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1	JAMIE L. DUPREE (SBN: 158105) jdupree@fddcm.com		
3	jtouchstone@fddcm.com		
4	601 Montgomery Street, Suite 333		
5	Telephone: (415) 399-3840		
6	Facsimile: (415) 399-3838		
7	BRAD D. BRIAN (State Bar No. 79001) brad.brian@mto.com		
8	KATHERINE M. FORSTER (State Bar No. 217 katherine.forster@mto.com	609)	
9	JACOB S. KREILKAMP (State Bar No. 248210 jacob.kreilkamp@mto.com)	
10	ROBERT E. BOWEN (State Bar. No. 335932)		
11	MUNGER, TOLLES & OLSON LLP		
12	Fiftieth Floor		
13	Los Angeles, California 900/1-3426 Telephone: (213) 683-9100		
15	Atterment for Descion		
16	J. Clark Kelso		
17	UNITED STATES	DISTRICT COUR	Т
18	NORTHERN DISTRICT OF CAL	IFORNIA, OAKLA	AND DIVISION
19		,	
20	MARCIANO PLATA, et al.,	Case No. 4:01-cv	-01351-JST
21	Plaintiffs,	RECEIVER'S O	PPOSITION TO
22	vs.	MOTIONS TO S	AND CCPOA'S STAY (ECF NOS. 3715,
23	GAVIN NEWSOM, et al.,	5722)	
24	Defendants.		
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28			
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	RECEIVER'S OPPOSITION TO DEFENDA	NTS' AND CCPOA'S	S MOTIONS TO STAY

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1	INTRODUCTION
2	Nearly one month after this Court issued its order requiring vaccination for COVID-19 of
3	all staff entering California Department of Corrections and Rehabilitation (CDCR) institutions and
4	of incarcerated persons with outside contacts, Defendants seek a stay and claim for the first time
5	that implementation of the order would cause them irreparable harm. Defendants did not make
6	this argument in responding to this Court's Order to Show Cause, perhaps because Defendants'
7	own healthcare expert disagrees. On October 11, 2021, Defendants submitted to another court a
8	declaration from that expert that agreed fully with the Receiver's recommendation and this Court's
9	order:
 10 11 12 13 	Staff are the primary vector for introduction of the virus into the prison setting These facilities are highly unlikely to be able to prevent or control outbreaks of COVID-19 solely through the application of non-pharmaceutical interventions COVID-19 vaccination of all employees of the CDCR without a valid contraindication or exemption is the single most effective intervention available to prevent cases and outbreaks of COVID-19
14	Kreilkamp Decl., Ex. A., Reingold Decl. ¶ 25.
15	A full month after this Court's order, the California Correctional Peace Officers
16	Association (CCPOA) likewise filed a motion for stay, which largely incorporates Defendants'
17	arguments.
18	Unable to combat the factual record, which they have not disputed, Defendants and
19	CCPOA mischaracterize the Court's order in an attempt to show a likelihood of success on the
20	merits of their appeal. Contrary to Defendants' and CCPOA's repeated assertions that the Court
21	failed to consider evidence of Defendants' responses to COVID-19, this Court's order expressly
22	considered all of Defendants' responses and found them ineffective at addressing the primary
23	vector for introducing infection into institutions—institutional staff—and unreasonable in light of
24	the undisputed evidence that COVID-19 is easily transmitted in institutions. ECF No. 3684 at 18.
25	Defendants recycle two alternative policies they propose are more narrowly tailored and
26	less intrusive alternative remedies to correct the violation of Plaintiffs' Eighth Amendment rights.
27	As the Court has already found, each is insufficient to correct the violation. Mandatory
28	vaccination of all incarcerated persons, as the Court found, does not address that even fully
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vaccinated incarcerated persons face a substantial risk of serious harm when staff introduce
 COVID-19 to institutions. ECF No. 3684 at 19. As the Court also found, the August 19
 California Department of Public Health (CDPH) order is far too narrow to correct the violation
 because it applies to only some of those workers who are likely to introduce COVID-19 to an
 institution. *See* ECF No. 3684 at 14-19. Defendants and CCPOA cannot show a likelihood of
 success on the merits of their appeal.

In support of their claims of irreparable harm, Defendants and CCPOA now raise (in
Defendants' case, for the first time) highly speculative claims that a significant number of CDCR
and CCHCS employees would leave their jobs rather than become vaccinated. They present no
reliable evidence to support this claim, and recent similar vaccine mandates suggest that staff
departures will be minimal. Their claims of irreparable harm are also belied by their month-long
delay in seeking injunctive relief.

Against these speculative harms are set the strong public interest in curing an ongoing violation of Plaintiffs' constitutional rights. "[I]t is always in the public interest to prevent the violation of a party's constitutional rights." *Am. Beverage Ass'n v. City & Cnty. Of S.F.*, 916 F.3d 749, 758 (9th Cir. 2019). There is a similarly strong public interest in preventing the spread of COVID-19 in CDCR institutions and outside them. The public interest weighs strongly in favor of implementing the Court's order immediately.

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PROCEDURAL HISTORY

20 On August 4, 2021, the Receiver submitted to this Court his Report containing a 21 recommendation that the Court order mandatory vaccination for workers who enter institutions 22 and for incarcerated persons with outside contacts. The Receiver did so in response to the 23 unprecedented challenge COVID-19 has posed to his mission to cure constitutional insufficiencies 24 in the delivery of healthcare in CDCR institutions. Like the Receiver, the federal government and 25 at least eight states have recognized that prisons cannot be made reasonably safe without 26 27 28 48360536.8 Case No. 4:01-cv-01351-JST RECEIVER'S OPPOSITION TO DEFENDANTS' AND CCPOA'S MOTIONS TO STAY

vaccination of all those who go between the institutions and communities and have required
 workers in their prison systems to be vaccinated for COVID-19.¹

3	The Receiver's Report documented the primary role of staff in introducing COVID-19 to
4	CDCR institutions, the difficulty of containing outbreaks once they enter CDCR institutions, and
5	the consequences both in direct risk to patients from contracting the virus and from increasing
6	delays in access to non-COVID healthcare. Although Defendants and the CCPOA opposed the
7	Receiver's recommendation, as the Court noted, "Defendants do not dispute any of the relevant
8	facts, nor do they present any evidence suggesting it would be reasonable not to adopt the
9	Receiver's recommendations." ECF 3684 No. at 12. Notably, Defendants presented none of the
10	arguments they now advance regarding the asserted harms they will face should the Court's order
11	be implemented. On September 27, 2021, this Court found that CDCR was deliberately
12	indifferent to a substantial risk of serious harm to incarcerated persons by failing to require CDCR
13	institutional staff to be vaccinated for COVID-19 and ordered that the Receiver's recommendation
14	be implemented. ECF No. 3684.
15	LEGAL STANDARD
16	"A stay is not a matter of right, even if irreparable injury might otherwise result. It is
17	instead an exercise of judicial discretion The party requesting a stay bears the burden of
18	showing that the circumstances justify an exercise of that discretion." Nken v. Holder, 556 U.S.
19	418, 433-34 (2009). A stay is an extraordinary remedy because parties are "generally entitled to
20	the prompt execution of orders" Id. at 427.
21	
22	
23	¹ Hart Decl. ¶ 34, ECF No. 3663-1 at 16 (Colorado, Illinois, Massachusetts, Oregon, Washington):
24	The White House, <i>Executive Order on Requiring Coronavirus Disease 2019 Vaccination for</i>
25	actions/2021/09/09/executive-order-on-requiring-coronavirus-disease-2019-vaccination-for-
26	federal-employees/; Office of the Governor, State of Hawai'i, <i>Emergency Proclamation Related to the COVID-19 Response</i> (Aug. 5, 2021), https://governor.hawaii.gov/wp-
27	content/uploads/2021/08/2108026-ATG_Emergency-Proc-for-COVID-19-Response-distribution- signed pdf: Sam Metz. Nevada to require vaccines for prison guards. health workers. Las Vegas
28	Sun (Sept. 10, 2021), https://lasvegassun.com/news/2021/sep/10/nevada-to-require-vaccines-for-
	prison-guards-healt/.
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In considering whether to grant a stay pending appeal, courts consider "(1) whether the
 stay applicant has made a strong showing that he is likely to succeed on the merits; (2) whether the
 applicant will be irreparably injured absent a stay; (3) whether issuance of the stay will
 substantially injure the other parties interested in the proceeding; and (4) where the public interest
 lies." *Id.* at 434. "Likelihood of success on the merits is the 'most important factor." *California v. Azar*, 911 F.3d 558, 575 (9th Cir. 2018).

7 In the Ninth Circuit, the first two factors may also be evaluated on a "sliding scale in 8 which the required degree of irreparable harm increases as the probability of success decreases." 9 Golden Gate Rest. Ass'n v. City and Cntv. of S.F., 512 F.3d 1112, 1116 (2008). At one extreme, 10 the movant must show "both a probability of success on the merits and the possibility of irreparable injury." Id. at 1115 At the other extreme, the movant must "demonstrate that serious 11 12 legal questions are raised and that the balance of hardships tips sharply in its favor." *Id.* at 1116 13 Where the Government is a party, the final two factors – injury to the other interested parties and 14 the public interest – merge. See Padilla v. Immigr. & Customs Enf't, 953 F.3d 1134, 1141 (9th Cir. 2020). 15

16

ARGUMENT

17 I. DEFENDANTS AND CCPOA ARE NOT LIKELY TO SUCCEED ON THE MERITS OF THEIR EIGHTH AMENDMENT AND PLRA ARGUMENTS 18 18

Defendants and CCPOA cannot demonstrate a likelihood of success on the merits of their
appeal of this Court's order because the undisputed record and the findings of the Court in this
case demonstrate that Defendants were deliberately indifferent to a substantial risk of serious harm
to incarcerated persons and that the Receiver's recommendation is narrowly tailored to correct the
violation of Plaintiffs' Eighth Amendment rights. **A. Defendants and CCPOA Are Not Likely to Succeed on the Merits of their**

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26

Defendants and CCPOA Are Not Likely to Succeed on the Merits of their Appeal of the Court's Finding that They Violated Plaintiffs' Eighth Amendment Rights

To demonstrate that the conditions of confinement with respect to COVID-19 do not

27 || violate the Eighth Amendment rights of persons incarcerated in CDCR custody, Defendants and

28 || the CCPOA must show either that incarcerated persons are not at a substantial risk of serious harm

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from COVID-19 or that Defendants have acted reasonably in abating the risk. *Farmer v. Brennan*,
 511 U.S. 825, 834, 847 (1994). "A prison official's duty under the Eighth Amendment is to
 ensure 'reasonable safety." *Id.* at 844. Prison officials act unreasonably where they take
 substantial steps to improve safety but "serious deficiencies remain." *Jones v. City and Cnty. of S.F.*, 976 F.Supp. 896, 908 (N.D. Cal. 1997).

6

7

1.

On the Undisputed Record, Defendants Cannot Show a Likelihood of Success on the Merits of Their Appeal of the Court's Finding of an Eighth Amendment Violation.

8 Defendants and CCPOA cannot show that incarcerated persons are not at a substantial risk 9 of serious harm, because the risk to incarcerated persons is uncontested. As this Court noted, 10 "[t]he unrebutted evidence is that, 'although vaccination greatly reduces the risk of harm, the Delta variant presents a substantial risk of serious harm even to fully vaccinated patients."" ECF No. 11 3684 at 9. It is likewise uncontested that "'[a]dditional program modifications and the renewed 12 13 diversion of healthcare resources to address COVID-19 cases from Delta variant outbreaks put patients at a substantial risk of serious harm." ECF No. 3684 at 11 (quoting Bick Suppl. Decl. 14 ¶ 8). 15

16 Nor can Defendants and CCPOA show they have acted reasonably in abating the risk. 17 Courts have repeatedly found Eighth Amendment violations where prison administrators take 18 substantial steps to address a risk, but omit other reasonable precautions, thereby allowing a 19 substantial risk of serious harm to continue, and neither Defendants nor CCPOA point to instances 20 of the Court of Appeals holding that such a finding is insufficient to support an Eighth 21 Amendment violation. In litigation over the response to Valley Fever in this case, the Court held 22 that CDCR's substantial steps in response to Valley Fever were constitutionally inadequate, even 23 though CDCR transferred the majority of high-risk patients out of institutions affected by Valley 24 Fever, because it refused to transfer other groups of high-risk patients. *Plata v. Brown*, 427 25 F.Supp.3d 1211, 1225-27 (2013). Similarly, in *Jones*, another court in this district found defendants to be deliberately indifferent despite making "commendable improvements" to address 26 27 fire safety hazards because "serious deficiencies remain that defendants have not addressed. . . . 28 976 F.Supp. 896 at 908. The court found that "the continued presence of serious inadequacies 48360536.8 Case No. 4:01-cv-01351-JST suggests that defendants' response has been something less than reasonable." *Id.* In assessing
 deliberate indifference "the Court cannot restrict its examination to whether defendants made
 substantial efforts to improve safety, thereby excluding any consideration of whether the
 improvements have actually left inmates reasonably safe" *Id.*

5 This Court found that, in light of the undisputed record, Defendants "fail[ed] to take reasonable measures to abate" the substantial risk of serious harm to incarcerated persons from 6 7 COVID-19. ECF No. 3684 at 18. In so finding, the Court noted that Defendants and CCPOA do 8 not dispute any of the facts showing that serious deficiencies remain in Defendants' response to 9 COVID-19. See ECF No. 3684 at 12. It is "uncontested that institutional staff are primary vectors 10 for introducing COVID-19 into CDCR facilities, and that institutions with low staff vaccination rates experience larger and more frequent COVID-19 outbreaks." ECF No. 3684 at 13 (internal 11 12 quotations, citations, and brackets omitted). It is likewise uncontested that stopping COVID-19 13 from entering institutions is paramount because it is difficult to stop the spread of COVID-19 once 14 it enters an institution. Id. And it is uncontested that Defendants' testing strategy is insufficient to 15 address the risk of workers introducing COVID-19 to CDCR institutions. Id. Just last month, 16 Defendants' expert in another case attested that "COVID-19 vaccination of all employees of the 17 CDCR without a valid contraindication or exemption is the single most effective intervention 18 available to prevent cases and outbreaks of COVID-19 "Kreilkamp Decl., Ex. A., Reingold 19 Decl. ¶ 25. In short, "Defendants do not dispute any of the relevant facts, nor do they present any 20 evidence suggesting it would be reasonable not to adopt the Receiver's recommendations." Id. at 21 12. Having failed to dispute any relevant fact in the record, Defendants and CCPOA ask the Court 22 to ignore "whether the improvements have actually left inmates reasonably safe" and find that, 23 despite these undisputed "serious deficiencies," of which Defendants are aware, Defendants have 24 done enough. See Jones, 976 F.Supp. at 908. On this record, Defendants and CCPOA are not 25 likely to succeed on the merits of their appeal.

26

2. The Court Applied the Proper Eighth Amendment Standard

Unable to dispute the record, Defendants assert that the Court applied the wrong legal
standards to arrive at its ruling. ECF No. 3715-1 at 6-10. The Court applied the correct legal

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standards, and Defendants' arguments to the contrary distort the Court's order and the governing
 law.

Defendants repeatedly assert, incorrectly, that the Court failed to consider the full scope of
Defendants' response to COVID-19. *E.g.* ECF No. 3715-1 at 6-7 (asserting the Court
inappropriately "focus[ed] solely on Defendants' decision *not* to implement the Receiver's
recommended vaccination policy "); ECF No. 3715-1 at 10 (asserting the Court found the
variety of pandemic measures it took unpersuasive because "it need only consider Defendant's
current attitude and conduct . . . miss[ing] the fact that many of these efforts are ongoing").

9 The Court did consider the full spectrum of Defendants' responses to COVID-19, and 10 found the response wanting for several reasons. First, the Court found that what measures were reasonable "based on a toolbox without a vaccine has little relevance when the same toolbox now 11 12 includes a vaccine that everyone agrees is one of the most important tools, if not the most 13 important one, in the fight against COVID-19." ECF No. 3684 at 11-12. Second, the Court found 14 that it was undisputed in the record that institutional staff were the primary vector for COVID-19 15 infection and that it was critical to stop COVID-19 from entering institutions because it spread 16 easily once inside. Id. at 13. The Court found that existing CDCR policies, including frequent 17 testing, did not adequately address the vector problem. Id. at 13-14.

18 The Court also found the August 19 CDPH order, when implemented, would not 19 reasonably address the problem either because the incarcerated population is not only, or even 20 most, at risk in areas covered by the CDPH order; the CDPH order does not protect vulnerable 21 persons who do not reside in those settings, including 15,246 patients at high risk from COVID-22 19; the CDPH order does not prevent transmission of COVID-19 to or from healthcare areas; and 23 the limitation only to regularly assigned healthcare workers, and not to the many others who work 24 there on irregular assignments, would render the CDPH order ineffective. Id. at 14-17. Thus, far 25 from failing to consider Defendants' existing efforts, the Court carefully explained why, on the basis of undisputed record evidence, Defendants' failure to implement a vaccine mandate on top 26 27 of their existing efforts was unreasonable.

1 Defendants also assert that the Court particularly ignored Defendants' efforts to control the 2 spread of COVID-19 within institutions. ECF No. 3715-1 at 11 ("the measure of Defendants" 3 current attitudes and conduct should not be limited to their efforts to prevent the introduction of the virus.") It did not. The Court found that even Defendants' own medical expert did not attest 4 5 that "vaccination, even when in combination with other measures, offers incarcerated persons sufficient protection from COVID-19. Nor could such a conclusion be reconciled with the 6 7 uncontested evidence regarding the dangers COVID-19 presents to vaccinated incarcerated 8 persons." ECF No. 3684 at 12. The Court further observed that "even if other measures 9 'significantly mitigate' the spread of the virus, Watt does not say that they are sufficient to protect Plaintiffs from those harms." Id. The Court considered Defendants' efforts to control the spread 10 of COVID-19 once inside institutions; Defendants failed to supply any evidence (because there is 11 none) that those efforts "ensure[d] reasonable safety." Farmer, 511 U.S. at 844 (internal quotation 12 omitted). 13

14 Defendants also suggest that the Court erred by finding their failure to adopt the Receiver's 15 recommendation unreasonable. See ECF No. 3715-1 at 6-7 (asserting the Court inappropriately 16 "focus[ed] solely on Defendants' decision not to implement the Receiver's recommended 17 vaccination policy"). That argument is unavailing. Whether or not a party acted reasonably 18 is determined in part by reference to whether there are further steps that it was unreasonable *not* to 19 take. See Wilk v. Neven, 956 F.3d 1143, 1147-48 (9th Cir. 2020) (collecting cases evaluating 20 whether prison officials acted reasonably by considering whether there was an action it would be 21 unreasonable not to take). The Court made exactly that determination on multiple occasions in 22 this litigation before the order at issue in this case, finding that CDCR had acted reasonably in 23 abating the risk of COVID-19 before vaccines were available, see Plata v. Newsom, 445 24 F.Supp.3d 557, 564-69 (2020), but acted unreasonably in transferring some but not all inmates at a 25 high risk for Valley Fever from institutions in which the fungal cause was prevalent, see Plata v. 26 Brown, 427 F.Supp.3d 1211, 1225 (2013).

 Finally, Defendants contend that the Court failed to "determin[e] whether all the measures
 Defendants *are* implementing . . . ensure 'reasonable safety' of the incarcerated population under

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the Eighth Amendment" ECF No. 3715-1 at 6-7. Again, this misrepresents the Court's 1 order. The Court found: "Given recent outbreaks, there is no doubt that the limited vaccine 2 3 requirements adopted by Defendants are insufficient 'to ensure reasonable safety." ECF No. 3684 at 15. Defendants nonetheless repeatedly imply, without a citation to the order, that the 4 5 Court held them to the standard of completely eliminating the risk of COVID-19, rather than assuring reasonable safety. See ECF No. 3715-1 at 7 ("The Eighth Amendment requires prison 6 7 officials to *reasonably* abate the risk, not to completely eliminate it."); ECF No. 3715-1 at 12 8 ("The Eighth Amendment demands reasonableness . . . not a complete elimination of the risk. . . 9 ."). The Court did not hold Defendants to such a standard. The Court found, and Defendants did 10 not dispute, that incarcerated persons, far from being reasonably safe from COVID-19, face a substantial risk of serious harm, both directly from contracting it and indirectly from the 11 12 disruptions to medical services it causes. ECF No. 3684 at 9, 11. And the Court found an 13 "absence of any evidence suggesting that Defendants' existing mitigation measures reasonably 14 address" the risk of harm from COVID-19. ECF No. 3684 at 18.

Contrary to Defendants' assertions, the Court correctly framed the legal question and
carefully considered the relevant evidence. The Court properly found that Defendants were
deliberately indifferent.

18

3. Fraihat Does Not Undermine This Court's Order

Defendants rely heavily on *Fraihat v. U.S. Immigr. and Customs Enf't*, ---F.4th---, 2021
WL 4890884 (9th Cir. Oct. 20, 2021), in their bid to demonstrate that the Court misapplied the
Eighth Amendment standards. Nothing in *Fraihat* undermines this Court's order.

22 Fraihat notes that the reckless disregard standard is "formidable," ECF No. 3715-1 at 8, 23 but Defendants omit the Fraihat Court's elaboration of the actual standard, which is exactly the 24 one this Court faithfully applied: "[A] plaintiff must show that the defendant 'disregarded an 25 excessive risk' to the plaintiff's health and safety by failing to take 'reasonable and available measures' that could have eliminated the risk." Fraihat, 2021 WL 4890884 at *19. As the court 26 observed, mere negligence such as "lack of due care" or "inadvertent failure to provide adequate 27 medical care" or "medical malpractice" is insufficient. Id. Knowledge amounting to recklessness 28 48360536.8 Case No. 4:01-cv-01351-JST RECEIVER'S OPPOSITION TO DEFENDANTS' AND CCPOA'S MOTIONS TO STAY

is precisely what this Court found here. ECF No. 3684 at 18. As the Court noted, no one disputes 1 2 the substantial risk of serious harm. *Id.* Nor does anyone dispute that staff are the primary vectors 3 for introducing infection into institutions or that testing was an inadequate response to the risk. Id. Defendants' own medical expert believes that "COVID-19 vaccination of all employees of the 4 5 CDCR without a valid contraindication or exemption is the single most effective intervention 6 available to prevent cases and outbreaks of COVID-19 Kreilkamp Decl., Ex. A., Reingold 7 Decl. ¶ 25. And Defendants concede that mandatory vaccination of workers is a reasonable 8 measure, instituting their own mandatory vaccination policy in the August 19 CDPH order. 9 Accordingly, there is no doubt that Defendants were subjectively aware of a substantial risk of 10 serious harm to incarcerated persons from COVID-19 that had not been reasonably controlled by the inadequate steps they took to abate the risk. Defendants therefore disregarded an excessive 11 risk to Plaintiff's health and failed to take reasonable and available measures that could have 12 13 abated that risk.

14 Defendants also rely on *Fraihat* for the proposition that the Eighth Amendment does not require implementation of "a court's idea of how best to operate a detention facility." ECF No. 15 16 3715-1 at 8. That familiar point does not undermine this Court's order. As detailed above, see 17 supra pp. 5-6, the Court conscientiously applied Eighth Amendment standards—not its own idea 18 of how to run a prison—to the undisputed record in this case. While there are cases, like Fraihat, 19 where a court oversteps by applying its own policy preferences, here, faithful application of the 20 Eighth Amendment standards to the undisputed facts before the Court made it inescapably clear 21 that the government was aware of the substantial risk of serious harm to Plaintiffs and that it failed to take reasonable steps to mitigate that risk. 22

Finally, the *Fraihat* court emphasized the need for deference to the Executive Branch on administration of detention and correctional facilities. *Fraihat*, 2021 WL 4890884 at *21. In *Fraihat*, the district court imposed a comprehensive, nine-point response to COVID-19, less than six weeks into the pandemic, as preliminary relief. *Id.* at *13, *15. Here, the Court has acted with restraint, requiring implementation of a single policy only after finding a constitutional violation, not weeks into a pandemic, but nineteen months into the State's response to the pandemic after

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extensive efforts to improve vaccination rates without a court order. The case for deference to 1 2 prison authorities is also far weaker in this case. CDCR has already been found incapable of 3 constitutionally providing medical care for those incarcerated in its institutions, and the Court 4 appointed the Receiver in order to raise the standard of care to a constitutional level.

5 In sum, Fraihat applies the very same standard that the Court did here, but unlike in 6 Fraihat, the record in this case makes clear that Defendants violated the Eighth Amendment.

7

4.

Defendants' Remaining Cases Do Not Undermine This Court's Ruling

8 Defendants next argue that it was error for the Court not to accord greater weight to certain 9 non-binding district court opinions cited to by Defendants. ECF No. 3715-1 at 13-15. The Court 10 appropriately considered each, and nothing in those cases commands a different result.

11 Defendants contend that Zatko v. Rowland stands for the proposition that "prison officials 12 do not violate the Eight Amendment if incarcerated people refuse to accept the vaccine," and that 13 this Court disregarded the case only by reference to the difference between individual and 14 systemic relief. ECF No. 3715-1 at 13. See Zatko v. Rowland, 835 F.Supp. 1174, 1178 (N.D. Cal. 15 1993). That is incorrect. This Court continued: "More significantly, Defendants fail to consider 16 that it is not only the unvaccinated population that is at substantial risk of serious harm from COVID-19, and that such risk would be present even if the entire incarcerated population were 17 18 vaccinated." ECF No. 3684 at 9. That fact is uncontested in the record. Likewise uncontested is 19 that incarcerated persons face a substantial risk of serious harm from the disruption COVID-19 20 outbreaks cause to the provision of non-COVID healthcare. ECF No. 3684 at 11. A patient's 21 decision whether or not to become vaccinated has no bearing on their likelihood of suffering this latter harm. The Court fully considered and fairly rejected Defendants' argument. 22

23

Defendants also rely on Davis v. Allison, No. 1:21-cv-00494-HBK, 2021 WL 3761216 24 (E.D. Cal. Aug. 25, 2021), a pro se challenge of a fully-vaccinated person to the conditions of his 25 confinement. See ECF No. 3715-1 at 13-15. The Court noted in its order that plaintiff in that case "did not raise the issues that are currently before this Court," and that while the Davis Court found 26 27 Plaintiff's claims speculative at best, in this case, "the Receiver and Plaintiffs have presented

evidence – unrebutted by Defendants – that the harms faced by vaccinated incarcerated persons
 are substantial and not speculative" ECF No. 3684 at 9 n.3. That holding was correct.

3

5.

Voluntary Vaccination Efforts Will Not Achieve Reasonable Safety

Finally, Defendants and CCPOA point to the significant reduction in risk achieved by its
vaccination programs as evidence that it was reasonable not to require staff vaccination. ECF No.
3715-1 at 15; ECF No. 3722 at 8. But that fact actually further demonstrates how important
vaccination is. As this Court found, it is precisely because of the proven efficacy of vaccines and
the persistence of a substantial risk of serious harm that it was deliberately indifferent to continue
with a policy that allowed so many unvaccinated people to daily enter CDCR institutions.

Defendants and CCPOA also point to the recent rise in vaccination rates as evidence that Defendants' voluntary vaccination program was not reckless. ECF No. 3715-1 at 16; ECF No. 3722 at 10. The facts show just the opposite. The rise in vaccination has principally occurred after the issuance of the August 19 CDPH order, which requires many previously unvaccinated staff members to be vaccinated, and follows months of voluntary vaccination efforts that barely moved vaccination rates. The recent gains in fact provide further evidence that mandatory vaccination is required to cure the Eighth Amendment violation.

17 18

B. Defendants Cannot Demonstrate a Likelihood of Success on Their PLRA Arguments

19 Defendants have likewise failed to demonstrate a likelihood of success on their argument 20 that the Court's vaccination order did not comport with the least intrusive means test set forth in 21 the PLRA. The PLRA requires that any court-ordered relief intended to remedy the violation of a 22 federal right "in any civil action with respect to prison conditions" be "narrowly drawn, extend[] 23 no further than necessary to correct the violation of the Federal right, and [be] the least intrusive 24 means necessary to correct the violation of the Federal right." 18 U.S.C. § 3626(a)(1)(A). This 25 Court's vaccination order satisfies all three conditions, and Defendants' arguments to the contrary are unavailing. 26

27Defendants' suggestion that "a more narrowly tailored solution" to the Eighth Amendment28violation this Court identified "would be to vaccinate all class members before evaluating the

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necessity for a vaccine mandate addressing everyone else," ECF No. 3715-1 at 17, is plainly 1 unsupported by the record.² The Court found, as was undisputed, that institutional staff are the 2 primary vector for bringing infections into institutions. ECF No. 3684 at 18. And the record 3 shows the Delta variant frequently causes breakthrough infections in fully vaccinated patients in 4 5 CDCR custody, at least one of whom later died of COVID-19 and some of whom have exhibited serious, potentially long-term symptoms. *Id.* at 9. Accordingly, the record reflects that even if all 6 7 prisoners were vaccinated as Defendants propose, there would still be a substantial risk of serious 8 harm to prisoners that is incapable of being redressed by any solution narrower than the one set 9 forth in the Court's vaccination order. Id. at 19 (concluding that "[a] policy directed towards 10 vaccination of the incarcerated population" would not address "the continued risk of harm to vaccinated incarcerated persons" or the "introduction of the virus into the prisons"). 11

12 Defendants do not put forward evidence to show that vaccination of all incarcerated 13 persons would correct the violation of the Eighth Amendment. That much is apparent from the 14 declaration of Dr. James Watt, upon which Defendants previously relied, which simply states that 15 "[t]he best way for *patients* in correctional settings to reduce their risk of severe illness ... would 16 be to get vaccinated," ECF No. 3661 at 6-7 (emphasis added)-not that the best way Defendants 17 can reduce the spread or risk of severe illness to incarcerated persons would be to mandate 18 vaccines for prisoners but not the staff who oversee them. It is precisely because the incarcerated 19 have a limited ability to control with whom they interact—in this case, unvaccinated staff members who are primarily responsible for introducing COVID-19 into correctional facilities-20 21 that the best way for prisoners to protect themselves is *not* a less intrusive means to correct Defendants' Eighth Amendment violation. See ECF No. 3684 at 12. 22

 ² The same is true of the California Correctional Peace Officers' Association's (similarly unsupported) suggestion that mandating the vaccination of prisoners "would be a less intrusive, *and more effective*, means of protecting prisoners from COVID-19 than mandatory vaccination of staff," ECF No. 3722 (emphasis added). There is no evidence that vaccinating prisoners alone would be as effective, must less more effective, than mandating vaccinations for the staff members who work in Defendants' facilities and whose freedom of movement to and from those facilities is unimpaired.
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1 Defendants' focus on whether this Court's order could "completely protect[]," ECF No. 2 3715-1 at 18, vaccinated incarcerated persons from COVID-19 is misplaced. The Eighth 3 Amendment standard articulated in Farmer is one of "substantial risk," 511 U.S. at 834, and the record is replete with evidence that vaccinating all staff members—the predominant source of 4 5 outbreaks in CDCR—will mitigate the substantial risk of serious breakthrough infections in ways that mandating vaccinations for the prisoners will not. See, e.g., Vijayan Decl. ¶ 18, ECF No. 6 7 3683-3 ("[A] very high vaccination rate, *particularly among those with contact with the outside* 8 community who may introduce SARS-CoV2 into a CDCR institution, is the most effective means 9 of preventing outbreaks in CDCR institutions." (emphasis added)). Indeed, the gap between 10 Defendants' proposed remedy of vaccinating all prisoners and the substantial risk of harm to prisoners to which Defendants have been deliberately indifferent, see supra p. 5, only bolsters this 11 12 Court's conclusion that a vaccine mandate for CDCR staff is "proportional to the scope of the 13 violation" and "extend[s] no further than necessary to remedy the violation." Id. at 8 (quoting 14 Brown v. Plata, 563 U.S. 493, 531 (2011)), 20.

15 Defendants' additional argument that the CDPH order constitutes a less intrusive means of 16 remedying the violation identified by this Court fares no better. As this Court correctly 17 recognized, the CDPH order mandates vaccines only for two correctional institutions in their 18 entirety and for workers "regularly assigned to work in certain designated healthcare settings at the 19 remaining institutions." ECF No. 3684 at 14. This limited requirement does nothing to address the substantial risk of infection that accompanies the "myriad ways in which incarcerated persons 20 21 come into close contact with staff outside of healthcare settings," id., and cannot remedy the 22 Eighth Amendment violation identified by this Court. Recent experience bears this conclusion 23 out: "Of the 48 outbreaks traceable to staff since July 31, only 14, or 29%, were traced back to a 24 person that the CDPH order would require to be vaccinated." Id. at 15 (internal quotation marks 25 omitted).

In addition, although Defendants complain that the Court was unable to consider the "fully
 implemented" CDPH order at the time it issued its decision, ECF No. 3715-1 at 14, there is no
 reason to think—let alone any evidence—that full implementation of the plan could address the
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concerns raised by the Court in its order. That is because the Court's concern was with the fact 1 2 that the plan contemplates mandatory vaccination for only a limited pool of workers. Thus, even 3 full implementation and compliance would not address the substantial risk of infection prisoners would face when interacting with any other staff member in spaces outside of the healthcare 4 5 facility, as is commonplace.

Nor is it the case that, as Defendants suggest, the Court "speculated" wrongly when it 6 7 determined that further voluntary efforts would be unlikely to materially increase vaccination 8 rates. ECF No. 3715-1 at 18. While it may true that "staff vaccination rates have increased from 9 fifty-three to sixty-three percent since the Court issued its order to show cause," *id.* at 18, much of 10 the recent increase in staff vaccination rates can be attributed to the *mandatory* vaccinations required by the CDPH order, as opposed to any voluntary efforts on Defendants' parts. See Toche 11 12 Decl. ¶ 3 ("[H]ealthcare staff who are fully vaccinated increased from seventy-two percent on 13 August 6, 2021, to eighty-two percent on October 14, 2021.").

14 In short, Defendants have failed either to point to a clear error in the Court's findings of 15 fact or a misapplication of the law in the Court's conclusion that its order mandating vaccinations 16 for all correctional staff is "narrowly drawn, extends no further than necessary to correct the 17 violation of the Federal right, and is the least intrusive means necessary" to correct Defendants' 18 violation of Plaintiffs' Eighth Amendment rights. ECF No. 3684 at 20 (quoting 18 U.S.C. 19 § 3626(a)(1)(A)). Accordingly, Defendants are unlikely to succeed on the merits of their appeal, 20 and Defendants' request for a stay of this Court's order should be denied.

21 II.

22

DEFENDANTS AND CCPOA WILL NOT SUFFER IRREPARABLE HARM FROM IMPLEMENTATION OF THIS COURT'S ORDER

23 Defendants and CCPOA contend (ECF No. 3715-1 at 15-19; ECF No. 3722 at 6-9) that 24 they will suffer irreparable harm in the absence of a stay. Because they can show neither a "strong 25 likelihood of success on the merits" nor that "serious questions are raised" as to the merits, Golden 26 Gate Rest. Ass'n, 512 F.3d at 1115-16, Defendants' and CCPOA's arguments as to irreparable 27 harm are irrelevant. In any event, even assuming the Court takes into account Defendants'

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purported irreparable harm, their speculative arguments as to the effect of this Court's order do not
 meet their burden of showing likely irreparable harm.

3 4 A.

Defendants Will Not Suffer Irreparable Harm from Implementation of This Court's Order.

5 As an initial matter, while Defendants (and CCPOA) now raise numerous speculative 6 arguments about the effects of compliance with the Court's order, they made none of these 7 arguments in their response to this Court's Order to Show Cause. The Court specifically 8 requested that the parties "show cause as to why it should not order the Receiver's 9 recommendations be implemented." ECF No. 3647, at 2. Both Defendants and CCPOA filed 10 lengthy responses, but neither argued against implementation due to the potential harms they 11 would suffer. Given that all of the now-asserted harms would have been readily apparent to 12 Defendants and CCPOA when they opposed the Receiver's recommendations, they should not be 13 able to raise these arguments for the first time in their motions to stay. See Norsworthy v. Beard, 14 No. 14-CV-00695-JST, 2015 WL 1907518, at *3 (N.D. Cal. Apr. 27, 2015) (refusing to consider argument raised for the first time on a motion to stay); cf. Kona Enterprises, Inc. v. Est. of Bishop, 15 16 229 F.3d 877, 890 (9th Cir. 2000) (a motion for reconsideration may not be used to 17 raise arguments for the first time when they could reasonably have been raised earlier in the 18 litigation).³ 19 Defendants first contend that they have a strong interest in administering their own prisons. 20 ECF No. 3715-1 at 15. That is, of course, true, but the argument carries little force in this 21 particular case. As noted above, see supra pp. 10-11, the Court determined that the State is 22 incapable of meeting its obligations to provide care consistent with the Eighth Amendment and in 23 spite of a long effort, has not yet been able to meet those obligations on its own. The Receivership 24

 ³ Moreover, while Defendants and CCPOA now claim urgency regarding the need to prevent implementation of this Court's Order, they waited nearly a month before filing their stay motions. They have offered no explanation for why they waited such a substantial period of time to file their motion. Such a "delay undercut[s a party's] claim of irreparable harm," *Garcia v. Google, Inc.*, 786 F.3d 733, 746 (9th Cir. 2015); *see, e.g., California v. Health & Hum. Servs.*, 390 F.
 Supp. 3d 1061, 1066 (N.D. Cal. 2019) (same), and is a factor to consider in whether to grant equitable relief, *Cuviello v. City of Vallejo*, 944 F.3d 816, 833 (9th Cir. 2019).
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exists and continues solely for this reason. And in its September 27 order, the Court once again
 found that the State violated patients' Eighth Amendment Rights. The Court's decision to impose
 a vaccine mandate does not interfere with Defendants' ability "to fulfill its responsibilities under
 state and federal law," *id.*—the decision was made precisely because Defendants failed to do so.

5 In all events, Defendants' arguments regarding irreparable harm are speculative. 6 Defendants rely heavily on data from two facilities covered by the August 19 CDPH Order— 7 California Medical Facility (CMF) in Vacaville and California Health Care Facility (CHCF) in 8 Stockton—which show that as of October 25, 2021, 10.14% of correctional officers at CMF and 9 8.26% of officers at CHCF have not complied with the vaccine mandate nor sought an exception 10 to it. But the deadline for correctional officers to comply with the order was moved from October 11 14, 2021 to November 24, 2021, meaning that Defendants' numbers do not actually demonstrate rates of noncompliance. 12

Moreover, even if the level of non-compliance were similar at the deadline for compliance, it is not unusual for roughly 10% of staff to have failed to comply with a new policy shortly after the deadline for compliance. *See* Foss Decl. ¶ 2. What CDCR refers to as "high levels of noncompliance" is speculation based on data from long before the compliance date which, even if it were an accurate predictor of non-compliance at the deadline, would in fact be a normal level of delayed compliance with a policy or training that CDCR and CCHCS requires of its employees. *See id.* at ¶¶ 2-3.

20 Indeed, the progressive discipline process, which is effective in encouraging staff 21 compliance with CDCR and CCHCS policies, see id. at ¶ 8, has not even begun for the officers at 22 CMF or CHCF who have not yet complied with the CDPH Order. Id. at ¶ 3. Progressive 23 discipline begins with corrective action, and can then escalate to adverse action should non-24 compliance persist. Discipline is imposed on a case-by-case basis and may involve imposition of 25 less-serious measures initially before escalating to suspension or termination. See id. at $\P 6$. 26 While there are officers at each institution have not yet complied with the mandate, no 27 officers have yet been told they must choose between getting vaccinated and keeping their jobs. 28 Once that process has run its course, the number of noncompliant officers is likely to be 48360536.8 Case No. 4:01-cv-01351-JST -17-RECEIVER'S OPPOSITION TO DEFENDANTS' AND CCPOA'S MOTIONS TO STAY

substantially lower. See id. at ¶¶ 2-3, 8. Defendants' argument, premised on the current rates at CMF and CHCF being representative of *ultimate* noncompliance with this Court's order, is not only highly speculative; experience shows it substantially overestimates final noncompliance with this Court's order. And that is particularly true for noncustodial workers in the prisons, who have had higher vaccination rates than corrections officers, *see* ECF No. 3670-1 at 5-6, meaning the rates of noncompliance are likely to be lower than for corrections officers.

7 The state's dire predictions are particularly unlikely to come to pass because in many 8 communities, employment at a CDCR facility is among the most desirable jobs available, due to a 9 combination of salary, benefits, stability, and opportunity for advancement. See Foss Decl. ¶ 9. 10 Corrections officers in many locations would be giving up a coveted job without other, similarly attractive options, which diminishes the chances that they would take such action. Defendants 11 note that at least three unions representing CDCR staff have voiced their opposition to the CDPH 12 13 order. ECF No. 3715-1 at 16. Defendants have nonetheless continued to implement the CDPH 14 order in spite of this "vigorous[] push[] back," and they offer no explanation why this Court's 15 order cannot also be implemented in the face of opposition. Id. at 20.

Vaccine mandates of other large workforces provide substantial reason to doubt CDCR's
dire predictions about staff resignations and retirements. For example, after unions representing
New York City police officers predicted that the city's vaccine mandate would lead to 10,000
officers being pulled from their posts, just 34 officers out of the city's 35,000 person police force
were placed on unpaid leave for noncompliance, or less than .1%. *See* Annabelle Timsit, *NYC*

21 Police Unions Warned Vaccine Mandates Would Pull 10,000 Officers Off Streets. So Far, The

22 *Number is 34*, Washington Post, Nov. 2, 2021, at A1

23 || https://www.washingtonpost.com/nation/2021/11/02/nypd-unpaid-leave-vaccine-mandate/.

24 Similarly, less than 1% of United Airlines employees quit or were terminated due to

25 noncompliance with the airline's vaccine mandate. Jack J. Barry, Ann Christiano and Annie

26 Neimand, Half of Unvaccinated Workers Say They'd Rather Quit Than Get A Shot – But Real-

27 World Data Suggest Few Are Following Through, The Conversation, Updated Sept. 27, 2021,

28 || https://theconversation.com/half-of-unvaccinated-workers-say-theyd-rather-quit-than-get-a-shot-

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but-real-world-data-suggest-few-are-following-through-168447. And just .3% of the 35,800
 employees of the Indiana University Health Center failed to comply with its vaccine mandate,
 while only 2% of Houston Methodist Hospital's staff resigned or were terminated due to lack of
 compliance with its vaccine mandate. Jack J. Barry, Ann Christiano and Annie Neimand, *Half of Unvaccinated Workers Say They'd Rather Quit Than Get A Shot – But Real-World Data Suggest Few Are Following Through*, The Conversation, Updated Sept. 27, 2021,

7 https://theconversation.com/half-of-unvaccinated-workers-say-theyd-rather-quit-than-get-a-shot8 but-real-world-data-suggest-few-are-following-through-168447. Defendants' vastly higher
9 projected numbers, like the numbers projected for the NYPD, are not supported by the
10 implementation of similar mandates.

11 Based on their speculative numbers, Defendants forecast substantial negative consequences 12 with regard to staffing from a vaccine mandate. See ECF No. 3715-1 at 17-18. Defendants' 13 contention that this Court's order will lead CDCR prisons to be unable to operate safely is pure 14 speculation, and is contravened by the experience of CDCR and CCHCS during the pandemic. Defendants state that if this Court's order is implemented, "normal operations would not be 15 16 possible in all of CDCR's prisons." ECF No. 3715-1 at 20-21 n. 2. But Defendants ignore that 17 normal operations are already impossible at some CDCR prisons, both due to staff shortages 18 because of open positions and COVID-19-related absences, and due to quarantines because of the 19 presence of COVID-19. Ten institutions already have correctional officer vacancy rates of higher 20 than 10%, and will face programming limitations regardless of this Court's order. See Foss Decl. 21 ¶ 12. Defendants also ignore that adequate contingency plans are in place, and have been effective 22 at ensuring that essential medical care can be provided even in the event of staff shortages. See id. 23 at ¶ 11. Precisely for scenarios such as this one, CDCR has contingency plans for each prison for 24 significant staff shortages, and those contingency plans have been used at various points during 25 the pandemic. See id. Essential services such as medical care are prioritized where staff shortages 26 exist, and as the last 20 months have shown, CDCR facilities can be run safely and securely for 27 staff and incarcerated persons even when contingency plans are in place. See id.

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In addition, while it is true that the pandemic has led to smaller academy classes over the 1 past several years, CDCR projects that more than 900 cadets will graduate this fiscal year. See id. 2 3 at ¶ 14. CDCR is already undertaking efforts to increase recruitment and expedite the hiring process, and additional action is possible. For example, CDCR could increase its applicant pool 4 5 by offering bonuses to applicants and/or run additional academies to increase the number in incoming corrections officers, as it has done to address shortages in the past. Id. \P 15. To the 6 7 extent that CDCR is concerned about the number of vacancies it currently has, and any additional 8 vacancies that may result from this Court's order, it has options to increase the number of 9 corrections officers in order to meet any shortfall.

10 11

B. CCPOA Also Will Not Suffer Irreparable Harm from Implementation of the Court's Order.

12 CCPOA argues that its members will be irreparably harmed by losing their employment if 13 they decline to be vaccinated. ECF No. 3722 at 10-11. Union members would not be *irreparably* 14 harmed by losing employment. In Sampson v. Murray, the Court found that "temporary loss of income, ultimately to be recovered, does not usually constitute irreparable injury." 415 U.S. 61, 15 16 90 (1974). Although the Court found that in a "genuinely extraordinary situation," id. at 91 n.68, 17 loss of employment could constitute irreparable harm, CCPOA has put forward no evidence that this is such a case, and other courts have found no irreparable harm from the job loss that could 18 19 accompany failure to comply with a vaccine mandate. See, e.g., Williams v. Brown, No. 6:21-CV-20 01332-AA, 2021 WL 4894264, at *10 (D. Or. Oct. 19, 2021); Johnson v. Brown, No. 3:21-CV-21 1494-SI, 2021 WL 4846060, at *25 (D. Or. Oct. 18, 2021). Though CCPOA asserts that its members would have such difficulty in obtaining alternative employment that they may have to 22 move from the communities in which they live,⁴ Sampson found such harms to be insufficient, and 23 at any rate, there is nothing in the record to support them. ECF No. 3722 at 11. 24 25

²⁶
⁴ CCPOA cites to *Leiva-Perez*, a case concerning asylum, for the proposition that "uprooting [one's] life to settle elsewhere" and the resulting "separation from family members" is irreparable harm. ECF No. 3722 at 11 (citing *Leiva-Perez*, 640 F.3d 962 (9th Cir. 2011)). Voluntarily relocating to another community to find employment is not in any sense comparable to denial of

asylum and deportation to another country.

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Even if CCPOA could demonstrate a "genuinely extraordinary situation" justifying a
finding of irreparable harm, it would be outweighed by the public health necessity of the mandate. *See Kheriaty v. Regents of the Univ. of California*, No. SACV2101367JVSKESX, 2021 WL
4714664 (C.D. Cal. Sept. 29, 2021) ("The Regents are attempting to protect a campus community
of more than half a million students, faculty, and staff from a deadly infectious disease. This far
outweighs any harm Kheriaty may face in choosing between receiving a medically-approved
vaccination or suffering undetermined employment-related consequences.")

8 CCPOA builds speculation on top of speculation in arguing that the Court's order would 9 cause staff shortages that would deteriorate working conditions. ECF No. 3722 at 12-13. As 10 noted above, see supra pp. 16-20, Defendants and CCPOA offer nothing more than speculation that the vaccine mandate will result in a material reduction in the number of institutional staff. 11 12 CCPOA compounds this speculation by stating that employees qualifying for a religious 13 exemption to the vaccination mandate will be re-assigned from their regular positions that entail 14 contact with incarcerated persons. ECF No. 3722 at 11-12. The process of determining accommodations is individualized; CCPOA lacks any basis for statements about how assignments 15 16 will function. CCPOA likewise offers nothing but speculation in asserting that voluntary overtime 17 would be inadequate to cover staffing needs and that staff will be required to work mandatory 18 overtime due to staff shortages caused by the Court's order. See ECF No. 3722 at 12-13.

19 There is, however, an impact of the Court's order on working conditions that is not 20 speculative: If the Court's order were implemented, CDCR institutions would be a far safer 21 workplace for all CDCR staff. Roughly 42% of correctional officers were fully vaccinated for 22 COVID-19 before this Court's order. ECF No. 3670-1, Ex. A. The undisputed record in this case 23 is that they, like incarcerated persons, are not safe while COVID-19 continues to circulate in 24 CDCR institutions because many remain unvaccinated. ECF No. 3684 at 9. CCPOA members 25 would not suffer irreparable harm from changed working conditions if the Court's order is 26 implemented; the record shows CCPOA members, like incarcerated persons, would benefit, 27 indeed, that some of their lives may be saved, by the implementation of the order.

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1 To the extent that CCPOA argues its members would be irreparably harmed by becoming 2 vaccinated, that is also without support in the record. See ECF No. 3722 at 10-11 ("Those Union 3 members who alternatively choose vaccination in the wake of the Mandatory Vaccination Order to avoid the dire consequences of termination will also be irreparably injured. Once injected, they 4 5 cannot reverse their exposure to the vaccine and any negative side effects they experience."). The undisputed evidence is that COVID-19 vaccines are safe and effective. See e.g., ECF No. 3638-3 6 7 at 7. CCPOA does not identify a single example of one of its members being harmed by 8 vaccination. And CCPOA itself acknowledges that it "has repeatedly and consistently supported 9 vaccinations" ECF No. 3591 at 1-2. To the extent that CCPOA members may be irreparably 10 injured depending on the outcome of this motion, they will be irreparably injured if it is granted. As of this filing, 48 CDCR staff members have died of COVID-19.⁵ Nine of those deaths have 11 12 occurred in the little more than a month since the date of the Court's order, September 27, 2021. 13 *Id.* The risk of further deaths, and of serious illnesses, will be greatly reduced through timely 14 implementation of the Court's order.

15 16

III. THE PUBLIC INTEREST AND BALANCE OF HARMS CONFIRM THAT THE STAY SHOULD BE DENIED.

17 The public interest and balance of the equities, merged in this case, counsel strongly 18 against granting the stay. As an initial matter, "it is always in the public interest to prevent the 19 violation of a party's constitutional rights," Am. Beverage Ass'n, 916 F.3d at 758, even where the 20 court's order would enjoin the state's conduct in enforcing the laws or administering prisons, see 21 Melendres v. Arpaio, 695 F.3d 990, 1002 (9th Cir. 2012). Even where, as here, the government argues there are significant practical impediments to complying with the Eighth Amendment, it 22 23 "cannot suffer harm from an injunction that merely ends an unlawful practice [E]ven if the 24 government faced severe logistical difficulties . . . they would merely represent the burdens of 25 complying with . . . the Constitution." Rodriguez v. Robbins, 715 F.3d 1127, 1145 (9th Cir. 2013). 26

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 ⁸ California Department of Corrections and Rehabilitation, CDCR/CCHCS COVID-19 Employee
 Status (last accessed November 3, 2021), https://www.cdcr.ca.gov/covid19/cdcr-cchcs-covid-19status/.

1 Here, the Court properly held that defendants' conduct violates the Eighth Amendment, and 2 Defendants' countervailing arguments about the administrative difficulties of compliance cannot justify ongoing constitutional violations.

3

4 As this Court has already found, urgent public health considerations support 5 implementation of this Court's order without further delay. No party challenges this Court's 6 finding that every incarcerated person, vaccinated and unvaccinated, faces an ongoing substantial risk of serious harm, directly through contracting COVID-19 and indirectly through lost access to 7 8 health care and other services caused by outbreaks. ECF No. 3684 at 9, 11. It is undisputed, and 9 indeed trumpeted by Defendants themselves, that staff vaccination is the most effective way to 10 prevent COVID-19 from entering CDCR institutions, where its spread cannot be controlled. See 11 ECF No. 3684 at 13; Bick Decl. in Supp. of Report ¶ 16, ECF No. 3638-1 at 3; Kreilkamp Decl., 12 Ex. A., Reingold Decl. ¶ 25.

13 The past several months have confirmed the urgent need to implement the Court's order. 14 Between June 1, 2021 and September 10, 2021, twelve patients were hospitalized and two died, 15 including one fully vaccinated patient. Bick Reply Decl. ¶ 2, 9, ECF No. 3670-1 at 1-2. There are 16 currently major outbreaks at five institutions, including a combined 104 patients sick with 17 COVID-19 in the neighboring institutions the Substance Abuse Treatment Facility and State Prison, Corcoran and California State Prison, Corcoran.⁶ From September 26 to October 30, 18 19 2021, 518 incarcerated persons have contracted COVID-19.⁷ During that same period 9 staff 20 members have died from COVID-19. In addition to causing severe illness, hospitalization, and 21 death, COVID-19 leaves some patients with chronic long-term symptoms. Bick Reply Decl. ¶ 9, 22 ECF No. 3670-1 at 2. The public interest strongly supports implementing the Court's order, so 23 that patients and staff members can be protected from further outbreaks of COVID-19. 24 25

26

⁶ California Department of Corrections and Rehabilitation, Population COVID-19 Tracking, 27 https://www.cdcr.ca.gov/covid19/population-status-tracking/ (updated Sept. 10, 2021)

⁷ California Department of Corrections and Rehabilitation, Population COVID-19 Tracking, 28 https://www.cdcr.ca.gov/covid19/population-status-tracking/ (updated Sept. 10, 2021)

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1 Preventing outbreaks in prisons also serves the public interest by protecting the 2 communities surrounding the prisons. See, e.g., Steel MMA, LLC v. Newsom, 2021 WL 778654 at 3 *5 (S.D. Cal. Mar. 1, 2021) ("[T]he public interest here lays with the continued protection of the population as a whole."); *Tandon v. Newsom*, 517 F.Supp.3d 922, 957-59 (N.D. Cal. Feb. 5, 2021) 4 5 (explaining the connection between spread in care facilities and the broader community). The 6 public has a particular interest in preventing COVID-19 spread in communal environments that 7 might overwhelm community healthcare resources. See Seth v. McDonough, 461 F.Supp.3d 242, 8 263 (D. Md. 2020) ("As to the public interest, reducing the spread of this deadly virus in 9 communal environments—whether they be assisted living, group homes, detention facilities, or prisons—remains front and center. . . . The public also maintains a broader interest in reaping the 10 collateral benefits of reduced risk, such as conserving precious healthcare resources."). Several 11 12 CDCR facilities are located in particularly vulnerable rural areas where COVID-19 outbreaks in 13 CDCR facilities could easily overwhelm community hospital capacity. Bick Decl. in Supp. of 14 Report ¶ 6, ECF No. 3638-1 at 1-2. Preventing outbreaks in prisons preserves critical healthcare resources in already-strained systems. 15

16 Defendants and CCPOA contend that the balance of the equities tips in their favor because 17 risk to the incarcerated population is reduced due to current vaccination levels of patients and 18 staff, and because of the risk that staff members will leave their jobs in large numbers rather than 19 comply. But this Court has already held based on undisputed facts that patients face substantial 20 risk of serious harm in the absence of a vaccine mandate. ECF No. 3684 at 9, 11. As noted 21 above, see supra pp. 16-20, Defendants' and CCPOA's discussions of the consequences of the 22 mandate on staffing harms are highly speculative, and cannot overcome the strong interests of 23 Plaintiffs and of the general public in being protected from COVID-19. See, e.g., Massachusetts Correction Officers Federated Union v. Baker, No. 21-11599-TSH, 2021 WL 4822154, at *8 (D. 24 25 Mass. Oct. 15, 2021) (finding the balance of the equities favored mandatory vaccination of prison staff because of "the legitimate and critical public interest in preventing the spread of COVID-19 26 27 by increasing the vaccination rate, particularly in congregate facilities"); *Kheriaty*, 2021 WL 4714664, at *9 (noting, in finding that the balance of the equities supported a vaccine mandate, 28 T

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1	that the policy "not only impacts the members of the campus community who it directly applies to,		
2	but also provides indirect protections to other members of the public at large"). The balance of the		
3	equities therefore strongly cuts against Defendants and CCPOA.		
4	CONCLUSION		
5	For the foregoing reasons, the Receiver respectfully requests that the Court deny		
6	Defendants' and CCPOA's motion to stay the Court's September 27 order pending appeal.		
7			
8	DATED: November 8, 2021 MUNGER, TOLLES & OLSON LLP		
9	Phank		
10	By:		
11	Attorneys for Receiver J. Clark Kelso		
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	48360536.8 -25- Case No. 4:01-cv-01351-JST		
	RECEIVER'S OPPOSITION TO DEFENDANTS' AND CCPOA'S MOTIONS TO STAY		

Declaration of Jacob Kreilkamp

I declare, under penalty of perjury and pursuant to 28 U.S.C. § 1746, as follows:

- 1. I am an attorney admitted to practice in the State of California and before this Court. I am an attorney at the law firm of Munger, Tolles & Olson LLP and counsel of record for the Receiver, J. Clark Kelso in the above-captioned matter. I have personal knowledge of the facts set forth in this declaration, and, if called as a witness, I could and would testify competently to the matters set forth herein.
- Attached hereto as Exhibit A is the October 12, 2021 Declaration of Arthur L. Reingold, M.D., submitted in opposition to Plaintiffs' Ex Parte Application for a Temporary Restraining Order enjoining enforcement of the August 19 CDPH order, by Defendants California Department of Public Health (CDPH), Thomas J. Aragon, California Department of Corrections and Rehabilitation (CDCR), and Kathleen Allison, in the case *Robert Davis, Jr., et al. v. California Department of Public Health, et al.*, No. BCV-21-102318 (Kern County Sup. Ct.). On November 8, 2021, my office received an electronic copy of this declaration in from the clerk of the court.

Executed on this 8th day of November, 2021, at Los Angeles, California.

Jacob Kreilkamp

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EXHIBIT A

I	Case 4:01-cv-01351-JST Document 3738-:	1 Filed 11/08/21 Page 3 of 52
1	ROB BONTA Attorney General of California	ELECTRONICALLY FILED
2	PAUL STEIN	Kern County Superior Court
3	RITA B. BOSWORTH	By Gricelua Evans, Deputy
4	Deputy Attorney General NATASHA SAGGAR SHETH	
5	Deputy Attorney General State Bar No. 282896	
6	455 Golden Gate Avenue, Suite 11000 San Francisco, CA 94102-7004	
7	Telephone: $(415) 510-3818$ Fax: $(415) 703 5480$	
0	E-mail: Natasha.Sheth@doj.ca.gov	
8 9	Department of Public Health (CDPH); To J. Aragon, in this official capacity as State	omas e
10	Public Health Officer and Director of CD California Department of Corrections and	PH; d
11	Rehabilitation (CDCR); Kathleen Allison, her official capacity as Secretary of CDC.	in R
12		
13	IN THE SUPERIOR COURT OF THE STATE OF CALIFORNIA	
13	COUNTY	OF KERN
14		
15	ROBERT DAVIS JR. et al.,	Case No. BCV-21-102318
16	Plaintiffs,	DECLARATION OF ARTHUR L. REINGOLD, M.D. IN SUPPORT
17	V.	OF DEFENDANTS' OPPOSITION TO PLAINTIFF'S
18	CALIFORNIA DEPARTMENT OF PUBLIC HEALTH; et al,	APPLICATION FOR TEMPORARY RESTRAINING
19	Defendants.	ORDER Developeration
20		Date: October 13, 2021 Time: 8:30 A.M.
21		Dept.: 12 Hon: Linda S. Etienne
22		-
23		
24		
25		
26		
27		
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		REINGOLD, M.D., DECL. ISO DEF.'S OPP. TO PL.'S APP. FOR TRO; CASE NO. BCV-21-cv-102318

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I, Arthur L. Reingold, M.D., declare as follows:

1. I provide this declaration in support of Defendants California Department of Public Health, Tomas J. Aragon, California Department of 3 4 Corrections and Rehabilitation ("CDCR"), and Kathleen Allison ("Defendants") Opposition to Plaintiffs' Application for Temporary Restraining Order. I base this 5 declaration on my expertise as outlined below and facts within my personal 6 knowledge, to which I could and would testify competently if called upon to do so. 7

I am the Division Head of Epidemiology at the University of 2. 8 9 California, Berkeley, School of Public Health. I have worked on the prevention and control of infectious diseases in the United States, including eight years at the U.S. 10 11 Centers for Disease Control and Prevention (CDC), and with numerous developing countries around the world for over forty years. Since its inception in 1994, I have 12 directed or co-directed the CDC-funded California Emerging Infections Program. I 13 am a member of the Society for Epidemiologic Research and elected member of the 14 American Epidemiological Society; an elected Fellow of the Infectious Disease 15 Society of America and of the American Association for the Advancement of 16 Science; and an elected member of the Institute of Medicine of the National 17 Academy of Sciences. I was previously the President of both the Society for 18 Epidemiologic Research and the American Epidemiological Society. I have served 19 20 on the editorial boards of the following journals: American Journal of Epidemiology, Epidemiology, and Global Public Health, and currently serve as 21 Associate Editor for the journal Vaccine. 22

23

3. I received my A.B. in biology from the University of Chicago in 1970, and my M.D. from the University of Chicago in 1976. Among other things, I 24 completed a residency in internal medicine and a preventive medicine residency 25 with the CDC. I retain an active medical license in California and board 26 certification in internal medicine. 27

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4. My career in public health has been in the area of infectious diseases

1 and epidemiology. Following my positions at the CDC (1979-1987), I joined the faculty of the School of Public Health at the University of California, Berkeley as a 2 Professor of Epidemiology (1987-present), the faculty of the Department of 3 4 Epidemiology and Biostatistics at the University of California, San Francisco (UCSF) (1989-2005), and as a Clinical Professor in the Department of Medicine at 5 6 UCSF (1991-2005). From 1990-1994, I was the Head of the Epidemiology Program, Department of Biomedical and Environmental Health Sciences, 7 University of California, Berkeley; from 1994-2000, I was the Head of the Division 8 9 of Public Health Biology and Epidemiology, University of California, Berkeley; from 2000 continuing through the present, I have been the Head of the Division of 10 Epidemiology, School of Public Health, University of California, Berkeley. 11

My research focuses on emerging and re-emerging infections in the
 United States and in developing countries; respiratory infections and vaccine preventable diseases in the United States and in developing countries; and disease
 surveillance, outbreak detection, and outbreak response. I have published almost
 400 research articles on these topics, including multiple articles about Coronavirus
 Disease 2019 (COVID-19).

I have been and am currently involved in multiple research studies of 6. 18 SARS-CoV-2, the novel coronavirus that causes COVID-19 and of COVID-19. I 19 20 am also serving on COVID-19 advisory groups for multiple organizations, including UC Berkeley, the University of California system, and the City and 21 County of San Francisco, among others. In addition, as an elected member of the 22 23 National Academy of Medicine, I have served on two committees related to COVID-19: the National Academies of Science, Engineering, and Medicine's 24 Committee on Equitable Allocation of Vaccines for the Novel Coronavirus and the 25 National Academies of Sciences, Engineering, and Medicine's Workshop on 26 Airborne Transmission of SARS-CoV-2. I also currently chair the Western States 27 Scientific Safety Review Workshop to review the safety and efficacy of all 28

COVID-19 vaccines being introduced in the U.S.

Attached hereto as **Exhibit A** and incorporated by reference to this 7. 2 declaration is a copy of my curriculum vitae. 3

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COVID-19 Pandemic and the SARS-CoV-2 Virus

8. The disease COVID-19 is caused by infection with the novel 5 6 coronavirus, SARS-CoV-2. Chinese health officials reported the first cluster of cases of COVID-19 on December 31, 2019 in persons associated with a seafood 7 and live animal market in the City of Wuhan, Hubei Province. On January 7, 2020, 8 they confirmed the role of SARS-CoV-2 in these cases. The earliest date of onset of 9 symptoms in the report from China was December 1, 2019. Studies of the SARS-10 11 CoV-2 virus show that it is closely related to coronaviruses found in bats and pangolins and that the first human infections likely occurred in November, 2019. ⁽¹⁻ 12 ⁵⁾ While the consensus is that the initial human infection was the result of a 13 "spillover event" (i.e. direct animal to human transmission), some experts believe it 14 could have resulted from escape of the virus from a laboratory in Wuhan.

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Whatever the original source of the SAR-CoV-2 virus, it is a novel 9. 16 coronavirus that is not known to have infected the human population before its 17 emergence in China in the latter part of 2019. As a result, when the COVID-19 18 pandemic began, few, if any people anywhere in the world had either acquired or 19 20 innate immunity to it -i.e. the entire population, including that of the U.S., was susceptible to infection with the SARS-CoV-2 virus. 21

22

10. SARS-CoV-2 is a single stranded RNA virus that is capable of 23 mutating frequently. As a result of this process, multiple variants of the virus have developed in various geographic locations and spread widely, including what are 24 classified as variants of interest and variants of concern. Currently, one of the 25 26 variants of concern, the Delta variant, is responsible for a high proportion of SARS-27 CoV-2 infections in the U.S. and elsewhere. Evidence suggests that the Delta variant is more readily transmitted from person-to-person and also produces, on 28

1 average, more severe illness.

11. SARS-CoV-2 is spread from person-to-person via respiratory droplets,
including small droplet sometimes referred to as aerosols. Human activities that can
lead to transmission of the SARS-CoV-2 virus include coughing, sneezing, singing,
and talking. Infection is often asymptomatic, and transmission of the virus can
occur from individuals who are symptomatic and from individuals who do not have
symptoms, including those who never go on to develop symptoms and those who
subsequently do develop symptoms.

9 12. Among those infected with SARS-CoV-2, the elderly, especially the frail elderly, and those with a variety of immunosuppressive conditions are at 10 greatest risk of severe illness, hospitalization, the need for mechanical ventilation, 11 and death. However, severe illnesses and deaths due to COVID-19 can occur in 12 individuals of all ages, including previously healthy individuals. Among children 13 and adolescents, a severe illness called Multisystem Inflammatory Syndrome in 14 Children (MISC) can result from COVID-19, as can a similar illness in adults, 15 16 Multisystem Inflammatory Syndrome in Adults (MISA). In addition, many individuals with COVID-19, including those with mild cases, go on to have 17 persistent sequelae, so-called long COVID or long-haul COVID, the frequency, 18 duration, and severity of which remain to be characterized. 19

13. As of October 10, 2021, almost 237,000,000 COVID-19 cases and
over 4,800,000 COVID-19 deaths have been reported worldwide, including over
44,000,000 cases and over 711,000 deaths in the U.S.¹ These number of cases and
deaths, however, are widely understood to substantially underestimate the numbers
of SARS-CoV-2 infections and the numbers of COVID-19 cases and deaths, for a
variety of reasons. The U.S. experienced a relatively small peak in COVID-19

¹ For current numbers of reported COVID-19 cases and deaths worldwide, see The New York Times "Coronavirus World Map: Tracking the Global Outbreak," available at

 <u>https://www.nytimes.com/interactive/2021/world/covid-cases.html</u>. For current numbers of reported COVID-19 cases and deaths in the United States, see The New York Times https://www.nytimes.com/interactive/2021/world/covid-cases.html.
1 cases, hospitalizations, and deaths in the summer of 2020 and a much larger peak in the 2020-2021 winter months. After the numbers of cases, hospitalizations, and 2 deaths in the U.S. declined sharply in the spring and early summer, the numbers 3 began to climb again in July, 2021, including in California as a whole and in the 4 5 S.F. Bay Area, and many parts of the United States are currently experiencing sharp 6 increases in infections, hospitalizations, and deaths. These trends over time undoubtedly reflect the influence of diverse factors (e.g. human behavior change, 7 such as social distancing and use of masks and other facial coverings; introduction 8 9 of COVID-19 vaccines; seasonal changes in temperature and humidity; and changes in the SARS-CoV-2 variants that predominate, among others), making it 10 11 difficult to predict future trends.

14. Before the development, approval, and introduction of safe and 12 effective COVID-19 vaccines, the only interventions available for reducing the 13 spread of SARS-CoV-2 were so-called nonpharmaceutical interventions. Among 14 these interventions were (and are) travel restrictions and bans; closures of schools, 15 16 restaurants, bars, and other establishments; tele-working; use of masks and other facial coverings; screening in various settings of individuals for fever, other 17 symptoms, possible exposures to others with COVID-19, or the presence of SARS-18 CoV-2 in the nose or throat; contact tracing and quarantine; improved hand hygiene 19 20 and decontamination of surfaces. Some of these interventions (e.g. decontamination of surfaces) most likely had no impact on the transmission of SARS-CoV-2, while 21 for others (e.g. closing of restaurants and implementation of mask mandates), 22 evidence suggests there was an impact, although other, negative social, economic, 23 and even health impacts also resulted. Improved indoor ventilation is also 24 considered to be an effective means of reducing transmission of SARS-CoV-2 25 inside buildings, when possible. Even all of these non-pharmaceutical interventions 26 27 combined, however, provide less than complete protection against transmission of SARS-CoV-2 in a population, especially when they are imperfectly implemented, 28

as is almost invariably the case in the "real world."

2

1

COVID-19 Vaccine Development and Efficacy

Development of vaccines against COVID-19 began in early 2020, 15. 3 soon after SARS-CoV-2 was determined to be the cause of the disease. Since that 4 time, multiple COVID-19 vaccines have been developed and tested in the U.S., 5 6 Europe, China, Russia, and elsewhere. Thus far, three COVID-19 vaccines have been granted Emergency Use Authorization (EUA) by the U.S. FDA, two using an 7 RNA approach (Pfizer/BioNTech and Moderna) and one using an adenovirus 8 vector approach (Janssen/Johnson & Johnson), similar to COVID-19 vaccines that 9 have been developed, tested, and approved for use in diverse other countries. The 10 three COVID-19 vaccines currently approved for use in the U.S. received EUA 11 approval on December 10, 2020 (Pfizer/BioNTech), December 17, 2020 (Moderna) 12 and January 27, 2021 (Janssen/Johnson & Johnson), respectively.² The mRNA 13 COVID-19 vaccine made by Pfizer/BioNTech received full approval by the FDA 14 on August 23, 2021.³ All three vaccines were shown in large phase 3 trials to be 15 highly efficacious against COVID-19 disease, particularly against COVID-19-16 related hospitalization and death. Since the granting of EUA status by FDA and the 17 development of guidelines for their use by the Advisory Committee on 18 Immunization Practices (ACIP), almost 402,000,000 doses of the three vaccines 19 had been administered in the U.S. as of October 9, 2021, with 78% of the U.S. 20 population \geq 18 years of age having received at least one dose.⁴ Post-approval 21 observational studies have demonstrated that the COVID-19 vaccines have a very 22 23 high level of effectiveness in preventing severe illnesses, hospitalizations, and deaths from COVID-19, including cases caused by the Delta variant of SARS-CoV-24

25

² FDA, COVID-19 Vaccines, available at <u>https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/covid-19-vaccines.</u>
 ³ FDA, Comirnaty and Pfizer-BioNTech COVID-19 Vaccine, available at

FDA, Comirnaty and Pfizer-BioNTech COVID-19 Vaccine, available at
 <u>https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-</u>19/comirnaty-and-pfizer-biontech-covid-19-vaccine

28 ⁴ CDC, COVID Data Tracker, COVID-19 Vaccination in the United States, available at <u>https://covid.cdc.gov/covid-data-tracker/#vaccinations_vacc-total-admin-rate-pop18</u>

1	2.5 While "breakthrough" SARS-CoV-2 infections do occur among partially and
2	fully vaccinated individuals, they are typically associated with mild illness or no
3	symptoms, and vaccinated individuals are less likely to transmit COVID-19
4	compared to those who are not vaccinated. ⁶ As of July 31, 2021, ~97% of all
5	hospitalizations for COVID-19 in the U.S. are among unvaccinated individuals. ⁷
6	COVID-19 Vaccine Safety
7	16. In the clinical trials that led to granting of EUA status to the three
8	COVID-19 vaccines being used in the U.S. currently, reactogenicity and various
9	side effects were carefully monitored in the days and weeks following receipt of the
10	various vaccines. The side effects observed (e.g. injection site pain, malaise,
11	headache, etc.), while more common in recipients of the COVID-19 vaccines than
12	in placebo recipients, were comparable to those seen following receipt of other
13	vaccines commonly given to adults (e.g. vaccines against influenza, Herpes Zoster
14	and <u>S</u> . <u>pneumoniae</u>), and were generally mild and self-limited, resolving within two
15	to three days. ⁸
16	17. As the three COVID-19 vaccines were introduced in the U.S., multiple
17	systems were employed to monitor reported adverse events following
18	5 International Vaccina Access Contar, Johns Hanking Plaambarg School of Dublic Haalth and
19	World Health Organization, "Results of COVID-19 Vaccine Effectiveness Studies: An Ongoing
20	<u>07/COVID%2019%20VE%20Team%20Literature%20Review%20-%20Summary%20Table.pdf;</u>
21	Med, Vol 383, pp 2603-2615 (efficacy of Pfizer/BioNTech vaccine), available at
22	the mRNA-1273 SARS CoV-2 Vaccine" N Engl J Med, Vol 384, pp 403-416 (efficacy of
23	et al, "Safety and Efficacy of Single-Dose Ad26, COV.S Vaccine against Covid-19" N Engl J
24	Med, Vol 384, pp 218/-2201 (efficacy of Janssen/Johnson & Johnson Vaccine), available at <u>https://www.nejm.org/doi/full/10.1056/NEJMoa2101544</u> .
25	England" N Engl J Med, Letter to the Editor, Jun. 23, 2021, available at
26	^{https://www.nejm.org/doi/full/10.1056/NEJMc210//17.} ⁷ White House Press Briefing by White House COVID-19 Response Team and Public Health
27	briefings/2021/07/16/press-briefing-by-white-house-covid-19-response-team-and-public-health-
28	^{omclais-45/.} ⁸ CDC, Possible Side Effects, available at <u>https://www.cdc.gov/coronavirus/2019-</u>
	ncov/vaccines/expect/after.ntml.
	REINGOLD M.D. DECL. ISO DEF 'S OPP. TO PL 'S
	REINGOLD, M.D., DECL. ISO DEF.'S OPP. TO PL.'S -7- APP. FOR TRO;

immunization, including both existing and new surveillance systems. One 1 important component of the U.S. system for monitoring and evaluating the safety of 2 vaccines is the Vaccine Adverse Event Reporting System (VAERS), which is a 3 collaborative effort of the FDA and the CDC.⁹ This system is designed to make it 4 easy for vaccine recipients, family members, healthcare providers, and others to 5 6 report any condition or event observed at any time point following the administration of a vaccine. The system, which is passive in nature, is intended to 7 help detect "signals" – that is, events or conditions that might be related to the 8 9 receipt of a vaccine. However, the report of an illness or death in the days, weeks, months, or years following the receipt of a vaccine does not and cannot establish a 10 causal connection between receipt of that vaccine and the illness or death 11 reported.¹⁰ Rather, such reports can help generate hypotheses concerning such 12 relationships, which must then be tested using appropriate epidemiological and 13 biostatistical studies and methods. 14

18. To date, data from these various systems suggest that the three 15 COVID-19 vaccines are very safe and that their benefits far outweigh any risks 16 associated with receipt of the vaccines. As expected, and as seen with other 17 vaccines and medications, there is a very small risk of a severe allergic reaction (i.e. 18 anaphylaxis) in the 15 to 30 minutes following receipt of a dose of a COVID-19 19 vaccine; such reactions can be reversed with appropriate medical care and are the 20 reason vaccines should be administered at a facility equipped to promptly recognize 21 and treat such reactions. 22

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In addition, three very rare side effects have been noted in small 19. numbers of recipients of the COVID-19 vaccines being used in the U.S., including 24 cases of Guillain-Barré Syndrome (GBS) and cases of Thrombosis with 25 Thrombocytopenia Syndrome (TTS) in recipients of the Janssen/Johnson & 26

²⁷

⁹ CDC, Vaccine Adverse Event Reporting System (VAERS), available at https://www.cdc.gov/vaccinesafety/ensuringsafety/monitoring/vaers/index.html. 28 ¹⁰ *Id.* ("VAERS data alone cannot determine if the vaccine caused the reported adverse event.")

Johnson COVID-19 vaccine and cases of myocarditis in recipients of the two
MRNA COVID-19 vaccines. Based on analyses presented by CDC experts to the
ACIP at its meeting on July 22, 2021, even taking these rare adverse events
following receipt of COVID-19 vaccines into account, the benefits of COVID-19
vaccination with regard to illnesses, hospitalizations, and deaths prevented far
outweigh any known risks, both in men and in women and across all adult age
groups, including those 18 – 29 years of age.¹¹

8

9

Use of COVID-19 Vaccines in Individuals with a Prior History of COVID-19 Illness or with Detectable SARS-CoV-2 Antibodies

20. Individuals described as having been "infected before" with SARS-10 11 CoV-2 (or COVID-19) comprise a heterogeneous group, whose level of immunity to subsequent SARS-CoV-2 infection and COVID-19 illness is equally 12 heterogeneous. Included in this heterogeneous group might be: 1) individuals with a 13 history of a clinical illness they or their healthcare provider believe to have been 14 COVID-19, with no laboratory evidence that the illness was COVID-19; 2) 15 16 individuals with a prior illness that is clinically compatible with COVID-19 and a contemporaneous laboratory test (e.g., PCR or antigen detection) positive for 17 SARS-CoV-2; 3) individuals with no signs or symptoms of COVID-19 who, for 18 whatever reason, underwent testing for SARS-CoV-2 and whose test was reported 19 20 as positive; and 4) individuals with a positive result on a serological (i.e., antibody) test, with or without a history in the past of a clinically compatible illness. To 21 consider all such individuals as protected against future SARS-CoV-2 infection 22 and, therefore, not in need of COVID-19 vaccination, is neither reasonable nor 23 scientifically sound. 24

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21. While individuals who have had a documented case of COVID-19

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¹¹ ACIP Presentation Slides, H Rosenblum, "COVID-19 vaccines: benefits-risk discussion," (July 22, 2021), available at <u>https://www.cdc.gov/vaccines/acip/meetings/slides-2021-07-22.html;</u>

ACIP Presentation Slides, H. Rosenblum, "Benefit-risk discussion for use of Pfizer-BioNTech COVID-19 vaccine in individuals >16 years of age (August 30, 2021), available at https://www.cdc.gov/vaccines/acip/meetings/slides-2021-08-30.html. 1 typically have antibodies to the SARS-CoV-2 virus detectable in their blood and are believed to have a reduced risk of getting COVID-19 again in the months that 2 follow, neither the completeness nor the durability of protection against a second 3 case of COVID-19 has been established. The extent to which any such immunity 4 resulting from having had COVID-19 provides protection against new variants of 5 6 SARS-CoV-2 is also unknown. Because available evidence suggests that the risk of a second episode of COVID-19 is extremely low in the 90 days following a first 7 episode, current recommendations advise waiting for that period of time before 8 9 administering COVID-19 vaccine to someone who has had COVID-19.

22. While many SARS-CoV-2 antibody tests have been authorized by the
FDA, none of these tests is currently considered to provide a reliable indication of a
person's level of immunity to or protection from COVID-19 in the future. Both the
FDA and the CDC specifically caution against using the results of SARS-CoV-2
antibody tests to guide decisions about administration of COVID-19 vaccines. On
its website, the CDC advises that "Antibody testing is NOT currently recommended
to assess the need for vaccination in an unvaccinated person."¹²

Furthermore, studies suggest that administration of the COVID-19 17 23. vaccine provides enhanced neutralization of some circulating variants of SARS-18 CoV-2, compared with that induced by natural infection, as measured by in vitro 19 (i.e., laboratory) studies.¹³ In addition, a recently published study from Kentucky 20 has demonstrated that among individuals who have recovered from a documented 21 SARS-CoV-2 infection, receipt of a COVID-19 vaccine is associated with a 22 23 significantly reduced risk of re-infection; in that study, those who remained unvaccinated had 2.34 times the odds of re-infection with SARS-CoV-2, compared 24

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¹² CDC, COVID-19, Antibody Testing Interim Guidelines, available at <u>https://www.cdc.gov/coronavirus/2019-ncov/lab/resources/antibody-tests-guidelines.html</u>.

^{28 &}lt;sup>13</sup> Stamatatos L, Czartoski J, wan YH et al., mRNA vaccination boosts cross-variant neutralizing antibodies elicited by SARS-CoV-2 infection. Science, Epub March 27, 2021.

to those who were vaccinated.14 1

2	24. With regard to the safety of administering COVID-19 vaccine to
3	individuals with antibodies to SARS-CoV-2, while the available evidence suggests
4	that such individuals may have a modestly increased incidence of some side effects
5	in the first few days following receipt of a COVID-19 vaccine, the side effects in
6	question (e.g. injection site pain and tenderness and fatigue) are ones that are self-
7	limited and that improve with little or no treatment within a day or two. There is no
8	evidence to suggest that the rare side effects referred to above in section 11 occur
9	more often in individuals with either a history of prior COVID-19 or detectable
10	antibodies to SARS-CoV-2. Furthermore, there is no evidence that administration
11	of other commonly used vaccines (e.g. measles, hepatitis A and B, and human
12	papilloma virus, etc.) to individuals with antibodies to those infectious agents is
13	associated with an increased risk of serious adverse events or is otherwise unsafe.
14	Rationale for a COVID-19 Vaccine Mandate Applying to
15	Employees of the CDCR
16	25. All of the available evidence strongly suggests that SARS-CoV-2, the
17	virus that causes COVID-19, will continue to circulate and cause infections,
18	illnesses, hospitalizations, and deaths globally, throughout the U.S., and in every
19	county in California for the foreseeable future, including the highly transmissible
20	Delta variant. It is also likely that new variants of SARS-CoV-2 will arise as a
21	result of mutation of the virus, with unpredictable consequences. Since the onset of
22	the pandemic, over 50,000 individuals incarcerated in California's state prisons
23	have been infected by the SARS-CoV-2 virus, and at least 240 have died. ¹⁵ Over
24	20,000 employees in the state prison system have been infected by SARS-CoV-2
25	
26	¹⁴ Cavanaugh AM, Spicer KB, Thoroughman D, Glick C and Winter K, Reduced Risk of

Reinfection with SARS-CoV-2 After COVID-19 Vaccination-Kentucky. May-June 2021, 27 MMWR 70(32); pages 1081-83; August 13, 2021. ¹⁵ Inmate Population COVID-19 Tracking, available at <u>https://www.cdcr.ca.gov/covid19/population-status-tracking/</u>.

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1	virus and 33 have died. ¹⁶ The opportunities for transmission of SARS-CoV-2 in
2	locations within correctional facilities and detention centers where health care is
3	provided is substantial, and it is difficult to control the virus once it has been
4	introduced into a prison setting. Staff are the primary vector for introduction of the
5	virus into the prison setting, and only 42% of custodial staff have been vaccinated
6	to date. ¹⁷ These facilities are highly unlikely to be able to prevent or control
7	outbreaks of COVID-19 solely through the application of non-pharmaceutical
8	interventions. Available COVID-19 vaccines have an excellent safety and efficacy
9	profile, and the benefits of COVID-19 vaccination far outweigh any known risks.
10	COVID-19 vaccination of all employees of the CDCR without a valid contra-
11	indication or exemption is the single most effective intervention available to
12	prevent cases and outbreaks of COVID-19, both among those who are vaccinated
13	and those who cannot be vaccinated.
14	I declare under penalty of perjury under the laws of the United States of
15	America that the foregoing is true and correct.
16	
17	Executed this 11th day of October 2021 at BERVELEY, CA
18	
19	Amore
20	Arthur L. Reingold, M.D.
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27 28	 ¹⁶ CDCR/CCHCS COVID-19 Employee Status, available at <u>https://www.cdcr.ca.gov/covid19/cdcr-cchcs-covid-19-status/</u>. ¹⁷ Order Re: Mandatory Vaccinations, <i>Plata v. Newsom</i>, Case No. 01-cv-01351-JST, Dkt. 3684 at
	4 (N.D. Cal. September 27, 2021). -12- REINGOLD, M.D., DECL. ISO DEF.'S OPP. TO PL.'S APP. FOR TRO; CASE NO. BCV-21-cv-102318

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Exhibit A

October, 2021

CURRICULUM VITAE Arthur Lawrence Reingold

PRESENT POSITION:	Professor of Ep Division Head, School of Publi University of C 2121 Berkeley Berkeley, Calif Phone: (510) Fax: (510) E-mail: Reing	idemiology Epidemiolog c Health California, Be Way, #5302 Fornia 94720- 0 642-0327 0 643-5056 gold@berkel	gy erkeley -7360 ley.edu
DATE OF BIRTH:	October 31, 194	48	
PLACE OF BIRTH:	Chicago, Illinoi	is	
MARITAL STATUS:	Married		
EDUCATION:	1966 - 70 1970 - 76	A.B. M.D.	University of Chicago University of Chicago
Postgraduate Training:	1976 - 78	Internal Me Cambridge,	edicine Resident, Mount Auburn Hospital Massachusetts
	1980 - 82	Preventive Control (CI	Medicine Resident, Centers for Disease DC) - Atlanta, Georgia
POSITIONS HELD:	1979 - 80	Epidemic In State of Co Hartford, C	ntelligence Service Officer, nnecticut - Department of Health Services onnecticut
	1980 - 81	Epidemic In Special Path Centers for	ntelligence Service Officer, hogens Branch - Bacterial Diseases Division Disease Control (CDC) - Atlanta, Georgia
	1981 - 85	Assistant C Epidemiolo Centers for	hief, Respiratory & Special Pathogens ogy Branch, Center for Infectious Diseases Disease Control (CDC) - Atlanta, Georgia
	1985 - 87	CDC Liaiso Centers for	on Officer, Office of the Director Disease Control - Atlanta, Georgia
FACULTY APPOINTMENTS:	1979 - 80	Instructor, I University	Department of Medicine (Epidemiology) of Connecticut - Hartford, Connecticut
	1985 - 87	Visiting Le Environmen University	cturer, Department of Biomedical and ntal Health Sciences (Epidemiology) of California, Berkeley
	1987 -	Professor o University	f Epidemiology, School of Public Health, of California, Berkeley
	1989 - 2014	Professor, I Biostatistic	Department of Epidemiology and s - University of California, San Francisco

Faculty Appointments (Continued)	1990 - 94	Head, Epidemiology Program, Department of Biomedical and Environmental Health Sciences, University of California, Berkeley
	1991 -	Clinical Professor, Department of Medicine University of California, San Francisco
	1994 - 2000	Head, Division of Public Health Biology and Epidemiology University of California, Berkeley
	2008 - 2014	Associate Dean for Research, School of Public Health, University of California, Berkeley
	2009 - 2014	Edward Penhoet Distinguished Chair for Global Health and Infectious Disease
	2000 - 2018	Head, Division of Epidemiology, School of Public Health, University of California, Berkeley
	2018 - 2020	Head, Division of Epidemiology & Biostatistics, School of Public Health University of California, Berkeley
	2020 -	Head, Division of Epidemiology, School of Public Health, University of California, Berkeley

MEDICAL LICENSURE:		California	
BOARD CERTIFICATION:	1980	American Board of Internal Medicine	
AWARDS:	1970 - 74 1985 1986	Medical Scientist Training Program Commendation Medal, U.S. Public Health Service Charles Shepard Award, Centers for Disease Control (CDC)	
Memberships:	1970 1978 1983 1984 1986 1988 1991 1994 2003	Sigma Xi American College of Physicians American Society for Microbiology Society for Epidemiologic Research Infectious Disease Society of America (Fellow) American Epidemiological Society American College of Epidemiology (Fellow) AAAS (Fellow) Institute of Medicine, National Academy of Medicine (Member)	

PROFESSIONAL ACTIVITIES

SELECTED Consultations:	1981	Institute of Medicine: Toxic-shock syndrome
	1981	Food and Drug Administration: Toxic-shock syndrome
	1982	United States Agency for International Development: Control of meningococcal meningitis in West Africa

CONSULTATIONS (CONTINUED)	1983	World Health Organization (WHO): Control of meningococcal meningitis in Nepal
	1983	East-West Center, University of Hawaii: Role of indoor air pollution in acute respiratory infections in developing countries
	1984	Institute of Medicine: Meningococcal vaccines
	1986	World Health Organization (WHO): Control of meningococcal meningitis in South Asia
	1987 - 1993	Center for Child Survival, University of Indonesia: Control of Acute Respiratory Infections
	1988	Evaluation of the Combating Communicable Childhood Disease Program, Ivory Coast
	1994	Evaluation of National Epidemiology Board Program, Rockefeller Foundation
	1995	Planning of a School-based Acute Rheumatic Fever Prevention Project - New Zealand Heart Foundation
	1995	Vaccines Advisory Committee, Food & Drug Administration Approval of accellular pertussis vaccine
	1996	External Reviewer, NIAID Group B Streptococcus Research Contract with Harvard University
	1996 - 2000	U.S. Food and Drug Administration; Consultant to the Vaccines Advisory Committee
	1996	World Health Organization, Consultation on Control of Meningococcal Meningitis in Africa
	1998 - 2002	Advisor to the INCLEN "Indiaclen" project
	2002 - 2003	Evaluation of a School-based Acute Rheumatic Fever Prevention Project – New Zealand Heart Association
SELECTED ADVISORY		
BOARDS AND PANELS:	1988 - 1989	Member, Advisory Committee on Ground Water and Reproductive Outcomes, State of California Department of Health Services
	1989 - 1990	AIDS Advisory Committee, Alameda County Board of Supervisors
	1989 - 1993	Advisory Committee, Birth Defects Monitoring Program, State of California Department of Health Services
	1993 - 1995	Centers for Disease Control (CDC): Public Health Service Advisory Panel on the Case Definition for Lyme Disease
	1992 - 1994	World Health Organization (WHO): Task Force on Strengthening Epidemiologic Capacity; Childhood Vaccine Initiative

1996 - 2000 Armed Forces Epidemiological Board

ADVISORY BOARDS AND PANELS	1997 - 2012	University of California, San Francisco AIDS Research Institute Steering Committee
(CONTINUED)	1998 - 2003	Emerging Infections Committee of the Infectious Diseases Society of America
	1998 - 2000	Panelist, Howard Hughes Medical Institute Predoctoral Fellowship
	2001 - 2006	Technical expert, Sub-Committee on the Protection of Public Health; California
	2003 - 2008 Infectious Dis	Advisory Board, Chinese University of Hong Kong – Centre for Emerging AND eases
	2004 -	Advisory Board, University of California, Berkeley Clinical Research Center
	2004 - 2008	Advisory Board, New York University School of Medicine Fellowship in Medicine and Public Health Research
	2004 - 2005	Institute of Medicine Committee on Measures to Enhance the Effectiveness of CDC Quarantine Station Plan for U.S. Ports of Entry
	2005 - 2012	Strategic Advisory Group of Experts (SAGE) for Vaccine Policy, World Health Organization (WHO) (Deputy Chairman, 2010-2012)
	2005 -	Data and Safety Monitoring Committee; F.I. Proctor Foundation, University of California, San Francisco (UCSF)
	2007 - 2012	NIH Fogarty International Center External Advisory Board
	2007 - 2009	Chair, Working Group on Pneumococcal Vaccine, Strategic Advisory Group of Experts (SAGE), World Health Organization (WHO)
	2008 - 2012	Working Group on H5N1 Influenza Vaccines, Strategic Advisory Group of Experts (SAGE), World Health Organization (WHO)
	2008 - 2011	Chair, Leptospirosis Burden Epidemiology Reference Group, World Health Organization (WHO)
	2008 - 2012	National Biosurveillance Advisory Subcommittee of the Advisory Committee to The Director, Centers for Disease Control and Prevention (CDC)
	2008 - 2009	Institute of Medicine Committee on the Review of Priorities in the National Vaccine Plan
	2009 - 2012	Chair, Working Group on Hepatitis A Vaccine, Strategic Advisory Group of Experts (SAGE), World Health Organization (WHO)
	2011 - 2013	Member, Institute of Medicine Committee on Vaccine Priorities
	2011 - 2014	Member, Working Group on Vaccine Hesitancy, Strategic Advisory Group of Experts (SAGE), World Health Organization (WHO)
	2012 - 2014	Chair, Review of the Heterologous Effects of Childhood Vaccines, World Health Organization (WHO)
	2012 - 2014	Chair, External Review of the Measles Rubella Initiative (of WHO, CDC, UNICEF, American Red Cross, and United Nations Foundation)

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Arthur Lawrence Reingold

Advisory Boards And Panels (continued)	2013 - 2018	Advisory Committee on Immunization Practices (ACIP), U.S. Department of Health and Human Services
	2016 - 2017	Member, Institute of Medicine Committee on a National Strategy for the Elimination of Hepatitis B and C
	2018 - 2019	Member, Independent Review Committee, Global Alliance for Vaccines and Immunizations (GAVI)
	2018 -	Member, Strategic Advisory Group, Partnership for Influenza Vaccination Introduction
	2020	Member, Organizing Committee, National Academics of Science, Engineering, and Medicine (NASEM) Workshop on Airborne Transmission of SARS-CoV-2
	2020	Member, National Academies of Science, Engineering, and Medicine (NASEM) Committee on Equitable Allocation of Vaccines for the Novel Coronavirus
	2020 -	Chair, Western States Scientific Safety Review Workgroup on COVID-19 Vaccines

LEADERSHIP POSITIONS:

1997 - 2012	Secretary-Treasurer, American Epidemiological Society
2009 - 2010	President, Society for Epidemiologic Research
2015 - 2016	President, American Epidemiological Society (AES)

EDITORIAL BOARDS:

1995 - 2000	Board of Editors, American Journal of Epidemiology
2001 - 2005	Board of Editors, Epidemiology
2005 -	Editorial Advisory Board, Global Public Health
2009 - 2010	Editorial Advisory Board, American Journal of Epidemiology

ASSOCIATE EDITORSHIPS:

2018 - Vaccine

PUBLICATIONS:

- Hayes RV, Pottenger LA, Reingold AL, Getz GS, Wissler RW. Degradation of I¹²⁵ labeled serum low density lipoprotein in normal and estrogen-treated male rats. Biochem Biophys Res Comm 1971;44:1471-1477.
- 2. Reingold AL, Kane MA, Murphy BL, Checko P, Francis DP, Maynard JE. Transmission of hepatitis B by an oral surgeon. J Infect Dis 1982;145:262-268.
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- Broome CV, Hayes PS, Ajello GW, Feeley JC, Gibson RJ, Graves LM, Hancock GA, Anderson RJ, Highsmith AK, Mackel DC, Hargrett NT, Reingold AL. In-vitro studies of interactions between tampons and Staphylococcus aureus. Ann Intern Med 1982;96:959-962.
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- 9. Schlech WF III, Shands KN, Reingold AL, et al. Risk factors for development of toxic-shock syndrome: association with a tampon brand. JAMA 1982;248:835-839.
- 10. Reingold AL, Bank JD. Legionellosis. In: Easmon CSF, Jeljaszewicz J, eds. Medical Microbiology. London: Academic Press 1982 (I):217-239.
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- 55. Reingold AL, Hearst N. Identifying the health care needs of the community. In: Overall N, Williamson J, eds. Community Oriented Primary Care in Action: A Practice Manual for Primary Care Settings. U.S. Department of Health and Human Services.
- 56. Koo D, Bouvier B, Wesley M, Courtright P, Reingold AL. Epidemic keratoconjunctivitis in a university medical center ophthalmology clinic: need for re-evaluation of the design and disinfection of instruments. Inf Control and Hosp Epi 1989;10:547-552.
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- 86. Sudarti K, Harrison GG, Sutrisna B, Reingold AL. Acute respiratory infection in children under five years in Indramayu, West Java, Indonesia: a rapid ethnographic assessment. Medical Anthropology. 1994;15:1-10.
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Declaration of Tammatha Foss

I declare, under penalty of perjury and pursuant to 28 U.S.C. § 1746, as follows:

- 1. I am Tammatha Foss, Director, Corrections Services at California Correctional Health Care Services (CCHCS). I was appointed to that role, which involves coordinating between the Receivership and CDCR, in November 2020. Prior to November 2020, I worked at CDCR for twenty-four years in a variety of roles from corrections officer to acting warden. From 1996 to 2009, I held several positions at Pelican Bay State Prison, corrections officer, budget analyst, and Procurement Officer. After serving in administrative roles at San Quentin State Prison and CDCR Headquarters from 2009 to 2016, I was appointed chief deputy warden at High Desert State Prison, where I served from 2016 to 2018. From 2018 to 2019, I was acting warden at Salinas Valley State Prison. In 2019, I was appointed Associate Director of Female Offenders Programs and Services.
- 2. It is too soon to estimate reliably the number of employees who are covered by either the August 19 CDPH order or this Court's September 27 order that will fail to comply. Estimates of the likely staff resignations, retirements, and separations as a result of the vaccination mandate in the range of 4.5% to 10% are highly speculative. It is common for a significant number of staff members to be out of compliance initially with a new policy, and a 10% non-compliance rate at or before the deadline for compliance is not unusual. The rate of non-conformance with a policy before progressive discipline has begun is not a reliable indicator of how many employees will ultimately refuse to comply because the progressive discipline process is effective in encouraging compliance.
- 3. California Health Care Facility (CHCF), Stockton and California Medical Facility (CMF) are each covered in their entirety by the California Department of Public Health's August 19 order. On October 25, 2021, in response to an implementation delay caused by a temporary restraining order, CDCR granted staff in Bargaining Unit (BU) 6, correctional officers, an extension of until November 24, 2021 to establish proof of full vaccination. Letters of instruction for BU 6 members out of compliance with the policy will not be issued until November 29, 2021. Because the deadline for compliance has not yet been reached, the number of correctional officers at CHCF and CMF who are not yet fully vaccinated is a particularly poor predictor of how many correctional officers will ultimately choose to leave CDCR employment rather than become vaccinated.
- 4. Progressive discipline offers a range of responses to an employee's non-compliance with CDCR policy. As described more fully below, the process begins with non-punitive corrective action before escalating to an adverse action if non-compliance persists. Discipline is imposed on a case-by-case basis and may involve the imposition of less-serious measures initially before escalating to suspension or termination. While every case is handled individually, the progressive discipline process is usually lengthy, and an employee who declines to comply with a policy is unlikely to be excluded from the workplace, if at all, until at least three to four months (or more) after issuance of a letter of instruction informing the employee of the violation.

- 5. Initial corrective action options include verbal counseling, where the supervisor or manager meets with the employee to discuss the violation; and letters of instruction, in which the employee is informed in writing of the violation, what the employee must do to conform with CDCR policy, and the required timeframe for compliance. A supervisor may also require employees to undergo training. These are non-punitive initial steps that cannot result in removal from post or a loss of pay.
- 6. If an employee remains out of compliance after corrective action, the supervisor or manager institutes an adverse action. An investigation is then conducted and a report made to the hiring authority. The hiring authority then determines whether or not a violation has been proven, and if so, which disciplinary action is appropriate. The hiring authority may begin, as appropriate in the individual circumstances of the case, with lesser forms of discipline before progressing to more severe discipline if non-compliance persists. Additionally, the employee can appeal the hiring authority's decision to the State Personnel Board. These steps take many months.
- 7. There are five possible adverse actions: a letter of reprimand; salary reduction up to the minimum salary of the employee's class; suspension without pay; demotion to a lower class; or dismissal from state service. Salary reduction is typically used in place of a suspension where an employee's continued service on the job is necessary. Dismissal may be preceded by other forms of adverse action.
- 8. The progressive discipline process is highly effective in ensuring employee compliance with CDCR policy. In the progressive discipline process it is common to see some employees stay out of compliance right up to the point at which they would be fired, but then comply to retain their employment. It is likely that some correctional officers will choose to go through the progressive discipline process to see what the career consequences would be before deciding ultimately to become vaccinated.
- 9. A career as a correctional officer is highly valued by employees and by many applicants. In many communities it is among the most desirable jobs available, providing a good salary and benefits, job stability, and the opportunity for advancement with increased seniority. In some communities, there is a shortage of alternative employers, making a CDCR career particularly valuable.
- 10. A reduction in program modifications caused by COVID-19 outbreaks will also mitigate the impact of any program modifications caused by staff shortages. Currently 26 facilities are in Phase 1 or Phase 2 of reopening, operating under modified programming due to a current or recent COVID-19 outbreak.
- 11. CDCR has contingency plans for significant staff shortages. Healthcare is the top programming priority. Accordingly, contingency plans call for limiting non-essential programming as necessary to maintain security and prioritize healthcare. Throughout the pandemic, and before, these plans have been effective at ensuring medical care can be provided even in the event of staff shortages. Operations under program modifications during the pandemic demonstrate that prisons can be run with modified programming safely for both incarcerated persons and staff. While violence is always a possibility,

during widespread program modifications throughout the pandemic, violence did not increase.

- 12. Turnover of 5% of correctional officer positions would be an ordinary annual rate of attrition. Assuming a loss of 5% of correctional officers in a year, modified programming would typically be necessary only in institutions with pre-existing high rates of vacancy. Ten institutions are currently operating with a correctional officer vacancy rate of ten percent or higher. This level of vacancy requires program modifications to maintain a safe environment and support essential programs and services such as health care services. Even in the absence of a vaccine mandate, programming would be similarly modified at these institutions. As such, any impact on programming from a loss of approximately 5% of correctional officers would be primarily attributable to pre-existing staff vacancies, not to a vaccine mandate.
- 13. As a result of these pre-existing vacancies, High Desert State Prison (HDSP), Facility B, will be temporarily de-activated in order to concentrate staff in the remainder of the institution. Historically HDSP has been difficult to staff. In the past, as CDCR has sent cadets to HDSP to decrease the vacancy rate, a similar number of officers have transferred out of the institution. The recent difficulty in maintaining high staffing levels at HDSP may have been amplified by the announced closure of California Correctional Center (CCC), located next door to High Desert State Prison. In April 2021, CDCR announced a plan to close CCC and transfer CCC staff to HDSP. As a result, CDCR temporarily stopped sending academy graduates to HDSP. CDCR has now resumed sending academy graduates to HDSP. A final likely factor in recent staffing shortages at HDSP has been the inability to offer permanent positions at the institution for some job classifications.
- 14. Over the past two years, COVID-19 restrictions have required smaller classes at CDCR's twelve-week-long academy program for new correctional officers. Public health orders are now less restrictive, and academy class sizes have been increased from 140 to 250 cadets. While only 461 cadets have graduated so far in the 2021-22 fiscal year, CDCR currently projects that more than 900 cadets will graduate this fiscal year. CDCR has increased recruitment and is still expediting candidates who want to staff the hard to fill prisons. CDCR just recently started overlapping academies again in September, increasing the number of cadets at one time from 220 to 440.
- 15. More could be done to bring in larger class sizes. CDCR could increase its applicant pool by offering bonuses. CDCR could also run additional academies, as it has in the past, to hire more correctional officers, utilizing alternate satellite academy sites or institutions to run local academies. For example, California City Correctional Facility and Salinas Valley State Prison each operated institution-based academies at their institutions. Holding academies or hiring events in hard to fill areas could increase the interest in joining the CDCR team.

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Tammatha Foss