

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

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

Attorneys for Plaintiffs

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

Attorneys for Defendants

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA, OAKLAND DIVISION

MARCIANO PLATA, et al.,

Plaintiffs,

v.

GAVIN NEWSOM, et al.,

Defendants.

CASE NO. 01-1351 JST

JOINT BRIEF ON QUARANTINE

Judge: Hon. Jon S. Tigar
Date: December 23, 2020
Time: 10:00 a.m.
Crtrm.: 6, 2nd Floor

Pursuant to the Scheduling Order of November 20, 2020, ECF No. 3493, the parties hereby submit their joint brief.

AREAS OF EXPERT AGREEMENT

The parties and their experts agree to the following:

From an infection control perspective, the ideal space for quarantine of a potentially exposed patient is in a single cell behind a solid door.

Precautionary quarantine, not following exposure, may be done in cohorts in shared air spaces.

People are considered far less susceptible to being re-infected with COVID-19 in the three months after they contract and recover from it. CDCR and CCHCS should take this into consideration in their efforts to safely house people.

AREAS OF EXPERT DISAGREEMENT

The parties' experts disagree on to what extent, if at all, it is acceptable under public health guidance to quarantine cohorts in shared air spaces. In this section, the parties will directly and succinctly state their positions on this area of dispute. In the sections that follow, each party will outline its overall position regarding Plaintiffs' request for Court intervention.

Plaintiffs' position:

According to Plaintiffs' expert Dr. Adam Luring, "it is not safe to quarantine people in dormitories or celled housing with open bars or porous doors." Declaration of Adam Luring, filed herewith, ¶ 6. This opinion is shared by AMEND and the Berkeley School of Public Health authors of the evaluation of the outbreak at California Men's Colony, who opine that "[n]o one in a dormitory environment can quarantine properly." Luring Decl., Exh C at 37.

The Centers for Disease Control and Prevention (CDC) confirms that "[c]ohorting multiple quarantined close contacts could transmit SARS-CoV-2 from those who are infected to those who are uninfected" and concludes that "cohorting individuals with suspected COVID-19 is not recommended due to high risk of transmission from infected

1 to uninfected individuals.” Interim Guidance on Management of Coronavirus Disease
 2 2019 (COVID-19) in Correctional and Detention Facilities, posting date October 7, 2020,
 3 [https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-](https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html)
 4 [correctional-detention.html](https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html) (last visited December 9). However, the CDC factors in
 5 feasibility in some correctional settings, and directs that “[c]ohorting should only be
 6 practiced if there are no other available options” and corrections officials must “**make**
 7 **every possible effort to individually quarantine close contacts of individuals with**
 8 **confirmed or suspected COVID-19.**” *Id.* (emphasis in original).

9 The Receiver, while recognizing the risk of transmission from quarantining cohorts
 10 in shared air space and the necessity for significantly limiting that risk, has determined that
 11 double-celling in solid-door cells is also acceptable. His position is that “post-exposure
 12 quarantine in shared airspace housing more than 2 persons fails to adequately achieve the
 13 intended goals of a COVID-19 post-exposure quarantine to facilitate the prompt
 14 identification of new cases and to help limit the spread of COVID-19 to new, uninfected
 15 people.” Declaration of Rana Anabtawi in Support of Plaintiffs’ Position, filed herewith,
 16 Exh. A (Receiver’s Statement on Quarantine, December 4, 2020). He has therefore
 17 directed that quarantine for exposed people will no longer be allowed in cohorts of more
 18 than two people (in other words, double-celling), and directing that “[a]ll efforts should be
 19 made” at those prisons with relatively few cells “to find quarantine alternatives that satisfy
 20 the purposes of a post-exposure quarantine” that would “help limit the spread of COVID-
 21 19 to new, uninfected people.” *Id.*

22 Plaintiffs, having carefully considered the Receiver’s and CDC’s guidance, have
 23 agreed to a compromise of our initial position that quarantining must take place in single
 24 cells with solid doors. We are willing to accept double celling (cohorts of two) in solid-
 25 door cells in order to further the aim of keeping as many people as possible as safe as
 26 possible. Our position is therefore that only single- or double-celling in solid-door cells is
 27 acceptable housing for exposure quarantine, and that CDCR can achieve that end by
 28 making “every possible effort” to do so.

1 *Defendants' position:*

2 **1. The Purpose of Public Health Guidance is to Achieve the Safest**
 3 **Possible Conditions in the Context of What is Available.**

4 Dr. Luring opines that quarantine in anything other than a single cell with a solid
 5 door is not possible: “use of living units with common air space to quarantine people with
 6 known exposure to the virus is effectively not quarantine at all.” Decl. Luring at ¶ 13.
 7 He further believes that “there are no mitigating steps that would reduce the risk of placing
 8 people in these common air living units for quarantine purposes, so that it would more
 9 closely approximate the risk of quarantine in living units with solid-door cells.” *Id.* at ¶
 10 14.

11 Defendants' expert disagrees with Dr. Luring's opinions. Risk mitigation is a
 12 cornerstone of public health. Decl. Spaulding ¶ 18. The purpose of public health guidance
 13 is to provide strategies for preventing the spread of COVID-19 and the harm it can cause,
 14 taking into consideration the unique needs of different populations. *Id.* at ¶ 8. The CDC
 15 recognizes this and provides separate sets of guidelines for populations like correctional
 16 systems, whose needs and circumstances vary from those of the general public. From a
 17 public health perspective, Dr. Luring's opinion that quarantining a cohort of incarcerated
 18 people in an open-air space is like not quarantining at all is absurd. Quarantining such a
 19 cohort prevents them from potentially exposing all other areas and housing units of the
 20 prison to the virus. *Id.* ¶ 19.

21 Dr. Luring does not cite or discuss the Centers for Disease Controls (CDC)
 22 guidelines—the preeminent national source of public health guidance—including
 23 guidelines that are specifically applicable to correctional facilities, at all, except to say that
 24 the CDC acknowledges that COVID-19 is transmitted through aerosolized droplets. *Id.* at
 25 ¶ 18. Instead, he cites to reports prepared in response to specific situations in CDCR
 26 institutions, and a study conducted in Connecticut jails and prisons that does not discuss
 27 whether any efforts to reduce the spread of infection were in effect at the time of the study,
 28 or the degree to which the surge examined occurred in jails versus prisons. *Id.* at 5; Decl.

1 Spaulding ¶ 17.

2 Dr. Spaulding’s opinions are grounded in the CDC guidelines for correctional and
 3 detention facilities, which state “cohorting individuals with suspected COVID-19 is not
 4 recommended due to high risk of transmission from infected to uninfected individuals.”¹
 5 The CDC immediately follows this statement with a reference to guidelines for quarantine
 6 in correctional settings “for specific details about ways to implement cohorting as a *harm*
 7 *reduction strategy* to minimize the risk of disease spread and adverse health outcomes.”²
 8 (Emphasis added.) The guidelines further state that “guidance may need to be adapted
 9 based on individual facilities’ physical space, staffing, population, operations, and other
 10 resources and conditions.”³ Thus, as the CDC acknowledges, the best possible option is
 11 not always available, so “it is critical for public health experts to identify other, next-best
 12 strategies to mitigate the risk of infection. Decl. Spaulding ¶ 18. Dr. Luring ignores this
 13 reality.

14 The purpose of public health guidance is to achieve the safest possible conditions in
 15 the context of what is available, not an unachievable ideal. Decl. Spaulding at ¶ 48. To
 16 allow institutions to identify appropriate areas for quarantine, the CDC provides a list of
 17 options available for quarantining patients in correctional settings in order of preference,
 18 stating “[i]f the ideal choice does not exist in a facility, use the next best alternative as a
 19 harm reduction approach.”⁴ If single cells with solid doors are not available, the CDC
 20

21
 22 ¹ Centers for Disease Control and Prevention, *Guidance for Correctional and Detention*
 23 *Facilities*, [https://www.cdc.gov/coronavirus/2019-ncov/community/correction-](https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html)
[detention/guidance-correctional-](https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html)
[detention.html](https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html) (Updated Dec. 3, 2020).

24 ² *Id.*

25 ³ Centers for Disease Control and Prevention, *Coronavirus Disease: Guidance for*
 26 *Correctional and Detention Facilities*, [https://www.cdc.gov/coronavirus/2019-](https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html#QuarantineCloseContacts)
[ncov/community/correction-detention/guidance-correctional-](https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html#QuarantineCloseContacts)
[detention.html#QuarantineCloseContacts](https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html#QuarantineCloseContacts) (Updated Dec. 3, 2020).

27 ⁴ *Id.*

1 guidelines recommend options ranging from quarantining separately in single cells without
 2 solid doors to quarantining in various group settings with at least six feet of space around
 3 each individual.⁵ The CDC guidelines propose an option of quarantining an entire housing
 4 unit in place if the entire unit has been exposed and other better options are not available.⁶
 5 As indicated by the order of preference, quarantining people in small cohorts is more ideal
 6 than in large groups. Decl. Spaulding at ¶ 20.

7 Per the CDC guidelines, it is appropriate for correctional systems in general to
 8 consider and implement the safest quarantine options available and feasible in a particular
 9 setting. *Id.* And while post-exposure quarantine in cohorts is not ideal from an infection
 10 control standpoint, quarantining in small groups is less of a risk to those in quarantine than
 11 quarantining in large groups. *Id.* When people must be quarantined in cohorts in shared
 12 air spaces because single cells with solid doors are not available, institutions can make
 13 them safer by implementing a multipronged application of evidence-based strategies to
 14 reduce harm, like those outlined in a Morbidity and Mortality Weekly Report of the CDC
 15 published on December 4, 2020. *Id.* at ¶ 24. The report concludes that a multipronged
 16 approach to implementing all evidence-based strategies to reduce COVID-19 transmission
 17 is essential.⁷ *Id.*

18
 19 ⁵ In order of preference, recommendations for quarantine space include (1) single cells
 20 with solid walls and doors; (2) single cells with solid walls but without solid doors; (3) a
 21 cohort in a large, well-ventilated cell with solid walls, a solid door that closes fully, and at
 22 least six feet of space around each person; (4) same as (3), but without a solid door; (5) a
 23 cohort in single cells without solid walls or doors, preferably with an empty cell between
 24 occupied cells to create at least six feet of space between people; (6) a cohort in multi-
 25 person cells without solid walls or solid doors, preferably with an empty cell between
 26 occupied cell and at least six feet of space between each person; (7) a cohort in the
 27 individuals' regularly assigned housing unit but with no movement outside the unit and at
 28 least six feet of space between people; (8) quarantining an entire housing unit that has been
 exposed in place; and (9) safely transfer to another institution with capacity to quarantine
 in one of the previous arrangements. *Id.*

⁶ *Id.*

⁷ Margaret A. Honein, et al., *Summary of Guidance for Public Health Strategies to Address*

1 The strategies include universal face mask use; maintaining physical distance and
 2 limiting in-person contacts; avoiding nonessential indoor spaces and crowded outdoor
 3 spaces; increasing testing to rapidly identify and isolate positive cases; promptly
 4 identifying, quarantining, and testing close contacts of persons with known COVID-19;
 5 safeguarding people with a higher risk of comorbidity or mortality from COVID-19;
 6 providing essential workers with personal protective equipment and safe work practices;
 7 postponing travel; increasing indoor air ventilation; enhancing hand hygiene and
 8 environmental disinfection; and achieving widespread availability of effective COVID-19
 9 vaccines.⁸

10 Dr. Spaulding disagrees with Dr. Lauring’s position that quarantining in anything
 11 short of a single cell with a solid door cannot be done safely, and opines that “institutions
 12 can implement multiple evidence-based strategies to reduce potential harm.” Decl.
 13 Spaulding ¶¶ 7, 24. Dr. Lauring makes no mention of these critical harm-reduction
 14 strategies.

15 Dr. Lauring states, “[n]o one in a dormitory environment can quarantine properly’.
 16 . . . This is not a contested opinion; all experts I’ve read or spoken with have come to the
 17 same conclusion[.]” Decl. Lauring ¶¶ 6-7 & Ex. C at 37. But Dr. Lauring does not define
 18 “properly” or cite to the expert opinions he relies on. This statement is ambiguous. To the
 19 extent it means that post-exposure quarantine in prisons is not possible, or that the risk in
 20 those settings cannot be mitigated, Dr. Spaulding disagrees. Decl. Spaulding ¶ 7.

21 2. Susceptibility to COVID-19.

22 Dr. Lauring opines that “[i]f you quarantine [exposed people] together in shared air
 23 space, the risk level for all rises to the highest risk level among them; everyone will be at
 24 the same risk as the person who was most exposed.” Decl. Lauring at ¶ 11. But as

26 *High Levels of Community Transmission of SARS-CoV-2 and Related Deaths*, vol. 69,
 27 Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report 1
 28 (Dec. 4, 2020), <https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6949e2-H.pdf>.

⁸ *Id.*

Defendants’ expert, Dr. Spaulding, observes, aside from proximity to and duration of exposure, the factors affecting the risk of acquisition of infection—as opposed to risk of dire outcomes—have not been elucidated. Decl. Spaulding ¶ 22. Moreover, as discussed above, Defendants’ expert opines that multipronged evidence-based strategies can be used to reduce harm when two or more people must share airspace during quarantine. *Id.* at ¶¶ 24, 48.

Plaintiffs state in their motion that they “amended [their] position to incorporate double-celling for exposure quarantine, in recognition of the reasonableness of the Receiver’s approach” in the Receiver’s December 4, 2020 Statement on Quarantine. But because this means quarantining two people in a shared-airspace in prisons, Plaintiffs’ position does not appear to be consistent with Dr. Lauring’s.

3. Household Versus Correctional Setting.

Dr. Lauring suggests that quarantine in shared-air living spaces is acceptable in a household, where “there are no other options but to continue to interact with them even in quarantine.” Decl. Lauring ¶ 15. Dr. Lauring states that people in households “have the option to try to separate internally, to use separate rooms and airspaces, keep windows open, and take other measures to reduce interaction and common airspace.” *Id.* According to Dr. Lauring, “People in prison have no such options.” *Id.*

Dr. Lauring makes a false distinction between homes and prisons. First, the statement that people have no choice but to interact in household is also true of prisons. And in the same way that households can decrease the risk of spreading infection at home, prisons can decrease the risk of spreading infection by socially distancing individuals in the shared airspace by moving beds farther apart, providing personal protective equipment, and encouraging minimal interaction. In other words, use a multipronged evidence-based approach to reducing harm. Decl. Spaulding ¶ 24. Dr. Spaulding disagrees with Dr. Lauring’s statement that “[p]eople in prisons have no such options.”

Dr. Lauring states that “[i]t would be possible to reduce the enhanced risk of quarantining in such settings by reducing the number of people who are housed in the

1 shared airspace.” Decl. Lauring ¶ 15. Dr. Spaulding agrees with this statement, assuming
 2 it extends to the prison setting. Decl. Spaulding at ¶ 24.

3 **4. When Shared Airspaces Can Be Used for Quarantine.**

4 Dr. Lauring states that the use of shared-air living spaces could be explored “only
 5 for people who have already had COVID-19.” Decl. Lauring ¶ 19. Defendants’ expert,
 6 Dr. Spaulding, opines that quarantining in shared-air living spaces—when better options
 7 are not available—is a strategy that can mitigate harm for all incarcerated people, not just
 8 people who have had COVID-19. Decl. Spaulding ¶¶ 19-21. CDC guidance for
 9 correctional facilities supports Dr. Spaulding’s opinion, and recommends various options
 10 for use of shared air living spaces for quarantine where single cells with solid doors are
 11 unavailable. (*See* fn. 5.)

12 **PLAINTIFFS’ POSITION**

13 **I. Introduction**

14 California prisons have endured multiple alarming outbreaks of COVID-19 over the
 15 last nine months. More than 90 people have died and nearly 700 have been hospitalized,
 16 many of whom are likely to have serious long-term health consequences. While a vaccine
 17 is on the horizon, the danger has never been greater, with case counts surging in California
 18 and around the country and at the highest levels yet seen in CDCR.

19 Tragically, one of the most critical tools to stem outbreaks – quarantining people
 20 who have been exposed to the virus – has been employed inadequately and inappropriately
 21 in California prisons. Defendants routinely place people with known exposure to COVID-
 22 19 on quarantine status in housing units that have shared air space, such as dormitories or
 23 cells with barred or porous doors. This practice occurs both in the Court-ordered set-aside
 24 space for quarantine, which in some prisons includes shared air locations, and also in
 25 housing units that are “quarantined in place,” where Defendants choose to quarantine an
 26 entire shared-air-space living unit without moving the residents. Dormitories and housing
 27 units with porous-door cells are essentially incubators of infection; the use of such space
 28

1 for quarantine places the residents at substantially higher risk of contracting COVID-19
 2 than if they were housed in solid-door cells. CDCR's failure to take steps to avoid and
 3 prevent such placements thus constitutes deliberate indifference to the health care needs of
 4 its patients, particularly when solid-door celled housing is available at the same prison.
 5 Unless CDCR is required to expand the quarantine set-aside space at individual prisons to
 6 include adequate numbers of solid-door cells, its quarantine practices will continue to
 7 violate the Eighth Amendment.

8 Since commencement of briefing in this matter, the Receiver has issued clear
 9 direction that "post-exposure quarantine in shared airspace housing more than 2 persons
 10 fails to adequately achieve the intended goals of a COVID-19 post-exposure quarantine to
 11 facilitate the prompt identification of new cases and to help limit the spread of COVID-19
 12 to new, uninfected people." Declaration of Rana Anabtawi in Support of Plaintiffs'
 13 Position, filed herewith, Exh. A (Receiver's Statement on Quarantine, December 4, 2020).
 14 Accordingly, he directed that quarantine for exposed people will no longer be allowed in
 15 cohorts of more than two people (in other words, double-celling), and directing that "[a]ll
 16 efforts should be made" at those prisons with relatively few cells "to find quarantine
 17 alternatives that satisfy the purposes of a post-exposure quarantine" that would "help limit
 18 the spread of COVID-19 to new, uninfected people." *Id.*

19 In response to this direction, Plaintiffs have amended our position to incorporate
 20 double-celling for exposure quarantine, in recognition of the reasonableness of the
 21 Receiver's approach.⁹ Defendants have not yet indicated how the Receiver's statement
 22 impacts their position. The parties will continue to discuss and attempt to find common
 23 ground in the two weeks remaining before the hearing in this matter.

24 Plaintiffs seek Court intervention on an additional concern: Defendants have not

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 26
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 28
⁹ Cellmates are likely to have spent several days in close proximity to one another prior to the discovery of the exposure to an infected person, given the unavoidable lag in test results and contact tracing. Their risk is thus closer to equivalent by the time the exposure is discovered.

1 adjusted quarantine reserves at individual prisons to provide additional space to separate
 2 newly arrived residents from the rest of the population (precautionary quarantine). This
 3 failure violates the Receiver's clear direction. Unless CDCR is required to set aside space
 4 for such quarantine, the growing population in the system and the large number of inter-
 5 prison transfers will inevitably lead to crowding and encroach on the space already set
 6 aside at the direction of the Court to combat outbreaks. By failing to follow the Receiver's
 7 instructions, Defendants impermissibly endanger the *Plata* plaintiff class.

8 Plaintiffs seek an order requiring Defendants to follow the Receiver's directive to
 9 use only solid-door single or double cells for quarantine and to follow the Receiver's
 10 directive to set aside space for precautionary quarantine. The space designated at each
 11 prison for quarantine and isolation must be adjusted accordingly, and Defendants must
 12 urgently find alternate solutions at those prisons with very few or no cells currently
 13 available.

14 **II. Procedural background**

15 On July 22, 2020, following a series of disastrous and deadly outbreaks in the
 16 prisons, the Court ordered CDCR to set aside at least 100 quarantine and isolation beds at
 17 each prison and then to

18 assess whether additional space is required at the institution for isolation
 19 and quarantine purposes and, if so, whether that space will be obtained by
 20 vacating additional housing units or through other means. The Receiver
 21 and the parties' health experts, as well as institution leadership, shall be
 22 included in these discussions. Assessments shall be guided by health
 considerations, without regard to whether sufficient space can be reserved
 at the institution without a further reduction in population.

23 Order to Set Aside Isolation and Quarantine Space, July 22, 2020, ECF No. 3401 at 4.
 24 Following this order, the Receiver convened a Public Health Workgroup to provide
 25 guidance regarding the number of beds to set aside at each prison. The Workgroup
 26 accepted the Receiver's proposal to set aside a number equivalent to the populations in the
 27 two largest congregate living spaces of each prison, because those are the likeliest settings
 28 for the quick spread of the virus. Declaration of Adam Luring, M.D., in Support of

1 Plaintiffs’ Position on Quarantine in Housing Units with Shared Air Space, filed herewith,
 2 Exh. D (Order to Set Aside Isolation and Quarantine Space: Public Health Workgroup
 3 Recommendations, August 17, 2020) at 2. The Workgroup did not require CDCR to
 4 designate which set-aside beds would be used for quarantine and which for isolation, but
 5 noted that most would be used for quarantine, which “should be configured as equivalent
 6 to *single cells with solid doors*.” *Id.* at 1, 2 (emphasis in original).

7 The Workgroup did allow for “minimal exceptions” to the single-cell solid-door
 8 rule: San Quentin and Folsom State Prisons, which have enormous congregate living areas,
 9 and the California Rehabilitation Center (CRC), which has no cells. *Id.* at 1, 3. These
 10 prisons required “unique solutions.” *Id.*

11 The Workgroup noted that “if the [quarantine] space is single cells with solid doors
 12 and all public health measures are enforced along with the de-densification that has already
 13 occurred, the proposed space plan, though imperfect, is a reasoned and supportable
 14 approach that protects residents and staff.” *Id.* at 2.

15 After the Workgroup issued its guidance, the parties and the Receiver met to discuss
 16 the set-asides for each prison, along with representatives from the *Coleman* Special
 17 Master, the *Armstrong* Court Expert, and counsel for those cases. Plaintiffs raised multiple
 18 concerns and objections. Following the discussions, CDCR established and vacated its
 19 chosen set-aside space at each prison, pursuant to the Court’s order. Some of Plaintiffs’
 20 objections remained, including the inadequacy of quarantine space.

21 The July 22 Order required the Receiver to “continually monitor whether isolation
 22 and quarantine space reserves are appropriate in light of changing circumstances” and
 23 allowed either party to request modifications. ECF No. 3401 at 4. If the parties are unable
 24 to reach agreement, they may present the dispute in a joint brief to the Court. *Id.* Plaintiffs
 25 formally registered objections on September 16 (used of shared air space for quarantine)
 26 and October 27 (failure to set aside space for precautionary quarantine). Anabtawi Decl.,
 27 Exhs. B and C.

28 Since sending formal objections on September 16, Plaintiffs have continued to raise

1 concerns about Defendants' use of quarantine space. For example, during a call with
 2 CCHCS and Defendants on October 2, 2020, Plaintiffs asked CCHCS executives about the
 3 use of set-aside space at the California Institution for Men (CIM), which was experiencing
 4 an outbreak. Anabtawi Decl. ¶ 5. Despite having a significant number of vacant cells,
 5 CIM continued to house quarantined patients in congregate living spaces. *Id.* During that
 6 call, a CCHCS executive noted Plaintiffs' persistent line of questioning over whether
 7 institutions use available single cells for quarantine purposes, and noted that that area
 8 would be explored in subsequent weeks. *Id.* On October 9, 2020, during a call with
 9 CCHCS and Defendants, Plaintiffs asked why 38 patients housed in a dorm on quarantine
 10 status at the Correctional Training Facility (CTF) were not moved to available cells in the
 11 designated set-aside space. *Id.* ¶ 6. On October 16, 2020, during a call with CCHCS and
 12 Defendants, Plaintiffs asked why patients at the California Men's Colony (CMC) and the
 13 California Correctional Institution (CCI) were quarantined in dorms despite a significant
 14 number of vacant cells in the designated set-aside spaces at both prisons. *Id.* ¶ 7.

15 Plaintiffs have also raised these concerns in Court filings, noting questions about
 16 the current outbreak at the Substance Abuse and Treatment Facility at
 17 Corcoran, why some people are being quarantined in dorms, in units that
 18 have not been designated for quarantine, rather than the designated celled
 unit, and whether they will be moved to cells.

19 Corrected Joint Case Management Conference Statement, Sept. 16, 2020, ECF No. 3449 at
 20 20. Similarly, we informed Defendants and the Court that

21 at CIM, nearly 50 people who medical staff determined had been exposed
 22 to COVID-19 were quarantined together in a gym, even though single cells
 23 with solid doors—which CCHCS mandates be used if available—were
 available. . . . Subsequently, a number of people in the gym tested positive.

24 Joint Case Management Conference Statement, Oct. 20, 2020, ECF No. 3469 at 17-18.

25 Defendants never commented on these concerns and gave no indication that they
 26 would provide any additional quarantine space as a result until December 4, Anabtawi
 27 Decl. ¶ 8, after Plaintiffs had already provided a draft expert declaration, proposed order,
 28 and brief in the matter and five days before the parties' joint brief was due.

Also on December 4, the Receiver issued a new policy regarding quarantine, stating that “post-exposure quarantine in shared airspace housing more than 2 persons fails to adequately achieve the intended goals of a COVID-19 post-exposure quarantine to facilitate the prompt identification of new cases and to help limit the spread of COVID-19 to new, uninfected people. The first choice for post-exposure quarantine housing should be solid-door cells occupied by only one person. Quarantine cohorting as defined in the Interim Guidance is to be used with no more than 2 persons per shared airspace housing.” Anabtawi Decl., Exh. A. The Receiver further noted that there are five prisons -- Avenal State Prison, California Rehabilitation Center, Chuckawalla Valley State Prison, Folsom State Prison, and San Quentin State Prison -- where “the available facilities are insufficient” to comply with these standards. *Id.* He directed that “[a]ll efforts should be made” at those prisons “to find quarantine alternatives that satisfy the purposes of a post-exposure quarantine as set forth above.” *Id.*

III. Quarantine of people with known exposure in living units with shared air space constitutes deliberate indifference

A. Prison officials have an affirmative duty to protect residents from known harm from infectious disease

“A prison official’s ‘deliberate indifference’ to a substantial risk of serious harm to an inmate violates the Eighth Amendment.” *Farmer v. Brennan*, 511 U.S. 825, 828 (1994) (citation omitted); *see Parsons v. Ryan*, 754 F.3d 657, 677 (9th Cir. 2014). Failure to prevent the spread of a contagious illness constitutes deliberate indifference to a serious medical need. *Helling v. McKinney*, 509 U.S. 25, 33 (1993) (officials may not be “deliberately indifferent to the exposure of inmates to a serious, communicable disease”); *Hutto v. Finney*, 437 U.S. 678, 682 (1978) (housing incarcerated people where infectious diseases could spread easily violates 8th Amendment); *Gates v. Collier*, 501 F.2d 1291, 1300, 1303 (5th Cir. 1974) (plaintiffs entitled to relief where state allowed “inmates with serious contagious diseases . . . to mingle with the general prison population”).

The State must also take action to prevent harm: the Three-Judge Court in this

1 matter recognized that “the Eighth Amendment requires Defendants to take adequate steps
 2 to curb the spread of disease within the prison system.” Order Denying Plaintiffs’
 3 Emergency Motion to Modify Population Reduction Order, April 4, 2020, ECF No. 3261
 4 at 8; *see Jolly v. Coughlin*, 76 F.3d 468, 477 (2d Cir. 1996) (“correctional officials have an
 5 affirmative obligation to protect inmates from infectious disease”). In particular, prison
 6 officials must implement reasonable measures to ensure that people in their custody are
 7 safely housed and are not unnecessarily exposed to infectious diseases. When they fail to
 8 do so, courts will intervene to ensure appropriate housing. *See, e.g., Hutto*, 437 U.S. at
 9 682-87 (affirming limits on placements in crowded punitive segregation); *Gates*, 501 F.2d
 10 at 1300, 1303 (plaintiffs entitled to relief where state allowed “inmates with serious
 11 contagious diseases . . . to mingle with the general prison population”); *Hernandez v. Cty.*
 12 *of Monterey*, 110 F. Supp. 3d 929, 944 & n.88, 959 (N.D. Cal. 2015) (granting preliminary
 13 injunction requiring plan to address prevention and control of tuberculosis, including
 14 placement in medical isolation).

15 **B. It is impossible to effectively quarantine people exposed to COVID-19 in**
 16 **shared air living spaces**

17 The purpose of quarantine is to prevent the exposed person who may be infected
 18 from transmitting the virus to others. *See* Lauring Decl. ¶ 11. That cannot be done in a
 19 dormitory or cells without solid doors, where everyone shares the same air. As Dr.
 20 Lauring explains, “transmission through the air is one of the primary means by which
 21 people contract COVID-19. . . . The shared air in dormitories or cells with barred or porous
 22 doors allows for ready transmission of the virus.” *Id.* ¶ 8; *see also id.*, Exh. A at 7
 23 (Receiver’s Report on Transferring COVID-19 High-Risk Patients to Safer Housing)
 24 (“Dorms and open-cell-front housing are more dangerous than closed-door cells because,
 25 as very recently confirmed by the CDC, transmission of COVID-19 occurs both through
 26 droplets and through aerosolization”).

27 CDCR’s own experience with outbreaks demonstrates that the virus spreads rapidly
 28 among residents in dorms and shared air living spaces. According to the Receiver,

1 “[e]ighty-one percent (81%) of the 69 deaths [of CDCR residents] acquired COVID-19
 2 while living in a dorm or open-cell-front housing unit.”¹⁰ Luring Decl., Exh. A at 6. The
 3 Receiver also found that “the six largest outbreaks in CDCR institutions – outbreaks
 4 resulting in more than 1,000 confirmed COVID-19 patients – have all been in institutions
 5 that predominately house patients in common airspace, dorm and open-cell-front housing
 6 units.”¹¹ *Id.* One example illustrates the widespread problem: Dorm 106 at CRC was
 7 placed on quarantine on June 24, 2020, and remained on quarantine until September 23,
 8 2020, due to frequent new infections among those who resided in the unit. Anabtawi
 9 Decl., Exh. D at 1. Each time a patient tested positive, the clock for the unit’s 14-day
 10 quarantine was reset. *Id.* at 1-2. Ultimately, the virus spread throughout the dorm and, at
 11 the end of the quarantine three months later, 65 of 69 patients who resided in that unit had
 12 been infected with COVID-19. *Id.* at 1-2.¹²

13 Other experts reviewing COVID-19 outbreaks in jails and prisons have reached the
 14

15 ¹⁰ Plaintiffs’ review of the information available to us suggests that this percentage has not
 16 substantially changed in the weeks since this report: of the subsequent 24 deaths, 15 people
 17 were housed in dorms when infected, eight in solid-door cells, and one unknown.

18 ¹¹ Since the Receiver’s report was issued, a massive outbreak of more than 2,600 cases at
 19 the Substance Abuse Treatment Facility and State Prison at Corcoran (SATF), in both
 20 dorms and solid-door celled housing, has become the second largest in the system to date.

21 ¹² Perplexingly, Defendants use CRC as an example of their ability to effectively manage
 22 an outbreak. A more complete picture is that CRC experienced a lengthy and significant
 23 outbreak that developed over six months, resulting in far more than half of its population
 24 infected with COVID-19. Anabtawi Decl. ¶ 9. CRC has a population of approximately
 25 2100 patients and has had over 1600 active cases. *Id.* CRC has been fortunate to have
 26 experienced no COVID-19 related deaths, but this good fortune can likely be attributed to
 27 the very low medically high risk population housed within the facility, rather than the
 28 management of the outbreak. *Id.* ¶ 10. Based on recent data, only 102 of the over 2200
 patients residing at CRC had a COVID-weighted risk score of over 4. *Id.* These are
 among the patients who were offered tented housing in an attempt to limit their exposure
 to COVID in a large dorm setting, but such offers did not begin until mid to late October
 2020, months after the virus had already run rampant throughout the facility and infected
 over half the resident population, and at which point the spread of the infection within the
 institution was already waning. *Id.* ¶ 11.

1 same conclusion: the virus spreads with dangerous speed in open air housing units. In a
 2 recent correspondence published in the New England Journal of Medicine, the authors
 3 noted that they had tested 10,304 people in the Connecticut prison system and found that
 4 people in dorms were 35 times more likely to be infected with the SARS-CoV-2 virus than
 5 people in cells. Luring Decl., Exh. B (New England Journal of Medicine, Risk Factors
 6 for SARS-CoV-2 in a Statewide Correctional System, November 24, 2020) at 1. In a study
 7 by AMEND and the Berkeley School of Public Health of the outbreak at California Men’s
 8 Colony (CMC), experts noted that “[d]ue to incarcerated persons living in close, prolonged
 9 proximity and the close physical distance of dormitory pods, CMC’s West dorms are
 10 primed for super-spreader events.” Luring Decl., Exh. C at 37.

11 There have been serious outbreaks in celled environments, notably at High Desert
 12 and Pleasant Valley State Prisons. This does not contradict the fundamental truth that cells
 13 are safer than dorms. As Dr. Luring explains, “[b]y far the largest outbreaks have been in
 14 shared air spaces”; the outbreak in solid-door cell environments “would have been far
 15 worse in dorms or cells with barred or porous doors.” Luring Decl. ¶ 10. Put simply,
 16 “[t]he fact that this virus possesses tenacity that is very difficult to counter even under
 17 suitable conditions does not let [Defendants] off the hook from knowingly placing people
 18 in harm’s way.” *Id.*

19 There can be no serious dispute that placement of anyone in a dorm increases their
 20 risk of catching COVID-19. But placement of groups of people, all of whom have known
 21 risk of exposure to the virus, *together* in dorms or porous door cells and thus exposing
 22 them to others with high risk of infection is far more serious. Because these units function
 23 like incubators for the virus, “[i]f you quarantine them together in shared air space, the risk
 24 level for all rises to the highest risk level among them; everyone will be at the same risk as
 25 the person who was most exposed.” *Id.* ¶ 11. An example illustrates this point: if 10
 26 people are exposed to the virus, “[i]t is likely that not all of those people will actually wind
 27 up being infected” because of “[t]he numerous variations in how different exposed people
 28 have interacted with the infected person – the frequency of interaction and proximity to

1 each other, the airflow at the time, whether the infected person coughs or sneezes or laughs
 2 or speaks loudly during the interaction.” *Id.* ¶ 12. Out of the 10 people exposed, “maybe
 3 two or three . . . will become infected, and the other seven or eight will be lucky. If you
 4 quarantine each person in a single cell after exposure, you have only two or three
 5 secondary cases. However, if you quarantine them together, the lucky ones will continue
 6 to be exposed -- to the secondary cases, now -- over the ensuing 14 days. So, you have
 7 actually increased their total exposure to COVID-19 positive people and increased their
 8 risk for contracting the disease.” *Id.* Thus, “[t]he use of living units with common air
 9 space to quarantine people with known exposure to the virus is effectively not quarantine
 10 at all.” *Id.* ¶ 13.

11 The Centers for Disease Control and Prevention (CDC) come to the same
 12 conclusion: “cohorting individuals with suspected COVID-19 is not recommended due to
 13 high risk of transmission from infected to uninfected individuals.” Interim Guidance on
 14 Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention
 15 Facilities, posting date October 7, 2020, [https://www.cdc.gov/coronavirus/2019-](https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html)
 16 [ncov/community/correction-detention/guidance-correctional-detention.html](https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html) (last visited
 17 December 9, 2020) (“CDC Guidance”). Thus, “[f]acilities should make every possible
 18 effort to individually quarantine close contacts of individuals with confirmed or
 19 suspected COVID-19” and “[c]ohorting should only be practiced if there are no other
 20 available options.” *Id.*

21 It is no surprise that the Receiver, Plaintiffs’ expert, the Public Health Workgroup,
 22 and the experts at AMEND and the Berkeley School of Public Health all have reached the
 23 same conclusion: people exposed to COVID-19 cannot be effectively quarantined in
 24 dormitories or shared air space housing units.¹³ See Anabtawi Decl., Exh. A (Receiver
 25 _____

26 ¹³ Defendants cast doubt on Dr. Luring’s credentials as an expert in this area, criticizing
 27 him for lack of correctional experience, and fault him for failing to state how to prioritize
 28 safe housing among at-risk populations. But they do not contradict any of his scientific

1 directs that only single or double celled housing is permissible for quarantine for known
 2 exposure); Lauring Decl. ¶ 6 (“My review of the literature, conversations with public
 3 health and correctional experts, and knowledge of outbreaks in CDCR all strongly support
 4 the conclusion that it is not safe to quarantine people in dormitories or celled housing with
 5 open bars or porous doors”); *id.*, Exh. C. at 37 (AMEND/Berkeley School of Public
 6 Health, Evaluation of CMC Outbreak) (“[n]o one in a dormitory environment can
 7 quarantine properly”); *id.*, Exh. D at 2 (Workgroup Recommendations) (“[i]ndividuals
 8 who have been exposed should be quarantined in the equivalent of single cells with solid
 9 doors”).

10 **C. Defendants knowingly place people in living units with shared air space**
 11 **for quarantine**

12 Despite the clear direction from the Public Health Workgroup and the Receiver,
 13 CDCR continues to quarantine large numbers of people in shared air living spaces, both in
 14 designated set-aside units and through quarantine in place.

15 In some prisons, CDCR uses shared air living spaces for quarantine despite the fact
 16 that there are multiple living units of solid-door cells that are available or could be made
 17 available. In some of these instances, Defendants have misused the reserve space by using
 18 solid-door cells for isolation of confirmed cases and dorms for quarantine. (Isolation may
 19 be done in shared air spaces because people with confirmed infections do not present a
 20 medical risk of harm to other infected people.) For example, at CIM, Plaintiffs discovered
 21 that people were quarantined in dorms and a gym despite cells being available in the
 22 designated set-aside space; at the California Men’s Colony, patients were quarantined in

23 _____
 24
 25 opinions or credentials for assessing risk and protective factors for this pandemic, and the
 26 fact remains that his conclusions find strong support in the CDC’s guidance, the Receiver’s
 27 statement, the Public Health Workgroup, and the experts from AMEND and U.C.
 28 Berkeley, including members of this Court’s Advisory Panel. It is Defendants’ expert
 whose opinion -- that Defendants can place people at risk of harm without fully making
 use of all other options available to them to prevent it – is out of line with the national
 leaders in this field.

1 dorms while many cells were available in the designated set-aside space. Anabtawi Decl.
 2 ¶¶ 5, 7. Plaintiffs have been raising concerns with CCHCS and Defendants over the use of
 3 dorms for quarantine at prisons with available solid-door cells for more than two months,
 4 including regarding CIM (October 2), CTF (October 9), and CMC and CCI (October 16).
 5 Anabtawi Decl. ¶¶ 5-7. Plaintiffs have also included some of these concerns in the Joint
 6 Case Management Conference Statements filed with the Court, regarding quarantines at
 7 SATF (ECF No. 3449 at 20) and at CIM (ECF No. 3469 at 17-18).

8 Defendants confirm that they have used “[q]uarantine cohorts” instead of the set-
 9 aside space for quarantine in “some instances” and admit that “it is possible that less than
 10 optimal decisions [on quarantine housing] have been made in some circumstances.”
 11 Declaration of Connie Gipson in Support of Defendants’ Opposition ¶ 20.

12 The problem continues: it appears from the information available to Plaintiffs that
 13 Valley State Prison, California Institution for Men, Mule Creek State Prison, California
 14 State Prison at Solano, Central California Women’s Facility, California Men’s Colony,
 15 Avenal State Prison, R.J. Donovan State Prison, and SATF have in recent weeks used
 16 dorm housing for quarantine despite available solid-door cells at the same prison.¹⁴
 17 Anabtawi Decl. ¶¶ 2-4. All of these recent examples appear to be quarantine in place.

18 In some prisons, CDCR has designated shared air living spaces as part of its Court-
 19 ordered reserves for quarantine and isolation purposes, along with celled housing. *Id.*,
 20 Exh. E. At CRC, CDCR has designated *only* shared air living spaces. *Id.* Plaintiffs have
 21 objected to these designations for months: on September 16, Plaintiffs informed
 22
 23

24 ¹⁴ Plaintiffs determined this information from reviewing the Outbreak Management Tools,
 25 only recently made available to us, as well as CDCR’s bed audit (to determine which
 26 locations are celled housing and which are dorms). Anabtawi Decl. ¶ 2. The information
 27 needed to identify these problems has always been available to Defendants. Defendants’
 28 complaint that Plaintiffs have failed to bring this problem to their attention previously is
 therefore perplexing. Plaintiffs first raised it formally September 16 and have consistently
 since then maintained the position that quarantine in shared air space locations is wrong,
 giving Defendants numerous examples along the way. *Id.* ¶¶ 2-8, 15 and Exhs. B & D.

1 Defendants and CCHCS that “[s]ome prisons have not designated appropriate space,”
 2 including CRC, which “has not designated any cells with solid doors for quarantine,
 3 because there is no celled housing at the prison.” *Id.*, Exh. B. Plaintiffs further noted that
 4 at other prisons “celled housing is designated for the reserve space, but the doors are
 5 perforated and thus allow for the flow of air outside of the cell, such as the celled housing
 6 at San Quentin, Chuckawalla Valley, and Pelican Bay,” and argued that a “solution must
 7 be found to allow safe quarantine consistent with the Public Health Workgroup’s
 8 guidance.” *Id.*

9 Defendants have failed to take steps available to them to avert unsafe quarantine
 10 housing and prevent known risk of harm. They have not used reserve or other solid-door
 11 cells to their fullest capacity, as discussed above. Nor have they taken other available
 12 steps such as a targeted reduction of the population density at these prisons to significantly
 13 reduce the need for quarantine and increase the ability to accomplish it safely, whether
 14 through attrition¹⁵ or targeted transfers or the population reduction measures at their
 15 disposal.¹⁶ Instead, they have chosen to keep the populations at these prisons too high to
 16 allow for safe quarantine practices. They have failed to restrict the populations at these
 17 prisons to only people who have already had COVID-19 to provide a possibly significantly
 18 reduced risk of infection and outbreaks. With very limited exceptions, they have not
 19 activated unused space to serve as isolation or quarantine space, as suggested in the
 20 AMEND and UC Berkeley School of Public Health report on San Quentin. Anabtawi
 21 Decl., Exh. G (Urgent Memo – COVID-19 Outbreak: San Quentin Prison, June 13, 2020)
 22 at 5-6.

24 ¹⁵ Defendants did restrict some transfers into these prisons, but only for people at high risk
 25 from complications from COVID-19. Anabtawi Decl., Exh. F. There is no restriction on
 26 transferring others into these prisons in their place.

27 ¹⁶ Defendants have chosen to release only a very few of the elderly people who are high
 28 risk for COVID complications and low risk to public safety that their various population
 reduction measures would allow, as noted in multiple Joint Case Management Conference
 Statements. *See, e.g.*, ECF No. 3460 at 2-3; ECF No. 3477 at 3.

1 In all of these situations, Defendants have made clear and knowing choices to
2 quarantine people in housing that places them at substantial risk of serious harm.

3 The Public Health Workgroup found that “if the [quarantine] space is single cells
4 with solid doors and all public health measures are enforced along with the de-
5 densification that has already occurred, the proposed space plan, though imperfect, is a
6 reasoned and supportable approach that protects residents and staff.” Luring Decl., Exh.
7 D, at 2. But the quarantine space is too often *not* single cells with solid doors; as a result,
8 the space plan is unreasonable, unsupportable, and fails to protect residents and staff.

9 **D. Defendants violate the Eighth Amendment by placing people exposed to**
10 **COVID-19 together in shared air living spaces**

11 Defendants place residents exposed to COVID-19 on living units with shared air
12 space. This practice knowingly subjects them to substantial risk of serious harm. As set
13 forth in the previous section, Defendants have failed to take available steps to avoid these
14 dangers – in some cases, even quarantining people in dorms when there are solid-door
15 cells they could have made available at the same prison. They thus demonstrate deliberate
16 indifference to the serious health care needs of the plaintiff class in violation of the Eighth
17 Amendment. *See Farmer*, 511 U.S. at 828 (a “prison official’s ‘deliberate indifference’ to
18 a substantial risk of serious harm to an inmate violates the Eighth Amendment”) (citation
19 omitted).

20 Defendants argue that their actions do not constitute deliberate indifference because
21 their actions are reasonable. Significantly, they do not deny that they knowingly place
22 people at a substantial risk of harm when they place them in shared air spaces for
23 quarantine with other exposed people. It is unreasonable to knowingly expose people to
24 enhanced risk of harm without making use of means at their disposal to avert that harm.

25 Defendants also argue that they are not deliberately indifferent because they are
26 taking reasonable steps to stem outbreaks and protect people from transmission by other
27 means. But the other steps Defendants have taken during the pandemic, while necessary
28 and important, do not eliminate the substantial risk of serious harm to the Plaintiff class

1 members who have been exposed to the virus and are then placed in shared air space with
2 other exposed people, thus facing a higher risk of contracting COVID-19. Mask-wearing
3 is essential, as are the significant efforts Defendants have expended on testing, hygiene,
4 and movement restrictions and precautions during the pandemic. (Notably, many of these
5 efforts were not fully implemented until the Court ordered, the Receiver directed, or
6 Plaintiffs insisted on them.) But those efforts do not absolve Defendants of their
7 responsibility to provide safe housing for people who have been exposed.

8 After listing at length the steps they have taken to address the pandemic in other
9 ways, Defendants profess helplessness in the face of the need to find safe quarantine space
10 for the people in their custody. They argue that it is unreasonable to be required to safely
11 house people, apparently no matter the heightened risk they would otherwise face, because
12 of “the reality of incarceration that there simply are not enough single cells with solid
13 doors at all institutions.” The fundamental flaw in their argument is that the national
14 standards they themselves cite require far more than this passive approach. Defendants
15 quote the CDC guidelines, but ignore the section that requires them to “**make every**
16 **possible effort to individually quarantine close contacts of individuals with confirmed**
17 **or suspected COVID-19.**” CDC Guidance (emphasis in original). The CDC confirms
18 that “[c]ohorting multiple quarantined close contacts could transmit SARS-CoV-2 from
19 those who are infected to those who are uninfected” – indeed, that there is a “high risk” of
20 such transmission -- and instructs that “[c]ohorting should only be practiced if there are no
21 other available options.” *Id.*

22 Defendants have other available options. Most prisons have both dormitories and
23 solid-door celled housing. They can use the solid-door celled housing at their disposal,
24 something that they fail to do all too often, as noted in the prior section. There are
25 additional tools at their disposal to plan for adequate safe quarantine space, as listed in the
26 previous section: proper use of the celled set-aside space they already have; reduction of
27 population density at prisons with inadequate celled housing through attrition, targeted
28 transfers, or available population reduction measures; restriction of dorm populations to

1 people who have already had COVID-19; activation of unused space. They have not made
 2 “every possible effort” to ensure adequate celled quarantine space, as required by the
 3 CDC.

4 Echoing the CDC’s Guidance, the Receiver recently gave clear direction that people
 5 with known exposure should be quarantined “with no more than 2 persons per shared
 6 airspace housing.” Anabtawi Decl., Exh. A. He acknowledged that at some prisons, “the
 7 available facilities are insufficient” to accomplish that end, but did not allow Defendants to
 8 simply throw up their hands. Instead, he required that “[a]ll efforts should be made at
 9 these institutions to find quarantine alternatives that satisfy the purposes of a post-exposure
 10 quarantine as set forth above.” *Id.*

11 Defendants’ argument thus ignores the clear and unambiguous direction from
 12 undeniable national leaders at the intersection of corrections and public health. Defendants
 13 cannot credibly hold that it is unreasonable to be required to follow the CDC’s and the
 14 Receiver’s guidance. *See Hernandez v. Cty. of Monterey*, 110 F. Supp. 3d 929, 959 (N.D.
 15 Cal. 2015) (“known noncompliance with generally accepted guidelines for inmate health
 16 strongly indicates deliberate indifference to a substantial risk of serious harm”).

17 **IV. Precautionary quarantine**

18 The Receiver, in the COVID-19 Screening and Testing Matrix for Patient
 19 Movement, August 19, 2020 (Movement Matrix), required CDCR to set aside enough
 20 precautionary quarantine space at each prison to accommodate its historical average of
 21 transfers.¹⁷ Anabtawi Decl, Exh. H. Plaintiffs asked for the set-aside space to be modified
 22 and expanded for this purpose nearly six weeks ago and received no answer. *Id.*, Exh. C.
 23 Defendants have never produced a designation of precautionary quarantine space at any
 24 prison. *Id.* ¶ 14.

25
 26
 27 ¹⁷ The Movement Matrix requires precautionary quarantine for people who arrive at the
 28 Reception Centers and who transfer between prisons and other facilities in order to curb
 spread of the virus. The Receiver issued a draft revised Matrix on November 24 that also
 requires post-transfer precautionary quarantine in the same amount. Anabtawi Decl. ¶ 19.

1 The Public Health Workgroup developed a methodology for determining how many
 2 beds should be set aside for quarantine and isolation based on outbreak prevention. They
 3 did not consider precautionary quarantine, likely because there was minimal movement in
 4 the system at that time. Transfers now happen in far greater numbers. These changed
 5 circumstances necessitate set-aside space dedicated for this purpose.

6 It is essential to consider precautionary quarantine space along with quarantine
 7 space for people with known viral exposure because the precautionary quarantines take up
 8 set-aside space, making it unavailable in event of an outbreak. That could render the space
 9 inadequate to comply with the Court's order. Defendants admit that they do not know if
 10 this is happening. Gipson Decl. ¶ 19.

11 Defendants argue that the number of cells required for this purpose is small, and
 12 they might be able to fill the need with current space. *Id.* Compliance with Plaintiffs'
 13 proposed order should thus be well within their reach. Moreover, since people placed in
 14 precautionary quarantine are not known to have been exposed to the virus, they do not
 15 present an enhanced risk of transmission to each other and may be housed in congregate
 16 settings in small cohorts. Laring Decl. ¶ 20.

17 **V. The Court should order Defendants to quarantine people with known exposure**
 18 **only in solid-door cells or the equivalent and to set aside adequate space for**
 19 **precautionary quarantine**

20 Defendants' quarantine practices thus violate the Eighth Amendment rights of
 21 Plaintiff class members. The Court should order CDCR to cease placing its residents at
 22 known risk of harm. As the Supreme Court directed in this case, where a "government
 23 fails to fulfill [its] obligation [to provide adequate health care], the courts have a
 24 responsibility to remedy the resulting Eighth Amendment violation." *Brown v. Plata*, 563
 25 U.S. 493, 511 (2011). Thus, while courts should be sensitive to principles of federalism,
 26 "[c]ourts nevertheless must not shirk from their obligation to enforce the constitutional
 27 rights of all persons, including prisoners," and "may not allow constitutional violations to
 28 continue simply because a remedy would involve intrusion into the realm of prison

1 administration.” *Id.*

2 Defendants protest that the task of quarantining in solid-door cells is unreasonable
 3 while at the same time acknowledging that most people are already single or double celled
 4 for exposure quarantine and that there is ample capacity available in CDCR’s prisons. See
 5 Spaulding Decl. ¶ 23 and Exh. B (a snapshot of recent quarantines by the Receiver shows
 6 that 77% are single- or double-celled); Gipson Decl. ¶ 6 (“CDCR has reduced its
 7 population by over 23,000 [people] since the beginning of the pandemic”). Further, they
 8 assert that (following several disastrous experiences in which they spread the virus from
 9 prison to prison), they can now safely transfer people within the system. Gipson Decl. ¶ 7.
 10 Why, then, is it unreasonable to require them to be more creative in using the available
 11 space and in making space available in order to safely house people who have been
 12 exposed to the virus?

13 Defendants’ final argument is that a hearing on this matter is premature because the
 14 Receiver’s direction in this area was issued on December 4 and they have not yet decided
 15 what to do about it. But they have long known of this problem and have demonstrated
 16 their reluctance to act without Court intervention: despite Plaintiffs’ longstanding objection
 17 that the allocated quarantine space is inadequate, they identified additional quarantine
 18 space only after Plaintiffs asked for a hearing date. Anabtawi Decl. ¶ 8. The Receiver’s
 19 direction is clear and unambiguous: it does not need interpretation, only a plan for
 20 implementation. Plaintiffs’ proposed order provides such a plan. In the two weeks
 21 remaining before the hearing, Plaintiffs will continue to meet and confer with Defendants
 22 and the Receiver and, as appropriate, the public health experts, on how it can be
 23 accomplished.

24 The coronavirus pandemic has brought tremendous difficulties to prison systems
 25 around the world, and California is no exception. Finding solid-door cells or the
 26 equivalent for quarantine space will be difficult in some prisons. But the means to make it
 27 possible are well within Defendants’ reach. As described in Section III.C, above, they
 28 have repeatedly failed to use the available celled housing effectively, have failed to reduce

1 population density at the prisons with little or no celled housing, and have chosen to
 2 release only a very few of the elderly people who are high risk for COVID complications
 3 and low risk to public safety.¹⁸ A significantly reduced population density at all the
 4 prisons, but particularly those with few to no cells, would make the work of quarantining
 5 exposed cases far easier. The Public Health Workgroup instructed Defendants to
 6 quarantine people in solid-door cells and to find unique solutions at the prisons without
 7 adequate celled space nearly four months ago and the evidence demonstrates that that they
 8 have failed to do so in a meaningful way.

9 For the above reasons, Plaintiffs respectfully request the Court grant the relief in the
 10 proposed order filed herewith.

11 12 **DEFENDANTS' POSITION**

13 **INTRODUCTION**

14 Plaintiffs are again asserting that Defendants' response to the COVID-19 pandemic
 15 is deliberately indifferent, and now ask this Court for an order requiring Defendants to
 16 comply with guidance issued by the Receiver not less than three business days ago.
 17 Simply the temporal nature of their requested relief alone is unreasonable. If that were not
 18 enough to justify the denial of this motion, Plaintiffs' legally and factually flawed claim of
 19 deliberate indifference does not square with the incredible and tireless efforts of CDCR,
 20 California Correctional Health Care Services (CCHCS) and their staff to combat the spread
 21 of the virus and to treat the patients who have contracted it. CDCR and CCHCS have
 22 significantly reduced the patient population, periodically frozen intake of new patients
 23 from the counties, reserved large quantities of space for isolation and quarantine, made
 24 efforts to remove high-risk-medical inmates to safer environments, developed a corrections
 25 industry leading transfer matrix, updated that transfer matrix based upon experience and

26 _____
 27 ¹⁸ Plaintiffs do not seek a population reduction order. The remedy should recognize,
 28 however, that it is within the authority of the Defendants to reduce their population as one
 option to facilitate compliance.

1 evolving public health guidance, developed surge plans for prisons with challenging
 2 facilities, and implemented a constellation of additional measures to combat the spread of
 3 the virus and prevent or reduce bad outcomes. Moreover, CDCR has demonstrated time
 4 after time that it is willing to diligently work with Plaintiffs and the Receiver to address
 5 changes in public health guidance, issues raised by Plaintiffs, and to improve its efforts to
 6 keep incarcerated persons and staff safe. These facts collectively demonstrate that
 7 Defendants are not deliberately indifferent.

8 Because the entire country is in the grip of this devastating pandemic and its current
 9 crippling surge of cases and deaths, Defendants understand Plaintiffs' urgency in seeking
 10 relief. But in their haste to present these challenging and complex issues to the Court, they
 11 did not allow sufficient time for Defendants and the Receiver to assess them or to
 12 determine how and whether they can be addressed. For example, Plaintiffs committed to
 13 bringing this motion before considering the fact that CDCR has significant additional
 14 space suitable for quarantine and isolation far beyond the already-reserved quarantine and
 15 isolation spaces. An accurate compilation of that data was only completed and produced
 16 to Plaintiffs on December 4, though Plaintiffs were advised on December 2 of the likely
 17 availability of this space. Decl. Ryan Gille Supp. Defs.' Opp'n to Pltfs.' Mot. re
 18 Quarantine and Isolation Space ("Gille Dec.") ¶ 2. Consequently, the parties and the
 19 Receiver have yet to meet to discuss how this additional space might be used to address the
 20 issues Plaintiffs raise here. Nor have they discussed the potential impact of recent updated
 21 guidance from the Centers for Disease Control and Prevention may have on current
 22 isolation and quarantine policies and protocols, which include the transfer matrix. And
 23 based on their conduct since the onset of the pandemic, it is apparent that the Receiver and
 24 Defendants are fully dedicated to the many measures already implemented to protect
 25 patients.

26 Despite Defendants' and the Receiver's efforts to date, and willingness to discuss
 27 further modifications and improvements related to quarantine, Plaintiffs ask this Court to
 28 set an impossibly high standard—one which most, if not all, jails and prisons in this

1 country cannot meet, and one which is not mandated by the Eighth Amendment. This
 2 Court may not grant the dramatic and unprecedented relief Plaintiffs seek because
 3 Defendants have not been deliberately indifferent to the COVID-19 pandemic, and further,
 4 Plaintiffs’ requested relief is not narrowly drawn or the least intrusive means necessary to
 5 correct the harm.

6 **PROCEDURAL AND FACTUAL BACKGROUND**

7 In a July 22, 2020 order, the Court adopted CDCR’s interim proposal for quarantine
 8 and isolation space, which required that spaces with at least 100 beds would be set aside at
 9 each prison for isolation and quarantine purposes. ECF No. 3401 at 4. The Court further
 10 ordered that the Receiver, the parties’ experts, and institution leadership work together to
 11 help CDCR determine whether additional space should be reserved for isolation and
 12 quarantine at each prison based on health considerations. *Id.*

13 The parties’ experts, advisory board members, and the Receiver’s public health
 14 experts at CCHCS (the “Public Health Workgroup”) met several times in late July and
 15 early August to develop a methodology for determining the amount of space that should be
 16 reserved for quarantine and isolation at each prison. Declaration of Connie Gipson Supp.
 17 Defs.’ Opp’n Re Quarantine Motion (“Decl. Gipson”) Ex. D at 1. The Receiver arranged
 18 for the parties—including counsel representing the plaintiffs in the *Armstrong* and
 19 *Coleman* class actions—and members of the Public Health Work Group to meet on August
 20 7 and 12 to further discuss the reserves that should be set aside at each prison. *Id.*

21 On August 18, 2020, CCHCS issued a document explaining the methodology for
 22 determining appropriate isolation and quarantine reserves developed by the Public Health
 23 Work Group, which was based on the number of inmates living in each prison’s largest
 24 congregate living space. *Id.* at 2. Congregate living spaces include dorms and housing
 25 units with cells that have barred or porous doors. *Id.* The document’s attachments
 26 provided specific recommendations for reserves at each prison. *Id.*

27 CCHCS’s recommendation document included several significant observations.
 28 First, it noted that “[g]iven the recommendations and application of the method, it appears

1 that nearly all institutions already had reserved or vacated enough suitable bed space for
 2 isolation and quarantine.” *Id.* Second, it noted that unique solutions would be required for
 3 San Quentin, Folsom, and California Rehabilitation Center because of their designs and
 4 lack of sufficient cells with solid doors. *Id.* at 3. Third, it noted that San Quentin needed
 5 less reserve space than the formal recommendation indicated because of the large number
 6 of patients at that prison who had already contracted COVID-19.¹⁹ *Id.* at 2. And fourth, it
 7 observed that “many institutions have excess capacity, beyond what was identified for
 8 purpose of Judge Tigar’s order, and could quickly identify additional buildings for use as
 9 quarantine and/or isolation space.” *Id.* at 3.

10 From July through September 2020, CDCR took on the massive task of vacating
 11 and preparing the spaces it identified for isolation and quarantine in every prison. Decl.
 12 Gipson ¶¶ 13-14. This undertaking presented numerous logistical challenges, including
 13 the transfer of hundreds of inmates to other housing units and prisons and ensuring that
 14 reserved spaces were appropriate for *Armstrong* and *Coleman* class members. *Id.* CDCR
 15 continued to work on a number of these challenges through October and November 2020.
 16 *Id.*

17 At many of the prisons, the reserved quarantine and isolation space exceeds the
 18 amount of space recommended by CCHCS and the public health workgroup, and some
 19 prisons exceeded the recommendations by a large quantity (e.g., California City
 20 Correctional Facility, California Institution for Women, and California State Prison-
 21 Sacramento). Decl. Gipson ¶¶ 15-16, Ex. E. CDCR’s reserved space has capacity to
 22 house approximately 7,809 patients in cells if they are mostly double celled, and up to
 23 about 4,228 patients if they are single celled. *Id.* CDCR has also formally reserved about
 24 1,195 beds that are in congregate living spaces, such as dorms, tents, gyms, and other
 25 converted spaces for isolation and quarantine. *Id.*

26
 27
 28 ¹⁹ This same consideration should apply to other prisons that have large numbers of
 patients who have recovered from COVID-19.

Furthermore, because of CDCR’s reduced population, a number of prisons currently have abundant additional space available—beyond the reserved space—that could be used for quarantine and isolation if needed. *Id.* ¶ 17. In total, the additional cell space is sufficient to house about 2,620 patients if they are mostly double celled, and about 1,347 patients if they are single celled. *Id.* And there are about 1,999 additional beds in congregate settings that are also currently available for quarantine or isolation use. *Id.*

ARGUMENT

I. Plaintiffs Have Not Established Defendants’ Deliberate Indifference to the COVID-19 Pandemic.

To be entitled to injunctive relief, Plaintiffs must first establish an Eighth Amendment violation. Here, Plaintiffs have not, and cannot, demonstrate that Defendants have been deliberately indifferent to the COVID-19 pandemic in light of the myriad measures Defendants and the Receiver have put in place to attempt to mitigate the spread of the virus.

In order to establish a violation of their Federal rights, Plaintiffs must prove that Defendants have acted with deliberate indifference toward those rights. *Farmer v. Brennan*, 511 U.S. 825, 828 (1994). A deliberate indifference finding requires Plaintiffs to show that the deprivation of their rights is “objectively, ‘sufficiently serious,’” and further, that Defendants are acting with a “‘sufficiently culpable state of mind.’” *Farmer*, 511 U.S. at 834 (*quoting Wilson v. Seiter*, 501 U.S. 294, 297 (1991)). As Defendants have indicated in response to Plaintiffs’ previous challenges to Defendants’ response to the COVID-19 pandemic, COVID-19 objectively poses a risk of harm to incarcerated persons, and those who are incarcerated may be at a higher risk for contracting COVID-19 given the circumstances of incarceration, including the congregate living environment inherent in carceral settings. *See* ECF Nos. 3235 at 17 (“Defendants do not dispute the risk of harm that COVID-19 poses to inmates, as well as the community at large”), 3291 at 5:5-13 (“Defendants do not attempt to relitigate the issue here, and the Court finds that this element has been established”).

1 However, Plaintiffs have not previously established, and cannot now establish the
 2 second prong of the deliberate indifference inquiry. Since the onset of the pandemic,
 3 Defendants have taken immediate, far reaching, and reasonable action in response to the
 4 pandemic, and thus are not disregarding the serious risk of harm posed by COVID-19.

5 **A. Defendants Have Taken Significant and Unprecedented Steps to**
 6 **Respond to the COVID-19 Pandemic.**

7 Under the second, subjective prong, Plaintiffs must show that prison officials knew
 8 of and disregarded “an excessive risk to inmate health or safety; the official must both be
 9 aware of facts from which the inference could be drawn that a substantial risk of serious
 10 harm exists, and he must also draw the inference.” *Farmer*, 511 U.S. at 837. The state of
 11 mind required for deliberate indifference equates to the *mens rea* element for criminal
 12 recklessness. *Farmer*, 511 U.S. at 839-840. For that reason, courts must “focus[] on what
 13 a defendant’s mental attitude actually was (or is), rather than what it should have been (or
 14 should be).” *Id.* at 839. This approach is required, according to the Supreme Court,
 15 because the “Eighth Amendment does not outlaw cruel and unusual ‘conditions’; it
 16 outlaws cruel and unusual ‘punishments.’” *Id.* at 838. Thus, prison officials who
 17 understand a substantial risk to inmate health or safety may be found free from liability if
 18 they respond reasonably to the risk “even if the harm ultimately was not averted.” *Id.* at
 19 844.

20 This standard affords “due regard for prison officials’ unenviable task of keeping
 21 dangerous men in safe custody under humane conditions.” *Farmer*, 511 U.S. at 845
 22 (*quoting Spain v. Procunier*, 600 F.2d 189, 193 (9th Cir. 1979)). This standard is also
 23 exacting, and the Court has rejected attempts to dilute it. *See Estelle v. Gamble*, 429 U.S.
 24 97, 106-108 (1976) (“insufficient treatment, malpractice, or negligence does not amount to
 25 a constitutional violation); *Wilson v. Seiter*, 501 U.S. 294, 305 (1991) (mere negligence
 26 does not meet the deliberate indifference standard); *Baze v. Rees*, 553 U.S. 35 (2008) (risk
 27 of negligence does not establish a cognizable Eighth Amendment claim).

28 Here, Plaintiffs cannot establish that Defendants have disregarded an excessive risk

1 to their health. To the contrary, Defendants have taken immediate, decisive, and
 2 significant steps to mitigate the spread of COVID-19 within CDCR. Defendants' efforts in
 3 this regard are extensive, and just as our understanding of the pandemic has evolved, so
 4 too has CDCR's response.²⁰ For example, in March and early April 2020, which was only
 5 a short period after the beginning of the pandemic, CDCR had already implemented the
 6 following measures:

- 7 • CCHCS and CDCR established a multi-disciplinary team, chaired by a
 8 public health physician, to take all feasible steps to prevent a COVID-19
 9 outbreak in CDCR's institutions and to develop a thorough and solid
 10 response action plan for dealing with outbreaks;
- 11 • CDCR activated the Department Operations Center (DOC)—a centrally-
 12 located command center where CDCR and CCHCS experts monitor
 13 information, prepare for known and unknown events, and exchange
 14 information centrally in order to make decisions and provide guidance
 15 quickly in the event of outbreaks;
- 16 • CDCR developed Pandemic Operational Guidelines;
- 17 • CDCR suspended public visiting in the prisons;
- 18 • CDCR suspended intake from the county jails (intake has since resumed on
 19 a limited and intermittent basis, but it is currently suspended);
- 20 • CDCR implemented symptom screening for individuals entering the
 21 prisons;
- 22 • CDCR initiated efforts to educate staff and inmates about the need for

24
 25 ²⁰Accurate descriptions of many of CDCR and CCHCS's efforts to address the pandemic
 in the prisons can be found on CDCR's website at:

26 <https://www.cdcr.ca.gov/covid19/covid-19-response-efforts/>;
 27 <https://www.cdcr.ca.gov/covid19/san-quentin-state-prison-response/>; and
 28 <https://www.cdcr.ca.gov/covid19/memos-guidelines-messaging/>. Decl. Gipson ¶ 5.

1 taking precautions such as physical distancing and hygiene;

- 2 • CDCR initiated efforts to reduce the populations in dorms by transferring
- 3 significant numbers of inmates out of dorms to other housing throughout the
- 4 system;
- 5 • CDCR implemented enhanced cleaning efforts throughout the prisons and
- 6 widely distributed hand soap and hand sanitizer dispensers;
- 7 • CDCR implemented quarantines for exposed patients;
- 8 • CDCR implemented an expedited release plan to quickly reduce the
- 9 system's population by nearly 3,500 inmates;
- 10 • CDCR implemented a modified program to manage and restrict inmate
- 11 movement throughout the system and to provide guidance on physical
- 12 distancing and efforts to cohort inmates in their housing units;
- 13 • CDCR placed physical-distancing markings throughout the prisons to
- 14 encourage physical distancing;
- 15 • CDCR developed plans to convert certain areas in prisons, such as gyms,
- 16 chapels and visiting areas, into additional housing for the purpose of
- 17 allowing greater physical distancing in housing units;
- 18 • The California Prison Industry Authority initiated efforts to manufacture
- 19 cloth face masks and hand sanitizer for inmates and staff throughout the
- 20 system;
- 21 • CDCR created physical-distancing cohorts within dorm settings; and
- 22 • CDCR placed restrictions on inmate transfers and implemented
- 23 requirements to obtain approval for transfers from the Health Care
- 24 Placement Oversight Program and the CCHCS's public health team.

25 Decl. Gipson ¶¶ 3-4; *see also* ECF Nos. 3240 and 3275 (Director Gipson's previous
 26 declarations, provide more detail concerning these early efforts).

27 This Court has previously determined that Defendants' initial response to the
 28 pandemic, which included these (and other) measures, to be Constitutionally adequate.

1 ECF No. 3291 at 17:19-22. Since those early days of the pandemic, CDCR and CCHCS
 2 have worked tirelessly to further address and mitigate the impact of the pandemic on the
 3 prison system.²¹ For example, beginning in July 2020, CDCR implemented several
 4 measures to expedite the release of additional inmates to further reduce the prison
 5 population. Decl. Gipson ¶ 6. Those measures resulted in the early release of an
 6 additional 7,060 inmates from the 35 institutions and camps (including California City
 7 Correctional Facility) during the period from July 1 through December 3, 2020. *Id.*
 8 Combined with the previous early release efforts, natural releases, and restrictions on
 9 intake from the counties, CDCR reduced its population by over 23,000 inmates since the
 10 beginning of the pandemic.²² *Id.*

11 To ensure that transfers of inmates between institutions are conducted safely,
 12 CCHCS developed the Movement Matrix. Decl. Gipson ¶ 7, Ex. A. By carefully
 13 complying with the requirements of the Movement Matrix, CDCR has been able to safely
 14 transfer inmates throughout the system for a number of important reasons, including
 15 moving medically high-risk patients into safer settings and reducing the population in
 16 particular housing units to provide for greater social distancing. *Id.* CDCR takes the
 17 Movement Matrix requirements seriously, and has turned away intake buses from counties
 18 that have not complied with transfer requirements. *Id.*

19 Additionally, CCHCS conducts a robust COVID-19 surveillance-testing program
 20 for CDCR staff and incarcerated persons. Decl. Gipson ¶ 8. In addition to sending tests to
 21 _____

22 ²¹ Beginning in April 2020, the Court began holding frequent case management
 23 conferences to discuss CDCR's efforts to respond to the pandemic. For each of those
 24 conferences, the parties submitted joint statements describing evolving issues related to the
 25 pandemic and detailing CDCR's evolving efforts to respond to it. Those joint statements
 26 provide an overview of CDCR's monumental efforts to respond to the pandemic. *See* ECF
 27 Nos. 3269, 3294, 3304, 3316, 3322, 3332, 3345, 3356, 3367, 3370, 3371, 3389, 3405,
 28 3417, 3427, 3435, 3436, 3448, 3449, 3460, 3469, 3477, 3486, and 3487.

²² The press release concerning the early-release measures implemented in July 2020
 provides additional details and can be found at:

<https://www.cdcr.ca.gov/news/2020/07/10/cdcr-announces-additional-actions-to-reduce-population-and-maximize-space-systemwide-to-address-covid-19/>.

1 labs for results, every prison now also has the ability to conduct point-of-care tests that
2 usually provide results in about fifteen minutes. *Id.* Furthermore, wastewater monitoring
3 has been initiated at two prisons and might be expanded to others to assess its feasibility
4 and effectiveness for early detection of outbreaks. *Id.*

5 CDCR and CCHCS are also collaborating on an effort to move medically high-risk
6 patients out of dorms and into cells. Decl. Gipson ¶ 10. On October 21, 2020, the
7 Receiver issued a memorandum entitled “Transferring COVID-19 High-Risk Patients to
8 Safer Housing,” which requires CDCR to offer each person with a COVID-weighted risk
9 score of three or higher a single cell with a solid door. *Id.* The Receiver has also restricted
10 the transfer of medically high-risk patients to a specific group of prisons that do not have
11 the ability to house them in cells with solid doors. *Id.* As a result of these decisions,
12 CDCR is now prioritizing movement of medically high-risk patients who have not
13 contracted COVID-19 in the last three months from congregate living spaces to cells with
14 solid doors. *Id.* And CDCR and CCHCS are working on a process for mandating the
15 transfer of patients who do not voluntarily move to cells. *Id.* The implementation of the
16 plan to move medically high-risk patients has already commenced at San Quentin, and
17 plans for three other institutions are being developed. *Id.*

18 As discussed above, since April 2020, CDCR has been providing cloth face masks
19 to incarcerated persons and staff and providing guidance and directives on mask use. Decl.
20 Gipson ¶ 11. CDCR currently requires mask wearing in the prisons and provides all staff
21 with surgical face masks. *Id.* As an additional mitigation effort during serious outbreaks
22 at particular prisons, CDCR has issued N95 masks to all incarcerated persons and staff to
23 help stop the virus’s spread. *Id.* To date, this type of prison-wide N95 measure has been
24 implemented at Folsom State Prison, San Quentin State Prison, and Avenal State Prison.
25 *Id.* And at other prisons experiencing outbreaks, CDCR has required the use of N95 masks
26 by staff and incarcerated persons who work or reside in the areas experiencing the
27 outbreaks. *Id.*

28 CDCR has also implemented other measures to protect incarcerated persons at

1 prisons experiencing serious outbreaks, such as transferring medically high-risk patients
 2 out of dorms and into cells, and the implementation of increased testing rates of patients
 3 and staff. Decl. Gipson ¶ 12. And as discussed in more detail above, CDCR has set aside
 4 vast quantities of isolation and quarantine space throughout the prison system. *Id.* ¶¶ 13-
 5 17, Ex. E. This massive undertaking has reserved spaces throughout the prison system that
 6 provide thousands of beds for quarantine and isolation use in the event of outbreaks. *Id.*

7 Because some prisons were unable to reserve the recommended space for isolation
 8 and quarantine, and because their facility design is likely to present challenges in the event
 9 of an outbreak, they have developed plans for how to deal with a surge of COVID-19
 10 cases. Decl. Gipson ¶ 18. San Quentin, Folsom, California Rehabilitation Center,
 11 California Health Care Facility, and Avenal State Prison have developed such plans, which
 12 are based on experience gained during past serious outbreaks, such as the outbreak at San
 13 Quentin. *Id.*

14 CDCR also makes a concerted effort to learn from past outbreaks how to better
 15 respond to new outbreaks. Decl. Gipson ¶ 22. For instance, CDCR immediately took a
 16 number of steps at the beginning of an outbreak at Folsom in August 2020 that were based
 17 on lessons learned from San Quentin, which resulted in a far better outcome. *Id.* Those
 18 steps included the early installation of tents to provide additional capacity for quarantine,
 19 isolation, and medical treatment, the preparation of Folsom's limited cell capacity to help
 20 manage the outbreak, the movement of medically high-risk patients to cells, close
 21 monitoring of staffing needs and the implementation of plans to ensure sufficient staffing
 22 for the duration of the outbreak, the implementation of a mandatory prison-wide N95 mask
 23 policy for staff and inmates, and greatly increased testing rates. *Id.* Through all of these
 24 efforts, CDCR was able to prevent an outcome similar to the outbreak at San Quentin,
 25 even though Folsom and San Quentin faced many of the same challenges based on their
 26 age and design. *Id.*

27 Similarly, through lessons learned from past outbreaks, CDCR was able to
 28 effectively manage an outbreak that occurred at California Rehabilitation Center (CRC).

Decl. Gipson ¶ 23. Despite a dearth of cells for quarantining patients, CRC was able to control a large outbreak and prevent the loss of life from COVID-19. *Id.* The reduction in CRC’s population allowed it to utilize several large dorms for quarantine space, and CRC’s installation of climate controlled tents increased housing capacity. *Id.* Furthermore, CRC installed additional climate controlled tents for the specific purpose of housing medically high-risk patients away from the general population, and CRC assigned dedicated staff to essentially cohort with those high-risk patients during the outbreak to further limit their potential exposure to the virus. *Id.* The medically high-risk areas contained full services, including bathrooms and showers, dedicated to those patients so they would not come in contact with the general population. *Id.* The tents were designed to house ten people, but only four medically high-risk people were assigned to each tent, which allowed for greater physical distancing. *Id.*

Despite these significant and successful mitigation efforts, Plaintiffs state that they are “perplex[ed]” by Defendants’ use of CRC as an example of CDCR’s ability to effectively manage an outbreak, and instead suggest the outcome of the outbreak at CRC was the result of “good fortune” that is “likely attributed to the very low medically high risk population housed within the facility, rather than the management of the outbreak.” Pltfs.’ Mot. at 16, fn. 12. Plaintiffs cite to the declaration of one of their own attorneys for this determination, and notably, not to the opinion of any public health expert. Moreover, Plaintiffs fail to recall that the primary goal of managing the pandemic has always been to flatten the curve so that healthcare professionals and resources are not overwhelmed, and so the sick can be properly treated. Spaulding Dec. ¶ 8. From that perspective, CRC’s management of its outbreak was successful. At its peak, CRC never exceeded 550 active cases.²³ CRC isolated the medically vulnerable and kept them safe. In the end, no lives were lost. And they did this all without any cells. Decl. Gipson ¶ 23.

²³ Statistics pertaining to the impact of COVID-19 at CRC are available at <https://www.cdcr.ca.gov/covid19/population-status-tracking/>

1 Finally, CCHCS and CDCR are actively communicating with the California
 2 Department of Public Health to ensure that inmates and staff are provided the opportunity
 3 to be vaccinated in accordance with public health guidelines for vaccine distribution.
 4 Decl. Gipson ¶ 24.

5 As these efforts reflect, CDCR has worked tirelessly and dedicated significant
 6 resources to responding to the pandemic in California’s prisons. Plaintiffs’ accusations of
 7 deliberate indifference to the risks presented by COVID-19 are simply inconsistent with
 8 and unsupported by this record.

9 **B. Defendants’ Quarantine Efforts Comport with Public Health Guidance**
 10 **and Cannot be Said to Violate the Constitution.**

11 Plaintiffs assert that the failure to quarantine incarcerated persons in anything other
 12 than a cell with a solid door constitutes an Eighth Amendment violation. Plaintiffs state
 13 that they have “amended” their position, and now find double-celling for quarantine
 14 purposes acceptable “in recognition of the reasonableness of the Receiver’s approach,”
 15 contrary to their own expert’s opinion. Pltfs.’ Mot. at 8; Decl. Luring, ¶ 15 (stating “the
 16 risk is significant for ... cellmates of people who are double-celled in quarantine”).
 17 Although Plaintiffs acknowledge the correct legal standard and admit that “prison officials
 18 must implement reasonable measures to ensure that people in their custody are safely
 19 housed and are not unnecessarily exposed to infectious diseases,” Plaintiffs disregard the
 20 “reasonableness” standard and request an order from this Court that would far exceed that
 21 which is mandated by the Constitution. *See* Pltfs.’ Mot. at 15:5-7. In making this
 22 aggressive and unprecedented request, Plaintiffs rely on the opinion of Dr. Adam Luring,
 23 a physician who is board certified in infectious diseases, but who lacks public health or
 24 correctional expertise.²⁴ *See* Defs.’ Objections to the Luring Decl.; Gille Dec. ¶ 7 & Ex.

25
 26 ²⁴ In response, Plaintiffs state that Defendants “do not contradict any of [Luring’s]
 27 scientific opinions or credentials for assessing risk and protective factors for this
 28 pandemic....” Pltfs.’ Mot. at 18, fn. 13. But Defendants do disagree with his opinion, and

1 C. Indeed, Dr. Lauring admitted while testifying in a different case in a Michigan District
 2 Court earlier this year that he *does not* specialize in healthcare in jails or prisons. Gille
 3 Dec. ¶ 7 & Ex. C at 78:18-20. While Defendants do not dispute Dr. Lauring's
 4 uncontroversial assertions that "transmission through the air is one of the primary means
 5 by which people contract COVID-19," and that the *best* way to minimize the spread of
 6 COVID-19 is to quarantine exposed persons in single cells with solid doors, Dr. Lauring
 7 fails to acknowledge the reality of incarceration that space is limited in all correctional
 8 systems. *See* Lauring Decl. ¶ 8. This is not surprising, given Dr. Lauring has never been
 9 to a jail or prison. Gille Dec. ¶ 7 & Ex. C at 83:8-10.

10 But public health experts and prison administrators do not have the luxury of
 11 operating in the best of environments or considering only the most ideal public health
 12 response. Rather, in the reality in which they operate, they have the unenviable task of
 13 determining acceptable alternatives, and ensuring that reasonable steps are taken to ensure
 14 the safety and wellbeing of incarcerated persons under difficult circumstances. Indeed, the
 15 cornerstone of public health is risk mitigation and management. (Decl. Spaulding, ¶ 18.)
 16 Dr. Lauring's opinion is therefore of little value, not simply because he does not have the
 17 education, training, or experience to opine upon best practices for disease mitigation in a
 18 carceral setting from a public health standpoint, but because he offers no practical
 19 alternatives or solutions. (*See* Defs.' Obj. to Decl. Lauring.) Because Defendants have
 20 responded reasonably under the circumstances, and have acted consistent with public
 21 health guidance from the Centers for Disease Control and Prevention (CDC), and because
 22 Plaintiffs offer no viable alternatives (despite carrying the burden to do so), Defendants
 23 may not be found deliberately indifferent.

24 **1. The Vast Majority of Persons Incarcerated by CDCR Who Must**
 25 **Undergo Quarantine Are Housed Alone or With One Cellmate in**
 26 **Cells with Solid Doors.**

27 in this regard, it bears noting that the Eighth Amendment does not allow a deliberate
 28 indifference finding based merely on a difference of medical opinion about appropriate
 treatment. *Estelle v. Gamble*, 429 U.S. 97, 107 (1976).

1 A recent table of data provided by the Receiver presents a breakdown of the
 2 locations where currently quarantining patients are housed in CDCR's prisons. Decl.
 3 Spaulding Ex. B. Consistent with the CDC guideline preferences for quarantine, the table
 4 indicates that over three-quarters (77%) of the quarantining patients are either celled alone
 5 (33%) or with only one cellmate (44%). Decl. Spaulding ¶ 22, Ex. B. Another 12% are
 6 housed in cohorts of ten or fewer patients, and 11% are housed in larger cohorts. *Id.* This
 7 data demonstrates that CDCR prioritizes placing quarantining patients in cells with solid
 8 doors consistent with CDC guidelines. *Id.* Although Plaintiffs contend these efforts are
 9 insufficient, as explained below, Defendants' quarantine practices are consistent with the
 10 Constitution.

11 **2. It Is Not an Eighth Amendment Violation to Quarantine**
 12 **Incarcerated Persons in Space Other Than Cells with Solid Doors.**

13 Plaintiffs ask this Court to extend the reach of the deliberate indifference standard
 14 to subsume reasonable governmental action. Rather than require Defendants to act
 15 reasonably, Plaintiffs seek to require Defendants to do what is best without regard to
 16 resources and institutional constraints. They also ask this Court to ignore the myriad
 17 measures Defendants have put in place to mitigate the spread of COVID-19, to the
 18 exclusion of the one measure they deem superior. But this is not the law, and Defendants
 19 are not required to adopt what Plaintiffs believe to be the superior solution, particularly
 20 without any consideration of what is reasonable under the circumstances.

21 There can be no finding of an Eighth Amendment violation where prison officials
 22 respond reasonably to address medical concerns, even if the harm is not ultimately averted.
 23 *Farmer*, 511 U.S. at 844. To find otherwise would require this Court to conclude that
 24 Defendants have acted with a "sufficiently culpable state of mind" of "criminal
 25 recklessness." *Id.* Such a finding cannot reasonably be made under the set of facts before
 26 this Court. Even if Defendants' response is "imperfect[, t]hat is not enough to establish
 27 deliberate indifference." *Cameron v. Bouchard*, 815 Fed. Appx. 978, 986 (6th Cir. 2020).

28 Here, Defendants have made significant and reasonable efforts to quarantine

1 incarcerated persons who have been exposed to the virus in single or double cells with
 2 solid doors. Spaulding Ex. B. Those efforts have been effective, as over three quarters of
 3 the quarantined population is currently housed in such a setting. *Id.* There are, however, a
 4 handful of institutions where it simply is not feasible to quarantine all exposed incarcerated
 5 persons in single cells with solid doors. Decl. Gipson Ex. D at 3. The Public Health
 6 Workgroup acknowledged this reality when it described single cell, solid door quarantine
 7 space as “ideal,” but conceded that “[t]here are multiple institutions where the
 8 recommendations of the CCHCS and public health experts is difficult, if not impossible.”
 9 *Id.* For those institutions, the workgroup suggested implementation of “a unique strategy
 10 on quarantining patients.” *Id.* Defendants have implemented unique and reasonable
 11 strategies at these institutions, and Plaintiffs do not proffer *any* alternatives. Decl. Gipson
 12 ¶¶ 18, 22-23; Decl. Spaulding, ¶¶ 12; *see* Pltfs.’ Prop. Order at ¶ 5.

13 Further, Plaintiffs’ argument selectively cites CDC guidance on this topic, and Dr.
 14 Laurant’s declaration ignores this guidance altogether. Plaintiffs are correct to note that
 15 the CDC advises jails and prisons to make every effort to individually quarantine persons
 16 with suspected COVID-19. However, Plaintiffs neglect to mention that the CDC also
 17 acknowledges that “the next best alternative” to the “ideal choice” of single cells with solid
 18 walls should be used “as a harm reduction approach” when single cells with solid walls are
 19 unavailable. (CDC Interim Guidance on Management of COVID-19 in Correctional and
 20 Detention Facilities, Dec. 3, 2020, available at [https://www.cdc.gov/coronavirus/2019-](https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html)
 21 [ncov/community/correction-detention/guidance-correctional-detention.html](https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html) (“CDC
 22 Interim Guidance”).) In fact, the CDC provides the following seven alternatives for
 23 housing multiple quarantined individuals, *in order of preference*:

- 24 • Separately, in single cells with solid walls but without solid doors
- 25 • As a cohort, in a large, well-ventilated cell with solid walls, a solid door that
- 26 closes fully, and at least 6 feet of personal space assigned to each individual
- 27 in all directions
- 28 • As a cohort, in a large, well-ventilated cell with solid walls and at least 6 feet
- of personal space assigned to each individual in all directions, but without a

1 solid door

- 2 • As a cohort, in single cells without solid walls or solid doors (i.e., cells
3 enclosed entirely with bars), preferably with an empty cell between occupied
4 cells creating at least 6 feet of space between individuals
- 5 • As a cohort, in multi-person cells without solid walls or solid doors (i.e.,
6 cells enclosed entirely with bars), preferably with an empty cell between
7 occupied cells. Employ social distancing strategies related to housing to
8 maintain at least 6 feet of space between individuals housed in the same cell
- 9 • As a cohort, in individuals' regularly assigned housing unit but with no
10 movement outside the unit (if an entire housing unit has been exposed –
11 referred to as “quarantine in place”). Employ social distancing strategies
12 related to housing to maintain at least 6 feet of space between individuals
- 13 • Safely transfer to another facility with capacity to quarantine in one of the
14 above arrangements, though transfer should be avoided due to the potential
15 to introduce infection to another facility

16 Decl. Spaulding ¶ 19, n.13. It bears noting that even the CDC’s “next best alternative”—
17 housing patients separately in cells without solid doors—is unacceptable to Plaintiffs, and
18 that each of these options would violate the Constitution, according to Plaintiffs. But as
19 explained above, Defendants’ reasonable efforts to quarantine individuals under
20 challenging circumstances comport with this guidance. Decl. Spaulding ¶ 22, Ex. B.
21 Moreover, the Eighth Amendment does not mandate “the best possible solution[;] [r]ather,
22 the question is whether Defendants’ actions to date are reasonable.” Order Denying Pltfs.’
23 Emergency Mot. Re: Prevention and Management of COVID-19, ECF No. 3291, at 13:24-
24 14:1. Plaintiffs’ advocacy of a “best possible solution” standard is misplaced, and they
25 have failed to prove Defendants’ actions to date are unreasonable.

26 But rather than acknowledge these reasonable, CDC-sanctioned alternatives,
27 Plaintiffs claim that Defendants have “profess[ed] helplessness” at the need to find safe
28 quarantine space. Pltfs.’ Mot. at 23:9. Nothing could be further from the truth.
Defendants have gone to extensive lengths to identify safe housing, and indeed, 77% of
CDCR’s quarantined population is housed alone or with only one other cellmate in a cell
with solid doors. Decl. Spaulding, Ex. B. Defendants have also converted unused or

1 alternative space like gyms and factories, transferred incarcerated persons as appropriate to
 2 increase social distancing, installed climate-controlled tents, and, when necessary, housed
 3 incarcerated persons in cohorts. Decl. Gipson ¶¶ 4, 15, 23. These efforts are consistent
 4 with CDC guidance, which instructs correctional facilities to “use the next best alternative
 5 as a harm reduction approach.” (CDC Interim Guidance.)

6 Moreover, Defendants are entitled to deference here, where Defendants have acted
 7 reasonably and consistent with public health guidance. Neither this Court nor Plaintiffs
 8 may substitute their judgment for that of state experts and officials. *Farmer*, 511 U.S. at
 9 844; *Jacobson v. Commonwealth of Massachusetts*, 197 U.S. 11, 30 (1905) (“It is no part
 10 of the function of a court or jury to determine which one of two modes was likely to be the
 11 most effective for the protection of the public against disease”). Courts lack “judicial
 12 power to second-guess the state’s policy choices in crafting emergency public health
 13 measures.” *In re Abbott*, 954 F.3d 772, 784 (5th Cir. 2020), citing *Jacobson v.*
 14 *Commonwealth of Massachusetts*, 197 U.S. 11, 27-28 (1905). Plaintiffs ignore the realities
 15 of this legal maxim and its impact on their position here. But because Plaintiffs may not
 16 substitute their judgment for that of prison administrators and State officials, and because
 17 the law does not require Defendants to adopt the superlative means to address the risk of
 18 harm at issue, Plaintiffs’ motion must be denied consistent with long established Eighth
 19 Amendment jurisprudence. *Farmer*, 511 U.S. at 844.

20 **C. Plaintiffs’ Claim that Reserved Quarantine Space Is Not Being**
 21 **Appropriately Used Is Incomplete and Premature.**

22 Plaintiffs allege that reserved quarantine space is not being appropriately used by
 23 some institutions. But the data recently produced by the Receiver suggests that the
 24 reserved space is used much of the time during outbreaks. Decl. Spaulding Ex. B. To the
 25 extent there are instances where this space is not being properly used for quarantine, the
 26 parties should work together with the Receiver, who has now issued new guidance on
 27 quarantine housing, to determine whether correct decisions are being made on the use of
 28 reserved quarantine space.

1 The management of outbreaks in prison settings is extremely complex, and there
 2 may be practical reasons why officials at outbreak institutions have decided to quarantine
 3 incarcerated persons in cohorts despite available reserved quarantine space. Decl. Gipson
 4 ¶ 20. Those reasons are likely not readily apparent to those who are not on the ground at
 5 that facility during the outbreak. *Id.* On the other hand, it is possible that different
 6 decisions could have been made in some circumstances. *Id.* Regardless, and in light of the
 7 additional space Defendants have recently identified, Defendants intend to ensure that all
 8 available single and double cells with solid doors are utilized first, and that cohorting in
 9 groups of three or more persons occur as a secondary option. Decl. Gipson, ¶ 20.
 10 Defendants are aware, however, that Plaintiffs have submitted an inquiry to the Receiver
 11 about quarantines at a number of prisons related to this issue, and the results of that
 12 inquiry, once obtained, should help determine to what extent there is a problem that needs
 13 to be addressed. This issue clearly warrants further investigation and Defendants welcome
 14 the opportunity to work with the Receiver and Plaintiffs in that regard. But it is premature
 15 for Plaintiffs to seek relief for an issue that has not been fully investigated or validated.

16 **D. Plaintiffs' Claim that Reserved Quarantine Space Has Been Improperly**
 17 **Used for Precautionary Quarantines is Premature and Unsubstantiated.**

18 Plaintiffs' motion complains that reserved isolation and quarantine space is
 19 sometimes improperly used for precautionary quarantines associated with inmate transfers.
 20 Defendants have not yet fully investigated whether or to what extent this is happening, but
 21 even if the claim were true, it would not cause much of an impact on availability of
 22 quarantine space during outbreaks, and would not amount to a constitutional violation.

23 When there is an outbreak of three or more patients at a prison, that prison closes to
 24 transfers, with the possible exception of intake from reception centers. Decl. Gipson ¶ 19.
 25 This means that most transfers to or from that prison cease once there are three positive
 26 cases of COVID-19. *Id.* This likely greatly reduces the need for precautionary quarantine
 27 space at institutions experiencing outbreaks. *Id.* Furthermore, as discussed above, most
 28 prisons have already reserved more quarantine and isolation space than the public-health

1 workgroup recommended, and many prisons have abundant additional space beyond the
2 reserved space. *Id.* ¶¶ 15-17, Ex. E.

3 Additionally, anticipated modifications to the precautionary quarantine protocols
4 that are reflected in the new draft Movement Matrix should further mitigate any issue in
5 this area, if one exists, because there will be fewer precautionary quarantines taking place.
6 Decl. Gipson, ¶ 19, Ex. B. Regardless, because this issue has only recently been raised by
7 Plaintiffs, Defendants have not yet had the opportunity to coordinate with the Receiver and
8 investigate this issue to determine whether the limited transfers that can occur at a closed
9 prison have impacted the ability to quarantine exposed inmates in reserved areas. As such,
10 Plaintiffs' motion on this subject is premature.

11 **II. Plaintiffs' Requested Relief Does Not Meet the Prison Litigation Reform Act's**
12 **Needs-Narrowness-Intrusiveness High Standard.**

13 To be entitled to the injunctive relief Plaintiffs seek here, in addition to proving
14 deliberate indifference, they must also comply with the Prison Litigation Reform Act
15 (PLRA). 18 U.S.C. § 3626(a)(1)(A). The PLRA mandates that courts may not "grant or
16 approve any prospective relief unless the court finds that such relief is narrowly drawn,
17 extends no further than necessary to correct the violation of the Federal right, and is the
18 least intrusive means necessary to correct the violation of the Federal right." *Id.*
19 Plaintiffs' requested relief—in the form of an order requiring Defendants to "use only
20 solid-door cells to quarantine people for known exposure to the virus in all prisons except
21 the five noted below"—fails to comply with this strict standard and, instead, extends far
22 broader than necessary to address the narrow risk of harm Plaintiffs allege. Pltfs.' Prop.
23 Order, ¶ 1.

24 Plaintiffs contend that incarcerated persons who have been exposed to a COVID-19
25 positive individual must only be quarantined alone or with one other cellmate in a cell with
26 a solid door. Plaintiffs assert that Defendants' inability to do so in all instances of
27 exposure equates to a Constitutional violation. However, Plaintiffs ignore that 77% of all
28 incarcerated persons currently undergoing quarantine are indeed housed in single or double

1 cells with solid doors. Decl. Spaulding Ex. B. Similarly, Plaintiffs ignore that at least 12
 2 institutions currently have *zero* incarcerated persons who are quarantined with more than
 3 one other person. *Id.* Indeed, the Public Health Workgroup noted that “it appears that
 4 nearly all institutions already had reserved or vacated enough suitable bed space for
 5 isolation and quarantine.” Decl. Gipson Ex. D at 2. Thus, the relief Plaintiffs seek here is
 6 inapplicable to these institutions, which may not be subjected to prospective relief under
 7 the PLRA given these factual realities.

8 Even for those institutions that do utilize shared airspace for quarantine, not all
 9 institutions are alike. Institutions that lack single cells with solid doors, like California
 10 Rehabilitation Center, have implemented additional measures to control outbreaks and
 11 prevent the loss of life from COVID-19. Decl. Gipson ¶ 23. But Plaintiffs do not
 12 comment on the effectiveness of these measures, including whether the use of similar
 13 measures at other institutions is an acceptable alternative. Plaintiffs’ one-size-fits-all
 14 approach to require all institutions to adopt the same form of relief thus runs afoul of the
 15 PLRA, which instead calls for a more narrowly tailored approach. 18 U.S.C. §
 16 3626(a)(1)(A).

17 Additionally, Plaintiffs fail to specify the relief they propose for those institutions
 18 that lack sufficient single cells with solid doors. For instance, San Quentin State Prison
 19 and Folsom State Prison lack an adequate number of single cells with solid doors. For
 20 these institutions and others that are similarly situated, Plaintiffs ask this Court to require
 21 Defendants to “place [people in need of quarantine] in cells with solid doors or use another
 22 alternative that will provide equivalent safety.” Pltfs.’ Prop. Order, ¶ 5. Plaintiffs do not
 23 specify what such an alternative would consist of. Elsewhere, in Plaintiffs’ Motion,
 24 Plaintiffs further elucidate their request as it relates to these institutions lacking in
 25 sufficient (or any) single cells with solid doors: order population reductions. Pltfs.’ Mot. at
 26 27:3-5 (“A significantly reduced population density at all the prisons, but particularly those
 27 with few to no cells, would make the work of quarantining exposed cases far easier.”). But
 28 as Plaintiffs are aware, this Court lacks jurisdiction to order CDCR to reduce its

1 population; even the targeted reduction envisioned by Plaintiffs may only be considered by
 2 a three-judge court. 18 U.S.C. § 3626(a)(3)(B). And to the extent Plaintiffs seek to place
 3 limits on the number of incarcerated persons who may be housed at those institutions, that
 4 too would violate the PLRA's requirement that a prisoner release order only be considered
 5 by a three-judge court. *Id.* at §(g)(4) ("the term 'prisoner release order' includes any order,
 6 including a temporary restraining order or preliminary injunctive relief, that has the
 7 purpose or effect of reducing or limiting the prison population, or that directs the release
 8 from or nonadmission of prisoners to a prison").

9 Because Plaintiffs' relief sought does not square with CDCR's current reality,
 10 which is that each institution requires a different approach to setting aside and utilizing
 11 quarantine and isolation space, they are not entitled to such relief under the PLRA.

12 **III. Plaintiffs' Motion is Premature.**

13 On December 4, 2020, the Receiver issued new recommendations concerning
 14 housing options for patients under quarantine. Gille Dec. ¶ 21. Defendants are in the
 15 process of evaluating this new recommendation and have not yet had the opportunity to
 16 discuss it either with the Receiver or Plaintiffs' counsel, or determine the extent to which
 17 this guidance will impact Plaintiffs' instant motion, or Defendants' current practices. *Id.*

18 Also on December 4, 2020, Defendants produced to Plaintiffs a chart setting forth
 19 the spaces that have been reserved under the Court's July 2020 order for quarantine and
 20 isolation and further describes substantial additional space at many prisons that is currently
 21 available and could potentially be used for quarantine or isolation if needed. Gille Dec. ¶
 22 3; Decl. Gipson Ex. E. The parties have not yet discussed this information, including the
 23 extent to which this additional space impacts Plaintiffs' motion. *Id.*

24 After the close of business on December 7, 2020, and after Defendants had
 25 provided Plaintiffs with their draft opposition and supporting declarations earlier that day,
 26 Plaintiffs informed Defendants that they were modifying their position, and now believe
 27 double celling for purposes of quarantine is reasonable. Gille Dec. ¶ 5. Defendants then
 28 had to wait until 4:30 p.m. on December 8 to receive Plaintiffs' revised briefing, which

1 included eight additional pages of argument from the version initially sent. *Id.* ¶ 6. In the
2 span of one week, Plaintiffs’ motion morphed from a “very straightforward, simple
3 argument” requiring “about ten pages,” to a 23-page brief that has shifted the relief sought
4 at least twice. ECF No. 3495-2 at 2; Gille Dec. ¶ 5.

5 In light of the rapidly evolving nature of Plaintiffs’ position with respect to
6 quarantine, as well as Defendants’ and CCHCS’s response to the pandemic, including the
7 new information produced by the Receiver and Defendants last week, Plaintiffs’ motion is
8 premature. If any order issues in response to this motion, it should direct the parties to
9 further meet and confer about the subjects raised in Plaintiffs motion to determine whether
10 the parties can informally resolve Plaintiffs’ concerns.

11 CONCLUSION

12 Since the onset of the pandemic, CDCR and its partners at CCHCS have worked
13 tirelessly to mitigate the risks associated with COVID-19 and to protect the incarcerated
14 and the staff who work in the system. Approaches have evolved as more is learned about
15 this dreaded disease and public health guidance has changed. CDCR has strived to comply
16 with evolving CDC guidelines. CDCR and CCHCS have also capitalized on lessons
17 learned as they react in real time to this crisis. Plaintiffs’ motion and the relief they request
18 ignores these facts, CDC’s Interim Guidance, the law, and the realities of correctional
19 systems. Plaintiffs’ motion must fail because it is abundantly clear that CDCR has not
20 been deliberately indifferent to this public health emergency generally and quarantine
21 specifically, and the Court cannot grant the unprecedented and broad relief Plaintiffs seek.

1 DATED: December 9, 2020

HANSON BRIDGETT LLP

2
3 By: /s/ Samantha Wolff

4 PAUL B. MELLO

5 SAMANTHA D. WOLFF

6 Attorneys for Defendants

7 DATED: December 9, 2020

XAVIER BECERRA

Attorney General of California

8
9
10 By: /s/ Damon McClain

11 DAMON MCCLAIN

Supervising Deputy Attorney General

12 RYAN GILLE

13 IRAM HASAN

Deputy Attorneys General

14 Attorneys for Defendants

15
16 DATED: December 9, 2020

PRISON LAW OFFICE

17
18
19 By: /s/ Sara Norman

20 DONALD SPECTER

STEVEN FAMA

21 ALISON HARDY

SARA NORMAN

22 SOPHIE HART

23 Attorneys for Plaintiffs

1 PRISON LAW OFFICE
DONALD SPECTER (83925)
2 STEVEN FAMA (99641)
ALISON HARDY (135966)
3 SARA NORMAN (189536)
RANA ANABTAWI (267073)
SOPHIE HART (321663)
4 1917 Fifth Street
Berkeley, California 94710
5 Telephone: (510) 280-2621
Fax: (510) 280-2704
6 dspecter@prisonlaw.com
Attorneys for Plaintiffs

7
8 **UNITED STATES DISTRICT COURT**
9 **NORTHERN DISTRICT OF CALIFORNIA**
10 **OAKLAND DIVISION**

11 MARCIANO PLATA, et al.,
12 *Plaintiffs,*
13 v.
14 GAVIN NEWSOM., et al.,
15 *Defendants.*

Case No. 4:01-cv-1351 JST

**[PROPOSED] ORDER ON
QUARANTINE SPACE**

16 The Court finds that it is the unanimous opinion of public health experts from both
17 parties, the Receiver, and the Centers for Disease Control and Prevention (CDC) that
18 people in CDCR on quarantine for known coronavirus exposure are at significantly
19 greater risk of contracting COVID-19 if they are placed in cells with porous or barred
20 doors or in dormitories instead of in cells with solid doors. That is because contact
21 through the air in shared air spaces¹ is one of the primary modes of transmission of the
22 disease.

23
24 ¹ The term “shared air spaces” refers to places where there is no meaningful barrier
25 separating people breathing the same air, such as cell walls and solid doors.

1 According to the CDC, when people with known exposure are housed together
 2 with other quarantined people, rather than in cells with solid doors, they are placed at a
 3 “high risk of transmission from infected to uninfected individuals.” Interim Guidance on
 4 Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention
 5 Facilities, posting date October 7, 2020 ([https://www.cdc.gov/coronavirus/2019-](https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html)
 6 [ncov/community/correction-detention/guidance-correctional-detention.html](https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html)). Thus,

7 **Facilities should make every possible effort to individually quarantine**
 8 **close contacts of individuals with confirmed or suspected COVID-19.**
 9 Cohorting multiple quarantined close contacts could transmit SARS-CoV-2
 10 from those who are infected to those who are uninfected. Cohorting should
 11 only be practiced if there are no other available options.

12 *Id.* (emphasis in original).

13 In accordance with this national Guidance, the Receiver has directed that “post-
 14 exposure quarantine housing should be solid-door cells occupied by only one person,”
 15 but that double celling is allowable: “Quarantine cohorting as defined in the Interim
 16 Guidance is to be used with no more than 2 persons per shared airspace housing.” The
 17 Receiver further noted that there are five prisons -- Avenal State Prison, California
 18 Rehabilitation Center, Chuckawalla Valley State Prison, Folsom State Prison, and San
 19 Quentin State Prison -- where “the available facilities are insufficient” to comply with
 20 these standards. In those prisons, the Receiver directed that “[a]ll efforts should be made
 21 . . . to find quarantine alternatives that satisfy the purposes of a post-exposure quarantine
 22 as set forth above.” The Court finds this approach strikes a reasonable balance between
 23 what is safe and what is possible for Defendants to achieve, given that according to
 24 Defendants, approximately three quarters of people on quarantine for exposure to the

1 virus are already single- or double-celled.

2 Defendants knowingly place people at substantial risk of serious harm when they
3 fail to set aside sufficient space to quarantine people in a cell with a solid door. Failure to
4 take appropriate measures to provide quarantine in a solid-door cell thus constitutes
5 deliberate indifference to the serious health needs of the patient population. Order
6 Denying Plaintiffs' Emergency Motion to Modify Population Reduction Order, April 4,
7 2020, ECF No. 3261 at 8 ("the Eighth Amendment requires Defendants to take adequate
8 steps to curb the spread of disease within the prison system"); *see also Jolly v. Coughlin*,
9 76 F.3d 468, 477 (2d Cir. 1996) ("correctional officials have an affirmative obligation to
10 protect inmates from infectious disease").
11

12 Plaintiffs have demonstrated that CDCR has to date failed to take adequate steps
13 to prevent this risk of harm to the people in its custody. Defendants have housed people
14 in shared air spaces for quarantine at prisons with celled housing available or that could
15 have been made available. They have failed to pursue all reasonable options at those
16 prisons with no or very few solid-door cells, such as reducing population density or
17 providing alternative safe locations for quarantine.

18 In addition, CDCR has not set aside quarantine space at individual prisons for the
19 separation of newly arrived residents from the rest of the population (precautionary
20 quarantine). This failure violates the Receiver's clear direction and places class members
21 at risk of harm.

22 Accordingly, the Court hereby orders the following:

23 1. In light of the current surge in COVID-19 cases and the extreme risk to the
24

1 CDCR population, within seven days of the date of this Order, Defendants shall use only
2 solid-door cells to quarantine people known to have been exposed to the virus. The first
3 choice for post-exposure quarantine shall be solid door cells occupied by only one
4 person. Defendants shall not quarantine people post-exposure in cohorts larger than two.

5 2. Defendants shall set aside enough cells with solid doors for quarantine
6 purposes to accomplish this end. Defendants shall explore the activation of unused space
7 in the prisons for isolation or quarantine purposes and shall identify and create options for
8 housing in order to accomplish this end. Defendants may consult CCHCS and public
9 health experts regarding whether people who have already recovered from COVID-19
10 maybe be quarantined together in shared air spaces.
11

12 3. Within seven days of the date of this Order, Defendants shall set aside enough
13 space at each prison for precautionary quarantine pursuant to the Receiver's direction.
14 Precautionary quarantine need not be in solid-door cells.

15 4. The space set aside for quarantine and isolation purposes at each prison shall be
16 used consistent with the following direction:

17 (a) Congregate or shared air living spaces shall not be used for quarantine
18 following exposure but may be used for isolation;

19 (b) solid-door celled housing shall be prioritized for use for quarantine over
20 isolation; and

21 (c) Precautionary modified programs may be used in shared air living
22 spaces where there was significant potential but not positive exposure pending
23 appropriate testing of the potential contact.
24

1 5. Avenal State Prison, California Rehabilitation Center, Chuckawalla Valley
2 State Prison, Folsom State Prison, and San Quentin State Prison are prisons with
3 relatively few, if any, cells with solid doors. Thus, the people housed in those institutions
4 are particularly at risk. Once quarantine is medically necessary, Defendants must place
5 these people in cells with solid doors, alone where possible and where not possible, with
6 one other person, or use another alternative that satisfies the purposes of a post-exposure
7 quarantine.

8 6. In recognition of the materially different missions and operations at California
9 Health Care Facility and California Medical Facility, decisions about post-exposure
10 housing at those prisons are committed to the discretion of their medical leadership and
11 the Receiver.
12

13
14 The Court finds that this Order is narrowly drawn, extends no further than
15 necessary to correct the violation of the Federal right, and is the least intrusive means
16 necessary to correct the violation of the Federal right.
17

18 IT IS SO ORDERED.

19 Dated: December __, 2020

20 _____
21 THE HONORABLE JON S. TIGAR
22 U.S. DISTRICT COURT JUDGE
23
24

1 PRISON LAW OFFICE
2 DONALD SPECTER (83925)
3 STEVEN FAMA (99641)
4 ALISON HARDY (135966)
5 SARA NORMAN (189536)
6 SOPHIE HART (321663)
7 1917 Fifth Street
8 Berkeley, California 94710
9 Telephone: (510) 280-2621
10 Fax: (510) 280-2704
11 dspecter@prisonlaw.com

12 *Attorneys for Plaintiffs*

13
14 **UNITED STATES DISTRICT COURT**
15 **NORTHERN DISTRICT OF CALIFORNIA, OAKLAND DIVISION**
16

17
18 MARCIANO PLATA, et al.,

19 Plaintiffs,

20 v.

21 GAVIN NEWSOM, et al.,

22 Defendants.
23
24
25
26
27
28

CASE NO. 01-1351 JST

**DECLARATION OF RANA
ANABTAWI IN SUPPORT OF
PLAINTIFFS' POSITION**

1 I, Rana Anabtawi, declare,

2 1. I am an attorney at law admitted to practice before this Court and the
3 courts of the state of California. I am an attorney at the Prison Law Office and
4 counsel for Plaintiffs in this litigation. If called as a witness, I would and could
5 competently testify to the facts stated herein, all of which are within my personal
6 knowledge.

7 2. In order to determine which prisons were using dorms for quarantine
8 purposes, I reviewed on December 1, 2020, the most recently available Outbreak
9 Management Tools for each institution, which CCHCS has recently started to
10 provide to us. Based on the data included regarding which yards were on quarantine,
11 I cross-referenced that information with the November 25, 2020, bed audit, provided
12 to us by CDCR, which noted which yards consisted of dorms and which of cells. If
13 an entire yard consisted of dorms, then I concluded that the patients on quarantine
14 on that yard were quarantining in dorms.

15 3. In order to determine whether the listed institutions had cells available,
16 I again reviewed the November 25, 2020, bed audit and determined whether the
17 institution also had cell living available at the prison. I also determined, based on
18 the institutional bed count, whether there remained empty beds available in the
19 celled living units.

20 4. Based on this review, I concluded that Valley State Prison, California
21 Institution for Men, Mule Creek State Prison, California State Prison at Solano,
22 Central California Women's Facility, California Men's Colony, Avenal State Prison,
23 R.J. Donovan State Prison and Substance Abuse Treatment Facility and State Prison
24 at Corcoran have in recent weeks used dorm housing for quarantine despite the fact
25 that solid-door cells were available at the same prison. I emailed CCHCS and
26 Defendants these concerns on December 1, 2020.

27 5. On October 2, 2020, I participated in a phone conference with CCHCS
28

1 executives and Defendants where we discussed a COVID-19 outbreak at California
2 Institution for Men (CIM). Although there were a significant number of vacant cells
3 at that prison, we were told that CIM continued to house quarantined patients in
4 congregate living spaces. During that call, CCHCS executives noted our persistent
5 line of questioning regarding whether prisons were using available single cells for
6 quarantine purposes and stated that this issue would be explored in subsequent
7 weeks.

8 6. On October 9, 2020, I participated in a phone conference with CCHCS
9 executives and Defendants where we discussed an outbreak at Correctional Training
10 Facility (CTF). Counsel for Plaintiffs asked why 38 patients housed in a dorm
11 setting on quarantine at that prison were not moved to available cells in the
12 designated set-aside space.

13 7. On October 16, 2020, I participated in a phone conference with
14 CCHCS executives and Defendants where we discussed outbreaks at California
15 Men's Colony (CMC) and California Correctional Institution (CCI). Counsel for
16 Plaintiffs asked why patients were being quarantined in dorms despite the
17 availability of a significant number of vacant cells in the designated set-aside spaces
18 at both prisons.

19 8. We have raised similar concerns in our portion of the Joint Case
20 Management Conference Statements, including on September 16, 2020 (ECF 3449)
21 and October 20, 2020 (ECF 3469). Defendants did not comment on these concerns
22 and, until they provided us with a revised chart of set-aside spaces on December 4,
23 gave no indication that they would set aside any additional quarantine space.

24 9. On December 8, 2020, I reviewed the CDCR COVID Tracker for
25 California Rehabilitation Center (CRC) at
26 <https://www.cdcr.ca.gov/covid19/population-status-tracking/>. The COVID Tracker
27 shows that CRC experienced a lengthy and significant outbreak that developed over
28

1 six months, resulting in far more than half of its population infected with COVID-
2 19. It also states that CRC has a population of approximately 2100 patients and has
3 had over 1600 active cases.

4 10. According to the COVID Tracker, CRC has had no COVID-19 related
5 deaths. I reviewed the Outbreak Management Tool for CRC dated November 20,
6 2020. That document states that only 102 of the over 2200 patients residing at CRC
7 at that time had a COVID-weighted risk score of over four.

8 11. During the October 16, 2020, phone conference with CCHCS
9 executives and Defendants, we also discussed the outbreak at CRC. We were told
10 that the patients with a risk score of three or higher at CRC were offered tented
11 housing in an attempt to limit their exposure to COVID in a large dorm setting.
12 CCHCS staff said that the offers did not begin until mid-October. This was months
13 after the virus had already run rampant throughout the facility and infected over half
14 the resident population, and at which point the spread of the infection within the
15 institution was already waning.

16 12. On December 4, 2020, counsel for the Receiver emailed to us a
17 Statement on Quarantine, a true and correct copy of which is attached hereto as
18 Exhibit A.

19 13. The Court's July 22 Order required the Receiver to monitor the
20 adequacy of isolation and quarantine space reserves and allowed either party to
21 request modifications to those reserves. On September 16, 2020, my coworker Sara
22 Norman emailed to the Receiver and Defendants a memorandum seeking such
23 modifications, entitled "Plaintiffs' Concerns Over Isolation/Quarantine Set-aside
24 Space at Individual Prisons." A true and correct copy of the September 16, 2020
25 memorandum is attached hereto as Exhibit B.

26 14. On October 27, 2020, Ms. Norman sent to the Receiver and Defendants
27 an email requesting modification to the set-aside space reserves to account for the
28

1 need for precautionary quarantine, in light of the growing number of inter-prison
2 transfers and expansion of intake. A true and correct copy of Ms. Norman's email is
3 attached hereto as Exhibit C. We have never received from Defendants any
4 designation of set-aside space for precautionary quarantine.

5 15. I wrote to the Receiver's office on October 5, 2020, regarding concerns
6 about quarantine practices at California Rehabilitation Center. On October 6, I
7 received a response from Jackie Clark, CCHCS Deputy Director of Internal
8 Operations. A true and correct copy of Ms. Clark's response is attached hereto as
9 Exhibit D.

10 16. On December 4, 2020, Defendants' counsel Damon McClain emailed
11 me a chart listing the CDCR prisons and the space allocated at each prison for the
12 housing of people who require isolation for COVID-19 infection development of
13 symptoms or quarantine based on exposure to the virus. A true and correct copy of
14 the chart is attached hereto as Exhibit E. This chart updates an earlier chart that was
15 provided to plaintiffs on October 15, 2020, and designates some additional space for
16 quarantine and isolation.

17 17. On November 9, 2020, DeAnna Gouldy, Deputy Director of Policy and
18 Risk Management Services, emailed me a copy of a November 9 memo to the
19 Wardens and others from Connie Gipson, Director of Division of Adult Institutions
20 and Tammy Foss, Director, CCHCS Corrections Services. This memo bars the
21 transfer of people who have a COVID-19 risk score of three or higher to six prisons:
22 Avenal State Prison, California Institution for Men (Facilities A and D), California
23 Rehabilitation Center, Chuckawalla Valley State Prison, Folsom State Prison and
24 San Quentin State Prison. A true and correct copy of the November 9 memorandum
25 is attached hereto as Exhibit F.

26 18. Physicians and infectious disease experts, some affiliated with the
27 Berkeley School of Public Health and others with Amend at UCSF, a health-focused
28

1 program “aimed at correctional culture,” issued a memo on June 13, 2020,
2 recommending substantial population reduction at San Quentin State Prison to
3 reduce the risk for transmission of COVID-19. A true and correct copy of the June
4 13 memo is attached hereto as Exhibit G.

5 19. On August 19, 2020, the Receiver issued a COVID-19 Screening and
6 Testing Matrix for Patient Movement. A true and correct copy of the Matrix is
7 attached hereto as Exhibit H. The Receiver issued a draft revised Matrix on
8 November 24 that contains some changes to the August 19 version but also requires
9 precautionary quarantine at each prison to accommodate its historical average of
10 transfers.

11 I declare under penalty of perjury under the laws of the United States that the
12 foregoing is true and correct.

13 Executed on December 9, 2020, in San Bruno, CA.

14
15 _____/s/_____

16 Rana Anabtawi
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27
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EXHIBIT A



Rana Anabtawi <rana@prisonlaw.com>

Statement on Quarantine

1 message

Barrow, Roscoe@CDCR <Roscoe.Barrow@cdcr.ca.gov>

Fri, Dec 4, 2020 at 11:59 AM

To: Lopes Matthew <mlopes@pdlolaw.com>, Ed Swanson <ed@smllp.law>, Don Specter <dspecter@prisonlaw.com>, Sara Norman <snorman@prisonlaw.com>, Steve Fama <sfama@prisonlaw.com>, Alison Hardy <ahardy@prisonlaw.com>, Rana Anabtawi <rana@prisonlaw.com>, Sophie Hart <sophieh@prisonlaw.com>, "Neill, Jennifer@CDCR" <Jennifer.Neill@cdcr.ca.gov>, "Renteria, Simone@CDCR" <Simone.Renteria@cdcr.ca.gov>, "Stafford, Carrie@CDCR" <Carrie.Stafford@cdcr.ca.gov>, "Scofield, Bryant" <Bryant.Scofield@cdcr.ca.gov>, "Ferguson, Patricia@CDCR" <Patricia.Ferguson@cdcr.ca.gov>, "Davis, Tamiya@CDCR" <Tamiya.Davis@cdcr.ca.gov>, "Ryan, Amanda@CDCR" <Amanda.Ryan@cdcr.ca.gov>, "Damon.McClain@doj.ca.gov" <Damon.McClain@doj.ca.gov>, "Kyle.Lewis@doj.ca.gov" <Kyle.Lewis@doj.ca.gov>, "Iram.Hasan@doj.ca.gov" <Iram.Hasan@doj.ca.gov>, "Ryan.Gille@doj.ca.gov" <Ryan.Gille@doj.ca.gov>, "Paul B. Mello" <Pmello@hansonbridgett.com>, Samantha Wolff <SWolff@hansonbridgett.com>, "Michael W. Bien" <MBien@rbgg.com>, Lisa Ells <LElls@rbgg.com>, Thomas Nolan <TNolan@rbgg.com>, Ernest Galvan <EGalvan@rbgg.com>, Martin Dodd <MDodd@fddcm.com>, Jamie Dupree <JDupree@fddcm.com>
Cc: Clark Kelso <ckelso@pacific.edu>, "Kirkland, Richard@CDCR" <Richard.Kirkland@cdcr.ca.gov>, "Toche, Diana@CDCR" <Diana.Toche@cdcr.ca.gov>, "Bick, Dr. Joseph@CDCR" <Joseph.Bick@cdcr.ca.gov>, "Foss, Tammy@CDCR" <Tammy.Foss@cdcr.ca.gov>, "Heintz, Lisa@CDCR" <Lisa.Heintz@cdcr.ca.gov>, "Gransee, Elizabeth@CDCR" <Elizabeth.Gransee@cdcr.ca.gov>, "Larson, Cheryl@CDCR" <Cheryl.Larson@cdcr.ca.gov>, "Saich, Lara@CDCR" <Lara.Saich@cdcr.ca.gov>, "Bauer, Heidi@CDCR" <Heidi.Bauer@cdcr.ca.gov>, "Clark, Jackie" <Jackie.Clark@cdcr.ca.gov>

The Receiver has asked that I share the following Statement on Quarantine with you:

Consistent with CCHCS's COVID-19 Interim Guidance and the analysis set forth in my memorandum of October 21, 2020, dealing with Transferring COVID-19 High-Risk Patients to Safer Housing, and in light of recently received data showing the number of patients in various quarantine settings, I have determined that, as a general matter, post-exposure quarantine in shared airspace housing more than 2 persons fails to adequately achieve the intended goals of a COVID-19 post-exposure quarantine to facilitate the prompt identification of new cases and to help limit the spread of COVID-19 to new, uninfected people. The first choice for post-exposure quarantine housing should be solid-door cells occupied by only one person. Quarantine cohorting as defined in the Interim Guidance is to be used with no more than 2 persons per shared airspace housing.

At a number of institutions, including ASP, CRC, CVSP, FSP and SQ, the available facilities are insufficient to achieve the standard set forth above. In those institutions, quarantining in groups of larger than 2 patients has been undertaken. All efforts should be made at these institutions to find quarantine alternatives that satisfy the purposes of a post-exposure quarantine as set forth above.

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

Roscoe Barrow
Chief Counsel

California Correctional Health Care Services

CCHCS Office of Legal Affairs; Building D

P.O. Box 588500

Elk Grove, CA 95758

916-691-6633 Office

916-956-7467 Cell

916-691-6172 Fax

Roscoe.Barrow@cdcr.ca.gov



CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

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EXHIBIT B

Plaintiffs’ concerns over isolation/quarantine set-aside space at individual prisons

Pursuant to the Order to Set Aside Isolation and Quarantine Space of July 22, 2020, Plaintiffs hereby “request that the Receiver consider whether reserve levels at a particular institution should be modified.” *Id.*, ¶ 6. The specific reasons for modifications to individual prisons are noted below. Along with our modification requests, we also note some questions regarding the adequacy of the reserve space.

In requesting these specific modifications, Plaintiffs do not represent that additional modifications are not needed to the reserve levels. In particular, at this time, Plaintiffs do not raise modifications that might be needed based on the disability and mental health housing needs of people at the prison. Those concerns are currently being raised in the *Armstrong* and *Coleman* cases, and Plaintiffs do not believe it is necessary to reiterate them at this time.

General concerns

1. Quarantine set-aside space must be single cells with solid doors. According to the Public Health Workgroup, “if the [quarantine set-aside] space is single cells with solid doors and all public health measures are enforced along with the de-densification that has already occurred, the proposed space plan, though imperfect, is a reasoned and supportable approach that protects residents and staff.” Further, “patients suspected to have COVID-19 infection must be separated from each other in single cells with solid doors, with minimal exceptions noted.” Some prisons have not designated appropriate space. For instance, CRC has not designated any cells with solid doors for quarantine, because there is no celled housing at the prison. In other cases, celled housing is designated for the reserve space, but the doors are perforated and thus allow for the flow of air outside of the cell, such as the celled housing at San Quentin, Chuckawalla Valley,

and Pelican Bay. A solution must be found to allow safe quarantine consistent with the Public Health Workgroup's guidance.

2. Set-aside space for different classifications: Where a prison houses people classified as general population and as sensitive needs, there should be separate isolation and quarantine space for each classification. Past experience shows that actual or serious threats of harm will be suffered by many of those classified as sensitive needs if housed in the same unit as those who are not. Further, many classified as general population are adamant about ever being housed with those who are classified as sensitive needs. Thus, if the two populations are not housed separately, CDCR and CCHCS face a very real possibility that large numbers of people will refuse to be tested and/or refuse to be moved to the designated isolation and quarantine space, seriously hampering the prison's ability to control the spread of the virus. (The same problem occurs when a prison has facilities designated SNY and non-designated programming facility: people might refuse to transfer to the SNY for quarantine and isolation.) We believe that this is an unnecessary barrier to treatment and detection that can be addressed by the appropriate allocation of separate reserve space. High Desert State Prison expanded its reserve space for exactly this reason, as confirmed by the warden. Salinas Valley did the same. Several prisons, including CTF, Mule Creek, and SCC, must follow suit.

3. Separate space for isolation and for quarantine: The Public Health Work Group directed that those confirmed to have active COVID-19 infection not share air space with any other group. However, 14 prisons have only identified one building for both quarantine and isolation purposes: California City, California Conservation Center, Central California Women's Facility, California Institution for Women, California Men's Colony, CSP-Corcoran, Correctional Training Facility, Deuel Vocational Institution, Ironwood State Prison, Mule Creek State Prison, North Kern State Prison, Pelican Bay

State Prison, Pleasant Valley State Prison, and R.J. Donovan State Prison. Given the Workgroup's recommendations, we believe each of these prisons should (a) identify at least one additional quarantine and isolation building or (b) explain how quarantine and isolation patients can be housed safely in the single building (for example, it may be appropriate to use the same building for both isolation and quarantine if the building is divided into celled pods that do not share air space) and provide a plan for how the groups will be kept separate, including for purposes of access to yard, dayroom, showers, and phones and receiving medications and meals.

Individual prisons

Correctional Health Care Facility

QUESTION: The CCHCS Quality Management Unit recommended that CHCF reserve 277 beds for quarantine and isolation. CHCF has identified and reserved 92 negative-pressure-room beds and 100 tent beds. CDCR reports that, in the event of an outbreak, additional beds (the number to be determined by healthcare staff) will be provided through the quick activation (within 72 hours) of more tents triggered by the occupancy of 40 negative-pressure-room beds. Is this plan acceptable to CCHCS?

MODIFICATION: We believe that the reserve space must be modified because many of the 92 negative-pressure-room beds are only available to the inpatient mental health population, since they are located in inpatient mental health units, A and B. If non-mental health patients cannot be housed in these rooms for isolation or quarantine, the number available to them is significantly smaller than stated and might need to be supplemented by addition designations to reach the threshold.

California Medical Facility

QUESTION: We discussed on the initial isolation and quarantine conference call in August the need for a plan for patients at the OHU level of care residing in a dorm setting who may not be able to move to the designated isolation and quarantine space. How will this population be quarantined or isolated? (We agree that people at an OHU level of care who are residing in cells with solid doors can be isolated or quarantined in place.)

California Rehabilitation Center

QUESTION: Based on the most recent isolation and quarantine chart provided, Dorms 311 and 410, as well as the gym, have been designated as the isolation and quarantine set-aside space. However, according to information received from Vince Cullen on August 30th, CRC shifted to the use of alternate space for isolation, e.g. Dorm 214. Does the chart need to be updated to reflect the current units being used for isolation and quarantine?

MODIFICATION: CRC has designated two dorms and a gym, for a total of 233 beds. All are in congregate living spaces. Is there room in these designated group living spaces for people to distance while quarantining? We are very concerned about the lack of cells available and believe there must be a clear plan for safe quarantining.

Correctional Training Facility

MODIFICATION: All quarantine and isolation space are on Y wing of Facility C, which is Level II general population, while Facilities A and B are Level II SNY. We believe that people housed on Facility A and B will resist testing for COVID if they know they will be housed on a general population facility if they

test positive, out of fear for their safety, and may resist transferring to a quarantine unit if exposed. See general concern above. We believe space must be designated on Facility A or B for quarantine and isolation.

Chuckawalla Valley State Prison

MODIFICATION: The celled housing added – A-3 – does not have solid doors; the doors are perforated. We believe Chuckawalla Valley must have reserve space with solid doors for quarantine.

Folsom State Prison/Folsom Prison for Women

MODIFICATION: One of the dorms designated, with 126 beds, is in the women's facility. We have been told that that will be used for men and based on review of the Registry, we believe men are currently housed there. That leaves the approximately 100 women without set-aside space.

MODIFICATION: CDCR Reports that “[t]he CCHCS Quality Management Unit recommended that Folsom reserve 1380 beds for quarantine and isolation. Folsom has already identified 88 cell beds (double celled) and 158 dorm beds that it has reserved for isolation and quarantine. In the event of an outbreak, additional beds (the number to be determined by healthcare staff) will be provided through the quick activation (within 72 hours) of tents.” We are concerned with activating such an enormous number of tents in the event of a major breakout. What if the air quality is too dangerous to allow for the use of tents? We believe more indoor space should be set aside. Additionally, we do not know whether the cells that have been reserved have solid doors.

Mule Creek State Prison

MODIFICATION: The sole space designated is on Facility A, a Level IV SNY. We believe that people housed on Facilities D and E (Level II NDPFs) and the MSF will resist testing for COVID if they know they will be housed on an SNY facility if they test positive, and may resist transferring to a quarantine unit if exposed. See general objection above.

Pelican Bay State Prison

MODIFICATION: The cells set aside (facility A-1) do not have solid doors; the door are perforated. We believe Pelican Bay must have reserve space with solid doors for quarantine.

Substance Abuse Treatment Facility and State Prison at Corcoran

QUESTIONS: We need additional information to determine whether the set aside space is adequate. First, Plaintiffs previously raised the concern that SATF had reserved too few quarantine and isolation beds. The prison then increased the amount of space it had designated for quarantine and isolation purposes, but many of these units are currently in use, because SATF has an active outbreak. Will SATF be able to keep these units vacated and ready for use as isolation and/or quarantine space when this outbreak is over? If not, which spaces will be kept vacated? Second, on a September 4 *Armstrong* call, CDCR reported E2 was being used for SNY quarantine, F1 for SNY isolation, C4 for both GP isolation and quarantine (with solid walls between each section), and C3 for GP isolation. Is this correct? If so, will Level 4 SNYs from D go to F1 pods for isolation? If not, where will they go?

Sierra Conservation Center

MODIFICATION: The designated spaces are on Facility C, a Level III SNY. We believe that people housed on Facilities A and B (Level I and Level II NDPFs) will resist testing for COVID if they know they will be housed on an SNY if they test positive, and may resist transferring to a quarantine unit if exposed. See general objection above.

San Quentin State Prison

MODIFICATION: We are concerned that San Quentin's reserve space is not nearly enough beds, with no solid cell doors. Tents are not appropriate to rely on for large populations. Defendants' plan is not in accord with what CCHCS QM recommended.

Valley State Prison

QUESTION: CCHCS QM identified the largest two open air spaces to total 16. This calculation appears to be inaccurate. According to the August 26, 2020, bed count, VSP's two largest open air spaces are Dorms B3 at 235 and D1 at 224, totaling 459. The current reserve space totals 287 double or 143 single cells. This is insufficient. Will additional space be set aside?

EXHIBIT C



Sophie Hart <sophiehart@prisonlaw.com>

Precautionary quarantine space

Sara Norman <snorman@prisonlaw.com>

Tue, Oct 27, 2020 at 4:32 PM

To: "Kelso, Clark@CDCR" <Clark.Kelso@cdcr.ca.gov>, "Kirkland, Richard@CDCR" <Richard.Kirkland@cdcr.ca.gov>, "Cullen, Vincent@CDCR" <Vincent.Cullen@cdcr.ca.gov>, "Bick, Joseph@CDCR" <Joseph.Bick@cdcr.ca.gov>

Cc: Roscoe Barrow <Roscoe.Barrow@cdcr.ca.gov>, Martin Dodd <MDodd@fddcm.com>, Alison Hardy <ahardy@prisonlaw.com>, Don Specter <dspecter@prisonlaw.com>, Rana Anabtawi <rana@prisonlaw.com>, sophieh@prisonlaw.com, Steven Fama <sfama@prisonlaw.com>, "Neill, Jennifer@CDCR" <Jennifer.Neill@cdcr.ca.gov>, "Renteria, Simone@CDCR" <Simone.Renteria@cdcr.ca.gov>, "Stafford, Carrie@CDCR" <Carrie.Stafford@cdcr.ca.gov>, "Scofield, Bryant" <Bryant.Scofield@cdcr.ca.gov>, Damon McClain <Damon.McClain@doj.ca.gov>, Nasstaran Tara Ruhparwar <Nasstaran.Ruhparwar@doj.ca.gov>, Ryan Gille <Ryan.Gille@doj.ca.gov>, "Paul B. Mello" <Pmello@hansonbridgett.com>, Samantha Wolff <SWolff@hansonbridgett.com>

Dear Clark,

Pursuant to the Order to Set Aside Isolation and Quarantine Space of July 22, 2020, we “request that the Receiver consider whether reserve levels at a particular institution should be modified.” In particular, we ask that you consider whether the set-aside space at all institutions should be modified to account for the growing number of inter-prison transfers and expansion of intake.

The COVID-19 Screening and Testing Matrix for Patient Movement of August 19, 2020, requires people to be placed in precautionary quarantine pre- and post-transfer in celled housing (except for those prisons that have no cells). Each prison “shall maintain sufficient quarantine space to accommodate its historical average volume of transfers.” (Definitions at 2.b.ii.)

Does the current plan for set-aside space (I attach the October 15 version, the most recent we have received) include quarantine space at each prison sufficient to comply with the Movement Matrix’s requirement, in addition to the quarantine space set aside to contain outbreaks consistent with the Public Health Workgroup’s methodology? If not, is there a separate listing of quarantine space for pre- and post-transfers? What is the historical average volume of transfers for each prison?

Thank very much for helping us understand whether sufficient space has been set aside for precautionary quarantines as well as for quarantines based on exposure. We look forward to your response.

--Sara

EXHIBIT D



CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES



MEMORANDUM

Date: October 6, 2020

To: Rana Anabtawi, Prison Law Office

From: Jackie Clark, Deputy Director (A) of Internal Operations

Subject: PRISON LAW OFFICE CONCERNS RELATED TO A PATIENT REPORT FROM CRC

This is a response from California Rehabilitation Center (CRC) in regards to a concern dated October 5, 2020. Please see below.

1) Has Dorm 106 been on quarantine status since June? If not, please provide the dates that the unit was on quarantine status. The dorm was on Quarantine from June 24 to Sept 23. There were four patients left in the dorm that did not contract COVID.

- Once the inmate were cleared from quarantine, we did move additional inmate-patients into this 66-bed (COVID capacity) dorm. Currently there are 36 COVID Naïve patients housed in the dorm.

2) Since June, have patients from Dorm 106 tested positive for COVID? If so, on what date(s) did patients test positive, how many on each date, and where were the patients moved for isolation?

- All COVID positive patients were rehoused in appropriate COVID-positive Isolation housing upon testing positive.
Below is the detail.
- Quarantine extended 9.23.20. Positive Patient (Keene BI8802) exposed Dorm 106; last contact 9.9.20. Dorm Quarantine Extended/Total Movement Restriction 9.9.20 to 9.23.20.
- Quarantine extended 9.11.20. Positive Patient (Vasquez F22971) exposed Dorm 106; last contact 8.28.20. Dorm was pending test results from mass testing 8.26.20. Dorm Quarantine Extended 8.28.20 to 9.11.20.
- Quarantine extended 8.27.20. Positive Patients (4) exposed Dorm 106; last contact 8.13.20. Dorm Quarantine 8.13.20 to 8.27.20.
- Quarantine extended 8.14.20. Positive Patient exposed Dorm (Peters BL7881); last contact 7.31.20. Dorm Quarantine extended 7.31.20 to 8.14.20.
- Quarantine extended 8.1.20. Inconclusive Patient (Boxley BI1906) 7/17/20; re-tested Positive 7.20.20. Patient rehoused in Dorm 407 7.22.20; last dorm contact 7.18.20. Dorm Quarantine extended 7.18.20 to 8.1.20.

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- Inconclusive Patient (Boxley BI1906) tested 7.17.20; last dorm contact 7.18.20. Dorm will remain on Quarantine 7.14.20 to 7.28.20. Patient moved to Dorm 408B 7.18.20.
- Quarantine extended 7.28.20. Inconclusive Patient (Compton AR8195); re-tested Positive 7.13.20. Patient rehoused in Dorm 407 7.14.20. Last contact 7.14.20. Dorm Quarantine extended 7.14.20 to 7.28.20.
- Inconclusive Patient (Compton AR8195); tested Inconclusive 7.10.20 in Dorm 109. Patient rehoused in Dorm 408B pending test results 7.14.20.
- In order to free up additional housing space to utilize for COVID Patient Housing; Dorm 109, which houses 12 patients will be re-housed with Dorm 106 and begin their quarantine together 7.13.20. Quarantine Date 7/12/20 to 7/26/20, due to Positive Patient. Last contact with Dorm 109 7/12/20.
- Due to mass testing in Dorm 105 and Dorm 106, Dorm 106 was initiated as a Highly Suspected Close Contact Dorm 7.8.20. All negative COVID cases from Dorm 105 and 106 will be housed in Dorm 106. 10 Patients were rehoused 7.8.20 from Dorm 106 to Dorm 105 who tested positive 7.6.20. 21 patients were rehoused 7.8.20 from Dorm 105 to Dorm 106 who tested negative 7.6.20. Dorm 106 exposed to positive patients rehoused in Dorm 105 7.8.20; Dorm Quarantine 7.8.20 to 7.22.20.
- Suspected Patient (Rodriguez BI5751) tested Positive 6.26.20. Dorm will remain on Quarantine 6.24.20 to 7.8.20.
- Dorm exposed to suspected patient case 6.24.20 (Rodriguez BI5751); Dorm Quarantine 6.24.20 to 7.8.20. Patient moved to Dorm 407B.

3) Did any additional patients move into Dorm 106 while the unit was in quarantine status?

Yes on July 13, 2020, 12 inmates were moved into the dorm because they were also on quarantine with similar time lines and space was needed in Dorm 109.

Please provide the number of patients who resided in Dorm 106 at the beginning of the quarantine period, how many patients tested positive and were moved out into isolation during the length of the Dorm 106 quarantine, and how many patients remained residing in the Dorm at the end of the quarantine period, if it is over?

The Quarantine is over as of 9/23/20. In late June, Dorms 105 and 106 were mass-tested at the same time. Positives went to Dorm 105 and negatives went to 106. We had 57 test negative and house in 106. On 7/13/20, 12 negative quarantined patients were moved to 106 from 109 due to space needs. This brought the total inmates to 61 by 7/20/20. By the time the quarantine was over it was four inmates that did not contract COVID.

4) At any point since June, has CRC staff moved additional patients into a Dorm that was under quarantine? Please explain.

As noted above, patients were moved into 106 on 7/13/20, 12 negative quarantined patients were moved to 106 from 109 due to space needs.

MEMORANDUM

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Thank you,

Cc: Clark Kelso, Receiver
Joseph Bick, M.D., Director, Health Care Services, CCHCS
Rasco Barrow, Chief Counsel, CCHCS Office of Legal Affairs
Robert Herrick, Southern Region Chief Executive Officer, CCHCS

EXHIBIT E

Institution	Original Plata Reserved Space	Number of Original Reserved Beds	Additional Available Space	Additional Available Beds
ASP	Facility C, Housing Unit 330 (192 Dorm Beds) Facility A, Housing Unit 140 (200 Cell Beds)	Dorm Beds - 192 Cell Beds - 200 double or 100 single CCHCS QM Recommendation - 248	None	N/A
CAC	Facility A, Building 2, A and B Pod - (168 Cell Beds)	Cell Beds - 168 double or 84 single CCHCS QM Recommendation - 4	Facility A, Building 2, C Pod	Cell Beds (88 double or 44 single)
CAL	Facility A, Building 5 (200 Cell Beds); Facility B, Building 5 (200 Cell Beds)	Cell Beds - 400 double or 200 single CCHCS QM Recommendation - 180	Facility C, Building 2	Cell Beds (200 double or 100 single)
CCC	Facility C, Building 3 (200 Cell Beds)	Cell Beds - 200 double or 100 single CCHCS QM Recommendation - 48	Facility A Dorms 6, 7, 13 - Isolation Facility A Dorms 1, 2, 12 - Quarantine Facility B Dorms 67, 75, 76 - Isolation Facility B Dorms 62, 69, 70 - Quarantine Facility C Gym Isolation	60 Dorm Beds 30 Dorm Beds 30 Dorm Beds 60 Dorm Beds 98 Dorm Beds
CCI	Facility A, Housing Unit 8 (124 Cell Beds) Facility C Housing, Unit 1 (200 Cell Beds) Facility E, Davis Hall (94 Dorm Beds) Facility D, Housing Unit 9 (48 Cell Beds) Facility D Gym (60 beds)	Dorm/Gym Beds - 154 Cell Beds - 248 double or 124 single CCHCS QM Recommendation - 235	None	None
CCWF	Facility A, Building 503 (200 Cell Beds)	Cell Beds - 200 double or 100 single CCHCS QM Recommendation - 16	Facility A, Building 502 B, C and D Wings - Isolation Facility B, Building 508- D-wing - Quarantine EOP Facility A, Building 502, A-wing - Isolation EOP	192 Cell Beds (Solid door 8 person cells) 64 Cell Beds (Solid door 8 person cells) 64 Cell Beds (Solid door 8 person cells)
CEN	Facility A, Building 5 (200 Cell Beds) Facility D, Building 5 (200 Cell Beds)	Cell Beds - 400 double or 200 single CCHCS QM Recommendation - 193	Facility B, Building 4 (200 Cell Beds) Facility A, Building 3 (200 Cell Beds)	Cell Beds (400 double or 200 single)
CHCF	Facility E, Main Yard Tents (100 beds) Facilities A, B, C and D Negative Pressure Rooms (NPR) (92 NPR beds)	NPR Beds - 92 Tent Beds - 100 CCHCS QM Recommendation - 277	None	N/A
CIM	Facility B, Birch Hall (102 single Cell Beds) Facility C, Del Norte (200 Cell Beds)	Single Cell Beds - 102 Cell Beds - 200 double or 100 single CCHCS QM Recommendation - 188	Facility A 10 DPW beds in Tent #9	10 DPW beds (Tent #9)
CIW	Housing Unit A RCU (220 Cell Beds)	Cell Beds - 220 double or 110 single CCHCS QM Recommendation - 4	None	N/A
CMC	Facility C, Building 5 (300 single Cell Beds)	Single Cell Beds - 300 CCHCS QM Recommendation - 143	None	N/A
Institution	Original Plata Reserved Space	Number of Original Reserved Beds	Additional Available Space	Additional Available Beds
CMF	S-3 Housing Unit (18 Cell Beds) W-1 Housing Unit (41 Cell Beds) W-3 Housing Unit (42 Cell Beds) H-1 Housing Unit (21 Cell Beds, 26 Dorm Beds) I-1 Housing Unit (10 Dorm Beds, 36 Cell Beds)	Single Cell Beds - 158 Dorm Beds - 36 CCHCS QM Recommendation - 162	None	N/A
COR	Facility 3B, Building 02 (200 Cell Beds)	Cell Beds - 200 double or 100 single CCHCS QM Recommendation - 46	Facility 3C, Building 03 - Quarantine 4A1L C-Section - Isolation A1L A-Section - Isolation EOP 4B4R C-Section - Quarantine 4B4L - Isolation 4A2L B-Section - Quarantine	Cell Beds (200 double or 100 single) Cell Beds (48 double or 24 single) Cell Beds (40 double or 20 single) Cell Beds (48 double or 24 single) Cell Beds (128 double or 64 single) Cell Beds (40 double or 20 single)
CRC	Facility D, Dorm 410 (78 Dorm Beds) Facility D, Dorm 311 (77 Dorm Beds)	Dorm Beds - 155 Gym Beds - 78 CHCS QM Recommendation - 187	Dorms 407 - Isolation Dorm 408 - Quarantine Dorm 411 - Quarantine Dorm 214 - Isolation	72 Dorm Beds 72 Dorm Beds 12 Dorm Beds 200 Dorm Beds
CTF	Central Facility, Y wing (258 Cell Beds)	Cell Beds - 258 double or 129 single CCHCS QM Recommendation - 127	Central Gym - Isolation South Gym - Isolation Fremont Dorm - Isolation Central Chapels 1 & 2 - Isolation	56 Dorm Beds 54 Dorm Beds 200 Dorm Beds 24 Dorm Beds
CVSP	Facility D, Building 11 (192 Dorm Beds) Facility A, Building 3 (200 Cell Beds)	Cell Beds - 200 double or 100 single Dorm Beds - 192 CCHCS QM Recommendation - 91	None	N/A
DVI	Facility A, G-wing (264 Cell Beds)	Cell Beds - 264 double or 132 single CCHCS QM Recommendation - 66	L-1 - Isolation	Cell Beds (96 double or 48 single)
FOL	Facility A, Unit IV, Tier 2, A & B side cells (88 Cell Beds); MSF Dorm 500 (10 Dorm Beds) MSF 600 (18 Dorm Beds)	Cell Beds - 92 double or 44 single Dorm Beds - 10 Dorm Beds - 18 CCHCS QM Recommendation - 1380	Facility A, Unit IV, Tier 3 A & B side cells - Quarantine Facility B, FWF, B Dorm (Male Beds) - Isolation Facility B, FWF A Dorm DRP Mod (Female Beds) - Isolation Facility B, FWF A Dorm Pod 2 - Quarantine	Cell Beds (92 double or 46 single) 282 Dorm Beds 20 Dorm Beds 9 single Cell Beds
HDSP	Facility C, Building 1 (128 Cell Beds); Facility A, Building 4 (200 Cell Beds)	Cell Beds - 328 double or 164 single CCHCS QM Recommendation - 71	None	N/A
ISP	Facility C, Building 1 (200 Cell Beds);	Cell Beds - 200 double or 100 single; CCHCS QM Recommendation - 63	Facility C, Building 2 - Isolation	(200 double or 100 single)
KVSP	Facility D, Building 6 (128 Cell Beds); Facility A, Building 1, Section B (20 Cell Beds)	Cell Beds - 148 double or 74 single CCHCS QM Recommendation - 66	Facility D, Building 7, B Section - Flex space (empty) Facility B, Building 1 B/C section - Isolation	Cell Beds (40 double or 20 single) 80 Cell Beds (80 double or 40 single)
Institution	Original Plata Reserved Space	Number of Original Reserved Beds	Additional Available Space	Additional Available Beds
LAC	Facility C, Building 5 (200 Cell Beds) Facility B, Building 2 (200 Cell Beds) Facility B Gym (24 beds)	Cell Beds - 400 double or 200 single Gym Beds - 24 CCHCS QM Recommendation - 210	None	N/A

MCSP	Facility A, Building 2 (200 Cell Beds)	Cell Beds - 200 double or 100 single; CCHCS QM Recommendation - 29	Facility A Gym - Isolation Facility B Gym - Isolation Facility C Gym - Isolation Facility D, Building 18 - Quarantine (2 six men cells)	100 Dorm Beds 100 Dorm Beds 100 Dorm Beds 12 Cell Beds (Solid door 6 person cells)
NKSP	Facility D, Building 3 (198 Cell Beds)	Cell Beds - 198 double or 99 single CCHCS QM Recommendation - 78	Facility B, Building 4	Cell Beds (198 double or 99 single)
PBSP	Facility A, Building 1 (128 Cell Beds)	Cell Beds - 128 double or 64 single CCHCS QM Recommendation - 49	None	N/A
PVSP	Facility D-5 Building (200 Cell Beds)	Cell Beds - 200 double or 100 single CCHCS QM Recommendation - 78	Facility D, Building 3 - Isolation	Cell Beds (200 double or 100 single)
RJD	Facility D, Housing Unit 20 (200 Cell Beds)	Cell Beds - 200 double or 100 single CCHCS QM Recommendation - 39	Facility C Gym - Isolation	24 Dorm Beds
SAC	Facility A, Building 2 (20 Cell Beds); Facility B, Building 1 (48 Cell Beds); Facility C, Building 8 (128 Cell Beds)	Cell Beds - 196 double or 98 single CCHCS QM Recommendation - 11	None	N/A
SATF	Facility E, Building 2 (200 Cell Beds); Facility C, Building 4 sec. B and C (88 Cell Beds) Facility C Building 3 (128 Cell Beds) Facility F, Housing Unit F1, A-section- 11 pods (88 Dorm Beds)	Cell Beds - 200 double or 100 single CCHCS QM Recommendation - 260	Facility A Gym - Isolation Facility B Gym - Isolation Facility F/G Gym - Isolation Facility C, Building 4 - Isolation	46 Dorm Beds 46 Dorm Beds 40 Dorm Beds Cell Beds (256 double or 128 single)
SCC	Facility C, Building 3 (200 Cell Beds) Facility C gym (100 beds)	Cell Beds - 200 double or 100 single CCHCS QM Recommendation - 63	None	N/A
SOL	Facility B, Building 7 (200 Cell Beds) Facility B, Building 9 (200 Cell Beds) Facility B Gym (150 Dorm Beds)	Cell Beds - 400 double or 200 single Gym Beds - 128 CCHCS QM Recommendation - 211	Facility C Gym - Isolation	150 Dorm Beds
SQ	Gym (108 beds)	Gym Beds - 108 CCHCS QM Recommendation - 1550	Adjustment Center 1st tier North - Isolation Adjustment Center 1st tier South - Quarantine Adjustment Center 2nd tier North - Isolation Adjustment Center 2nd tier South - Quarantine (Sections will be emptied as needed). Chapel A, Quarantine Chapel B, Quarantine Chapel C Quarantine	17 Single Cell Beds 11 Single Cell Beds 17 Single Cell Beds 18 Single Cell Beds 10 Dorm Beds 10 Dorm Beds 10 Dorm Beds
SVSP	Facility C, Building 7 (182 Cell Beds); Facility D, Building 6, Section B (40 Cell Beds)	Cell Beds - 222 double or 111 single CCHCS QM Recommendation - 78	Facility C Gym - Flex space (empty) Facility D, Building 6, C Section - Flex space (empty) EOP Family Visiting - Flex space (empty)	1 Dorm Bed Cell Beds (48 double or 24 single) 2 Dorm Beds
VSP	Facility A, Building 4 (88 Cell Beds) Facility A, Building 3 (199 Cell Beds)	Cell Beds - 287 double or 143 single CCHCS QM Recommendation - 16	Main Yard Gym - Isolation Facility B, Building 4 - Isolation	80 Single Beds 256 Cell Beds (8 man Rooms)
WSP	Facility B, Building 1 (200 Cell Beds); Facility B, Building 5 (200 Cell Beds)	Cell Beds - 400 double or 200 single CCHCS QM Recommendation - 152	None	N/A

EXHIBIT F



CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES



MEMORANDUM

Date: November 9, 2020

To: ASSOCIATE DIRECTORS, DIVISION OF ADULT INSTITUTIONS (DAI)
WARDENS
CHIEF EXECUTIVE OFFICERS

From:

Original Signed:
CONNIE GIPSON
Director
Division of Adult Institutions

Original Signed:
TAMMY FOSS, Director
Corrections Services
California Correctional Health Care Services

Subject: COVID-19 RISK TRANSFERS - REVISED

Effective immediately, inmates who have a COVID-19 risk score of three or higher cannot be referred, endorsed, or transferred to the following institutions:

Avenal State Prison (ASP)
California Institution for Men - Facility D *and Facility A* (CIM)
California Rehabilitation Center (CRC)
Chuckawalla Valley State Prison (CVSP)
Folsom State Prison (FSP)
San Quentin State Prison (SQ)

Inmates who currently have a COVID-19 risk score of 3 or higher and are housed at one of the above institutions, shall be allowed to remain at the institution. Statistics from the California Correctional Health Care Services (CCHCS) has identified that inmates who have a higher risk for COVID-19, and are housed in either open dormitory settings or open bar cells are more susceptible to becoming infected with COVID-19, which can lead to increased morbidity and mortality.

It is the responsibility of the Chairperson of any committee who is referring an inmate for transfer to verify the inmate's COVID-19 risk score via the CCHCS COVID-19 Risk Registry-Custody. The registry can be accessed at <http://gmtools/Reports/report/QM/NonClinical/COVIDRiskCustody> (screenshot attached - with names and numbers redacted). If an inmate has a COVID-19 risk

MEMORANDUM

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score of 3 or higher, the inmate is precluded from placement at the above institutions, and an alternate institution must be selected for referral to the Classification Services Unit, or Health Care Population Oversight Program (HCPOP) Classification Staff Representative.

For inmates in the reception center, the Correctional Counselor II (Supervisor) (CCII) will be required to review the Institution Staff Recommendations Summary, and verify if the recommendation from the Correctional Counselor I (CCI) is appropriate, given the constraints above, by verifying the inmate's COVID-19 risk score in the Registry. For inmates that are already endorsed in conflict with the above direction, they must be redirected to alternate locations.

Institution Classification & Parole Representatives shall ensure the transfer requirements are met by verifying the inmate's COVID-19 risk score before processing the transfer to any of the above listed institutions.

On-the-Job Training (OJT) will be required of all CCII's, CCIII's, Captains, and any other staff who chair classification committees. ***Please use the following course code and BET code: COVID-19 Risk Transfers – Online- OJT – 11062359.*** OJT must be completed by ***November 30, 2020.***

It is incumbent on CCHCS staff to ensure all the above identified staff have access to the COVID-19 Risk Registry. Proof of OJT will be provided as follows:

- For DAI staff: Certification memorandum from the Warden to the Associate Director.
- For CCHCS staff: Certification memorandum from the Chief, HCPop, to the Director, Corrections Services.

If you have any questions or concerns, please contact your respective Associate Director or Regional Healthcare Executive.

Attachment

cc:	Clark Kelso	Kimberly Seibel	Robert Herrick
	Richard Kirkland	Charles Callahan	Christopher Podratz
	Diana Toche	Joseph Moss	Donald McElroy
	Roscoe Barrow	Dennis Halverson	Rainbow Brockenborough
	Dr. Joseph Bick	Brian Moak	
	Jackie Clark	Heidi Dixon	

EXHIBIT G



Urgent Memo

COVID-19 Outbreak: San Quentin Prison

June 13, 2020

San Quentin California State Prison is experiencing a rapidly evolving COVID-19 outbreak with profoundly inadequate resources to keep it from developing into a full-blown local epidemic and health care crisis in the prison and surrounding communities. The combination of San Quentin's antiquated facilities and severe overcrowding places the prison at high risk of significant COVID19-related morbidity and mortality unless the population is quickly reduced by 50% or more, in addition to adoption of the prevention measures outlined below. The urgent resources San Quentin requires range from human capital to environmental risk reduction and rapid testing. Failure to meet these urgent needs will have dire implications for the health of incarcerated people at San Quentin, correctional staff and the healthcare capacity of Bay Area hospitals.

Background

San Quentin arrives at this tenuous moment with several significant assets including a strong Chief Medical Executive (Dr. Alison Pachynski) and a Chief Physician and Surgeon (Dr. Shanon Garrigan) who have spent the past 3.5 months doing everything in their power to prepare for an unavoidable COVID-19 outbreak. However, these two physicians, even with the enormous assistance they have received from many other healthcare staff including a strong public health nurse, a notably excellent partnership with custody leadership (Acting Warden Ronald Broomfield and the recently arrived Chief Executive Clarence Cryer), and additional staffing from the Regional level, is simply not enough to meet the needs of San Quentin given its size and complexity. As a result, there are multiple vulnerabilities that we witnessed at San Quentin which must be urgently addressed to protect the health and safety of thousands of staff, residents and surrounding community members.

Although this memo outlines the urgent needs of San Quentin Prison, it is our belief that most – if not all – of these recommendations are important for all California Prisons that are certain to experience an outbreak if they have not already.

Urgent needs and immediate actions required:

1. **Develop a COVID-Outbreak Emergency Response Team:** At present, the over-reliance on local existing medical and correctional leadership to develop an outbreak response plan means that these leaders are tasked with making multiple acute decisions on a daily basis without enough people on the ground to operationalize a centralized game plan or long term strategy. This

responsibility - overwhelming on its own - is then magnified with the additional responsibility of providing implementation oversight of the ad-hoc plan. Instead, local leadership should have the support needed to step back and see the whole picture with a team of staff who can implement and recommend adjustments to the overarching central COVID-19 control strategy as needed on the local level. There simply do not appear to be sufficient on the ground staff who are not working from home. This daily management of the acute phase of the outbreak has the secondary effect of making the lead physicians also less available to coordinate the care and treatment of patients who become acutely ill in the facility and also increases the vulnerability of San Quentin to small errors with potentially dire consequences. Minimum positions required for such a team are included below. Dr. Pachynski and Dr. Garrigan appear to be personally responsible for all of the tasks described below with insufficient tools to support their success. While there may be some central guidance and support offered, additional human capital is urgently needed to achieve the CCHCS's pandemic response goals.

Minimum Recommended Leadership Team Positions:

- **Environment of Care Leader.** This position would be responsible for evaluating and optimizing the physical plant of the prison for ventilation, sanitation, path of patient flow (for example developing policies and procedures for how infected patients are transferred through the institution) and planning for how to reconfigure and reimagine needed space for quarantine, general population or medical isolation units depending on how the number of affected patients increases or decreases over time. This position would also work with plant operations to ensure that all air vents are cleaned and well functioning and would organize the creation of a field hospital(s) or quarantine tents as needed.

- **Healthcare – Custody Coordination Leader.** This position would focus on partnering with Custody (and working closely with the Staff Healthcare Liaison Leader, described below) to review current housing on a daily basis, and to determine the appropriate way to cohort and house residents including developing quarantine areas (in partnership with the Environment of Care Leader). This position would also be responsible for ensuring that appropriate testing is done prior to any transfer of residents to other state facilities or to the community.
- **COVID-19 Testing Leader.** This position would be responsible for coordinating with the testing center (at this moment QUEST Diagnostics) including reaching out through public and private sources and coordinating with the state and local departments of public health to improve testing turnaround time, running the list with medical staff (and the Epidemiologist, described below) on a daily basis to determine who has – and who needs – testing, and coordinating contact tracing in response to testing results and reporting of symptoms throughout the facility.

- **Staff Healthcare Liaison Leader.** This position would work with correctional leadership to cohort staff, develop plans that eradicate staff working at more than one housing facility throughout the day, train and enforce PPE rules, support contact tracing and administrative leave needs among exposed and infected staff, and investigate alternatives to potential

- **Epidemiologist Analyst Leader.** This position would be responsible for maintenance of a line listing of all active cases and for all data analysis and reporting. This position would also be responsible for a "patient tracking process" of the facility including daily review of the COVID Monitoring Registry to provide a close scrutiny of who has tested positive or is in quarantine – where they are currently housed (and were recently housed), and the same for those who have tested negative. In addition, this position would assist the Environment of Care leader and the Healthcare – Custody Coordination Leader to manage patient movement to quickly clear people when they have tested negative and return them to the General Population in order to free up much-needed quarantine cells. This position would also manage testing data (e.g., some inmates in the reception area have been tested 3-4 times and test results are coming in at different times).

2. **Address Unsafe Overcrowding.** Although there are currently 3547 total inmates, approximately ~1400 have at least one COVID risk factor (as do many, unknown, staff members). This means they are at heightened risk of requiring ICU treatment and/or mortality if infected. We detail the units of most immediate concern below. Given the unique architecture and age of San Quentin (built in the late 1800s and early 1900s), there is exceedingly poor ventilation, extraordinarily close quarters exacerbated by overcrowding, and inadequate sanitation, we recommend that the prison population at San Quentin be reduced to 50% of current capacity (even further reduction would be more beneficial) via decarceration; this will allow every cell in North and West blocks to be single-room occupancy and would allow leadership at San Quentin to prioritize which units to depopulate further including the high-risk reception center and gymnasium environments. It is important to note that we spoke to a number of incarcerated people who were over the age of 60 and had a matter of weeks left on their sentences. It is inconceivable that they are still housed in this dangerous environment. It is a frightening public health reality that in a matter of days there may be no cells to isolate a potentially infectious COVID-19 patient; the only way to manage the situation is to significantly reduce the prison population (and it is too risky to move inmates to other facilities).

Housing units of most concern at San Quentin at present time:

- **North Block and West Block** are each open-grill, 5-tier buildings with a capacity of 800 persons each. Ventilation is poor - windows have been welded shut and the fan system does not appear to have been turned on for years; heat on the far side of the building can be stifling. Over 50% of the residents housed in these units have at least 1 COVID risk factor, and an alarming ~300 inmates have 4 or more COVID risk factors. An outbreak in North and West blocks could easily flood – and overwhelm – San Quentin as well as Bay Area hospitals. (For example, see San Francisco hospital capacity: <https://data.sfgov.org/stories/s/Hospital-Capacity/qtdt-yqr2/>)

- **Reception center** which currently houses ~500 persons. In the reception Center's "Badger Unit" where people from C1M were transferred, the fear and outrage are palpable – people are yelling throughout the housing unit due to discontent about the COVID-19 situation including intake of inmates from C1M and loss of privileges (thereby increasing the risk of COVID-19 spread throughout the tiers via respiratory droplets). It is hard to imagine that violent incidents will not erupt at some point soon further threatening the safety and health of residents and staff alike.
- **The Gymnasium**, which has been converted to a dorm. There is little to no ventilation in the housing unit creating high-risk for a catastrophic super spreader event. At a minimum, the gymnasium beds should be spread out more to ensure additional distance between residents and the second set of doors in the gymnasium dorm must be opened to ensure air turnover which may necessitate a second officer station for security reasons. This unit should be prioritized for closure if sufficient population reduction can be achieved.
- **HVAC - in all units above and in other housing areas** there is an immediate need to clean and turn on all fan and HVAC systems immediately (North Block, Gymnasium, Dorms) in order to maximize air exchange and ventilation as soon as possible – ideally in the next few days. Of note, the exhaust pumps and filters appear dirty on visual inspection, and require clearing and cleaning. Since maximizing ventilation and air exchange decreases COVID-19 transmission, doors and windows should be opened as much as possible (some have been welded shut - and must be remediated). If opening doors makes it difficult for officers to do their jobs then we would recommend that officer stations be rearranged or new ones set up so as to improve air exchange. Note that the important aspect is *air exchange*, not only the movement of air within the room. Fans that blow air around may help cool people, but they don't decrease rebreathing aerosols unless they filter the air or increase air exchange (diluting the aerosol).

3. **Immediately Improve Testing.** It is inconceivable that in the Bay Area the medical leadership at San Quentin is having to manage an outbreak in their massive antediluvian facilities with PCR tests on a 5-6 day turn-around time. We would argue that there is no higher testing priority for around 100 miles and resources need to be shifted immediately to respond or there will be a massive, uncontrollable outbreak (if it is not too late already). In addition (and this certainly goes without saying), transfers between all facilities must halt until medical staff are able to certify that all testing and quarantine procedures can be followed. Our recommendations are as follows:

- **Liaise with testing laboratory to streamline testing**, including exploring observed self-collection of samples and alternate anatomical sites of testing (e.g. saliva, nares swabs)
- **Improve testing turnaround time at QUEST or go through other laboratories that will be able to improve turnaround time (5-6 days or more is completely unacceptable).** As an example, CMC was able to respond rapidly to their outbreak with a turnaround testing time of 24 hours at some points in the outbreak. Large-scale testing with rapid receipt of results is essential to allow the medical team to minimize community spread. If tests are sent to

laboratories other than QUEST, support San Quentin in adding these results to the EMR as the current process of scanning and manual entry is overly laborious.

- **The California Department of Public Health** should be compelled to prioritize specimens from San Quentin given the potential for super-spreading in that environment.

- **Testing of symptomatic patients must be done with individual testing. Testing of**

asymptomatic patients to identify people who are shedding virus can be done with pools of samples. Without additional information, pools of 10 should be used. This approach can be used for frequent retesting of people at especially high risk of spreading the virus (staff and inmates in large housing units — i.e. almost all of San Quentin).

- **San Quentin requires on-site testing** - including cartridges and well-trained staff to conduct these (currently they have inadequate staffing to conduct mass swabbing). Sample transport just adds time. San Quentin will need high volume testing for many months, perhaps years. They should have testing capacity on-site and available round-the-clock.

- **Of note, because testing time is so slow, little to no contact tracing can happen.**

Furthermore, patients cannot be appropriately housed based on test results when these results return 6 days later as a patient may have been exposed in the interim. As a result, *entire units are put on lockdown status for the span of a quarantine.* In the long term, as this pandemic will last at least another year and likely longer, this will threaten long term good will between residents and staff and have profound mental health consequences for the population and staff alike.

4. **Develop Additional Medical Isolation and Quarantine Housing.** Those in *Quarantine* (for

those with a credible exposure to COVID-19 and are asymptomatic) are housed in Carson. Of note, all who arrived from CIM were housed in the Reception Center's Badger Unit 4th and 5th Tiers. This was beyond usual practice due to volume. Those in *Medical Isolation* (for those who have tested positive for COVID-19 and suspects with symptoms who are awaiting testing) have been housed in the Adjustment Center as this is the only unit at San Quentin that has single cells with solid doors. There are ~102 cells in the Adjustment Center of this type and already ~80 cells are full. At the advice of the local health department, 3 of the CIM buses were placed in this isolation unit once a person from the bus turned positive due to the high-level serious exposure. Therefore, some of these individuals might end up with negative tests and can then be moved out of Medical Isolation.

However, a massive outbreak at San Quentin will significantly overwhelm the availability of these 102 Medical Isolation cells, and there will quickly be nowhere for infectious cases to be moved. For this reason, we believe that there is an **urgent need for immediate creation of a field hospital to relieve the imminent overflow problem in the Medical Isolation unit.** In addition, people with COVID-19 are known to experience rapid physical decompensation; this is therefore



not an ideal time for a patient to be behind a solid door in the most secure areas of the prison out of the sight of medical or nursing staff in the case of an emergency.

Some suggestions for additional Quarantine and Medical Isolation space below:

- **Convert nearby chapels (there are 3) into field hospitals.** This field hospital can house all people with confirmed COVID-19 ("Medical Isolation Unit") as there are not substantial risks to housing infected patients together and these patients would then have access to supervising nurses who could regularly check their respiratory status and comfort levels. The chapels are large, well-ventilated rooms conveniently located near the current Medical Isolation Unit and with road access for ambulances and other transport. We recognize the housing plans will become increasingly complex as people of multiple security levels require housing in Quarantine or Medical Isolation housing. This again reinforces the need for a dedicated team leader (the **Healthcare – Custody Coordination Leader**) who oversees the work of partnering with corrections to identify medically appropriate housing solutions.

- **Once a field hospital is created, San Quentin will need another site for Quarantine.** One option is to keep Adjustment Center housing for Quarantine. Due to the incredible fear involved with being moved to the Adjustment Center cells not to mention possible short- and long-term mental health effects, we would strongly recommend that custody immediately develop additional, positive incentives to improve mental health for the 14-day quarantine period for those housed in the Adjustment Center for Quarantine, such as access to personal tablets with movies, increased access to canteen items, personal effects and a certain number of free phone calls, perhaps on state-owned cell phones. While these interventions may seem beyond the normal routine of prisons in California, they are simple, low-cost measures that would go a long way toward building good will and ensuring that inmates who become symptomatic are willing to come forward to medical treatment with their symptoms. Furthermore, they may dampen the growing security risk associated with the aforementioned discontent among inmates. It is also possible that if enough high-security level individuals need medical isolation then they would need to use this unit for them and would require alternate housing options for Quarantine (perhaps the Carson housing unit which is currently being used for quarantine, although ideally the Carson housing unit would be only used for quarantine, further necessitating population reduction to control this epidemic at San Quentin). An mentioned above, in a matter of days/weeks, there may be no reasonable isolation locations for infectious COVID patients.

5. **Improve General Prevention efforts throughout the facility.** In particular, we witnessed suboptimal mask use by staff, and three "medical pass nurses" sitting in a work room without masks. Moreover, custody work stations are not set up to physically distance, no additional workstations appear to have been built yet. As a result, even with the best of efforts, officers wind up clustered near each other around a central podium. An infection control nurse and environmental assessment would go a long way towards identifying opportunities to partially alleviate these problems.



<https://amend.us/covid>

6. Staffing Cohorting is a necessity. At present work shift plans are inadequate from a public health perspective. For example, we learned about staff who were working in the Medical Isolation Unit (Adjustment Center) during the shift and were scheduled to work the next shift in the dorms. This is an enormous risk for the spread of COVID-19 between housing units.

Sandra McCoy, Associate Professor of Epidemiology & Biostatistics, The University of California, Berkeley School of Public Health

Stefano M. Bertozzi, MD, PhD, Professor of Health Policy & Management and Dean Emeritus, The University of California, Berkeley School of Public Health

David Sears, MD, Assistant Professor of Internal Medicine, Infectious Diseases, The University of California, San Francisco

Ada Kwan, PhD Candidate, Division of Health Policy & Management, The University of California, Berkeley School of Public Health

Catherine Duarte, PhD Candidate, Division of Epidemiology & Biostatistics, The University of California, Berkeley School of Public Health

Brie Williams, MD, MS, Professor of Medicine, The University of California, San Francisco and Director of Amend at UCSF

Amend at UCSF is a health-focused correctional culture change program led by experts in medicine, infectious diseases, public health, and correctional health and policy that is providing correctional leaders, policymakers, and advocates the evidence-based tools they need to protect the health and dignity of those who live and work in jails and prisons during the COVID-19 pandemic.

The University of California, Berkeley School of Public Health is working on the leading edge of research, educating the public, and mobilizing to serve California's most vulnerable populations during the COVID-19 pandemic.

For more information:

<https://amend.us/covid>

EXHIBIT H

COVID-19 SCREENING AND TESTING MATRIX FOR PATIENT MOVEMENT
August 19, 2020

- 1. To reduce the likelihood of COVID-19 spreading from one location to another, movement shall be limited to that which is necessary for clinical care, medical isolation or quarantine, reduction of overcrowding, and serious custody concerns.**
- 2. If transfer from one institution to another must take place, pre and post transfer quarantine and COVID-19 testing shall be performed.**
- 3. Inmates and transportation staff shall wear N95 masks during transfer. Transportation vehicles shall be disinfected after each trip. Transportation staff shall be tested as per the staff testing policy.**
- 4. Every effort shall be made to avoid layovers during transportation.**
- 5. Inmates who were previously infected with COVID and have been moved to the resolved status are considered to be immune from re-infection for at least twelve weeks, and shall not be required to re-test for movement purposes during that time frame.**
- 6. Inmates moving into higher level of care (HLOC) beds (medical CTC, OHU, MHC, PIP) shall be quarantined in the HLOC**

TYPE OF MOVEMENT	COVID TESTING STRATEGY	HOUSING	WHAT TO DO IF PATIENT REFUSES COVID TEST
From jail to reception center	<p>All inmates and transportation staff shall wear an N 95 respirator during transfer</p> <p>Quarantine all new arrivals for 14 days after arrival in cell based housing.</p> <p>Screen all new arrivals for COVID-19 symptoms upon arrival and then daily while in quarantine.</p> <p>Test all new arrivals for COVID-19 within 24 hours, again on day 7 and again prior to release from quarantine (no sooner than day 12).</p> <p>Place any inmate who tests positive in isolation.</p> <p>May release inmates from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative.</p>	Quarantine in cell based housing.	<p>Inmate to remain in pre-transfer quarantine for at least 21 days and receive daily symptom screening.</p> <p>Disposition to be determined in consultation with CME and public health.</p>
From jail directly to Specialized Medical Beds (SMB)	<p>Advance authorization required by the Director, Health Care Services and Director, Health Care Operations.</p> <p>All inmates and transportation staff shall wear an N 95 respirator during transfer.</p> <p>Quarantine all new arrivals for 14 days after arrival in cell based housing.</p> <p>Screen all new arrivals for COVID-19 symptoms upon arrival and then daily while in quarantine.</p> <p>Test all new arrivals for COVID-19 within 24 hours, again on day 7 and again prior to release from quarantine (no sooner than day 12).</p> <p>Place any inmate who tests positive in isolation.</p>		<p>Inmate to remain in pre-transfer quarantine for at least 21 days and receive daily symptom screening.</p> <p>Disposition to be determined in consultation with CME and public health.</p> <p>.</p>

COVID-19 SCREENING AND TESTING MATRIX FOR PATIENT MOVEMENT
August 19, 2020

	May release inmates from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative.		
From reception center to institution	Screen all inmates for COVID-19 symptoms and then test for COVID-19 just prior to transfer utilizing a methodology that allows for no more than 48 hours turnaround time for results. If inmate tests negative and patient is asymptomatic, transfer as soon as possible but no more than 72 hours after test was obtained. All inmates and transportation staff shall wear an N 95 respirator during transfer.		Inmate to remain in pre-transfer quarantine for at least 21 days and receive daily symptom screening. Disposition to be determined in consultation with CME and public health.
Institution intake from reception center	Quarantine all new arrivals for 14 days in cell based housing. Facilities which by design have no cell based housing shall house newly arriving inmates in cohorts of no more than 10 in a dorm or small tent solely dedicated to the cohorts who arrive on the same day. Screen all new arrivals for COVID-19 symptoms upon arrival and then daily while in quarantine. Test all new arrivals for COVID-19 within 24 hours, on day 7 and prior to release from quarantine (no sooner than day 12). Place any inmate who tests positive in isolation. May release inmates from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative.	Quarantine in celled housing, with minor exceptions as noted.	Inmate to remain in quarantine for at least 21 days. Disposition to be determined in consultation with CME and public health.
General population movement from one institution to another, including to camp hubs	<p>Sending institution Quarantine all inmates prior to transfer in cell based housing. Facilities which by design have no cell based housing shall house inmates in cohorts of no more than 10 in a dorm or small tent solely dedicated to the cohorts who will depart on the same day. Screen all inmates for COVID-19 symptoms initially and then daily while in quarantine. Test symptomatic patients. Place any inmate who tests positive in isolation. Test for COVID after 14 days in quarantine utilizing a methodology that allows for no more than 48 hours turnaround time for results. If inmate tests negative, transfer as soon as possible but no more than 72 hours after test was obtained. All inmates and transportation staff shall wear an N 95 respirator during transfer.</p> <p>Receiving institution Quarantine all new arrivals for 14 days in cell based housing. Facilities which by design have no cell based housing shall house newly arriving inmates in cohorts of no more than 10 in a dorm or small tent solely dedicated to the cohorts who arrive</p>	Quarantine in celled housing, with minor exceptions as noted.	Inmate to remain in quarantine for at least 21 days. Disposition to be determined in consultation with CME and public health.

COVID-19 SCREENING AND TESTING MATRIX FOR PATIENT MOVEMENT
August 19, 2020

	<p>on the same day.</p> <p>Screen all new arrivals for COVID-19 symptoms upon arrival and then daily while in quarantine. Test all new arrivals for COVID-19 on day 12 of quarantine.</p> <p>May release inmates from quarantine after 14 days if asymptomatic and COVID-19 test- is negative.</p> <p>Place any inmate who tests positive in isolation.</p>		
<p>Movement from one institution to another for specialized medical bed placement</p>	<p>Sending institution</p> <p>Movement that is not considered clinically urgent or emergent:</p> <ul style="list-style-type: none"> Quarantine all inmates prior to transfer in cell based housing. Screen all inmates for COVID-19 symptoms initially and then daily while in quarantine. Test symptomatic patients. Place any inmate who tests positive in isolation. Test for COVID after 14 days in quarantine utilizing a methodology that allows for no more than 48 hours turnaround time for results. If inmate tests negative, transfer as soon as possible but no more than 72 hours after test was obtained. All inmates and transportation staff shall wear an N 95 respirator during transfer. <p>Movement that is considered clinically urgent or emergent:</p> <ul style="list-style-type: none"> Perform rapid testing for COVID-19 prior to movement. Communicate results to receiving facility. All inmates and transportation staff shall wear an N 95 respirator during transfer. <p>Receiving institution</p> <p>House appropriately at receiving institution (isolation vs quarantine) depending upon the results of the rapid test.</p> <p>New arrivals who tested positive at sending institution shall be housed in isolation at receiving institution and managed per CCHCS guidelines.</p> <p>New arrivals who tested negative at sending institution shall be quarantined for 14 days in cell based housing. These inmates shall be screened for COVID-19 symptoms upon arrival and then daily while in quarantine. Test these inmates for COVID-19 on day 12 of quarantine.</p> <p>May release inmates from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative.</p>		<p>Inmate to remain in quarantine for at least 21 days.</p> <p>Disposition to be determined in consultation with CME and public health.</p>

COVID-19 SCREENING AND TESTING MATRIX FOR PATIENT MOVEMENT
August 19, 2020

	Place any inmate who tests positive in isolation.		
Movement within same institution <ul style="list-style-type: none"> • Release from STRH, LTRH, ASU, SHU • PIP / MHCB admission or discharge • CTC, OHU, hospice admission or discharge • Mental health level of care change • DPP moves • DDP moves • All other routine movement 	<p>No screening or testing if remains at current institution UNLESS</p> <p>Moving from a COVID-19 outbreak unit to a non-outbreak unit:</p> <ul style="list-style-type: none"> • All such movement should be avoided. • If movement from a COVID-19 outbreak unit to a non-outbreak unit is essential, inmate shall be quarantined in new unit and screened/tested as if coming from a different institution. (See "General population movement from one institution to another, including to camp hubs"). <p>Moving into a large dorm (50 or more residents):</p> <ul style="list-style-type: none"> • Perform COVID-19 symptom screening and COVID-19 rapid testing of the inmate prior to this move. 	No COVID-19 related housing restrictions EXCEPT inmates moving from a COVID-19 outbreak unit to a non-outbreak unit shall be quarantined in a cell in the new unit and tested prior to release.	Inmate to remain in quarantine for at least 21 days, unless placement in quarantine is impossible (e.g.: MSF), in which case the inmate will not be moved. Disposition to be determined in consultation with CME and public health.
Movement from one institution to another for MHCB or PIP placement	<p>MH Regional required to receive approval from the Deputy Director, Health Care Services, to move patient who declines testing.</p> <p>Sending institution</p> <p>Perform rapid testing for COVID-19 prior to movement. Communicate results to receiving facility.</p> <p>All inmates and transportation staff shall wear an N 95 respirator during transfer.</p> <p>Receiving institution</p> <p>House appropriately at receiving institution (isolation vs quarantine) depending upon the results of the rapid test.</p> <p>New arrivals who tested positive at sending institution shall be housed in isolation at receiving institution and managed per CCHCS guidelines.</p> <p>New arrivals who tested negative at sending institution shall be quarantined for 14 days in cell based housing. These inmates shall be screened for COVID-19 symptoms upon arrival and then daily while in quarantine. Test these inmates for COVID-19 on day 12 of quarantine.</p> <p>May release inmates from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative.</p> <p>Place any inmate who tests positive in isolation.</p>	Quarantine in celled housing.	Inmate to remain in quarantine for at least 21 days. Disposition to be determined in consultation with CME and public health.
Admission to DSH from CDCR	Quarantine all inmates prior to transfer in cell based housing. Screen all inmates for COVID-19 symptoms initially and then	As per DSH protocols upon arrival to DSH	Inmate to remain in quarantine for at least 21 days.

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	<p>daily while in quarantine. Test symptomatic patients. Place any inmate who tests positive in isolation. Test for COVID after 14 days in quarantine utilizing a methodology that allows for no more than 48 hours turnaround time for results. If inmate tests negative, transfer as soon as possible but no more than 72 hours after test was obtained. All inmates and transportation staff shall wear an N 95 respirator during transfer.</p>		Disposition to be determined in consultation with the Deputy Director, Mental Health and public health.
DSH discharge to CDCR	<p>Sending DSH institution Quarantine all inmates prior to transfer in cell based housing. Screen all inmates for COVID-19 symptoms initially and then daily while in quarantine. Test for COVID after 14 days in quarantine utilizing a methodology that allows for no more than 48 hours turnaround time for results. If inmate tests negative, transfer as soon as possible but no more than 72 hours after test was obtained. All inmates and transportation staff shall wear an N 95 respirator during transfer.</p> <p>Receiving CDCR institution Quarantine all new arrivals for 14 days in cell based housing. Screen all new arrivals for COVID-19 symptoms upon arrival and then daily while in quarantine. Test all new arrivals for COVID-19 on day 12 of quarantine. May release inmates from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative Place any inmate who tests positive in isolation.</p>	Quarantine in celled housing.	Inmate to remain in quarantine for at least 21 days. Disposition to be determined in consultation with the Deputy Director, Mental Health and public health.
To MCCF, ACP, CTRP, MCRP, fire camp	<p>Quarantine all inmates prior to transfer in cell based housing. Facilities which by design have no cell based housing shall house newly arriving inmates in cohorts of no more than 10 in a dorm or small tent solely dedicated to the cohorts who arrive on the same day. Screen all inmates for COVID-19 symptoms initially and then daily while in quarantine. Test symptomatic patients. Place any inmate who tests positive in isolation. Test for COVID after 14 days in quarantine utilizing a methodology that allows for no more than 48 hours turnaround time for results. If inmate tests negative, transfer as soon as possible but no</p>	Quarantine in celled housing, with minor exceptions as noted.	Do not transfer.

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	more than 72 hours after test was obtained. All inmates and transportation staff shall wear an N 95 respirator during transfer.		
From MCCF, ACP, CCTRP, MCRP, fire camp to an institution	All inmates and transportation staff shall wear an N 95 respirator during transfer. Screen all new arrivals for COVID-19 symptoms upon arrival and then daily while in quarantine. Test all new arrivals for COVID-19 on day 12 of quarantine. May release inmates from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative Place any inmate who tests positive in isolation.	Quarantine in celled housing.	
Parole, medical parole, PRCS release	All inmates shall be screened for COVID-19 symptoms and then tested for COVID one week prior to transfer. Results of testing shall be communicated to parole agent or probation officer and local public health officer in county of release. If inmate tests positive, immediately consult with HQ public health unit re transportation and placement All inmates and transportation staff shall wear an N 95 respirator during transfer.		Inmates cannot be held beyond their parole date regardless of whether they agree to test or if the test is positive.
Out to court, same day return	All inmates and transportation staff shall wear an N 95 respirator during transfer. Use videoconferencing to avoid out to court travel in all cases unless court refuses to do so. Perform daily COVID screening for 14 days upon return. Place symptomatic returns in single cell quarantine while awaiting testing.	No housing restrictions.	.
Out to court, overnight stay.	Manage like an intake from jail to reception center All inmates and transportation staff shall wear an N 95 respirator during transfer. Use video conferencing to avoid out to court travel in all cases unless court refuses to do so. Quarantine all new arrivals for 14 days after arrival in cell based housing. Facilities which by design have no cell based housing shall house newly arriving inmates in cohorts of no more than 10 in a dorm or small tent solely dedicated to the cohorts who arrive on the same day. Screen all new arrivals for COVID-19 symptoms upon arrival and then daily while in quarantine. Test all new arrivals for COVID-19 within 24 hours, again on day 7 and again prior to release from quarantine (no sooner than	Quarantine in celled housing, with minor exceptions as noted.	Inmate to remain in quarantine for at least 21 days. Disposition to be determined in consultation with CME and public health.

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	<p>day 12).</p> <p>Place any inmate who tests positive in isolation.</p> <p>May release inmates from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative.</p>		
Out for clinical appointment, same day return	<p>All inmates and transportation staff shall wear an N 95 respirator during transfer.</p> <p>Use “e-consult” and telemedicine whenever possible to avoid unnecessary offsite transportation.</p> <p>Perform daily COVID screening for 14 days upon return.</p> <p>Place symptomatic returns in single cell quarantine while awaiting testing.</p>	No housing restrictions.	
Return from outside hospitalizations and emergency department visits	<p>Manage like an intake from jail to reception center</p> <p>All inmates and transportation staff shall wear an N 95 respirator during transfer.</p> <p>Quarantine all new arrivals for 14 days after arrival in cell based housing.</p> <p>Facilities which by design have no cell based housing shall house newly arriving inmates in cohorts of no more than 10 in a dorm or small tent solely dedicated to the cohorts who arrive on the same day.</p> <p>Screen all new arrivals for COVID-19 symptoms upon arrival and then daily while in quarantine.</p> <p>Test all new arrivals for COVID-19 within 24 hours, on day 7 and prior to release from quarantine (no sooner than day 12).</p> <p>Place any inmate who tests positive in isolation.</p> <p>May release inmates from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative.</p>	Quarantine in celled housing, with minor exceptions as noted.	<p>Inmate to remain in quarantine for at least 21 days.</p> <p>Disposition to be determined in consultation with CME and public health.</p>

DEFINITIONS

Patients placed in isolation or quarantine shall not move outside of the isolation or quarantine housing unless approved by clinical staff. Medical care and meals shall be provided/served within the isolation/quarantine space. Isolated and quarantined patients shall shower and toilet separately from other patients, and the showers/toilets shall be disinfected prior to use by others. All group activities shall be canceled.

1. ISOLATION

a. Persons who are CONFIRMED to have COVID-19:

- i. Isolation is necessary.

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- ii. For individual cases, the preference is for isolation in a negative pressure room.
- iii. The second choice is isolation in a private room with a solid, closed door.
- iv. Multiple confirmed COVID-19 positive cases can be housed together.
- v. Confirmed positive patients shall not be housed in the same unit with those who are not known to have COVID-19.
- vi. If there are no other options and these patients must be housed in the same building with non-infected patients, they must be physically separated from patients who do not have COVID-19. Physical separation requires solid walls and solid doors.
- vii. Patients confirmed to have COVID-19 shall not be housed in dorms with those who are not confirmed to have COVID-19.
- viii. Daily healthcare monitoring shall be conducted for patients diagnosed with COVID-19.
- ix. All staff interacting with confirmed positive patients shall wear appropriate PPE including N 95 respirators.
- x. To the extent possible, staff who are working in housing units with COVID-19 infected patients shall be cohorted such that they are not interacting with patients who are not known to be infected.

2. QUARANTINE

a. Persons who have been exposed to COVID-19

- i. Quarantine is necessary.
- ii. These patients are at risk of being infected as a result of their exposure. Thus, they shall be separated from both the confirmed cases and from the symptomatic but not yet confirmed cases to avoid re-exposure.
- iii. For individual cases, the preference is for quarantine in a private room with a solid, closed door.
- iv. Exposed persons shall not be housed in dorms with those who are not known to be exposed.
- v. If private rooms are not available, exposed persons can be quarantined together as a cohort.
- vi. If cohorting is essential, quarantine cohorts shall be as small as possible (1-10 persons) to minimize spread.
- vii. Cohorts with different exposure dates shall not be housed together.
- viii. Cohorts with different types of exposures shall also be separated, including those coming in from jails.
- ix. Daily healthcare monitoring shall be conducted for patients who are under quarantine.
- x. Serial testing and healthcare surveillance is used to identify those infected so that they can be moved to isolation.

b. Precautionary Quarantine for persons who are not known to be exposed

- i. Quarantine is necessary.
- ii. Each facility shall maintain sufficient quarantine space to accommodate its historical average volume of transfers
- iii. For individual cases, the preference is for quarantine in a private room with a solid, closed door.
- iv. If private rooms are not available, exposed persons can be quarantined together as a cohort.
- v. If cohorting is essential, quarantine cohorts shall be as small as possible (1-10 persons) to minimize spread.
- vi. Cohorts with different movement dates shall be separated. Cohorts with different types of movement shall also be separated, including those coming in from jails or transferring between institutions.
- vii. Serial testing and healthcare surveillance is used to identify those infected so that they can be moved to isolation.

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- viii. Patients arriving to an institution shall not be released from quarantine until they have completed quarantine and tested negative for COVID-19.

1 PRISON LAW OFFICE
DONALD SPECTER (83925)
2 STEVEN FAMA (99641)
ALISON HARDY (135966)
3 SARA NORMAN (189536)
RANA ANABTAWI (267073)
SOPHIE HART (321663)
4 1917 Fifth Street
Berkeley, California 94710
5 Telephone: (510) 280-2621
Fax: (510) 280-2704
6 dspecter@prisonlaw.com
Attorneys for Plaintiffs

7
8
9 **UNITED STATES DISTRICT COURT**
10 **NORTHERN DISTRICT OF CALIFORNIA**
11 **SAN FRANCISCO**

12 MARCIANO PLATA, et al.,

Plaintiffs,

13 v.

14 GAVIN NEWSOM., et al.,

Defendants.

Case No. C01-1351 JST

**DECLARATION OF ADAM
LAURING, M.D., Ph.D. IN SUPPORT
OF PLAINTIFFS' POSITION ON
QUARANTINE IN HOUSING UNITS
WITH COMMON AIR SPACE**

DECLARATION OF ADAM LAURING, M.D, Ph.D.

I, Adam Luring, declare as follows:

1. I am a physician and Associate Professor in the Division of Infectious Diseases and the Department of Microbiology and Immunology at the University of Michigan. I am board certified in infectious diseases and have a Ph.D. in Molecular and Cellular Biology. In 2019, I became a Fellow of the Infectious Diseases Society of America, an honor given to individuals who have demonstrated excellence in the field. In 2020, I was elected to the Governing Council of the American Society for Virology.

2. I specialize in molecular virology and have published extensively on virus transmission and spread. In particular, I study how viruses evolve and spread with a focus on influenza and other respiratory viruses. I am the Principal Investigator on a 5-year, \$3.7 million NIH grant on respiratory virus transmission. I have cared for COVID-19 patients and was instrumental in developing and implementing many aspects of the University of Michigan's epidemic response: I developed our diagnostic and testing guidelines, contributed to institutional treatment guidelines, and worked closely with hospital infection control to manage patient flow over the first two weeks of the Michigan epidemic. I also helped to set up our Regional Infection Containment Unit, a dedicated COVID-19 intensive care unit.

3. My curriculum vitae is attached as Exhibit A to my Declaration submitted in this case on July 15, 2020 (ECF No. 3391-1). Further biographical details and qualifications are available at <https://medicine.umich.edu/dept/microbiology-immunology/adam-luring-md-phd>.

4. I am familiar with the scientific literature on the transmission, treatment, and prevention of COVID-19, and I am in frequent contact with experts in the field around the country and the world.

5. I am also familiar with a growing body of scientific literature detailing the enhanced risks and dangers that COVID-19 presents in correctional settings, and

particularly in congregate living spaces within correctional facilities, including the following:

- Clark Kelso’s report of October 21, 2020, entitled “Transferring COVID-19 High-Risk Patients to Safer Housing” (attached as Exhibit A). According to Mr. Kelso, in CDCR, “[e]ighty-one percent (81%) of the 69 deaths acquired COVID-19 while living in a dorm or open-cell-front housing unit.” Mr. Kelso further found that “the six largest outbreaks in CDCR institutions – outbreaks resulting in more than 1,000 confirmed COVID-19 patients – have all been in institutions that predominately house patients in common airspace, dorm and open-cell-front housing units.”
- “Risk Factors for SARS-CoV-2 in a Statewide Correctional System,” published in the New England Journal of Medicine on November 24, 2020 (attached as Exhibit B). The writers tested 10,304 people in the Connecticut prison system and found that people living in dorms were 35 times more likely to be infected with SARS-CoV-2 than people living in cells. I have reviewed the methodology published in this letter and find it sound.¹
- the “Urgent Memo” on the COVID-19 outbreak at San Quentin State Prison from AMEND and the Berkeley School of Public Health, dated June 13, 2020 (attached as Exhibit B to my Declaration submitted in this case on July 15, 2020).
- “Evaluation of the April-May 2020 COVID-19 Outbreak at California Men’s Colony,” July 20, 2020, by AMEND and the Berkeley School of Public Health (attached as Exhibit C). This report, by the same authors of the San Quentin

¹I note that the study did not find dormitory living to be predictive of hospitalization, ICU admission, or death. I suspect that this is because, as the authors suggest, when people were identified as infected they were moved out of dorms into cells, and subsequent hospitalization, ICU admission, or death would be recorded as occurring from the celled housing. Further, serious complications from COVID-19 are largely dependent on the presence of high risk factors, and in order to draw any conclusions from the rates of complications among people living in dorms and cells in the Connecticut system, we would have to know the relative presence of high risk factors in those populations. More study is clearly needed on this point. There is no ambiguity, however, in the finding that dorm living made infection overwhelmingly more likely.

1 “Urgent Memo,” investigates a relatively minor outbreak at the California Men’s
2 Colony, a CDCR prison with both dorm and celled housing. They “partially
3 attributed” the “[s]low rate of spread” of that outbreak to the “unit type (solid-door
4 units with solid-floor tiers),” which “bought time to implement more precautions,
5 access resources, and reinforce communication.” They further note that “[d]ue to
6 incarcerated persons living in close, prolonged proximity and the close physical
7 distance of dormitory pods, CMC’s West dorms are primed for super-spreader
8 events.”

9 6. My review of the literature, conversations with public health and
10 correctional experts, and knowledge of outbreaks in CDCR all strongly support the
11 conclusion that it is not safe to quarantine people in dormitories or celled housing with
12 open bars or porous doors. (For convenience, I will refer to such housing units as having
13 common air space.) I held that opinion in July and subsequent events and studies have
14 only strengthened my convictions. Simply put, I agree with the experts at AMEND and
15 the UC Berkeley School of Public Health that “[n]o one in a dormitory environment can
16 quarantine properly.” Exhibit C at 37.

17 7. This is not a contested opinion; all the experts I’ve read or spoken with
18 have come to the same conclusion, including the Public Health Workgroup convened for
19 purposes of this case, of which I was a member. *See* Order to Set Aside Isolation and
20 Quarantine Space: Public Health Workgroup Recommendations at 1 (“quarantine spaces.
21 . . . should be configured as equivalent to *single cells with solid doors*”) (emphasis in
22 original) (attached as Exhibit D).

23 8. The unanimity derives from the consensus in the scientific community that
24 transmission through the air is one of the primary means by which people contract
25 COVID-19. As Clark Kelso put it, “[d]orms and open-cell-front housing are more
26 dangerous than closed-door cells because, as very recently confirmed by the CDC,
transmission of COVID-19 occurs both through droplets and through aerosolization.”

1 Exhibit A at 7. The shared air in dormitories or cells with barred or porous doors allows
2 for ready transmission of the virus.

3 9. I cannot stress enough the risk faced by people occupying shared air space
4 with someone who is infected. The study in the Connecticut prison system, with a
5 preliminary finding that people in dorms are 35 times more likely than those in cells to
6 contract COVID-19, *see* Exhibit B, is chilling but not surprising. California has
7 experienced first-hand the ravages of outbreaks in shared air spaces.

8 10. The fact that there have also been significant outbreaks in solid-doored
9 celled living units is not surprising and does not change my opinion. By far the largest
10 outbreaks have been in shared air spaces. Exhibit A at 6-7. Like the AMEND and UC
11 Berkeley experts who studied the CMC outbreak, I have no doubt that the outbreaks in
12 solid-door cells would have been far worse in dorms or cells with barred or porous doors.
13 The fact that this virus possesses tenacity that is very difficult to counter even under
14 suitable conditions does not let us off the hook from knowingly placing people in harm's
15 way.

16 11. I am not simply saying that living in dorms is more risky than living in
17 solid door cells, although that is certainly the case. I am saying that the decision to
18 quarantine people in living units with common air space knowingly places them at
19 enhanced risk of infection. To understand why, we need to keep in mind the reason why
20 quarantine is an essential feature in our fight against the spread of the SARS-CoV-2
21 virus. The purpose of quarantine is to separate people with known exposure, who are
22 more likely to develop COVID-19, from others without that enhanced risk. In any group
23 of exposed people, however, each individual will have different levels of exposure and
24 therefore of risk. If you quarantine them together in shared air space, the risk level for all
25 rises to the highest risk level among them; everyone will be at the same risk as the person
26 who was most exposed. In other words, you knowingly expose some people to a higher
risk they would not have otherwise faced.

1 12. Another way of looking at it is to use the example of 10 people who were
2 exposed to someone who was COVID-19 positive and contagious. It is likely that not all
3 of those people will actually wind up being infected. The numerous variations in how
4 different exposed people have interacted with the infected person – the frequency of
5 interaction and proximity to each other, the airflow at the time, whether the infected
6 person coughs or sneezes or laughs or speaks loudly during the interaction, etc. -- mean
7 that exposed people will inhale different quantities of the virus. So maybe two or three of
8 the 10 exposed people will become infected, and the other seven or eight will be lucky.
9 If you quarantine each person in a single cell after exposure, you have only two or three
10 secondary cases. However, if you quarantine them together, the lucky ones will continue
11 to be exposed -- to the secondary cases, now -- over the ensuing 14 days. So, you have
12 actually increased their total exposure to COVID-19 positive people and increased their
13 risk for contracting the disease. This is why it is not safe to quarantine people together
14 who have all faced the same exposure – for example, to a staff member who worked in
15 their housing unit.

16 13. The use of living units with common air space to quarantine people with
17 known exposure to the virus is effectively not quarantine at all. In medical parlance, I
18 would call it substandard care. This is the why the public health working group stressed
19 that quarantine should be in single cell solid-door housing.

20 14. In my opinion, there are no mitigating steps that would reduce the risk of
21 placing people in these common air living units for quarantine purposes, so that it would
22 more closely approximate the risk of quarantine in living units with solid-door cells. It is
23 possible to mitigate risk of transmission for people who must interact with others indoors,
24 such as in a workplace, by protocols such as social distancing and mask-wearing at all
25 times. But this situation is not comparable to a workplace. Remember that all the people
26 you place in quarantine have known exposure to the virus -- in a workplace setting, they
would be sent home.

1 15. It is true that people are often directed to quarantine at home, where they
2 share living space with the rest of their household. There are three essential differences
3 between that situation and prison quarantine in shared air living spaces. First, when there
4 are children to care for, there are no other options but to continue to interact with them
5 even in quarantine. Bringing another caregiver into the setting, or sending the children
6 out, would expose others to risk. Second, households have the option to try to separate
7 internally, to use separate rooms and airspaces, keep windows open, and take other
8 measures to reduce interaction and common airspace. People in prison have no such
9 options. Finally, households are generally far smaller than the prison living units under
10 discussion here, where dormitories and units with open-barred cells can have upwards of
11 100 people in them. It would be possible to reduce the enhanced risk of quarantining in
12 such settings by reducing the number of people who are housed in the shared airspace.
13 But the risk is significant for those who remain, including for cellmates of people who are
14 double-celled in quarantine.

15 16. It is also essential to point out that household infection is one of the largest
16 -- if not the largest -- factor in the spread of the virus identified to date. Quarantining at
17 home with family might be unavoidable, but it undeniably results in extremely high
18 levels of transmission. If CDCR prisons are to avoid such ready transmission, they must
19 prepare safer alternatives.

20 17. I am aware that current CDCR guidelines, while favoring quarantine in
21 solid-doored cells, allow for exceptions. The Public Health Workgroup stated that
22 “unlike patients with confirmed infection who can be housed together in larger cohorts
23 within dorm-like settings, patients suspected to have COVID-19 infection must be
24 separated from each other in single cells with solid doors, *with minimal exceptions*
25 *noted.*” Exhibit C at 1 (emphasis added). The only exceptions we allowed were in three
26 prisons (San Quentin, Folsom State Prison, and the California Rehabilitation Center)
where congregate living areas predominate. *Id.* at 3. *Id.* Similarly, the Receiver’s

1 current protocols direct institutions to use “private room[s] with a solid, closed door” for
2 quarantine “where possible.” *See* COVID-10 Screening and Testing Matrix for Patient
3 Movement at 8 (Aug. 19, 2020).

4 18. I cannot stress enough the degree to which any exceptions must be severely
5 limited. Even at the three prisons we designated as exceptions to the rule that quarantine
6 must take place in single solid-doored cells, we did not simply exempt them from
7 quarantining safely; we made it clear that they require unique solutions in order to keep
8 people safe. (I note that the “Urgent Memo” on the COVID-19 outbreak at San Quentin
9 State Prison from AMEND and the Berkeley School of Public Health, dated June 13,
10 2020, contains suggestions that could be explored.) Those unique solutions must be
11 grounded in our knowledge of how the virus spreads and how to prevent transmission.
12 Since the time those guidelines were issued, our knowledge of the relative danger of
13 quarantining in shared air space has grown: the Centers for Disease Control and
14 Prevention has recognized the importance of aerosolized droplets in the transmission of
15 the virus, which acknowledges the profound risk of shared airspace, and the data we have
16 gathered around the country has demonstrated even more convincingly that people who
17 share air share the virus. Given the known risk involved in placing people in shared
18 airspaces for quarantine, CDCR must act now to ensure that this practice is minimized.
19 Single-celled, solid-door quarantine space must be identified and people must be shifted
20 as appropriate *before* an outbreak, when it is often too late to organize precautionary
21 steps.

22 19. Other options to explore would be to use shared air living spaces only for
23 people who have already had COVID-19. The current scientific consensus is that it is
24 reasonable to expect that reinfections within 90 days will be extremely rare.

25 20. Precautionary quarantine is different. Here, there has been no exposure.
26 The rationale for quarantine here is to mitigate the risk of transferring an individual who
potentially is in the incubation period for COVID19. All individuals all have the same

1 risk of having COVID-19 as the general population of the facility. I do not have the same
2 concerns about keeping individuals apart for precautionary quarantine as I do for
3 quarantine following an exposure.

4
5 Pursuant to 28 U.S.C. 1746, I declare under penalty of perjury that the foregoing is
6 true and correct.

7
8 Executed this 8th day of December, 2020, in Ann Arbor, Michigan.

9
10 
11

12 _____
13 Adam Luring, M.D., Ph.D.
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EXHIBIT A

Transferring COVID-19 High-Risk Patients to Safer Housing
J. Clark Kelso, Receiver
October 21, 2020

Introduction

We are now into the eighth month of the COVID-19 pandemic. Responding to the pandemic remains the highest priority for both the California Department of Corrections and Rehabilitation (“CDCR”) and California Correctional Health Care Services (“CCHCS”). Since early 2020, we have implemented unprecedented organizational changes to respond to COVID-19 while also facing global Personal Protective Equipment (“PPE”) shortages and testing delays. Over the course of the last several months, CDCR and CCHCS, in collaboration and after regularly consulting with public health experts including the California Department of Public Health (“CDPH”), have revised operational practices, implemented regular statewide testing of staff and patients, taken initial steps to de-populate dorms, provided educational programs for staff, implemented gate screening, mandated use of face coverings, aggressively distributed and required use of PPE, provided cleaning supplies and hand sanitizer, and created complex movement guidelines to minimize the risk of spread. Additional information can be found on the COVID-19 Preparedness website (<https://www.cdcr.ca.gov/covid19/>) and in the Receiver’s Forty-fifth Tri-Annual Report filed with the Court on October 1, 2020 (https://cchcs.ca.gov/wp-content/uploads/sites/60/TR/T45_20201001_TriAnnualReport.pdf).

From a systemwide perspective, CDCR’s population has experienced a COVID-19 positive case rate and death rate that is similar to what other prisons around the country have experienced. But we can do better. Because of the risk of greater morbidity and mortality to patients with certain defined COVID-19 risk factors (most importantly, age), throughout the pandemic, we have paid special attention to measures to reduce risks to this population. We now have actual data based on CDCR’s own experience with COVID-19, and that data, combined with the recent determination by the Centers for Disease Control and Prevention (“CDC”) that COVID-19 can spread by aerosolization, strongly points to a single conclusion:

Dorm and open-cell-front housing poses particularly high risks of morbidity and mortality to our patients with COVID-19 risk-factors.

This conclusion drives an urgent search for additional steps that would reduce or eliminate those particularly high risks to those patients. We recommend that CDCR extend an offer to the over 8,200 patients with COVID-19 risk scores of 3 and above¹ who are currently housed in dorms or open-cell-front housing the opportunity to transfer into closed-front cells either at their existing institution or at another institution.

¹ Based upon our data and CDC guidelines, we developed a tool for assigning each patient a “COVID-19 risk score” which represents that individual’s risk for having serious illness or death if they become infected with COVID-19.

Status Report on CDCR's COVID-19 Cases and Deaths

Prisons and jails have not been designed, built or operated with consideration of the risks posed by communicable diseases. As noted over a decade ago by CCHCS's Statewide Medical Executive, Dr. Joseph Bick, "most jails and prisons were constructed to maximize public safety, not to minimize the transmission of disease or to efficiently deliver health care." Joseph A. Bick, M.D., "Infection Control in Jails and Prisons," 45 Clinical Infectious Diseases 1047-1055 (Oxford Academic 2007).

Faced with the COVID-19 pandemic, a particularly dangerous and rapidly spreading infectious disease, prisons have struggled to protect their patients. CDCR's experience with COVID-19 is similar to the experience of prisons and other congregate living environments around the country (e.g., skilled nursing facilities, shelters, and cruise ships). Focusing on the federal prison system and the ten largest state prison systems, CDCR has had a larger number of cases per capita than most, but a lower number of deaths per capita than most. The following two tables are based on data reported by The Marshall Project's "State by State Look at Coronavirus in Prisons" as of October 10, 2020 (<https://www.themarshallproject.org/2020/05/01/a-state-by-state-look-at-coronavirus-in-prisons>):²

State (numeric ranking of largest prison systems)	Cases	Per 10,000
Florida (#3)	16428	1942
Texas (#1)	23065	1904
Michigan (#10)	5572	1612
California (#2)	14870	1528
Ohio (#5)	6499	1443
Federal Prisons	16012	1086
Arizona (#9)	2599	659
Illinois (#8)	1846	591
Georgia (#4)	1917	385
New York (#6)	791	213
Pennsylvania (#7)	469	109

Table 1. Cases in Federal and Top Ten State Prisons

² The per capita calculations for California in these tables is based upon an assumed population of 97,317. According to the Project's website, its population numbers were updated as of July 28, 2020. In California, there had, by that time, been a substantial reduction in CDCR's population. During the early months of the pandemic, CDCR's population was much larger (e.g., its population in March was over 120,000). Because of the difference between the population number used by the Project and CDCR's generally higher population numbers during much of the pandemic, the per capita rates for California listed in Tables 1 and 2 are slightly overstated.

State (numeric ranking of largest prison systems)	Deaths	Per 10,000
Ohio (#5)	100	22
Michigan (#10)	73	21
Florida (#3)	141	17
Georgia (#4)	69	14
Texas (#1)	161	13
Federal Prisons	134	9
California (#2)	69	7
Arizona (#9)	28	7
New York (#6)	17	5
Pennsylvania (#7)	11	3
Illinois (#8)	22	n/a

Table 2. Deaths in Federal and Top Ten State Prisons

It is much more difficult to compare cases and deaths in prisons with how COVID-19 has affected the general public in California, the United States or any other possibly relevant geographic unit. One of many methodological challenges in making such comparisons is that the number of cases and deaths in the prisons tends to be much more precise than the number of cases and deaths reported in the free world. For example, it is generally agreed that the number of reported COVID-19 confirmed cases in the United States substantially undercounts the number of actual COVID-19 cases. This is because, among other things, testing for COVID-19 has not been as widespread as it would need to be to count the actual number of cases. For example, according to CDCR's COVID-19 Tracker, there have been 340.2 tests per 1,000 persons in the United States. This means that two-thirds of the population in the United States has not had a COVID-19 test. By contrast, CDCR has tested 800.3 per 1,000 of its patients, making CDCR's count of cases much closer to the true number. A number of studies have concluded that it is likely there are *at least* 6 times more COVID-19 cases in the United States than have been reported (the range of underreporting goes from 6 to 24 times). *See, e.g.*, "Seroprevalence of Antibodies to SARS-CoV-2 in 10 Sites in the United States, March 23 – May 12, 2020," JAMA Internal Med. (July 21, 2020) (doi:10.1001/jamainternmed.2020.4130). The State of California has done a little more testing per 1,000 persons than the United States, but its testing rate of 395.4 per 1,000 also suggests that its reported count of COVID-19 cases is likely to be low.

The following table, Table 3, depicts the COVID-19 case rate for CDCR, the United States, California and Los Angeles. To account for the likely undercount of cases in the United States, California and Los Angeles County, the second column reports an unadjusted case rate based on the cases being currently reported, and the third column reports a case rate adjusted by

multiplying the case rate in the second column by 6, the lowest multiplier suggested by the undercount studies cited above:³

	Case Rate (unadj) per 100,000	Case Rate (6x adj) per 100,000
CDCR	13,944	Not Applicable
United States	2,344	14,063
California	2,133	12,798
Los Angeles County	2,710	16,264

Table 3. Case Rates in CDCR, the United States, California and Los Angeles.

A similar problem exists with respect to the reported number of deaths from COVID-19. Because CDCR's population is so much smaller than the United States or California, and because we actually monitor the condition of each patient in CDCR, the number of deaths CDCR reports from COVID-19 is likely to be more accurate than the death rates reported for the United States and California. The magnitude of the undercount in free world reports is not as well studied as the undercount in cases, making it nearly impossible to adjust free world death rates to account for the likely undercount.

There is a second methodological problem in trying to compare CDCR COVID-19 death rates with free world COVID-19 death rates. The rate of COVID-19 deaths is highly dependent upon age with well over 70% of deaths occurring in persons age 65 and older, and the age distribution of patients within CDCR does not match the age distribution of free world populations. In general, CDCR's population is slightly younger. Absent an adjustment to match the age distribution of CDCR's population to the age distribution of free world populations, the effective rate of CDCR COVID-19 deaths will be lower than if an age adjustment is made.

A third methodological problem is that it is generally recognized that persons who live for lengthy periods of time in prison tend, in terms of their health, to age more quickly than persons who are not in prison. A person who has been living in prison for decades and who has reached age 50 and above is likely to have an effective age anywhere from 5 to 10 years higher than their actual age. Whether this general tendency applies to the risk of death from COVID-19 is unknown at this time making any age adjustment of death rates even more problematic.

Given the uncertainties described above, Table 4 depicts the COVID-19 death rate for CDCR, the United States, California and Los Angeles County without making any adjustment for actual or effective age, or for the likely undercount of free world deaths. Because of the methodological challenges in comparing CDCR's death rate with free world death rates, the numbers in Table 4 should be viewed with extreme caution:

³ The rates reported in Tables 3, 4, and 5 are calculated using a CDCR population number of 108,387 which is equal to the average of the monthly population during the pandemic.

	Death Rate per 100,000
CDCR	64
United States	65
California	42
Los Angeles County	65

Table 4. Death Rates in CDCR, the United States, California and Los Angeles.

It is not surprising that CDCR's case and death rates would be somewhat similar to the rates experienced in the state and in the country. Prisons are not hermetically sealed. Tens of thousands of employees and contractors enter CDCR institutions from their communities every day, hundreds of patients are transferred from one institution to another each week, and scores of patients are sent out to or return from court and local hospitals every month. CDCR's prisons are part of the community for COVID-19 purposes.

Discussion of COVID-19 in Dorms and Open-Cell-Front Housing

The data above is based on the cumulative number of cases and deaths throughout the CDCR system. However, we have more granular data for each institution which shows that dorm housing used at institutions throughout CDCR and open-cell-front housing used at San Quentin State Prison and Folsom State Prison pose a significantly higher risk to our patients than closed-cell-front housing.⁴ The disparity in risk is so great that it demands focus on the housing assignments for our COVID-19 high-risk patients.

As of October 10, 2020, 69 patients in CDCR custody have died from COVID-19-associated illnesses. Eighty-four percent (84%) of those 69 deaths had a COVID-19 risk score of 3 or above at the time of death, and there has been only one patient with a risk score of 0 who has died from COVID-19. Table 5 depicts the number of deaths and death rates by COVID-19 risk score:

⁴ There actually are a number of different dorm designs used within CDCR that are likely to have materially different COVID-19 spread risks: e.g., 270 Dorms, E-Dorms, Cross-Top Dorms, and Small 4-8 Man Dorms with Closed Doors. Further analysis and discussion may conclude that closed-door, small dorms are an appropriate alternative to residing in a large dorm with shared air space. However, for purposes of this paper, all dorm types have been grouped together in a single "dorm" category. If it is ultimately determined that the 4-8 man dorms are reasonably safe housing for the COVID-19 high-risk population, a significant number of patients will not require relocation since there appear to be approximately 3,475 COVID-19 high-risk patients currently living in such housing.

COVID-19 Risk Score	Deaths	Patient Count with Score	Death Rate per 1,000
0	1	43987	0.023
1	3	25817	0.116
2	7	11779	0.594
3	10	5954	1.679
4	4	3145	1.272
5	6	1962	3.058
6	7	1628	4.300
7	6	1322	4.539
8	10	1025	9.756
9	5	637	7.849
10 to 17	10	1097	9.116
Grand Total	69	98353	0.702

Table 5. Deaths and Death Rates by COVID-19 Risk Score.

For purposes of further analysis, “COVID-19 high-risk patients” refers to all patients with a COVID-19 risk score of 3 and above. This threshold has been chosen primarily because, as depicted in Table 5, there is a substantial increase in the death rate from risk score 2 to risk score 3, and the death rate beginning at risk score 3 and above is higher than the overall death rate for the entire population

An analysis of the housing location of all COVID-19 patients who have died highlights dorm and open-cell-front housing as being particularly problematic to our COVID-19 high-risk patients. Eighty-one percent (81%) of the 69 deaths acquired COVID-19 while living in a dorm or open-cell-front housing unit.

In addition, it is noteworthy that the six largest outbreaks in CDCR institutions – outbreaks resulting in more than 1,000 confirmed COVID-19 patients – have all been in institutions that predominately house patients in common airspace, dorm and open-cell-front housing units:

Prison	Total cases (as of 10/20/2020)	Prison Population (as of 10/14/2020)	Percent of population testing COVID-19 positive⁵
Avenal State Prison	2938	3514	83%
San Quentin Prison	2239	2898	77%
Cuckawalla Valley State Prison	1397	1940	72%
California Rehabilitation Center	1624	2316	70%
California Institution for Men	1403	2265	62%
Folsom State Prison	1339	2229	60%

Table 6. COVID-19 Cases at Institutions with Six Largest Outbreaks

Two additional prisons, California Conservation Center (CCC) and California Correctional Institution (CCI) also sustained major outbreaks, with 661 and 845 cases, respectively. In both institutions, the outbreaks occurred primarily in the areas of the institutions where patients live in dorms as opposed to closed-cell-front housing. As a general matter, outbreaks at prisons which house patients primarily in closed-cell-front spaces have been much more successful in containing the size of outbreaks. A study by Amend and the Berkeley School of Public Health commissioned by the Receiver of the outbreak at California Men's Colony confirms the conclusion that COVID-19 outbreaks are easier to manage successfully in celled housing units with solid doors than in open air dorms which are "primed for super-spreader events." *See* Drew Cameron, Catherine Duarte, Ada Kwan, Sandra McCoy, with Brie Williams and Stefano Bertozzi, *Evaluation of the April-May 2020 COVID-19 Outbreak at California Men's Colony* (July 20, 2020) (https://amend.us/wp-content/uploads/2020/07/CMC_Report_20200720.pdf).

Dorms and open-cell-front housing are more dangerous than closed-door cells because, as very recently confirmed by the CDC, transmission of COVID-19 occurs both through droplets and through aerosolization. Early on in the pandemic, it was believed that transmission occurred only through droplets which supported putting the social distancing requirement at 6 feet (since droplets can only rarely travel more than 6 feet from the source) and not being as concerned about situations where aerosol spread might occur. In response to that understanding, CDCR made efforts to depopulate enough dorm space so that there was 6-feet of distance between groups of 8.

As the world's experience with the pandemic progressed, it increasingly became clearer that transmission was occurring through aerosolization in addition to droplet spread. Pathogens that spread via aerosolization can travel in air currents over greater distances and remain in the air for longer periods of time as opposed to large droplets which rapidly fall to the ground within

⁵ These percentages do not take into account movement into and out of the listed prisons. However, since movement has been severely restricted during the pandemic, the percentages are very close estimates.

approximately six feet. As a result, aerosolized organisms result in an increased risk of transmission in closed rooms and spaces where the virus can infect people who are more than 6 feet from an original source.

The fact of spread by aerosolization makes dorms and open-cell-front housing substantially more problematic in terms of the speed and extent of COVID-19 spread among our patients than closed-cell-front housing. COVID-19 high-risk patients, who are at a much higher risk of morbidity and mortality, should not be housed in dorms or open-cell-front housing.

Table 7 depicts the distribution of COVID-19 high-risk patients (i.e., those with COVID-19 risk scores of 3 and above) in dorm, open-cell-front and closed-cell-front housing:

Housing Type	Number of Patients with COVID-19 Risk Score of 3 and Above
Dorm	6,916
Open-cell-front	1,357
Closed-cell-front	8,420
Total	16,693

Table 7. Housing of COVID-19 High-Risk Patients

In summary, about fifty percent (50%) of the COVID-19 high-risk population remain in the most problematic housing for the transmission of COVID-19. Strategies for reducing these risks include:

- Consideration for release from CDCR of COVID-19 high-risk patients in problematic housing;
- Inter-institution transfer of COVID-19 high-risk patients from dorms and open-cell-front housing to closed-cell-front housing;
- Intra-institution transfer of COVID-19 high-risk patients from dorms and open-cell-front housing to closed-cell-front housing; and,
- Adding housing capacity at select prisons in the form of small tents to further depopulate dorms and open-cell-front housing (certainly not as effective as closed-cell-front housing, but better than large dorms and large open-cell-front housing).

CDCR has already reviewed and considered for release thousands of COVID-19 high-risk patients; a small number of those patients have been released. Consideration for release of COVID-19 high-risk patients in high-risk housing should continue.

If all of the COVID-19 high-risk patients currently in dorms and open-cell-front housing were moved into small tents, it would require some 800 10-person tents to be installed throughout the CDCR system. This number of tents would pose substantial resource and operational challenges, even if that number of tents was readily available. At select institutions, however, installation of 10-person tents may result in a marginal improvement in risk, but this should be a last resort employed only if no other solution is possible because small tents are certainly not as effective as closed-cell-front housing.

The transfer of COVID-19 high-risk patients from dorms and open-cell-front housing to closed-cell-front housing, either by intra-institution transfer or inter-institution transfer, may be feasible on a large enough scale to significantly reduce the risk of COVID-19 to our high-risk patients. As explained in footnote 4 above, further analysis is necessary to determine whether the almost 3,500 patients currently housed in 4-8 man dorms are safe enough in their current housing.

Transferring large numbers of patients within institutions or, particularly, between institutions is not a risk-free endeavor. Much more stringent movement requirements were adopted after the movement of high-risk patients from CIM to Corcoran and San Quentin in May (e.g., pre-transfer quarantine and testing, and post-transfer quarantine and testing). However, no matter what protections are placed around inter-institution transfers, there is a risk that the transfer of large numbers of patients between institutions might itself trigger further COVID-19 spread, particularly at the receiving institution. On the other hand, CDCR is currently transferring hundreds of patients per week between institutions without incident, so the risks associated with transfer already exist within CDCR's system, and the marginal increase in risk of transfers associated with a program to transfer patients from dorms and open-cell-front housing to closed-cell-front housing appears to be outweighed by the benefit to patients of offering such a move.

CDCR has already offered intra-institution transfers to several hundred COVID-19 high-risk patients with COVID-19 risk scores of 11 and above, so we have some experience with this type of program. Where it has been tried, a significant percentage of patients has refused the transfer offer. For example, of the 123 patients recently offered such a move, only 19 accepted the offer, an acceptance rate of fifteen percent (15%). Because these moves are intended primarily to benefit the patient, we have respected the patients' decisions to remain in their existing housing. Additional efforts should be employed to encourage high-risk patients to accept transfer to safer housing.

It should be noted that a transfer program of this magnitude cannot occur without close coordination with the *Coleman* Court and its Special Master to ensure appropriate protection of the interests of patients within the mental health program and coordination with the *Armstrong* Court and its Court Expert to ensure appropriate protection of patients with disabilities. The Receiver looks forward to working with the *Coleman* Special Master and the *Armstrong* Court Expert as this transfer program moves forward.

Conclusion

Now is a particularly good time to implement this initiative. As of October 21, 2020, the number of currently active COVID-19 cases throughout CDCR is 477, the lowest number of cases since mid-May. Before case numbers begin rising again during the coming winter months, we should rehouse our high-risk patients in safer settings.

Based on the above analysis, we conclude that CDCR should offer to every patient with a COVID-19 risk score of 3 and above who is currently housed in a dorm setting or in open-cell-front housing, the option of being transferred to closed-cell-front housing either at their existing institution or at some other institution.

EXHIBIT B

CORRESPONDENCE

Risk Factors for SARS-CoV-2 in a Statewide Correctional System

TO THE EDITOR: More than 2 million persons are incarcerated in the United States, and many of them are vulnerable to infection because of chronic medical conditions. Correctional settings are considered to be high-risk environments for transmission of the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).¹⁻⁴ However, data on risk factors for SARS-CoV-2 infection and outcomes in this population are limited.

We conducted both symptom-based and mass testing by reverse-transcriptase–polymerase-chain-reaction assay (Quest Diagnostics) to detect SARS-CoV-2 infection among incarcerated persons in the Connecticut statewide correctional system (prisons and jails combined) from March 13, 2020, when the first case of Covid-19 was identified in the correctional system, through June 26, 2020. A total of 10,304 persons underwent testing, with at least 14 days of follow-up after testing to monitor clinical status, such as Covid-19–related symptoms, as well as hospitalization, intensive care unit (ICU) admission, and death. The baseline characteristics of the study population are provided in Table S1 in the Supplementary Appendix, available with the full text of this letter at NEJM.org. While increased testing of asymptomatic persons was undertaken over the period of the study, the SARS-CoV-2 positivity rate in the correctional system decreased over time and plateaued on approximately June 12 (Fig. S1).

We used multilevel, multivariate logistic-regression analysis to identify risk factors associated with SARS-CoV-2 infection, hospitalization, ICU admission, and death (Table S2).⁵ Chronic conditions, demographic characteristics, and facility-level factors were covariates. Associations are reported as odds ratios with 95% confidence intervals. The widths of confidence intervals have not been adjusted for multiplicity and should not be used to draw inferences about definitive as-

sociations. A random-effects intercept term for each facility was used to account for clustering. For the SARS-CoV-2 prevalence model, we included only 9699 men because no female inmates tested positive. Other models included only those inmates who tested positive.

Among the 1240 SARS-CoV-2–positive men (approximately 13% of the male population in the system), there were 62 hospitalizations, 20 ICU admissions, and 7 deaths. Risk factors for SARS-CoV-2 infection were dormitory housing (odds ratio, 35.3; 95% confidence interval [CI], 7.9 to 157), Hispanic or Latino ethnic group (as compared with White race) (odds ratio, 1.4; 95% CI, 1.2 to 1.6), and older age (odds ratio, 1.2 per decade; 95% CI, 1.2 to 1.3). Predictors of hospitalization were heart disease (odds ratio, 7.2; 95% CI, 2.8 to 18.5), dormitory housing (odds ratio, 0.22; 95% CI, 0.06 to 0.74), and older age (odds ratio, 2.3 per decade; 95% CI, 1.9 to 2.9). Predictors of ICU admission were heart disease (odds ratio, 7.7; 95% CI, 1.8 to 33.6), autoimmune disease (odds ratio, 13.5; 95% CI, 2.2 to 82.6), and older age (odds ratio, 2.4 per decade; 95% CI, 1.6 to 3.5). Older age was the only predictor of death (odds ratio, 3.3 per decade; 95% CI, 1.7 to 6.3).

The finding that dormitory housing was the strongest risk factor for SARS-CoV-2 infection is consistent with an earlier study involving multiple prison and jail systems and suggests that social distancing is more challenging in such settings than in cells that house one or two inmates.⁴ Dormitory housing may also have been protective with respect to hospitalization, and we speculate that sick inmates from dormitories were identified early and housed in cells before testing and subsequent hospitalization.

Both individual factors and facility-level factors such as dormitory housing rather than cell housing were associated with SARS-CoV-2 infection

and outcomes in a statewide correctional system. Whether these findings are generalizable to other correctional systems is uncertain.

Byron S. Kennedy, M.D., Ph.D.

Robert P. Richeson, D.C.

Amy J. Houde, L.C.S.W.

Connecticut Department of Correction

Wethersfield, CT

byron.kennedy@ct.gov

Disclosure forms provided by the authors are available with the full text of this letter at NEJM.org.

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1. Kaebler D, Cowhig M. Correctional populations in the United States, 2016. Washington, DC: Department of Justice, Bureau of

Justice Statistics, April 2018 (<https://www.bjs.gov/content/pub/pdf/cpus16.pdf>).

2. Maruschak LM, Berzofsky M, Unangst J. Medical problems of state and federal prisoners and jail inmates, 2011-12. Washington, DC: Department of Justice, Bureau of Justice Statistics, February 2015 (<https://bjs.gov/content/pub/pdf/mpsfpi1112.pdf>).

3. Akiyama MJ, Spaulding AC, Rich JD. Flattening the curve for incarcerated populations — Covid-19 in jails and prisons. *N Engl J Med* 2020;382:2075-7.

4. Hagan LM, Williams SP, Spaulding AC, et al. Mass testing for SARS-CoV-2 in 16 prisons and jails — six jurisdictions, United States, April–May 2020. *MMWR Morb Mortal Wkly Rep* 2020; 69:1139-43.

5. Discacciati A, Orsini N, Greenland S. Approximate Bayesian logistic regression via penalized likelihood by data augmentation. *Stata J* 2015;15:712-36 (<https://journals.sagepub.com/doi/pdf/10.1177/1536867X1501500306>).

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EXHIBIT C



Photo Credit: Paso Robles Press

Evaluation of the April-May 2020 COVID-19 Outbreak at California Men's Colony

Report | July 20, 2020

Drew Cameron, Catherine Duarte, Ada Kwan, Sandra McCoy
with Brie Williams and Stefano Bertozzi



Note on Report

In summer 2020, a multidisciplinary team of academics and health professionals conducted an on-site evaluation of the April-May 2020 Novel Coronavirus (COVID-19) outbreak at California Men's Colony (CMC), located in San Luis Obispo (SLO) County, California. A part of Amend's Covid in California Prisons Program, the multidisciplinary team from the University of California, Berkeley has expertise in clinical medicine, public health, epidemiology, health economics, infectious disease, and health systems.

This document describes the on-site evaluation and provides recommendations for the Federal Receiver, CMC, and the California Department of Corrections and Rehabilitation (CDCR) on necessary next steps to address pressing concerns related to COVID-19 and the long-term health of incarcerated people and staff.

This report is based on the most updated research as of July 20, 2020 to reflect our rapidly evolving understanding of the novel SARS-CoV-2 virus and disease (COVID-19). Continued engagement with the public health and medical community regarding how best to implement these recommendations is critical.



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Purpose of this Assessment

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

We achieve this through the following guiding questions:

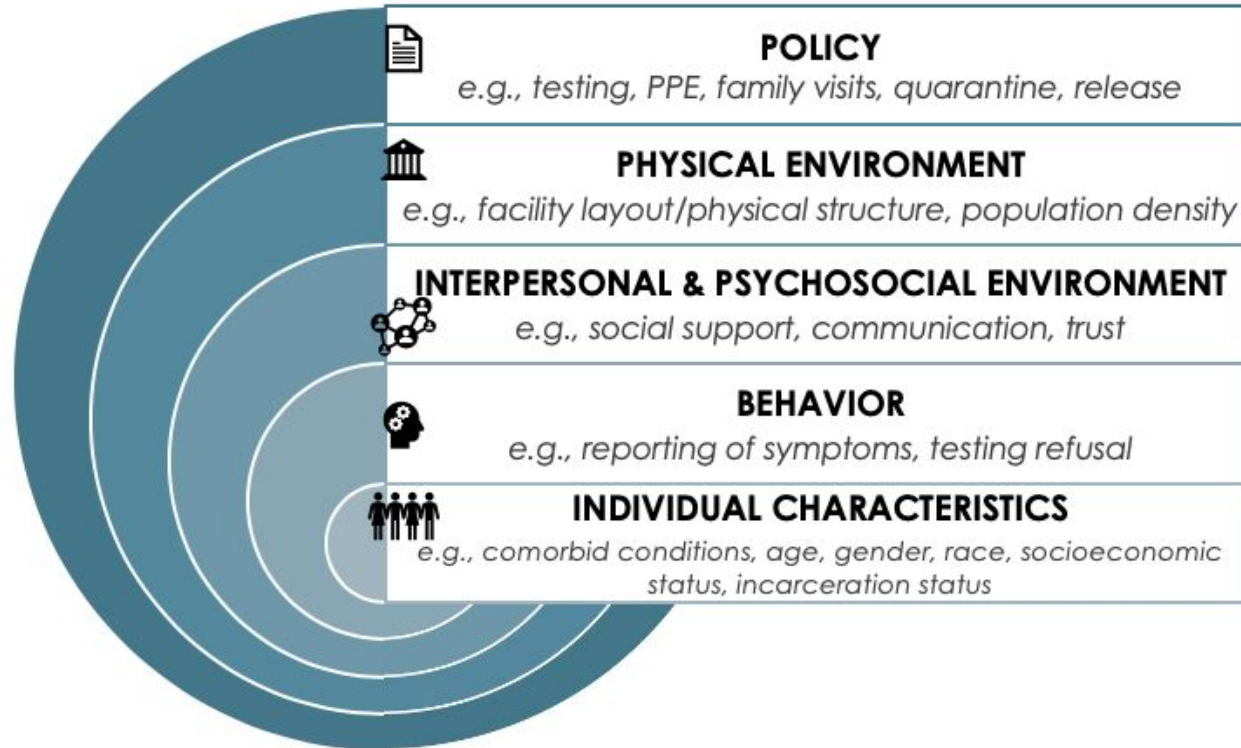
1. How was the April-May 2020 COVID-19 outbreak at California Men's Colony (CMC) contained?

- What factors contributed to containment of the April-May outbreak?
 - To what extent were these factors a function of **planning**, **responsiveness**, or **luck**?
- What factors might contribute to successful mitigation of future outbreaks?
- In which areas do vulnerabilities to future COVID-19 outbreaks remain at CMC?

2. What lessons might be transferable to other settings and how are these lessons translated to policy?

Background: Guiding Health Framework

A guiding framework serves to inform both the health scientists conducting the analysis, as well as readers of the findings, about the overall approach and underlying assumptions guiding the assessment.



Approach: We use an adapted social determinants of health framework to examine the complexity of COVID-19 determinants and risk factors operating at multiple levels in prisons and jails. This helps us to understand how individual characteristics, for example, biological risk factors (e.g., comorbid conditions, age) or social factors (e.g., discrimination on the basis of gender, race, incarceration status) place particular populations at increased risk for COVID-19. Further, it illustrates how that individual-level risk itself is influenced by each of the outer layers in which it is nested (e.g., physical environment, policy). We use this framework to evaluate the outbreak response and inform ongoing prevention and control.

NOTE: This framework has been adapted for application within prisons. It is critical to note that it does not include structural determinants (e.g., legal policy) that shape likelihood of incarceration. That certain populations are disproportionately affected by incarceration, and that prisons and jails are particularly vulnerable to COVID-19 will have implications for statewide inequity in COVID-19-related harm.

Adapted from: Dahlgren, G. and Whitehead, M. (1991). Policies and Strategies to Promote Social Equity in Health. Stockholm, Sweden: Institute for Futures Studies.

Background: Incarceration and Health

People incarcerated in US jails and prisons already experience a higher disease burden than the general population.

Incarcerated persons are at increased risk for:

- **Mental health conditions** (e.g., depression, trauma)
- **Substance Use disorders**
- **Self-harm** (e.g., suicide)
- **Chronic conditions** (e.g., hypertension, diabetes, heart disease, asthma, cancer, arthritis)
- **Infectious Disease** (e.g., HIV, hepatitis C, tuberculosis, chlamydia, gonorrhea, syphilis)

Sources:

Massoglia, M., & Remster, B. (2019). Linkages between incarceration and health. *Public Health Reports*, 134(1_suppl), 8S-14S.

Incarceration and health: A family medicine perspective. American Academy of Family Physicians. (April 2017)[Accessible at:

<https://www.aafp.org/about/policies/all/incarcerationandhealth.html#statistics>]

Condition	Population in State/Federal Prisons	Population in Jails	US Population
Hypertension	30.2	26.3	18.1
Heart-Related Problems	9.8	10.4	2.9
Diabetes	9.0	7.2	6.5
Asthma	14.9	20.1	10.2
Stroke	1.8	2.3	0.7
Any Chronic Condition	43.9	44.7	31.0

Values are %. On the basis of data from the National Inmate Survey 2011 to 2013 (NIS-3), a survey of randomly selected people incarcerated in state prisons (N=3,833) and jails (N=5,494). General population estimates are from a community-based survey, the National Survey on Drug Use and Health, 2009 to 2012.

Source: Wang, E. A., Redmond, N., Himmelfarb, C. R. D., Pettit, B., Stern, M., Chen, J., ... & Roux, A. V. D. (2017). Cardiovascular disease in incarcerated populations. *Journal of the American College of Cardiology*, 69(24), 2967-2976.

Existing health conditions must be centered when making public health recommendations to address COVID-19 in prisons and jails given that:

- Comorbid conditions increase risk for severe COVID-19-related illness and death
- Some COVID-19 mitigation efforts within prisons and jails may increase risk for adverse short- and long-term physical and mental health outcomes

Background: Incarceration and COVID-19 in US

Prisons and jails are highly vulnerable to infectious disease outbreaks, placing incarcerated people at higher risk of acquiring COVID-19 as well as severe illness and death compared to the general population in the US.

CASES CONNECTED TO	▼ CASES
Marion Correctional Institution — Marion, Ohio	2,440
San Quentin State Prison — San Quentin, Calif.	2,319
Pickaway Correctional Institution — Scioto Township, Ohio	1,794
Harris County jail — Houston, Texas	1,723
Trousdale Turner Correctional Center — Hartsville, Tenn.	1,382
North County jail — Castaic, Calif.	1,368
Ouachita River Unit prison — Malvern, Ark.	1,276
Cummins Unit prison — Grady, Ark.	1,131
California Institution for Men — Chino, Calif.	1,120
Chuckawalla Valley State Prison — Blythe, Calif.	1,116
Cook County jail — Chicago, Ill.	1,093
Avenal State Prison — Avenal, Calif.	1,056

Figure 2: Of the 12 COVID-19 clusters in the US exceeding 1000 cases, all are in prisons and jails

Source: New York Times COVID-19 Dashboard [Accessible at: <https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html#clusters>]

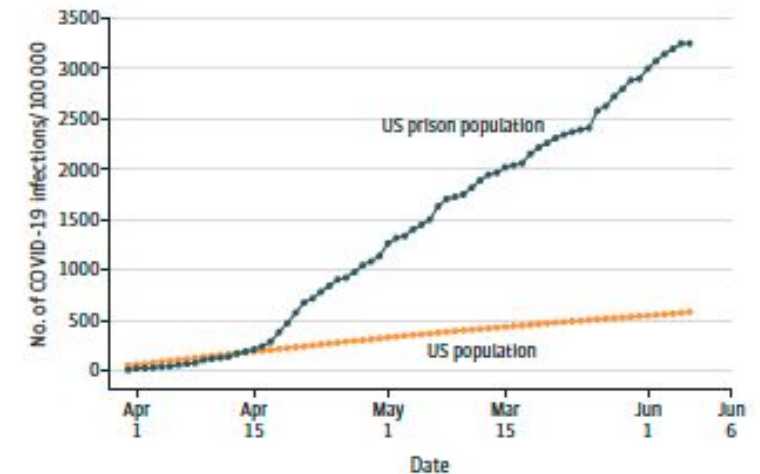
Between March 31-June 6, 2020:

The COVID-19 case rate for people incarcerated in the US was **5.5 times higher** than the US general population

Age and sex adjusted rate of death for people incarcerated in the US was **3.0 times higher** than in the US general population

NOTE: These estimates are based on known COVID-19 cases to-date among people in prisons and the general population. Comparisons should be interpreted with caution as COVID-19 case rates depend upon testing coverage and frequency - characteristics that may vary within and across carceral institutions and states.

Figure. Trends in Cumulative Coronavirus Disease 2019 (COVID-19) Confirmed Case Rate per 100 000 People for Prison and US Populations



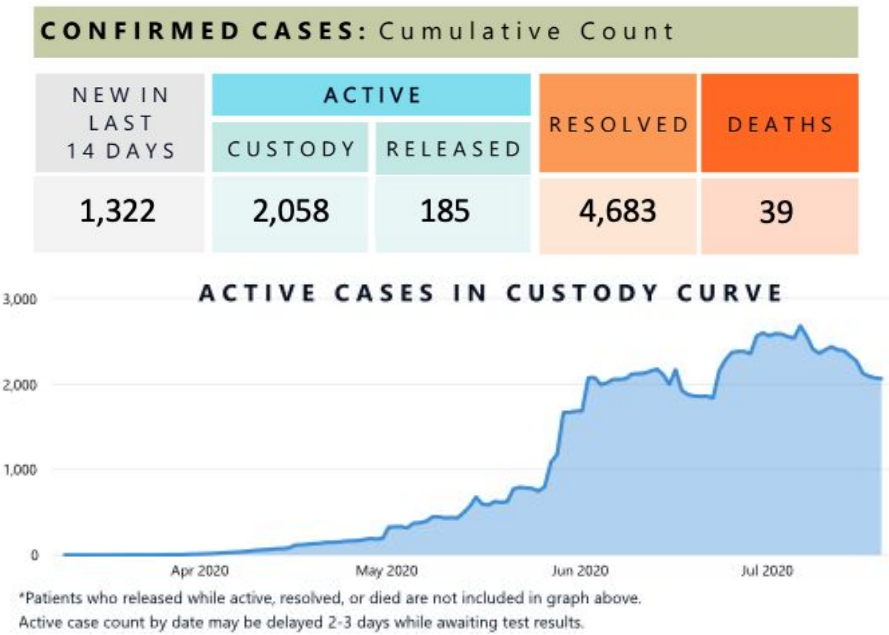
Data are from the UCLA Law COVID-19 Behind Bars Data Project and the US Centers for Disease Control and Prevention.^{3,4} The US population is 327 167 439 and the US prison population is 1 295 285.

Figure 3: COVID-19 risk was initially lower in prisons but surpassed the US population on April 14, 2020. The mean daily case growth was 8.3% per day in prisons and 3.4% per day in the US population.

Source: Saloner, B., Parish, K., Ward, J. A., DiLaura, G., & Dolovich, S. COVID-19 Cases and Deaths in Federal and State Prisons. JAMA.

Background: Incarceration and COVID-19 in CA

Prisons and jails are highly vulnerable to infectious disease outbreaks, placing incarcerated people at higher risk of acquiring COVID-19 as well as severe illness and death compared to the general population in California.



On July 20, 2020:

The COVID-19 case rate for people incarcerated in CDCR was **13.6 times higher** than the California general population.

The COVID-19 case rate for people incarcerated in CDCR was **9.1 times higher** than the US general population.

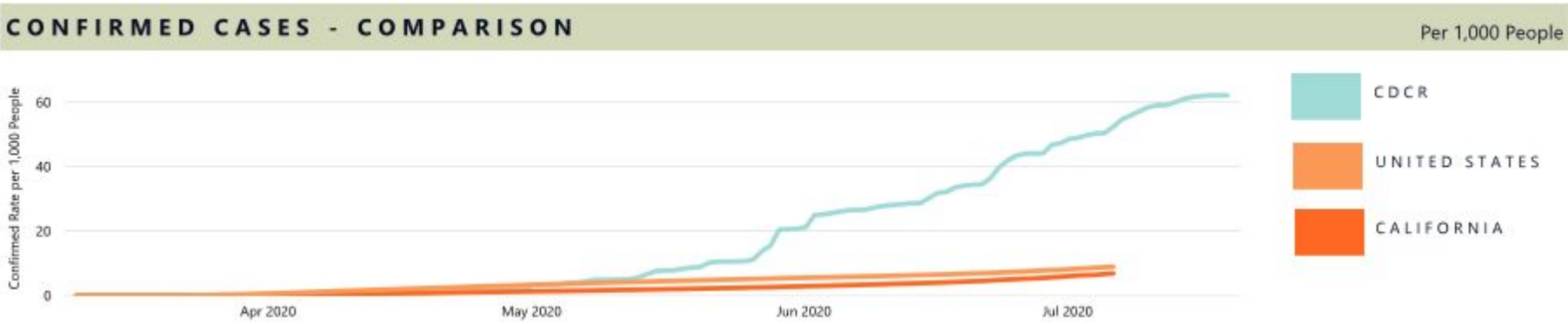
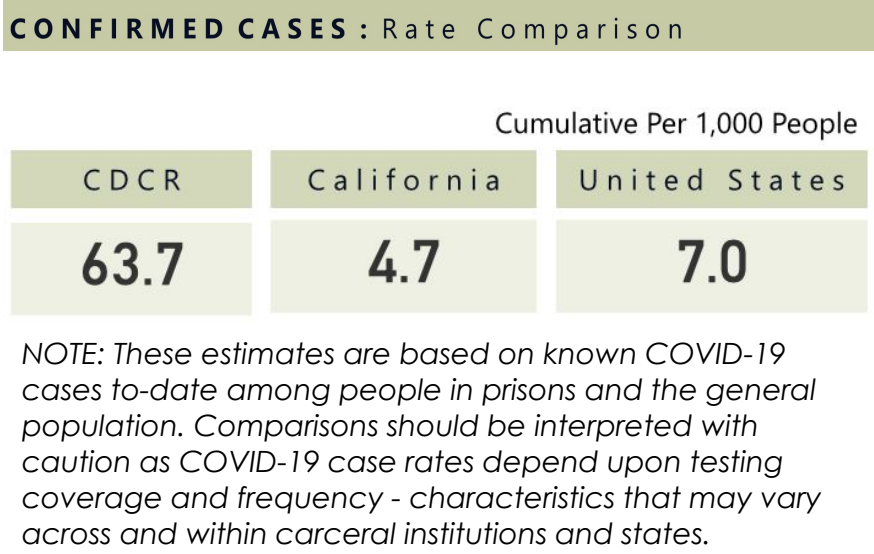


Figure 4: COVID-19 cases per 1,000 people incarcerated in CDCR far exceeds cases per 1,000 in the general California population as well as across the US

Source: California Department of Corrections and Rehabilitation Dashboard [Accessible at: <https://www.cdcr.ca.gov/covid19/population-status-tracking/>]

Background: Incarceration and COVID-19

Why is it so much worse?

What are specific issues in prisons and jails that place incarcerated people at increased risk of COVID-19 related harm?

- High prevalence of comorbid conditions
- Confined, densely populated conditions for prolonged periods of time
- Movement of custody/staff within and to/from prison, which can accelerate transmission
- Transfers of incarcerated people between and within facilities, which can introduce and transmit COVID-19
- Facilities themselves are not designed for health promotion, including but not limited to lacking in healthful spaces for quarantine & medical isolation
- People in prisons already deprived of liberty, exacerbating challenges associated with imposition of further restrictive measures and loss of privileges

Glossary: Key Terms & Critical Knowledge Gaps

The following key terms related to COVID-19 prevention and control are defined in subsequent slides. These terms are important for understanding identified assets and vulnerabilities at CMC to address urgent COVID-19 related mitigation and for informing future recommendations. Areas where there are critical knowledge gaps in the scientific literature are highlighted and discussed.

Active Case

Modes of Transmission

Social Distancing

Recovered Case

Tests

Quarantine

Contact

Contact Tracing

Medical Isolation

Key Terms: Case Classification

Term	Definition	Critical Knowledge Gaps as of July 20, 2020
Active Case		<p>SARS-CoV-2 transmission from pre-symptomatic and asymptomatic cases makes clear the importance of implementing measures that prevent spread by people who may be infectious and not be aware of their infection without testing ("silent spreaders"). Critical knowledge gaps include:</p> <ul style="list-style-type: none"> • The relative proportions of pre-symptomatic, asymptomatic, and symptomatic SARS-CoV-2 among new infections • The relative infectiousness of symptomatic, pre-symptomatic, and asymptomatic persons (likelihood that they will infect others) • Relative efficacy of public health interventions that prevent pre/asymptomatic transmission (e.g., if pandemic is driven by undetected asymptomatic SARS-CoV-2 infections, new techniques in disease detection/prevention – i.e., beyond contact tracing, mass testing, and isolation of asymptomatic contacts – may be needed)
Symptomatic case	SARS-CoV-2 detected with symptom onset	
Pre-symptomatic case	SARS-CoV-2 detected before symptom onset	
Asymptomatic case	SARS-CoV-2 detected but symptoms never develop	
Resolved Case	SARS-CoV-2 infection resolved as assessed through either a <i>test-based strategy</i> (e.g., serial negatives) or <i>symptom-based strategy</i> (e.g., 10 days since symptoms first appeared & 24+ hours have passed <i>since last</i> fever without the use of fever-reducing medications & symptoms have improved)	<ul style="list-style-type: none"> • Test-based strategy is contingent on the availability of ample testing supplies and laboratory capacity as well as convenient access to testing • Determination of the resolution of clinical COVID-19 disease via the symptom-based strategy does not provide information on the duration of infectiousness, which could theoretically extend past the symptomatic period. • Knowledge of SARS-CoV-2 immunity among previously infected persons is needed: <ul style="list-style-type: none"> ◦ How long does protective immunity last? ◦ Does asymptomatic or mild SARS-CoV-2 infection confer full or partial immunity? ◦ Is it possible to be immune from reinfection but still asymptomatically transmit SARS-CoV-2 while in a carrier state (i.e., resolved and infectious)?

Sources:

Furukawa NW, Brooks JT, Sobel J. Evidence supporting transmission of severe acute respiratory syndrome coronavirus 2 while presymptomatic or asymptomatic. Emerg Infect Dis. 2020 Jul 16. <https://doi.org/10.3201/eid2607.201595>.

Discontinuation of Isolation for Persons with COVID-19 Not in Healthcare Settings. Centers for Disease Control and Prevention. 2020 Jul 16.

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html>.

Note: Information on this slide is dated as of July 20, 2020. Given the evolving knowledge of COVID-19, more accurate and up to date information may be available.

Key Terms: Contact

Term	Definition	Critical Knowledge Gaps as of July 20, 2020
Contact: characterized by <u>proximity</u> and <u>duration</u>		
Physical contact	Direct person-to-person contact	<ul style="list-style-type: none"> Relative importance of varying levels of contact given confluence of other factors (e.g., population density, duration of exposure, air exchange)
Close contact	Contact of less than 6 ft for approximately 15 minutes or greater	
Proximate contact	Contact of greater than 6 ft in the same room for an extended period of time	

Source: Public Health Guidance for Community-Related Exposure. Centers for Disease Control and Prevention. 2020 Jul 16.

<https://www.cdc.gov/coronavirus/2019-ncov/php/public-health-recommendations.html>

Note: Information on this slide is dated as of July 20, 2020. Given the evolving knowledge of COVID-19, more accurate and up to date information may be available.

Key Terms: Modes of SARS-CoV-2 Transmission

Term	Definition	Critical Knowledge Gaps as of July 20, 2020
Direct: an infectious agent is transferred from a reservoir to a susceptible host by direct contact or droplet spread.		<ul style="list-style-type: none">Relative importance of droplet vs. vehicle vs. airborne spread in SARS-CoV-2 transmission in various settingsThe frequency of airborne transmissionHow often and why superspreading events occur
Contact	Occurs through direct person-to-person contact	
Droplet	Spray with relatively large, short-range aerosols produced by sneezing, coughing, or even talking. Droplet spread is classified as direct because transmission is by direct spray over a few feet, before the droplets fall to the ground	
Indirect: refers to the transfer of an infectious agent from a reservoir to a host by suspended air particles or inanimate objects (vehicles)		
Airborne	Smaller, longer-range aerosols nuclei that remain suspended in the air for long periods of time and blow over greater distances	
Vehicles	Vehicles (food, objects) that may passively carry a pathogen	

Source: Principles of Epidemiology in Public Health Practice, Third Edition. An Introduction to Applied Epidemiology and Biostatistics. Centers for Disease Control and Prevention. 2020 Jul 16. <https://www.cdc.gov/csels/dsepd/ss1978/lesson1/section10.html>

Note: Information on this slide is dated as of July 20, 2020. Given the evolving knowledge of COVID-19, more accurate and up to date information may be available.

Key Terms: Testing Approaches

Term	Definition	Critical Knowledge Gaps as of July 20, 2020
Tests		
Viral RNA Tests	Identifies active COVID-19 case by detecting SARS-CoV-2 viral RNA at the moment specimen was taken	<ul style="list-style-type: none"> Under what circumstances is individual vs. pooled (combining patient specimens in order to clear the entire group with one negative test or subsequently test the entire group if pooled results are positive) testing preferred to speed up and reduce cost of testing in prison settings? Viral antigen tests confer advantages in speed of testing, but have decreased accuracy relative to viral RNA tests - under what circumstances would each test be available/preferred? While antibody tests identify previous COVID-19 disease, what is their accuracy over what period of time (recent data suggests that antibodies wane in many individuals within a couple of months of infection. Does prior infection confer immunity? And if so, for how long? Data on false negative rates post-exposure for a given testing type are still emerging, which will help to elucidate how early after exposure a test can reliably detect a positive case
Viral Antigen Tests	Identifies active COVID-19 case by detecting presence of viral protein at the moment specimen was taken	
Antibody Tests	Detects antibodies a person's immune system has made in response to the virus, indicating whether a person had been previously infected with COVID-19	

Source: Contact Tracing. Centers for Disease Control and Prevention. 2020 Jul 16. <https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/contact-tracing.html>

Note: Information on this slide is dated as of July 20, 2020. Given the evolving knowledge of COVID-19, more accurate and up to date information may be available.

Key Terms: Prevention and Control

Term	Definition	Critical Knowledge Gaps as of July 20, 2020
Contact Tracing	Technique used by health professionals to prevent the spread of infectious disease. In general, contact tracing involves identifying people who have an infectious disease (cases) and their contacts (people who may have been exposed) and working with them to interrupt disease transmission.	<ul style="list-style-type: none"> Relative proportion of pre-symptomatic and asymptomatic cases who may be infectious and not be aware absent testing.
Social Distancing	<p>Limiting face-to-face contact by keeping adequate space (~6 ft) between oneself and other people who are not from your "household" in both indoor and outdoor spaces.</p> <p>Should be practiced in combination with other everyday preventive actions to reduce spread of COVID-19, including wearing masks, avoiding touching face with unwashed hands, and frequently washing hands with soap and water for 20+ seconds.</p>	<ul style="list-style-type: none"> How many people constitute a "household"? (e.g., to what extent is social distancing possible in various environments and what are the highest risk situations where social distancing would have the largest impact (e.g., cells, dorms, showers, commissary) No evidence about how much physical distancing measures within a shared living environment (e.g., pods within a shared dormitory) confer protection
Quarantine	Separates and restricts movement of people with credible exposure to determine COVID-19 status for quarantine period of up to 14 days	<ul style="list-style-type: none"> Effectiveness of quarantine relies on (1) timing and accuracy of quarantine period, (2) capacity to follow quarantine procedure (without significantly exacerbating risk for other adverse health outcomes), (3) ability to quarantine individually, and (4) if a group is in quarantine together, ability to rapidly detect and isolate any infectious individuals Current evidence to inform quarantine is limited and COVID-19 infection trends raise critical questions regarding implementation effectiveness
Medical Isolation	Separates people who have tested positive of COVID-19 from those who have not	<ul style="list-style-type: none"> Risk of spread from probable cases of COVID-19 absent testing Accuracy/availability of testing to identify positive cases

Sources:

Social Distancing. Centers for Disease Control and Prevention. 2020 Jul 16. <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/social-distancing.html>

Is a 14-day quarantine effective against the spread of COVID-19? The Centre for Evidence-Based Medicine. University of Oxford. 2020 Jul 20.

<https://www.cebm.net/covid-19/is-a-14-day-quarantine-effective-against-the-spread-of-covid-19/>

Note: Information on this slide is dated as of July 20, 2020. Given the evolving knowledge of COVID-19, more accurate and up to date information may be available.

Pressing Takeaways and Why They Matter

Slides 11 through 15 highlight areas where, as of June 20, 2020, there remain critical knowledge gaps in the scientific literature. Those which we perceive to be most urgent for prisons include:

- 1. What is the relative importance of different modes of transmission in prisons?**
 - The World Health Organization released a statement acknowledging airborne (aerosol) transmission
 - Airborne transmission is serious threat in prisons and jails for superspreader events
 - The greater the potential for airborne transmission in a prison, the more critical the need for decarceration
- 2. What is the relative proportion of pre-symptomatic, asymptomatic, and symptomatic SARS-CoV-2 among new infections?**
 - Some evidence that pre-symptomatic and asymptomatic cases account for nearly half of active cases in prisons
 - If pandemic driven by undetected asymptomatic infections, then current practices (e.g., verbal symptom screening, contact tracing) - while necessary - will be entirely insufficient to prevent and control spread in prisons
 - Bolsters critical need for decarceration
- 3. Can people who have recovered from COVID-19 experience re-infection?**
 - Some evidence suggests that people who have recovered from COVID-19 are testing positive again
 - Resolved cases may not have protective immunity, which means incarcerated people and staff/custody could be re-infected and continue to spread the virus
 - Bolsters critical need for regular testing and decarceration

Methods: Data Sources

1. Literature Review

Best practices for COVID-19 prevention and control

2. Interviews with key stakeholders

E.g., Warden, CDCR's Public Health Officer, Receiver

3. Group discussions

San Luis Obispo (SLO) Public Health Department (June 10, 2020)

CMC administration

Inmates Councils (East and West)

The Gold Coats Program

4. Direct observation and physical space assessment at CMC

Visit: June 11, 2020

5. CDCR Administrative Reports & Records

About California Men's Colony: Physical Infrastructure

East "cells" - Est. 1961

Five independent facilities: A,B,C,D,H

- A, B, C, D yards:
 - Quadrangles with 2 units, each with 3 solid-floor tiers
 - Each tier of 100 cells split into two halves/sides: each half had a grilled gate entrance, 1 TV room, 1 shower room, and 1 day room
 - Custody station and stairway between each half tier
 - Single-unit, closed door cells with window
- H (Est. 2013): stand-alone, 50-bed mental health crisis unit
- Security: Level III

West "dorms" - Est. 1954

Four independent facilities: E, F, G, M

- Dormitories with approx. 30-50 individuals per unit with pods 6' apart comprised of max. 4 bunk beds each
- Security: Level I and II

NOTE: Physical structures across the CDCR system are highly heterogeneous. For example, they are built in different time periods and were designed for different levels of security. **Consequently, each structure poses unique challenges for COVID-19 prevention and control efforts.**

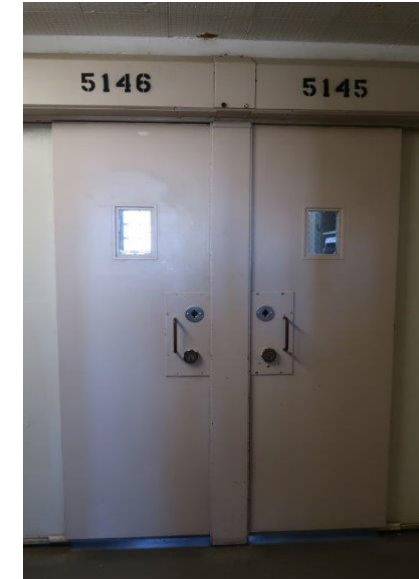


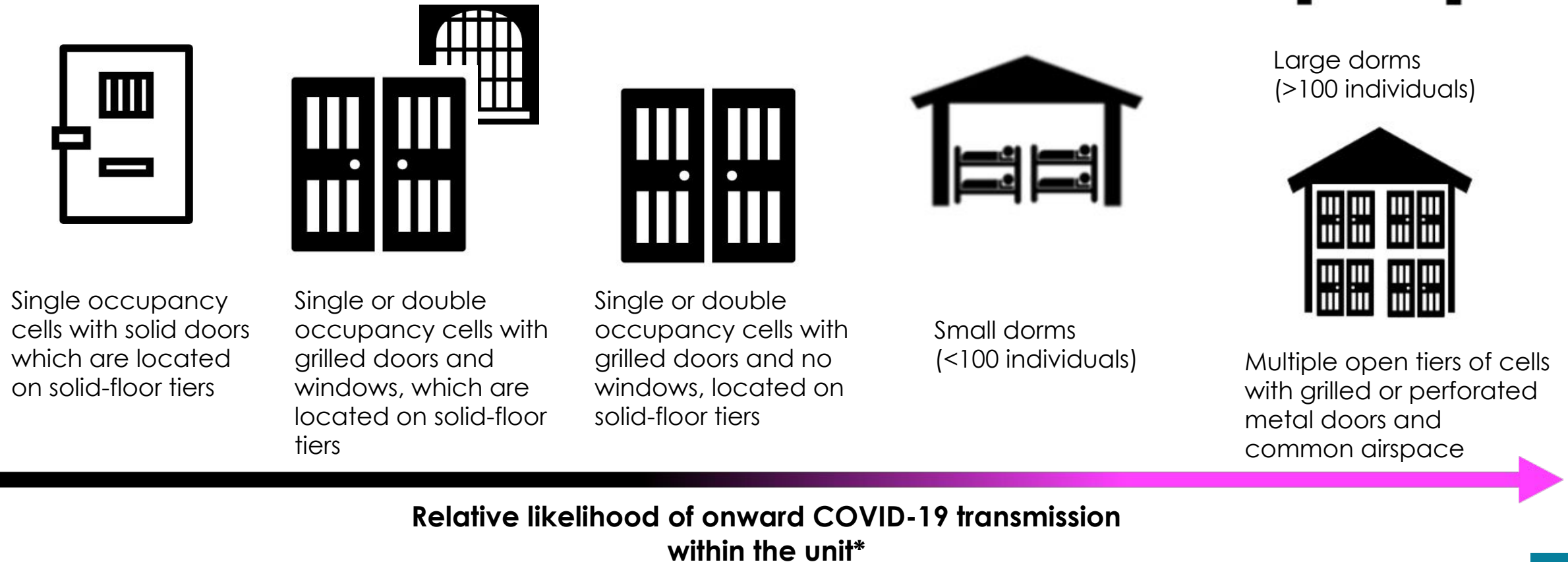
Figure.
Closed-door, single-unit cells in Medical Isolation area in Building C5



Figure.
CMC facilities: East cells (E), West dorms (W)

A Note on Physical Infrastructure in Prisons

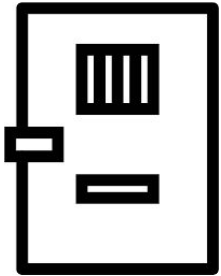
Within jails and prisons, density in the form of close, prolonged contact is a critical risk factor for COVID-19 transmission, which is primarily influenced by *population density, shared air space, and unit type*. While all units pose some level of risk for COVID-19 transmission, particular types of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



Note: The risk of infection also increases with the number and proportion of positive cases. This slide does not consider important transmission routes outside the unit.

About California Men's Colony: Physical Infrastructure

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



An outbreak occurring in
East cells vs. **West dorms**
can have very different
outcomes.



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

Small dorms
(<100 individuals)

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

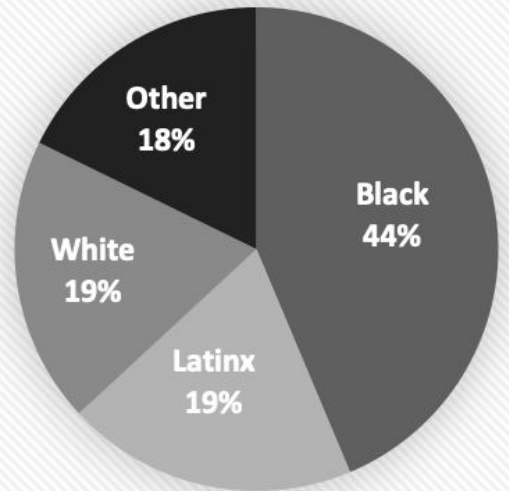
Note: The risk of infection also increases with the number and proportion of positive cases. This slide does not consider important transmission routes outside the unit.

About California Men's Colony: Incarcerated People

Demographics of People Incarcerated at CMC:

On March 1, 2020: 3,782 people incarcerated at CMC
[98.5% of design capacity* (3,848)]

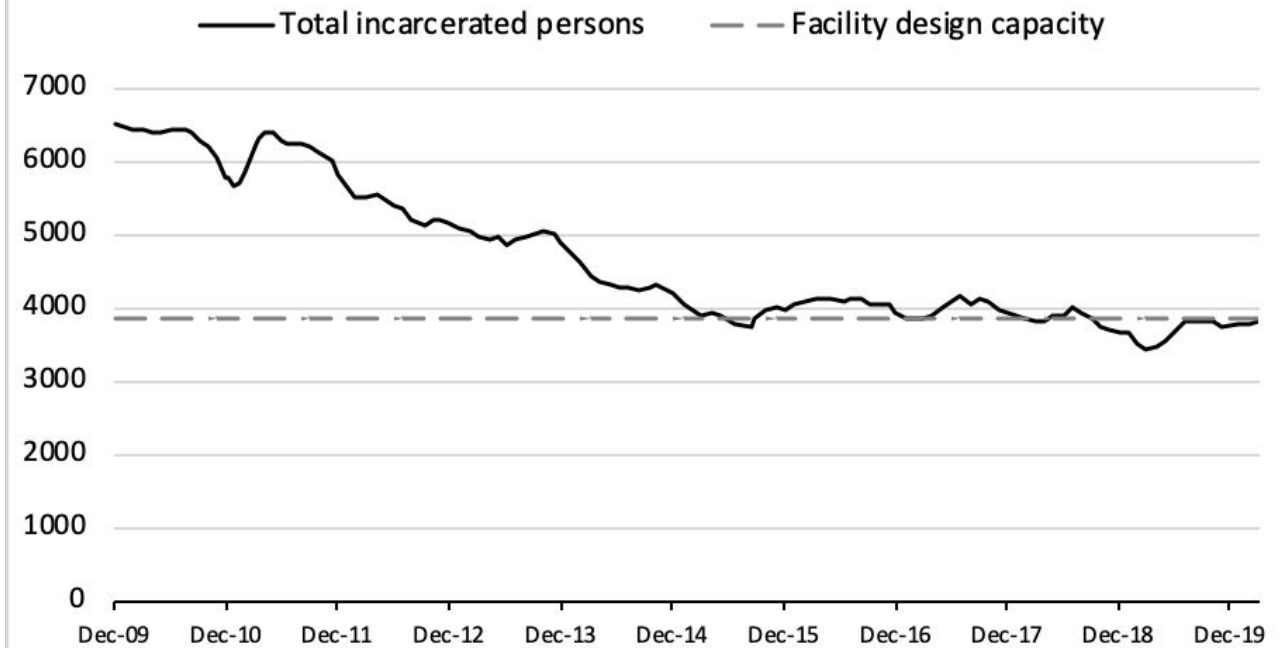
CMC Incarcerated Persons by Race



■ Black ■ Latinx ■ White ■ Other

8.9% of people incarcerated at CMC have
ADA-classified disability

CMC Population Over Time



***NOTE:** 'Facility design capacity' is an architectural definition that does not have salience for risk of COVID-19 infection (i.e., a prison can be below design capacity and still pose an insurmountable superspreader risk absent decarceration)

About California Men's Colony: Incarcerated People

People incarcerated at CMC are of older age and have a higher burden of existing medical conditions compared to the CDCR average.

Characteristics of people incarcerated at CMC:

- **Age:** 38% are age 50 years or older (CDCR avg. 25%); 11% are age 65 years or older (2020)*
- **Specialty care referrals:** approximately 71 referrals per 1000 people incarcerated at CMC (CDCR avg. 53/1000)
- **Mental Health Enhanced Outpatient Program (EOP):** 13.8% are in a mental health outpatient program (CDCR avg. 5.4%)

Population General Medical Risk Profile

Risk Level	CMC	CDCR avg
High Risk 1 (trigger 2+ high risk selection criteria, below)	7.2%	5.9%
High Risk 2 (trigger 1 high risk selection criterion, below)	15.9%	8.8%
Medium Risk (trigger at least 1 chronic condition, below)	38%	34%
Low Risk (includes subset with well-managed stable conditions)	39%	52%

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

Source: CDCR Dashboard, October 2019

*CDCR internal reporting June 2020; Rates are subject to change.

About California Men's Colony: Incarcerated People

Individual-level 'Weighted COVID-19 Risk Score' shows West block has highest risk of disease severity

	All CMC		East Block		West Block		Other*	
Weighted Risk Score	Count	% CMC	Count	% East	Count	% West	Count	% Other
Risk score = 0	2,384	66%	1,189	72%	1,034	59%	161	72%
Risk score = 1	440	12%	213	13%	207	12%	20	9%
Risk score = 2	273	8%	111	7%	149	8%	13	6%
Risk score = 3	69	2%	19	1%	40	2%	10	4%
Risk score >= 4	463	13%	112	7%	331	19%	20	9%
Total	3,629	-	1,644	-	1,761	-	224	-

Risk score, developed by CCHCS Quality Management Unit, computed by summing scores (**score = #**) across all persons with the following:

Age 65+ (**score = 4**); pregnant (**1**); moderate-severe persistent asthma (**1**); cancer (**2**); diabetes (**1**); high-risk diabetes (**1**); heart disease (**1**); high-risk heart disease (**1**); HIV/AIDS (**1**); poorly controlled HIV/AIDS (**1**); immunocompromised (**2**); BMI 40+ (**1**); on hemodialysis (**1**); advanced liver disease (**2**); having any of the following chronic conditions [hypertension, coccidioidomycosis, connective tissue disorder, dementia/Parkinson's disease, endocrine disorder, MS, Myasthenia Gravis, neurologic disorder, vasculitis] (**1**)

Data from **July 10, 2020**

Note: *Other includes Ad-Seg, CTC Medical, CTC Mental Health, Out-to-Court; Total population includes patients who are currently endorsed to CMC but "out-to-medical" or "-court" and were not physically at CMC when the analysis was run. Therefore, population count will differ from the CDCR population report as CDCR institution pop. definition excludes incarcerated people "out-to-medical" or "-court".

About California Men's Colony: Staff/Custody

More than 1 in every 3 CMC staff/custody are age 50 and older. Several commute from surrounding communities and towns via vanpools.

On March 1, 2020: 1,719 total employees at CMC

Characteristics of CMC Staff/Custody:

- **Age:** 38.9% are age 50 years or older (range 20-83 years); 3% are age 65 years or older

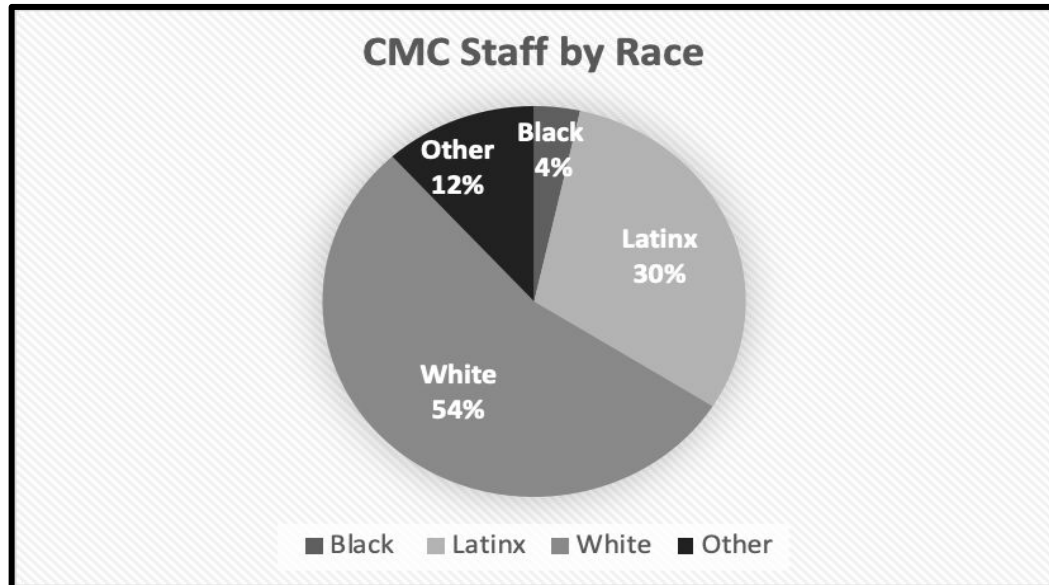


Figure. CMC staff racial breakdown

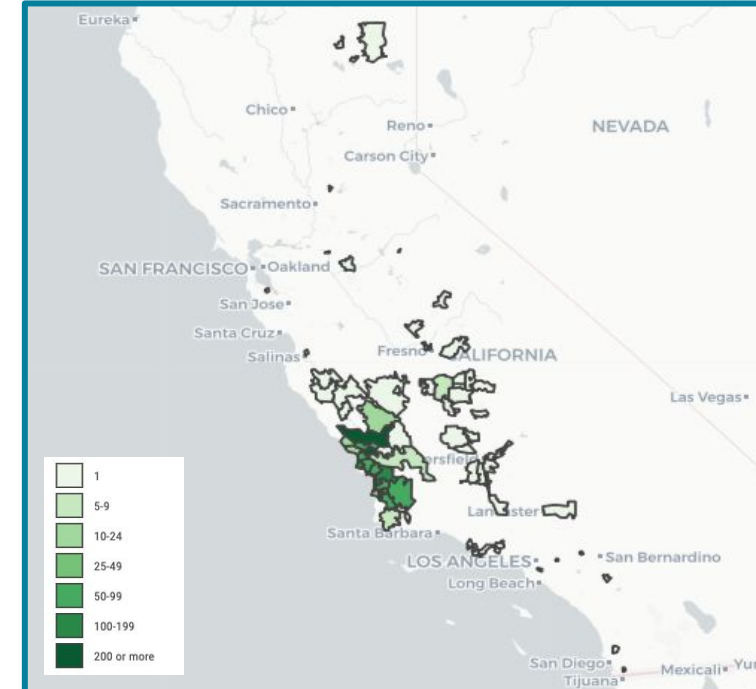


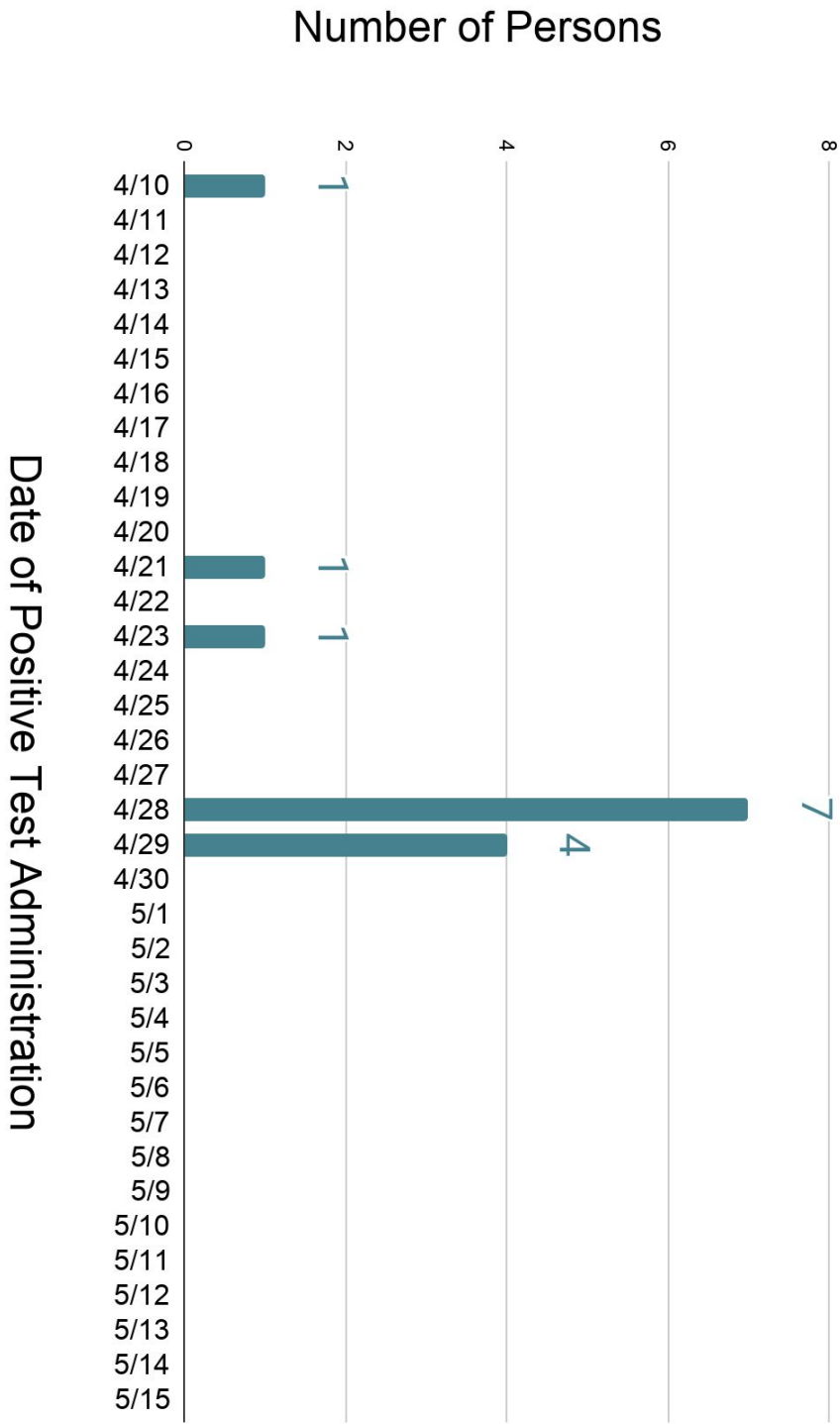
Figure. Concentration of CMC staff by county of residence

Staff/custody live and commute from various counties

- **Majority live within 30 miles** (e.g., SLO, Paso Robles, Atascadero, Arroyo Grande)
- **Small number commute from much further** (e.g., Fresno 141 miles from CMC)
- **Commute with each other in 'vanpools' and/or often stay at nearby hotels during shift days**

Note: Data not available on the number or percent of staff with other COVID-19 risk comorbidities

Outbreak Characterization: Epidemic Curve



During CMC's April/May outbreak, a total of 14 cases were reported: 11 among incarcerated persons 3 among custody/staff

Figure: These 14 cases first tested positive at different points over the month of April 2020. The first test that would later be returned as positive for COVID-19 occurred on April 10, with the second on April 21, and the third on April 23. On April 28, seven of the specimens would later be returned as positive for COVID-19, with four additional positive tests collected the following day.

NOTE: Typically, epidemic curves illustrate date of illness onset. However, this figure depicts date on which first positive nasopharyngeal swab specimen was collected. This figure should be interpreted with caution given variation in - and delays between - illness onset, symptom presentation, and first positive test. Still, this **does** reflect the timing of test administration that guided subsequent decisions.

Outbreak Characterization: Introductions

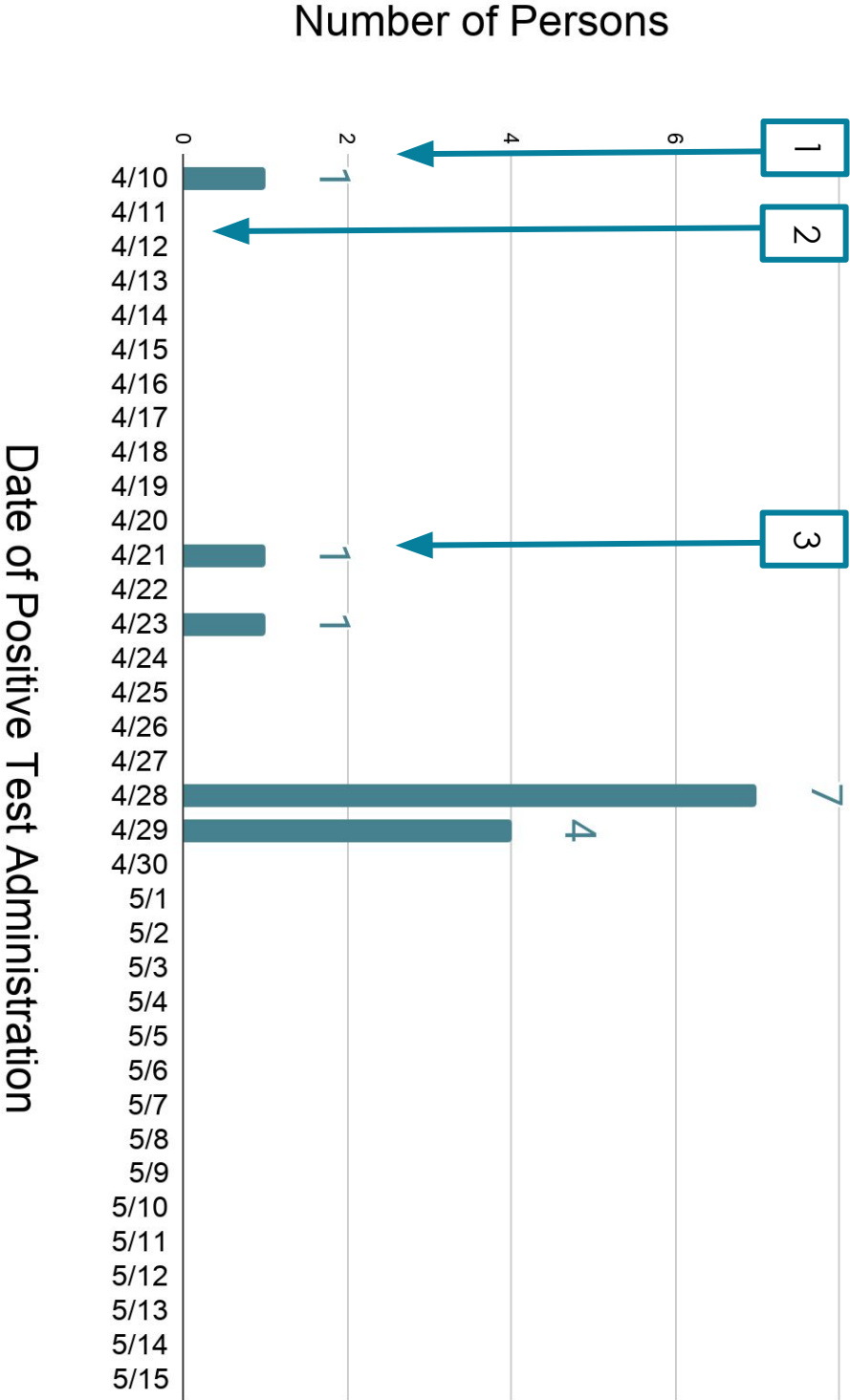
There were two, possibly three, introductions of SARS-CoV-2 into CMC during the April-May 2020 outbreak

- 1. Person returning from court, previously at LA County Jail (East)**

 - April 6: Entered CMC and placed in isolation on C5, L1
 - April 10: Symptom onset and test collected
 - April 11: First positive test
 - April 24: Second positive test collected (result on April 28)
 - No epidemiologically linked onward transmission, but cannot rule out this possibility
- 2. Custody staff member (West)**

 - April 5: Last day prior to parental leave
 - April 12: After partner's diagnosis, tested in Santa Barbara County
 - April 22: Returned to CMC after case resolved (i.e., did not develop symptoms in 10 days following asymptomatic positive test)
 - No epidemiologically linked onward transmission at CMC, but cannot rule out this possibility
 - NOTE: Not included in case counts
- 3. Symptomatic incarcerated person (East)**

 - Resided on C5, L3
 - April 21: Test collected
 - April 22: First positive test
 - Epidemiologically linked to 12 additional cases
 - 9 among incarcerated persons
 - 2 among custody
 - 1 among healthcare staff



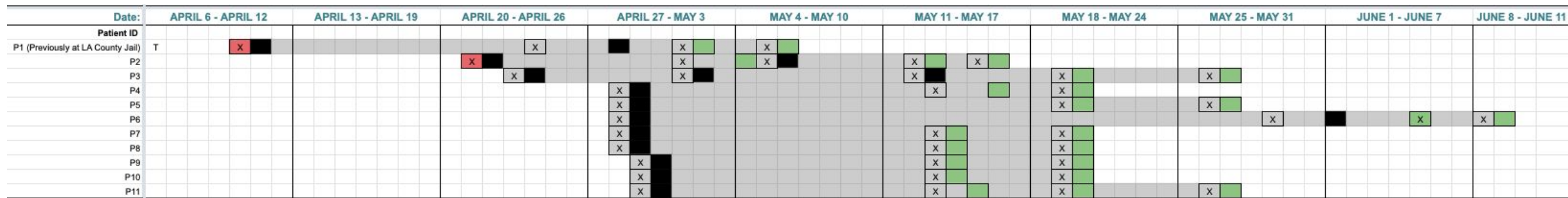
Outbreak Characterization: Testing Timeline for Positive Cases [April - June 2020]

Outbreak response involved inter-institutional coordination, facilitated faster testing turnaround time, and implemented standard outbreak investigation procedures.

- **Coordinated response:** San Luis Obispo (SLO) Public Health Department led investigation with CMC Medical
- **Rapid testing turnaround:** mean testing turnaround approximately 24 hours (range 0-4 days) using SLO Public Health Department labs (bypassing Quest)
- **Serial negative testing of positives:** after initial positive test, repeat testing until two consecutive negative results
- **Staff/custody tested:** Approximately 200 custody/staff tested with 50% refusal of second test
- **People incarcerated in building C5 and C6 tested:** Approximately 400 incarcerated persons tested with no refusals
- **Implemented standard outbreak investigation procedure:**
 - Concentric testing around first symptomatic case
 - Contact tracing identified custody person who crossed buildings C5 and C6
 - Mass testing on C5 and C6

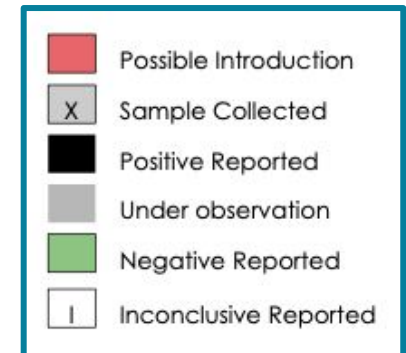
Outbreak Characterization: Testing Timeline for Positive Cases [April - June 2020]

Outbreak response involved inter-institutional coordination, facilitated faster testing turnaround time, and implemented standard outbreak investigation procedures.



Source: San Luis Obispo County Department of Public Health

Figure: This timeline illustrates the testing process for positive cases among people incarcerated at CMC over the course of the outbreak. For example, row 1 documents the testing experience of the person returning from court and previously at LA County Jail. They arrived at CMC on April 6, 2020 and were first tested on April 10th. A positive test result was returned the following day. They were tested again on April 24th, and received a second positive result four days later. On May 1st, they were tested a third time, receiving a negative result the following day. Their last test was administered on May 5th, and it, too, was negative.

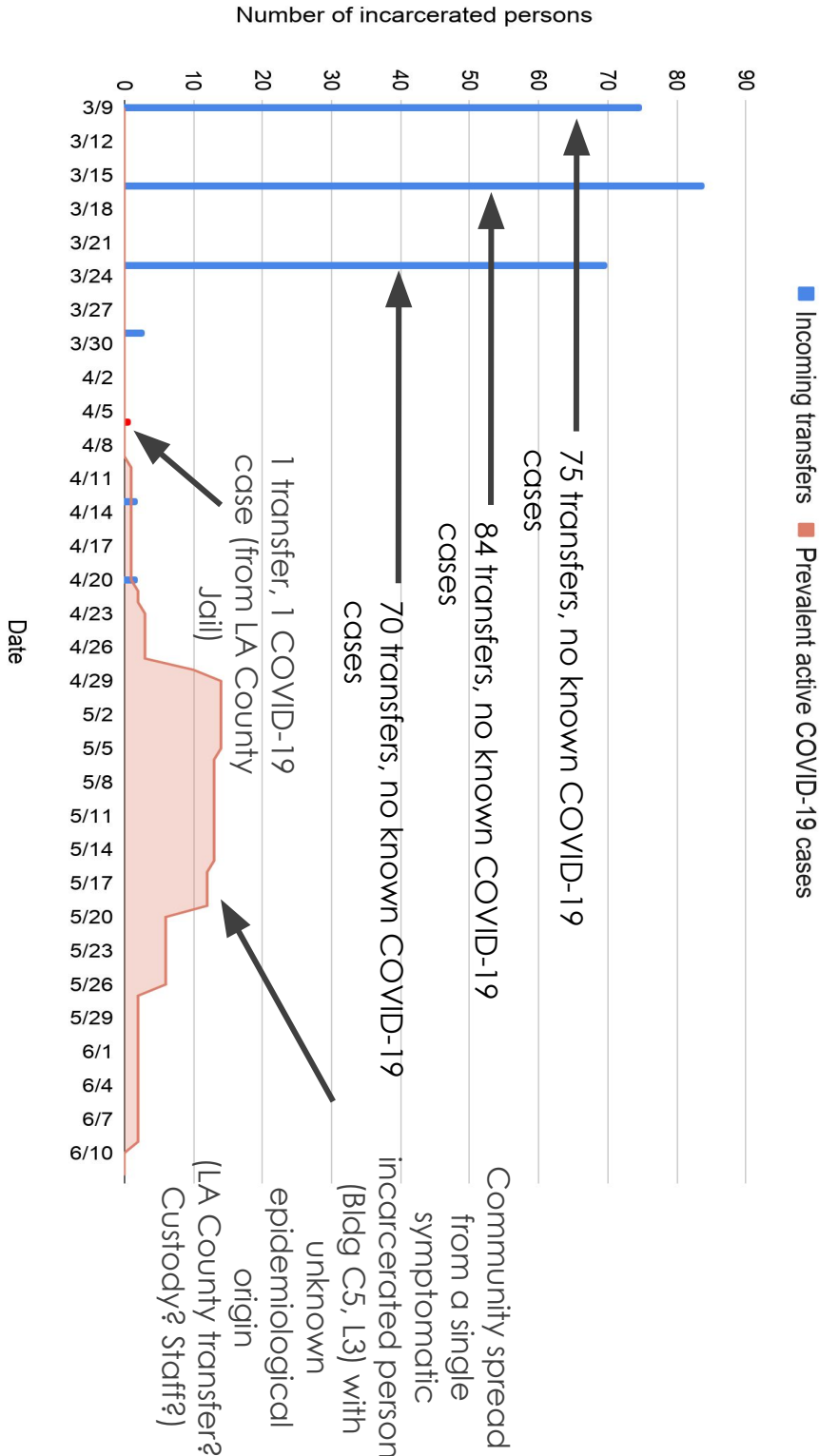


NOTE: Testing data reflect 11 known positive cases among people incarcerated at CMC only; Staff/custody who tested positive and all individuals who tested negative are not shown on this slide.

Onward Transmission with ~24 Hour Testing Turnaround

Figure: The red shaded region illustrates known daily point prevalence of active COVID-19 cases. This includes new cases and those under observation who previously tested positive. This number can be impacted by several factors, including testing turnaround time, people being transferred from other jails and prisons, people being transferred within a prison (e.g., East to West at CMC), and onward transmission in the prison. For example, the longer the testing turnaround time, the longer quarantined individuals must remain under observation, and the greater the daily prevalence.

At CMC, the policy to stop transfers was implemented around this time. Testing turnaround of approximately 24 hours meant that once COVID-19 cases resolved, people could be released from the conditions of quarantine. There were also, fortunately, no other new introductions at this time allowing for limited quarantine capacity to not be overwhelmed.



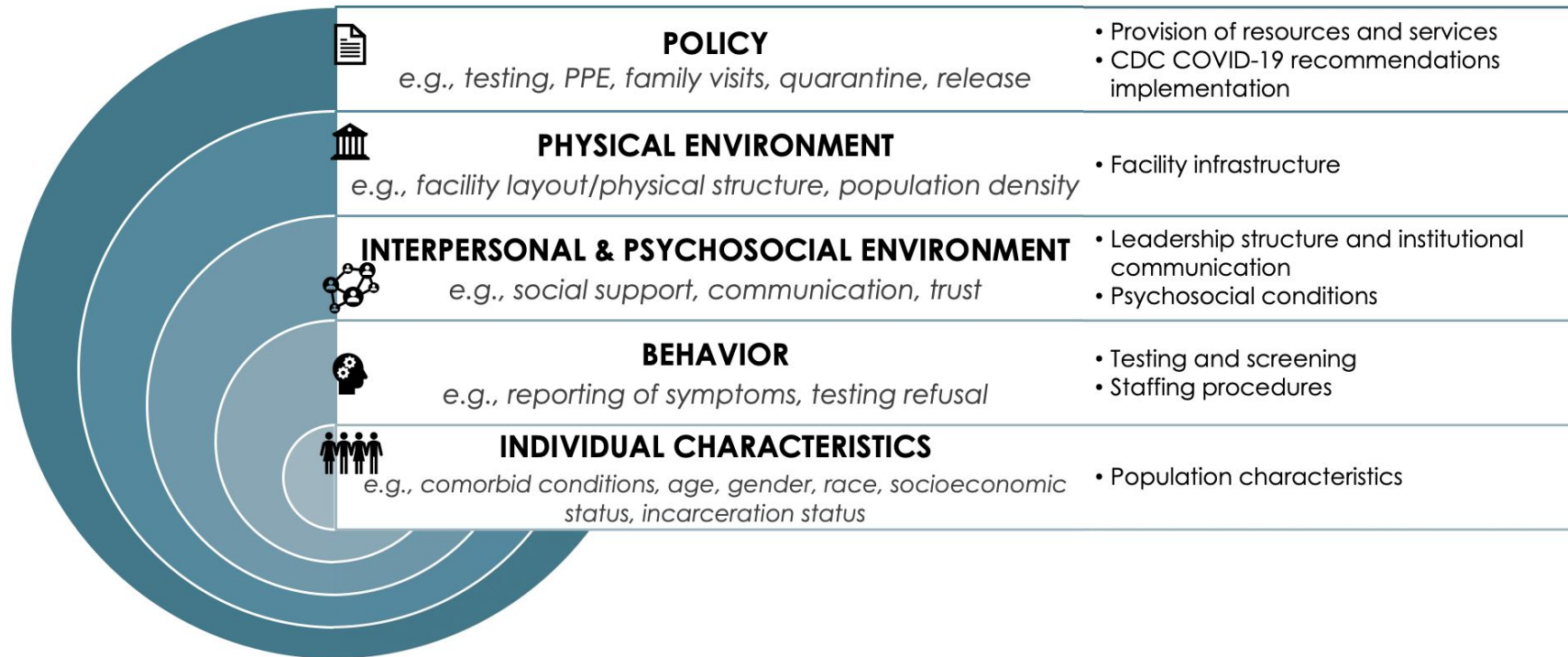
Source: CMC Medical

1. How was the April-May 2020 COVID-19 outbreak at CMC contained?



CMC Prevention and Control Efforts

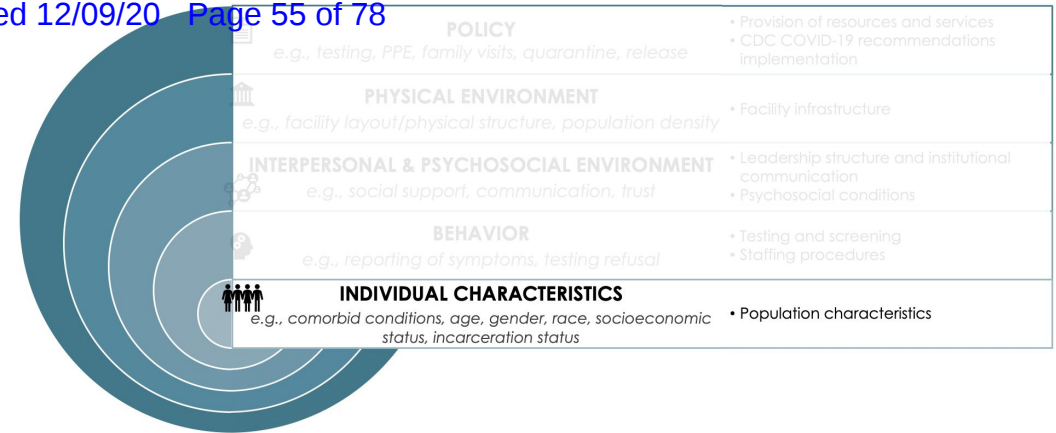
In this section, we examine the outbreak in the context of the **eight dimensions** of our guiding framework to understand, 'How was the April-May 2020 COVID-19 outbreak at CMC contained?'



These **eight dimensions** help us identify conditions that may have either **facilitated** or **hindered** prevention of COVID-19 introduction and/or control during the April-May 2020 COVID-19 outbreak and may affect future outbreaks at CMC.

To evaluate the CMC outbreak response, we begin by examining population characteristics at the individual level, including **biological factors (e.g., comorbid conditions, age) and social factors (e.g., discrimination/barriers on the basis of socioeconomic status, incarceration status)**. We then move outwards in our framework, assessing how each subsequent outer level acts on the more core levels. We end with an analysis of the **policy level**.

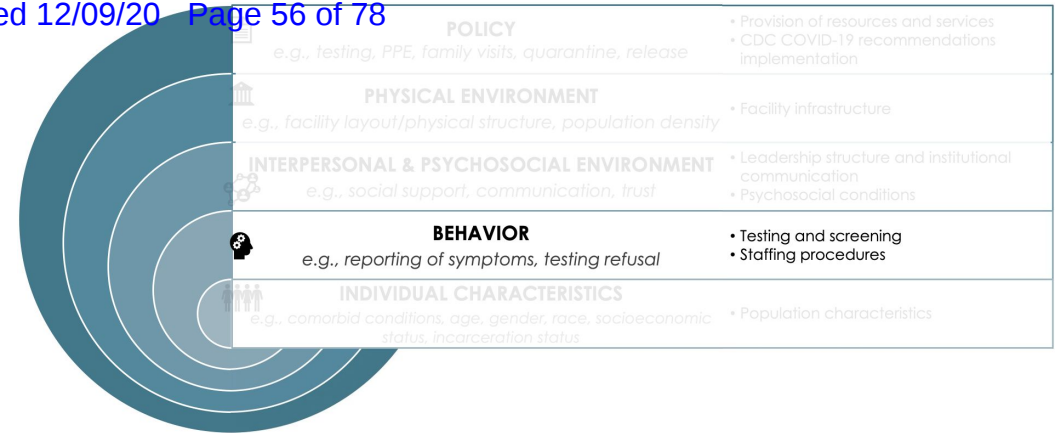
CMC Prevention and Control Efforts: Takeaways



Population Characteristics that hindered efforts:

- **Underlying comorbid conditions among staff/custody and people incarcerated at CMC increase risk for severe COVID-19 related illness and death**
 - ~40% of people incarcerated at CMC are aged ≥ 50 and ~40% of staff/custody are aged ≥ 50
 - In the presence of comorbidities, even those of younger age may be at increased risk for severe illness and death
- **Staff/custody commute to and from CMC daily and can propel COVID-19 spread to both people incarcerated at CMC as well as surrounding communities.**
 - Given high housing costs in San Luis Obispo County, several staff/custody reside outside the county, as far as 141 miles away, and commute together to work in 'vanpools'
 - As a result, if infected, they could introduce COVID-19 to people incarcerated at CMC, other staff/custody, as well as to their home communities.

CMC Prevention and Control Efforts: Takeaways



Testing & Screening factors that facilitated efforts:

- The relationship with SLO Public Health Department, early and rapid COVID-19 testing, and existing internal procedures to respond to prior infectious disease outbreaks facilitated CMC's response in April-May

Testing & Screening factors that hindered efforts:

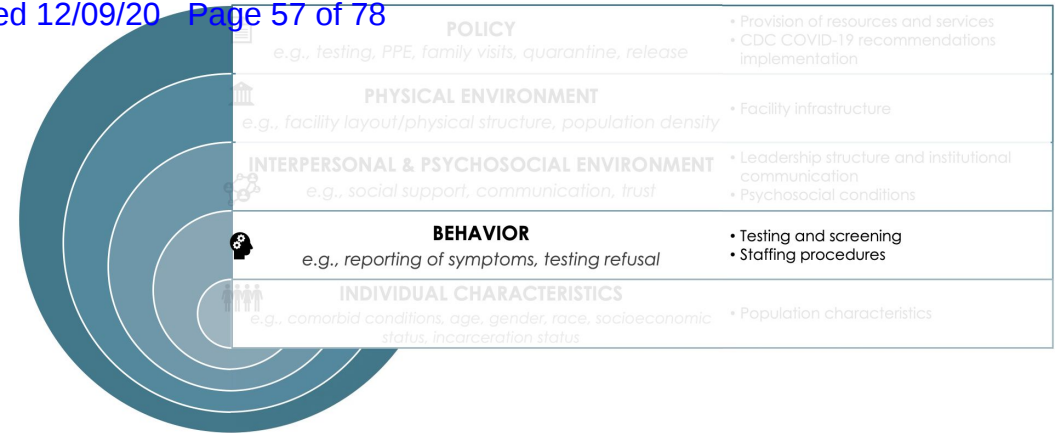
- At initial stages of the outbreak, there were challenges identifying resources and responsibilities**
 - SLO Public Health Department was not the primary agency for testing
 - CMC Medical requested PPE supplies from Headquarters, but none were initially available
 - Statewide institutional staff testing was not announced until July 3, 2020
- CMC's April-May strategy of symptom screening, contact tracing, and one-time testing (of negatives) are necessary but insufficient**
 - Symptom screening and contact tracing alone can identify those who are symptomatic, but will miss pre-symptomatic and asymptomatic individuals
 - One-time testing: Serial testing of negative cases may be needed since positive cases have been identified among those who previously test negative (false negatives, see box).

A MMWR report on COVID-19 in a Louisiana prison found:

45% of positive cases were asymptomatic or pre-symptomatic

25% of positive cases were among those who previously tested negative

CMC Prevention and Control Efforts: Takeaways



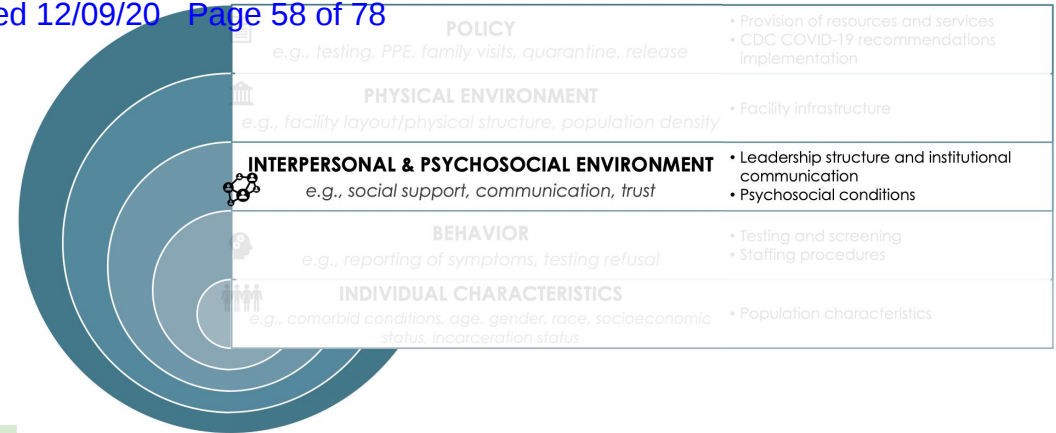
Staffing Procedures factors that facilitated efforts:

- Some staff elected to remain on the same unit(s) which may have reduced COVID-19 transmission
- Some staff were aware of measures to mitigate *fomite/droplet/airborne* transmission
 - Mask supplies and use appeared commonplace

Staffing Procedures factors that hindered efforts:

- Many staff did not elect to remain in the same unit(s) leading to incomplete staff cohorting**
 - Union regulations on shift selection, seniority, and overtime prevented formal staff cohorting to reduce transmission
- Staff leave during the Apr-May COVID-19 outbreak contributed to insufficient healthcare staffing**
 - Reports of "large numbers of staff taking leave" due to threat of COVID-19
 - This hindered efforts to conduct testing & maintain other critical healthcare services
- Awareness of actions to mitigate *fomite/droplet/airborne* transmission appeared low among some staff**
 - Inefficient mask use and improper fit among staff/custody
 - Attitudes of "I'm strong enough to handle it" among some staff/custody reflected low perception of risk (including role of staff/custody as facilitators of introductions to prison and onward transmission)

CMC Prevention and Control Efforts: Takeaways



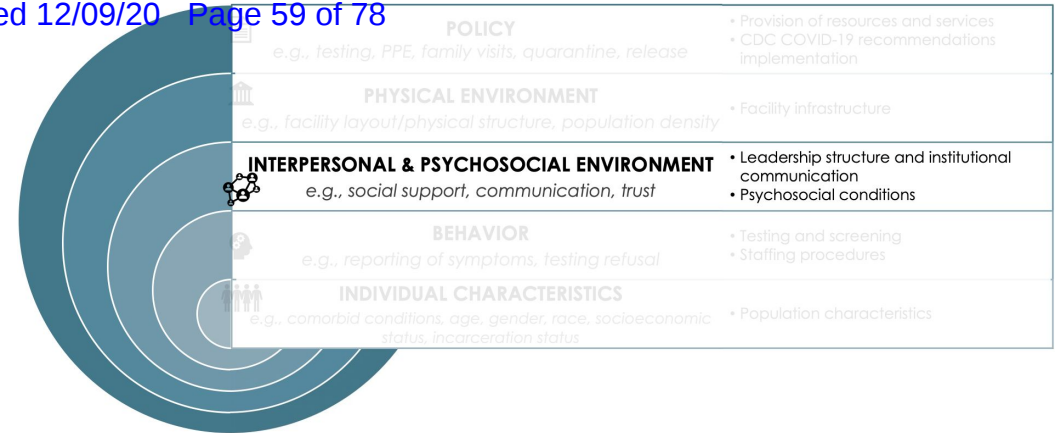
Leadership Structure & Institutional Communication factors that facilitated efforts:

- **CMC had working relationships with SLO Public Health Department and CCHCS**
 - Coordinated efforts, good rapport, and respect within and across teams
 - CMC leveraged and strengthened these relationships over time
- **Within CMC, pre-existing, effective working relationships**
 - Warden Gastelo widely respected by staff/custody and collaborated with Union Rep. and CEO Macias
 - Involvement and coordination by CEO Macias & organization by CME Dr. Haar during outbreak
 - Regular weekly and biweekly meetings at different levels for timely communication and action
 - Established grievance processes for staff/custody and people incarcerated at CMC

Leadership Structure & Institutional Communication factors that hindered efforts:

- **Statewide institutional staff testing was not announced until July 3, 2020**
- **Some communication breakdowns and access issues**
 - Reports of overwhelming amounts of information/data from multiple managers at initial stages of outbreak
 - Communication about COVID-19 transmission instilled fear and anxiety among some people incarcerated at CMC given restricted agency to implement recommendations
 - During Building C5 lockdown, no administration communication to people incarcerated in C5 for 2-3 weeks
 - Unknown extent to which CDCR policies regarding communications and program accessibility for people with disabilities or who do not speak English were effective/followed

CMC Prevention and Control Efforts: Takeaways



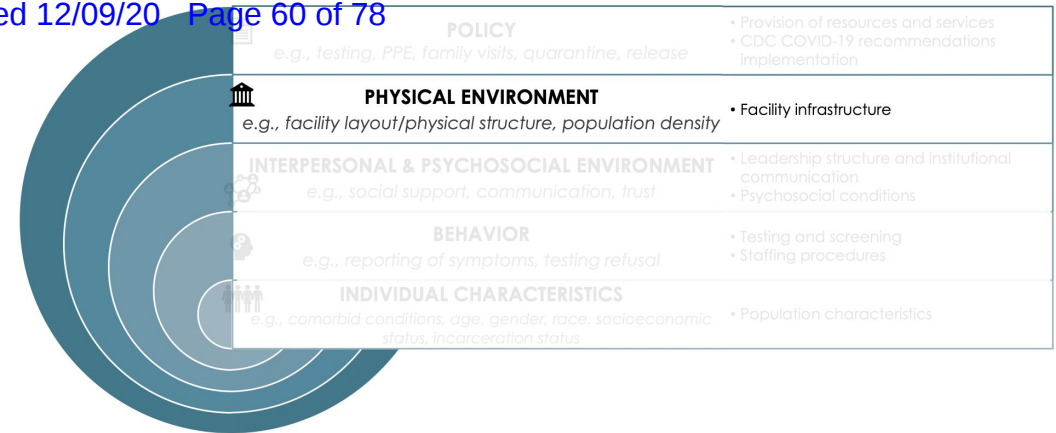
Psychosocial Conditions that facilitated efforts:

- **Despite the COVID-19 outbreak, CMC maintained some services that are essential for physical and mental health**
 - Many services switched to cell-side, including library and commissary services
 - Yard times, though reduced, were available (and re-opened for C yard)

Psychosocial Conditions that hindered efforts:

- **Ensuring mental health and care/treatment needs was challenging**
 - Need to socially distance undermined the ability to hold group therapy sessions
 - Staff reported being overworked, further exacerbating staff shortages
 - Incarcerated people reported communication lapses and loss of privileges, with potential mental health harms
- **The asymmetry of COVID-19 risk and power was noted by people incarcerated at CMC**
 - People incarcerated at CMC noted that once visitation was halted, the primary risk of virus introduction was from staff/custody
 - However, this risk was sometimes met with nonchalance by staff/custody (e.g., inconsistent mask use; ~50% re-testing refusal rate reported during April-May 2020 outbreak among staff, higher than re-testing refusal rates among incarcerated people)

CMC Prevention and Control Efforts: Takeaways



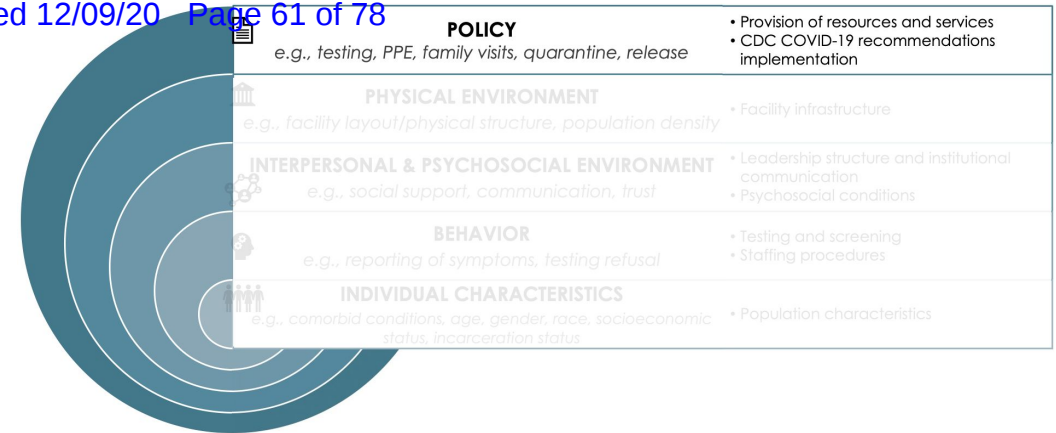
Facility Infrastructure factors that facilitated efforts:

- **CMC's April-May COVID-19 outbreak occurred in East Building C5, which CMC had pre-prepared for medical isolation**
 - C5, Tier 1 was designated for quarantine in other outbreaks (e.g., norovirus, chicken pox, flu) at CMC
 - Slow rate of spread partially attributed to unit type (solid-door units with solid-floor tiers) bought time to implement more precautions, access resources, and reinforce communication
 - CMC "isolated" C yard, prevented crossover to other yards, and provided cell-side services during this time
- **Low prevalence of COVID-19 in the county at large may have helped limit the risk of additional introductions to CMC**

Facility Infrastructure factors that hindered efforts:

- **While prisons, including CMC, are largely incompatible with COVID-19 mitigation measures, some additional precautions in different areas across CMC could have improved urgent transmission risks.**
 - Maximizing air exchange in common spaces had not yet been prioritized.
 - Due to incarcerated persons living in close, prolonged proximity and the close physical distance of dormitory pods, CMC's West dorms are primed for super-spreader events
 - No one in dormitory environment can quarantine properly
 - **A future outbreak could overwhelm C5 quarantine unit and restrict local health care capacity** (e.g., SLO county: 449 total beds)
 - Precautions were made for movement of objects across CMC, but the more worrisome risk of movement of staff/custody were not put into place because of challenges posed by union regulations

CMC Prevention and Control Efforts: Takeaways



Factors that facilitated the Provision of Resources/Services & CDC COVID-19 Recommendation Implementation*:

- **Coordination for PPE.** Headquarters' provision and coordination of PPE aided CMC, whose executive leadership formed a PPE committee to assess daily burn rates and distribute PPE across CMC areas.
- **For CDC COVID-19 recommendations, an awareness of reducing risks of fomite/droplet spread was exhibited** by:
 - Designation of C5 as quarantine unit, frequent cleaning and disinfection, good knowledge of mask/PPE use, ground markers in place for physical distancing, sanitizing products available for staff and incarcerated people

Factors that hindered the Provision of Resources/Services & CDC COVID-19 Recommendation Implementation*:

- **Across CDCR/Receivership System, several factors related to system-wide policies posed as risks, including:**
 - Halting transfers across CDCR was not comprehensive
 - Absence of strategies to reduce population via decarceration
 - Absence of systemwide policies until July 3, 2020 for ongoing staff testing for prisons (i) with and (ii) without positive cases
 - No emergency or central purchasing for masks, PPE, oxygen concentrators, and monitoring equipment
 - Any centralized coordination of resources was not connected to conditions on the ground (e.g., PPE was substandard quality or inadequate)
- **Strong need to clarify how staff/custody pose great risks to the safety and wellbeing of people incarcerated at CMC**
- **Strong need to maximize air exchange through ventilation to prevent airborne transmission**

*NOTE: More details on CMC prevention and control efforts related to the CDC COVID-19 Recommendations are available in supplemental slides at the end of this presentation.

Summary Messages, CMC COVID-19 Outbreak

CMC established policies and procedures before the outbreak:

- East building C5, Tier 1 designated as quarantine unit
- Established communication structure through trusted avenues like the Inmates Councils

Aided by SLO Public Health Department, CMC leadership made decisions that centered urgent health needs:

- Public health and medical decision-makers guided evidence-based, team-based response across entities and within CMC
- SLO Public Health Department provided testing kits and conducted testing (with rapid results) among staff/custody, using the SLO County lab

At the same time, CMC was lucky:

- Custody COVID-19 case on West was on parental leave, sparing the dorms from a superspreader event
- All remaining introductions were on East, not West
- COVID-19 risk score was lower on East than West
- SLO County had low COVID-19 prevalence (low risk of entry) during April-May 2020 outbreak (see Figure)
- Only 1 active case among people who transferred from other facilities
- CMC had space to use C5, Tier 1 for quarantine unit
- Despite barriers to staff/custody cohorting, spread beyond C5 to C6 did not occur. Some staff elected to stay in the same workstations.

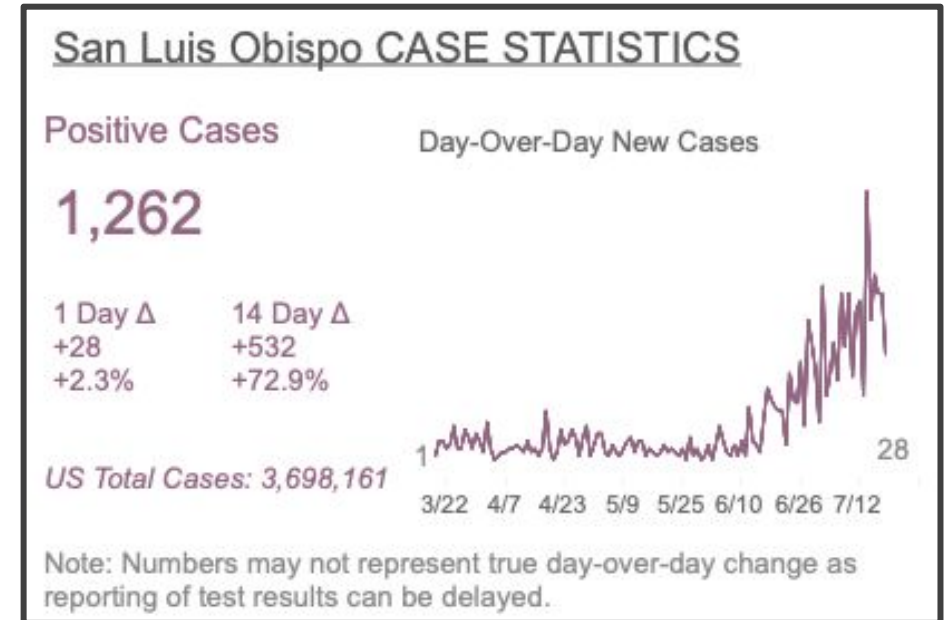


Figure: While prevalence of cases in SLO County was fortunately low during April-May outbreak, recent increases in prevalence since indicate higher risk of entry from the surrounding community. Similar concerns remain regarding COVID-19 prevalence in other counties from which custody/staff commute.

2. What lessons might be transferable to other settings and how are these lessons translated to policy?



Existing Guidance on COVID-19 Prevention and Control in Jails, Prisons, and Detention Centers

The U.S. Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO), UCSF Amend, and others have issued recommendations for COVID-19 prevention and control in jails, prisons, and detention centers. For example, CDC recommends

PREPARE-PREVENT-MANAGE:

1

PREPARE

Communications

Personnel Practices

Operations

Supplies

2

PREVENT

Hygiene

Cleaning

Screening for Symptoms

Social Distancing

3

MANAGE

Medical Isolation

Quarantine

Infection Control

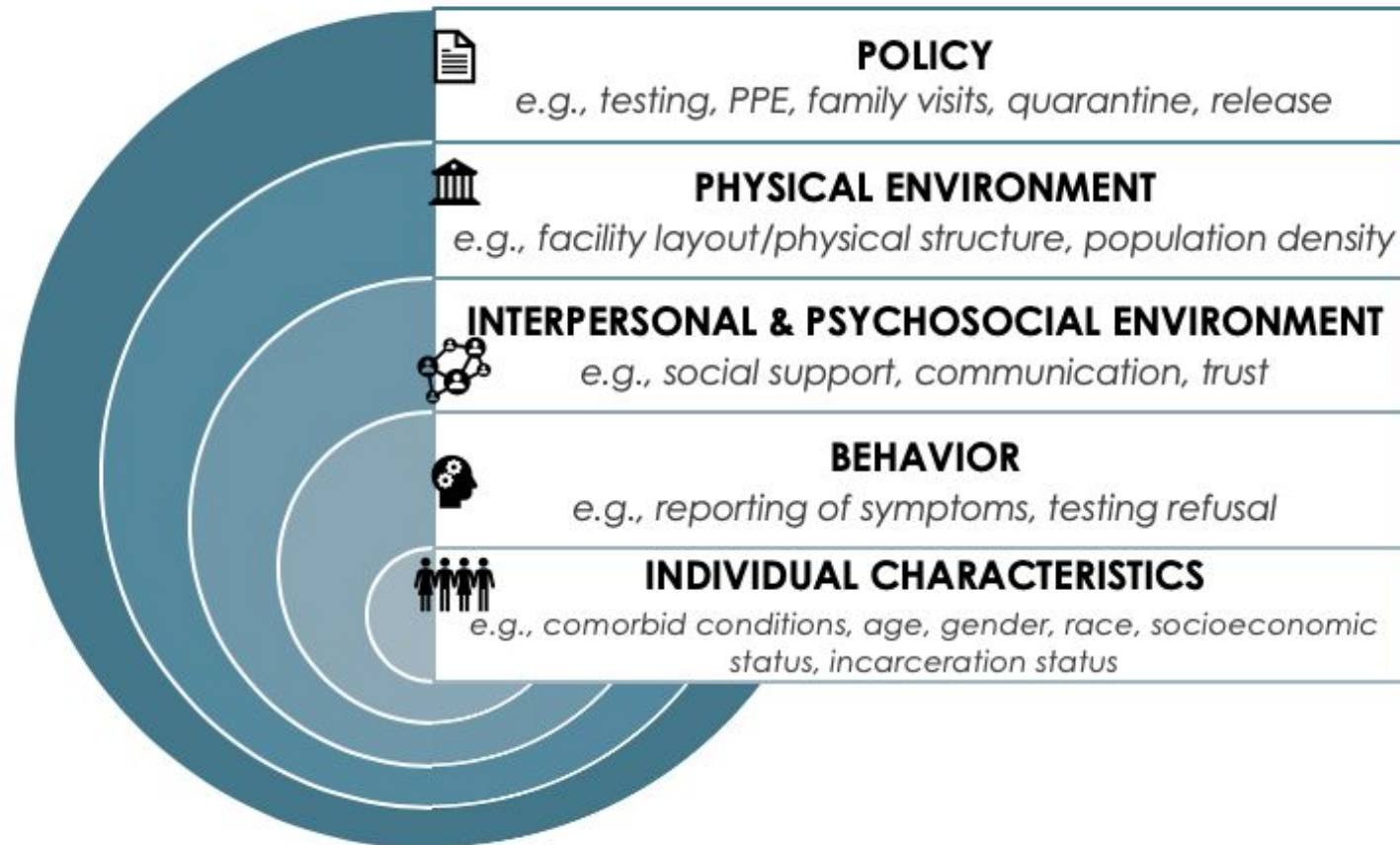
Clinical Care

Sample of Existing Guidance

- [CDC Guidance for Jails, Prisons, Detention Facilities](#)
- [COVID-19 testing in high-density workplaces](#)
- [WHO Preparedness, prevention and control of COVID-19 in prisons](#)
- [AMEND Guidance: Release, Cohort, Test](#)

Given this existing guidance, the following recommendations focus on evidence- based policies that are **poorly implemented** and/or areas where **existing guidance falls short**.

New and/or Modified Recommendations for COVID-19 Prevention: Based on CMC Assessment

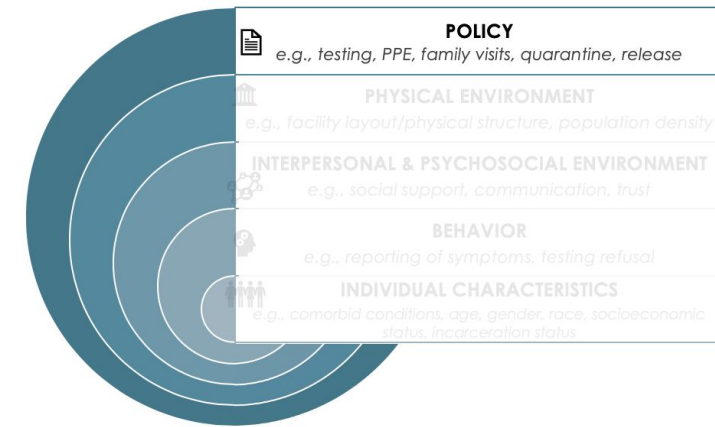


To inform ongoing prevention and control based on our evaluation of the CMC outbreak and outbreak response, we provide **five new and/or modified recommendations for COVID-19 prevention**.

We begin with the outermost level - the **policy level** - in our framework and move through to the most granular levels on which it acts. However, each of these five recommendations reflect one or span multiple levels of this framework.

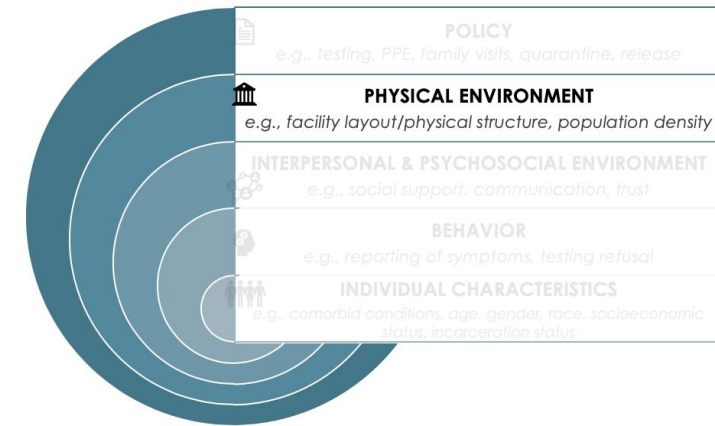
New and/or Modified Recommendations for COVID-19 Prevention: Based on CMC Assessment

1. Decarceration is the single most effective strategy to prevent and reduce transmission.



- Population density and overcrowding is a central issue.
 - **Why is this important?** Both population density and overcrowding influence the feasibility and effectiveness of every preparation, prevention, and management recommendation from CDC
 - Institutions must have capacity for quarantine and isolation
 - While Plata required a decrease in number of incarcerated persons to 137.5% of design capacity to be able to provide “ordinary level of care,” this is insufficient to meet urgent level of care needs in response to COVID-19 (e.g., a prison can even be below design capacity and still pose an insurmountable risk for superspreader events)
 - **How?** Urgently decarcerate population with support for re-entry. May involve collaboration with local university dorms, hotels, etc. for quarantine prior to release.
- All subsequent recommendations rely on decarceration for effective implementation.

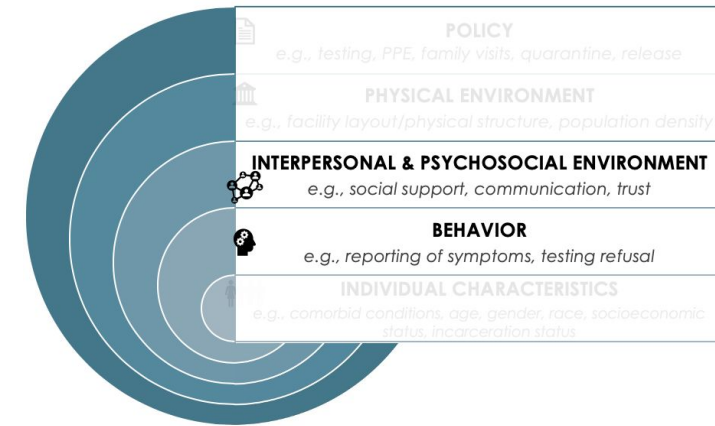
New and/or Modified Recommendations for COVID-19 Prevention: Based on CMC Assessment



2. Maximize air exchange to the fullest extent possible in all housing units.

- The role of the physical space, including ventilation, in facilitating or preventing COVID-19 transmission has been dramatically underappreciated
 - **Why is this important?** Minimizing rebreathing of air to the maximum extent possible is essential to reduce the risk of direct and indirect COVID-19 transmission
 - **How?**
 1. Implement decarceration strategy (slide 43)
 2. Categorize population density on basis of individuals in common air space (i.e., not separated by solid doors/walls w/ external ventilation)
 3. Channel air from the exterior through common areas then through cells/dorms to the exterior (seeking “positive pressure”)
 4. Increase air exchange differentially to decrease rebreathing in least well ventilated units; Test all housing areas to determine level of rebreathing (CO₂ monitors)
- Ensure that new N95 masks (w/out one-way valves) are available and being used and frequently and effectively disinfected or replaced with new masks for both people who are incarcerated and staff/custody who have any contact with infected or exposed persons

New and/or Modified Recommendations for COVID-19 Prevention: Based on CMC Assessment



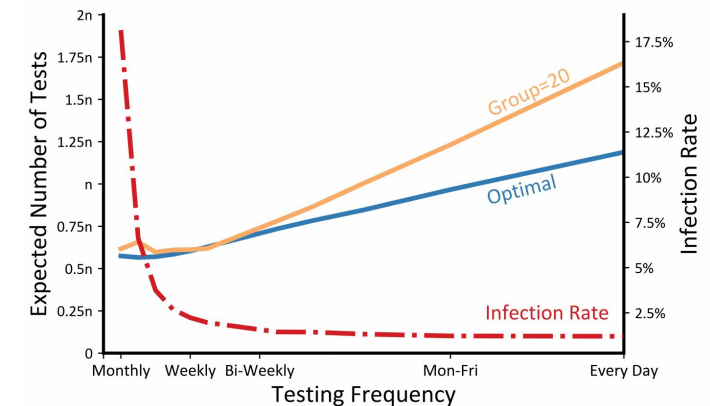
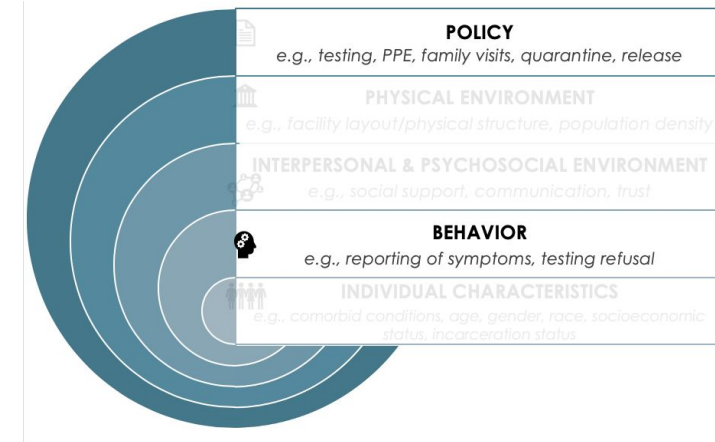
3. COVID-19 prevention/control among staff/custody must be prioritized.

- The great risk that staff/custody pose to the safety and wellbeing of incarcerated people must be clarified
 - **Why is this important?** Staff/custody play an outsized epidemiological role in transmission, exposing people incarcerated throughout CDCR to COVID-19 from surrounding communities and facilitating spread to other communities
 - **How?**
 1. Implement decarceration strategy (slide 43)
 2. Provide and require use of proper PPE and designated locations for quarantine/medical isolation (to protect incarcerated people, families of custody/staff, and surrounding communities)
 3. Minimize staff crossover between units as much as possible, *despite administrative & logistical constraints*. If crossover is unavoidable, a process of more frequent/rapid testing (prioritizing testing on the day of cross-over) should be triggered and those personnel should be closely monitored

New and/or Modified Recommendations for COVID-19 Prevention: Based on CMC Assessment

4. Frequent testing is the backbone of a successful response. This includes diagnostic testing of symptomatic individuals, screening of quarantined individuals, and widespread surveillance testing of staff/custody.

- **Why is this important?** Short turnaround times for results (≤ 24 hours) maximize efficiency, and CMC and SLO Public Health Department partnership on testing permitted evidence-based decision-making, minimizing onward COVID-19 transmission.
- **How?**
 1. Implement decarceration strategy (slide 43).
 2. Implement system wide policies for ongoing staff testing for (i) prisons that have positive cases and (ii) prisons that do not have positive cases
 - Statewide institutional staff testing was announced July 3, 2020. This effort should not be one-time and must be ongoing with a frequency aligned with transmission risks.
 - For prisons that do *not* have positive cases, pooled testing offers (1) large efficiency gains when COVID-19 prevalence is low, and (2) an opportunity to rapidly detect an outbreak.
 - Implement sewage testing when possible
 3. Implement serial testing of negative and positive cases in high-density workplaces (CDC, June 13th, 3-day intervals). This has been critical to meet urgent need in other prison outbreaks (MMWR, July 3, w/ testing on days 1, 4, and 14).



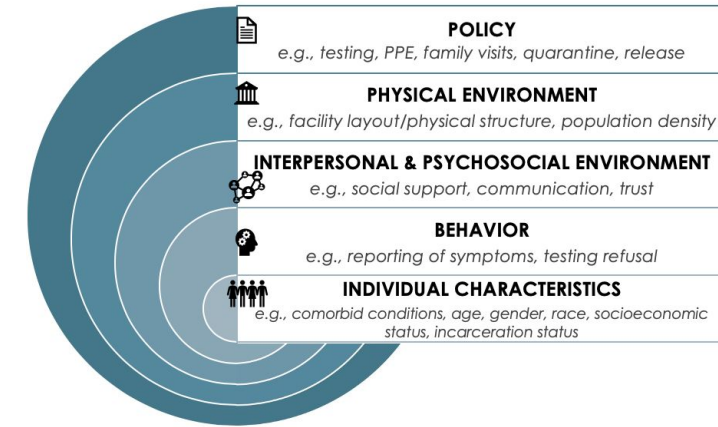
NOTE: Increased frequency of testing lowers infections with fewer additional tests using pooled testing; however, this works best when COVID-19 prevalence is low. Expected numbers of tests needed are plotted based on testing frequency for a group size of $n=20$ (orange) and an optimal group size (blue). Rate of COVID-19 infections decreases when testing frequency is increased (red).

Source: Augenblick N, Kolstad JT, Obermeyer Z, Wang A. Group testing in a pandemic: The role of frequent testing, correlated risk, and machine learning. NBER Working Paper No. 27457.

New and/or Modified Recommendations for COVID-19 Prevention: Based on CMC Assessment

5. Prioritize the health, wellbeing, and dignity of incarcerated persons through support for emotional and psychological needs and continuous communication through trusted avenues.

- **Why is this important?** People in prisons are already deprived of liberty, exacerbating health and wellbeing challenges associated with imposition of further restrictive measures and loss of privileges (e.g., related to COVID-19, as well as other physical and mental health outcomes).
- **How?**
 1. Implement decarceration strategy (slide 43)
 2. Rely on people incarcerated throughout CDCR as thought partners by engaging directly through trusted avenues (Inmate Councils) regarding policy/procedural changes
 3. Formation of Family Councils to build trust and confidence and to review and advise on strategies
 4. Continuous provision of resources to support the health and well-being of people incarcerated throughout CDCR
 - a. Maintain programming (e.g., regular healthcare provisions, library, educational programs, etc.)
 - b. Given baseline restrictions of prison environment, if there is any hope to reduce adverse short- and long-term physical and mental health outcomes associated with quarantine or medical isolation provide access to personal effects and free phone calls, free access to personal tablets with movies, increased access to free canteen items, and daily opportunities for yard time



Critical Areas of Uncertainty / Need for Future Work

- **Improve air exchange:** How can air exchange be maximized by improving ventilation, utilizing existing air flow systems, opening windows and doors, and leveraging other creative options?
 - Utilize CO₂ monitors in common spaces to identify where air exchange is poor
- **Cohorting:** Are there strategies that circumnavigate Union regulations and leadership hierarchies such that staffing plans can adhere to the cohorting model needed to reduce risk of transmission?
 - E.g., implementing decarceration strategy can also reduce risk of COVID-19 spread posed by (1) volume of staff entering prison daily; (2) staffing shortages; and (3) lack of staff cohorting
- **Quality of Life:** What are the associated physical/mental health consequences (and the relative transmission risks, if applicable) of various implementation models:
 - E.g., halting family visits, free video communication alternatives
 - E.g., halting outdoor time, organized sports, programming
- **Health Communication:** What are the best ways to engage with staff/custody to share COVID-19 information about their own health while simultaneously emphasizing their outsized epidemiologic role in bridging exposure risk between community and incarcerated populations?
- **Engagement:** How can people incarcerated throughout CDCR and their families be engaged as thought partners to provide expertise on their own healthcare needs, advise on implementation of COVID-19 prevention and control measures and distribute information?

Acknowledgments

California Men's Colony

Warden Josie Gastelo

Chief Deputy Warden Danny Samuel

CEO Teresa Macias

Dr. Johannes Haar

Lieutenant John Hill

Healthcare Staff and Custody

Inmates Councils East and West Chairmen

Gold Coats

San Luis Obispo Health Department

Dr. Penny Borenstein

Dr. Frederick Rosen

Ms. Christine Gaiger

Ms. Ann McDowell

California Department of Corrections and Rehabilitation

Dr. Heidi Bauer

Dr. Justine Hutchinson

Dr. Marcus Dahlstrom

Ms. Connie Gipson

Amend's COVID-19 in California Prisons Program

Dr. Brie Williams, UCSF

Dr. Stefano Bertozzi, UC Berkeley

Dr. David Sears, UCSF

Receiver Clark Kelso

The Honorable Judge Jon Tigar



Evaluation of the April-May 2020 COVID-19 Outbreak at California Men's Colony

Appendix

CMC Prevention and Control Efforts - Additional Details

CDC COVID-19 recommendation implementation (Behavior & Policy)

Modes of transmission	Facilitates prevention/control efforts	Hinders prevention/control efforts
Direct - Contact <i>Occurs through direct person-to-person contact</i>	<ul style="list-style-type: none"> → Frequent cleaning and disinfection; mask use → Physically distinct buildings allowed reduced transmission risks across units within prison - enables potential for isolation and quarantine to mitigate transmission 	<ul style="list-style-type: none"> → Dormitories and pods exacerbated risks because of close, prolonged contact → Poor mask fit could be improved → Some transfers between facilities continued → Staff/custody cohorting could not be mandated → Daily volume of staff/custody movement in and out of facility
Direct - Droplet <i>Spray with larger, short-range aerosols that travel > few feet, before droplets fall</i>	<ul style="list-style-type: none"> → Good knowledge of mask and PPE use → Social distancing measures in place (e.g., ground markers) 	<ul style="list-style-type: none"> → Poor mask fit; inconsistent mask use among staff/custody → Some transfers between facilities continued → Staff/custody cohorting could not be mandated → Daily volume of staff/custody movement in and out of facility
Indirect - Airborne <i>Smaller, longer range droplet (aerosols) nuclei that can suspend in the air for long periods of time and blow over great distances</i>	<ul style="list-style-type: none"> → Good knowledge of mask and PPE use → Ability to medically isolate and quarantine in Building C5 	<ul style="list-style-type: none"> → Dormitory and pods exacerbated risks because of close, prolonged contact → Lack of mitigation strategies to prevent airborne risks compared to other transmission routes; strong need to improve air exchange through better ventilation and to systematically measure CO₂ levels → Staff/custody cohorting could not be mandated → Daily volume of staff/custody movement in and out of facility
Indirect - Vehicles <i>Vehicles (food, fomites) that may passively carry a pathogen</i>	<ul style="list-style-type: none"> → Frequent cleaning of common spaces; soap and sanitizer available for staff and people incarcerated at CMC 	<ul style="list-style-type: none"> → Shared common spaces, such as stairwells and staff/custody stations, on East exacerbated risks; similarly, dormitories, pods, and common spaces exacerbated risks on West.

EXHIBIT D

ORDER TO SET ASIDE ISOLATION AND QUARANTINE SPACE

Public Health Workgroup Recommendations

Background

The *Order to Set Aside Isolation and Quarantine Space* (case number 01-cv-01351-JST) issued on July 22, 2020 requires the California Department of Corrections (CDCR) and California Correctional Health Care Services (CCHCS) to identify, and keep vacated or reserved, at least 100 beds to be used for isolation and quarantine housing in the event of a COVID-19 outbreak for a period of at least 180 days.

The *Order* also requires assessment of whether additional space is required at each institution for isolation and quarantine purposes and, if so, whether that will be obtained by vacating additional housing units or through other means. Assessments shall be guided by health considerations, without regard to whether sufficient space can be reserved at the institution without further reduction in the population.

The purpose of the remainder of this document is to summarize the public health workgroup's deliberations and recommendations regarding additional space needs that occurred during three separate meetings on July 28th, July 31st and August 4th, 2020. On August 7th and 12th, the workgroup's draft recommendations were discussed with each institution's leadership, court representatives and other stakeholders. The focus of the discussions was to determine what types of space must be created at each institution to isolate and quarantine different subpopulations including, but is not limited to, persons with disabilities, mental health and/or other special/restricted housing needs.

Workgroup Deliberations

Representatives from CDCR and CCHCS met with the parties' health experts to devise a method for determining whether additional bed space above the ordered 100 beds per institution is required to protect residents from COVID-19 infection and if additional space is required, how much space is needed at each institution. It is expected that if an outbreak were to occur that has the potential of infecting significant numbers of residents it would likely start and spread within congregate living spaces such as dormitories or cells with open bars or porous doors.

During the deliberations, the workgroup reviewed space information provided by CDCR and CCHCS staff that showed, at the end of July, approximately two-thirds of residents live in existing celled housing settings that usually are comprised of solid walls and doors and have a two person occupancy. Also noted was that many large dorm settings had already been de-densified leaving significant vacancies in these large dorms at most institutions.

While additional dedicated space will be a mixture of isolation and quarantine spaces, each will serve a different purpose. Isolation space is used to house patients who are confirmed or suspected to be infected with COVID-19. Suspected cases must be housed separate from each other, and unlike patients with confirmed infection who can be housed together in larger cohorts within dorm-like settings, patients suspected to have COVID-19 infection must be separated from each other in single cells with solid doors, with minimal exceptions noted.

Currently there are four institutions where the proportion of residents infected with COVID-19 ranges from approximately one-third to nearly two-thirds involving almost 1,000 to 2,000 individuals at those prisons. What this means from a housing perspective is that dorm housing or cells with open bars or porous doors can be used to cohort the significant numbers of residents with confirmed infection at these prisons, depending on other factors which may impact the type of housing and patients who can be cohorted together in isolation.

On the other hand, at most of the remaining institutions, either no cases have been identified among residents or smaller numbers of persons have been infected. Therefore quarantine spaces will be required for the majority of space rather than isolation space, and these should be configured as equivalent to *single cells with solid doors*. Quarantine space is the most restrictive because it's used to house residents who have been exposed to COVID-19 but have not tested positive for the virus. Under optimal circumstances, residents, in quarantine, should be housed individually, in a setting that has solid walls and doors, to ensure that if an exposed person tests positive the risk of transmission to others is significantly reduced.

General Space and Other Recommendations

Although these recommendations focus on space considerations for isolation and quarantine for incarcerated persons, it is assumed that the following basic measures and resources in sufficient amounts are in effect and available respectively in order to prevent and contain COVID-19, which include but are not limited to: restricted movement, timely testing for residents and staff, assignment of staff in cohorts that do not mix, and utilization of face coverings, personal protective equipment and environmental controls.

The general space recommendations noted below apply to all institutions and focus on the quality or types of space that need to exist at all institutions rather than the quantity of space per se. The general recommendations include:

- Individuals confirmed to have active COVID-19 infection can be isolated together in congregate living spaces but must be not share air space with any of the other groups (except resolved cases; see below).
- Individuals suspected of COVID-19 infection should be housed in the equivalent of single cells with solid doors.
- Individuals who have been exposed should be quarantined in the equivalent of single cells with solid doors.
- Individuals who have not been infected and have not been exposed should be housed in sparsely populated spaces that allow for as much physical distancing as possible and in the smallest cohorts as possible.
- Individuals who have resolved COVID-19 infection can be housed with most other individuals noted above except for suspected cases. This assumes that individuals who have resolved their infection are not contagious and do not get re-infected within at least three months of the initial infection.

Specific Institution Space Recommendations

Based on the above concepts and general recommendations, it was determined that a sound method to ensure sufficient quantity of space to house infected and exposed individuals who require isolation and quarantine respectively would be to base it on each institution's largest congregate living spaces because the risk of transmission of infection to large numbers of residents is greatest in these equivalent dorm-like settings that include, at some institutions, celled housing with open bars and porous doors.

Information in Attachment A, which was prepared by Quality Management staff, provides the numbers of isolation and quarantine beds required at each institution based on the method of reserving enough space to equal the *combined occupancy in each institution's two largest congregate housing units*. Also shown in Attachment A are numbers of persons with disabilities, patients in the Enhanced Outpatient Program level of mental health services and patients with a COVID-19 risk score of 4 or more as well as other data.

Given the recommendations and application of the method, it appears that nearly all institutions already had reserved or vacated enough suitable bed space for isolation and quarantine. However there were notable exceptions in terms of either institutions requiring significantly more space than other institutions such as Folsom State Prison or the space that had been identified is not adequate because it's dorm space or cells with porous doors. It should be noted that San Quentin also required significantly more space than others but since so many of the residents have already been infected the actual isolation and quarantine space that needs to be set aside is less than calculated once those patients have been excluded.

Although the quantity and quality of bed space identified appears adequate for isolation and quarantine purposes at most prisons, there were concerns raised by plaintiffs' representatives regarding whether there needs to be specific numbers of beds set aside for isolation versus quarantine, both in general and for patients with disabilities or in the mental health program, and whether patients in isolation and quarantine need to be in different housing units even if all occupants are in cells with solid doors with physical distancing among individuals and face coverings/masking are required and environmental controls are aggressively implemented. Regarding the concerns, the point of the method proposed by the public health experts is to identify and respond to an outbreak at the earliest onset which means most of the space will be for quarantine and if the space is single cells with solid doors and all public health measures are enforced along with the de-densification that has already occurred, the proposed space plan, though imperfect, is a reasoned and supportable approach that protects residents and staff.

Conclusion:

Through the extensive process described above, CCHCS has provided a summary of conclusions reached in terms of assessing whether additional space is required beyond what was identified by CDCR. This summary is provided as Attachment B. However, public health experts have opined that ideal quarantine space is single-cell based housing. Attachment C reflects the identified bed needs if the CDCR identified spaces were converted to single-cell housing. There are a number of issues that have arisen in the course of the discussions with public health experts, plaintiffs, and prison leadership. While Judge Tigar's order is quite specific, it is difficult to address all 35 prisons with the same approach. Such exceptions are noted below:

- There are multiple institutions where the recommendations of CCHCS and public health experts is difficult, if not impossible: San Quentin State Prison (SQP), Folsom State Prison (FSP), and the California Rehabilitation Center (CRC). SQP and FSP have entirely too large of a congregate living area and require unique solutions (as are occurring now) to address an outbreak. CRC has zero cells on the entire property and will require a multitude of vacant dorms (already accomplished) and a unique strategy on quarantining patients.

Also in the course of the discussions described above, it is anticipated that plaintiffs' counsel and court monitors will express concerns with CDCR's identified space or current policies regarding the housing of isolation and quarantine patients. These concerns are noted below:

- Many institutions have vacated the identified space(s) in accordance with Judge Tigar's order, but were utilizing less-desirable locations for quarantine/isolation. During the meetings with prison leadership, they were directed to begin utilizing the space.
- In multiple instances, institutions were housing isolation and quarantine patients in the same building. When asked, they clearly articulated how they were maintaining maximum distancing between quarantine and isolation.
- The identified space(s) is intended to be utilized by inmates from differing levels and differing programs. Plaintiffs and court monitors expressed concern about the ability to effectively program in the same building. Examples: EOP inmates with Non-EOP inmates, SNY inmates with GP inmates, Level II with Level IV, etc.
- Many of the spaces identified did not have adequate housing for Armstrong class members according to the Armstrong Court Expert and plaintiffs.
- How to address inmates who refuse to move to the designated locations.
- When tents were mentioned for isolation cases, plaintiffs expressed concerns about accessibility and public health requirements.
- For institutions with Arizona (perforated steel) doors (CEN, CAL, LAC), plaintiffs expressed a need for lexan to be placed on cell fronts. At CAL, all doors already have lexan installed in the identified building. At LAC, some of the cells have lexan installed in the identified building. At CEN, none of the cell doors have lexan installed.
- While the public health experts have opined that single cells are ideal for quarantine space, it is entirely appropriate for space identified for isolation to be in dorms or tents as the patients have already been identified as positive for Covid.

Lastly, from the perspective of CCHCS, many institutions have excess capacity, beyond what was identified for purposed of Judge Tigar's order, and could quickly identify additional buildings for use as quarantine and/or isolation space.

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

Attorneys for Defendants

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

**IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA, OAKLAND DIVISION**

MARCIANO PLATA, et al.,

Plaintiffs,

v.

GAVIN NEWSOM, et al.,

Defendants.

01-cv-01351-JST

**DECLARATION OF ANNE
SPAULDING, M.D., M.P.H. IN
SUPPORT OF DEFENDANTS'
POSITION ON QUARANTINE AND
ISOLATION SPACE**

Judge: The Honorable Jon S. Tigar
Date: December 23, 2020
Time: 10:00 a.m.
Courtroom: 6, 2nd Floor

I, Anne Spaulding, declare:

I. BACKGROUND.

1. I am currently an Associate Professor of Epidemiology with tenure at Rollins School of Public Health, Emory University. I am also an Associate Professor of Medicine at Emory School of Medicine and an Adjunct Associate Professor at Morehouse School of Medicine. A copy of my curriculum vitae is attached as Exhibit A.

2. I obtained my MD degree from the Medical College of Virginia and my Master of Public Health degree from Johns Hopkins School of Public Health.

1 3. Through my career, I have gained significant experience in the field of
2 correctional healthcare and public health. For example, I have served as a Staff Physician
3 and as an Infectious Disease Consultant for Fulton County Jail in Georgia; a Physician
4 Consultant, an Infectious Disease Consultant, and an Associate Statewide Medical
5 Director for Georgia Correctional Health Care through the Medical College of Georgia;
6 and a statewide Medical Program Director for the Rhode Island Department of
7 Corrections. I have lectured on subjects related to correctional healthcare and public
8 health at Johns Hopkins, Medical College of Georgia, Georgia Institute of Technology,
9 University of North Carolina, University of British Columbia, and Brown University. I
10 have also given talks and presentations at a number of national and international
11 conferences and meetings on subjects related to correctional healthcare and public health.
12 I received the 2020 B. Jaye Anno Award of Excellence in Communication from the
13 National Commission on Correctional Health Care for the writing and speaking I have
14 done on correctional healthcare topics, most recently in the area of COVID-19
15 management in jails and prisons.

16 4. I am a fellow of the American College of Physicians, the Infectious Disease
17 Society of America, and the American College of Correctional Physicians.

18 5. Over the course of my career, I have visited correctional facilities in roughly
19 half of the US States, including several California Department of Corrections and
20 Rehabilitation (CDCR) institutions. Since the start of the COVID-19 pandemic, I have
21 been working with a number of jails and prisons across the country, including the Harris
22 County Sheriff's Office in Houston, Texas and the Washington, DC Department of
23 Corrections. Because I have closely followed the progression of the pandemic in the
24 correctional context, I have learned how various other prison and jail systems are
25 responding to the pandemic and the measures they have implemented to address it. I am
26 familiar with the developing scientific literature regarding COVID-19 generally, and in
27 the specific contexts of correctional healthcare and public health. My publications on
28 COVID-19 in corrections have appeared in the New England Journal of Medicine and the

1 Morbidity and Mortality Weekly Report of the Centers for Disease Control and
2 Prevention (CDC).

3 6. Counsel for CDCR have retained me to consult with CDCR regarding its
4 response to the COVID-19 pandemic and to assist with litigation in this proceeding if
5 necessary. I have been kept apprised of developments in CDCR's COVID-19 guidance,
6 policies, and response.

7 7. I understand that Plaintiffs are challenging CDCR's procedures for
8 quarantining incarcerated people following a possible COVID-19 exposure. According to
9 Plaintiffs' Proposed Order on Quarantine Space, I understand their position to be that
10 "Defendants shall use only solid-door cells to quarantine people known to have been
11 exposed to the virus. The first choice for post-exposure quarantine shall be solid door
12 cells occupied by only one person. Defendants shall not quarantine people post-exposure
13 in cohorts larger than two." Dr. Luring takes the position that quarantine in anything
14 short of a single cell with a solid door cannot be done safely. I believe that institutions
15 can implement multiple evidence-based strategies to reduce potential harm from
16 quarantining more than one person in a shared airspace.

17 **II. CDCR PRACTICES COMPLY WITH PUBLIC HEALTH GUIDANCE.**

18 8. The CDC has provided public health guidance to mitigate the potential harm
19 from COVID-19 since the start of the pandemic. One of the CDC's goals is to "flatten the
20 curve," or slow the accumulation of cases. The success of the management of an outbreak
21 can be determined by both the number of cases and the outcome. A slower accumulation
22 of cases, even if the total number of cases is the same, can lead to better individual
23 outcomes—i.e. less mortality. The purpose of public health guidance is to provide
24 strategies for preventing the spread of disease and the harm it can cause, taking into
25 consideration the unique needs of different populations. The CDC recognizes this and
26 provides separate sets of guidelines for populations whose needs vary from those of the
27 general public including, for example, correctional institutions, schools, retirement
28 communities, and first responders. The CDC's guidance on COVID-19, like the guidance

1 and opinions of worldwide public health experts, has evolved over the past nine months as
 2 more information about COVID-19 becomes available. My understanding is that the
 3 California Correctional Health Care Services (CCHCS) and CDCR strive to achieve the
 4 safest approaches offered by the CDC guidelines.

5 **A. Quarantine Duration.**

6 9. Until recently, the CDC's guidelines recommend that people who have been
 7 in close contact with someone who has COVID-19, excluding people who have had
 8 COVID-19 in the past three months, quarantine for 14 days.¹ On December 2, 2020, the
 9 CDC amended its guidelines to include the option of ending quarantine for people without
 10 symptoms on day 10 without testing, or on day 7 after receiving a negative test result.²
 11 Although the CDC's correctional guidelines do not have detailed guidance about how to
 12 enact these new recommendations, the new guidelines are consistent with experience that
 13 suggests if a person has become infected with COVID-19 after a known exposure, the
 14 infection usually will be detectable well before 14 days.

15 10. I have reviewed CCHCS's current healthcare guidance entitled "COVID-19
 16 and Seasonal Influenza: Interim Guidance for Health Care and Public Health providers"
 17 (Interim Guidance).³ I also reviewed the current August 19, 2020 version of the COVID-
 18 19 Screening and Testing Matrix⁴ and the November 24, 2020 draft COVID-19 Screening
 19 and Testing Matrix. Decl. Gipson Ex. B.

20 11. According to the Interim Guidance, people who have been exposed to

21
 22 ¹ A "close contact" includes being within six feet of someone infected with COVID-19 for
 23 a total of 15 minutes or more, having direct physical contact with a person infected with COVID-
 24 19 (e.g. hugging), sharing eating or drinking utensils with a person infected with COVID-19, or if
 respiratory droplets of a person infected with COVID-19 get on you. Centers for Disease Control
 and Prevention, *When to Quarantine*, <https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/quarantine.html> (Updated Dec. 2, 2020).

25 ² *Id.*

26 ³ California Correctional Health Care Services, *COVID-19 and Seasonal Influenza: Interim Guidance for Health Care and Public Health Providers*, <https://cchcs.ca.gov/covid-19-interim-guidance/> (Updated Nov. 20, 2020).

27 ⁴ California Correctional Health Care Services, *COVID-19 Screening and Testing Matrix for Patient Movement*, Aug. 21, 2020, <https://cchcs.ca.gov/wp-content/uploads/sites/60/COVID19/Appendix13-PatientMovement.pdf>.

28 (continued...)

COVID-19 must be placed on quarantine for 14 days, and each person on quarantine must be tested and receive a negative result before being released from quarantine.⁵ It further requires that people who are symptomatic or test positive are immediately placed in isolation.⁶ Quarantine is extended for 7 additional days for those who refuse to test.⁷ Quarantine is also extended by 14 days for every new exposure.⁸ The Interim Guidelines suggest that CCHCS and CDCR are striving for one of the safest approaches among the options presented in the CDC guidelines. It also appears that safety of the incarcerated population is being prioritized over monetary concerns.

B. Quarantine Space.

12. I participated in the Public Health Workgroup that convened on July 31, 2020 and August 4, 2020 to address quarantine and isolation space related to this case. The workgroup recommended that each CDCR institution set aside a number of beds equal to the combined occupancy of its two largest congregate housing units. The Workgroup acknowledged that San Quentin State Prison, Folsom State Prison, and the California Rehabilitation Center, which have few or no cells with solid doors, would require unique solutions. I am informed that, with few exceptions, CDCR has since set aside space at each institution to use for quarantine or isolation purposes. Decl. Gipson ¶¶ 13-18.

13. I am informed that as part of its formally reserved quarantine space, CDCR has set aside a sufficient number of cells to house approximately 7,809 patients if most of them are double celled, and up to about 4,228 patients if they are single celled. CDCR has also formally reserved about 1,195 beds that are in congregate living spaces, such as dorms, tents, gyms, and other converted spaces. Decl. Gipson ¶ 15. I am not aware of another state prison system that has formally reserved such large quantities of quarantine

⁵ California Correctional Health Care Services, *COVID-19 and Seasonal Influenza: Interim Guidance for Health Care and Public Health Providers*, <https://cchcs.ca.gov/covid-19-interim-guidance/> (Updated Nov. 20, 2020).

⁶ *Id.*

⁷ *Id.*

⁸ *Id.*

1 and isolation space throughout its system.

2 14. I have been further informed that, as a result of reductions in the population,
3 CDCR currently has additional space that is open and available throughout the system that
4 can also be used for quarantine or isolation. This space is in addition to the reserved space
5 described above. Specifically, the additional cell space is sufficient to house about 2,620
6 patients if they are mostly double celled, and about 1,347 patients if they are single
7 celled. And there are about 1,999 additional beds in congregate living spaces that are also
8 currently available for quarantine or isolation use. Decl. Gipson ¶ 17.

9 15. According to Plaintiffs' Position on Quarantine and Isolation Space, I
10 understand that they believe Defendants must reserve and set aside even more space for
11 quarantine, and in addition, separate space to use for precautionary quarantine. In my
12 opinion, this course of action is questionable and may simply not be advisable. CDCR
13 already has much space reserved and available for quarantine and isolation purposes, and
14 there would be opportunity costs associated with keeping even more space held in
15 reserve.

16 16. Reserving even more cells for quarantine would mean they could not be
17 used to house medically high-risk patients or to reduce the population of dorms and other
18 more crowded spaces in the institutions. In my opinion, there needs to be a balance
19 between reserving additional available housing for a future quarantine and assigning it
20 now for medically high-risk patients to prevent them from contracting the virus in the first
21 place. I understand that this is what CDCR is currently doing. Decl. Gipson ¶ 10. I am
22 also concerned that requiring the reservation of even more space for a possible future
23 quarantine and isolation could force CDCR to concentrate the patient population in other
24 areas of its institutions, which may not be advisable because COVID-19 spreads easier
25 through densely housed populations.

26 **C. Quarantine Best Practices.**

27 17. The optimal way to quarantine incarcerated patients from an infection
28 control perspective is in single cells with solid doors and walls. Because COVID-19 is

spread through aerosolized respiratory droplets, containing the airspace of each person who may have been exposed to COVID-19 helps to prevent the virus's spread. A recent report I co-authored examined data from mass testing in 16 prisons and jails across six jurisdictions, including the Federal Bureau of Prisons and CDCR, and concluded that a person is roughly three times more likely to contract COVID-19 in dorm-based housing than in cell-based housing.⁹ A research letter describing testing from March 13 through June 26, 2020 in one combined jail/prison correctional system, the Connecticut Department of Corrections, found in its system that people housed in dorms were 35 times more likely to contract COVID-19.¹⁰ Transmission rates depend on many factors: building architecture, physical distance, frequency of testing, and PPE, for example. It would be important to know Connecticut's degree of compliance in the spring of 2020 with universal mask wearing, whether other efforts to reduce the spread of infection were in effect at the time, and how much of the surge was in their jail versus sentenced population. In other words, how much of the Connecticut experience early in the epidemic can be related to the current state of the pandemic in California prisons?

18. Single-celled housing is not always possible or ideal in every prison all of the time. For example, solitary housing may not be ideal for a patient's overall health. It is therefore critical for public health experts to identify other, next-best strategies to mitigate the risk of infection. In my opinion, public health guidance would have little value or success in achieving the goal of protecting populations from a virus like COVID-19 if it only recommended the most optimal measures from an infection control standpoint, regardless of whether those measures are feasible in a specific context. Risk mitigation is a cornerstone of public health. In providing guidance, it is appropriate for public health experts to consider the types of resources that are available and other

⁹ Liesl M. Hagan, MPH, et al., *Mass Testing for SARS-CoV-2 in 16 Prisons and Jails – Six Jurisdictions, United States, April-May 2020*, Centers for Disease Control and Prevention, August 21, 2020, at 1141, <https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6933a3-H.pdf>.

¹⁰ Byron S. Kennedy, MD, PhD, et al., *Risk Factors for SARS-CoV-2 in a Statewide Correctional System*, *The New England Journal of Medicine*, Nov. 24, 2020, <https://www.nejm.org/doi/full/10.1056/NEJMc2029354>.

1 concerns and risks that must be balanced when determining the most appropriate solution,
 2 and to provide feasible alternatives. This is precisely what the CDC guidelines
 3 appropriately do.

4 19. The CDC guidelines for correctional institutions state that “guidance may
 5 need to be adapted based on individual facilities’ physical space, staffing, population,
 6 operations, and other resources and conditions.”¹¹ In fact, the CDC provides a list of
 7 options available for quarantining patients in correctional settings in order of preference,
 8 stating “[i]f the ideal choice does not exist in a facility, use the next best alternative as a
 9 harm reduction approach.”¹² If single cells with solid doors are not available, the CDC
 10 guidelines recommend options ranging from quarantining separately in single cells
 11 without solid doors to quarantining in various group settings with at least six feet of space
 12 around each individual.¹³ The CDC guidelines propose an option of quarantining an
 13 entire housing unit in place if the entire unit has been exposed and other better options are
 14 not available.¹⁴ I agree with the CDC guidelines that it is appropriate for correctional
 15 systems in general to consider and implement the safest quarantine options available and
 16 feasible in a particular setting. Post-exposure quarantine in shared-air living spaces is
 17 safer than not quarantining at all, because it reduces the risk of spreading the virus to all
 18 other areas of the institution.

19 _____
 20 ¹¹ Centers for Disease Control and Prevention, *Coronavirus Disease: Guidance for*
 21 *Correctional and Detention Facilities*, <https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html#QuarantineCloseContacts> (Updated Oct. 21, 2020).

22 ¹² *Id.*

23 ¹³ In order of preference, recommendations for quarantine space include (1) single cells
 24 with solid walls and doors; (2) single cells with solid walls but without solid doors; (3) a cohort in
 25 a large, well-ventilated cell with solid walls, a solid door that closes fully, and at least six feet of
 26 space around each person; (4) same as (3), but without a solid door; (5) a cohort in single cells
 27 without solid walls or doors, preferably with an empty cell between occupied cells to create at
 28 least six feet of space between people; (6) a cohort in multi-person cells without solid walls or
 solid doors, preferably with an empty cell between occupied cell and at least six feet of space
 between each person; (7) a cohort in the individuals’ regularly assigned housing unit but with no
 movement outside the unit and at least six feet of space between people; (8) quarantining an
 entire housing unit that has been exposed in place; and (9) safely transfer to another institution
 with capacity to quarantine in one of the previous arrangements. *Id.*

¹⁴ *Id.*

(continued...)

20. Quarantining people in small cohorts is more ideal than in large groups. At times, double-celling may be preferable to quarantining persons one to a cell. In fact, solitary housing poses risks to mental health.¹⁵ One strategy to minimize the use of solitary housing may be to house a person susceptible to deleterious effects from isolation with someone who has recovered from COVID-19 within the previous three months and thus at least some immunity, provided that the pairing of the two would not be at odds with good institutional management. It is appropriate to consider the possible adverse impact on an individual's overall wellbeing when deciding whether quarantining in isolation is the best option.

21. People are considered far less susceptible to being re-infected with COVID-19 in the three months after they contract and recover from it. As more is learned about the virus, it is possible that this period of "immunity" is much longer—it will vary by the individual host, but may be longer for some people.¹⁶ Over 17,000 incarcerated people in CDCR institutions have recovered from COVID-19.¹⁷ Those who are still within the three-month period are good candidates for dorm-based or perforated-door cell housing, as has been seen in Harris County, Texas. I understand that CDCR and CCHCS are taking this into consideration in their efforts to safely house people. (Decl. Gipson ¶ 10.) In addition to the ample quarantine space described above, assigning housing this way could also free up more cells with solid doors.

22. Quarantining persons singly, or in the smallest sized cohort possible, is ideal from an infection control perspective. For an individual in quarantine who was not infected when exposed, the probability that another person in the room is infected goes down as the number of exposed cell-mates decreases. Dr. Lauring's assertion, "[i]f you

¹⁵ Emily Boren, et al., *The Suicidal Inmate: A Comparison of Inmates Who Attempt Versus Complete Suicide*, vol. 48, 570 *Suicide and Life-Threatening Behavior* (2017).

¹⁶ Gregory A Poland, et al., *SARS-CoV-2 immunity: review and applications to phase 3 vaccine candidates*, vol. 396, *The Lancet* (Nov. 14, 2020), [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)32137-1/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)32137-1/fulltext).

¹⁷ California Department of Corrections and Rehabilitation, *CDCR Patients: COVID-19 By Institution*, <https://www.cdcr.ca.gov/covid19/population-status-tracking/> (last visited Dec. 4, 2020.)

1 quarantine [exposed people] together in shared air space, the risk level for all rises to the
 2 highest risk level among them; everyone will be at the same risk as the person who was
 3 most exposed” is difficult to understand. Decl. Luring 11. Either the cellmate is infected
 4 or is not. Furthermore, aside from proximity to and duration of exposure to the virus, the
 5 factors affecting the risk of acquisition of infection (as opposed to risk of dire outcomes)
 6 are not yet clear. A recent well-conducted study that examined blood type failed to find
 7 risk factors for acquisition, putting the hypothesis that blood group A is more susceptible
 8 to rest.¹⁸

9 23. I understand that the Receiver recently produced the Quarantine Patient
 10 Housing spreadsheet, attached as Exhibit B to my declaration. I have reviewed this
 11 spreadsheet and note that it shows that most patients in quarantine (about 77% of them)
 12 are either celled alone or with only one other person. The spreadsheet further indicates
 13 that far fewer patients (about 11%) are in quarantine cohorts greater than 10
 14 peoples. These numbers suggest that CDCR has implemented a quarantine practice that
 15 endeavors to quarantine patients alone or in small cohorts when possible rather than
 16 having them quarantine in place in large cohorts in dorms. Such a practice would
 17 generally comport with CDC quarantine guidelines. I have been advised that this
 18 document was recently produced. This data appears encouraging if my interpretation is
 19 correct. I understand the parties must evaluate the Receiver’s recent analysis of
 20 quarantine spaces and the large amount of additional space CDCR identified for possible
 21 quarantine and isolation. I look forward to learning more about the representations made
 22 in this document and I welcome an opportunity to collaborate with other experts in this
 23 case to identify the most effective use of space identified.

24 24. When people must be quarantined in cohorts in shared air spaces because
 25 single cells with solid doors are not available, institutions can make them safer by

26
 27 ¹⁸ Laurys Boudin, et al., *ABO blood groups are not associated with risk of acquiring the*
 28 *SARS-CoV-2 infection in young adults*, vol. 105, *Haematologica* (Dec. 2020),
<https://www.haematologica.org/article/view/9825>.

(continued...)

1 implementing multipronged application of evidence-based strategies to reduce harm.¹⁹ I
 2 understand that CDCR has implemented many such strategies, a sampling of which is
 3 discussed in section D below.

4 **D. Harm-Reduction Strategies for Shared Air Space Quarantine Conditions.**

5 **1. Prioritization of High-Risk Patients.**

6 25. When single-celled housing is limited, CDC guidelines prioritize cells for
 7 those who are at increased risk for severe illness from COVID-19. Even before
 8 quarantines are imposed, CDCR is proactively assigning cells to medically high-risk
 9 people who meet criteria for safe housing in the setting of a quarantine. Decl. Gipson ¶
 10 ¶7, 10, 12.

11 26. I reviewed the Receiver's October 21, 2020 memorandum entitled
 12 "Transferring COVID-19 High-Risk Patients to Safer Housing," which requires CDCR to
 13 offer each person with a COVID-weighted risk score of three or higher (medically high-
 14 risk) a single cell with a solid door, but that initial efforts resulted in a low acceptance rate
 15 of 15%. Decl. Gipson Ex. C at 9. I also understand that CDCR is now prioritizing
 16 movement of medically high-risk people who have not contracted COVID-19 in the last
 17 three months from congregate living spaces to cells with solid doors. Decl. Gipson ¶¶ 7,
 18 10. I understand these medically high-risk people will be transferred to celled housing
 19 and that this process has already commenced at San Quentin and plans for three other
 20 institutions are being developed. *Id.* This strategy should lower the risk of harm from
 21 quarantining incarcerated people in large cohorts should an exposure occur.

22 27. In the event of an exposure, if no cells are available at an institution, the
 23 institution should make every effort to quarantine its medically high-risk population in a
 24 safer place. I understand that CDCR recently accomplished this successfully during a
 25 COVID-19 outbreak at California Rehabilitation Center, which has no celled housing. *Id.*

26 ¹⁹ Margaret A. Honein, et al., *Summary of Guidance for Public Health Strategies to*
 27 *Address High Levels of Community Transmission of SARS-CoV-2 and Related Deaths*, vol. 69,
 28 Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report (Dec. 4,
 2020), <https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6949e2-H.pdf>.

(continued...)

at ¶ 23. I understand that CRC experienced a COVID-19 outbreak at this prison between September and November, 2020, reaching a peak number of 546 cases on October 3.²⁰ California Rehabilitation Center's leadership worked in close collaboration with CDCR and CCHCS to formulate and implement its outbreak response on a daily basis until the outbreak resolved. *Id.*

28. In the absence of cells, California Rehabilitation Center activated tents in a separate area away from the general population. *Id.* The tents were equipped with electricity, climate control, and bathrooms and showers dedicated to those people so they would not have to visit areas where the general population resided. *Id.* The tents were designed to house ten people, but four medically high-risk people were assigned to each tent, which allowed for greater physical distancing. *Id.* The outbreak resolved in November and resulted in no deaths.²¹ CDCR's efforts at the California Rehabilitation Center demonstrated that it successfully managed an outbreak, and kept its medically high-risk population safe, even absent solitary housing for quarantine. And it further demonstrates that it is possible to implement measures that mitigate the risk of cohorting people in quarantine.

2. COVID-19 Surveillance, Screening, and Testing.

29. Surveillance is the "ongoing, systematic collection, analysis, and interpretation of health-related data essential to planning, implementation, and evaluation of public health practice."²² Screening is a tool used to detect presence of infection in a population; testing refers to confirming or ruling out a diagnosis when clinically suspected. Regular surveillance is an important tool for COVID-19 detection. The CDC recommends proactive strategies to monitor the prevalence of disease in correctional

²⁰ California Department of Corrections and Rehabilitation, *CDCR Patients: COVID-19 By Institution*, <https://www.cdcr.ca.gov/covid19/population-status-tracking/> (last visited Dec. 4, 2020.)

²¹ California Department of Corrections and Rehabilitation, *CDCR Patients: COVID-19 By Institution*, <https://www.cdcr.ca.gov/covid19/population-status-tracking/> (last visited Dec. 4, 2020.)

²² Sonja A. Rasmussen and Richard A. Goodman, *The CDC Field Epidemiology Manual* (2018).

(continued...)

1 institutions to detect new infections soon after they develop, to reduce the chances of
 2 broad transmission and a large outbreak.²³ The CDC encourages correctional institutions
 3 to formulate their plans, taking into consideration practical considerations like testing
 4 availability and turnaround time for results.²⁴ I understand that every CDCR institution
 5 has onsite testing capabilities, including laboratory-based PCR testing for which results
 6 are typically received within two to three days of testing, and point-of-care or “rapid”
 7 antigen tests²⁵ which provide results in about 15 minutes. Decl. Gipson ¶ 8.

8 30. I also understand that it is CDCR’s practice to conduct regular surveillance
 9 testing of a sampling of its incarcerated population and staff on each yard at each
 10 institution when there is no outbreak, regardless of whether people are symptomatic.²⁶
 11 This is an important preventative practice, consistent with CDC guidelines, because early
 12 detection allows for early response efforts. This is also important to detect infection in
 13 asymptomatic people, as COVID-19 is often spread by asymptomatic people who are
 14 infected.

15 31. It is my understanding that when people are placed on quarantine, they are
 16 tested within 24 hours of being placed on quarantine, and then again on days 7 and 12 of
 17 quarantine before ending the quarantine period.²⁷ I also understand that during outbreaks,
 18 medically high-risk people are tested as frequently as every three to five days.²⁸ I also
 19 understand that CDCR staff is tested regularly.²⁹

20 32. In my opinion, successful COVID-19 management requires careful,
 21 preventative surveillance strategies. I understand that CDCR does regularly monitor its
 22 institutions’ populations.

23 ²³ Centers for Disease Control and Prevention, *Testing in Correctional & Detention*
 24 *Facilities*, [https://www.cdc.gov/coronavirus/2019-ncov/community/correction-](https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/testing.html)
[detention/testing.html](https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/testing.html) (updated Dec. 3, 2020).

25 ²⁴ *Id.*

26 ²⁵ California Correctional Health Care Services, *COVID-19 and Seasonal Influenza:*
Interim Guidance for Health Care and Public Health Providers - Testing,
<https://cchcs.ca.gov/covid-19-interim-guidance/> (Updated Nov. 16, 2020.)

27 ²⁶ *Id.*

28 ²⁷ *Id.*

²⁸ *Id.*

²⁹ *Id.*

33. I understand that, because of testing fatigue in its incarcerated population and staff, CCHCS started testing using mid-turbinate swabs, which are much more comfortable than the nasal-pharyngeal swabs used before. Decl. Gipson ¶ 9. This is an important development to encourage a high rate of testing compliance.

34. Because people infected with COVID-19 shed detectable virus in their stools, particularly early in the COVID-19 disease course, monitoring sewage for SARS-CoV-2 can herald the presence of SARS-CoV-2 in a population, as an early warning system.³⁰ On a municipal level, this was recently shown in a study conducted in New Haven, Connecticut.³¹ Daily samples were collected from the municipal wastewater treatment facility serving about 200,000 people between March and May 2020.³² COVID-19 was detected in the wastewater three days before the spike at the hospitals.³³ Around the country, universities are employing wastewater testing on a building level. For example, at my university, the wastewater from dorms are checked each week for coronavirus. Similar strategies can be implemented in prisons. I understand that wastewater testing has commenced at two of CDCR's institutions to assess its feasibility and effectiveness for early detection of outbreaks, and may expand to other institutions. Decl. Gipson ¶ 9. This a significant, proactive measure to detect COVID-19 early. The early virus detection that wastewater-based surveillance affords could allow CDCR to begin outbreak response and mitigation efforts before a significant outbreak occurs.

III. CDCR'S LESSONS LEARNED FROM PREVIOUS OUTBREAKS.

A. Example of Folsom State Prison.

35. Effective outbreak management, particularly for a novel disease like COVID-19, depends on early mitigation efforts. The study of outbreaks that have already occurred at institutions is essential in formulating effective response plans in the event of

³⁰ Jordan Peccia, et al., *SARS-CoV-2 RNA concentrations in primary municipal sewage sludge as a leading indicator of COVID-19 outbreak dynamics*, available at <https://www.medrxiv.org/content/10.1101/2020.05.19.20105999v2.full.pdf+html> (posted June 12, 2020.)

³¹ *Id.*

³² *Id.*

³³ *Id.*

1 future outbreaks. I understand that CDCR does this each time there is an outbreak, and
 2 that CDCR institutions formulate plans to manage COVID-19 outbreaks, taking into
 3 account the unique physical plants and resources of the specific institutions. Decl. Gipson
 4 ¶ 22. I further understand that the development of these “resurgence plans” became
 5 particularly important after the unprecedented COVID-19 outbreak at San Quentin and
 6 that San Quentin developed a resurgence plan to include lessons learned from the
 7 outbreak it experienced in June and July 2020. San Quentin’s outbreak involved an
 8 incidence of roughly 1,500 cases in 15 days to peak at 1,636 cases on July 7. In total the
 9 prison experienced 2,180 cases, including 28 deaths.³⁴ I also understand that Folsom,
 10 which has a similar layout to San Quentin, experienced an outbreak between August and
 11 October 2020 involving a total of about 1,300 cases, but a peak number of 611 active
 12 cases on September 21. This represented a “flattened curve,” resulting in 2 deaths as
 13 opposed to San Quentin’s 28.³⁵

14 36. I have reviewed Folsom’s resurgence plan, as well as plans for San Quentin
 15 and the California Rehabilitation Center. These are thorough documents that take into
 16 account detailed logistics like included cancelling intake and non-emergent transfers,
 17 serial testing of staff and incarcerated people, activating alternate housing, creating plans
 18 to ensure inmates receive necessary healthcare services, arranging for additional staff as
 19 needed, requesting assistance from outside entities and government agencies, and safely
 20 housing medically high-risk people, among many other considerations.

21 37. I understand Folsom implemented a number of measures, such as cancelling
 22 intake and non-emergent transfers, conducting serial testing of staff and incarcerated
 23 people, cohorting staff and incarcerated people, activating alternate housing options,
 24 creating plans to ensure inmates receive necessary healthcare services, arranging for

25
 26 ³⁴ California Department of Corrections and Rehabilitation, *CDCR Patients: COVID-19*
By Institution, <https://www.cdcr.ca.gov/covid19/population-status-tracking/> (last visited Dec. 4,
 2020.)

27 ³⁵ Matthew Akiyama, et al., *Flattening the Curve for Incarcerated Populations—Covid-19*
in Jails and Prisons, vol. 382, New Eng. J. Med. 2075 (May 28, 2020),
 28 <https://www.nejm.org/doi/full/10.1056/NEJMp2005687>.

1 additional staff as needed, requesting assistance from outside entities and government
2 agencies, and safely housing medically high-risk people, among many other measures. I
3 understand that Folsom quickly implemented these measures as part of its response to the
4 outbreak. Decl. Gipson ¶ 22. I understand that Folsom prioritized safely housing its
5 medically high-risk population by transferring high-risk people to cells. *Id.*

6 38. CDCR's outbreak responses at Folsom and the California Rehabilitation
7 Center shows that CDCR learned from San Quentin how to better manage outbreaks in
8 prisons without ideal quarantine spaces like Folsom, even short of quarantining in solitary
9 housing. In fact, the response at Folsom showed that CDCR can flatten the curve, and the
10 response at the California Rehabilitation Center showed that it can manage an outbreak
11 using an innovative housing solution in a setting that lacked an adequate number of single
12 cells with solid doors.

13 **B. Movement Matrix.**

14 39. Following the transfers that appear to have led to the outbreak at San
15 Quentin in June and July, CDCR institutions were temporarily closed to intake and non-
16 emergent movement. I understand that intake was closed from March 24 to May 25, then
17 again from June 19 until the week of August 24. (ECF No. 3405 at 4:18-21 and ECF No.
18 3436). Intake has since resumed on a limited basis and is currently paused. Decl. Gipson
19 ¶ 3. Minimizing movement minimizes the risk of infection transmission.

20 40. I understand CCHCS developed its COVID-19 Screening and Testing
21 Matrix during this period, has since revised it twice, and works closely with CDCR to
22 execute it. Decl. Gipson, Exs. A & B. The current Matrix employs an aggressive testing
23 and quarantine strategy: it requires that county jails sending people to CDCR institutions
24 identify the people they wish to transfer, quarantine them for 14 days before arrival, test
25 them, and provide CDCR with a list of names and test results in advance of the transfer.
26 As discussed above, CDCR tests the arrivals three times during the 14-day quarantine:
27 days 1, 7, and 12. CDCR also assigns quarantine housing units based on arrivals from the
28 same county that arrive on the same bus. I believe that this policy represents one of the

1 more stringent transfer strategies in the country.

2 41. According to the Matrix, the arrivals are not moved to regular housing until
3 a third, final negative result is received or, if infected, persons are out of the contagious
4 period. Each county is also required to provide N95 masks to each incarcerated person
5 and staff member on each bus, which they are required to wear for the duration of the
6 journey, with limited exception. Staff on the bus are required to verify to the receiving
7 CDCR institution that bus occupants complied with mask-wearing requirements during
8 the journey. I also understand that institutions cancel intake and non-emergent transfers
9 during outbreaks. These practices comport with CDC guidelines. CDCR took aggressive,
10 proactive action with its movement and transfer policies to prevent the occurrence of
11 another outbreak like San Quentin, showing again that CDCR learned from past
12 experiences.

13 42. I understand that receiving institutions have refused intake from
14 noncomplying counties and that, on at least two occasions, receiving institutions turned
15 away county jail buses that arrived at the institution but failed to comply with Matrix
16 requirements. Decl. Gipson ¶ 7. This shows that CDCR attempts to adhere to these
17 protocols and that the likelihood of a major outbreak resulting from a transfer is low.

18 43. The new Matrix alters current policy by requiring CDCR to house people
19 undergoing precautionary, post-transfer quarantine in cohorts of no more than four people
20 in a dorm or small tent, solely dedicated to a cohort that arrived on the same day, as
21 opposed to a maximum of 10 allowed under the current Matrix. It also prohibits transfer
22 of medically high-risk people to six institutions with few or no solid-door cells, and
23 requires that medically high-risk people be housed only in cells with solid doors. These
24 mitigation measures comport with CDC guidelines and further reduce the risk to people
25 who may be quarantined in shared airspaces.

26 **C. Personal Protective Equipment.**

27 44. I understand that CDCR has provided patients and staff throughout the
28 system with either cloth or surgical face masks since very early on in the pandemic. Since

1 April 2020, CDCR has been providing cloth face masks to incarcerated people and staff
 2 and providing guidance and directives on mask use. CDCR currently requires mask
 3 wearing in the institutions and provides all staff with surgical face masks. As an
 4 additional mitigation effort during serious outbreaks at particular prisons, CDCR has
 5 issued N95 masks to all incarcerated people and staff to help stop the virus's spread. To
 6 date, this type of institution-wide N95 measure has been implemented at Folsom State
 7 Prison, San Quentin State Prison, and Avenal State Prison. And at other prisons
 8 experiencing outbreaks, CDCR has begun to require the use of N95 masks by staff and
 9 inmates who work or reside in the areas experiencing the outbreaks. Gipson Decl. ¶. 11.
 10 This is an important practice for preventing the spread of COVID-19 because masks trap
 11 respiratory droplets from the nose and mouth. CDCR's standardized mask distribution
 12 practice also ensures all staff and incarcerated people have access to proper face
 13 coverings. And the wide distribution of N95 masks in prisons with significant outbreaks
 14 is a measure that can mitigate the spread and harm from the outbreak even if ideal
 15 conditions for quarantine are not available.

16 **D. COVID-19 Vaccine.**

17 45. Pfizer and Moderna recently announced that COVID-19 vaccines would
 18 become available as early as December 2020. I understand that CDCR is actively seeking
 19 vaccines for eligible staff and incarcerated people from the California Department of
 20 Public Health (CDPH). Decl. Gipson ¶ 24. I also understand that CDPH recently
 21 convened a workgroup which proposed including correctional officers in the first phase of
 22 vaccine distribution.³⁶ These vaccines may lower the risk of severe outcomes in
 23 vulnerable persons after exposure. Future vaccines may prevent transmission and may
 24 permit more flexibility in housing strategies.

25
 26
 27 ³⁶ California Department of Public Health, *Phased Allocation of COVID-19 Vaccines*,
 28 December 1, 2020, <https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2020-12/COVID-02-Dooling.pdf>.

(continued...)

1 **E. Population Reduction.**

2 46. Since the start of the COVID-19 pandemic, CDCR reduced its population by
3 over 23,000 people, or approximately 20%.³⁷ Its institutions' current population of 92,259
4 occupies 108.4% of its design capacity.³⁸ This is the first time CDCR's population
5 dropped below 100,000 since 1990.³⁹ The Receiver's data analyzing the types of spaces
6 used for quarantine, discussed above, suggests this significant reduction has allowed
7 CDCR to create a large reserve of space for quarantine and isolation purposes.

8 **IV. CONCLUSION**

9 47. Based on the information provided to me and through my own research, I
10 believe CDCR generally endeavors to quarantine its population in single cells or the
11 smallest possible cohorts that can be achieved based on the facilities available. If that is
12 not happening in some instances, I believe that CDCR is committed to seeking ways to
13 improve quarantine conditions, and is making reasonable efforts to satisfy the CDC's
14 public health guidelines for correctional institutions and CCHCS's, healthcare policy. I
15 believe CDCR's goal is to comply with the safest possible measures for quarantine.

16 48. In sum, while I agree that quarantining in single cells with solid doors is the
17 optimal scenario from the standpoint of controlling COVID-19, other strategies short of
18 this are acceptable if necessary. I disagree that there is no alternative if facilities and
19 resources available do not provide the ability to quarantine in this manner. Aggressive
20 use of a multi-pronged application of evidence-based strategies can reduce harm when
21 two (or sometimes more) persons need to share airspace during quarantine. And
22 improving surveillance can hasten the detection of outbreaks and decrease the number of
23 persons infected and exposed. The purpose of public health guidance is to achieve the
24 safest possible conditions in the context of what is available, not an unachievable ideal.

25 _____
26 ³⁷ This total is calculated using the institution and camp population data from CDCR's
27 population reports for February 26, 2020 and December 2, 2020, available at
<https://www.cdcr.ca.gov/research/weekly-total-population-report-archive-2020/>.

28 ³⁸ *Id.*

³⁹ Molly Sullivan, *California prison population drops below 100,000 for the first time in 30 years*, July 31, 2020, <https://www.sacbee.com/news/local/crime/article244633057.html>.

1 This is why public health guidance, like the CDC guidelines, ranks alternatives in order of
2 preference. When optimal measures are not achievable, the next best alternatives should
3 be implemented. And while CDCR's efforts cannot be characterized as the perfect public
4 health response to the pandemic, and there are likely areas where its responses can be
5 improved, this is what CDCR has attempted to do.

6
7 I declare under penalty of perjury that I have read this document, and its contents are
8 true and correct to the best of my knowledge. Executed on December 9, 2020, in Decatur,
9 Georgia.

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12 ANNE SPAULDING, MD, MPH

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Exhibit A

ANNE C. SPAULDING, M.D., M.P.H., F.I.D.S.A., F.A.C.P., F.A.C.C.P.

Office: 1518 Clifton Road, CNR 3033 Rollins School of Public Health, Atlanta, GA 30322

Home: 1275 Oak Grove Drive, Decatur, GA 30033

Phone: Day (404) 727-3369; Evening (404) 315-6110; Cell (404) 313-5298.

Fax: (404)727-8737. Email: ASpauld@emory.edu

EDUCATION

9/2001-5/2005	Johns Hopkins School of Public Health, Baltimore, MD (M.P.H. degree)
8/1985-5/1989	Medical College of Virginia, Richmond, VA (MD degree)
9/1980-6/1984	Brown Univ., Providence, RI (Sc.B degree, Major: Applied Mathematics/ Biology)

TRAINING

7/1993-6/1996	Infectious Diseases Fellow, U Mass. Medical Center, Worcester, MA
6/1992-6/1993	Internal Medicine Residency, Chief Resident, VA Medical Center, Providence, RI
6/1989-6/1992	Internal Medicine Resident, Miriam Hospital, Providence, RI, Internal Medicine

CURRENT ACADEMIC, PROFESSIONAL APPOINTMENTS

10/2014-present	Associate Professor of Epidemiology with Tenure Rollins School of Public Health, Emory University
1/2015-present	Associate Professor of Medicine (Joint), Emory School of Medicine
2018-present	Adjunct Associate Professor, Morehouse School of Medicine

PREVIOUS ACADEMIC, PROFESSIONAL APPOINTMENTS

1/2017-8/2018	Staff Physician/ID Consultant (one day per week) Fulton County Jail
1/2013-4/2016	Staff Physician (one day per week) Haven of Hope, Ryan White HIV Clinic for Georgia Public Health District 4 (Overseen by AIDS Healthcare Foundation since May 2015)
10/2005-9/2014	Assistant Professor of Epidemiology (Tenure Track: 9/2008-9/2014) Rollins School of Public Health, Emory University Assistant Professor (Joint) of Medicine, Emory School of Medicine
10/2005-7/2012	HIV and HCV Physician Consultant, Georgia Correctional Health Care/Medical College of Georgia <i>Responsibilities:</i> Evaluated women in Georgia prisons
10/2003-10/2005	Associate Statewide Medical Director, Georgia Correctional Health Care/Medical College of Georgia. <i>Administrative Responsibilities & Accomplishments</i> <ul style="list-style-type: none"> • Assisted statewide medical director in supervision and auditing of approximately 50 physicians caring for 45,000 prisoners at 70 prison sites across the state of Georgia • Developed quality assurance programs such as performance evaluation, peer review, credentialing, and utilization review • Managed annual budget of \$113 million/year <i>Clinical Responsibilities</i> <ul style="list-style-type: none"> • HIV and HCV specialty care to women in Georgia prisons

- 11/2001-9/2003 Centers for Disease Control and Prevention
 11/2002-09/2003: Researcher, appointed via Oak Ridge Institute for Science and Education to CDC/National Center for Infectious Disease, Division of Viral Hepatitis. Supervisor: Drs. Hal Margolis, Cindy Weinbaum
 11/2001-10/2002: Medical Officer, CDC/National Center for HIV, STD & TB Prevention/CDC. Office of the Director/Prevention Support Office: Corrections and Substance Abuse Activities
- 10/2000-10/2001 Director/Consultant, RI Department of Health, RI State Sexually Transmitted Disease Clinic Medical, Providence, RI
- 06/1996-10/2001 Medical Program Director, Rhode Island Department of Corrections
 39 Howard Avenue, Cranston, RI 02920

Responsibilities & Accomplishments

- Health care delivery to system with average daily population of 3,500 patients; 15,000 admissions/year
- Managed annual budget of approximately \$12 million
- Oversaw approximately 100 health care workers (staff and consultants)

- 06/1996-10/2001 Staff Physician, Rhode Island Hospital
 593 Eddy St., Providence, RI 2903

Responsibilities & Accomplishments

- Attending Physician on Consult Service, Division of Infectious Disease
- Liaison between Department of Corrections and RI Hospital for inpatient and outpatient care of incarcerated individuals
- Attending Physician, Medical Primary Care Unit, with emphasis on Infectious diseases (HIV, Hepatitis C) and health needs of ex-offenders

PART-TIME CLINICAL PRACTICE

- 12/2019- Infectious Disease Consultant, MercyCare HIV Services, Atlanta GA
 1/2017-8/2018 Infectious Disease Consultant, Fulton County Jail
 1/2013-4/2016 Infectious Disease Consultant, Haven of Hope Ryan White HIV Clinic, Georgia District 4 Health Department, Newnan, GA
 9/2012-12/2012 Volunteer Physician, Ponce Infectious Disease Clinic, Atlanta GA
 10/2005-9/2012 Infectious Disease Consultant, Georgia Correctional HealthCare Consultation for HIV- and HCV-infected women in the Georgia Prison System (16-32 hours/month)

LICENSES

Georgia # 051387
 Initial date of license: 2002
 Current license expiration date: 11/30/2021

CERTIFICATION

Specialty Boards

American Board of Internal Medicine, 1992, 2002, 2013: Diplomate, Internal Medicine
 American Board of Internal Medicine, 1996, 2006, 2016: Diplomate, Infectious Disease

HOSPITAL PRIVILEGES

2012- Present Grady Memorial Hospital, Atlanta, GA—Admitting Privileges
2004-2006 Medical College of Georgia Hospital—Courtesy Staff
1996-2001 Rhode Island Hospital/Miriam Hospital, Providence, RI—Admitting Privileges
1996-2001 Eleanor Slater Hospital, Cranston, RI—Admitting Privileges
1997-2001 Women and Infants Hospital, Providence, RI—Consulting Privileges

HONORS AND AWARDS

2019 Rollins School of Public Health Supervisor Award: Nominated by mentee who traveled to National Penitentiary of Haiti
2016 Team Lead of “Program of the Year”, for HIV Jail Testing Program, by Fulton County Department of Health and Wellness TestAtlanta
2015 Finalist, Healthcare Hero, Community Outreach. Atlanta Business Chronicle
2009 Recipient, 2009 Partners in Public Health Improvement Award, given by CDC as member of External Group in recognition of collaboration in developing HIV Implementation Guidance for Correctional Settings
2008 Armand Start Award for Excellence in Correctional Medicine Society of Correctional Correctional Physicians
1995 Selected "Research Fellow of the Year"
Maxwell Finland Award of the Massachusetts ID Society
1989 Recipient, Medical Assistance Program-Reader's Digest Foundation Scholarship for Oversees Travel
1989 Awarded second place, MCV medical school wide research competition
1986 Summer research fellowship: American Academy of Allergy and Immunology to fund work at the National Institute of Allergy and Infectious Disease

PROFESSIONAL SOCIETIES

Infectious Disease Society of America
American College of Physicians
Society of Correctional Physicians/American College of Correctional Physicians
American Correctional Health Association
American Medical Association
American Public Health Association

PROFESSIONAL SERVICE

Community Service

2018 Appointed to HIV Advisory Committee, Fulton County Board of Commissioners
1997 Appointed to Leadership Rhode Island, a 10-month training program for a diverse group of community and business leaders to serve as catalysts of positive change for Rhode Island

Academic Committees

University-wide, Emory University
2013-2015, Research Administration, Faculty Advisory Board, Rollins School of Public Health
Rollins School of Public Health, Emory University
2016-Present, Epidemiology Department Curriculum Committee
2011-Present, Rollins Career Services Advisory Committee
2011-2016, Rollins Research Committee

2011-2012, Rollins Committee on Reaccreditation

Brown University School of Medicine

1999 Department of Pediatrics, Division of Adolescent Medicine. Search Committee for Medical Director, RI Training School for Boys and Girls.

NIH and NSF Advisory Panels

2020 NSF review panel, Smart and Connected Health. (P200079)
2017 NIH Phase I AIDS Avenir Reviewer (May 2017 council)
2016 NIDA Research Education Program/ Clinical (R25)
2010-2012 Ad hoc participant, NIDA K award review panel. (7 review panel/SEP meetings)
1/2009 NIH Review Panel, ad hoc participation in Biobehavioral Regulation, Learning and Ethnology Study Section
7/2008 NIDA Special Emphasis Panel ZDA1 JXR-D (12) Effectiveness of SBIRT in medical settings to reduce drug abuse.

Editorial Boards or Editorships

- Editorial board: Public Health Reports 2018 - Present
- Guest editor: AIDS and Behavior, Supplement on Correctional Health, 2012-2013
- Editorial board: Correctional Health Report 2011- Present
- Editorial board: Health & Justice 2016-Present
- Editorial board: Journal of Correctional Healthcare. 2008- Present. Assisted with obtaining PubMed listing of journal in 2009
- Have reviewed papers for JAMA, Journal of Correctional Healthcare, Journal of Women's Health, Annals of Internal Medicine, Annals of Epidemiology, Clinical Infectious Disease, Lancet, New England Journal of Medicine, PLoS One, Journal of Viral Hepatitis
- Received letter of commendation from the editor of Annals of Internal Medicine for being in the "top 30% of all reviewers for 2008"

Conference Chairs

Co-chair, Tenth Annual Academic and Health Policy Conference on Correctional Health, Atlanta, GA, March 16-17, 2017.

Co-chair, Fifth Annual Academic and Health Policy Conference on Correctional Health, Atlanta, GA, March 22-23, 2012.

Co-organizer, Society of Correctional Physicians, Semi-Annual Meetings, 1998-2017.

Course Director, American Correctional Health Services Association Annual Meeting, Reno, NV, June 4-7, 2007.

Co-Chair, Management of Hepatitis C in Prisons, San Antonio, TX, January 25-26, 2003. Sponsored by Centers for Disease Control and National Institutes of Health.

Course Director, Hepatitis C: Controversies facing the Primary Care Provider, December 2002.

Brown Medical School, Brown University AIDS Program, RI Department of Health, Providence, RI. Four-hour CME program.

International Health Experiences

- 2012- present Travel to National Penitentiary, Port-au-Prince, Haiti. Trips sponsored by Health Through Walls (www.healththroughwalls.org): seven visits total
- 2010 Volunteer with Global Health Outreach—Medical team with 9 Emory Medical Students, Port-au-Prince, Haiti
- 1997 Volunteer with Prison Fellowship--Medical Team visiting prisons in Quito and Guayaquil, Ecuador, S.A
- 2/89-3/89 Senior year elective rotations at Centre Medical Evangelique, Nyankunde, Zaire [Congo] as recipient of MAP-Reader's Digest Foundation scholarship
- 8/84-5/85 Administrative volunteer at Hopital Ste. Croix in Leogane, Haiti. Also accompanied public health team on village visits

Elected Office, National Organizations

- 2001-2003 National President, Society of Correctional Physicians
- 1997-2005 Board Member, Society of Correctional Physicians

Appointed Office, National Organizations

- 2012-2016 Executive Board Member, Academic Consortium on Criminal Justice Health

National Advisory Committee Service

- 2013 Liaison. CDC/STD Guidelines Committee
- 2011 Member, CDC/Division of Viral Hepatitis: Screening for Hepatitis C Virus Infection in Adults
- 2010 Member, Department of Justice, Bureau of Justice Statistics/CDC, National Center for Health Statistics, Correctional Health and Healthcare. Invited Speaker to address topic: Identifying and Prioritizing Data Needs
- 2003-2005 Member, Subcommittee on Subpart C/Research on Prisoners, Secretary's Advisory Committee on Human Research Protection, Department of Health and Human Services
- 2002-2003 Invited Member of Francis J. Curry National Tuberculosis Center Work Group on Strategic Plan for TB Training and Education for Correctional Facilities
- 2002 Invited Participant/Speaker: National Human Research Protections Advisory Committee, on the risks of involving inmates in medical research. Washington, DC
- 2001 Invited Participant/Speaker, Conference on Recommendations for the Prevention and Control of Infections with Hepatitis Viruses in Correctional Settings. Centers for Disease Control, Atlanta, GA
- 1998-1999 Member, Member, National Institute of Justice/National Commission on Correctional Health Care. Expert Panel on Communicable Diseases among Soon-To-Be-Released Inmates. For preparation of commissioned report to US Congress

TEACHING EXPERIENCE

Emory University

- Courses developed and taught
 - 2007-Present (each spring except 2011): Correctional Healthcare Epidemiology (2 credits).
- Other courses taught
 - Fall 2015- Present: Case Studies in Infectious Diseases (2 credits).
 - Spring 2013- Present: Field Epidemiology (2 credits).
 - Spring 2011- Present: Sexually Transmitted Disease Epidemiology (2 credits).
 - 2010-2016: Epidemiology PhD Journal Club (1 credit).

Medical College of Georgia

Lecture to ID Division, GA Regents University HIV in Prisons (December 2013)
House Staff, Medical College of Georgia
Correctional Medicine and Public Health, March 2005

Brown School of Medicine

Small Group Leader, Infectious Diseases Course, 2nd year Brown medical students, Providence, RI, 1997-2001

Other Teaching Experience

- Modeling of HIV in Jails. T. Ayer, Healthcare Delivery. GA Tech. HS6000. Spring, 2014
- Guest Lecture, "Hepatitis C in Correctional Facilities." Course in Correctional Health, Johns Hopkins Bloomberg School of Public Health, 2013
- Guest Lecture: Lecture in "Mentored Training Program to Increase Diversity in HIV, Substance Use and Mental Health" 2006. NIH Grant (R25MH080669-01A1); program conducted by Ronald Braithwaite, PhD, Morehouse School of Medicine
- Guest Speaker: Live Talk on Correctional Health for course, "Current Concepts in Public Health." Johns Hopkins School of Public Health, 2005
- Presentation to Combined House Staff, Medical College of Georgia: Correctional Health, 2005, Augusta, GA
- Presentations to University of Rhode Island, School of Pharmacy, graduate students. Guest Lecturer: Sexually Transmitted Diseases, Urinary Tract Infections. Kingston, RI, 2000
- Presentation to Brown University undergraduate course in U.S. health care systems, Department of Community Health. Topic: Corrections and Public Health. Providence, RI, 2000

MPH/MSPH Thesis Committees Chaired (Emory University)

2020 Laura Dirks, Jason Massey
2019 Haley Kehus, Mingli Qi, Hilary Hunt, Sierra Thompson
2018 Ye Ji Kim.
2017 Ana Drobeniuc, Adrienne Tanus, Ellie Kerr [Also MS in Bioethics: Joel Zivot]
2016 Marion Rice
2015 Colleen Haynes, Frances Kim, Nikki Roth, Elizabeth Smith
2014 Philip Aka, Sarah Demas, Liesl Hagan, Cece Ibeson, Takiyah Ball
2013 Tristan Cordier, Liesl Hagan, Simona Lang, Shawnta Lloyd, Gui Liu, Da Mao, Daniel Mercer, Kimberly Miller, Emily Ridgeway
2012 Grace Oguntebi, Aminata Mboup, Mary Mbaba, Matthew Stein
2011 Megan Eguchi, Madhura Adiga Hallman, Cassandra Harrison, Alice Sun Lee, Rose Wanjala
2010 Phoebe Alleman, Julia Hood
2009 Amber Bishop, Lauren Christiansen, Victoria McCallum (nominated for Shepherd Award), Elenore Patterson, Erica Shultz, Ryan Seals
2008 Ashiru Bisola

PhD Dissertation Committees, Emory University

Chris Bond, Matthew Page, Mohammed Khan

Guest Lectures, Emory University

Coursera on AIDS (Hagen, Massive Open Online Course, 2013)
Lecture to Medical Students/Residents, Social Medicine Series (George), 2011-present
Lecture to Gastroenterology Fellows, Emory School of Medicine, 2011
Epi 541: Hospital/Healthcare Epidemiology (McGowan), 2008-2009
HIV Seminar for Humphrey Fellows (DelRio), 2009, 2013
Epi 540: Case studies in Infectious Disease (McGowan), 2007-Present

Guest Laboratory Session

Epi 591U Lab: Application of Epi Concepts (Drews), 2008-2009

Residents Talks

Internal Medicine House Staff: Various Noontime Conferences
Miriam Hospital, RI Hospital, VA Medical Center, 1997-2001
Topics: Community Acquired Pneumonia, Endocarditis
Fever in the Neutropenic Host
Viral Illnesses other than HIV
Mycology Jeopardy

LABORATORY RESEARCH EXPERIENCES

1993-96 Dengue: Cytotoxic T Lymphocyte assays; viral quantification by new ELISA. Laboratory of F. Ennis, University of Massachusetts.

1991 Schistosomiasis epitopes present at different life stages. Laboratory of R. Olds and P. Wiest, Brown University.

1989 LAK cells and fibrin coating of bladder tumor cells. Laboratory of M. Carr, VAMC/Medical College of Virginia.

1986 Serum levels of eosinophilic proteins in parasitic disease. Laboratory of R. Davey, T. Nutman, E. Ottesen, National Institute for Allergy and Infectious Disease at the National Institutes of Health.

RESEARCH

Grant Support

Active

PI: A. Spaulding. "Direct Comparison of HIV Testing Strategies in the District of Columbia Department." [Gilead IN-US-985-5712: January 2020-December 2020.]

PI: Matthew Akiyama, Co-Investigator: Spaulding. "Enhancing a Universal Testing and Treatment Strategy in Jail to Promote Viral Load Suppression among Justice Involved People Living with HIV." [NIAID/ Centers for AIDS Research Supplement. Subcontract: July 2019-June 2020.]

PI: A. Spaulding. "Evaluation by Focus Groups, Surveys and Observation of TB Reach: Improving TB treatment adherence and outcomes for current and former prisoners in Haiti." [Stop TB Partnership via Health through Walls: 2018-2020].

PI: J. May, Co-Investigator: Spaulding. "Haiti Prisons Health, Sanitation, and Nutrition Program." Subcontract with Emory, A Spaulding subcontract PI. [US Department of State: April 2020-October 2021.]

PI: A. Spaulding/J. Chhatwal/T. Ayer. "Collaborative Research: Smart Intervention Strategies for Hepatitis C Elimination." [National Science Foundation 1722906: August 15, 2017-July 31, 2021.]

PI: A. Spaulding. "TB Reach: Improving TB treatment adherence and outcomes for current and former prisoners in Haiti." [Stop TB Partnership via Health through Walls: 2018-2020.]

Completed

PI: R. DiClemente, Co-Investigator: Spaulding. "Knowing about intervention and implementation in Detention Sites (KiiDS)" - Translational Research on Interventions for Adolescents in the Legal System (TRIALS) Consortium. [NIDA: July 2013-June 2018.]

PI: A. Spaulding. "Enhancing Linkage to Care." [Elton John Foundation: 2014-2019.]

PI: A. Spaulding. "Hepatitis C Screening in the Georgia Prison System." [Gilead Sciences: 2016-2017, followed by no cost extension.]

PI: F. Wong, Co-Investigator: Spaulding. "A Molecular-Social Network Investigation of HIV-HCV Co-infection in Chinese MSM." [NIAID 1R01 AI106715, Percent Effort: 10%.]

PI: A. Spaulding. "Planning for SUCCESS." [NIH/NIDA R34: March 15, 2014 – February 28, 2017.]

PI: A. Spaulding. "Tuberculosis: Behind Bars and Beyond." [Emory University Research Committee and the Atlanta Clinical & Translational Science Institute: June 1, 2013-May 31, 2014; \$30,000 directs]

PI: W. Ferguson, Co-Investigator: A. Spaulding. "Academic and health policy conference on correctional health care." [NIH/NIDA 1R13DA030822-01: 2010-2015; no salary support]

Lead Co-Investigator: A Spaulding. Title: Predicting the effect of seeking, testing and treating HIV in correctional facilities. Funding period 2010-12. Supplement to Center for AIDS Research Grant. [NIH funded program (P30 AI 050409); \$ 74,780 direct; \$41,128 indirect; \$115,908 total]

PI: L. Miller. Co-Investigator: Spaulding. TILT-C: internal medicine Trainees Identifying and Linking to Treatment for hepatitis C (Role: Co-investigator). [Funding period: 10/1/2012-9/30/2013. Refunded for a second year: 10/1/2013-9/30/2014. Centers for Disease Control. \$150,000 directs + indirects]

PI: A. Spaulding. Title: Assessing and Overcoming Barriers for HIV+ Releases from Urban and Rural Jails: A Pilot Study on the Use of Case Management and Texting Technology to Enhance Connections to Community Care. Funding period: 4/2012-4/2013, followed by NCE through 4/2014. Grant from Bristol Myers Squibb. [Award Number AI424-486, \$100,166 direct; \$25,042 indirect; \$125,208 total]

PI: A. Spaulding. Cancer in a Prisoner Cohort: Comparison of Subjects with and without HIV. Awarded 2012. CFAR03 Grant. Emory Center for AIDS Research and Winship Cancer Center. Funding period 03/01/12-02/28/13, with one year no cost extension. [NIH funded program (P30 AI 050409); directs: \$48,387, \$26,613 indirect, \$75,000 total]

PI: A. Spaulding. Title: Evaluation and Support Center for Models of Identifying HIV Infected Person in Jail Settings and Enhancing Linkages to Primary Care. Funding period 9/1/2007 – 8/31/2012. Cooperative Agreement with HRSA. [Award Number U90HA07632; \$3,089,429 direct, \$867,182 indirect, \$3,956,611 total.]

PI: A. Spaulding. Title: 2011 Annual Conference: Controlling Glucose in Controlled Environments. Funding period 09/30/2011 – 09/29/2012. [CDC, Award number 1U13DP003317-01, \$20,000 directs]

PI: A. Spaulding. Integrating Infectious Disease Detection at Entry and Linkage. Cooperative Agreement with CDC, at Fulton County (GA) Jail. Funding period 9/2010-8/2012. [Award Number: 1H62PS003187-01. \$748,136 direct; \$202,798 indirect; \$950,934 total]

PI: S. Sacks. Co-Investigator: A. Spaulding Title: NDRI Rocky Mountain Research Center for CJDATS 2. Funding period: 04/01/2011 – 03/31/2012. Grant from National Development and Research Institutes,

Inc. Funding as subcontract, 2012. [NIH/NIDA Award to NDRI, Award Number 5U01DA016200-08, \$8,000 direct, \$4,400 indirect, \$12,400 total]

PI: A. Spaulding Public Health and Correctional Healthcare Provider Partnerships in Responding to the H1N1 Influenza Pandemic: A National Survey of Jails. Funding period: 2008-2013. Grant from CDC via Emory Preparedness and Emergency Response Research Center. [CDC funded program, Award Number 5-P01-TP000300; \$20,000--directs only]

PI: A. Spaulding. Title: Mortality and Survival of a Cohort of Inmates in Georgia Prisons, 1991. Funding period: 7/1/07-6/30/09. Pfizer Scholar Grant in Public Health, Medical and Academic Partnership Program; [Total \$130,000]

PI: A. Spaulding. Title: Study of Gonorrhea and Chlamydia Testing in Large Jails-Current State of the Field. Funding Period: 8/20-12/31/08. CDC PO 2008-M-27389. [Total \$20,000]

PI: A. Spaulding. Title: MATCHing Needs and Resources: Assessing the Needs of HIV+ Prisoners Coming Home. Funding period 7/01/2006-4/30/2007; CFAR03 Grant; Center for AIDS Research, Emory University [NIH funded program (P30 AI 050409); \$30,000]

JOURNAL PUBLICATIONS: [*Denotes Emory University trainee]

1. Carr M, Sajer SA, **Spaulding A**. Fibrin coating of bladder tumor cells is not protective against LAK cell cytotoxicity. *Journal of Laboratory & Clinical Medicine*. 1992 Feb; 119(2): 132-8.
2. **Spaulding AC** Rothman AL. *Escherichia vulneris* as a cause of IV catheter-related bacteremia. *Clinical Infectious Disease*. 1996 Apr; 22(4): 728-9.
3. Rich J, Dickenson BP, **Spaulding A**, LaFazia L, Flanigan TP. Interpretation of indeterminate HIV serology results in an incarcerated population. *J AIDS and Human Retrovirology*. 1998 Apr 1; 1794):367-9.
4. **Spaulding A**. The Role of Correctional Facilities in Public Health: The Example of Sexually Transmitted Diseases. *Medicine & Health/Rhode Island*. 1998; 81(6)204-6.
5. Mitty JA, Holmes L, **Spaulding A**, Flanigan T, Page J. Transitioning HIV-Infected Women after release from incarceration: Two models for bridging the gaps. *J Correctional Health Care*. 1998; 5(2):239-54.
6. **Spaulding A**, Kurane I, Ennis F, Rothman A. Analysis of Murine CD8+T-cell clones specific for the Dengue virus NS3 protein: flavivirus cross reactivity and influence by the infectious serotype. *J. Virology*. 1999 Jan; 73(1): 398-403.
7. **Spaulding A**, Green C, Davidson K, Schneidermann K, Rich J. Hepatitis C in State Correctional Facilities. *Preventative Medicine*, 1999 Jan; 28(1): 92-100.
8. **Spaulding AC**, Lally M, Rich JD, Dieterich DT. Hepatitis B and C in the context of HIV disease: implications for incarcerated populations. *AIDS Reader*. 1999 Oct; 9(7): 481-91.

9. Rich JD, Dickinson BP, Macalino G, Flanigan TP, Towe CW, **Spaulding A**, Vlahov D. Prevalence and incidence of HIV among incarcerated and re-incarcerated women in Rhode Island. JAIDS 1999 Oct 1; 22(2): 161-6.
10. Flanigan TP, Rich JD, **Spaulding A**. HIV care among incarcerated persons: a missed opportunity [Editorial]. AIDS. 1999 Dec 3; 13 (17): 2475-6.
11. Farley JL, Mitty JA, Lally MA, Burzynski JN, Tashima K, Rich JD, Cu-Uvin S, **Spaulding A**, Normandie L, Snead M, Flanigan TP. Comprehensive medical care among HIV-positive incarcerated women: the Rhode Island experience. Journal of Women's Health and Gender Based Medicine: 2000 Jan-Feb; 9(1): 51-6.
12. Clarke JG, Cyr MG, **Spaulding A**. Prisons: learning about women's health and substance abuse. Acad Med; 2000 May; 75(5): 544.
13. **Spaulding AC**, Allen S, Osei A, Ballard R. Hepatitis C infection: opportunity for exposure in many settings. Medicine & Health, Rhode Island 2000 Jul; 83(7):204-6.
14. **Spaulding A**, Lubelczyk RB, Flanigan T. Can (unsafe) sex behind bars be barred? Invited editorial for Am J Pub Hlth. 2001 Aug; 91(8):1176-7.
15. Rich JD, Hou JC, Charuvastra A, Towe CW, Lally M, **Spaulding A**, Bandy U, Donnelly EF, Rompalo A. Risk factors for syphilis among incarcerated women in Rhode Island. AIDS Patient Care and STDs 2001 Nov; 15(11):581-5.
16. Charuvastra A, Stein J, Schwartzapfel B, **Spaulding A**, Horowitz E, Macalino G, Rich JD. Hepatitis B vaccination practices in state and federal prisons. Public Health Rep. 2001 May-Jun; 116(3):203-9.
17. Rich JD, Macalino G, Merchant RC, Salas C, Marcussen P, Grundy M, **Spaulding A**. HIV seroprevalence of adult males incarcerated for a sexual offense in Rhode Island, 1994-1999. JAMA. 2002 Jul 10;288(2):164-5.
18. Desai AA, Latta ET, **Spaulding A**, Rich JD, Flanigan TP. The importance of routine HIV testing in the incarcerated population: the Rhode Island Experience. AIDS Education and Prevention 2002 Oct; 14(Supplement B):45-52.
19. **Spaulding A**, Stephenson B, Macalino G, Ruby W, Clarke JG, Flanigan TP. HIV in Correctional Facilities: A Review [Invited Article]. Clinical Infectious Diseases 2002 Aug 1; 35(3):305-12.
20. Clarke J, Schwartzapfel B, Pomposelli J, Allen S, **Spaulding A**, Rich JD. Hepatitis B vaccination of incarcerated women: a pilot program. Journal of Health Care for the Poor & Underserved 2003Aug; 14(3):318-23.
21. Allen SA, Osei A, Taylor L, Cabral A, **Spaulding A**, Rich JD. Treatment of Chronic Hepatitis C in a State Correctional Facility. Annals of Internal Medicine, 2003 Feb 4;138(3):187-90.
22. Remillino C, Brown HW, Adelson-Mitty J, Clarke J, **Spaulding A**, Boardman L, Flanigan T, Cu-Uvin C. Lower genital tract infections among HIV-seropositive and HIV-seronegative incarcerated women. J Correctional Healthcare, 2004; 10(4): 527-42.

23. Kelley M, Linthicum L, Small R, **Spaulding A**, Billah K, Weinbaum C. Hepatitis B Vaccination of Inmates in Correctional Facilities ---Texas, 2000--2002. *MMWR* 2004; 53(30): 681-3.
24. **Spaulding AC**, Weinbaum, CM, Lau DT-Y, Sterling R, Seeff LB, Margolis HS, Hoofnagle JH. A Framework for Management of Hepatitis C in Prisons. *Ann Intern Med*, 2006; 144(10):762-9.
25. **Spaulding AC**, Arriola KJ, Ramos KL , Hammett T, Kennedy S, Norton G, Tinsley M. Enhancing linkages to primary care in jail settings. *Journal of Correctional Health Care*. 2007; 13(2) 93-128.
26. **Spaulding AC**, Arriola KJ, Hammett T, Kennedy S, Tinsley M. Rapid HIV Testing In Rapidly Released Detainees: Next Steps. *Sexually Transmitted Diseases*. 2009 Feb; 36(2 Suppl):S34-6.
27. **Spaulding AC**, Clarke JE, Jonco A, Flanigan TP. Small Reservoirs--Jail Screening for Gonorrhea and Chlamydia in Low Prevalence Areas. *Journal of Correctional Health Care* 2009; 15(1): 28-34.
28. Baillargeon J , Snyder N, Soloway R, Paar D, **Spaulding A**, Pollock BH, Arcari CM, Williams BA, Raimer BG, Murray OJ, Pulvino JS. Hepatocellular Carcinoma Prevalence and Mortality in a State Prison Population. *Public Health Reports*. 2009 Jan-Feb; 124(1):120-6.
29. **Spaulding AC**, McCallum V*, Walker D, Reeves A, Drenzek C, Lewis S, Bailey E, Buehler JW, Berkelman, RL. How Public Health Can Partner with Prisons for Pandemic Influenza Preparedness--Report from Georgia. *Journal of Correctional Health Care*. 2009 Apr; 15(2):118-28.
30. Elger BS, **Spaulding A**. Research on prisoners – a comparison between the IOM committee recommendations (2006) and European regulations. *Bioethics*. 2010 Jan; 24(1):1-13.
31. **Spaulding AC**, Seals RM*, Page MJ*, Brzozowski AK*, Rhodes W, Hammett TM. HIV/AIDS among inmates of, and releasees from, US correctional facilities, 2006: declining share of epidemic but persistent public health opportunity. *PLoS One*. 2009 Nov 11; 4(11):e7558.
32. **Spaulding AC**, Sumbry AR*, Matthews AK*, Ramos KL, Maggio D*, Seals RM*, Wingood GM. Pairing HIV-positive prisoners with volunteer life coaches to maintain health promoting behavior upon release: a mixed-method pilot study. *AIDS Education and Prevention*. 2009 Dec; 21(6):552-69.
33. **Spaulding AC**, Perez SD*, Seals RM*, Hallman M*, Kaversy R, Weiss P. The Diversity of Release Patterns for Jail Detainees: Implications for Public Health Interventions. *American Journal of Public Health*. 2011 Dec; 101(S1):S347-52. DOI: 10.2105/AJPH.2010.300004
34. Baillargeon J, Giordano TP, Harzke AJ, **Spaulding AC**, Wu ZH, Grady JJ, Baillargeon G, Paar DP. Predictors of reincarceration and disease progression among released HIV-infected inmates. *AIDS Patient Care and STDs*. 2010 June; 24(6):389-94.
35. Draine J, Ahuja D, Altice F, Avery A, Arriola KJ, Beckwith C, Ferguson A, Figueroa H, Lincoln T, Ouellet LJ, Porterfield J, Booker C, Tinsley M, **Spaulding A**. Strategies to Enhance Linkages between Care for HIV/AIDS in Jail and Community Setting. *AIDS Care* 2011 Mar;23(3):366-77.
36. **Spaulding AC**, Seals RM*, McCallum VA*, Perez SD*, Brzozowski AK*, Steenland NK. Prisoner Survival Inside and Outside of the Institution: Implications for Healthcare Planning. *American Journal of Epidemiology*, 2011 Mar 1; 173(5):479-87.

37. Springer SA, **Spaulding AC**, Meyer JP, Altice FL. Public Health Implications for Adequate Transitional Care for HIV-Infected Prisoners: Five Essential Components. *Clinical Infectious Diseases* 2011; 53(5):469-79. Erratum in: *Clin Infect Dis*. 2011 Oct;53(8):851.
38. Rich JD, Wohl DA, Beckwith CG, **Spaulding AC**, Lepp NE, Baillargeon J, Gardner A, Avery A, Altice FL, Springer S. HIV-Related Research in Correctional Populations: Now is the Time. *Current HIV/AIDS Reports* 2011; 8(4):288–296. DOI:10.1007/311904-011-0095-3.
39. Lim JR*, Sullivan PS, Salazar L, **Spaulding AC**, DiNenno EA. History of Arrest and Associated Factors among Men Who Have Sex with Men. *Journal of Urban Health*. 2011 Aug; 88(4): 677-89. DOI: 10.1007/s11524-011-9566-5.
40. Chen NE, Meyer JP, Avery AK, Draine J, Flanigan TP, Lincoln T, **Spaulding AC**, Springer SA, Altice FL. Adherence to HIV Treatment and Care among Previously Homeless Jail Detainees. *AIDS and Behavior*. October 2013, 17(8): 2654-2666. DOI: 10.1007/s10461-011-0080-2.
41. Lee SA*, Berendes DM*, Seib KG, Whitney EAS, Berkelman RL, Omer SB, **Spaulding AC**; Chavez RS, Meyer LP. Receipt of 2009 H1N1 Influenza Vaccine by Prisons and Jails--United States, 2009-2010. *MMWR* 2012; 101(S1):S347-S352.
42. **Spaulding AC**, Thomas DL. Screening for HCV Infection in Jails. *JAMA* 2012; Mar 28;307(12): 1259-1260. DOI: 10.1001/jama.2012.374.
43. De Voux A*, **Spaulding AC**, Beckwith C, Avery A, Williams C, Messina LC, Ball S, Altice FL. Early Identification of HIV: Empirical Support for Jail-Based Screening. *PLoS ONE* 2012; 7(5): e37603.
44. Bond TC*, **Spaulding AC**, Krisher J, McClellan W. Mortality of Dialysis Patients According to Influenza and Pneumococcal Vaccination Status. *American Journal of Kidney Diseases*, 2012, Jun 11.
45. Hood JE*, Mackellar D, Spaulding A, Nelson R, Mosiakgabo B, Sikwa B, Puso I, Raats J, Loeto P, Alwano MG, Monyatsi B. Client Characteristics and Gender-specific Correlates of Testing HIV positive: A Comparison of Standalone Center versus Outreach HIV Testing and Counseling in Botswana. *AIDS and Behavior* 2012 Oct;16(7): 1902-16.
46. **Spaulding AC**, Messina LC*, Kim BI*, Chung K*, Lincoln T, Teixeira P, Avery A, Cunningham M*, Stein MS*, Ahuja D, Flanigan T. Planning for Success Predicts Virus Suppressed: Results of a Non-Controlled, Observational Study of Factors Associated with Viral Suppression among HIV-positive Persons Following Jail Release. *AIDS and Behavior* 2013. 17:s203-s211
47. Stein MS*, **Spaulding AC**, Cunningham M*, Messina LC*, Kim BI* Chung K*, Draine J, Jordan AO, Harrison A, Avery AK, Flanigan TP. HIV-Positive and in Jail: Race, Risk Factors, and Prior Access to Care. *AIDS and Behavior*. 2013. 17:s108-s117.
48. Spaulding AC, Booker CA, Freeman SH*, Ball SW, Stein MS*, Jordan AO, Ahuja D, Flanigan TP, Solomon L, Frew PM. The EnhanceLink Study Group. Jails, HIV Testing and Linkage to Care Services: An Overview of the EnhanceLink Project. *AIDS and Behavior*. 2013. 17:s100-107.
49. Booker CA, Flygare CT, Solomon L, Ball SW, Pustell MR, Bazerman LB, Simon-Levine D, Teixeira PA, Cruzado-Quinones J, Kling RN **Spaulding AC**, The EnhanceLink Study Group. Linkage to HIV care for jail detainees: findings from the first 30 days after release. *AIDS and Behavior*. 2013. 17:s128-s136.

50. **Spaulding AC**, Pinkerton SD, Superak H*, Cunningham MJ*, Resch S, Jordan AO, Yang Z. Cost Analysis of Enhancing Linkages to HIV Care Following Jail: A Cost-Effective Intervention. *AIDS and Behavior*. 2013. 17:s220-s226. 10.1007/s10461-012-0353-4.
51. Westergard R, **Spaulding AC**, Flanigan TP. HIV among persons incarcerated in the US: a review of evolving concepts in testing, treatment and linkage to community care. *Current Opinions in HIV*. 2013 February, volume 26 no.1 pages 10-6. doi: 10.1097/QCO.0b013e32835c1dd0.
52. Althoff A, Zelenev A, Meyer J, Fu J, Brown S, Vagenas P, Avery A, Cruzado J, **Spaulding A**, Altice F. Correlates of Retention in Care after Release from Jail: Results from a Multi-site Study. *AIDS and Behavior*. 2013. 17:s156-s170.
53. Williams CT, Kim S, Meyer J, **Spaulding A**, Teixeira P, Avery A, Moore K, Altice F, Murphy-Swallow D, Simon D, Wickersham J, Ouellet LJ. Gender Differences in Baseline Health, Needs at Release, and Predictors of Care Engagement among HIV-Positive Clients Leaving Jail. *AIDS and Behavior* 2013. 17:s195-s202.
54. **Spaulding AC**, Kim AY, Harzke AJ, Sullivan JC, Linas BP, Brewer A, Dickert J, McGovern BH, Strick LB, Trestman R, Ferguson WJ. Impact of new hepatitis C therapeutics on the funding of prison health care. *Topics in Antiviral Medicine*. 2013 Feb-Mar;21(1):27-35.
55. **Spaulding AC**, Miller J, Trigg BG, Braverman P, Lincoln T, Reams PN, Staples-Horne M, Sumbry A*, Rice D, Satterwhite CL. Screening for Sexually Transmitted Diseases in Short-Term Correctional Institutions: Summary of Evidence Reviewed for the 2010 Centers for Disease Control and Prevention Sexually Transmitted Diseases Treatment Guidelines. *Sexually Transmitted Diseases*. September 2013;40(9):67-684.
56. Arriola KJ, **Spaulding AC**, Booker C, Williams C, Avery A, Porter NJ, Jordan AO, Loewenthal H, Frew. Understanding the Relationship between Social Support and Physical and Mental Well-Being among Jail Detainees Living with HIV. *Journal of Health Psychology*. 2013 August, 0(0):1-10. doi: 10.1177/1359105313496447.
57. Zelenev A, Marcus R, Cruzado J, **Spaulding A**, Desabrais M, Lincoln T, Altice FL. Patterns of Homelessness and Implications for HIV Health after Release from Jail. *AIDS and Behavior* 2013. 17: s181-s194.
58. **Spaulding AC**, Bowden CJ, Kim BI*, Mann MC, Miller L, Mustaafta GR, Kyle RP*, Leon M*, Mbaba MV*, Messina LC*, Hampton S, MacGowan R, Reid L, Margolis A, and Belcher L. Integrating Routine Voluntary Opt-Out HIV Screening Into Medical Intake, Fulton County Jail—Atlanta, GA, 2011-2012. *MMWR*, 2013 June 21. 62(24); 495-497.
59. Varan AK*, Mercer DW*, Stein MS*, **Spaulding AC**. Seroprevalence of Hepatitis C among Prison Inmates since 2001: Still Widespread but Declining. *Public Health Reports* 2014. 129(2), 187-195.
60. Lee A*, Berendes D*, Seib K, Whitney E, Chavez S, Berkelman R, Omer SB, **Spaulding A**. Distribution of A (H1N1)pdm09 influenza vaccine: Greater consideration of smaller jails. *Journal of Correctional Health Care*. June 2014. 20(3):228-239.
61. Haddad MB*, Foote MK*, Ray SM, Maggio DM*, Sales RMF, Kim MJ*, Kempker RR, **Spaulding AC**. Substantial Overlap between Incarceration and Tuberculosis in Atlanta, Georgia, 2011. *Open Forum Infectious Diseases*. 2014; Jun 30;1(1):ofu041.

62. Moorjani H, Koenigsmann, C, Kim MJ*, **Spaulding AC**. Prisoners Treated for Hepatitis C with Protease Inhibitor, New York, USA, 2012. *Emerging Infectious Diseases*. 2015 Jan;21(1), 186-188.
63. **Spaulding AC**, Kim MJ*, Corpening KT*, Carpenter T, Watlington P, Bowden CJ. Establishing an HIV Screening Program Led by Staff Nurses in a County Jail. *Journal of Public Health Management and Practice*. 2015 Nov-Dec;21(6):538-545.
64. **Spaulding AC**, Sharma A*, Messina LC*, Zlotorzynska M, Miller L, Binswanger IA. A comparison of liver disease mortality with HIV and overdose mortality among Georgia Prisoners and Releasees: A 2-decade cohort study of prisoners incarcerated in 1991. *American Journal of Public Health*. May 2015. 105(5):e51-7. doi: 10.2105/AJPH.2014.302546.
65. **Spaulding AC**. Capsule Commentary on Rich et al., Higher Standards in Correctional Healthcare Could Improve Public Health. *Journal of General Internal Medicine*. 2015 Apr;30(4):494.
66. Lima VD, Graf I, Beckwith CG, Springer S, Coombs D, Altice F, Kim B*, Messina L*, Stein M*, Montaner JSG, **Spaulding A**. The Impact of Implementing a Test, Treat and Retain HIV Prevention Strategy in Atlanta among Black Men Who Have Sex with Men with a History of Incarceration: A Mathematical Model. *PLoS One*. Apr 2015. 10(4):e0123482. doi:10.1371/journal.pone.0123482
67. Nguyen JT, Rich JD, Brockmann BW, Vohr F, **Spaulding A**, Montague BT. A Budget Impact Analysis of Newly Available Hepatitis C Therapeutics and the Financial Burden on a State Correctional System. *Journal of Urban Health*. 2015 Aug;92(4):635-649.
68. **Spaulding AC**, MacGowan RJ, Copeland B, Shrestha RK, Bowden CJ, Kim MJ*, Margolis A, Mustaaafa G, Reid LC, Heilpern KL, Shah BB. Costs of Rapid HIV Testing in an Urban Emergency Department and a Nearby County Jail in the Southeastern United States. *PLoS One*. 2015 8;10(6):e0128408.
69. He T, Li K, Roberts MS, **Spaulding AC**, Ayer T, Grefenstette JJ, Chhatwal J. Prevention of Hepatitis C by Screening and Treatment in U.S. Prisons. *Annals of Internal Medicine*. 2016 Jan 19;164(2):84-92.
70. Vagemas P, Zelenev A, Altice FL, DiPaola A, Jordan AO, Teixeira PA, Frew PM, **Spaulding AC**, Springer S. HIV-Infected Men Who Have Sex with Men, Before and After Release from Jail: The Impact of Age and Race, Results from a Multi-site Study. *AIDS Care*. 2016 Jan;28(1):22-31.
71. Anderson A, Von Esenwein S, **Spaulding AC**, Druss BG. Involvement in the Criminal Justice System among Attendees of an Urban Mental Health Center. *Health and Justice*. 2015 Feb 25; 3(4), 1-5. doi: 10.1186/s40352-015-0017-3
72. Authors: International Advisory Panel of HIV Care Continuum Optimization (**Anne Spaulding**, Panelist) IAPAC Guidelines for Optimizing the HIV Care Continuum for Adults and Adolescents. *Journal of International Association of Providers of AIDS Care*. 2015 Nov-Dec;14 Suppl 1:S3-S34.
73. Zlotorzynska M,* **Spaulding AC**, Messina LC,* Coker D,* Ward K, Easley K, Baillargeon J, Mink PJ, Simard EP. A retrospective cohort study of cancer incidence and mortality by HIV status in a Georgia, USA prisoner cohort during the HAART era. *BMJ Open*. 2016 Apr; 6(4), 1-8. doi:10.1136/bmjopen-2015-009778.
74. Miller L, Rollin F, Fluker SA, Lundberg KL, Park B, Quairola K, Niyibizi NK*, **Spaulding AC**. High Yield Birth Cohort HCV Screening and Robust Linkage-to-Care in an Underserved, African American Population. *Public Health Reports*. 2016 Mar-Apr; 131(Supplement 2):84-90.

75. Schoenbachler BT, Smith BD, Sena A, Hilton A, Bachman S, Lunda M, **Spaulding AC**. Hepatitis C Virus (HCV) Testing and Linkage to Care in North Carolina and South Carolina Jails, 2012-2014. *Public Health Reports*. 2016 Mar-Apr; 131(Supplement 2):98-104.
76. **Spaulding AC**, Miller LS. Apportioning blame in the North American hepatitis C virus epidemic. In Press: *The Lancet Infectious Diseases*. 2016. doi:10.1016/S1473-3099(16)30002-0.
77. Ferguson WJ, Cloud D, **Spaulding AC**, Shelton D, Trestman RL, Altice FL, Champion-Lippmann C, Thomas D, Taxman FS. A Call to Action: A Blueprint for Academic Health Sciences in the Era of Mass Incarceration. *Journal of Health Care for the Poor and Underserved*. 2016 May; 27(2): 5-17. doi:10.1353/hpu.2016.0051.
78. Sage K, Ouellet LJ, Mazza J, **Spaulding AC**. Rasch Analysis and Differential Item Functioning of a Social Support Measure in Jail Inmates With HIV Infection. *Evaluation and the Health Professions*. *Eval Health Prof*. 2016 May 4. pii: 0163278716644954. PMID: 27150117.
79. **Spaulding AC**. The Missing Link: HIV, Corrections and Public Health. Invited editorial to *AJPH*. 107 (5): 641-642. doi: 10.2105/AJPH.2017.303754.
80. Chandler R, Gordon MS, Kruszka B, Strand LN, Altice FL, Beckwith CG, Biggs ML, Cunningham W, Chris Delaney JA, Flynn PM, Golin CE, Knight K, Kral AH, Kuo I, Lorvick J, Nance RM, Ouellet LJ, Rich JD, Sacks S, Seal D, **Spaulding A**, Springer SA, Taxman F, Wohl D, Young JD, Young R, Crane HM. Cohort profile: seek, test, treat and retain United States criminal justice cohort. Substance abuse treatment, prevention, and policy 2017;12:24. doi: 10.1186/s13011-017-0107-4.
81. Christopoulos KA, Cunningham WE, Beckwith CG, Kuo I, Golin CE, Knight K, Flynn PM, **Spaulding AC**, Coffin LS, Kruszka B. Lessons Learned From the Implementation of Seek, Test, Treat, Retain Interventions Using Mobile Phones and Text Messaging to Improve Engagement in HIV Care for Vulnerable Populations in the United States. *AIDS and Behavior* 2017;1-12. doi: 10.1007/s10461-017-1804-8.
82. **Spaulding AC**, Anderson EJ*, Khan MA*, Taborda-Vidarte CA*, Phillips JA. HIV and HCV in U.S. Prisons and Jails: The correctional facility as a bellwether over time for the community's infections. Invited article for *AIDS Reviews*. 2017: Oct-Dec;19(3):134-147. PMID: 28926560.
83. **Spaulding AC**, Eldridge G, Chico C, Morisseau N*, Drobeniuc A*, Fils-Aime R*, Day C, Hopkins R, Jin X, Dolan K. Smoking in Correctional Settings Worldwide: Prevalence, Bans, and Interventions." *Epidemiology Review*. 2018 Jun 1 ;40(1):82-95. doi: 10.1093/epirev/mxy005.
84. **Spaulding AC**, Drobeniuc A*, Frew PM, Lemon TL*, Anderson EJ*, Cerwonka C*, Bowden CJ, Freshley JR, delRio C. Jail, an unappreciated medical home: assessing the feasibility of a strengths-based case management intervention to improve the care retention of HIV-infected persons once released from jail. *PLoSOne*. 2018 Mar 30;13(3):e0191643. doi: 10.1371/journal.pone.0191643.
85. **Spaulding AC**, Chhatwal J, Adey M,* Lawrence R, von Oehsen W. Five Questions Concerning Managing Hepatitis C in the Justice System: Finding Practical Solutions for HCV Elimination. *Infectious Disease Clinics of North America*. 2018 Jun;32(2):323-345. doi: 10.1016/j.idc.2018.02.014.
86. Bedell P, **Spaulding AC**, So M, Sarrett J, The Names Have Been Changed to Protect the... Humanity: Person-First Language in Correctional Health Epidemiology. *American Journal of Epidemiology*. 2018 Apr 25. doi: 10.1093/aje/kwy073

87. Becan JE, Bartkowski JP, Knight DK, Wiley TRA, DiClemente R, Ducharme L, Aarons GA, Welsh WN, Bowser D, K, Hiller M, **Spaulding AC**, Flynn PM, Swartzendruber A, Dickson MF, Fisher JH. A Model for Rigorously Applying the Exploration, Preparation, Implementation, Sustainment (EPIS) Framework in the Design and Measurement of a Large Scale Collaborative Multi-Site Study. *Health Justice*. 2018 Apr 13;6(1):9. doi: 10.1186/s40352-018-0068-3
88. **Spaulding AC**, Chhatwal J, Adey M*, Lawrence R, von Oehsen W. Funding Hepatitis C Treatment in Correctional Facilities by Using a Nominal Pricing Mechanism. *Journal of Correctional Healthcare*. 2018 Oct 15. doi: 10.1177/1078345818805770
89. Ayer T, Zhang C, Bonifonte A, **Spaulding AC**, Chhatwal J. Prioritizing Hepatitis C Treatment in U.S. Prisons. *Operations Research*. 2016 November 14. doi: 10.2139/ssrn.2869158
90. **Spaulding AC**, Holstad MM. Lessons from HIV deaths post-release. *Lancet HIV*. 2018 Sep 6. doi: 10.1016/S2352-3018(18)30218-2
91. **Spaulding AC**, Lemon TL,* So M. Measuring Correctional Experience to Inform Development of HIV, STI and Substance Use Interventions for Incarcerated Black Men Who Have Sex with Men. *American Journal of Public Health*. 2018 Nov;108(S4):S237-S239. doi: 10.2105/AJPH.2018.304810
92. Bedell PS, So M, Morse DS, Kinner SA, Ferguson WJ, **Spaulding AC**. Corrections for Academic Medicine: The Importance of Using Person-First Language for Individuals Who Have Experienced Incarceration. *Acad Med*, 2019. 94(2), 172-175. doi:10.1097/acm.0000000000002501
93. Chhatwal J, Chen Q, Bethea ED, Hur C, **Spaulding AC**, Kanwal F. The impact of direct-acting anti-virals on the hepatitis C care cascade: identifying progress and gaps towards hepatitis C elimination in the United States. *Alimentary pharmacology & therapeutics*. 2019 Jul 1. 50(1):66-74 doi.org/10.1111/apt.15291.
94. Cunningham W, Nance R, Golin C, Flynn P, Knight K, Beckwith C, Kuo I, **Spaulding AC**, Delaney J, Crane H, Springer S. Self-reported ART Adherence and Viral Load in Criminal Justice-Involved Populations: Results of the NIDA Seek, Test, Treat and Retain Study. Accepted, *BMC Infectious Diseases*.
95. Gardner SK, Elkington KS, Knight DK, Huang S, DiClemente RJ, **Spaulding AC**, Oser CB, Robertson AA, Baird-Thomas C. Juvenile justice staff endorsement of HIV/STI prevention, testing, and treatment linkage. *Health Justice* 7(1):15 (2019) doi:10.1186/s40352-019-0096-7. PMID: 31485779.
96. **Spaulding AC**, Chen J,* Mackey CA,* Adey MG,* Bowden CJ, Selvage WD, Thornton KA. Assessment and Comparison of Hepatitis C Viremia in the Prison Systems of New Mexico and Georgia. *JAMA Network Open*. 2019 Sep 4;2(9):e1910900. doi: 10.1001/jamanetworkopen.2019.10900.
97. Dalgic OO, Samur S, **Spaulding AC**, Llerena S, Cobo C, Ayer T, Roberts MS, Crespo J, Chhatwal J. Improved Health Outcomes from Hepatitis C Treatment Scale-Up in Spain's Prisons: A Cost-Effectiveness Study. *Sci Rep*. 2019 Nov 14;9(1):16849. doi: 10.1038/s41598-019-52564-0 PMID: 31727921.
98. Akiyama MJ, **Spaulding AC**, Rich JD. Flattening the Curve for Incarcerated Populations: Covid-19 in Jails and Prisons. *New England Journal of Medicine*; 2020; 382 (22): 2075-7.

99. Ohuabunwa, T*, **Spaulding AC**. Control of epidemics in jails: Lessons from HIV to COVID-19. Invited editorial, Lancet HIV. Accepted.
100. Holloway, I.W., **Spaulding, A.**, Miyashita, A., Randall, L., King, A., and Frew, P.M. (2020), COVID-19 Vulnerability Among People Who Use Drugs: Recommendations for Global Public Health Programs and Policies. J Intern AIDS Soc. Accepted. doi:10.1002/jia2.25551
101. Hagan LM, Williams SP, Spaulding AC. et al. Mass Testing for SARS-CoV-2 in 16 Prisons and Jails — Six Jurisdictions, United States, April–May 2020. MMWR Morb Mortal Wkly Rep 2020;69:1139–1143. DOI: <http://dx.doi.org/10.15585/mmwr.mm6933a3>

Manuscripts Submitted/In Review

1. Fils-Aime R*, Lehnert JD*, Chamberlain A, Bowden CJ, Berkelman RL, **Spaulding AC**. Local Jails and Public Health Emergency Preparedness: A reproducible demonstration project to strengthen the ability of the public health infrastructure to deliver vaccines. Submitted to Public Health Report; under revision for submission elsewhere.
2. Chen J*, Mackey C*. Adey M*, Brown A, Bowden CJ, Miller L, **Spaulding AC**. The case for examining hepatitis C viremia in prison surveillance studies and treatment cost assessments: a lesson from the Deep South. Submitted to JAMA Network Open. Rejected in initial format. Will resubmit elsewhere.

Invited Book Review

1. Trost SL*, **Spaulding A**. The CDC Field Epidemiology Manual. American Journal of Epidemiology (in press.)

Letters to Journals

1. **Spaulding A**, Silverblatt FJ. Using grids to document laboratory results. Annals of Internal Medicine. 1993 Oct 15; 119(8) - 863.
2. Feller A, Dickenson B. Mitty J, **Spaulding A**, Flanigan T. Scaling prison walls, Lancet 1998 June 27; 351(9120):1968.
3. Allen SA, **Spaulding A**, Rich JD. Treatment of Chronic Hepatitis C in a State Correctional Facility. Annals of Internal Medicine, 2004; 140(2):151.
4. Allen SA, **Spaulding AC**, Taylor LE, Rich JD. Confined treatment continued. Gastroenterology. 2004; Mar; 126(3):928.
5. **Spaulding AC**, Allen SA, Stone A. Mortality after release from prison. [Research Letter] New England Journal of Medicine 2007 Apr26; 356 (17):1785.
6. **Spaulding A**, McCallum V*. Prior Reports of Medical Problems among Inmates. American Journal of Public Health. 2009; 99(11):1925.
7. Rosenberg E*, Delaney K*, Branson B, **Spaulding A**, Sullivan P, Sanchez T. Regarding, “Derivation and Validation of the Denver Human Immunodeficiency Virus (HIV) Risk Score for Targeted HIV Screening.” American Journal of Epidemiology 2012; 176(6): 567-568.

8. Poorman E*, **Spaulding A.** Response to--Cuellar AE, Cheema J. As Roughly 700,000 Prisoners Are Released Annually, About Half Will Gain Health Coverage and Care under Federal Laws. *Health Affairs* 2012: 31(5):931-938.
9. Lemon T*, **Spaulding A.**, Rich JD. Response to--State of Research Funding from the National Institutes of Health for Criminal Justice Health Research. *Annals of Internal Medicine* 2015: 162: 345-352.
10. Drobeniuc A*, **Spaulding A.** Censoring of HIV Viremia Data of Reincarcerated Individuals: A Response to Wohl et al. *JAIDS Journal of Acquired Immune Deficiency Syndromes* 2017: 76(1): e22-e23.
11. **Spaulding AC**, Kehus HE*, Sabol WJ. In Search of Denominators. *JAMA Surgery* (accepted).
12. **Spaulding A**, Graham C, Akiyama M, Chhatwal J, Nijhawan A, Ninburg M, Rich J, Strick L, Taylor L, Trooskin S, Westergaard R, Sabol W. HCV Prevalence Estimates Among Incarcerated Persons. *Hepatology: Hepatology*. 2019 Apr 2. doi: 10.1002/hep.30636.

Book Chapters

1. **Spaulding A.** Fever of undetermined origin. In: Ferri's Clinical Advisor. 2000 Edition, St. Louis: Mosby, 2000.
2. Cortez K, **Spaulding A.** Cysticercosis. In: Ferri's Clinical Advisor. 2000 Edition, St. Louis: Mosby, 2000.
3. **Spaulding AC.**, Durbin WA. Hepatitis. In: Manual of Clinical Problems in Pediatrics, 4th edition. Boston: Little Brown and Company, 1995.
4. Lloyd SL*, Messina, LC*, **Spaulding AC.** HIV Screening and Assessment in the Correctional System. In: Encyclopedia of Criminology and Criminal Justice. Springer. 2014.
5. Lloyd SL*, Messina, LC*, **Spaulding AC.** HIV Prevention in the Correctional System. In: Encyclopedia of AIDS. Springer. 2017.
6. Luffy S*, Lemon T*, **Spaulding AC.** Introduction to the Epidemiology, Detection, and Management of Infectious Diseases in Corrections: What the Corrections Manager Needs to Know about HIV, STDs, Tuberculosis, Hepatitis C, and Related Conditions. In Cohen, F ed., Correctional Health Care: Practice, Administration, and Law. In Press.

Guidance Document/White Paper

Centers for Disease Control and Prevention. HIV Testing Implementation Guidance for Correctional Settings. January 2009: 1-38. Available at:
<http://www.cdc.gov/hiv/topics/testing/resources/guidelines/correctional-settings>.

Presented Abstracts (Selected List)

1. Flanigan TP, Rich JD, Dickinson B, Vigilante K, **Spaulding A.** Incarceration as a Unique Opportunity for HIV Diagnosis, Initiation of Comprehensive Care, and Linkage to the Community. Poster 9183. 4th Conf. on Retroviruses and Opportunistic Infections. 1997.

2. Rich JD, Dickinson BP, **Spaulding A**, Lafazia L, Flanigan TP. Identification of Acute HIV Infection in the Incarcerated Setting. Poster 9580, 5th Conference on Retroviruses and Opportunistic Infections, Chicago, IL. 1998.
3. Schiffman JD, Ribaud SE, **Spaulding AC**, Iadevaia RA, Rich J, Flanigan TP. An HIV Prevention and Treatment Video Project for Incarcerated Women by Incarcerated Women. 12th World AIDS Conference, Geneva, Switzerland. 1998.
4. **Spaulding A**, Bansal T, Papagolos R. The Economics of Hepatitis C for Correctional Facilities. Oral presentation for the National Commission on Correctional Health Care. 22nd Annual Conference. Long Beach, CA. 1998.
5. **Spaulding AC**, Rich J, Mitty J, Flanigan T. Strategies for Managing Hepatitis C Virus in Prisons. 36th Annual Meeting, Infectious Diseases Society of America, Denver, CO. 1998.
6. Miles JR, Murrill CS, **Spaulding A**, Addressing the Burden of Infectious Disease Among Incarcerated Illicit Drug Users Through Model Prevention and Drug Treatment Programs. 126th Annual Meeting - American Public Health Association. Washington, D.C. 1998.
7. Rich J, Macalino GE, Salas C, Towe CW, Carpenetti NB, Dickenson BP, Foisie CK, McKenzie M, **Spaulding A**, Vlahov D. Community incidence and Prevalence of HIV and Hepatitis in Incarcerated Women in Rhode Island. Poster #478, 6th Conference on Retroviruses and Opportunistic Infections, Chicago, IL. 1999.
8. Lubelczyk RB, **Spaulding A**, Salas C, Rich J, Gershon R. Issues in Post-Exposure Prophylaxis Against Blood Borne Viruses in the Correctional Setting. Oral Presentation at the National Commission on Correctional Health Care 24th Annual Meeting. St. Louis, MO. 2000.
9. Jongco A, **Spaulding A**, Clarke JG, Jackson E, Kurpewski J, Flanigan TP. Testing Jail Entrants for Sexually Transmitted Diseases. Oral Presentation at the National Commission on Correctional Health Care 24th Annual Meeting. St. Louis, MO. 2000.
10. **Spaulding AC**, Jongco A, Clarke JG, Jackson E, Kurpewski J, Flanigan TP. High Jail Prevalence of gonorrhea (GC)/chlamydia (CT) in Low Prevalence Area. Poster Presentation at 38th Annual Meeting, Infectious Disease Society of America, New Orleans, LA. 2000.
11. Kaplan M, **Spaulding A**. "Working with Corrections." Oral Presentation at the 10th Annual Community Planning Leadership Summit for HIV Prevention, Chicago, IL. 2002.
12. Allen SA, Stone A, **Spaulding A**. Death Rate and Causes of Mortality in Rhode Island Inmates. Oral Presentation at the 26th National Commission on Correctional Health Care National Conference, Nashville, TN. 2002.
13. Stone TH, **Spaulding A**. Minimizing Risks to Prisoners as Human Subjects. Oral Presentation at 29th National Commission on Correctional Health Care National Conference, Denver, CO. 2005.
14. **Spaulding AC**, Abdulrahman S. When HCV Treatment Brings Out an Underlying Condition: Nailing the Diagnosis. Poster presentation at National Conference on Correctional Health Care. Atlanta, GA. October 2006.
15. **Spaulding AC**, Nazaire Y. An Unusual Rash in a Rash of HCV Infections: PCT in the Setting of HH and HCV. Poster presentation at National Conference on Correctional Health Care. Atlanta GA. October 2006.

16. **Spaulding AC**. Identifying LTBI and TB Disease in a Jail Population. Opening presentation on panel regarding putting CDC TB management guidelines into practice. National Conference on Correctional Health Care. Atlanta, GA. October 2006.
17. Kennedy S, **Spaulding AC**, Ramos K. Key Issues in HIV Testing in Jails: Rapid Testing, Linkage to Care and Evaluation. Oral presentation. Academic and Health Policy Conference on Correctional Health, University of Massachusetts. March 2007.
18. Lasry A, Sansom SL, Shrestha RK, Jafa-Bhushan, K, Taussig J, **Spaulding A**. Cost-effectiveness of HIV screening in prisons. Medical Decision Making, 2008. 28(1): E26-7. Poster Presentation at the 29th Annual Meeting of the Society for Medical Decision Making, Pittsburg, PA. October 2007.
19. **Spaulding AC**, Ramos K, Kennedy S, Hammett T, Norton G, Tinsley M. Evaluating best practices for identifying and linking HIV+ jail inmates to care. Oral presentation at National Conference on Correctional Health Care, Nashville, TN. October 2007.
20. Ashiru BO, Paul SM, **Spaulding AC**. HIV testing for minors without parental consent: Has new legislation in New Jersey increased the number of adolescents being tested for HIV? Poster presentation at 135th Meeting of the American Public Health Association, Washington, DC. November 2007.
21. Sumbry AR, **Spaulding AC**. Management of HIV infected pregnant women in the GA Department of Corrections (GDC). Poster presented at 2nd Annual Academic and Policy Conference on Correctional Health. Quincy, MA. March 2008.
22. **Spaulding AC**, Kent C, Kennedy S, Hammett T. Does privatization of jail health care impede the screening of detainees for STD? Oral presentation at 2008 National STD Prevention Conference, Chicago, Illinois. March 2008.
23. **Spaulding AC**, Sumbry AR, Matthews AK, Ramos KL, Wingood G. Pairing HIV+ prisoners with mentors to maintain health-promoting behavior upon release. Oral presentation at 2nd Annual Academic and Policy Conference on Correctional Health. Quincy, MA. March 27-28, 2008.
24. **Spaulding A**, Seals R, Page M, Matthews A, Rhodes W, Hammett T. HIV/AIDS Borne by US Correctional Releasees: Share of Burden Declines, Numbers Don't. Poster #1033. 16th Conference on Retroviruses and Opportunistic Infections. Montreal. February 2009.
25. **Spaulding A**, et al. Key Issues in HIV Testing In Jails. Presentation C15-3; CCT4. Presented at 2009 National HIV Prevention Conference. Atlanta, GA. August 23-26, 2009.
26. **Spaulding A**, Seals R, McCallum V. Long Term Mortality in a Cohort of Persons Imprisoned in Georgia, 1991. Presented at 137th Annual Meeting and Expo of the American Public Health Association. Philadelphia, PA. November 7-11, 2009.
27. **Spaulding A** and the Enhancing Linkages Study Group. HIV testing in jails—what is the yield? Poster presented at the 2008 National Summit on HIV Diagnosis, Prevention, and Access to Care, sponsored by the Forum for Collaborative HIV Research. Arlington, VA. November 19-21, 2009.
28. Lee AS, Berendes DM, **Spaulding AC**, Seib KG, Chung KW, Chavez RS, Whitney EAS, Meyer PL, Omer SB. Emergency preparedness practices in correctional facilities during the 2009 H1N1 influenza outbreak, National Conference on Correctional Healthcare, Las Vegas, NV. Oct 2010.

29. Berendes DM, Lee AS, **Spaulding AC**, Seib KG, Chavez RS, Whitney EAS, Meyer PL, Omer SB. H1N1 Influenza in Correctional Facilities: Public Health's Role and Room for Improvement in Prisons and Jails Nationwide (An Early Perspective), Public Health Preparedness Summit, Atlanta, GA. Feb 2011.
30. Salo A, **Spaulding A**, Beckwith C, Avery A, Shaikh I, Ball S, Williams C, Altice F. Jail Screening: Opportunity to Identify HIV⁺ Persons Early and Link Them with Care. Paper #1053. 18th Conference on Retroviruses and Opportunistic Infections. Boston, MA. February 2011.
31. Hood J, **Spaulding A**, Nelson R, Sikwa B, Mosiakgabo B, Sokwe M, Raats J, Monyatsi B. Frequency of HIV Test-seeking among Clients of a Maturing VCT Network in Botswana. Paper #1073. 18th Conference on Retroviruses and Opportunistic Infections. Boston, MA. February 2011.
32. Superak H, **Spaulding AC**, Yang Z, Resch S, Beckwith C, Jordan A, Michelman A, Shaikh I, Pinkerton S. 4th Annual Academic and Health Policy Conference on Correctional Health Care. Boston, MA, March 2011.
33. Lee A. S., Donohue M. T., Berendes D. M., Seib K. G., Whitney E. A. S., Chavez R. S., Omer S. B., Berkelman R. L., **Spaulding A. C.** The perils of overlooking jails in public health planning: emergency response to H1N1. *Georgia Public Health Association Conference, Atlanta, GA. April 12-13, 2011.*
34. Superak H, **Spaulding A**, Yang Z, Cunningham M, Pinkerton S. Cost and Cost-Effectiveness Considerations for Jail Linkage Services. Abstract 1902. CDC HIV Prevention Conference. Atlanta GA, August 2011.
35. **Spaulding A**, Bowden C, Miller L, Mbaba M, Church J. (Invited Presentation). An IIDDEALL Program for Jails: Integrating Infectious Disease Detection at Entry and Linkage to Care. CDC HIV Prevention Conference. Atlanta GA, August 2011.
36. **Spaulding A**, Cook J, Bowden C, et al. There's a Need and a Way; Where's the Will? Rapid HIV Testing for Jail Entrants. Abstract 1943. CDC HIV Prevention Conference. Atlanta GA, August 2011.
37. Malak M. Hepatitis B and C in Correctional Facilities. National Conference on Correctional Healthcare. October 2011.
38. Messina L, Ahuja D, Avery A, Stein M, Chung K-W, Lincoln T, **Spaulding A**, and EnhanceLink Study Group. Suppression of HIV Achievable with Prompt Medical Follow-up: A Longitudinal Observation Study of Outcomes 6 Months following Release from Jail. Poster Presentation. Conference on Retroviruses and Opportunistic Infections. Seattle WA, March 2012.
39. Varan A, Mercer D, Stein MS, **Spaulding A**. Surveillance of Hepatitis C Seropositivity in State Prison Systems: Prisoners with Declining Prevalence, Accounting for Declining Share of US Epidemic in 2006. 5th Annual Academic and Health Policy Conference on Correctional Healthcare, Atlanta GA, March 2012.
40. **Spaulding A**, Kim A. Treatment in Prison of Hepatitis C with Direct Acting Agents. 5th Annual Academic and Health Policy Conference on Correctional Healthcare, Atlanta GA, March 2012.
41. **Spaulding AC**, Stein MS, Messina LC, Kim BI. Reaching HIV+ Black MSM: Jail Interventions are Key. Treatment as Prevention Conference, Vancouver BC, May 2012.
42. Symposium on Enhance Link: 19th International AIDS Conference, Washington DC July 2012.

43. Lima V and the Seek Test Treat and Retain Corrections (STTaR Corr) Modeling Group. Modeling the impact of implementing a Seek, Test, Treat, and Retain (STTR) strategy to halt the HIV epidemic within the Criminal Justice System (CJS) in different regions in the US. Poster presentation, 19th International AIDS Conference, Washington DC July 2012.
44. Mboup A, Sarr M, **Spaulding AC**, Diouf O, Traore I, Dia MC, Ndiaye AG, S. Mboup S. Prospective study of the incidence of HIV among registered female sex workers in Dakar, Senegal. (1992-2010) Poster presentation, 19th International AIDS Conference, Washington DC July 2012.
45. **Spaulding A**, Reid L., Bowden C, Copeland B, MacGowan R, Margolis A, Shresta R, Mustaafta G, Heilpern K, Shah B. (2013). A Tale of One City, Two Venues: Comparing Costs of Routine Rapid HIV Testing in a High-volume Jail and a High-volume Emergency Department, Atlanta, Georgia. Abstract 1061. Paper presented at the 20th Conference on Retroviruses and Opportunistic Infections, March 3-6, Atlanta GA.
46. **Spaulding A**, Bowden C, Mustaafta G (presenter). Improving the Reach of HIV Testing in Jails. US Conference on AIDS, New Orleans LA, September 8-10, 2013.
47. **Spaulding A**, Bowden C. Jail Detainees Accessing HIV Testing: Linking New Positives to Care in Jail and in the Community. FOCUS Partners Meeting, San Francisco CA. October 29, 2013.
48. **Spaulding A**, Carpenter T. Project IMPACT: Expanding HIV Testing and Linkage at Fulton County Jail. National Conference on Correctional Healthcare. Nashville TN, October 28, 2013.
49. **Spaulding A**, Haddad M*, Foote M.* Ray S. Intersection of the epidemics of incarceration and community Tuberculosis (TB) in Atlanta, Georgia: An update. 7th Annual Academic and Health Policy Conference on Correctional Health, Houston, Texas, March 20-21, 2014.
50. Hagan L*, **Spaulding A**. Could all-oral regimens for Hepatitis C Be priced Within reach for prison healthcare? 7th Annual Academic and Health Policy Conference on Correctional Health, Houston, Texas, March 20-21, 2014.
51. **Spaulding A**, Mustaafta G, Kim M*, John K*, Bowden C. Universal offering of opt-out, rapid HIV testing in Atlanta's jails — finding a city's undiagnosed. 7th Annual Academic and Health Policy Conference on Correctional Health, Houston, Texas, March 20-21, 2014.
52. Miller L, Fuker, SA, Lundberg K, Rollin F, Park B, Quairola K, **Spaulding AC**. Successful Screening for and High Prevalence of Hepatitis C Among African American Baby Boomers in an Urban Primary Care Center. Society of General Medicine Conference. San Diego, CA April 22-25, 2014.
53. Miller L, Fuker SA, Turner B, **Spaulding AC**. Updates in Hepatitis C. Society of General Medicine Conference. San Diego, CA April 22-25, 2014.
54. Chhatwal J, He T, Roberts M, Grefenstette J, Li K, Ayer T, Spaulding A. Predicting the Benefit from Opt-out Hepatitis C Screening in United States Prisons through Mathematical Modeling. 8th Annual Academic and Health Policy Conference on Correctional Health, Boston MA, March 19-20, 2015.
55. **Spaulding A**, Staples-Horne M. JJ-TRIALS: Implementation Research in the Juvenile Justice System. 8th Annual Academic and Health Policy Conference on Correctional Health, Boston MA, March 19-20, 2015.

56. May J, Norvelus H, Duverger K, Smith L*, Varan A*, **Spaulding A**. Infectious disease screening: Using data to guide interventions in resource constrained settings. 8th Annual Academic and Health Policy Conference on Correctional Health, Boston MA, March 19-20, 2015.
57. **Spaulding A**. Exploring the Enhancement of Ethical Research Involving Persons under the Supervision of the Criminal Justice System. 9th Annual Academic & Health Policy Conference on Correctional Health: Advancing the Field of Academic Criminal Justice Health, March 16, 2017. Baltimore MD.
58. Anderson EJ*, **Spaulding AC**, Phillips J, Bowden C, Freshley. Implementing a nurse-led rapid opt-out HIV testing program in a county jail. 10th Annual Academic and Health Policy Conference on Correctional Health, March 16-17, 2017. Atlanta GA
59. Drobeniuc A*, **Spaulding A**. SUCCESS: Illustrating Trends of Improved Retention in HIV Care after Jail Release. 10th Annual Academic and Health Policy Conference on Correctional Health, March 16-17, 2017. Atlanta GA
60. Fils-Aime R*, **Spaulding A**, Chamberlain A, Bowden C, Lehnert JD*. Improving Jail and Health Department Preparedness Efforts by Demonstrating the Feasibility of Maternal Tdap Vaccine Education and Distribution. 10th Annual Academic and Health Policy Conference on Correctional Health, March 16-17, 2017. Atlanta GA
61. **Spaulding AC**. Exploring the Enhancement of Ethical Research Involving Persons under the Supervision of the Criminal Justice System. 10th Annual Academic and Health Policy Conference on Correctional Health, March 16-17, 2017. Atlanta GA
62. Elkington K, **Spaulding A**. Establishing feasibility of the JJ-health partnership approach to increasing HIV- testing of youth on probation. 10th Annual Academic and Health Policy Conference on Correctional Health, March 16-17, 2017. Atlanta GA
63. Lemon TL*, So M, **Spaulding A**. Lifetime Prevalence of Incarceration among U.S. Men by Race and Educational Level: Implications for Health? Society for Epidemiology Research 50, June 2017, Seattle WA.
64. Taborda Vidarte C, Anderson E, Khan M, Phillips J, **Spaulding A**. Where is the US Hepatitis C Epidemic *Now*? Putting the "Pen" on the Map as Elimination Efforts Hunt for Remaining Cases. Infectious Disease Week 2017, October 4-8, 2017. San Diego CA
65. Sales J, **Spaulding A**, Elkington K, Wiley T, Becan J, Belenko S, DiClemente R, Knoght D, Oser C, Robertson A, Staples-Horne M. Leveraging partnerships between health agencies and the juvenile justice system to increase HIV testing of youth on probation: An uphill road to address rising HIV diagnoses in youth. American Public Health Association Annual Meeting and Expo, November 4-8, 2017. Atlanta GA
66. J. Chhatwal, K. Li, T. He, M.S. Roberts, T. Ayer, S.S. Samur, J.J. Grefenstette, **A.C. Spaulding**. Hepatitis C Treatment as Prevention: Focusing on United States Prisons. EASL The Liver Congress. April 13-17, 2016. Barcelona Spain.
67. T. Ayer, C. Zhang, A. Bonifonte, **A.C. Spaulding**, J. Chhatwal. Prioritizing Hepatitis C Treatment in United States Prisons. 9th Academic & Health Policy Conference on Correctional Health. March 17-18 2016. Baltimore MD.

68. J. Chhatwal, K. Li, T. He. M.S. Roberts, T. Ayer, S. Samur, J. Grefenstette, **A.C. Spaulding**. Hepatitis C Treatment in United States Prisons Prevents Transmission and is Cost-Saving for the Society. AASLD The Liver Meeting. November 11-15, 2016. Boston MA.
69. **A. Spaulding**, K. Elkington. Establishing feasibility of the JJ-health partnership approach to increasing HIV- testing of youth on probation. 10th Academic & Health Policy Conference on Correctional Health. March 16-17, 2017. Atlanta GA.
70. *Vidarte CAT, *Anderson EJ, *Khan MA, Phillips JA, **Spaulding AC**. Where is the Us Hepatitis C Epidemic* now*? Putting the “pen” on the Map as Elimination Efforts Hunt for Remaining Cases. Infectious Disease Society of America Annual Conference, October 4-8, 2017, San Diego,CA
Abstract available:Open forum infectious diseases; 2017: Oxford University Press US. p. S195-S.
71. J. Chhatwal, Q. Chen, T. Ayer, X. Wang, M.S. Roberts, F. Kanwal, **A.C. Spaulding**. Updated Prevalence of Hepatitis C in the United States: Results from a Simulation Model Including the non-NHANES population. AASLD The Liver Meeting. October 20-24, 2017. Washington DC.
72. **A. Spaulding**, Richard Dembo, Ralph DiClemente, Carl Leukefeld, Julie Krupa, Eve Rose. Juvenile Justice Agency Involvement in Substance Abuse Treatment: Lessons Learned from JJ-TRIALS. 11th Academic and Health Policy Conference on Correctional Healthcare, March 22-23, 2018. Houston TX.
73. **A. Spaulding**, M. Adee, J. Chhatwal, R .Lawrence, W. von Oehsen. . Eliminating HCV transmission may require structural change in how prisons purchase medications. 11th Academic and Health Policy Conference on Correctional Healthcare. March 22-23, 2018. Houston TX.
74. P. Bedell, M. So, **A. Spaulding**, D. Morse, S. Kinner, W. Ferguson. Person-First Language for a New Era of Correctional Health Research: Words Matter When Promoting Health for All. 11th Academic and Health Policy Conference on Correctional Healthcare. March 22-23, 2018. Houston TX.
75. **A. Spaulding**, S. Thanthong-Knight, M. Adee, M.A. Ladd, T. Zhan, N. Nasir-Deen, J. Chhatwal. HepCorrections: An Upcoming Web-based Visualization of Hepatitis C in the Criminal Justice Population. 2018 National Conference on Correctional Healthcare. October 20-24, 2018. Las Vegas, NV.
76. **Spaulding A**, Chhatwal J., Adee M, Simon MJ, von Oehsen W. Eliminating syphilis may require structural change in how jails purchase penicillin. 12th Academic and Health Policy Conference on Correctional Healthcare, March 21-22, 2019. Las Vegas, NV.
77. **Spaulding AC**, Adee MG*, Bowden CJ, Qi M*, MacGowan R, Margolis A, Hutchinson AB. Routine Rapid HIV Screening of Jail Entrants in Fulton Co. (GA, US) is Cost Saving. International Association of Providers of AIDS Care. June 2019. Miami FL.
78. Hutchinson AB, MacGowan R, Margolis A, Adee MG*, Bowden CJ, **Spaulding AC**. June 2019. Costs and Consequences of Eliminating a Routine HIV Screening Program in a High Prevalence Jail. PS 1-31, 41st Annual Meeting of the Society for Medical Decision Making, Portland OR, October 20-23, 2019.

Invited Talks at National and International Professional Meetings (selected list)

November 1998

Panel participant (Lou Tripolli MD, moderator). Hepatitis C and Corrections. Panel discussion at the National Commission on Correctional Health Care. 22nd Annual Conference. Long Beach, CA

January 1999

PA AIDS Education and Training Center. Philadelphia, PA
Presentation with Douglas Dieterich MD. HIV and Hepatitis C

June 1999

National Meeting: Association of Physician Assistants. Atlanta, GA
Topic: Infectious Diseases in Corrections

June 1999

National Commission on Correctional Health Care
Special Session on Mental Health and Hepatitis C. Chicago, IL
Luncheon Speaker. Mental Health Issues with HCV Treatment

October 1999

Current Strategies for the Management of HIV in Corrections
Conference sponsored by Brown University and Yale University
AIDS Programs. Workshop topic: Hepatitis C and HIV

January 2000

American Correctional Association/ American Correctional Health
Service Association National Winter Conference. Phoenix, AZ.
Topic: HIV and HCV Co-infection in Corrections

March 2000

National Institute of Drug Abuse/ National Development and Research
Institutes. Bethesda, MD. Conference on Drug Abuse Treatment in the Correctional
System. Integrating Infectious Disease Services Drug Treatment in Corrections

May 2002

Federal Bureau of Prisons Infection Control Conference, Atlanta, GA.
Topic: "Smallpox in Correctional Facilities"

August 2002

"'Correctionalizing' the NIH Hepatitis C Consensus Conference Statement",
Correctional Medical Institute Annual Conference, Baltimore, MD

September 2002

Invited Presentation at the Serious and Violent Offenders Re-Entry
Conference, Department of Justice, Washington, DC. Topic: "Public Health is Public
Safety"

September 2003

Keynote Speaker: Montana Public Health Association
Kalispell, MT. Topic: "Correctional Hepatitis Management and Public Health"

February 2005

American Association of State and Territorial Health Officers
Washington, DC. Topic "Infectious Disease Prevention in Prison Populations"

October 2005

Luncheon Speaker: Society of Correctional Physicians Annual Meeting
Denver, CO. Topic: Is HBV Management in Prisons and Jails Necessary?

November 2005

New York State Department of Health. Addressing Hepatitis C in Prisons and Jails.
November 1: Buffalo, NY. November 15: NYC, New York Academy of Medicine.

February 2006

HIV in Incarcerated Women Georgia Chapter, American Correctional Health
Services Association. Cordele, GA

February 2007

HRSA's Initiative on Enhancing Linkages to HIV Primary Care in Jail Settings. National
Sheriff Association winter conference. Washington, DC

June 2007

Challenges Conducting Research to Benefit Those Moving Through Correctional
Facilities. Crossroads II conference. Institute for Community Research. Hartford, CT

September 2007

Unique challenges of pandemic influenza for prisons. Oral presentation at Planning for
Pandemic Influenza in Prison Settings conference, sponsored by RSPH, GA Division of
Public Health, Medical College of GA, and GA Department of Corrections. Macon, GA

January 2009

Invited speaker for the 2009 Women's Health Summit, Fulton County
Human Services. Atlanta, GA

July 2009

Joint CDC-HRSA HIV Planning Committee Talk, Atlanta, GA

September 2010

Hepatitis C in Correctional Populations. Hepatitis Foundation Int'l
Conference, Morehouse School of Medicine, Atlanta, GA

May 2011

HIV in Correctional Settings. Treatment as Prevention. NIH/UBC
Sponsored Workshop. Vancouver, BC, Canada

June 2011

Epidemiology of HIV in the United States' Criminal Justice
System. 12th Annual Symposium on HIV. Albany Medical College, Albany, NY

July 2011

Hepatitis C in Correctional Populations. Hepatitis Foundation Int'l Conference, Chicago,
IL

April 2013

EnhanceLink: A Legacy of Lessons Learned. NIH/UBC Sponsored Workshop
Vancouver, BC, Canada

May 2014

HCV testing and treatment in U.S. correctional facilities. Invited Talk at symposium, “Treating and Defeating Hepatitis C in Rhode Island”. Brown University. Providence RI

June 2014

Innovations in Teaching Correctional Health. Invited presentation at “A Public Health Approach to Incarceration” Conference at Columbia University

July 2014

Developing a feasible strategy for prisons to test and cure hepatitis C. Invited Lecture, National Commission on Correctional Healthcare Medical Director Boot Camp. Denver CO

October 2015

How to write a peer-reviewed journal article. Invited Lecture, National Conference on Correctional Healthcare, Dallas Texas

September 2016

Spaulding A. Routine, Rapid HIV Testing in Jails. Keynote Talk at California Office of AIDS Yearly Meeting. San Diego CA.

September 2016

Spaulding A. Viral Hepatitis and HIV in the Prison System. HIV and Hepatitis Conference. Jackson Hole WY.

October 2016

Spaulding A. Showing Jail Counts: Impacting the HIV Epidemic in Your Community and Communicating to Public Health Partners that Your Program Matters. National Conference on Correctional Healthcare.

December 2016

Spaulding A. Linkages to the Continuum of Care among Women in the Criminal Justice System. Women and HIV. Inter-CFAR Joint Symposium on HIV Research in Women. Birmingham, Alabama.

April 2017

Spaulding A. HCV Elimination for Jails and Prisons. A Problem of Execution. CDC Conference on HCV Elimination, Atlanta GA.

November 2017

Spaulding A. Managing HIV: Clinical and Ethical Perspectives. National Conference on Correctional Health Care, Chicago, IL.

November 2017

Spaulding A. Planning for Inevitable Infectious Disease Outbreaks. National Conference on Correctional Health Care, Chicago, IL.

March 2018

Spaulding A. von Oehsen W. Counting the Costs: Do we have a comprehensive strategy to fund hepatitis C treatment? National Hepatitis in Corrections Network Conference, Houston TX.

March 2018

Spaulding A. HCV Testing and Treatment in the Corrections Context. HHS Hepatitis C Medicaid Affinity Group Webinar.

October 2018

Spaulding AC. HIV 2018: Envisioning Improved Transitions to Community Treatment. Lunchtime Plenary Talk, National Conference on Correctional Healthcare (Conference of ~1,000). Las Vegas NV.

November 2018

Spaulding, A. HCV in the Criminal Justice System. American Association for the Study of Liver Diseases (AASLD) SIG Program: Navigating the Road to Elimination of HCV in the U.S., San Francisco, CA.

March 2019

Spaulding A. Hepatitis C in Corrections: Challenging the Status Quo. Plenary Address for the Academic and Health Policy Conference on Correctional Healthcare, Las Vegas NV.

April 2019

Spaulding AC. Breaking down Barriers to Effective HIV Treatment in Corrections as a Component of Ending the HIV Epidemic: A Plan for America. Lunchtime Plenary Talk, Spring Clinical Conference, National Commission on Correctional Healthcare. Nashville TN.

October 2019

Spaulding AC. National Conference on Correctional HealthCare. Lunchtime Plenary Talk, HIV Update. Ft. Lauderdale FL

May 2020

Spaulding AC. Correctional Management of HIV and HCV in the COVID-19 Era. Pre-Conference Lecture. Virtual Spring Clinical Conference National Commission on Correctional Healthcare

Invitations to Speak on Hepatitis C to State Correctional Systems:

- 1999 Connecticut Department of Corrections
- 1999 Massachusetts Department of Health/ Massachusetts DOC in attendance
- 1999 Virginia Department of Corrections
- 1999 Ohio Department of Corrections and Rehabilitative Services
(National Institute of Justice Technical Assistance Grant)
- 2000 New Hampshire Department of Corrections
- 2002 Georgia Department of Corrections

Grand Rounds, Academic Presentations, Etc.

1997

Grand Rounds, Department of Emergency Medicine, Brown University. "Every Hernia an Incarcerated Hernia: Corrections and Emergency Medicine." Providence, RI

December 1997

Grand Rounds, Department of Medicine, Brown University: "Current concepts in Correctional Medicine—update on STDs." Providence, RI

December 2005

Morehouse School of Medicine. Public Health Leadership Seminars. "Health Care Delivery to Prisoners in the Georgia Department of Corrections System." Atlanta, GA

December 2005

ID Rounds: "Should We Manage Hepatitis C in Prisons?" Emory University School of Medicine. Atlanta, GA

January 2009

Whole School Talk--RSPH. HIV among Correctional Populations. Atlanta, GA

April 2009

"Hepatitis C Management in the Georgia Community," Emory Division of Infectious Disease Research Rounds

September 2010

"HIV in Jail Populations." Infectious Disease Rounds, University of North Carolina, Chapel Hill

January 2012

"Jails as a Reservoir of HIV: Implications for control of community viral load." Emory Division of Infectious Disease Research Rounds

April 2015

"Screening for Tuberculosis in Haitian Prisons: Transitioning to Use Data to Guide Interventions in Resource-constrained Settings--Health through Walls." Emory Division of Infectious Disease Research Rounds.

February 2019

"Public Health Should Go to Jail." Sponsored by Health Law Society and Criminal Law Society, Public Health Student Association. UNLV, Las Vegas Nevada.

August 2019

Hepatitis C: Corrections for Corrections. Talk to Division of Viral Hepatitis, Centers for Disease Control, Atlanta GA.

October 2019

Management of Infectious Diseases in Jails. Emory Division of Infectious Disease Research Rounds

Exhibit B

Housing for Patients Currently in Quarantine

Measure Date: 12/2/2020

Institution	Total Patients in Quarantine	Housed Alone	% of Total	Housed With One Other Person	% of Total	Housed With 2 - 5 People	% of Total	Housed With 6 - 10 People	% of Total	Housed With 11 - 49 People	% of Total	Housed With 50+ People	% of Total
SW	14362	4728	33%	6248	44%	850	6%	922	6%	641	4%	973	7%
ASP	352	26	7%	0	0%	81	23%	34	10%	0	0%	211	60%
CAC	434	66	15%	368	85%	0	0%	0	0%	0	0%	0	0%
CAL	974	170	17%	804	83%	0	0%	0	0%	0	0%	0	0%
CCC	225	22	10%	39	17%	20	9%	76	34%	68	30%	0	0%
CCI	50	31	62%	2	4%	0	0%	5	10%	12	24%	0	0%
CCWF	207	131	63%	70	34%	6	3%	0	0%	0	0%	0	0%
CEN	1287	210	16%	1077	84%	0	0%	0	0%	0	0%	0	0%
CHCF	955	561	59%	11	1%	247	26%	10	1%	126	13%	0	0%
CJM	923	195	21%	60	7%	0	0%	0	0%	41	4%	627	68%
CIW	326	148	45%	178	55%	0	0%	0	0%	0	0%	0	0%
CMC	120	70	58%	0	0%	0	0%	0	0%	46	38%	4	3%
CMF	416	207	50%	112	27%	30	7%	10	2%	20	5%	37	9%
COR	581	261	45%	320	55%	0	0%	0	0%	0	0%	0	0%
CRC	112	2	2%	0	0%	3	3%	0	0%	99	88%	8	7%
CTF	186	53	28%	79	42%	3	2%	0	0%	2	1%	49	26%
CVSP	534	31	6%	6	1%	74	14%	423	79%	0	0%	0	0%
DVI	328	96	29%	232	71%	0	0%	0	0%	0	0%	0	0%
FSP	103	20	19%	10	10%	0	0%	0	0%	73	71%	0	0%
HDSP	402	67	17%	335	83%	0	0%	0	0%	0	0%	0	0%
ISP	36	34	94%	2	6%	0	0%	0	0%	0	0%	0	0%
KVSP	109	56	51%	53	49%	0	0%	0	0%	0	0%	0	0%
LAC	288	114	40%	174	60%	0	0%	0	0%	0	0%	0	0%
MCSP	1425	308	22%	980	69%	136	10%	0	0%	0	0%	1	0%
NKSP	377	111	29%	264	70%	0	0%	0	0%	1	0%	1	0%
PBSP	759	553	73%	206	27%	0	0%	0	0%	0	0%	0	0%
PVSP	175	60	34%	71	41%	0	0%	7	4%	37	21%	0	0%
RID	94	82	87%	7	7%	5	5%	0	0%	0	0%	0	0%
SAC	320	204	64%	115	36%	1	0%	0	0%	0	0%	0	0%
SATF	376	104	28%	64	17%	87	23%	120	32%	1	0%	0	0%
SCC	217	50	23%	43	20%	0	0%	10	5%	114	53%	0	0%
SOL	104	96	92%	3	3%	2	2%	0	0%	0	0%	3	3%
SQ	132	107	81%	15	11%	6	5%	1	1%	0	0%	3	2%
SVSP	352	267	76%	85	24%	0	0%	0	0%	0	0%	0	0%
VSP	500	65	13%	37	7%	149	30%	226	45%	0	0%	23	5%
WSP	583	150	26%	426	73%	0	0%	0	0%	1	0%	6	1%

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

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

**UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
OAKLAND DIVISION**

MARCIANO PLATA, et al.,

Plaintiffs,

v.

GAVIN NEWSOM, et al.,

Defendants.

CASE NO. 01-1351 JST

**DECLARATION OF RYAN GILLE IN
SUPPORT OF DEFENDANTS'
OPPOSITION TO PLAINTIFFS'
MOTION RE: QUARANTINE AND
ISOLATION SPACE**

Judge: Hon. Jon S. Tigar

I, Ryan Gille, declare:

1. I am the lead Deputy Attorney General and an attorney of record for Defendants.
2. On December 2, 2020, counsel for Defendants, Damon McClain, emailed Plaintiffs' counsel to advise them that CDCR had been working on assessing additional available space at each institution, beyond the space that was initially set aside. Mr. McClain advised that the "initial data [] indicates there are substantial additional cells at a number of prisons, and an even greater number of additional dorm/gym beds available at many prisons." Mr. McClain advised that Defendants were putting the information together in a producible format to share with Plaintiffs. A true and correct copy of Mr. McClain's December 2, 2020 email, of which I

1 was a recipient, is attached as **Exhibit A**.

2 3. Consistent with Mr. McClain's December 2, 2020 email, on December 4, 2020,
3 Defendants produced to Plaintiffs a chart setting forth the spaces that have been reserved under
4 the Court's July 2020 order for quarantine and isolation and further describes substantial
5 additional space at many prisons that is currently available and could potentially be used for
6 quarantine or isolation if needed. The parties have not yet discussed this information, including
7 the extent to which this additional space impacts Plaintiffs' motion. A true and correct copy of
8 Mr. McClain's December 4, 2020 cover email is attached as **Exhibit B**.

9 4. Also on December 4, 2020, the Receiver issued new recommendations concerning
10 housing options for patients under quarantine. Defendants are in the process of evaluating this
11 new recommendation and have not yet had the opportunity to discuss it either with the Receiver
12 or Plaintiffs' counsel, or determine the extent to which this guidance will impact Plaintiffs'
13 instant motion, or Defendants' current practices.

14 5. After the close of business on December 7, 2020, and after Defendants had
15 provided Plaintiffs with their draft opposition and supporting declarations earlier that day,
16 Plaintiffs informed Defendants that they were modifying their position, and now believe double
17 celling for purposes of quarantine is reasonable.

18 6. Defendants then had to wait until 4:30 p.m. on December 8 to receive Plaintiffs'
19 revised briefing, which included eight additional pages of argument from the version initially sent
20 on December 3.

21 7. On May 7, 2020, Dr. Luring testified in the United States District Court for the
22 Eastern District of Michigan, Southern Division, in a matter entitled *Jamaal Cameron, et al. v.*
23 *Michael Bouchard, et al.*, Case No. 20-10949. In the course of that testimony, Dr. Luring was
24 asked:

25 Q. Thank you. Dr. Luring, do you specialize in healthcare in jails
or prisons?

26 A. No, I do not.

27 (Tr. at 78:18-20.) Later in his testimony, Dr. Luring was asked:

28 Q. How many jails have you – jails/prisons have you ever been in

1 in your lifetime, sir?

2 A. I have not been in a jail or a prison.”

3 (Tr. at 83:8-10.) A true and correct copy of the relevant portions of this transcript is attached as

4 **Exhibit C.**

5 I declare under penalty of perjury that I have read this document, and its contents are
6 true and correct to the best of my knowledge. Executed on December 9, 2020, in San Francisco,
7 California.

8
9 /s/ Ryan Gille

10 Ryan Gille

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Exhibit A

Ryan Gille

From: Damon McClain
Sent: Wednesday, December 2, 2020 9:46 PM
To: Sara Norman; Foss, Tammy@CDCR; Gipson, Connie@CDCR
Cc: Martin Dodd; Paul B. Mello; Samantha Wolff; Ryan Gille; Iram Hasan; Stafford, Carrie@CDCR; Scofield, Bryant; Kelso, Clark@CDCR; Barrow, Roscoe@CDCR; Kirkland, Richard@CDCR; Toche, Diana@CDCR; Neill, Jennifer@CDCR; Alison Hardy; Don Specter; Rana Anabtawi; Sophie Hart; Steven Fama
Subject: RE: CDCR's quarantine and isolate set-aside space

Hi Sara,

Further to your below request, CDCR has been working on assessing additional available space at each of the prisons beyond the spaces identified in the chart we discussed below. I have received some initial data that indicates there are substantial additional cells at a number of prisons, and an even greater number of additional dorm/gym beds available at many prisons. I am working to confirm specific numbers and to clarify much of the data that was provided, and we will be putting all of the information into a producible format so that we can share it with Plaintiffs. In the meantime, it seems premature to brief issues related to the adequacy of isolation and quarantine space without having had a chance to digest and discuss this additional space available throughout the system, and I again suggest that we might be able to resolve some issues—and might be better able to present any issues that can't be resolved to Judge Tigar—if Plaintiffs would opt for later filing and hearing dates. I hope to be able to provide you with this additional data by Friday.

-Damon

From: Sara Norman <snorman@prisonlaw.com>
Sent: Thursday, November 19, 2020 5:28 PM
To: Damon McClain <Damon.McClain@doj.ca.gov>; Cullen, Vincent@CDCR <Vincent.Cullen@cdcr.ca.gov>; Gipson, Connie@CDCR <Connie.Gipson@cdcr.ca.gov>
Cc: Martin Dodd <MDodd@fddcm.com>; Paul B. Mello <Pmello@hansonbridgett.com>; Samantha Wolff <SWolff@hansonbridgett.com>; Ryan Gille <Ryan.Gille@doj.ca.gov>; Iram Hasan <Iram.Hasan@doj.ca.gov>; John Walters <John.Walters@doj.ca.gov>; Stafford, Carrie@CDCR <Carrie.Stafford@cdcr.ca.gov>; Scofield, Bryant <Bryant.Scofield@cdcr.ca.gov>; Prather, Alyssa@CDCR <Alyssa.Prather@cdcr.ca.gov>; Kelso, Clark@CDCR <Clark.Kelso@cdcr.ca.gov>; Barrow, Roscoe@CDCR <Roscoe.Barrow@cdcr.ca.gov>; Kirkland, Richard@CDCR <Richard.Kirkland@cdcr.ca.gov>; Toche, Diana@CDCR <Diana.Toche@cdcr.ca.gov>; Neill, Jennifer@CDCR <Jennifer.Neill@cdcr.ca.gov>; Alison Hardy <ahardy@prisonlaw.com>; Don Specter <dspecter@prisonlaw.com>; Rana Anabtawi <rana@prisonlaw.com>; Sophie Hart <sophieh@prisonlaw.com>; Steven Fama <sfama@prisonlaw.com>
Subject: CDCR's quarantine and isolate set-aside space

Hi Damon,

Thanks for the clarification. I think I understand this chart much better now. But I'm not sure it gets us what we need to know.

Let me be more specific about what we're looking for. On page 4 of the July 22 order, the Court says the following:

The Receiver will continually monitor whether isolation and quarantine space reserves are appropriate in light of changing circumstances. He will advise the parties if he believes reserve levels should be

modified at a particular institution. The parties may also request that the Receiver consider whether reserve levels at a particular institution should be modified.

In order to serve our clients, we need to know what the reserves are, so we can determine whether we think “isolation and quarantine space reserves are appropriate in light of changing circumstances” and whether “reserve levels at a particular institution should be modified.” If CDCR’s position is that its isolation and quarantine set-aside space consists solely of what is contained in the October 15 chart you sent, that’s fine – just let us know. If there is additional space for us to consider as we evaluate the adequacy of the space to meet the needs of the population, please let us know that as well.

Thank you. Please feel free to give me a call if you think it would be helpful to clarify any of this verbally.

--Sara

Exhibit B

Ryan Gille

From: Damon McClain
Sent: Friday, December 4, 2020 2:48 PM
To: Sara Norman; Foss, Tammy@CDCR; Gipson, Connie@CDCR
Cc: Martin Dodd; Paul B. Mello; Samantha Wolff; Ryan Gille; Iram Hasan; Stafford, Carrie@CDCR; Scofield, Bryant; Kelso, Clark@CDCR; Barrow, Roscoe@CDCR; Kirkland, Richard@CDCR; Toche, Diana@CDCR; Neill, Jennifer@CDCR; Alison Hardy; Don Specter; Rana Anabtawi; Sophie Hart; Steven Fama
Subject: RE: CDCR's quarantine and isolate set-aside space
Attachments: Isolation-Quarantine Space - 12-4-20.pdf

Hi Sara,

Here is the additional information I said would be coming your way. The second and third column on this chart reflect the reserved isolation and quarantine space, and the fourth and fifth columns show additional space that is currently available at each of the prisons.

From: Sara Norman <snorman@prisonlaw.com>
Sent: Thursday, December 3, 2020 10:15 AM
To: Damon McClain <Damon.McClain@doj.ca.gov>; Foss, Tammy@CDCR <Tammy.Foss@cdcr.ca.gov>; Gipson, Connie@CDCR <Connie.Gipson@cdcr.ca.gov>
Cc: Martin Dodd <MDodd@fddcm.com>; Paul B. Mello <Pmello@hansonbridgett.com>; Samantha Wolff <SWolff@hansonbridgett.com>; Ryan Gille <Ryan.Gille@doj.ca.gov>; Iram Hasan <Iram.Hasan@doj.ca.gov>; Stafford, Carrie@CDCR <Carrie.Stafford@cdcr.ca.gov>; Scofield, Bryant <Bryant.Scofield@cdcr.ca.gov>; Kelso, Clark@CDCR <Clark.Kelso@cdcr.ca.gov>; Barrow, Roscoe@CDCR <Roscoe.Barrow@cdcr.ca.gov>; Kirkland, Richard@CDCR <Richard.Kirkland@cdcr.ca.gov>; Toche, Diana@CDCR <Diana.Toche@cdcr.ca.gov>; Neill, Jennifer@CDCR <Jennifer.Neill@cdcr.ca.gov>; Alison Hardy <ahardy@prisonlaw.com>; Don Specter <dspecter@prisonlaw.com>; Rana Anabtawi <rana@prisonlaw.com>; Sophie Hart <sophieh@prisonlaw.com>; Steven Fama <sfama@prisonlaw.com>
Subject: RE: CDCR's quarantine and isolate set-aside space

Hi Damon,

That's great news. We are very glad to hear it and welcome the opportunity to review any information you send to us to potentially narrow areas of dispute between the parties. We don't agree to delay the filing and hearing dates but are happy to continue to meet and confer in an attempt to reach agreement. To that end, attached please find our draft brief section. Please confirm that you will get us your section by Sunday.

—Sara

Exhibit C

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

JAMAAL CAMERON, RICHARD BRIGGS, RAJ LEE,
MICHAEL CAMERON, MATTHEW SAUNDERS,
Individually and on behalf of all others
Similarly situated,

Plaintiffs,

V.

CIVIL ACTION
NO. 20-10949

MICHAEL BOUCHARD, in his official
Capacity as Sheriff of Oakland County,
CURTIS D. CHILDS, in his official
Capacity as Commander of Corrective
Services, OAKLAND COUNTY, MICHIGAN,

Defendants.

PRELIMINARY INJUNCTION HEARING-VOLUME 1
BEFORE THE HONORABLE LINDA V. PARKER
United States District Judge
Detroit, Michigan
(All Parties Appearing via Videoconference)
May 4, 2020

APPEARANCES:

PHILIP EDWIN MAYOR, DANIEL S. KOROBKIN
American Civil Liberties Union Fund of Michigan
2966 Woodward Avenue
Detroit, MI 48201
313-578-6824
Email: pmayor@aclumich.org, dkorobkin@aclumich.org.

- - -

To Obtain Certified Transcript:

Andrea E. Wabeke

Certified Realtime Reporter • Federal Official Court Reporter

Email: federalcourttranscripts@gmail.com

APPEARANCES CONT'D:

ALEXANDRIA TWINEM
Civil Rights Corps
1601 Connecticut Avenue NW
Suite 800
Washington, DC 20009
202-894-6126
Email: alexandria@civilrightscorps.org

KRITHIKA SANTHANAM, THOMAS BRADFORD HARVEY
Advancement Project
1220 L St NW
Suite 850
Washington, DC 20005
202-921-7327
Email: ksanthanam@advancementproject.org,
tharvey@advancementproject.org

CARY S. McGEHEE, KEVIN M. CARLSON
Pitt, McGehee
117 W. Fourth Street
Suite 200
Royal Oak, MI 48067-3804
248-398-9800
Email: cmcgehee@pittlawpc.com, kcarlson@pittlawpc.com

On behalf of Plaintiffs.

STEVEN M. POTTER, THOMAS M. DeAGOSTINO, ROBERT C. CLARK
Potter, DeAgostino, O'Dea & Patterson
2701 Cambridge Court
Suite 223
Auburn Hills, MI 48326
248-377-1700
Email: spotter@potterlaw.com, tmdeag@aol.com,
rclark@potterlaw.com.

PETER L. MENNA
Oakland County Corporation Counsel
1200 N. Telegraph Road
Pontiac, MI 48341
248-975-9616
Email: mennap@oakgov.com

On behalf of Defendants.

I N D E X

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E X H I B I T S

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1 reason to exclude people with hepatitis C from the list of
2 medically vulnerable people who have liver disease?

3 A. Not in my opinion.

4 Q. Thank you. What is the risk to people who are medically
5 vulnerable for contracting the coronavirus?

6 A. If they are infected, they're at significantly higher
7 risk, probably double or triple the risk of having a severe
8 outcome from their infection.

9 Q. And when you say it's double or triple the risk, who are
10 you comparing that against?

11 A. Against the general population.

12 Q. So it's your opinion that if a person is medically
13 vulnerable they are two or three times as likely to suffer
14 serious consequences of contracting the disease?

15 A. Yeah, and by serious consequences, that would be
16 hospitalization, potentially winding up in an ICU, or even
17 death.

18 Q. Thank you. Dr. Lauring, do you specialize in healthcare
19 in jails or prisons?

20 A. No, I do not.

21 Q. In your declaration, you make several claims about why
22 it's harder to prevent, control, and manage outbreaks in jails
23 or prisons. What is the basis for that opinion?

24 A. It's my basis from understanding how infectious diseases
25 spread, particularly in congregate settings. My experience

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1 draws from understanding how to control diseases in hospitals,
2 nursing homes, and situations like that.

3 Q. And based on your experience, is it your expert opinion
4 that jails and prisons have a higher rate -- a higher risk of
5 the spread of Covid-19?

6 A. Yes, I do. Anytime you have a large number of people in a
7 closed setting, with a respiratory virus like this, there is a
8 higher risk of spread.

9 Q. And what are some of the factors that contribute to that
10 risk?

11 A. That you have a high density of people. It's hard to
12 maintain social distancing and that it's hard to keep people
13 six feet apart. It's hard to ensure meticulous hygiene and
14 cleaning the environment. And then in jails, there's people,
15 you know, being taken into the jail, leaving the jail, staff
16 coming in on shifts into the jail from the community.

17 Q. In your opinion, what is the most effective strategy to
18 prevent the spread of Covid-19?

19 A. Social distancing is the single most important prevention
20 strategy for preventing Covid-19.

21 Q. And what are some other things that can be done in
22 addition to social distancing?

23 A. Sure. Beyond social distancing, which, again, is the
24 cornerstone, it's important to identify individuals who are
25 infected and, again, some of them may be asymptomatic, ensure

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1 proper hand washing and hygiene, disinfection of surfaces, use
2 of appropriate personal protective equipment among staff, and
3 then, in some cases, masking.

4 Q. Thank you, Dr. Luring. Would you advise as a medical
5 matter the transfer of people who are negative for Covid-19
6 into an area where people are positive for Covid-19?

7 A. I would not.

8 Q. Why not?

9 A. Because it runs the risk of those individuals becoming
10 positive for Covid-19, and there's also increased risk then for
11 the staff who are going in and out of places where they're --
12 where they're dealing with people that are Covid-19 positive
13 and they could potentially become infected themselves or
14 transmit the infection to other people who don't already have
15 Covid-19.

16 Q. Thank you. Have you reviewed the sworn declarations of
17 the named Plaintiffs in this case?

18 A. Yes, I have.

19 Q. Based on what you read in those declarations, is it your
20 opinion that the Oakland County jail has done a sufficient job
21 of preventing the spread of Covid-19?

22 A. No, they have not.

23 Q. Why do you say that?

24 A. It appears that it's been -- they have been unable to
25 maintain social distancing among the detainees in the jail, and

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1 based on the declaration, it also appears that there's been
2 insufficient attention to testing, hygiene, and cleaning the
3 environment.

4 Q. Did you base your opinion solely on the declarations of
5 the named Plaintiffs?

6 A. No. I based it on the declarations, as well as my
7 experience seeing patients with Covid-19 and understanding the
8 measures that institutions or congregate situations take to
9 limit the spread of the disease.

10 Q. And did you have a chance to review Dr. Paredes'
11 inspection report of the Oakland County jail?

12 A. Yes, I did.

13 Q. And based on the conditions in the -- described in his
14 inspection, do you agree with his overarching conclusion that
15 the single most important way to prevent the spread would be to
16 reduce the jail population?

17 A. Yes, I agree, in that the imperative is to maintain social
18 distancing. The CDC considers social distancing a cornerstone
19 in an effort to reduce spread in jails and other congregate
20 environments, and Dr. Paredes' report makes it very clear that
21 they are unable to maintain social distancing and that they
22 would need to reduce the jail population in order to achieve
23 that goal.

24 Q. In your expert opinion, what will happen if the Oakland
25 County jail's population is not reduced substantially during

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1 the pandemic?

2 **A.** There will be continued transmission if the virus went to
3 the jails, which will pose a significant risk of severe harm to
4 this population as well as to jail staff.

5 **Q.** And is there a group of people in the jail who are at a
6 heightened risk of infection and serious harm?

7 **A.** Yes. People who are medically vulnerable and at risk for
8 severe conditions, both by the CDC criteria and then the
9 additional conditions that I testified to earlier.

10 **MR. HARVEY:** Thank you, Dr. Lauring. That's all I
11 have for right now, your Honor.

12 **THE COURT:** Thank you, Mr. Harvey. Mr. Potter, any
13 questions, sir?

14 **MR. POTTER:** I do, your Honor. Thank you.

15 **CROSS EXAMINATION**

16 **BY MR. POTTER:**

17 **Q.** First off, Dr. Lauring, I mean this very sincerely, not
18 trying to be obsequious, but thank you for your service on
19 treating the individuals that you have in this pandemic. I
20 know it comes at risk to you personally. So on behalf of me
21 and my clients, we'd like to thank you for that.

22 **A.** Thank you.

23 **Q.** Dr. Lauring, have you testified in any similar litigation
24 such as this case prior to today?

25 **A.** I have not testified prior to today.

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1 Q. Have you been retained by the Plaintiffs in this case or
2 their lawyers in any other similar litigation without yet
3 having to testify?

4 A. I have provided a declaration for, as I understand it, a
5 case in Wayne County jail, and I've also provided a declaration
6 for a different action, I believe it's with the Michigan
7 Department of Corrections.

8 Q. How many jails have you -- jails/prisons have you ever
9 been in in your lifetime, sir?

10 A. I have not been in a jail or a prison.

11 Q. And you said you reviewed, in response to one of
12 Plaintiffs' attorney's questions, the inmate declarations; do
13 you recall that?

14 A. I'm sorry, can you repeat the question?

15 Q. Yeah. Your report indicates that you reviewed the inmate
16 declarations as part of your work in this case, correct?

17 A. That's correct.

18 Q. You reviewed those declarations before you wrote your
19 report, correct?

20 A. Yes.

21 Q. And other than the inmate declarations and your experience
22 in this area, what else are you relying upon in support of your
23 opinions, if anything?

24 A. Again, my experience taking care of people with Covid-19,
25 my experience in understanding how infectious disease is

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1 **THE COURT:** All right. We will probably send
2 something out just to confirm all of this, okay, everyone.

3 **MR. POTTER:** Thank you.

4 **THE COURT:** Thank you so much, everyone, for your
5 time.

6 (Proceedings concluded 5:27 p.m.)

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8
9 **C E R T I F I C A T I O N**

10 I, Andrea E. Wabeke, official court reporter for the
11 United States District Court, Eastern District of Michigan,
12 Southern Division, appointed pursuant to the provisions of
13 Title 28, United States Code, Section 753, do hereby certify
14 that the foregoing is a correct transcript of the proceedings
15 in the above-entitled cause on the date hereinbefore set forth.
16 I do further certify that the foregoing transcript has been
17 prepared by me or under my direction.

18
19 /s/Andrea E. Wabeke

May 7, 2020

20 Official Court Reporter
21 RMR, CRR, CSR

Date

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25

1 XAVIER BECERRA
Attorney General of California
2 MONICA N. ANDERSON
Senior Assistant Attorney General
3 DAMON MCCLAIN (209508)
Supervising Deputy Attorney General
4 JOHN WALTERS (216427)
RYAN GILLE (262105)
5 IRAM HASAN (320802)
Deputy Attorneys General
6 455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
7 Telephone: (415) 703-5500
Facsimile: (415) 703-58443
8 Email: Ryan.Gille@doj.ca.gov

HANSON BRIDGETT LLP
PAUL B. MELLO - 179755
SAMANTHA D. WOLFF - 240280
LAUREL O'CONNOR - 305478
DAVID CASARRUBIAS - 321994
425 Market Street, 26th Floor
San Francisco, California 94105
Telephone: (415) 777--3200
Facsimile: (415) 541-9366
pmello@hansonbridgett.com

9
10 *Attorneys for Defendants*

11
12 **UNITED STATES DISTRICT COURT**
13 **NORTHERN DISTRICT OF CALIFORNIA**
14 **OAKLAND DIVISION**

15
16 MARCIANO PLATA, et al.,
17 Plaintiffs,
18 v.
19 GAVIN NEWSOM, et al.
20 Defendants.

Case No. Co1-1351 JST

**DEFENDANTS' OBJECTIONS TO THE
DECLARATION OF ADAM LAURING,
M.D., Ph.D. IN SUPPORT OF
PLAINTIFFS' POSITION ON
QUARANTINE IN HOUSING UNITS
WITH COMMON AIR SPACE**

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**OBJECTION TO THE DECLARATION OF ADAM LAURING, M.D., Ph.D.
IN SUPPORT OF PLAINTIFFS' POSITION ON QUARANTINE IN HOUSING UNITS
WITH COMMON AIR SPACE**

Defendants Gavin Newsom, et al., hereby object to the following evidence presented by Plaintiffs Marciano Plata, et al., in connection with Plaintiffs' Position on Quarantine in Housing Units with Common Air Space:

No.	EVIDENCE	OBJECTIONS	RULING
1	"The writers tested 10,304 people in Connecticut prison system and found that people living in dorms were 35 times more likely to be infected with SARS-CoV-2 than people living in cells. I have reviewed the methodology published in the letter and find it sound." (Lauring Decl., ¶ 5, 3:11-14.)	Inadmissible Hearsay. (Fed. R. Evid. 801(c), 802.) This testimony is based on third-party hearsay and is inadmissible as to the truth of those statements. Dr. Lauring may not rely on hearsay because he is not an expert in public health or corrections. Indeed, his curriculum vitae does not appear to identify any education, training, or experience in the areas of public health or corrections. <i>See</i> ECF No. 3391-1; <i>see also</i> Fed. R. Evid. 703.	
2	"I suspect that this is because, as the authors suggest, when people were identified as infected they were moved out of dorms into cells, and subsequent hospitalization, ICU admission, or death would be recorded as occurring from the celled housing." (Lauring Decl., ¶ 5, 3 n. 1.)	Inadmissible Hearsay. (Fed. R. Evid. 801(c), 802.) This testimony is based on third-party hearsay and is inadmissible as to the truth of those statements. Dr. Lauring may not rely on hearsay because he is not an expert in public health or corrections. (<i>See</i> Fed. R. Evid. 703.) Inadmissible Opinion Testimony/Speculative. (Fed. R. Evid. 701.) By his own admission, Dr. Lauring is not an expert in correctional health care matters. Decl. Ryan Gille Supp. Defs.' Opp'n to Plfs.' Mot. Re: Quarantie (filed herewith) at Ex. C (Transcript from <i>Cameron v. Buchard</i> , Case No. 2:20-cv-10949 (E.D. MI))	

1		(May 7, 2020) ECF No. 56 at 78:18-20 (Q. Thank you. Dr. Lauring, do you specialize in healthcare in jails or prisons? A. No, I do not.)). Yet his declaration purports to be based on technical knowledge within the scope of Federal Rules of Evidence, Rule 702. Indeed, his curriculum vitae does not appear to identify any education, training, or experience in the areas of public health or corrections. <i>See</i> ECF No. 3391-1.	
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13	3	“My review of the literature, conversations with public health and correctional experts, and knowledge of outbreaks in CDCR all strongly support the conclusion that it is not safe to quarantine people in dormitories or celled housing with open bars or porous doors. . . . I held that opinion in July and subsequent events and studies have only strengthened my convictions. Simply put, I agree with the experts at AMEND and the UC Berkeley School of Public Health that “[n]o one in a dormitory environment can quarantine properly.” (Lauring Decl., ¶ 6, 4:8-14.)	<p>Lacks foundation. (Fed. R. Evid. 602.) Dr. Lauring fails to identify “the literature” he has purportedly reviewed, the “public health and correctional experts” he has purportedly conversed with, and the source of his “knowledge of outbreaks in CDCR” to establish the foundation of his personal knowledge.</p> <p>Inadmissible Hearsay. (Fed. R. Evid. 801(c), 802.) This testimony is based on third-party hearsay and is inadmissible as to the truth of those statements. Dr. Lauring may not rely on hearsay because he is not an expert in public health or corrections. (<i>See</i> Fed. R. Evid. 703.)</p> <p>Inadmissible Opinion Testimony/Speculative. (Fed. R. Evid. 701.) By his own admission, Dr. Lauring is not an expert in correctional health</p>
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1		care matters. Decl. Ryan Gille at Ex. C. Yet his declaration purports to be based on technical knowledge within the scope of Federal Rules of Evidence, Rule 702. Indeed, his curriculum vitae does not appear to identify any education, training, or experience in the areas of public health or corrections. <i>See</i> ECF No. 3391-1.	
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9	4	“This is not a contested opinion: all the experts I’ve read or spoken with have come to the same conclusion, including the Public Health Workgroup convened for purposes of this case, of which I was a member.” (Lauring Decl., ¶ 7, 4:15-17.)	<p>Lacks foundation. (Fed. R. Evid. 602.) Dr. Lauring fails to identify “all the experts” he has purportedly read or spoken with to establish the foundation of his personal knowledge.</p> <p>Inadmissible Hearsay. (Fed. R. Evid. 801(c), 802.) This testimony is based on third-party hearsay and is inadmissible as to the truth of those statements. Dr. Lauring may not rely on hearsay because he is not an expert in public health or corrections. (<i>See</i> Fed. R. Evid. 703.)</p> <p>Inadmissible Opinion Testimony/Speculative. (Fed. R. Evid. 701.) By his own admission, Dr. Lauring is not an expert in correctional health care matters. Decl. Ryan Gille at Ex. C. Yet his declaration purports to be based on technical knowledge within the scope of Federal Rules of Evidence, Rule 702. Indeed, his curriculum vitae does not appear to identify any education, training, or experience in the areas of public health or corrections. <i>See</i> ECF No. 3391-1.</p>
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1 2 3 4 5 6 7 8 9 10 11	5	<p>“The study in the Connecticut prison system, with a preliminary finding that the people in dorms are 35 times more likely than those in cells to contract COVID-19, [citation], is chilling but not surprising. California has experienced first-hand the ravages of outbreaks in shared spaces.” (Lauring Decl., ¶ 9, 5:4-6.)</p>	<p>Lacks foundation. (Fed. R. Evid. 602.) Dr. Luring fails to establish the foundation of his personal knowledge that “California has experienced first-hand the ravages of outbreaks in shared spaces.”</p> <p>Inadmissible Hearsay. (Fed. R. Evid. 801(c), 802.) This testimony is based on third-party hearsay and is inadmissible as to the truth of those statements. Dr. Luring may not rely on hearsay because he is not an expert in public health or corrections. (See Fed. R. Evid. 703.)</p>	
12 13 14 15 16 17 18 19 20 21 22 23 24 25 26	6	<p>“The fact that there have also been significant outbreaks in solid-doored celled living units is not surprising and does not change my opinion.” (Lauring Dec. ¶ 10, 5:7-8.)</p>	<p>Lacks foundation. (Fed. R. Evid. 602.) Dr. Luring fails to establish the foundation of his personal knowledge that there have been “significant outbreaks in solid-doored celled living units.”</p> <p>Inadmissible Opinion Testimony/Speculative. (Fed. R. Evid. 701.) By his own admission, Dr. Luring is not an expert in correctional health care matters. Decl. Ryan Gille at Ex. C. Yet his declaration purports to be based on technical knowledge within the scope of Federal Rules of Evidence, Rule 702. Indeed, his curriculum vitae does not appear to identify any education, training, or experience in the areas of public health or corrections. See ECF No. 3391-1.</p>	
27 28	7	<p>“By far the largest outbreaks have been in shared air spaces. [Citation.] Like the Amend and UC Berkeley</p>	<p>Inadmissible Hearsay. (Fed. R. Evid. 801(c), 802.) This testimony is based on third-</p>	

1		experts who studied the CMC outbreak, I have no doubt that the outbreaks in solid-door cells would have been far worse in dorms or cells with barred or porous doors.” (Lauring Decl., ¶ 10, 5:8-11.)	party hearsay and is inadmissible as to the truth of those statements. Dr. Lauring may not rely on hearsay because he is not an expert in public health or corrections. (<i>See</i> Fed. R. Evid. 703.)	
2			Inadmissible Opinion	
3			Testimony/Speculative. (Fed. R. Evid. 701.) By his own	
4			admission, Dr. Lauring is not an	
5			expert in correctional health	
6			care matters. Decl. Ryan Gille at	
7			Ex. C. Yet his declaration	
8			purports to be based on	
9			technical knowledge within the	
10			scope of Federal Rules of	
11			Evidence, Rule 702. Indeed, his	
12			curriculum vitae does not appear	
13			to identify any education,	
14			training, or experience in the	
15			areas of public health or	
16			corrections. <i>See</i> ECF No. 3391-	
17			1.	
18	8	“The fact that the virus possesses tenacity that is very difficult to counter even under suitable conditions does not let us off the hook from knowingly placing people in harm’s way.” (Lauring Decl., ¶ 10, 5:11-13.)	Inadmissible Opinion	
19			Testimony/Speculative. (Fed. R. Evid. 701.) By his own	
20			admission, Dr. Lauring is not an	
21			expert in correctional health	
22			care matters. Decl. Ryan Gille at	
23			Ex. C. Yet his declaration	
24			purports to be based on	
25			technical knowledge within the	
26			scope of Federal Rules of	
27			Evidence, Rule 702. Indeed, his	
28			curriculum vitae does not appear	
			to identify any education,	
			training, or experience in the	
			areas of public health or	
			corrections. <i>See</i> ECF No. 3391-	
			1.	
	9	“I am not simply saying that living in dorms is more risky than living in solid door cells, although that is certainly the case. I am saying that the	Inadmissible Opinion	
			Testimony/Speculative. (Fed. R. Evid. 701.) By his own	
			admission, Dr. Lauring is not an	

1		decision to quarantine people in living units with common air space knowingly places them at enhanced risk of infection.” (Lauring Decl., ¶ 11, 5:14-17.)	expert in correctional health care matters. Decl. Ryan Gille at Ex. C. Yet his declaration purports to be based on technical knowledge within the scope of Federal Rules of Evidence, Rule 702. Indeed, his curriculum vitae does not appear to identify any education, training, or experience in the areas of public health or corrections. <i>See</i> ECF No. 3391-1.	
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9	10	“If you quarantine each person in a single cell after exposure, you have only two or three secondary cases. However, if you quarantine them together, the lucky ones will continue to be exposed – to the secondary cases, now – over the ensuing 14 days. So, you have actually increased their total exposure to COVID-19 positive people and increased their risk for contracting the disease. This is why it is not safe to quarantine people together who have all faced the same exposure – for example, to a staff member who worked in their housing unit.” (Lauring Decl., ¶ 12, 6:8-13.)	Inadmissible Opinion Testimony/Speculative. (Fed. R. Evid. 701.) By his own admission, Dr. Lauring is not an expert in correctional health care matters. Decl. Ryan Gille at Ex. C. Yet his declaration purports to be based on technical knowledge within the scope of Federal Rules of Evidence, Rule 702. Indeed, his curriculum vitae does not appear to identify any education, training, or experience in the areas of public health or corrections. <i>See</i> ECF No. 3391-1.	
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20	11	“The use of living units with common air space to quarantine people with known exposure to the virus is effectively not quarantine at all. In medical parlance, I would call it substandard care. This is why the public health working group stressed that quarantine should be in single cell solid-door housing.” (Lauring Decl., ¶ 13, 6:14-17.)	Lacks foundation. (Fed. R. Evid. 602.) Dr. Lauring fails to identify the standard upon which he relies on to conclude that there is evidence of “substandard care.” Inadmissible Hearsay. (Fed. R. Evid. 801(c), 802.) This testimony is based on third-party hearsay and is inadmissible as to the truth of those statements. Dr. Lauring may not rely on hearsay because he is not an expert in public health or corrections. (<i>See</i> Fed.	
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1		R. Evid. 703.)	
2		Inadmissible Opinion	
3		Testimony/Speculative. (Fed. R.	
4		Evid. 701.) By his own	
5		admission, Dr. Luring is not an	
6		expert in correctional health	
7		care matters. Decl. Ryan Gille at	
8		Ex. C. Yet his declaration	
9		purports to be based on	
10		technical knowledge within the	
11		scope of Federal Rules of	
12		Evidence, Rule 702. Indeed, his	
		curriculum vitae does not appear	
		to identify any education,	
		training, or experience in the	
		areas of public health or	
		corrections. <i>See</i> ECF No. 3391-	
		1.	
13	12	“In my opinion, there are no	Inadmissible Opinion
14		mitigating steps that would reduce the	Testimony/Speculative. (Fed. R.
15		risk of placing people in these	Evid. 701.) By his own
16		common air living units for	admission, Dr. Luring is not an
17		quarantine purposes, so that it would	expert in correctional health
18		more closely approximate the risk of	care matters. Decl. Ryan Gille at
19		quarantine in living units with solid-	Ex. C. Yet his declaration
20		door cells.” (Luring Decl., ¶ 14,	purports to be based on
21		6:18-19.)	technical knowledge within the
22			scope of Federal Rules of
			Evidence, Rule 702. Indeed, his
			curriculum vitae does not appear
			to identify any education,
			training, or experience in the
			areas of public health or
			corrections. <i>See</i> ECF No. 3391-
			1.
23	13	“It is true that people are often	Inadmissible Opinion
24		directed to quarantine at home, where	Testimony/Speculative. (Fed. R.
25		they share living space with the rest of	Evid. 701.) By his own
26		their household. There are three	admission, Dr. Luring is not an
27		essential differences between that	expert in correctional health
28		situation and prison quarantine in	care matters. Decl. Ryan Gille at
		shared air living spaces. First, when	Ex. C. Yet his declaration
		there are children to care for, there are	purports to be based on
		no other options but to continue to	technical knowledge within the
		interact with them even in quarantine.	scope of Federal Rules of

1		Bringing another caregiver into the setting or sending the children out, would expose others to risk. Second, households have the option to try to separate internally, to use separate rooms and airspaces, keep windows open, and take other measures to reduce interaction and common airspace. People in prison have no such options. Finally, households are generally far smaller than the prison living units under discussion here, where dormitories and units with open-barred cells can have upwards of 100 people in them. It would be possible to reduce the enhanced risk of quarantining in such settings by reducing the number of people who are housed in the shared airspace. But the risk is significant for those who remain, including for cellmates of people who are double-celled in quarantine.” (Lauring Decl., ¶ 15, 7:1-12.)	Evidence, Rule 702. Indeed, his curriculum vitae does not appear to identify any education, training, or experience in the areas of public health or corrections. <i>See</i> ECF No. 3391-1.	
14	14	“If CDCR prisons are to avoid such ready transmission, they must prepare safer alternatives.” (Lauring Decl., ¶ 16, 7:16-17.)	Inadmissible Opinion Testimony/Speculative. (Fed. R. Evid. 701.) By his own admission, Dr. Lauring is not an expert in correctional health care matters. Decl. Ryan Gille at Ex. C. Yet his declaration purports to be based on technical knowledge within the scope of Federal Rules of Evidence, Rule 702. Indeed, his curriculum vitae does not appear to identify any education, training, or experience in the areas of public health or corrections. <i>See</i> ECF No. 3391-1.	
15	15	“Given the known risk involved in placing people in shared airspaces for quarantine, CDCR must act now to ensure that this practice is minimized. Single-celled, solid door quarantine	Inadmissible Opinion Testimony/Speculative. (Fed. R. Evid. 701.) By his own admission, Dr. Lauring is not an expert in correctional health	

1	space must be identified and people	care matters. Decl. Ryan Gille at	
2	must be shifted as appropriate <i>before</i>	Ex. C. Yet his declaration	
3	an outbreak, when it is often too late	purports to be based on	
4	to organize precautionary steps.”	technical knowledge within the	
5	(Lauring Decl., ¶ 18, 8:15-18.)	scope of Federal Rules of	
6		Evidence, Rule 702. Indeed, his	
7		curriculum vitae does not appear	
8		to identify any education,	
9		training, or experience in the	
10		areas of public health or	
11		corrections. <i>See</i> ECF No. 3391-	
12		1.	
13	16 “The rationale for quarantine here is	Inadmissible Opinion	
14	to mitigate the risk of transferring an	Testimony/Speculative. (Fed. R.	
15	individual who potentially is in the	Evid. 701.) By his own	
16	incubation period for COVID19. All	admission, Dr. Lauring is not an	
17	individuals all have the same risk of	expert in correctional health	
18	having COVID-19 as the general	care matters. Decl. Ryan Gille at	
19	population of the facility. I do not	Ex. C. Yet his declaration	
20	have the same concerns about keeping	purports to be based on	
21	individuals apart for precautionary	technical knowledge within the	
22	quarantine as I do for quarantine	scope of Federal Rules of	
23	following exposure.” (Lauring Decl.,	Evidence, Rule 702. Indeed, his	
24	¶ 20, 8:23-9)	curriculum vitae does not appear	
25		to identify any education,	
26		training, or experience in the	
27		areas of public health or	
28		corrections. <i>See</i> ECF No. 3391-	
		1.	

DATED: December 9, 2020

HANSON BRIDGETT LLP

By: /s/ Samantha Wolff

PAUL B. MELLO
 SAMANTHA D. WOLFF
 LAUREL O’CONNOR
 DAVID C. CASARRUBIAS
 Attorneys for Defendants

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XAVIER BECERRA
Attorney General of California

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3
4 By: /s/ Damon McClain
DAMON MCCLAIN
Supervising Deputy Attorney General
5 RYAN GILLE
6 IRAM HASAN
Deputy Attorney General
Attorneys for Defendants
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XAVIER BECERRA
Attorney General of California
MONICA N. ANDERSON
Senior Assistant Attorney General
DAMON G. MCCLAIN - 209508
Supervising Deputy Attorney General
RYAN GILLE (262105)
IRAM HASAN (320802)
Deputy Attorneys General
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 703-5500
Facsimile: (415) 703-58443
Email: Ryan.Gille@doj.ca.gov
Attorneys for Defendants

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

**UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
OAKLAND DIVISION**

MARCIANO PLATA, et al.,

Plaintiffs,

v.

GAVIN NEWSOM, et al.,

Defendants.

CASE NO. 01-1351 JST

**DECLARATION OF CONNIE GIPSON
IN SUPPORT OF DEFENDANTS'
OPPOSITION TO PLAINTIFFS'
POSITION ON QUARANTINE IN
HOUSING UNITS WITH SHARED AIR
SPACE**

Judge: Hon. Jon S. Tigar

I, Connie Gipson, declare:

1. I am the Director of the California Department of Corrections and Rehabilitation's (CDCR) Division of Adult Institutions. In 2019, I was promoted to the Acting Director of the Division of Adult Institutions, and was officially appointed to my current position as the Director in April 2019. I am competent to testify to the matters set forth in this declaration and, if called upon by this Court, would do so. I submit this declaration in support of Defendants' Opposition to Plaintiffs' Position on Quarantine in Housing Units with Shared Air Space.

2. I understand that Plaintiffs assert that CDCR has been deliberately indifferent to the

1 COVID-19 pandemic. Considering the fact that thousands of CDCR employees for many months
 2 have worked tirelessly on a daily basis to fight the spread of this unprecedented pandemic and
 3 struggle every day to make the best decisions for the welfare of inmates and staff in the prisons, it
 4 is difficult for me to understand Plaintiffs' allegations of deliberate indifference. In this
 5 declaration, I have tried to capture a number of the significant efforts CDCR, CCHCS, and their
 6 employees have made to address this pandemic, but it is not possible to identify all efforts to date
 7 aimed at combating this unprecedented public health crisis.

8 3. I have submitted two previous declarations this year that discussed CDCR's efforts
 9 to flatten the curve of the COVID-19 pandemic and to manage this crisis. The first declaration
 10 was filed on March 31, 2020, and can be found at ECF No. 3240. Below is a list summarizing
 11 some of the actions taken and measures implemented in response to the pandemic that I described
 12 in much more detail in that declaration:

- 13 • California Correctional Healthcare Services (CCHCS) and CDCR's establishment
 14 of a multi-disciplinary team, chaired by a public health physician, to take all
 15 feasible steps to prevent a COVID-19 outbreak in CDCR's institutions and to
 16 develop a thorough and solid response action plan for dealing with outbreaks;
- 17 • CDCR's activation of the Department Operations Center (DOC)—a centrally-
 18 located command center where CDCR and CCHCS experts monitor information,
 19 prepare for known and unknown events, and exchange information centrally in
 20 order to make decisions and provide guidance quickly in the event of outbreaks;
- 21 • CDCR's development of Pandemic Operational Guidelines;
- 22 • The suspension of public visiting in the prisons;
- 23 • The suspension of intake from the county jails (intake has since resumed on a
 24 limited and intermittent basis, but it is currently suspended);
- 25 • CDCR's implementation of symptom screening for individuals entering the prison
 26 system;
- 27 • CDCR's efforts to educate staff and inmates about the need for taking precautions
 28 such as physical distancing and hygiene;

- CDCR's efforts to reduce the populations in dorms by transferring significant numbers of inmates out of dorms to other housing throughout the system;
- CDCR's implementation of enhanced cleaning efforts throughout the prisons and the wide distribution of hand soap and hand sanitizer dispensers; and
- CDCR's implementation of quarantines for exposed patients;

4. I submitted another declaration on April 13, 2020, in which I described some of CDCR's additional efforts to respond to the pandemic. That declaration is located at ECF No. 3275. Below is a list summarizing some of the actions taken and measures implemented that I described in more detail in that declaration:

- CDCR's implementation of an expedited release plan to quickly reduce the system's population by nearly 3,500 inmates;
- The implementation of a modified program to manage and restrict inmate movement throughout the system and to provide guidance on physical distancing and efforts to cohort inmates in their housing units;
- CDCR's placement of physical-distancing markings throughout the prisons to encourage physical distancing;
- CDCR's ongoing efforts to reduce dorm populations by transferring inmates out of particular dorm settings;
- CDCR's development of plans to convert certain areas in prisons, such as gyms, chapels and visiting areas, into additional housing for the purpose of allowing greater physical distancing in housing units;
- The California Prison Industry Authority's efforts to manufacture cloth face masks and hand sanitizer for inmates and staff throughout the system;
- The creation of physical-distancing cohorts within dorm settings; and
- The placement of restrictions on inmate transfers and the implementation of requirements to obtain approval for transfers from the Health Care Placement Oversight Program and the CCHCS's public health team.

5. A host of additional measures that CDCR has implemented in response to the

1 pandemic can be found on CDCR's website at: [https://www.cdcr.ca.gov/covid19/covid-19-](https://www.cdcr.ca.gov/covid19/covid-19-response-efforts/)
2 [response-efforts/](https://www.cdcr.ca.gov/covid19/covid-19-response-efforts/); <https://www.cdcr.ca.gov/covid19/san-quentin-state-prison-response/>; and
3 <https://www.cdcr.ca.gov/covid19/memos-guidelines-messaging/>.

4 6. Beginning in July 2020, CDCR implemented several plans to expedite the release
5 of additional inmates to further reduce the prison population. Those measures resulted in the early
6 release of an additional 7,060 inmates from the 35 institutions and camps (including California
7 City Correctional Facility) during the period from July 1 through December 3, 2020. Combined
8 with the previous early release efforts, natural releases, and restrictions on intake from the
9 counties, CDCR has reduced its population by over 23,000 inmates since the beginning of the
10 pandemic. The press release concerning the early-release measures implemented in July 2020
11 provides additional details and can be found at [https://www.cdcr.ca.gov/news/2020/07/10/cdcr-](https://www.cdcr.ca.gov/news/2020/07/10/cdcr-announces-additional-actions-to-reduce-population-and-maximize-space-systemwide-to-address-covid-19/)
12 [announces-additional-actions-to-reduce-population-and-maximize-space-systemwide-to-address-](https://www.cdcr.ca.gov/news/2020/07/10/cdcr-announces-additional-actions-to-reduce-population-and-maximize-space-systemwide-to-address-covid-19/)
13 [covid-19/](https://www.cdcr.ca.gov/news/2020/07/10/cdcr-announces-additional-actions-to-reduce-population-and-maximize-space-systemwide-to-address-covid-19/).

14 7. To ensure that transfers of inmates between institutions are conducted safely,
15 CCHCS developed the Movement Matrix. The current version of this document is attached as
16 Exhibit A to this declaration, and a new draft version is attached as Exhibit B. By carefully
17 complying with the requirements of the Movement Matrix, CDCR has been able to safely transfer
18 inmates throughout the system for a number of important reasons, including moving medically
19 high-risk patients into safer settings and reducing the population in particular housing units to
20 make them safer. CDCR takes the Movement Matrix requirements seriously, and has turned away
21 intake busses from counties that have not complied with transfer requirements.

22 8. CCHCS conducts a robust COVID-19 surveillance-testing program for CDCR staff
23 and patients in the prisons. In addition to sending tests to labs for results, every prison now also
24 has the ability to conduct point-of-care tests that usually provide results in about fifteen minutes.
25 Furthermore, wastewater monitoring has commenced at two prisons and may be expanded to
26 others to assess its feasibility and effectiveness for early detection of outbreaks.

27 9. Because of testing fatigue among the incarcerated population and staff, CCHCS has
28 started testing using anterior nasal swabs, which are less invasive and more comfortable than the

1 nasopharyngeal swabs previously used. This change was made to encourage a high rate of testing
2 compliance.

3 10. CDCR and CCHCS are also collaborating on an effort to move medically high-risk
4 patients out of dorms and into cells. On October 21, 2020, the Receiver issued a memorandum
5 entitled “Transferring COVID-19 High-Risk Patients to Safer Housing,” which requires CDCR to
6 offer each person with a COVID-weighted risk score of three or higher a single cell with a solid
7 door. A copy of the Receiver’s memorandum is attached to this declaration as Exhibit C. The
8 Receiver has also restricted the transfer of medically high-risk patients to a specific group of
9 prisons that do not have the ability to house them in cells with solid doors. As a result of these
10 decisions, CDCR is now prioritizing movement of medically high-risk patients who have not
11 contracted COVID-19 in the last three months from congregate living spaces to cells with solid
12 doors. CDCR and CCHCS are working on a process for mandating the transfer of patients who do
13 not voluntarily move to cells. The implementation of the plan to move medically high-risk
14 patients has already commenced at San Quentin, and plans for three other institutions are being
15 developed.

16 11. Since April 2020, CDCR has been providing cloth face masks to inmates and staff
17 and providing guidance and directives on mask use. CDCR currently requires mask wearing in
18 the prisons and provides all staff with surgical face masks. As an additional mitigation effort
19 during serious outbreaks at particular prisons, CDCR has issued N95 masks to all inmates and
20 staff to help stop the virus’s spread. To date, this type of prison-wide N95 measure has been
21 implemented at Folsom State Prison, San Quentin State Prison, and Avenal State Prison. And at
22 other prisons experiencing outbreaks, CDCR required the use of N95 masks by staff and inmates
23 who work or reside in the areas experiencing the outbreaks.

24 12. CDCR has implemented other measures to protect inmates at prisons experiencing
25 serious outbreaks, such as transferring medically high-risk patients out of dorms and into cells,
26 and the implementation of increased testing rates.

27 13. In July 2020, CDCR began working on setting aside and reserving quarantine and
28 isolation space at all prisons based on guidance developed by CCHCS and various public health

1 experts, including input from the parties' experts. This public-health workgroup devised a method
2 for determining the amount of space that each prison should reserve for quarantine and isolation
3 purposes in the event of an outbreak. The methodology was based on the number of inmates
4 residing in the largest congregate living space in each prison. The workgroup's report on the
5 methodology is attached to this declaration as Exhibit D.

6 14. Attempting to reserve the recommended isolation and quarantine space for each
7 prison was a massive undertaking that presented the logistical challenge of transferring hundreds
8 inmates to different housing units and prisons. This effort was made more challenging because it
9 was necessary to ensure that reserved spaces satisfied the needs of the plaintiffs in the class actions
10 *Armstrong v. Newsom* and *Coleman v. Newsom*. It took months of work to achieve the current
11 reserves and CDCR continues to meet and confer with Plaintiffs and the parties to the other class
12 actions concerning the subject of reserved spaces, and work on these issues continued through
13 November 2020.

14 15. CDCR's reserved space has capacity to house approximately 7,809 patients in cells
15 if they are mostly double celled, and up to about 4,228 patients if they are single celled. CDCR
16 has also formally reserved about 1,195 beds that are in congregate living spaces, such as dorms,
17 tents, gyms, and other converted spaces for isolation and quarantine.

18 16. Attached as Exhibit E is a chart that describes the reserved space at each of the
19 prisons. The formally reserved spaces and beds are reflected in the second and third columns of
20 Exhibit E. The third column also indicates the space reserves recommended by the public-health
21 workgroup. As reflected in Exhibit E, many of the prisons reserved more space than was
22 recommend by the public-health workgroup, and some prisons exceeded the recommendations by
23 a large quantity (e.g., California City Correctional Facility (CAC), California Institution for
24 Women (CIW), and California State Prison-Sacramento (SAC)). Several prisons, however, could
25 not come close to reserving the recommended amount of quarantine and isolation space because of
26 their designs (e.g., San Quentin (SQ), Folsom (FOL), California Rehabilitation Center (CRC)).
27 The public-health working group recognized that these prisons would not be able to reserve the
28 recommended space because of their designs, and acknowledged that they would require unique

1 solutions.

2 17. Because of CDCR's reduced population, a number of prisons currently have
3 abundant additional space—beyond the reserved space—that could be used for quarantine and
4 isolation if needed. Those spaces are described in the fourth and fifth columns of Exhibit E. In
5 total, the additional cell space is sufficient to house about 2,620 patients if they are mostly double
6 celled, and about 1,347 patients if they are single celled. And there are about 1,999 additional
7 beds in congregate settings that are also currently available for quarantine or isolation use.

8 18. Because some of the prisons were unable to reserve the recommended space for
9 isolation and quarantine, and because their facility designs are likely to present challenges in the
10 event of an outbreak, they have developed plans for how to deal with a surge of COVID-19 cases.
11 San Quentin, Folsom, California Rehabilitation Center, California Health Care Facility, and
12 Avenal State Prison have developed such plans, which are based on experience gained during past
13 serious outbreaks, such as the outbreak at San Quentin.

14 19. I understand that Plaintiffs have complained that reserved isolation and quarantine
15 space might sometimes be used for precautionary quarantines associated with inmate transfers. I
16 have not yet fully investigated whether or to what extent this is happening, but even if this does
17 happen at some prisons, it should not cause much of an impact on availability of quarantine and
18 isolation space when there is an outbreak. When there is an outbreak of three or more patients at a
19 prison, that prison closes to transfers. This means that almost all transfers to or from that prison,
20 with the possible exception of intake from reception centers, cease once there are three positive
21 cases of COVID-19. If there are no more transfers to or from a prison, then there is no need for
22 precautionary quarantine. To the extent there is a reduced number of transfers at closed prisons, as
23 I explained above, most prisons have already reserved more quarantine and isolation space than
24 the public-health workgroup recommended, and many prisons have abundant additional space
25 beyond the reserved space. And finally, anticipated modifications to the precautionary quarantine
26 protocols that are reflected in the new draft Movement Matrix (see Exhibit B) should further
27 mitigate any issue in this area, if one exists, because there will be fewer precautionary quarantines
28 taking place. Regardless, I would welcome the opportunity to dig further into this issue and

1 discuss it with the Receiver and the Plaintiffs to determine whether there is a problem that needs to
2 be addressed, and if so, work on a plan to remedy it.

3 20. Quarantine cohorts have occurred in some instances even when reserved quarantine
4 space is available at a prison, and I understand that Plaintiffs have complained about this issue.
5 The Receiver has provided the parties with data that shows that most inmates on quarantine are
6 housed alone or with only one other inmate. But that data also confirms that significant numbers
7 of inmates are quarantined in cohorts of various sizes. Some of these situations are the result of
8 the reserved quarantine spaces being filled at a particular prison during an outbreak. The
9 management of outbreaks in prison settings is extremely complex. To the extent officials have
10 decided to use quarantine cohorts when there is still reserved space available for quarantine, there
11 could be good reasons for those decisions based on the circumstances of a particular outbreak at a
12 particular prison. And those good reasons might not be readily apparent to those who are not on
13 the ground in that facility during the outbreak. On the other hand, it is possible that less than
14 optimal decisions have been made in some circumstances. I understand that on December 1, 2020,
15 Plaintiffs asked the Receiver to look into some specific quarantines related to this issue, but I do
16 not believe the Receiver has yet completed his investigation or responded to that inquiry. I believe
17 this issue warrants further investigation and I welcome the opportunity to work on it with the
18 Receiver and Plaintiffs to ensure that the best available options for quarantine are utilized first.

19 21. I expect that the Receiver will want to discuss these quarantine issues with the
20 parties very soon because on December 4, 2020, he sent new guidance to the parties concerning
21 quarantine for patients who have been exposed to COVID-19. The new guidance states that the
22 first choice for post-exposure quarantine housing should be solid-door cells occupied by only one
23 person, and that quarantine cohorting is to be used with no more than two persons per shared
24 airspace. The Receiver's new guidance, however, recognized that at certain prisons this
25 quarantine standard is not achievable. At those institutions, CDCR should make all efforts to find
26 satisfactory quarantine alternatives. For two institutions—California Medical Facility and
27 California Health Care Facility—the Receiver committed decisions concerning post-exposure
28 quarantine to the discretion of medical leadership in light of the unique missions and operations at

1 those prisons. This new guidance will be a challenge to implement, but I look forward to working
2 with the Receiver to determine whether it is feasible and to explore possible options for
3 implementing it.

4 22. CDCR makes a concerted effort to learn from past outbreaks how to better respond
5 to new outbreaks. A good example of this was the handling of the outbreak at Folsom from
6 August through October 2020. Based on our experience with the outbreak at San Quentin, and
7 because we knew that Folsom faced many of the same challenges that made outbreak management
8 at San Quentin difficult, at the beginning of the Folsom outbreak, we immediately took a number
9 of steps that resulted in a far better outcome. Those steps included the early installation of tents to
10 provide additional capacity for quarantine, isolation, and medical treatment, the preparation of
11 Folsom's limited cell capacity to help manage the outbreak, the removal of medically high-risk
12 patients to cells, close monitoring of staffing needs and the implementation of plans to ensure
13 sufficient staffing for the duration of the outbreak, the implementation of a mandatory prison-wide
14 N95 mask policy for staff and inmates, and greatly increased testing rates. Through all of these
15 efforts, we were able to prevent an outcome similar to the outbreak at San Quentin even though
16 Folsom and San Quentin faced many of the same challenges based on their age and design.

17 23. Another good example of CDCR's improving ability to effectively respond to
18 outbreaks in challenging settings is the outbreak that occurred at California Rehabilitation Center.
19 This prison has no cells available for quarantining patients, and yet it was able to get a large
20 outbreak under control and prevent the loss of life from COVID-19. The reduction in California
21 Rehabilitation Center's population allowed it to utilize several large dorms for quarantine space,
22 and the installation of climate-controlled tents increased the housing capacity. Furthermore,
23 additional climate-controlled tents were installed for the specific purpose of housing medically
24 high-risk patients away from the general population, and dedicated staff were assigned to
25 essentially cohort with those high-risk patients during the outbreak to further limit their potential
26 exposure to the virus. The medically high-risk areas contained full services, including bathrooms
27 and showers, dedicated to those patients so they would not have to visit areas where the general
28 population resided. The tents were designed to house ten people, but only four medically high-

Exhibit A

COVID-19 SCREENING AND TESTING MATRIX FOR PATIENT MOVEMENT
August 19, 2020

- 1. To reduce the likelihood of COVID-19 spreading from one location to another, movement shall be limited to that which is necessary for clinical care, medical isolation or quarantine, reduction of overcrowding, and serious custody concerns.**
- 2. If transfer from one institution to another must take place, pre and post transfer quarantine and COVID-19 testing shall be performed.**
- 3. Inmates and transportation staff shall wear N95 masks during transfer. Transportation vehicles shall be disinfected after each trip. Transportation staff shall be tested as per the staff testing policy.**
- 4. Every effort shall be made to avoid layovers during transportation.**
- 5. Inmates who were previously infected with COVID and have been moved to the resolved status are considered to be immune from re-infection for at least twelve weeks, and shall not be required to re-test for movement purposes during that time frame.**
- 6. Inmates moving into higher level of care (HLOC) beds (medical CTC, OHU, MHCb, PIP) shall be quarantined in the HLOC**

TYPE OF MOVEMENT	COVID TESTING STRATEGY	HOUSING	WHAT TO DO IF PATIENT REFUSES COVID TEST
From jail to reception center	<p>All inmates and transportation staff shall wear an N 95 respirator during transfer</p> <p>Quarantine all new arrivals for 14 days after arrival in cell based housing.</p> <p>Screen all new arrivals for COVID-19 symptoms upon arrival and then daily while in quarantine.</p> <p>Test all new arrivals for COVID-19 within 24 hours, again on day 7 and again prior to release from quarantine (no sooner than day 12).</p> <p>Place any inmate who tests positive in isolation.</p> <p>May release inmates from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative.</p>	Quarantine in cell based housing.	<p>Inmate to remain in pre-transfer quarantine for at least 21 days and receive daily symptom screening.</p> <p>Disposition to be determined in consultation with CME and public health.</p>
From jail directly to Specialized Medical Beds (SMB)	<p>Advance authorization required by the Director, Health Care Services and Director, Health Care Operations.</p> <p>All inmates and transportation staff shall wear an N 95 respirator during transfer.</p> <p>Quarantine all new arrivals for 14 days after arrival in cell based housing.</p> <p>Screen all new arrivals for COVID-19 symptoms upon arrival and then daily while in quarantine.</p> <p>Test all new arrivals for COVID-19 within 24 hours, again on day 7 and again prior to release from quarantine (no sooner than day 12).</p> <p>Place any inmate who tests positive in isolation.</p>		<p>Inmate to remain in pre-transfer quarantine for at least 21 days and receive daily symptom screening.</p> <p>Disposition to be determined in consultation with CME and public health.</p> <p>.</p>

COVID-19 SCREENING AND TESTING MATRIX FOR PATIENT MOVEMENT
August 19, 2020

	May release inmates from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative.		
From reception center to institution	Screen all inmates for COVID-19 symptoms and then test for COVID-19 just prior to transfer utilizing a methodology that allows for no more than 48 hours turnaround time for results. If inmate tests negative and patient is asymptomatic, transfer as soon as possible but no more than 72 hours after test was obtained. All inmates and transportation staff shall wear an N 95 respirator during transfer.		Inmate to remain in pre-transfer quarantine for at least 21 days and receive daily symptom screening. Disposition to be determined in consultation with CME and public health.
Institution intake from reception center	Quarantine all new arrivals for 14 days in cell based housing. Facilities which by design have no cell based housing shall house newly arriving inmates in cohorts of no more than 10 in a dorm or small tent solely dedicated to the cohorts who arrive on the same day. Screen all new arrivals for COVID-19 symptoms upon arrival and then daily while in quarantine. Test all new arrivals for COVID-19 within 24 hours, on day 7 and prior to release from quarantine (no sooner than day 12). Place any inmate who tests positive in isolation. May release inmates from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative.	Quarantine in celled housing, with minor exceptions as noted.	Inmate to remain in quarantine for at least 21 days. Disposition to be determined in consultation with CME and public health.
General population movement from one institution to another, including to camp hubs	<p>Sending institution Quarantine all inmates prior to transfer in cell based housing. Facilities which by design have no cell based housing shall house inmates in cohorts of no more than 10 in a dorm or small tent solely dedicated to the cohorts who will depart on the same day. Screen all inmates for COVID-19 symptoms initially and then daily while in quarantine. Test symptomatic patients. Place any inmate who tests positive in isolation. Test for COVID after 14 days in quarantine utilizing a methodology that allows for no more than 48 hours turnaround time for results. If inmate tests negative, transfer as soon as possible but no more than 72 hours after test was obtained. All inmates and transportation staff shall wear an N 95 respirator during transfer.</p> <p>Receiving institution Quarantine all new arrivals for 14 days in cell based housing. Facilities which by design have no cell based housing shall house newly arriving inmates in cohorts of no more than 10 in a dorm or small tent solely dedicated to the cohorts who arrive</p>	Quarantine in celled housing, with minor exceptions as noted.	Inmate to remain in quarantine for at least 21 days. Disposition to be determined in consultation with CME and public health.

COVID-19 SCREENING AND TESTING MATRIX FOR PATIENT MOVEMENT
August 19, 2020

	<p>on the same day.</p> <p>Screen all new arrivals for COVID-19 symptoms upon arrival and then daily while in quarantine. Test all new arrivals for COVID-19 on day 12 of quarantine.</p> <p>May release inmates from quarantine after 14 days if asymptomatic and COVID-19 test- is negative.</p> <p>Place any inmate who tests positive in isolation.</p>		
<p>Movement from one institution to another for specialized medical bed placement</p>	<p>Sending institution</p> <p>Movement that is not considered clinically urgent or emergent:</p> <ul style="list-style-type: none"> Quarantine all inmates prior to transfer in cell based housing. Screen all inmates for COVID-19 symptoms initially and then daily while in quarantine. Test symptomatic patients. Place any inmate who tests positive in isolation. Test for COVID after 14 days in quarantine utilizing a methodology that allows for no more than 48 hours turnaround time for results. If inmate tests negative, transfer as soon as possible but no more than 72 hours after test was obtained. All inmates and transportation staff shall wear an N 95 respirator during transfer. <p>Movement that is considered clinically urgent or emergent:</p> <ul style="list-style-type: none"> Perform rapid testing for COVID-19 prior to movement. Communicate results to receiving facility. All inmates and transportation staff shall wear an N 95 respirator during transfer. <p>Receiving institution</p> <p>House appropriately at receiving institution (isolation vs quarantine) depending upon the results of the rapid test.</p> <p>New arrivals who tested positive at sending institution shall be housed in isolation at receiving institution and managed per CCHCS guidelines.</p> <p>New arrivals who tested negative at sending institution shall be quarantined for 14 days in cell based housing. These inmates shall be screened for COVID-19 symptoms upon arrival and then daily while in quarantine. Test these inmates for COVID-19 on day 12 of quarantine.</p> <p>May release inmates from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative.</p>		<p>Inmate to remain in quarantine for at least 21 days.</p> <p>Disposition to be determined in consultation with CME and public health.</p>

COVID-19 SCREENING AND TESTING MATRIX FOR PATIENT MOVEMENT
August 19, 2020

	Place any inmate who tests positive in isolation.		
Movement within same institution <ul style="list-style-type: none"> • Release from STRH, LTRH, ASU, SHU • PIP / MHCB admission or discharge • CTC, OHU, hospice admission or discharge • Mental health level of care change • DPP moves • DDP moves • All other routine movement 	<p>No screening or testing if remains at current institution UNLESS</p> <p>Moving from a COVID-19 outbreak unit to a non-outbreak unit:</p> <ul style="list-style-type: none"> • All such movement should be avoided. • If movement from a COVID-19 outbreak unit to a non-outbreak unit is essential, inmate shall be quarantined in new unit and screened/tested as if coming from a different institution. (See "General population movement from one institution to another, including to camp hubs"). <p>Moving into a large dorm (50 or more residents):</p> <ul style="list-style-type: none"> • Perform COVID-19 symptom screening and COVID-19 rapid testing of the inmate prior to this move. 	No COVID-19 related housing restrictions EXCEPT inmates moving from a COVID-19 outbreak unit to a non-outbreak unit shall be quarantined in a cell in the new unit and tested prior to release.	Inmate to remain in quarantine for at least 21 days, unless placement in quarantine is impossible (e.g.: MSF), in which case the inmate will not be moved. Disposition to be determined in consultation with CME and public health.
Movement from one institution to another for MHCB or PIP placement	<p>MH Regional required to receive approval from the Deputy Director, Health Care Services, to move patient who declines testing.</p> <p>Sending institution</p> <p>Perform rapid testing for COVID-19 prior to movement. Communicate results to receiving facility.</p> <p>All inmates and transportation staff shall wear an N 95 respirator during transfer.</p> <p>Receiving institution</p> <p>House appropriately at receiving institution (isolation vs quarantine) depending upon the results of the rapid test.</p> <p>New arrivals who tested positive at sending institution shall be housed in isolation at receiving institution and managed per CCHCS guidelines.</p> <p>New arrivals who tested negative at sending institution shall be quarantined for 14 days in cell based housing. These inmates shall be screened for COVID-19 symptoms upon arrival and then daily while in quarantine. Test these inmates for COVID-19 on day 12 of quarantine.</p> <p>May release inmates from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative.</p> <p>Place any inmate who tests positive in isolation.</p>	Quarantine in celled housing.	Inmate to remain in quarantine for at least 21 days. Disposition to be determined in consultation with CME and public health.
Admission to DSH from CDCR	Quarantine all inmates prior to transfer in cell based housing. Screen all inmates for COVID-19 symptoms initially and then	As per DSH protocols upon arrival to DSH	Inmate to remain in quarantine for at least 21 days.

COVID-19 SCREENING AND TESTING MATRIX FOR PATIENT MOVEMENT
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	<p>daily while in quarantine. Test symptomatic patients. Place any inmate who tests positive in isolation. Test for COVID after 14 days in quarantine utilizing a methodology that allows for no more than 48 hours turnaround time for results. If inmate tests negative, transfer as soon as possible but no more than 72 hours after test was obtained. All inmates and transportation staff shall wear an N 95 respirator during transfer.</p>		Disposition to be determined in consultation with the Deputy Director, Mental Health and public health.
DSH discharge to CDCR	<p>Sending DSH institution Quarantine all inmates prior to transfer in cell based housing. Screen all inmates for COVID-19 symptoms initially and then daily while in quarantine. Test for COVID after 14 days in quarantine utilizing a methodology that allows for no more than 48 hours turnaround time for results. If inmate tests negative, transfer as soon as possible but no more than 72 hours after test was obtained. All inmates and transportation staff shall wear an N 95 respirator during transfer.</p> <p>Receiving CDCR institution Quarantine all new arrivals for 14 days in cell based housing. Screen all new arrivals for COVID-19 symptoms upon arrival and then daily while in quarantine. Test all new arrivals for COVID-19 on day 12 of quarantine. May release inmates from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative Place any inmate who tests positive in isolation.</p>	Quarantine in celled housing.	Inmate to remain in quarantine for at least 21 days. Disposition to be determined in consultation with the Deputy Director, Mental Health and public health.
To MCCF, ACP, CCTRP, MCRP, fire camp	<p>Quarantine all inmates prior to transfer in cell based housing. Facilities which by design have no cell based housing shall house newly arriving inmates in cohorts of no more than 10 in a dorm or small tent solely dedicated to the cohorts who arrive on the same day. Screen all inmates for COVID-19 symptoms initially and then daily while in quarantine. Test symptomatic patients. Place any inmate who tests positive in isolation. Test for COVID after 14 days in quarantine utilizing a methodology that allows for no more than 48 hours turnaround time for results. If inmate tests negative, transfer as soon as possible but no</p>	Quarantine in celled housing, with minor exceptions as noted.	Do not transfer.

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	more than 72 hours after test was obtained. All inmates and transportation staff shall wear an N 95 respirator during transfer.		
From MCCF, ACP, CCTRP, MCRP, fire camp to an institution	All inmates and transportation staff shall wear an N 95 respirator during transfer. Screen all new arrivals for COVID-19 symptoms upon arrival and then daily while in quarantine. Test all new arrivals for COVID-19 on day 12 of quarantine. May release inmates from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative Place any inmate who tests positive in isolation.	Quarantine in celled housing.	
Parole, medical parole, PRCS release	All inmates shall be screened for COVID-19 symptoms and then tested for COVID one week prior to transfer. Results of testing shall be communicated to parole agent or probation officer and local public health officer in county of release. If inmate tests positive, immediately consult with HQ public health unit re transportation and placement All inmates and transportation staff shall wear an N 95 respirator during transfer.		Inmates cannot be held beyond their parole date regardless of whether they agree to test or if the test is positive.
Out to court, same day return	All inmates and transportation staff shall wear an N 95 respirator during transfer. Use videoconferencing to avoid out to court travel in all cases unless court refuses to do so. Perform daily COVID screening for 14 days upon return. Place symptomatic returns in single cell quarantine while awaiting testing.	No housing restrictions.	.
Out to court, overnight stay.	Manage like an intake from jail to reception center All inmates and transportation staff shall wear an N 95 respirator during transfer. Use video conferencing to avoid out to court travel in all cases unless court refuses to do so. Quarantine all new arrivals for 14 days after arrival in cell based housing. Facilities which by design have no cell based housing shall house newly arriving inmates in cohorts of no more than 10 in a dorm or small tent solely dedicated to the cohorts who arrive on the same day. Screen all new arrivals for COVID-19 symptoms upon arrival and then daily while in quarantine. Test all new arrivals for COVID-19 within 24 hours, again on day 7 and again prior to release from quarantine (no sooner than	Quarantine in celled housing, with minor exceptions as noted.	Inmate to remain in quarantine for at least 21 days. Disposition to be determined in consultation with CME and public health.

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	<p>day 12).</p> <p>Place any inmate who tests positive in isolation.</p> <p>May release inmates from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative.</p>		
Out for clinical appointment, same day return	<p>All inmates and transportation staff shall wear an N 95 respirator during transfer.</p> <p>Use “e-consult” and telemedicine whenever possible to avoid unnecessary offsite transportation.</p> <p>Perform daily COVID screening for 14 days upon return.</p> <p>Place symptomatic returns in single cell quarantine while awaiting testing.</p>	No housing restrictions.	
Return from outside hospitalizations and emergency department visits	<p>Manage like an intake from jail to reception center</p> <p>All inmates and transportation staff shall wear an N 95 respirator during transfer.</p> <p>Quarantine all new arrivals for 14 days after arrival in cell based housing.</p> <p>Facilities which by design have no cell based housing shall house newly arriving inmates in cohorts of no more than 10 in a dorm or small tent solely dedicated to the cohorts who arrive on the same day.</p> <p>Screen all new arrivals for COVID-19 symptoms upon arrival and then daily while in quarantine.</p> <p>Test all new arrivals for COVID-19 within 24 hours, on day 7 and prior to release from quarantine (no sooner than day 12).</p> <p>Place any inmate who tests positive in isolation.</p> <p>May release inmates from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative.</p>	Quarantine in celled housing, with minor exceptions as noted.	<p>Inmate to remain in quarantine for at least 21 days.</p> <p>Disposition to be determined in consultation with CME and public health.</p>

DEFINITIONS

Patients placed in isolation or quarantine shall not move outside of the isolation or quarantine housing unless approved by clinical staff. Medical care and meals shall be provided/served within the isolation/quarantine space. Isolated and quarantined patients shall shower and toilet separately from other patients, and the showers/toilets shall be disinfected prior to use by others. All group activities shall be canceled.

1. ISOLATION

a. Persons who are CONFIRMED to have COVID-19:

- i. Isolation is necessary.

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- ii. For individual cases, the preference is for isolation in a negative pressure room.
- iii. The second choice is isolation in a private room with a solid, closed door.
- iv. Multiple confirmed COVID-19 positive cases can be housed together.
- v. Confirmed positive patients shall not be housed in the same unit with those who are not known to have COVID-19.
- vi. If there are no other options and these patients must be housed in the same building with non-infected patients, they must be physically separated from patients who do not have COVID-19. Physical separation requires solid walls and solid doors.
- vii. Patients confirmed to have COVID-19 shall not be housed in dorms with those who are not confirmed to have COVID-19.
- viii. Daily healthcare monitoring shall be conducted for patients diagnosed with COVID-19.
- ix. All staff interacting with confirmed positive patients shall wear appropriate PPE including N 95 respirators.
- x. To the extent possible, staff who are working in housing units with COVID-19 infected patients shall be cohorted such that they are not interacting with patients who are not known to be infected.

2. QUARANTINE

a. Persons who have been exposed to COVID-19

- i. Quarantine is necessary.
- ii. These patients are at risk of being infected as a result of their exposure. Thus, they shall be separated from both the confirmed cases and from the symptomatic but not yet confirmed cases to avoid re-exposure.
- iii. For individual cases, the preference is for quarantine in a private room with a solid, closed door.
- iv. Exposed persons shall not be housed in dorms with those who are not known to be exposed.
- v. If private rooms are not available, exposed persons can be quarantined together as a cohort.
- vi. If cohorting is essential, quarantine cohorts shall be as small as possible (1-10 persons) to minimize spread.
- vii. Cohorts with different exposure dates shall not be housed together.
- viii. Cohorts with different types of exposures shall also be separated, including those coming in from jails.
- ix. Daily healthcare monitoring shall be conducted for patients who are under quarantine.
- x. Serial testing and healthcare surveillance is used to identify those infected so that they can be moved to isolation.

b. Precautionary Quarantine for persons who are not known to be exposed

- i. Quarantine is necessary.
- ii. Each facility shall maintain sufficient quarantine space to accommodate its historical average volume of transfers
- iii. For individual cases, the preference is for quarantine in a private room with a solid, closed door.
- iv. If private rooms are not available, exposed persons can be quarantined together as a cohort.
- v. If cohorting is essential, quarantine cohorts shall be as small as possible (1-10 persons) to minimize spread.
- vi. Cohorts with different movement dates shall be separated. Cohorts with different types of movement shall also be separated, including those coming in from jails or transferring between institutions.
- vii. Serial testing and healthcare surveillance is used to identify those infected so that they can be moved to isolation.

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- viii. Patients arriving to an institution shall not be released from quarantine until they have completed quarantine and tested negative for COVID-19.

Exhibit B

COVID-19 SCREENING AND TESTING MATRIX FOR PATIENT MOVEMENT

DRAFT VERSION 11.24.20

- 1. To reduce the likelihood of COVID-19 spreading from one location to another, movement shall be limited to that which is necessary for clinical care, medical isolation or quarantine, reduction of overcrowding, and serious custody concerns.*
- 2. Institutions and facilities/yards within institutions may be closed for movement in and/or out due to a COVID outbreak. Movement in and out of locations that are "closed" due to COVID activity may occur on a case by case basis and shall require prior approval from the Director, Health Care Services or designee. Close coordination shall take place between sending and referring institutions.*
- 3. COVID-19 screening consists of a verbal symptom questionnaire and temperature screening.*
- 4. All COVID-19 testing shall be by Polymerase Chain Reaction (PCR) unless specifically stated otherwise.*
- 5. Inmates and transportation staff shall wear N95 masks during transfer. Transportation vehicles shall be operated with reduced occupancy and shall be disinfected after each trip.*
- 6. Every effort shall be made to avoid layovers during transportation. If a layover is essential, this shall be preapproved by the Directors of DAI and Health Care Services or their designees and coordinated in advance with the receiving facilities.*
- 7. Whenever possible, precautionary transfer quarantine shall take place in celled housing with a solid door. Facilities which by design have no cell based housing shall conduct precautionary transfer quarantine in cohorts of no more than 4 in a dorm or small tent solely dedicated to a cohort that arrived on the same day.*
- 8. Symptomatic inmates shall be isolated alone in celled housing with a solid door and tested for COVID-19.*
- 9. Inmates with a PCR-confirmed diagnosis of COVID-19 may be housed together as a cohort on isolation status.*
- 10. Inmates who were previously infected with COVID and were subsequently moved to the resolved status are considered by the CDC to be immune from re-infection for 90 days from the date of first symptoms or first positive test, whichever came first. All movement of "resolved" patients within this 90 day window shall be coordinated by HCPOP in consultation with the CCHCS Public Health Unit.*
- 11. Inmates who have a COVID Risk Score of three or more who are transferred shall only be housed in cells with solid front doors. Inmates with COVID risk scores of three or more shall not transfer to SQ, FSP, ASP, CVSP, CRC, or CIM FAC-A and D.*

TYPE OF MOVEMENT	COVID SCREENING AND TESTING STRATEGY	WHAT TO DO IF PATIENT REFUSES COVID TEST
From jail to reception center	<p>Sending jail: Do not transfer inmates who are currently isolated or quarantined due to exposure. Test by PCR five days prior to scheduled transfer. If PCR negative and COVID screen negative, transfer within 5 days of PCR test collection. Inmates who are symptomatic and/or test positive during pre-transfer testing shall not be transferred. All inmates and transportation staff shall wear an N 95 respirator during transfer.</p> <p>Receiving reception center: Quarantine all new arrivals for 14 days. Screen all new arrivals for COVID-19 upon arrival and then daily while in quarantine. Test all new arrivals for COVID-19 within 24 hours, again on day 7 and again prior to release from quarantine (day 12-14). May release inmates from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative. Inmates who are symptomatic and/or test positive during pre-transfer testing shall be isolated as per interim guidance.</p>	<p>Inmate to remain in quarantine for at least 21 days and receive daily symptom screening. Disposition to be determined in consultation with the Deputy Director, Medical Services or designee.</p>
From jail directly to Specialized Medical Beds (SMB)	<p>Advance authorization required by the Director, Health Care Services or designee. The Intake Control Unit and HCPOP shall coordinate these moves and shall inform the receiving CEO and CME in advance. All inmates and transportation staff shall wear an N 95 respirator during transfer. Quarantine all new arrivals for 14 days. Screen all new arrivals for COVID-19 upon arrival and then daily while in quarantine. Test all new arrivals for COVID-19 within 24 hours, again on day 7 and again prior to release from quarantine (day 12-14). May release inmates from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative. Inmates who are symptomatic and/or test positive during pre-transfer testing shall be isolated as per interim guidance.</p>	<p>Inmate to remain in quarantine for at least 21 days and receive daily symptom screening. Disposition to be determined in consultation with the Deputy Director, Medical Services or designee.</p>

From reception center to institution	<p>Do not transfer inmates who are currently isolated or quarantined due to exposure.</p> <p>Pre-transfer precautionary quarantine not required unless inmate refuses testing or receiving institution unable to quarantine as described above.</p> <p>Test by PCR five days prior to scheduled transfer.</p> <p>If PCR negative, screen for COVID and obtain rapid test on day of scheduled transfer.</p> <p>If PCR negative, screen negative, and rapid test negative, transfer within 5 days of PCR test collection and one day of rapid test collection.</p> <p>Inmates who are symptomatic and/or test positive during pre-transfer testing shall not be transferred and shall be isolated as per interim guidance.</p> <p>All inmates and transportation staff shall wear an N 95 respirator during transfer.</p>	<p>Inmate to be placed in quarantine for at least 21 days and receive daily symptom screening. Disposition to be determined in consultation with the Deputy Director, Medical Services or designee.</p>
Institution intake from reception center	<p>Quarantine patients for 14 days. .</p> <p>Screen for COVID-19 upon arrival and then daily while in quarantine.</p> <p>Test for COVID-19 on day 5 and then again on day 12-14 of quarantine. May release inmates from quarantine after 14 days if asymptomatic and COVID-19 test is negative.</p> <p>Inmates who are symptomatic and/or test positive shall be isolated as per interim guidance.</p>	<p>Inmate to remain in quarantine for at least 21 days. Disposition to be determined in consultation with the Deputy Director, Medical Services or designee.</p>
General population movement from one institution to another, including to camp hubs; movement from ASU / STRH / LTRH / SHU to another facility; movement to facilitate out to court appearance	<p>Sending institution</p> <p>Do not transfer inmates who are currently isolated or quarantined due to exposure.</p> <p>Pre-transfer precautionary quarantine not required unless inmate refuses testing or receiving institution unable to quarantine as described above.</p> <p>Test by PCR five days prior to scheduled transfer.</p> <p>If PCR negative, screen for COVID and obtain rapid test on day of scheduled transfer.</p> <p>If PCR negative, screen negative, and rapid test negative, transfer within 5 days of PCR test collection and one day of rapid test collection.</p> <p>Inmates who are symptomatic and/or test positive during pre-transfer testing shall not be transferred and shall be isolated as per interim guidance.</p> <p>All inmates and transportation staff shall wear an N 95 respirator during transfer.</p> <p>Receiving institution</p> <p>Quarantine patients for 14 days.</p> <p>Screen for COVID-19 upon arrival and then daily while in quarantine.</p> <p>Test for COVID-19 on day 5 and then again on day 12-14 of quarantine.</p>	<p>Sending and receiving institutions:</p> <p>Inmate to be placed in quarantine for at least 21 days.</p> <p>Disposition to be determined in consultation with the Deputy Director, Medical Services or designee.</p>

	<p>May release inmates from quarantine after 14 days if asymptomatic and COVID- 19 test is negative. Inmates who are symptomatic and/or test positive shall be isolated as per interim guidance.</p>	
<p>Movement from one institution to another for OHU, CTC, or Hospice placement</p>	<p>Sending institution <u>Movement that clinicians have determined to not be urgent or emergent:</u> Pre-transfer precautionary quarantine not required unless inmate refuses testing or receiving institution unable to quarantine as described above. Test by PCR five days prior to scheduled transfer. If PCR negative, screen negative, and rapid test negative, transfer within 5 days of PCR test collection and one day of rapid test collection. Inmates who are symptomatic and/or test positive during pre-transfer testing shall not be transferred and shall be isolated as per interim guidance.</p> <p><u>Movement that clinicians have determined to be urgent or emergent:</u> Perform rapid testing for COVID-19 on day of transfer. Transfer patient regardless of the results of the COVID-19 test. Communicate results to receiving facility. All inmates and transportation staff shall wear an N 95 respirator during transfer.</p> <p>Receiving institution <u>New arrivals who tested positive at sending institution:</u> Isolate as per interim guidance.</p> <p><u>New arrivals who tested negative at sending institution:</u> Quarantine for 14 days. Screen for COVID-19 upon arrival and then daily while in quarantine. Test for COVID-19 on day 5 and then again on day 12-14 of quarantine. May release inmates from quarantine after 14 days if asymptomatic and COVID- 19 test is negative. Inmates who are symptomatic and/or test positive shall be isolated as per interim guidance.</p>	<p>Sending and receiving institutions: Inmate to be placed in quarantine for at least 21 days. Disposition to be determined in consultation with the Deputy Director, Medical Services or designee.</p>
<p>Movement within same institution</p> <ul style="list-style-type: none"> • Release from STRH, LTRH, ASU, SHU • PIP / MHC admission or 	<p>Patients shall not be moved to or from an outbreak unit at the same institution. No quarantine or testing required for movement within the same institution unless the patient will be moving into a large dorm (50 or more residents). If so, perform COVID screening and COVID-19 testing of the inmate prior to this move. Only move the patient if the COVID screen and test are negative. If movement is considered urgent or emergent, perform a rapid test and transfer within a day if COVID screen and test are negative.</p>	<p>Inmate to be placed in quarantine for at least 21 days, unless placement in quarantine is impossible (e.g., MSF), in which case the inmate will not be moved. Disposition to be determined in consultation with the Deputy</p>

discharge <ul style="list-style-type: none"> • CTC, OHU, hospice admission or discharge • Mental health level of care change • DPP moves • DDP moves • All other routine movement 		Director, Medical Services or designee.
Admission to MHCb or PIP at another institution	<p>Sending institution Perform rapid testing for COVID-19 on day of transfer. Transfer patient regardless of the results of the COVID-19 test. Communicate results to receiving facility. All inmates and transportation staff shall wear an N 95 respirator during transfer.</p> <p>Receiving institution <u>New arrivals who tested positive at sending institution:</u> Isolate as per interim guidance.</p> <p><u>New arrivals who tested negative at sending institution:</u> Quarantine for 14 days. Screen for COVID-19 upon arrival and then daily while in quarantine. Test for COVID-19 on day 5 and then again on day 12-14 of quarantine. May release inmates from quarantine after 14 days if asymptomatic and COVID- 19 test is negative. Inmates who are symptomatic and/or test positive shall be isolated as per interim guidance.</p>	Receiving institution: Inmate to be placed in quarantine for at least 21 days. Disposition to be determined in consultation with the Deputy Director, Medical Services or designee.
Discharge from MHCb or PIP to another institution	<p>Sending institution Do not transfer inmates who are currently isolated or quarantined due to exposure. Pre-transfer precautionary quarantine not required unless inmate refuses testing or receiving institution unable to quarantine as described above. Test by PCR five days prior to scheduled transfer. If PCR negative, screen for COVID and obtain rapid test on day of scheduled transfer.</p>	Sending and receiving institutions: Inmate to be placed in quarantine for at least 21 days. Disposition to be determined in consultation with the Deputy Director, Medical Services or designee.

	<p>If PCR negative, screen negative, and rapid test negative, transfer within 5 days of PCR test collection and one day of rapid test collection.</p> <p>Inmates who are symptomatic and/or test positive during pre-transfer testing shall not be transferred and shall be isolated as per interim guidance.</p> <p>Receiving institution Quarantine patient for 14 days. Screen for COVID-19 upon arrival and then daily while in quarantine. Test for COVID- 19 on day 5 and then again on day 12-14 of quarantine. May release inmates from quarantine after 14 days if asymptomatic and COVID-19 test is negative. Inmates who are symptomatic and/or test positive shall be isolated as per interim guidance.</p>	
Transfer to DSH from CDCR	<p>Screen inmate and test for COVID 19.</p> <p>If inmate is asymptomatic and tests negative, transfer as soon as possible but no more than 5 days after test was administered. If the patient tests positive, further conversation shall take place between the sending and receiving clinicians to determine if the patient will transfer immediately or complete isolation within the CDCR.</p> <p>All inmates and transportation staff shall wear an N 95 respirator during transfer.</p>	Disposition to be determined in consultation with Deputy Director Mental Health or designee and DSH.
OMDH paroles to DSH	<p>Screen inmate and test for COVID 19.</p> <p>Communicate results to DSH prior to inmate parole.</p> <p>Transport inmate on the day of their parole to DSH.</p> <p>All inmates and transportation staff shall wear an N 95 respirator during transfer.</p>	Communicate information to DSH and transport the inmate on their date of parole.
DSH discharge to CDCR	<p>Sending DSH institution Do not transfer inmates who are currently isolated or quarantined due to exposure. Screen and test for COVID prior to transfer. If inmate is asymptomatic and tests negative, transfer as soon as possible but no more than 5 days after test was administered. All inmates and transportation staff shall wear an N 95 respirator during transfer.</p> <p>Receiving CDCR institution Quarantine inmate for 14 days. Screen for COVID-19 upon arrival and then daily while in quarantine. Test for COVID-19 on day 5 and then again on day 12-14 of quarantine. May release inmates from quarantine after 14 days if asymptomatic and COVID-19 test is negative Inmates who are symptomatic and/or test positive shall be isolated as per</p>	<p>DSH: disposition to be determined in consultation with Deputy Director Mental Health or designee, DSH, the Deputy Director, Medical Services or designee.</p> <p>Receiving CDCR institution: Inmate to be placed in quarantine for at least 21 days. Disposition to be determined in consultation with the Deputy Director, Medical Services or designee.</p>

	interim guidance.	
To MCCF, ACP, CCTRP, MCRP, fire camp (unable to quarantine new arrivals)	<p>Do not transfer inmates who are currently quarantined due to exposure.</p> <p>Quarantine inmate prior to transfer.</p> <p>Screen for COVID-19 initially and then daily while in quarantine.</p> <p>Test for COVID on day 12-14 of quarantine.</p> <p>Inmate to remain in quarantine while awaiting results.</p> <p>If inmate tests negative, transfer as soon as possible but no more than 5 days after test was administered.</p> <p>All inmates and transportation staff shall wear an N 95 respirator during transfer.</p> <p>Inmates who are symptomatic and/or test positive shall be isolated as per interim guidance.</p>	Do not transfer.
From MCCF, ACP, CCTRP, MCRP, or fire camp to an institution (unable to quarantine prior to transport)	<p>All inmates and transportation staff shall wear an N 95 respirator during transfer.</p> <p>Receiving CDCR institution</p> <p>Screen for COVID-19 upon arrival and then daily while in quarantine.</p> <p>Test for COVID-19 on day 5 and then again on day 12-14 of quarantine.</p> <p>May release inmates from quarantine after 14 days if asymptomatic and COVID-19 test is negative.</p> <p>Inmates who are symptomatic and/or test positive shall be isolated as per interim guidance.</p> <p>Inmates returning to an institution for urgent/emergent dental treatment</p> <p>Perform rapid COVID test immediately upon arrival prior to dental treatment. If the inmate tests negative, dental care will be rendered as appropriate. If the inmate tests positive, the inmate shall be isolated and dental treatment will proceed pursuant to dental program policy for COVID-19 positive patients.</p>	<p>Inmate to be placed in quarantine for at least 21 days.</p> <p>Disposition to be determined in consultation with the Deputy Director, Medical Services or designee.</p>
From one fire camp to another fire camp	<p>Perform symptom screening.</p> <p>If screens negative, may transfer to new camp without testing.</p> <p>If screens positive, transport to closest prison for COVID testing and either isolation or quarantine depending upon the results.</p> <p>Inmate and staff shall wear N95 during transportation.</p>	NA
From fire camp to emergency room for treatment of minor injuries/conditions prior to release to fire camp.	Inmate and staff shall wear N95 during transportation and while in the emergency department.	NA
From fire camp to hospital	When released, inmate shall be transported back to a prison for	NA

for admission or other more serious condition	appropriate housing/quarantine/testing All inmates and transportation staff shall wear an N 95 respirator during transfer.	
Parole, medical parole, PRCS release	All inmates shall be screened for COVID-19 symptoms and then tested for COVID within one week of release. Results of testing shall be communicated to parole agent or probation officer and local public health officer in county of release. If inmate tests positive, manage as detailed in the COVID interim guidance. . All inmates and transportation staff shall wear an N 95 respirator during transfer.	Inmates cannot be held beyond their parole date regardless of whether they agree to test or if the test is positive.
Out to court, same day return	Use videoconferencing to avoid out to court travel in all cases unless court refuses to do so. If inmate remained in the custody of the transportation officer at all times, and if the inmate wore a face covering at all times, quarantine upon return shall not be required. All inmates and transportation staff shall wear an N 95 respirator during transfer.	NA
Out to court, at least one overnight stay in a jail or another prison.	Sending institution Do not transfer inmates who are currently isolated or quarantined due to exposure. Screen for COVID symptoms and perform rapid test on the day of departure. If COVID screen and test are negative, patient can be transported. Inmates who are symptomatic and/or test positive shall be isolated as per interim guidance. All inmates and transportation staff shall wear an N95 respirator during transfer. Receiving CDCR Institution Manage like an intake from jail to reception center. All inmates and transportation staff shall wear an N 95 respirator during transfer. Quarantine all new arrivals for 14 days after arrival. Screen all new arrivals for COVID-19 upon arrival and then daily while in quarantine. Test all new arrivals for COVID-19 within 24 hours, again on day 7 and again prior to release from quarantine (day 12-14). May release inmate from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative. Inmates who are symptomatic and/or test positive shall be isolated as per interim guidance.	Sending institution: Refusals to test prior to OTC appointments should be communicated to the courts. If approved, asymptomatic inmates who have completed quarantine may be transferred. Inmate to remain in quarantine for at least 21 days. Disposition to be determined in consultation with the Deputy Director, Medical Services or designee. . Receiving institution: Inmate to be placed in quarantine for at least 21 days. Disposition to be determined in consultation with the Deputy Director, Medical Services or designee.
Out for clinical appointment,	Use "e-consult" and telemedicine whenever possible to avoid unnecessary offsite transportation.	NA

same day return	<p>All inmates and transportation staff shall wear an N 95 respirator during transfer.</p> <p>Perform daily COVID screening for 14 days upon return.</p> <p>Symptomatic inmates shall be isolated and tested as per interim guidance.</p>	
Return from outside hospitalizations and emergency department visits	<p>Manage like an intake from jail to reception center</p> <p>All inmates and transportation staff shall wear an N 95 respirator during transfer.</p> <p>Quarantine for 14 days.</p> <p>Screen for COVID-19 upon arrival and then daily while in quarantine.</p> <p>Test for COVID-19 at 24 hours, again at day 7, and on day 12-14 of quarantine.</p> <p>May release inmates from quarantine after 14 days if asymptomatic and all COVID-19 tests are negative.</p> <p>Inmates who are symptomatic and/or test positive shall be isolated as per interim guidance.</p>	<p>Inmate to be placed in quarantine for at least 21 days.</p> <p>Disposition to be determined in consultation with the Deputy Director, Medical Services or designee.</p>

ISOLATION: GENERAL PRINCIPLES

Patients who are in isolation shall:

- Remain in their isolation location unless approved by clinical staff to move elsewhere
- Be medicated and fed in their isolation location
- Shall receive clinical care in their isolation location
- Shall not share showers or toilets with those who are not infected

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

1. Isolation of patients who are infected with COVID-19
 - a. All infected patients are to be isolated.
 - b. Patients who were diagnosed solely based upon a rapid point of case test (POC) shall not be housed with other infected patients unless the POC test is confirmed by a PCR test.
 - c. Infected patients shall not be housed with patients who are not confirmed to have COVID-19.
 - d. Infected patients can be housed in congregate living sites with other COVID-19 infected patients.
 - e. Twice daily health care monitoring shall be conducted for patients diagnosed with COVID-19.
 - f. All staff interacting with COVID-19 infected patients shall wear an N 95 respirator, eye protection, and when in direct contact gloves and gowns.
2. Precautionary isolation of symptomatic patients who are being evaluated for COVID-19 infection
 - a. Symptomatic patients who have not yet been confirmed to have COVID-19 shall be isolated separately from confirmed COVID-19 patients and separately from those who are not symptomatic.
 - b. Daily health care monitoring shall be conducted for symptomatic patients who are awaiting diagnosis.
 - c. All staff interacting with symptomatic isolated patients shall wear an N 95 respirator, eye protection, and when in direct contact gloves and gowns. .

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

1. Quarantine of Patients who have been Exposed to COVID-19
 - a. These patients are at risk of being infected as a result of their exposure. Thus, they shall be separated from both the confirmed cases and from the symptomatic but not yet confirmed cases.
 - b. For individual cases, the preference is for quarantine in a private room with a solid, closed door.
 - c. Exposed persons shall not be housed in dorms with those who are not know to be exposed.
 - d. If private rooms are not available, persons with the same exposure can be quarantined together as a cohort.
 - e. If cohorting is essential, quarantine cohorts shall be as small as possible (2-4 persons).

- f. Daily healthcare monitoring shall be conducted for patients who are under quarantine.
 - g. Serial testing and healthcare surveillance is used to identify those who are infected so that they can be moved to isolation.
 - h. Patients shall not be released from quarantine until they have completed quarantine and tested negative for COVID-19 by PCR.
 - i. Any inmate who develops symptoms shall be placed in isolation alone and tested for COVID-19.
2. Precautionary quarantine for persons who are post transfer
- a. Each facility shall maintain sufficient quarantine space to accommodate its historical average volume of transfers.
 - b. For individual cases, the preference is for quarantine in a private room with a solid, closed door.
 - c. If private rooms are not available, persons can be quarantined together as a cohort.
 - d. If cohorting is essential, quarantine cohorts shall be as small as possible (2-4 persons).
 - e. Cohorts with different movement dates shall be separated.
 - f. Cohorts with different types of movement shall also be separated, including those coming in from jails or transferring between institutions.
 - g. Patients arriving to an institution shall not be released from quarantine until they have completed quarantine and tested negative for COVID-19 by PCR.
 - h. Any inmate who develops symptoms should be placed in isolation alone and tested for COVID-19.

Exhibit C

**Report on Risks of COVID to High-Risk Patients
Draft October 14, 2020**

Introduction

We are now into the eighth month of the COVID-19 pandemic. Responding to the pandemic remains the highest priority for both the California Department of Corrections and Rehabilitation (“CDCR”) and California Correctional Health Care Services (“CCHCS”). Since early 2020, we have implemented unprecedented organizational changes to respond to COVID-19 while also facing global Personal Protective Equipment (“PPE”) shortages and testing delays. Over the course of the last several months, CDCR and CCHCS, in collaboration and after regularly consulting with public health experts including the California Department of Public Health (“CDPH”), have revised operational practices, implemented regular statewide testing of staff and patients, taken initial steps to de-populate dorms, provided educational programs for staff, implemented gate screening, mandated use of face coverings, aggressively distributed and required use of PPE, provided cleaning supplies and hand sanitizer, and created complex movement guidelines to minimize the risk of spread. Additional information can be found on the COVID-19 Preparedness website (<https://www.cdcr.ca.gov/covid19/>) and in the Receiver’s Forty-fifth Tri-Annual Report filed with the Court on October 1, 2020 (https://cchcs.ca.gov/wp-content/uploads/sites/60/TR/T45_20201001_TriAnnualReport.pdf).

From a systemwide perspective, CDCR’s population has experienced a COVID-19 positive case rate and death rate that is similar to what other prisons around the country have experienced. But we can do better. Because of the risk of greater morbidity and mortality to patients with certain defined COVID-19 risk factors (most importantly, age), throughout the pandemic, we have paid special attention to measures to reduce risks to this population. We now have actual data based on CDCR’s own experience with COVID-19, and that data, combined with the recent determination by the Centers for Disease Control and Prevention (“CDC”) that COVID-19 can spread by aerosolization, strongly points to a single conclusion:

Dorm and open-cell-front housing poses particularly high risks of morbidity and mortality to our patients with COVID-19 risk-factors.

This conclusion drives an urgent search for additional steps that would reduce or eliminate those particularly high risks to those patients. We recommend that CDCR extend an offer to the over 8,200 patients with COVID-19 risk scores of 3 and above who are currently housed in dorms or open-cell-front housing the opportunity to transfer into closed-front cells either at their existing institution or at another institution.¹

¹ Based upon our data and CDC guidelines, we developed a tool for assigning each patient a “COVID-19 risk score” which represents that individual’s risk for having serious illness or death if they become infected with COVID-19.

Status Report on CDCR's COVID-19 Cases and Deaths

Prisons and jails have not been designed, built or operated with consideration of the risks posed by communicable diseases. As noted over a decade ago by CCHCS's Statewide Medical Executive, Dr. Joseph Bick, "most jails and prisons were constructed to maximize public safety, not to minimize the transmission of disease or to efficiently deliver health care." Joseph A. Bick, M.D., "Infection Control in Jails and Prisons," 45 Clinical Infectious Diseases 1047-1055 (Oxford Academic 2007).

Faced with the COVID-19 pandemic, a particularly dangerous and rapidly spreading infectious disease, prisons have struggled to protect their patients. CDCR's experience with COVID-19 is similar to the experience of prisons and other congregate living environments around the country (e.g., skilled nursing facilities, shelters, and cruise ships). Focusing on the federal prison system and the ten largest state prison systems, CDCR has had a larger number of cases per capita than most, but a lower number of deaths per capita than most. The following two tables are based on data reported by The Marshall Project's "State by State Look at Coronavirus in Prisons" as of October 10, 2020 (<https://www.themarshallproject.org/2020/05/01/a-state-by-state-look-at-coronavirus-in-prisons>):²

State (numeric ranking of largest prison systems)	Cases	Per 10,000
Florida (#3)	16428	1942
Texas (#1)	23065	1904
Michigan (#10)	5572	1612
California (#2)	14870	1528
Ohio (#5)	6499	1443
Federal Prisons	16012	1086
Arizona (#9)	2599	659
Illinois (#8)	1846	591
Georgia (#4)	1917	385
New York (#6)	791	213
Pennsylvania (#7)	469	109

Table 1. Cases in Federal and Top Ten State Prisons

² The per capita calculations for California in these tables is based upon an assumed population of 97,317. According to the Project's website, its population numbers were updated as of July 28, 2020. In California, there had, by that time, been a substantial reduction in CDCR's population. During the early months of the pandemic, CDCR's population was much larger (e.g., its population in March was over 120,000). Because of the difference between the population number used by the Project and CDCR's generally higher population numbers during much of the pandemic, the per capita rates for California listed in Tables 1 and 2 are slightly overstated.

State (numeric ranking of largest prison systems)	Deaths	Per 10,000
Ohio (#5)	100	22
Michigan (#10)	73	21
Florida (#3)	141	17
Georgia (#4)	69	14
Texas (#1)	161	13
Federal Prisons	134	9
California (#2)	69	7
Arizona (#9)	28	7
New York (#6)	17	5
Pennsylvania (#7)	11	3
Illinois (#8)	22	n/a

Table 2. Deaths in Federal and Top Ten State Prisons

It is much more difficult to compare cases and deaths in prisons with how COVID-19 has affected the general public in California, the United States or any other possibly relevant geographic unit. One of many methodological challenges in making such comparisons is that the number of cases and deaths in the prisons tends to be much more precise than the number of cases and deaths reported in the free world. For example, it is generally agreed that the number of reported COVID-19 confirmed cases in the United States substantially undercounts the number of actual COVID-19 cases. This is because, among other things, testing for COVID-19 has not been as widespread as it would need to be to count the actual number of cases. For example, according to CDCR's COVID-19 Tracker, there have been 340.2 tests per 1,000 persons in the United States. This means that two-thirds of the population in the United States has not had a COVID-19 test. By contrast, CDCR has tested 800.3 per 1,000 of its patients, making CDCR's count of cases much closer to the true number. A number of studies have concluded that it is likely there are *at least* 6 times more COVID-19 cases in the United States than have been reported (the range of underreporting goes from 6 to 24 times). *See, e.g.*, "Seroprevalence of Antibodies to SARS-CoV-2 in 10 Sites in the United States, March 23 – May 12, 2020," JAMA Internal Med. (July 21, 2020) (doi:10.1001/jamainternmed.2020.4130). The State of California has done a little more testing per 1,000 persons than the United States, but its testing rate of 395.4 per 1,000 also suggests that its reported count of COVID-19 cases is likely to be low.

The following table, Table 3, depicts the COVID-19 case rate for CDCR, the United States, California and Los Angeles. To account for the likely undercount of cases in the United States, California and Los Angeles County, the second column reports an unadjusted case rate based on the cases being currently reported, and the third column reports a case rate adjusted by

multiplying the case rate in the second column by 6, the lowest multiplier suggested by the undercount studies cited above:³

	Case Rate (unadj) per 100,000	Case Rate (6x adj) per 100,000
CDCR	13,944	Not Applicable
United States	2,344	14,063
California	2,133	12,798
Los Angeles County	2,710	16,264

Table 3. Case Rates in CDCR, the United States, California and Los Angeles.

A similar problem exists with respect to the reported number of deaths from COVID-19. Because CDCR's population is so much smaller than the United States or California, and because we actually monitor the condition of each patient in CDCR, the number of deaths CDCR reports from COVID-19 is likely to be more accurate than the death rates reported for the United States and California. The magnitude of the undercount in free world reports is not as well studied as the undercount in cases, making it nearly impossible to adjust free world death rates to account for the likely undercount.

There is a second methodological problem in trying to compare CDCR COVID-19 death rates with free world COVID-19 death rates. The rate of COVID-19 deaths is highly dependent upon age with well over 70% of deaths occurring in persons age 65 and older, and the age distribution of patients within CDCR does not match the age distribution of free world populations. In general, CDCR's population is slightly younger. Absent an adjustment to match the age distribution of CDCR's population to the age distribution of free world populations, the effective rate of CDCR COVID-19 deaths will be lower than if an age adjustment is made.

A third methodological problem is that it is generally recognized that persons who live for lengthy periods of time in prison tend, in terms of their health, to age more quickly than persons who are not in prison. A person who has been living in prison for decades and who has reached age 50 and above is likely to have an effective age anywhere from 5 to 10 years higher than their actual age. Whether this general tendency applies to the risk of death from COVID-19 is unknown at this time.

Given the uncertainties described above, Table 4 depicts the COVID-19 death rate for CDCR, the United States, California and Los Angeles County without making any adjustment for actual or effective age, or for the likely undercount of free world deaths. Because of the methodological challenges in comparing CDCR's death rate with free world death rates, the numbers in Table 4 should be viewed with extreme caution:

³ The rates reported in Tables 3, 4, and 5 are calculated using a CDCR population number of 108,387 which is equal to the average of the monthly population during the pandemic.

	Death Rate per 100,000
CDCR	64
United States	65
California	42
Los Angeles County	65

Table 4. Death Rates in CDCR, the United States, California and Los Angeles.

It is not surprising that CDCR's case and death rates would be somewhat similar to the rates experienced in the state and in the country. Prisons are not hermetically sealed. Tens of thousands of employees and contractors enter CDCR institutions from their communities every day, hundreds of patients are transferred from one institution to another each week, and scores of patients are sent out to or return from court and local hospitals every month. CDCR's prisons are part of the community for COVID-19 purposes.

Discussion of COVID-19 in Dorms and Open-Cell-Front Housing

The data above is based on the cumulative number of cases and deaths throughout the CDCR system. However, we have more granular data for each institution which shows that dorm housing used at institutions throughout CDCR and open-cell-front housing used at San Quentin State Prison and Folsom State Prison pose a significantly higher risk to our patients than closed-cell-front housing.⁴ The disparity in risk is so great that it demands focus on the housing assignments for our COVID-19 high-risk patients.

As of October 10, 2020, 69 patients in CDCR custody have died from COVID-19-associated illnesses. Eighty-four percent (84%) of those 69 deaths had a COVID-19 risk score of 3 or above at the time of death, and there has been only one patient with a risk score of 0 who has died from COVID-19. Table 5 depicts the number of deaths and death rates by COVID-19 risk score:

COVID-19 Risk Score	Deaths	Patient Count with Score	Death Rate per 1,000
0	1	43987	0.023
1	3	25817	0.116
2	7	11779	0.594
3	10	5954	1.679
4	4	3145	1.272

⁴ There actually are a number of different dorm designs used within CDCR that are likely to have materially different COVID-19 spread risks: e.g., 270 Dorms, E-Dorms, Cross-Top Dorms, and Small 6-8 Man Dorms with Closed Doors. Further analysis and discussion may conclude that closed-door, small dorms are an appropriate alternative to residing in a large dorm with shared air space. However, for purposes of this paper, all dorm types have been grouped together in a single "dorm" category.

5	6	1962	3.058
6	7	1628	4.300
7	6	1322	4.539
8	10	1025	9.756
9	5	637	7.849
10 to 17	10	1097	9.116
Grand Total	69	98353	0.702

Table 5. Deaths and Death Rates by COVID-19 Risk Score.

For purposes of further analysis, “COVID-19 high-risk patients” refers to all patients with a COVID-19 risk score of 3 and above. This threshold has been chosen primarily because, as depicted in Table 5, there is a substantial increase in the death rate from risk score 2 to risk score 3, and the death rate beginning at risk score 3 and above is higher than the overall death rate for the entire population

An analysis of the housing location of all COVID-19 patients who have died highlights dorm and open-cell-front housing as being particularly problematic to our COVID-19 high-risk patients. Eighty-one percent (81%) of the 69 deaths acquired COVID-19 while living in a dorm or open-cell-front housing unit.

Dorms and open-cell-front housing are more dangerous than closed-door cells because, as very recently confirmed by the CDC, transmission of COVID-19 occurs both through droplets and through aerosolization. Early on in the pandemic, it was believed that transmission occurred only through droplets which supported putting the social distancing requirement at 6 feet (since droplets can only rarely travel more than 6 feet from the source) and not being as concerned about situations where aerosol spread might occur. In response to that understanding, CDCR made efforts to depopulate enough dorm space so that there was 6-feet of distance between groups of 8.

As the world’s experience with the pandemic progressed, it increasingly became clearer that some transmission was occurring through aerosolization in addition to droplet spread. Pathogens that spread via aerosolization can travel in air currents over greater distances and remain in the air for longer periods of time as opposed to large droplets which rapidly fall to the ground within approximately six feet. As a result, aerosolized organisms result in an increased risk of transmission in closed rooms and spaces where the virus can infect people who are more than 6 feet from an original source.

The fact of spread by aerosolization makes dorms and open-cell-front housing within CDCR substantially more problematic in terms of the speed and extent of COVID-19 spread among our patients than closed-cell-front housing. Accordingly, COVID-19 high-risk patients, who are at a much higher risk of morbidity and mortality from COVID-19, should not be housed in dorms or open-cell-front housing.

Table 6 depicts the distribution of COVID-19 high-risk patients (i.e., those with COVID-19 risk scores of 3 and above) in dorm, open-cell-front and closed-cell-front housing:

Housing Type	Number of Patients with COVID-19 Risk Score of 3 and Above
Dorm	6,916
Open-cell-front	1,357
Closed-cell-front	8,420
Total	16,693

Table 6. Housing of COVID-19 High-Risk Patients

In summary, about fifty percent (50%) of the COVID-19 high-risk population remain in the most problematic housing for the transmission of COVID-19. Strategies for reducing these risks include:

- Consideration for release from CDCR of COVID-19 high-risk patients in problematic housing;
- Inter-institution transfer of COVID-19 high-risk patients from dorms and open-cell-front housing to closed-cell-front housing;
- Intra-institution transfer of COVID-19 high-risk patients from dorms and open-cell-front housing to closed-cell-front housing; and,
- Adding housing capacity at select prisons in the form of small tents to further depopulate dorms and open-cell-front housing (certainly not as effective as closed-cell-front housing, but better than large dorms and large open-cell-front housing).

CDCR has already reviewed and considered for release thousands of COVID-19 high-risk patients; a small number of those patients have been released. Consideration for release of COVID-19 high-risk patients in high-risk housing should continue.

If all of the COVID-19 high-risk patients currently in dorms and open-cell-front housing were moved into small tents, it would require some 800 10-person tents to be installed throughout the CDCR system. This number of tents would pose substantial resource and operational challenges, even if that number of tents was readily available. At select institutions, however, installation of 10-person tents may result in a marginal improvement in risk, but this should be a last resort employed only if no other solution is possible because small tents are certainly not as effective as closed-cell-front housing.

The transfer of COVID-19 high-risk patients from dorms and open-cell-front housing to closed-cell-front housing, either by intra-institution transfer or inter-institution transfer, may be feasible on a large enough scale to significantly reduce the risk of COVID-19 to our high-risk patients.

Transferring large numbers of patients within institutions or, particularly, between institutions is not a risk-free endeavor. Much more stringent movement requirements were adopted after the failed movement of high-risk patients from CIM to Corcoran and San Quentin in May (e.g., pre-transfer quarantine and testing, and post-transfer quarantine and testing). However, no matter what protections are placed around inter-institution transfers, there is a risk that the transfer of large numbers of patients between institutions might itself trigger further COVID-19 spread,

particularly at the receiving institution. On the other hand, CDCR is currently transferring hundreds of patients per week between institutions, so the risks associated with transfer already exist within CDCR's system, and the marginal increase in risk of transfers associated with a program to transfer patients from dorms and open-cell-front housing to close-cell-front housing appears to be outweighed by the benefit to patients of offering such a move.

CDCR has already offered intra-institution transfers to several hundred COVID-19 high-risk patients with COVID-19 risk scores of 11 and above, so we have some experience with this type of program. Where it has been tried, a significant percentage of patients has refused the transfer offer. For example, of the 123 patients recently offered such a move, only 19 accepted the offer, an acceptance rate of fifteen percent (15%). Because these moves are intended primarily to benefit the patient, we have respected the patients' decisions to remain in their existing housing.

Conclusion

Based on the above analysis, we conclude that CDCR should offer to every patient with a COVID-19 risk score of 3 and above who is currently housed in a dorm setting or in open-cell-front housing, the option of being transferred to closed-cell-front housing either at their existing institution or at some other institution.

Exhibit D



ORDER TO SET ASIDE ISOLATION AND QUARANTINE SPACE

Public Health Workgroup Recommendations

Background

The *Order to Set Aside Isolation and Quarantine Space* (case number 01-cv-01351-JST) issued on July 22, 2020 requires the California Department of Corrections (CDCR) and California Correctional Health Care Services (CCHCS) to identify, and keep vacated or reserved, at least 100 beds to be used for isolation and quarantine housing in the event of a COVID-19 outbreak for a period of at least 180 days.

The *Order* also requires assessment of whether additional space is required at each institution for isolation and quarantine purposes and, if so, whether that will be obtained by vacating additional housing units or through other means. Assessments shall be guided by health considerations, without regard to whether sufficient space can be reserved at the institution without further reduction in the population.

The purpose of the remainder of this document is to summarize the public health workgroup's deliberations and recommendations regarding additional space needs that occurred during three separate meetings on July 28th, July 31st and August 4th, 2020. On August 7th and 12th, the workgroup's draft recommendations were discussed with each institution's leadership, court representatives and other stakeholders. The focus of the discussions was to determine what types of space must be created at each institution to isolate and quarantine different subpopulations including, but is not limited to, persons with disabilities, mental health and/or other special/restricted housing needs.

Workgroup Deliberations

Representatives from CDCR and CCHCS met with the parties' health experts to devise a method for determining whether additional bed space above the ordered 100 beds per institution is required to protect residents from COVID-19 infection and if additional space is required, how much space is needed at each institution. It is expected that if an outbreak were to occur that has the potential of infecting significant numbers of residents it would likely start and spread within congregate living spaces such as dormitories or cells with open bars or porous doors.

During the deliberations, the workgroup reviewed space information provided by CDCR and CCHCS staff that showed, at the end of July, approximately two-thirds of residents live in existing celled housing settings that usually are comprised of solid walls and doors and have a two person occupancy. Also noted was that many large dorm settings had already been de-densified leaving significant vacancies in these large dorms at most institutions.

While additional dedicated space will be a mixture of isolation and quarantine spaces, each will serve a different purpose. Isolation space is used to house patients who are confirmed or suspected to be infected with COVID-19. Suspected cases must be housed separate from each other, and unlike patients with confirmed infection who can be housed together in larger cohorts within dorm-like settings, patients suspected to have COVID-19 infection must be separated from each other in single cells with solid doors, with minimal exceptions noted.

Currently there are four institutions where the proportion of residents infected with COVID-19 ranges from approximately one-third to nearly two-thirds involving almost 1,000 to 2,000 individuals at those prisons. What this means from a housing perspective is that dorm housing or cells with open bars or porous doors can be used to cohort the significant numbers of residents with confirmed infection at these prisons, depending on other factors which may impact the type of housing and patients who can be cohorted together in isolation.

On the other hand, at most of the remaining institutions, either no cases have been identified among residents or smaller numbers of persons have been infected. Therefore quarantine spaces will be required for the majority of space rather than isolation space, and these should be configured as equivalent to *single cells with solid doors*. Quarantine space is the most restrictive because it's used to house residents who have been exposed to COVID-19 but have not tested positive for the virus. Under optimal circumstances, residents, in quarantine, should be housed individually, in a setting that has solid walls and doors, to ensure that if an exposed person tests positive the risk of transmission to others is significantly reduced.

General Space and Other Recommendations

Although these recommendations focus on space considerations for isolation and quarantine for incarcerated persons, it is assumed that the following basic measures and resources in sufficient amounts are in effect and available respectively in order to prevent and contain COVID-19, which include but are not limited to: restricted movement, timely testing for residents and staff, assignment of staff in cohorts that do not mix, and utilization of face coverings, personal protective equipment and environmental controls.

The general space recommendations noted below apply to all institutions and focus on the quality or types of space that need to exist at all institutions rather than the quantity of space per se. The general recommendations include:

- Individuals confirmed to have active COVID-19 infection can be isolated together in congregate living spaces but must not share air space with any of the other groups (except resolved cases; see below).
- Individuals suspected of COVID-19 infection should be housed in the equivalent of single cells with solid doors.
- Individuals who have been exposed should be quarantined in the equivalent of single cells with solid doors.
- Individuals who have not been infected and have not been exposed should be housed in sparsely populated spaces that allow for as much physical distancing as possible and in the smallest cohorts as possible.
- Individuals who have resolved COVID-19 infection can be housed with most other individuals noted above except for suspected cases. This assumes that individuals who have resolved their infection are not contagious and do not get re-infected within at least three months of the initial infection.

Specific Institution Space Recommendations

Based on the above concepts and general recommendations, it was determined that a sound method to ensure sufficient quantity of space to house infected and exposed individuals who require isolation and quarantine respectively would be to base it on each institution's largest congregate living spaces because the risk of transmission of infection to large numbers of residents is greatest in these equivalent dorm-like settings that include, at some institutions, celled housing with open bars and porous doors.

Information in Attachment A, which was prepared by Quality Management staff, provides the numbers of isolation and quarantine beds required at each institution based on the method of reserving enough space to equal the *combined occupancy in each institution's two largest congregate housing units*. Also shown in Attachment A are numbers of persons with disabilities, patients in the Enhanced Outpatient Program level of mental health services and patients with a COVID-19 risk score of 4 or more as well as other data.

Given the recommendations and application of the method, it appears that nearly all institutions already had reserved or vacated enough suitable bed space for isolation and quarantine. However there were notable exceptions in terms of either institutions requiring significantly more space than other institutions such as Folsom State Prison or the space that had been identified is not adequate because it's dorm space or cells with porous doors. It should be noted that San Quentin also required significantly more space than others but since so many of the residents have already been infected the actual isolation and quarantine space that needs to be set aside is less than calculated once those patients have been excluded.

Although the quantity and quality of bed space identified appears adequate for isolation and quarantine purposes at most prisons, there were concerns raised by plaintiffs' representatives regarding whether there needs to be specific numbers of beds set aside for isolation versus quarantine, both in general and for patients with disabilities or in the mental health program, and whether patients in isolation and quarantine need to be in different housing units even if all occupants are in cells with solid doors with physical distancing among individuals and face coverings/masking are required and environmental controls are aggressively implemented. Regarding the concerns, the point of the method proposed by the public health experts is to identify and respond to an outbreak at the earliest onset which means most of the space will be for quarantine and if the space is single cells with solid doors and all public health measures are enforced along with the de-densification that has already occurred, the proposed space plan, though imperfect, is a reasoned and supportable approach that protects residents and staff.

Conclusion:

Through the extensive process described above, CCHCS has provided a summary of conclusions reached in terms of assessing whether additional space is required beyond what was identified by CDCR. This summary is provided as Attachment B. However, public health experts have opined that ideal quarantine space is single-cell based housing. Attachment C reflects the identified bed needs if the CDCR identified spaces were converted to single-cell housing. There are a number of issues that have arisen in the course of the discussions with public health experts, plaintiffs, and prison leadership. While Judge Tigar's order is quite specific, it is difficult to address all 35 prisons with the same approach. Such exceptions are noted below:

- There are multiple institutions where the recommendations of CCHCS and public health experts is difficult, if not impossible: San Quentin State Prison (SQP), Folsom State Prison (FSP), and the California Rehabilitation Center (CRC). SQP and FSP have entirely too large of a congregate living area and require unique solutions (as are occurring now) to address an outbreak. CRC has zero cells on the entire property and will require a multitude of vacant dorms (already accomplished) and a unique strategy on quarantining patients.

Also in the course of the discussions described above, it is anticipated that plaintiffs' counsel and court monitors will express concerns with CDCR's identified space or current policies regarding the housing of isolation and quarantine patients. These concerns are noted below:

- Many institutions have vacated the identified space(s) in accordance with Judge Tigar's order, but were utilizing less-desirable locations for quarantine/isolation. During the meetings with prison leadership, they were directed to begin utilizing the space.
- In multiple instances, institutions were housing isolation and quarantine patients in the same building. When asked, they clearly articulated how they were maintaining maximum distancing between quarantine and isolation.
- The identified space(s) is intended to be utilized by inmates from differing levels and differing programs. Plaintiffs and court monitors expressed concern about the ability to effectively program in the same building. Examples: EOP inmates with Non-EOP inmates, SNY inmates with GP inmates, Level II with Level IV, etc.
- Many of the spaces identified did not have adequate housing for Armstrong class members according to the Armstrong Court Expert and plaintiffs.
- How to address inmates who refuse to move to the designated locations.
- When tents were mentioned for isolation cases, plaintiffs expressed concerns about accessibility and public health requirements.
- For institutions with Arizona (perforated steel) doors (CEN, CAL, LAC), plaintiffs expressed a need for lexan to be placed on cell fronts. At CAL, all doors already have lexan installed in the identified building. At LAC, some of the cells have lexan installed in the identified building. At CEN, none of the cell doors have lexan installed.
- While the public health experts have opined that single cells are ideal for quarantine space, it is entirely appropriate for space identified for isolation to be in dorms or tents as the patients have already been identified as positive for Covid.

Lastly, from the perspective of CCHCS, many institutions have excess capacity, beyond what was identified for purposed of Judge Tigar's order, and could quickly identify additional buildings for use as quarantine and/or isolation space.

ATTACHMENT A

Institution		Patients In Two Largest Air Spaces		COVID Resolved and Active				
				Institution		2 Largest Air Spaces		Instit
		#	%	#	%	#	%	#
ASP	3,804	248	7%	1,353	36%	95	38%	2,451
CAC	2,138	4	0%	1	0%	0	0%	2,137
CAL	2,926	180	6%	16	1%	0	0%	2,910
CCC	2,151	48	2%	512	24%	46	96%	1,639
CCI	3,426	235	7%	495	14%	124	53%	2,931
CCWF	2,130	16	1%	16	1%	0	0%	2,114
CEN	3,191	193	6%	38	1%	0	0%	3,153
CHCF	2,567	277	11%	3	0%	0	0%	2,564
CIM	2,521	188	7%	832	33%	8	4%	1,689
CIW	1,187	4	0%	310	26%	0	0%	877
CMC	3,425	143	4%	94	3%	0	0%	3,331
CMF	2,197	162	7%	5	0%	0	0%	2,192
COR	3,387	46	1%	195	6%	0	0%	3,192
CRC	2,690	187	7%	358	13%	16	9%	2,332
CTF	4,529	127	3%	3	0%	0	0%	4,526
CVSP	2,090	91	4%	983	47%	5	5%	1,107
DVI	1,473	66	4%	0	0%	0	0%	1,473
FSP	2,626	1,380	53%	5	0%	1	0%	2,621
HDSP	3,414	71	2%	3	0%	1	1%	3,411
ISP	3,004	63	2%	53	2%	0	0%	2,951
KVSP	3,546	66	2%	5	0%	0	0%	3,541
LAC	3,040	210	7%	128	4%	2	1%	2,912
MCSP	3,878	29	1%	20	1%	20	69%	3,858
NKSP	1,698	78	5%	9	1%	0	0%	1,689
PBSP	2,389	49	2%	0	0%	0	0%	2,389
PVSP	2,933	78	3%	1	0%	0	0%	2,932
RJD	3,635	39	1%	5	0%	1	3%	3,630
SAC	2,281	11	0%	4	0%	0	0%	2,277
SATF	4,627	16	0%	8	0%	0	0%	4,619
SCC	2,416	63	3%	0	0%	0	0%	2,416
SOL	3,553	211	6%	1	0%	0	0%	3,552
SQ	3,138	1,550	49%	1,983	63%	1,246	80%	1,155
SVSP	2,804	78	3%	3	0%	0	0%	2,801
VSP	2,896	16	1%	0	0%	0	0%	2,896
WSP	2,179	152	7%	123	6%	1	1%	2,056

ATTACHMENT A

COVID Naïve			COVID Naïve High Risk				COVID High Risk	
Institution			2 Largest Air Spaces		Institution		2 Largest Air Spaces	
%	#	%	#	%	#	%	#	%
64%	153	62%	16	0%	0	0%	25	1%
100%	4	100%	5	0%	0	0%	5	0%
99%	180	100%	7	0%	0	0%	7	0%
76%	2	4%	16	1%	0	0%	16	1%
86%	111	47%	40	1%	1	0%	55	2%
99%	16	100%	127	6%	1	6%	127	6%
99%	193	100%	9	0%	0	0%	9	0%
100%	277	100%	879	34%	87	31%	881	34%
67%	180	96%	380	15%	4	2%	684	27%
74%	4	100%	83	7%	0	0%	102	9%
97%	143	100%	449	13%	22	15%	457	13%
100%	162	100%	493	22%	62	38%	494	22%
94%	46	100%	106	3%	0	0%	116	3%
87%	171	91%	34	1%	1	1%	37	1%
100%	127	100%	253	6%	7	6%	253	6%
53%	86	95%	27	1%	0	0%	62	3%
100%	66	100%	31	2%	3	5%	31	2%
100%	1,379	100%	160	6%	114	8%	160	6%
100%	70	99%	20	1%	0	0%	20	1%
98%	63	100%	13	0%	0	0%	16	1%
100%	66	100%	53	1%	0	0%	53	1%
96%	208	99%	205	7%	10	5%	216	7%
99%	9	31%	846	22%	0	0%	848	22%
99%	78	100%	28	2%	0	0%	28	2%
100%	49	100%	35	1%	0	0%	35	1%
100%	78	100%	2	0%	1	1%	2	0%
100%	38	97%	537	15%	0	0%	539	15%
100%	11	100%	53	2%	0	0%	53	2%
100%	16	100%	266	6%	6	38%	266	6%
100%	63	100%	39	2%	1	2%	39	2%
100%	211	100%	491	14%	51	24%	492	14%
37%	304	20%	113	4%	41	3%	582	19%
100%	78	100%	77	3%	1	1%	77	3%
100%	16	100%	268	9%	3	19%	268	9%
94%	151	99%	26	1%	3	2%	26	1%

ATTACHMENT A

High Risk (4+)		ADA (Impacting Placement, Overall)				ADA Mobility Impacting Placement		
2 Largest Air Spaces		Institution		2 Largest Air Spaces		Institution		2 Largest Air Spaces
#	%	#	%	#	%	#	%	#
0	0%	1	0%	0	0%	0	0%	0
0	0%	0	0%	0	0%	0	0%	0
0	0%	3	0%	0	0%	3	0%	0
0	0%	0	0%	0	0%	0	0%	0
6	3%	0	0%	0	0%	0	0%	0
1	6%	130	6%	4	25%	124	6%	4
0	0%	5	0%	0	0%	5	0%	0
87	31%	885	34%	72	26%	856	33%	66
5	3%	155	6%	2	1%	139	6%	2
0	0%	11	1%	0	0%	11	1%	0
22	15%	6	0%	0	0%	6	0%	0
62	38%	545	25%	48	30%	489	22%	43
0	0%	48	1%	0	0%	48	1%	0
1	1%	2	0%	0	0%	2	0%	0
7	6%	11	0%	0	0%	11	0%	0
0	0%	1	0%	0	0%	0	0%	0
3	5%	33	2%	8	12%	31	2%	8
114	8%	6	0%	2	0%	5	0%	2
0	0%	46	1%	1	1%	39	1%	1
0	0%	7	0%	0	0%	5	0%	0
0	0%	89	3%	5	8%	89	3%	5
10	5%	172	6%	12	6%	163	5%	11
2	7%	216	6%	0	0%	206	5%	0
0	0%	23	1%	0	0%	22	1%	0
0	0%	1	0%	0	0%	1	0%	0
1	1%	22	1%	5	6%	22	1%	5
0	0%	705	19%	0	0%	677	19%	0
0	0%	9	0%	0	0%	8	0%	0
6	38%	474	10%	11	69%	379	8%	10
1	2%	4	0%	1	2%	4	0%	1
51	24%	11	0%	0	0%	11	0%	0
367	24%	52	2%	4	0%	40	1%	0
1	1%	176	6%	5	6%	167	6%	5
3	19%	357	12%	7	44%	357	12%	7
3	2%	20	1%	6	4%	19	1%	5

ATTACHMENT A

ement	ADA Non-Mobility				EOP And ADA			
Air Spaces	Institution		2 Largest Air Spaces		Institution		2 Largest Air Spaces	
%	#	%	#	%	#	%	#	%
0%	1	0%	0	0%	0	0%	0	0%
0%	0	0%	0	0%	0	0%	0	0%
0%	0	0%	0	0%	0	0%	0	0%
0%	0	0%	0	0%	0	0%	0	0%
0%	0	0%	0	0%	0	0%	0	0%
25%	6	0%	0	0%	5	0%	0	0%
0%	0	0%	0	0%	0	0%	0	0%
24%	29	1%	6	2%	113	4%	0	0%
1%	16	1%	0	0%	0	0%	0	0%
0%	0	0%	0	0%	2	0%	0	0%
0%	0	0%	0	0%	0	0%	0	0%
27%	56	3%	5	3%	74	3%	0	0%
0%	0	0%	0	0%	11	0%	0	0%
0%	0	0%	0	0%	0	0%	0	0%
0%	0	0%	0	0%	0	0%	0	0%
0%	1	0%	0	0%	0	0%	0	0%
12%	2	0%	0	0%	0	0%	0	0%
0%	1	0%	0	0%	0	0%	0	0%
1%	7	0%	0	0%	0	0%	0	0%
0%	2	0%	0	0%	0	0%	0	0%
8%	0	0%	0	0%	11	0%	0	0%
5%	9	0%	1	0%	12	0%	0	0%
0%	10	0%	0	0%	17	0%	0	0%
0%	1	0%	0	0%	0	0%	0	0%
0%	0	0%	0	0%	0	0%	0	0%
6%	0	0%	0	0%	0	0%	0	0%
0%	28	1%	0	0%	117	3%	0	0%
0%	1	0%	0	0%	1	0%	0	0%
63%	95	2%	1	6%	22	0%	0	0%
2%	0	0%	0	0%	0	0%	0	0%
0%	0	0%	0	0%	0	0%	0	0%
0%	12	0%	4	0%	7	0%	0	0%
6%	9	0%	0	0%	46	2%	0	0%
44%	0	0%	0	0%	9	0%	0	0%
3%	1	0%	1	1%	1	0%	0	0%

ATTACHMENT A

EOP No ADA				Facilities with Two Largest Air Spaces
Institution		2 Largest Air Spaces		
#	%	#	%	
7	0%	0	0%	C 320 1, B 220 1
0	0%	0	0%	C 002C1, C 002C2
1	0%	0	0%	D 002 2, C 005 2
0	0%	0	0%	A34, A12
14	0%	1	0%	E BH 1, D 00251
88	4%	0	0%	C 510 1, C 511 1
0	0%	0	0%	B 001 2, B 002 2
459	18%	0	0%	E304, E302
34	1%	27	14%	BH, SH
47	4%	0	0%	A EMUA1, A EMUA1
572	17%	0	0%	G 026 1, G 025 1
408	19%	0	0%	S COV 1, B DC 1
252	7%	0	0%	M 005 1, M 003 1
1	0%	0	0%	D 402 3, D 404 2
8	0%	0	0%	B TD 1, D 004 1
0	0%	0	0%	M 001 1, M 002 1
1	0%	0	0%	AEH
6	0%	2	0%	BldgU1, BldgU3
16	0%	0	0%	M 002 1, M 001 1
0	0%	0	0%	M 002 1, M 001 1
119	3%	0	0%	M 002 1, M 001 1
521	17%	0	0%	Z 001 1, B 003 1
629	16%	0	0%	M 002G1, C GYM 1
16	1%	0	0%	M 002 1, C 001 2
5	0%	0	0%	M 002 2, M 002 1
7	0%	0	0%	M 001 1, M 002 1
674	19%	0	0%	M 022 2, M 022 1
721	32%	0	0%	M 001F1, M 002J1
454	10%	0	0%	B 003 1, A 002 1
1	0%	0	0%	B 001D1, B 001E2
4	0%	0	0%	C 016 1, C 017 1
228	7%	34	2%	NBlock, WBlock
319	11%	0	0%	M 002 1, M 001 1
280	10%	0	0%	B 001 1, B 003 1
22	1%	0	0%	H 003 1, H 004 1

ATTACHMENT A

Rooms of Two Largest Air Spaces	Bed Type in Two Largest Air Spaces	Notes from Institution
ASP C 320 1000, ASP B 220 1000	Dorm	-
C 002C1, C 002C2	Cell	-
D 002 2, C 005 2	270 Cell	-
A34, A12	Dorm	-
CCI E BH 1000, CCI D 00251000	Dorm	-
CCWF C 510 1008, CCWF C 511 1030	Dorm	-
B 001 2, B 002 2	270 Cell	-
E304, E302	Dorm	-
BH, SH	Cell	RC Housing Unit pending conversion to NDPF Level II
A EMUA1, A EMUA1	Cell	-
CMC G 026 1000, CMC G 025 1000	Dorm	-
CMF S COV 1000, CMF B DC 1000	Dorm	-
COR M 005 1000, COR M 003 1000	Dorm	-
CRC D 402 3000, CRC D 404 2000	Dorm	-
CTF B TD 1000, CTF D 004 1000	Dorm	-
CVSP M 001 1000, CVSP M 002 1000	Dorm	-
AEH	Cell	Tiered Open Air
BldgU1, BldgU3	Cell	Tiered Open Air
HDSP M 002 1000, HDSP M 001 1000	Dorm	-
ISP M 002 1000, ISP M 001 1000	Dorm	-
KVSP M 002 1000, KVSP M 001 1000	Dorm	-
Z 001 1, B 003 1	Cell	-
MCSP M 002G1000, MCSP C GYM 1000	Dorm	-
NKSP M 002 1000, NKSP C 001 2000	Dorm	-
PBSP M 002 2000, PBSP M 002 1000	Dorm	-
PVSP M 001 1000, PVSP M 002 1000	Dorm	-
RJD M 022 2000, RJD M 022 1000	Dorm	-
SAC M 001F1000, SAC M 002J1000	Dorm	-
SATF B 003 1004, SATF A 002 1006	Dorm	-
SCC B 001D1050, SCC B 001E2051	Dorm	-
SOL C 016 1000, SOL C 017 1000	Dorm	-
NBlock, WBlock	Cell	Tiered Open Air
SVSP M 002 1000, SVSP M 001 1000	Dorm	-
VSP B 001 1001, VSP B 003 1008	Dorm	-
WSP H 003 1000, WSP H 004 1000	Dorm	-

ATTACHMENT B

Institution	Total Population	Patients In Two Largest Air Spaces		CDCR IDENTIFIED BEDS	CDCR IDENTIFIED SPACE(S)	ADDITIONAL SPACE REQUIRED	COMMENTS	Rooms of Two Largest Air Spaces	Bed Type in Two Largest Air Spaces	Door Type in Identified Beds
		#	%							
ASP	3,804	248	7%	191	A-120	(57)	Only 1 celled 270 housing unit at ASP.	ASP C 320 1000, ASP B 220 1000	Dorm	N/A
CAC	2,138	4	0%	168	A-2, A and B Pod			C 002C1, C 002C2	Cell	Solid
CAL	2,926	180	6%	198	A-5		Old ASU unit. Has lexan installed over Arizona doors	D 002 2, C 005 2	270 Cell	Perforated
CCC	2,151	48	2%	200	C-3			A34, A12	Dorm	Solid
CCI	3,426	235	7%	148	E-Clark Dorm D-9	(87)	Plaintiffs offered reasonable alternatives to identified spaces.	CCI E BH 1000, CCI D 00251000	Dorm	N/A & Solid
CCWF	2,130	16	1%	200	A-503			CCWF C 510 1008, CCWF C 511 1030	Dorm	Solid
CEN	3,191	193	6%	192	A-5	(1)		B 001 2, B 002 2	270 Cell	Perforated
CHCF	2,567	277	11%	192	E-Yard Tent (100) 92 negative pressure rooms	(85)		E304, E302	Dorm	N/A & Solid
CIM	2,521	188	7%	102	B-1 (Cypress)	(86)		BH, SH	Cell	Solid
CIW	1,187	4	0%	220	H-12		Incorrect space listed on chart. CIW identified H-12 as space.	A EMUA1, A EMUA1	Cell	Solid
CMC	3,425	143	4%	300	C-5			CMC G 026 1000, CMC G 025 1000	Dorm	Solid
CMF	2,197	162	7%		W-1, W-2, S-3	(162)	CDCR acknowledged that submitted plan needs to be completely redone.	CMF S COV 1000, CMF B DC 1000	Dorm	Solid
COR	3,387	46	1%	200	3B02			COR M 005 1000, COR M 003 1000	Dorm	Solid
CRC	2,690	187	7%	155	D-410, D-311		Unique solution required for CRC due to the institution be 100% dorms.	CRC D 402 3000, CRC D 404 2000	Dorm	N/A
CTF	4,529	127	3%	178	Central Y-Wing			CTF B TD 1000, CTF D 004 1000	Dorm	Solid
CVSP	2,090	91	4%	192	D-11		CDCR will revise CVSP's plan to revert current ASU to identified quarantine unit.	CVSP M 001 1000, CVSP M 002 1000	Dorm	N/A
DVI	1,473	66	4%	264	G-Wing			AEH	Cell	Solid
FSP	2,626	1,380	53%	286	Tents - 40 A-IV: 88 A dorm Pods 3/4 MSF 500/600		Unique solution required for FSP due to enormous single, congregate living areas.	BldgU1, BldgU3	Cell	Open Bar & N/A
HDSP	3,414	71	2%	128	C-1		Had an additional space identified and ready to house additional quarantine.	HDSP M 002 1000, HDSP M 001 1000	Dorm	Solid
ISP	3,004	63	2%	200	C-1			ISP M 002 1000, ISP M 001 1000	Dorm	Solid
KVSP	3,546	66	2%	128	D-6			KVSP M 002 1000, KVSP M 001 1000	Dorm	Solid
LAC	3,040	210	7%	200	C-5	(10)		Z 001 1, B 003 1	Cell	Perforated
MCSP	3,878	29	1%	200	A-2			MCSP M 002G1000, MCSP C GYM 1000	Dorm	Solid
NKSP	1,698	78	5%	200	D-3			NKSP M 002 1000, NKSP C 001 2000	Dorm	Solid
PBSP	2,389	49	2%	128	A-1			PBSP M 002 2000, PBSP M 002 1000	Dorm	Solid
PVSP	2,933	78	3%	200	D-5			PVSP M 001 1000, PVSP M 002 1000	Dorm	Solid
RJD	3,635	39	1%	200	D-20			RJD M 022 2000, RJD M 022 1000	Dorm	Solid
SAC	2,281	11	0%	196	A-2 B-1 C-8			SAC M 001F1000, SAC M 002J1000	Dorm	Solid
SATF	4,627	16	0%	200	E-2			SATF B 003 1004, SATF A 002 1006	Dorm	Solid
SCC	2,416	63	3%	100	Fac C Gym		CDCR acknowledged that submitted plan needs to be completely redone as SCC identified 100 beds in a gym.	SCC B 001D1050, SCC B 001E2051	Dorm	N/A
SOL	3,553	211	6%	200	B-7	(11)		SOL C 016 1000, SOL C 017 1000	Dorm	Solid
SQ	3,138	1,550	49%	258	Gym - 108 Tents - 150		Unique solution required due to enormous single, congregate living areas.	NBlock, WBlock	Cell	N/A
SVSP	2,804	78	3%	128	C-7			SVSP M 002 1000, SVSP M 001 1000	Dorm	Solid
VSP	2,896	16	1%	344	A-4 B-4			VSP B 001 1001, VSP B 003 1008	Dorm	Solid & N/A
WSP	2,179	152	7%	200	B-1			WSP H 003 1000, WSP H 004 1000	Dorm	Solid

Total

(499) Excludes CRC, FSP, & SQ

ATTACHMENT C

Institution	Total Population	Patients In Two Largest Air Spaces		CDCR IDENTIFIED BEDS	CDCR SINGLE CELL BEDS	CDCR IDENTIFIED SPACE(S)	ADDITIONAL SPACE REQUIRED	COMMENTS	Rooms of Two Largest Air Spaces	Bed Type in Two Largest Air Spaces	Door Type in Identified Beds
		#	%								
ASP	3,804	248	7%	191	0	A-120	(248)	Only 1 celled 270 housing unit at ASP.	ASP C 320 1000, ASP B 220 1000	Dorm	N/A
CAC	2,138	4	0%	168	84	A-2, A and B Pod			C 002C1, C 002C2	Cell	Solid
CAL	2,926	180	6%	198	100	A-5	(80)	Old ASU unit. Has lexan installed over Arizona doors	D 002 2, C 005 2	270 Cell	Perforated
CCC	2,151	48	2%	200	100	C-3			A34, A12	Dorm	Solid
CCI	3,426	235	7%	148	12	E-Clark Dorm D-9	(223)	Plaintiffs offered reasonable alternatives to identified spaces.	CCI E BH 1000, CCI D 00251000	Dorm	N/A & Solid
CCWF	2,130	16	1%	200	100	A-503			CCWF C 510 1008, CCWF C 511 1030	Dorm	Solid
CEN	3,191	193	6%	192	100	A-5	(93)		B 001 2, B 002 2	270 Cell	Perforated
CHCF	2,567	277	11%	192	92	E-Yard Tent (100) 92 negative pressure rooms	(185)		E304, E302	Dorm	N/A & Solid
CIM	2,521	188	7%	102	51	B-1 (Cypress)	(137)		BH, SH	Cell	Solid
CIW	1,187	4	0%	220	110	H-12		Incorrect space listed on chart. CIW identified H-12 as space.	A EMUA1, A EMUA1	Cell	Solid
CMC	3,425	143	4%	300	300	C-5			CMC G 026 1000, CMC G 025 1000	Dorm	Solid
CMF	2,197	162	7%			W-1, W-2, S-3		CDCR acknowledged that submitted plan needs to be completely redone.	CMF S COV 1000, CMF B DC 1000	Dorm	Solid
COR	3,387	46	1%	200	100	3B02			COR M 005 1000, COR M 003 1000	Dorm	Solid
CRC	2,690	187	7%	155	0	D-410, D-311		Unique solution required for CRC due to the institution be 100% dorms.	CRC D 402 3000, CRC D 404 2000	Dorm	N/A
CTF	4,529	127	3%	178	129	Central Y-Wing			CTF B TD 1000, CTF D 004 1000	Dorm	Solid
CVSP	2,090	91	4%	192	0	D-11	(91)	CDCR will revise CVSP's plan to revert current ASU to identified quarantine unit.	CVSP M 001 1000, CVSP M 002 1000	Dorm	N/A
DVI	1,473	66	4%	264	132	G-Wing			AEH	Cell	Solid
FSP	2,626	1,380	53%	286	0	Tents - 40 A-IV: 88 A dorm Pods 3/4 MSF 500/600		Unique solution required for FSP due to enormous single, congregate living areas.	BldgU1, BldgU3	Cell	Open Bar & N/A
HDSP	3,414	71	2%	128	64	C-1	(7)	Had an additional space identified and ready to house additional quarantine.	HDSP M 002 1000, HDSP M 001 1000	Dorm	Solid
ISP	3,004	63	2%	200	100	C-1			ISP M 002 1000, ISP M 001 1000	Dorm	Solid
KVSP	3,546	66	2%	128	64	D-6	(2)		KVSP M 002 1000, KVSP M 001 1000	Dorm	Solid
LAC	3,040	210	7%	200	100	C-5	(110)		Z 001 1, B 003 1	Cell	Perforated
MCSP	3,878	29	1%	200	100	A-2			MCSP M 002G1000, MCSP C GYM 1000	Dorm	Solid
NKSP	1,698	78	5%	200	102	D-3			NKSP M 002 1000, NKSP C 001 2000	Dorm	Solid
PBSP	2,389	49	2%	128	64	A-1			PBSP M 002 2000, PBSP M 002 1000	Dorm	Solid
PVSP	2,933	78	3%	200	100	D-5			PVSP M 001 1000, PVSP M 002 1000	Dorm	Solid
RJD	3,635	39	1%	200	100	D-20			RJD M 022 2000, RJD M 022 1000	Dorm	Solid
SAC	2,281	11	0%	196	108	A-2 B-1 C-8			SAC M 001F1000, SAC M 002J1000	Dorm	Solid
SATF	4,627	16	0%	200	100	E-2			SATF B 003 1004, SATF A 002 1006	Dorm	Solid
SCC	2,416	63	3%	100	0	Fac C Gym	(63)	CDCR acknowledged that submitted plan needs to be completely redone as SCC identified 100 beds in a gym.	SCC B 001D1050, SCC B 001E2051	Dorm	N/A
SOL	3,553	211	6%	200	100	B-7	(111)		SOL C 016 1000, SOL C 017 1000	Dorm	Solid
SQ	3,138	1,550	49%	258	0	Gym - 108 Tents - 150		Unique solution required due to enormous single, congregate living areas.	NBlock, WBlock	Cell	N/A
SVSP	2,804	78	3%	128	64	C-7	(14)		SVSP M 002 1000, SVSP M 001 1000	Dorm	Solid
VSP	2,896	16	1%	344	44	A-4 B-4			VSP B 001 1001, VSP B 003 1008	Dorm	Solid & N/A
WSP	2,179	152	7%	200	100	B-1			WSP H 003 1000, WSP H 004 1000	Dorm	Solid

Total

(1364) Excludes CRC, FSP, & SQ

Exhibit E

Institution	Original Plata Reserved Space	Number of Original Reserved Beds	Additional Available Space	Additional Available Beds
ASP	Facility C, Housing Unit 330 (192 Dorm Beds) Facility A, Housing Unit 140 (200 Cell Beds)	Dorm Beds - 192 Cell Beds - 200 double or 100 single CCHCS QM Recommendation - 248	None	N/A
CAC	Facility A, Building 2, A and B Pod - (168 Cell Beds)	Cell Beds - 168 double or 84 single CCHCS QM Recommendation - 4	Facility A, Building 2, C Pod	Cell Beds (88 double or 44 single)
CAL	Facility A, Building 5 (200 Cell Beds); Facility B, Building 5 (200 Cell Beds)	Cell Beds - 400 double or 200 single CCHCS QM Recommendation - 180	Facility C, Building 2	Cell Beds (200 double or 100 single)
CCC	Facility C, Building 3 (200 Cell Beds)	Cell Beds - 200 double or 100 single CCHCS QM Recommendation - 48	Facility A Dorms 6, 7, 13 - Isolation Facility A Dorms 1, 2, 12 - Quarantine Facility B Dorms 67, 75, 76 - Isolation Facility B Dorms 62, 69, 70 - Quarantine Facility C Gym Isolation	60 Dorm Beds 30 Dorm Beds 30 Dorm Beds 60 Dorm Beds 98 Dorm Beds
CCI	Facility A, Housing Unit 8 (124 Cell Beds) Facility C Housing, Unit 1 (200 Cell Beds) Facility E, Davis Hall (94 Dorm Beds) Facility D, Housing Unit 9 (48 Cell Beds) Facility D Gym (60 beds)	Dorm/Gym Beds - 154 Cell Beds - 248 double or 124 single CCHCS QM Recommendation - 235	None	None
CCWF	Facility A, Building 503 (200 Cell Beds)	Cell Beds - 200 double or 100 single CCHCS QM Recommendation - 16	Facility A, Building 502 B, C and D Wings - Isolation Facility B, Building 508- D-wing - Quarantine EOP Facility A, Building 502, A-wing - Isolation EOP	192 Cell Beds (Solid door 8 person cells) 64 Cell Beds (Solid door 8 person cells) 64 Cell Beds (Solid door 8 person cells)
CEN	Facility A, Building 5 (200 Cell Beds) Facility D, Building 5 (200 Cell Beds)	Cell Beds - 400 double or 200 single CCHCS QM Recommendation - 193	Facility B, Building 4 (200 Cell Beds) Facility A, Building 3 (200 Cell Beds)	Cell Beds (400 double or 200 single)
CHCF	Facility E, Main Yard Tents (100 beds) Facilities A, B, C and D Negative Pressure Rooms (NPR) (92 NPR beds)	NPR Beds - 92 Tent Beds - 100 CCHCS QM Recommendation - 277	None	N/A
CIM	Facility B, Birch Hall (102 single Cell Beds) Facility C, Del Norte (200 Cell Beds)	Single Cell Beds - 102 Cell Beds - 200 double or 100 single CCHCS QM Recommendation - 188	Facility A 10 DPW beds in Tent #9	10 DPW beds (Tent #9)
CIW	Housing Unit A RCU (220 Cell Beds)	Cell Beds - 220 double or 110 single CCHCS QM Recommendation - 4	None	N/A
CMC	Facility C, Building 5 (300 single Cell Beds)	Single Cell Beds - 300 CCHCS QM Recommendation - 143	None	N/A
Institution	Original Plata Reserved Space	Number of Original Reserved Beds	Additional Available Space	Additional Available Beds
CMF	S-3 Housing Unit (18 Cell Beds) W-1 Housing Unit (41 Cell Beds) W-3 Housing Unit (42 Cell Beds) H-1 Housing Unit (21 Cell Beds, 26 Dorm Beds) I-1 Housing Unit (10 Dorm Beds, 36 Cell Beds)	Single Cell Beds - 158 Dorm Beds - 36 CCHCS QM Recommendation - 162	None	N/A
COR	Facility 3B, Building 02 (200 Cell Beds)	Cell Beds - 200 double or 100 single CCHCS QM Recommendation - 46	Facility 3C, Building 03 - Quarantine 4A1L C-Section - Isolation A1L A-Section - Isolation EOP 4B4R C-Section - Quarantine 4B4L - Isolation 4A2L B-Section - Quarantine	Cell Beds (200 double or 100 single) Cell Beds (48 double or 24 single) Cell Beds (40 double or 20 single) Cell Beds (48 double or 24 single) Cell Beds (128 double or 64 single) Cell Beds (40 double or 20 single)
CRC	Facility D, Dorm 410 (78 Dorm Beds) Facility D, Dorm 311 (77 Dorm Beds)	Dorm Beds - 155 Gym Beds - 78 CHCS QM Recommendation - 187	Dorms 407 - Isolation Dorm 408 - Quarantine Dorm 411 - Quarantine Dorm 214 - Isolation	72 Dorm Beds 72 Dorm Beds 12 Dorm Beds 200 Dorm Beds
CTF	Central Facility, Y wing (258 Cell Beds)	Cell Beds - 258 double or 129 single CCHCS QM Recommendation - 127	Central Gym - Isolation South Gym - Isolation Fremont Dorm - Isolation Central Chapels 1 & 2 - Isolation	56 Dorm Beds 54 Dorm Beds 200 Dorm Beds 24 Dorm Beds
CVSP	Facility D, Building 11 (192 Dorm Beds) Facility A, Building 3 (200 Cell Beds)	Cell Beds - 200 double or 100 single Dorm Beds - 192 CCHCS QM Recommendation - 91	None	N/A
DVI	Facility A, G-wing (264 Cell Beds)	Cell Beds - 264 double or 132 single CCHCS QM Recommendation - 66	L-1 - Isolation	Cell Beds (96 double or 48 single)
FOL	Facility A, Unit IV, Tier 2, A & B side cells (88 Cell Beds); MSF Dorm 500 (10 Dorm Beds) MSF 600 (18 Dorm Beds)	Cell Beds - 92 double or 44 single Dorm Beds - 10 Dorm Beds - 18 CCHCS QM Recommendation - 1380	Facility A, Unit IV, Tier 3 A & B side cells - Quarantine Facility B, FWF, B Dorm (Male Beds) - Isolation Facility B, FWF A Dorm DRP Mod (Female Beds) - Isolation Facility B, FWF A Dorm Pod 2 - Quarantine	Cell Beds (92 double or 46 single) 282 Dorm Beds 20 Dorm Beds 9 single Cell Beds
HDSP	Facility C, Building 1 (128 Cell Beds); Facility A, Building 4 (200 Cell Beds)	Cell Beds - 328 double or 164 single CCHCS QM Recommendation - 71	None	N/A
ISP	Facility C, Building 1 (200 Cell Beds);	Cell Beds - 200 double or 100 single; CCHCS QM Recommendation - 63	Facility C, Building 2 - Isolation	(200 double or 100 single)
KVSP	Facility D, Building 6 (128 Cell Beds); Facility A, Building 1, Section B (20 Cell Beds)	Cell Beds - 148 double or 74 single CCHCS QM Recommendation - 66	Facility D, Building 7, B Section - Flex space (empty) Facility B, Building 1 B/C section - Isolation	Cell Beds (40 double or 20 single) 80 Cell Beds (80 double or 40 single)
Institution	Original Plata Reserved Space	Number of Original Reserved Beds	Additional Available Space	Additional Available Beds
LAC	Facility C, Building 5 (200 Cell Beds) Facility B, Building 2 (200 Cell Beds) Facility B Gym (24 beds)	Cell Beds - 400 double or 200 single Gym Beds - 24 CCHCS QM Recommendation - 210	None	N/A

MCSP	Facility A, Building 2 (200 Cell Beds)	Cell Beds - 200 double or 100 single; CCHCS QM Recommendation - 29	Facility A Gym - Isolation Facility B Gym - Isolation Facility C Gym - Isolation Facility D, Building 18 - Quarantine (2 six men cells)	100 Dorm Beds 100 Dorm Beds 100 Dorm Beds 12 Cell Beds (Solid door 6 person cells)
NKSP	Facility D, Building 3 (198 Cell Beds)	Cell Beds - 198 double or 99 single CCHCS QM Recommendation - 78	Facility B, Building 4	Cell Beds (198 double or 99 single)
PBSP	Facility A, Building 1 (128 Cell Beds)	Cell Beds - 128 double or 64 single CCHCS QM Recommendation - 49	None	N/A
PVSP	Facility D-5 Building (200 Cell Beds)	Cell Beds - 200 double or 100 single CCHCS QM Recommendation - 78	Facility D, Building 3 - Isolation	Cell Beds (200 double or 100 single)
RJD	Facility D, Housing Unit 20 (200 Cell Beds)	Cell Beds - 200 double or 100 single CCHCS QM Recommendation - 39	Facility C Gym - Isolation	24 Dorm Beds
SAC	Facility A, Building 2 (20 Cell Beds); Facility B, Building 1 (48 Cell Beds); Facility C, Building 8 (128 Cell Beds)	Cell Beds - 196 double or 98 single CCHCS QM Recommendation - 11	None	N/A
SATF	Facility E, Building 2 (200 Cell Beds); Facility C, Building 4 sec. B and C (88 Cell Beds) Facility C Building 3 (128 Cell Beds) Facility F, Housing Unit F1, A-section- 11 pods (88 Dorm Beds)	Cell Beds - 200 double or 100 single CCHCS QM Recommendation - 260	Facility A Gym - Isolation Facility B Gym - Isolation Facility F/G Gym - Isolation Facility C, Building 4 - Isolation	46 Dorm Beds 46 Dorm Beds 40 Dorm Beds Cell Beds (256 double or 128 single)
SCC	Facility C, Building 3 (200 Cell Beds) Facility C gym (100 beds)	Cell Beds - 200 double or 100 single CCHCS QM Recommendation - 63	None	N/A
SOL	Facility B, Building 7 (200 Cell Beds) Facility B, Building 9 (200 Cell Beds) Facility B Gym (150 Dorm Beds)	Cell Beds - 400 double or 200 single Gym Beds - 128 CCHCS QM Recommendation - 211	Facility C Gym - Isolation	150 Dorm Beds
SQ	Gym (108 beds)	Gym Beds - 108 CCHCS QM Recommendation - 1550	Adjustment Center 1st tier North - Isolation Adjustment Center 1st tier South - Quarantine Adjustment Center 2nd tier North - Isolation Adjustment Center 2nd tier South - Quarantine (Sections will be emptied as needed). Chapel A, Quarantine Chapel B, Quarantine Chapel C Quarantine	17 Single Cell Beds 11 Single Cell Beds 17 Single Cell Beds 18 Single Cell Beds 10 Dorm Beds 10 Dorm Beds 10 Dorm Beds
SVSP	Facility C, Building 7 (182 Cell Beds); Facility D, Building 6, Section B (40 Cell Beds)	Cell Beds - 222 double or 111 single CCHCS QM Recommendation - 78	Facility C Gym - Flex space (empty) Facility D, Building 6, C Section - Flex space (empty) EOP Family Visiting - Flex space (empty)	1 Dorm Bed Cell Beds (48 double or 24 single) 2 Dorm Beds
VSP	Facility A, Building 4 (88 Cell Beds) Facility A, Building 3 (199 Cell Beds)	Cell Beds - 287 double or 143 single CCHCS QM Recommendation - 16	Main Yard Gym - Isolation Facility B, Building 4 - Isolation	80 Single Beds 256 Cell Beds (8 man Rooms)
WSP	Facility B, Building 1 (200 Cell Beds); Facility B, Building 5 (200 Cell Beds)	Cell Beds - 400 double or 200 single CCHCS QM Recommendation - 152	None	N/A

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

HANSON BRIDGETT LLP
PAUL B. MELLO - 179755
SAMANTHA D. WOLFF - 240280
LAUREL O'CONNOR - 305478
DAVID CASARRUBIAS - 321994
425 Market Street, 26th Floor
San Francisco, California 94105
Telephone: (415) 777--3200
Facsimile: (415) 541-9366
pmello@hansonbridgett.com

Attorneys for Defendants

**UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
OAKLAND DIVISION**

MARCIANO PLATA, et al.,

Plaintiffs,

v.

GAVIN NEWSOM, et al.,

Defendants.

CASE NO. 4:01-1351 JST

**[PROPOSED] ORDER DENYING
PLAINTIFFS' MOTION TO
ENFORCE ORDER TO SET ASIDE
ISOLATION AND QUARANTINE
SPACE**

**Date: December 23, 2020
Time: 10:00 a.m.
Judge: Hon. Jon S. Tigar**

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