRINCIPLES

At a number of institutions, including ASP, CRC, CVSP, FSP and SQ, the available facilities are insufficient to achieve some basic isolation and quarantine standards. In those institutions, post exposure quarantining in groups of larger than two patients may be necessary. All efforts should be made at these institutions to find quarantine alternatives that satisfy the purposes of a post-exposure quarantine as set forth below.

Decisions about post-exposure quarantine housing at CHCF and CMF are committed to the discretion of the medical leadership at those institutions in recognition of the materially different missions and operations at those two facilities. CHCF and CMF shall maintain their minimum quarantine set-aside beds.

At institutions experiencing an outbreak where the number of COVID positive patients exceeds 200 or the number of patients who should be quarantined exceeds the number of beds set aside at that institution for quarantine, decisions about post-exposure quarantine and housing shall be committed to the discretion of the warden and CEO or their designees at the institution in consultation with CDCR and CCHCS regional and headquarters staff.

Refusals of patients to undergo necessary COVID testing and/or movement to isolation or quarantine space shall be promptly elevated to the warden and CEO who shall discuss their plans of action with the regional health care executive and AD.

ISOLATION: GENERAL PRINCIPLES

Patients who are in isolation shall:

- Remain in their isolation location unless approved by clinical staff to move elsewhere
- Be medicated and fed in their isolation location
- Shall receive clinical care in their isolation location
- Shall not share showers or toilets with those who are not infected
- Shall wear an N95 mask at all times when outside of their cell

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

1. Isolation of patients who are infected with COVID-19
    a. All infected patients are to be isolated.
    b. Asymptomatic patients who were diagnosed solely based upon a rapid point of care test (POC) shall be isolated apart from others until the POC test is confirmed by a PCR test.
    c. Infected patients shall not be housed with patients who are not confirmed to have COVID-19.
    d. Infected patients can be housed in congregate living sites with other COVID-19 infected patients.
    e. Twice daily health care monitoring shall be conducted for patients diagnosed with COVID-19.
    f. All staff interacting with COVID-19 infected patients shall wear an N95 mask, eye protection, and, when in direct contact, gloves and gowns.

2. Precautionary isolation of symptomatic patients who are being evaluated for COVID-19 infection
    a. Symptomatic patients who have not yet been confirmed to have COVID-19 shall be isolated separately from confirmed COVID-19 patients and separately from those who are not symptomatic.
    b. Twice daily health care monitoring shall be conducted for symptomatic patients who are awaiting diagnosis.
    c. All staff interacting with symptomatic isolated patients shall wear an N95 mask, eye protection, and, when in direct contact, gloves and gowns.

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

1. Quarantine of Patients who have been Exposed to COVID-19:
    a. These patients are at risk of being infected as a result of their exposure. Thus, they shall be separated from both the confirmed cases and from the symptomatic but not yet confirmed cases.
    b. For individual cases, the preference is for quarantine in a single cell with a solid, closed door.
    c. Exposed persons shall not be housed in dorms with those who are not known to be exposed.
    d. If single cells are not available, persons with the same exposure can be quarantined together as a cohort.
    e. If cohorting is essential, quarantine cohorts shall be as small as possible (2-4 persons).
    f. Daily healthcare monitoring shall be conducted for patients who are under quarantine.
    g. Serial testing and healthcare surveillance is used to identify those who are infected so that they can be moved to isolation.
    h. Patients shall not be released from quarantine until they have completed 14 days of quarantine and tested negative for COVID-19 by PCR. If testing is refused, quarantine shall be extended to 21 days.
    i. Any patient who develops symptoms shall be placed in isolation alone and tested for COVID-19.

2. Precautionary transfer quarantine
    a. Precautionary quarantine shall be utilized for all unvaccinated patients transferring from one institution to another.
    b. Precautionary quarantine shall take place post-transfer in the receiving institution, except in limited circumstances when patients are instead placed on pre-transfer precautionary quarantine. Pre-transfer precautionary quarantine shall only be utilized when transferring to MCCF, ACP, CCTRP, MCRP, or a fire camp.
    c. Precautionary post-transfer quarantine shall take place in celled housing with a solid door. Facilities which by design have no cell based housing (SQ, FSP, ASP, CVSP, CRC, CMC-West, or CIM FAC-A and D) shall conduct precautionary post-transfer quarantine in cohorts of no more than 20 in a dorm solely dedicated to a cohort that arrived on the same day from the same location to the same unoccupied dorm at the receiving institution.
    d. Cohorts of unvaccinated patients with different movement dates shall not be housed together during post transfer precautionary quarantine.
    e. Cohorts of unvaccinated patients coming from different locations shall not be housed together during post transfer precautionary quarantine.
    f. A negative PCR test on or after day 12 is required for release from quarantine on day 14. If testing is refused, quarantine shall be extended to 21 days.
    g. Any patient who develops influenza like symptoms should be placed in isolation alone and tested for COVID-19.