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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

OAKLAND DIVISION

MARCIANO PLATA, et al.,

Plaintiffs,

v.

GAVIN NEWSOM, et al.,

Defendants.

CASE NO. 01-1351 JST

JOINT CASE MANAGEMENT CONFERENCE STATEMENT

Judge: Hon. Jon S. Tigar
Date: January 14, 2021
Time: 10:00 a.m.
Crtrm.: 6, 2nd Floor

The parties submit the following joint statement in advance of the January 14, 2021 Case Management Conference.

Defendants' Preliminary Statement: As the second and third COVID-19 surges continue nationwide among the general population, cases within CDCR continue to decline from its apex on December 20, 2020 of 10,721 active cases of COVID-19 among the incarcerated population, to 4,956 active in-custody cases as of the date of this filing. During that same time, CDCR and CCHCS have diligently worked to immunize healthcare workers, staff and residents at skilled-nursing facilities (including those within CDCR institutions), and correctional staff at certain facilities who work closely with patients. As discussed in greater detail below, as of January 13, 2021, 2,945 incarcerated patients have been offered the COVID-19 vaccination, with approximately 90% of those patients accepting the vaccine. Significant progress has been made to mitigate against the spread of COVID-19 within CDCR's skilled nursing facilities, specifically. At CHCF, 54% of patients have been vaccinated and approximately 77% of all patients have either been vaccinated or were previously infected with COVID-19. At CMF, 54% of patients have been vaccinated and approximately 84% of all patients have either been vaccinated or were previously infected with COVID-19. With respect to employees at those institutions, at CHCF, approximately 61% of staff have either been vaccinated or previously infected with COVID-19, and at CMF, 63% of staff have either been vaccinated or previously infected with COVID-19.

Among staff, 18,539 employees have been vaccinated, amounting to 30% of all CDCR and CCHCS employees statewide.

These extensive efforts are ongoing and CDCR and CCHCS will move into Phase 1b of the vaccine distribution – to the entire incarcerated population – as soon as possible, and hopefully as early as next week.

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I. VACCINES

Plaintiffs' Position: Vaccination against COVID-19, especially for those at heightened risk of serious complications or death if infected, is essential, and could be done quickly by the Receiver and CCHCS if the Governor and state officials authorized and provided a minimal amount of vaccine now. Vaccinating this group will prevent a highly vulnerable population from developing disease and ultimately reduce significantly the number of individuals needing community hospital beds.

People incarcerated in CDCR are extremely vulnerable to infection. They are housed in congregate settings in which key COVID risk reduction measures are at best difficult and at times impossible. Thousands are housed in common air space settings, including many who are vulnerable to severe illness or death if they contract COVID-19. Copious amounts of outside air in many housing units is all but impossible, given the lack of open windows and ventilation limitations, meaning virus can circulate in the air (see below). Sadly, almost 45,000 have been diagnosed with COVID-19 already, including more than 75% (or even greater percentages) of the total population in many housing units, facilities, yards, and even prisons. CDCR prisons are the sites of the largest outbreaks in the country, and the rate of infection among the incarcerated is seven times higher than in the community at large. *See* ECF 3520 at 19:15-20. Large numbers of those infected have developed serious complications, including approximately 1,200 who have been hospitalized. Most tragically, 164 people have died. Approximately one-third of those deaths have occurred in the last approximately 30 days, and as of January 11, 114 were hospitalized, which further underscores the urgent need to vaccinate those at heightened risk.

According to CCHCS last week, approximately 9,000 people in CDCR are at heightened risk of serious complications or death if infected by the coronavirus. These people have a Weighted COVID Risk Score of three or higher, have not had COVID-19 within the last 90 days, and have not yet been vaccinated. CCHCS stated that if they were authorized and supplied sufficient vaccine doses, they could offer vaccinations to all 9,000

within a week.[1]

However, CCHCS cannot vaccinate the 9,000 most at risk because Governor Newsom and state officials have not provided authorization and vaccine supplies to do so. The State's failure to do so, knowing as it must the harm suffered and the risk to others, is extremely concerning. As of January 11, the California Department of Public Health reports it has shipped nearly 2.5 million doses of vaccine.[2] *Less than four-tenths of one percent* of that is needed for the first dose for those currently at highest risk of harm in CDCR. The State should immediately authorize and provide these vaccine doses.

CCHCS has so far shown that it can administer the vaccine more efficiently than the community as a whole. Statewide, as of the end of last week, only approximately 32% of vaccine doses had been administered.[3] In contrast, CCHCS had received approximately 35,000 initial dose allocations (for both patients and staff), and as of near the end of last week (January 7) had administered about 50% of them, and told us on January 8 it

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[1] To be clear, those with a Weighted COVID Risk Score of three or above are not the only patients at risk of serious complications or death. Approximately 25% of those currently hospitalized due to COVID-19 are patients that have either no risk factors or a Risk Score of 1 or 2, and such patients make up approximately that same percentage of the most recent 50 reported COVID-related deaths. All in CDCR need vaccination, but we agree CCHCS should prioritize those with a Weight COVID Risk Score of three or above, as the evidence shows the risk of harm is much greater for that group. In addition to such patients comprising approximately 75% of COVID-related current hospitalizations and recent deaths, data from CCHCS provided in mid-October shows that those with a Weighted COVID Risk Score of three or above had a COVID case fatality rate *forty times* higher than those who did not.

[2] *See* Cal. Dep't of Pub. Health, *COVID-19 Vaccine Doses Shipped* (Jan. 12, 2021), https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/VaccineDoses.aspx.

[3] *See* Catherine Ho, *Here's California's plan to speed up coronavirus vaccinations. Will it be enough?*, San Francisco Chronicle (Jan. 9, 2021), https://www.sfchronicle.com/bayarea/article/Here-s-California-s-plan-to-speed-up-15857102.php.

expected to administer almost all of the rest by the end of the current week. This includes offering vaccination to all patients who have not had COVID-19 in the last 90 days at the California Health Care Facility, California Medical Facility, and in two medical units at the Central California Women's Facility, a total of approximately 4,200 people. As of January 7, 2,350 of those had been offered vaccine, and 2,105 accepted, meaning the refusal rate was only approximately 10%.[4]

The patients vaccinated so far by CCHCS fall within Phase 1A of California's vaccination plan, which includes those in correctional facility hospitals. *See* Cal. Dep't of Pub. Health, *CDPH Allocation Guidelines for COVID-19 Vaccine During Phase 1A: Recommendations* (Dec. 5, 2020), https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/CDPH-Allocation-Guidelines-for-COVID-19-Vaccine-During-Phase-1A-Recommendations.aspx . All others in CDCR, including the 9,000 at heightened risk of harm that should be vaccinated now, are covered by California's Phase IB, which includes in its Tier One those age 75 and above, and in Tier Two those age 65 or above as well as all in "congregate settings with outbreak risk," specifically referencing the "incarcerated." *See Vaccines*, California All https://covid19.ca.gov/vaccines (last updated Jan. 8, 2021).

CCHCS says it is prohibited from vaccinating those in Phase 1B, and thus the 9,000 at heightened risk they want to vaccinate, until the California Department of Public Health – an agency under the direct control of Defendant Governor Newsom – authorizes it and provides vaccine. CCHCS says it has provided data to those state officials, and told them that it wants to start by vaccinating those who are most at risk for serious complications and death if infected. The State must authorize and provide vaccine for these most-at-risk people immediately, and then promptly do the same for all others in CDCR.

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[4] The other vaccine doses have been administered to staff, including frontline healthcare personnel and correctional officers, who have patient contact or are necessary for prison operations. CCHCS says it is considering whether to mandate vaccinations for staff.

Shortly before this Statement was finalized for filing, Defendants informed us that "CDCR and CCHCS will move into Phase 1b of the vaccine distribution – to the entire incarcerated population – as soon as possible, and hopefully as early as next week." That must happen, so that all, including the thousands at highest risk of serious illness and death, and thousands at risk of being quarantined in shared air spaces, can be vaccinated immediately.

Defendants' Position: CDCR is working closely with CCHCS and their public health partners to distribute the COVID-19 vaccine to both staff and incarcerated persons as efficiently and expeditiously as possible, and consistent with constantly evolving public health guidance. CDCR and CCHCS's distribution of the vaccine comports with federal and state public health guidelines for distribution prioritization. The State's prioritization, formalized in the California Department of Public Health's Allocation Guidelines,[5] was developed by the Drafting Guidelines Workgroup with input from the Community Vaccine Advisory Committee and was consistent with the Centers for Disease Control and Prevention's guidance on this topic at the time it was issued.[6] The CDC recently issued new guidance on January 11, 2021, recommending that staff and incarcerated persons be vaccinated at the same time because of their shared increased risk of disease. The California Department of Public Health issued further guidance on the evening of January 12, 2021, advising that providers may offer doses promptly to people in lower priority groups when demand subsides in the current groups or doses are about to expire.

CDCR is currently in the first phase of inoculation, Phase 1a. Healthcare personnel and frontline workers who are at risk of exposure to COVID-19 because of their role in

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[5] CDPH Allocation Guidelines for COVID-19 Vaccine During Phase 1A: Recommendations available at: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/CDPH-Allocation-Guidelines-for-COVID-19-Vaccine-During-Phase-1A-Recommendations.aspx

[6] CDC recommendations available at https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations.html.

direct health care or long-term care settings, as well as incarcerated residents of long-term care facilities were prioritized for receipt of the initial doses of the vaccine. As of January 13, 2021, 18,539 CDCR and CCHCS employees (or 30% of employees) have been vaccinated statewide. It is CDCR and CCHCS's goal to vaccinate at least 100 additional employees daily at each of CDCR's 35 institutions by January 15th, resulting in 30,000 employees being vaccinated by the end of January.[7]

Additionally, as of January 13, 2021, 2,945 patients have been offered the vaccine, and approximately 90% of those patients have accepted the vaccination (2,410).[8] Further, CDCR and CCHCS have developed COVID vaccine registries, which are updated daily to track the vaccination status of both staff and patient vaccinations.

Consistent with the California Department of Public Health and the CDC's very recently revised guidance regarding vaccine distribution, to maximize vaccine administration and reduce the potential for wastage, CCHCS advised on the evening of January 12, 2021, that incarcerated persons may be considered for inoculation if doses of the vaccine remain available at the conclusion of a staff vaccination clinic and those doses would otherwise expire. A joint meeting between CDCR and CCHCS is scheduled to occur on January 14 to further coordinate the distribution of vaccines in light of the

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[7] During the first several weeks of the vaccine distribution, COVID-19-naïve employees were prioritized for vaccination. Currently, the vaccination is available to all employees, including those who have resolved a prior COVID-19 infection.

[8] These numbers include 1,275 patients at CHCF (in addition to 164 refusals), 55 patients at CCWF (in addition to 6 refusals), 1,073 patients at CMF (in addition to 331 refusals), 2 patients at DVI (0 refusals), 1 patient each at Folsom State Prison and Avenal State Prison (0 refusals), and 3 Sacramento Control Office Unit (SACCO) patients (in addition to 1 refusal). A SACCO incarcerated person is someone who was sentenced to serve a prison term in California but is serving a concurrent or consecutive term in a facility in another jurisdiction, or an incarcerated person who served time in a county jail, was sentenced to serve a prison term in California, and was released before being transferred to CDCR custody.

constantly evolving guidance.

CDCR, CCHCS, the California Department of Public Health, and the Governor's Office had previously prioritized all incarcerated persons in the second phase, Phase 1b, starting with medically high-risk incarcerated persons. CDCR will commence Phase 1b as soon as possible, and hopefully as early as next week. In short, Plaintiffs' call upon the State to "immediately authorize" that the vaccine be provided to persons in Phase 1b would not materially advance or modify the State's current schedule.[9]

Finally, in an effort to vaccinate as many staff and patients as possible, as efficiently as possible, pursuant to the Governor's Executive Order N-39-20, the Director of the California Department of Consumer Affairs waived certain restrictions on dentists to enable them to administer COVID-19 vaccines statewide, including within CDCR institutions. CDCR's dentists began administering COVID-19 vaccinations on January 6, 2021.

II. POPULATION REDUCTION

Plaintiffs' Position: Further urgent population reductions are necessary to minimize the risk of and harm from COVID-19, as massive outbreaks continue and vaccine availability, as discussed above, remains uncertain. Defendants have acknowledged that reduced population contributes to fewer infections and deaths (*see* ECF No. 3469 at 3-4), and last month Secretary Allison reaffirmed that CDCR prisons' "large population and

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[9] It also bears clarification that the State does not have 2.1 million doses of the vaccine waiting around for distribution, as Plaintiffs seem to suggest. The overwhelming majority of vaccines received from the federal government flow directly to the counties and do not physically pass through the State's custody or control. The State receives a small number of doses for certain eligible populations under the State's care. The number of doses that are received by both the State and the counties is dependent upon the amount of vaccine available from the federal government each week and the eligible population in the Phase/tier as the entities use up their allotments.

physical layout make us particularly susceptible to the spread of COVID-19."[10]

The prison and camp population is currently approximately 92,000.[11] We appreciate that this total is approximately 25,000 fewer than in mid-March,[12] when the first incarcerated person in CDCR was diagnosed with COVID-19. We further recognize that approximately 11,000 of that reduction has resulted from early releases, including the program begun in July, which still continues, for some within 180 days of release.[13] The remainder of the reduction has resulted from natural releases and the suspending of or great limitations on intake from the county jails, where we understand more than 8,000 are incarcerated and currently awaiting transfer to CDCR.

But given the current number and size of outbreaks, and recent spike in COVID-related deaths, it is clear that more must be done. CDCR appears to have recognized that last month when it told this Court it would conduct individual reviews of certain medically vulnerable incarcerated people who they might release, presumably under the Secretary's emergency authority, or refer back to a superior court for resentencing, stating that they would begin with the most medically vulnerable among the eligible. *See* ECF No. 3501 at 5:7-21. But only 1,690 people are eligible for those reviews (*see* ECF No. 3520 at 7:3),

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[10] *See* Cal. Dep't of Corr. & Rehab., *Important COVID-19 message from Secretary Allison* (Dec. 4, 2020), https://www.cdcr.ca.gov/insidecdcr/2020/12/04/important-covid-19-message-from-secretary-allison.

[11] *See* CDCR Weekly Report of Population (Jan. 6, 2021) at Part A.I.1 (Institution/Camps), https://www.cdcr.ca.gov/research/wp-content/uploads/sites/174/2021/01/Tpop1d210106.pdf.

[12] *See and compare* CDCR Weekly Report of Population (March 18, 2020) at Part AI.1 (Institution/Camp), https://www.cdcr.ca.gov/research/wp-content/uploads/sites/174/2020/03/Tpop1d200318.pdf.

[13] This 180 day release program has resulted in about 400 early releases per month, per data provided by CDCR; however, information provided by Defendants below, that since December 2, 140 people have been released per this program, suggests this number may be diminishing.

and as reported by Defendants below, only 15 have been approved for released.

The Court on December 23, 2020 detailed why the State needed to urgently review others, including the indeterminately sentenced, for release. A week later, it was reported that Governor Newsom said he was reviewing individuals incarcerated in CDCR for release on a weekly basis. *See* Abené Clayton, *'People are terrified': a coronavirus surge across California's prisons renews calls for releases*, The Guardian (Dec. 29, 2020), https://www.theguardian.com/us-news/2020/dec/29/california-coronavirus-cases-prison-system. On December 30, we asked Defendants for information about these reviews.[14] Defendants below indicate there is no new program; rather, the Governor continues the work, that has always been done, of reviewing the cases of those granted release by the parole board.

As previously discussed, Secretary Allison last month indicated she would in the near future implement changes to CDCR's credit earning rules that will result in certain sub-groups of the incarcerated receiving additional time credits as they serve their terms. *See* ECF No. 3520 at 5:5-8. We agree that should be done, but repeat that unless implemented immediately and applied fully retroactively, will result only in incremental advances to release dates, with any substantial reduction to the current population only happening well in the future. Again, reduction in population is necessary now.

The Governor should grant additional medical reprieves of sentences, including of those indeterminately sentenced, of the kind done for a handful of people in November 2020. *See* ECF No. 3487 at 2:4-14. The Secretary should also re-start the program for early release for some with a year or less to serve that was done between July and September at a sub-set of prisons, except it should now apply to all given the pervasive outbreaks which put all incarcerated at risk. Further, the Secretary should grant

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[14] Among other things, we asked for the criteria for being eligible for review, how many and which people have been, are being, and will be brought to the Governor for review, the number of reviews completed, the number that resulted in a decision to release, the number actually released, and the timeframe within which the reviews will be done.

incarcerated people "Positive Programming Credits" (PPCs) as CDCR did in early July, approximately four months after the pandemic began, when it rightfully recognized that because of program restrictions imposed to limit the virus' spread people were unable to earn sentence-reducing time credits as they previously could. Granting additional PPC now would be fair, and result in relatively quick population reduction. The Governor and Secretary must take all these and other actions now, to further reduce crowding so as to reduce the spread of the virus, and thus sickness and death, in the prisons.

Defendants' Position: CDCR's population has decreased by 23,950—or over 20 percent—since the start of the COVID-19 public health crisis.[15] Between July 1, 2020 and January 7, 2021, 7,953 people were released from institutions and camps through the COVID-19 early-release programs Defendants announced on July 10.[16] This represents 140 more early releases than those reported in the December 23 case management statement.[17] An additional 11,927 were released in accordance with their natural release dates during this period. As of January 7, 2021, CDCR's institutions house approximately 90,313 persons.[18]

In addition to CDCR's COVID-19 early release programs and mitigation measures described in sections below, the Secretary is releasing medically high-risk individuals early on a discretionary basis. The Secretary is considering those with COVID-19 weighted risk

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[15] This figure is calculated by taking the difference between the total population in institutions and camps on February 26, 2020 and January 6, 2021. Weekly population reports can be found at https://www.cdcr.ca.gov/research/weekly-total-population-report-archive-2/.

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

[17] *See* ECF No. 3501 at 4:14-16.

[18] *See* December 16, 2020 population report at https://www.cdcr.ca.gov/research/wp-content/uploads/sites/174/2020/12/Tpop1d201216.pdf.

scores of three or more, and who have either served the base term of their sentence or are within one year of release. The Secretary first considered determinately-sentenced people who have the highest risk for morbidity or mortality should they contract COVID-19—those with COVID-19 weighted risk scores of six or more—and who are not required to register as a sex offender under Penal Code section 290. Those who pose a low risk for violent recidivism will either be approved for release per the Secretary's discretionary authority, or referred to the courts for expedited consideration for resentencing under Penal Code section 1170, subdivision (d)(1), depending on how much time remains on their sentence(s). Those being considered include people who have served their base term, but whose sentence(s) carry enhancements that were previously mandatory, but are now discretionary after the passage of Senate Bill 1393, which became effective on January 1, 2018. As of January 8, 2021, there are 1,690 people who meet this initial criteria for review. Of those, 553 persons made the next level of screening and were then individually reviewed by the Secretary. Of the 553 who were reviewed, 15 were approved for release and 152 were referred to the courts for consideration under Penal Code section 1170(d)(1).

As previously reported, the Secretary also considered indeterminately sentenced persons who were granted parole for their commitment offense(s), but remain incarcerated serving separate terms for offense(s) committed while in prison. CDCR identified 24 such incarcerated persons within this category. The Secretary reviewed all 24 and approved 19 of these individuals for early release, and they have all been released.

In addition, the Secretary is individually reviewing indeterminately sentenced individuals who have been granted parole but remain in prison because they have not yet reached their minimum eligible parole date or youth offender parole date. Secretary Allison has approved four individuals for release and is continuing to review the remaining twenty-two individuals in this group.

CDCR continues to process early releases on a rolling basis through the 180-day early-release program announced on July 10, which has accounted for the vast majority of early releases since then.

Finally, in response to Plaintiffs' statement above regarding reports that Governor Newsom is reviewing individuals incarcerated in CDCR for release on a weekly basis, each week the Governor reviews the parole grants of long-term incarcerated persons who have granted parole. These reviews include expedited consideration whenever possible.

III. INTAKE

Plaintiffs' Position: After pausing intake from county jails for six weeks, Defendants have started receiving new people at Wasco State Prison and North Kern State Prison the week of January 11, and will start receiving people at Central California Women's Facility during the week of January 18, 2021. In light of the continuing surge of cases throughout California, and the significant outbreaks at all three CDCR Reception Centers currently, Plaintiffs believe that CDCR should suspend intake, at least until all incarcerated people at high risk for complications from COVID infection are vaccinated.

Defendants' Position: Intake into CDCR from county jails was paused effective November 26, 2020, in accordance with public health guidance, due to the rise in the number of COVID-19 cases in the community. CDCR resumed intake the week of January 11, 2021 and will accept 104 incarcerated persons from San Joaquin and Amador Counties into custody at North Kern State Prison, and 76 incarcerated persons from Orange and Los Angeles Counties into custody at Wasco State Prison. CCWF remains closed to intake until the week of January 18, 2021 to ensure that adequate bed space is available in the event it becomes necessary for quarantine of its existing population.

Additionally, for the week of January 18, CDCR will plan to accept 80 incarcerated persons from county jails into North Kern State prison, 75 incarcerated persons into Wasco State Prison, and 20 into CCWF.

IV. QUARANTINE AND ISOLATION

Plaintiffs' Position: We respond to the Court's December 23 Order re Quarantine Space (ECF No. 3523) in Part XIII, below.

As mentioned in the late December Case Management Conference Statement (*see* ECF. No. 3520 at 18:4-7), we recently raised concerns to CCHCS and CDCR about

positive COVID-19 patients being co-located in cell-housing units at the California State Prison – Los Angeles County (LAC) and Richard J. Donovan Correctional Facility (RJD) with those not known to have the disease, in contravention of the Receiver's directives saying such should not occur. We also raised concerns about staff in those units permitting those who were positive to mix with those not known to be, including during phone access periods and when people picked up food trays, a practice which creates a serious risk of further infections. We relayed these same concerns early this year after receiving information that co-locating and mixing within housing units at the two prisons continued. Counsel in the *Armstrong* case had also done the same.

On January 8, CCHCS and CDCR confirmed that co-locating positive patients with those not known to be positive had occurred for weeks in housing units at LAC and RJD, and continued at RJD. It was explained that the co-locating was a result of a number of factors, including a shortage of custody staff at LAC (meaning that in the prison's view cell changes were not feasible as staff to supervise the moves were not available), some patients' refusal to move, and, at RJD, in effect being overwhelmed by the size of the COVID outbreak during the first weeks of December. We are also aware of significant co-locating of positive patients with others in cell-housing units at High Desert State Prison, Pleasant Valley State Prison, and Kern Valley State Prison.

We strongly agree with the Receiver's directive that COVID-positive patients must not be co-located in any housing unit with those not known to be positive. But given the repeated examples of that not happening, we have suggested harm reduction measures when that co-location occurs. Specifically, we have asked that CCHCS and CDCR issue written directives and guidance, for use by housing unit officers, regarding who, by reference to COVID-status, can and cannot be allowed to mix during common out-of-cell housing unit activities, including showers, phone access, medication lines, and food service. On January 8, CCHCS said it would consider adding provisions to its COVID "Interim Guidance," and CDCR indicated it would consider whether such could be done using a variant of the long-standing "Program Status Report," a daily document that among

other things tells staff which groups of people can and cannot for custody-based reasons be mixed when the usual prison program is modified. Such written directives and guidance is urgently necessary both to reduce the risk of additional infections and so that there is a clear basis to hold accountable officers who permit mixing of patients who for public health reasons must be kept apart.

In addition to the problem of co-locating COVID-positive patients with those who are not in the same housing units, we learned of and presented to CCHCS this week allegations that at LAC and RJD in December, patients who tested negative for COVID were kept in their cell with cell mates who tested positive, despite requests to be quarantined elsewhere.

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

CDCR continues to work in close collaboration with CCHCS to appropriately house quarantined and isolated incarcerated persons. However, a growing number of incarcerated persons refuse to relocate or transfer to such housing. For these incarcerated persons, CDCR and CCHCS continue to work together to educate and encourage their compliance with quarantine and isolation measures, including movement. While CDCR will not forcefully extract individuals who refuse to relocate, institutions have begun issuing Rules Violation Reports.

As it relates to Plaintiffs' specific concerns described above, the primary reason COVID-19 positive inmate-patients are comingled with those who are not known to be positive is due to incarcerated persons refusing to move. CDCR does not believe that cell extractions are appropriate, and instead, as indicated above, attempts to educate inmate-patients in an effort to encourage volunteer movement. Daily multi-disciplinary check-ins

are occurring with these inmate-patients to further encourage them to move to the designated housing. Additionally, while CSP-Los Angeles County was heavily impacted by staff vacancies between December 14 and 31, 2020, the institution was provided available staffing resources from both neighboring institutions (CCI and CAC), as well as resources from CDCR's statewide transportation unit.

Similarly, at both RJD and Pleasant Valley, inmate-patients continue to refuse to move to isolation, resulting in the co-locating of patients. Medical staff provide patient education and refusals are documented, but inmate-patients are not forcefully extracted from their cells. And at High Desert, CDCR initiated a conference call with Plaintiffs' counsel in December to solicit their assistance in convincing their clients to relocate to the appropriate quarantine or isolation housing.

Further discussion on Quarantine and Isolation appears in Part XIII, below.

V. SAFELY HOUSING MEDICALLY VULNERABLE PEOPLE

Plaintiffs' Position: As reported in the last Joint Case Management Conference Statement, CDCR and CCHCS suspended the plan to mandate transfers from common air-space housing to solid-door cell housing for the people most medically vulnerable to COVID-19 complications. Plaintiffs supported this decision in light of the rapid spread of the virus in CDCR prisons during November and December and concerns that movement within and between prisons could exacerbate the spread.

Dr. Joseph Bick informed us on January 8 that CCHCS currently has no plans to restart moving medically vulnerable people from one prison to another in order to place them in celled housing. As the outbreaks unfortunately continue statewide, we support extending the suspension of the rehousing plan.

Defendants' Position: CDCR has been working closely with CCHCS to provide safer housing to medically-high risk individuals in certain prisons by relocating those individuals from dorm or open-cell settings to cells with solid doors. On December 14, 2020, 26 individuals were moved from San Quentin State Prison (San Quentin) to California State Prison, Corcoran (Corcoran). Although CDCR had planned to move all

individuals housed at San Quentin with a COVID-19 risk score of three or greater by January 29, 2021, given the current surge in COVID-19 cases, these transfers have been suspended until CCHCS deems it safe to resume these transfers.

VI. TESTING AND TRANSFER PROTOCOLS

Plaintiffs' Position: Transfers between prisons continue, although in greatly reduced numbers in recent weeks, presumably due to substantial COVID-19 outbreaks statewide. Testing and quarantining of those transferred to reduce the risk of COVID-19 transmission have been governed by CCHCS's August 19 "Movement Matrix," although CCHCS appears to have stopped pre-transfer quarantine for some. CCHCS on January 8 said it was unaware of any cases of COVID transmission attributable to any transfers done pursuant to the current Matrix.

CCHCS in late November circulated a draft revised Movement Matrix, which we and others provided comments on during the second week of December. On January 12, CCHCS issued a final version of the revised Matrix, and CDCR and CCHCS jointly announced it supersedes all previous versions and is effective immediately. We are reviewing the revisions and will send any concerns to CCHCS and CDCR.

Defendants' Position: On November 25, 2020, the Receiver issued a draft revised version of the CDCR/CCHCS COVID-19 Screening and Testing Matrix for Patient Movement, and requested comments by December 7. The revised Matrix includes several significant updates to the August 19 version, including an increase in the number of people who may share the same airspace for precautionary transfer quarantine. The Receiver's Office met and conferred with the parties in the *Plata* and *Coleman* class actions regarding their comments to the Matrix on December 9. The Receiver's Office indicated that the comments would be addressed and a revised version of the Matrix would be distributed.

On the afternoon of January 12, 2021, the Receiver's Office sent an updated version of the movement matrix that previously went into effect on August 21, 2020. Of note, the revised matrix now states that inmates who were previously infected with COVID and who are considered resolved will not be required to re-test or be quarantined for movement

purposes for 90 days from the date of first symptoms or first positive test, whichever came first. The revised matrix also clarifies that for movement within the same institution, "inmates who are symptomatic and/or test positive shall not be transferred and shall be isolated as per interim guidance." The revised matrix also now includes the Receiver's prior guidance from December 4 and 18, 2020 pertaining to quarantine and isolation space, among other changes. A copy of the revised matrix is attached as **Exhibit 1.** A joint meeting between CDCR and CCHCS is scheduled to occur on January 14 to coordinate implementation of the revised matrix and to ensure consistency in implementation.

Further, CDCR and CCHCS continue to utilize measures to track patient information for transfers. Staff at each prison have procedures and processes in place to follow the requirements of the matrix. On October 6, 2020, CCHCS implemented an online registry to track all transfer information for incarcerated persons. The registry allows staff to review and update medical and other important data before, during, and after transfers. Finally, the prisons continue to offer comprehensive COVID-19 testing for incarcerated people, and the specific protocols for each prison are outlined for Plaintiffs during routine calls with CCHCS staff. CDCR will continue working closely with the Receiver's Office to implement the protocols set forth in the revised Matrix.

VII. STAFF SCREENING AND TESTING

Plaintiffs' Position: Staff remain the most significant vector for introducing COVID-19 into the state prison system. As of January 12, more than 2,500 staff were out with active cases of COVID-19, and nearly 14,000 had contracted COVID-19 since March. *See* Cal. Dep't of Corr. & Rehab., *CDCR/CCHCS COVID-19 Employee Status*, https://www.cdcr.ca.gov/covid19/cdcr-cchcs-covid-19-status (last updated Jan. 12, 2021). And while CCHCS and CDCR have begun offering vaccines to staff, it is not yet known whether vaccination prevents transmission. Frequent and rigorous testing thus remains essential to preventing the introduction and spread of COVID-19 in the prisons.

The Receiver continues to oversee the COVID-19 staff testing program. On December 4, CCHCS reported that, due to the number of outbreaks among patients and

staff, every prison was testing all staff weekly. On January 8, CCHCS reported that eight prisons had increased the frequency of staff testing to twice a week, given the number of positive cases at those prisons.[19] We asked whether CCHCS had considered conducting daily antigen testing in combination with weekly PCR testing, given the current rates of COVID-19 infections in California, and noted that the Department of State Hospitals has recently adopted this strategy. *See* Cal. Dep't of State Hospitals, *COVID-19 Transmission-Based Precautions and Testing*, https://www.dsh.ca.gov/COVID-19/docs/TransmissionBasedPrecautions_and_Testing.pdf (last updated Dec. 31, 2020). CCHCS said they were considering this strategy, but that it would require significant nursing staff resources, which is currently a challenge.

Regarding staffing for the testing program, testing continues to be largely carried out by vendors, who conduct testing during regular business hours. On January 8, CCHCS reported the vendors had the capacity to conduct twice-weekly testing of all staff at the eight prisons where CCHCS had determined more frequent testing was needed. As previously reported, CCHCS planned to hire nurses to supplement the testing carried out by vendors (specifically, to test staff at the entrances to prisons and test staff after-hours) by the end of December. However, on January 8, CCHCS reported they had so far hired only 29 of the 70 nurses required, and that they now anticipate these positions will be filled by the end of March.

Regarding monitoring compliance with the staff testing policies, on December 31, CCHCS provided Plaintiffs a report reflecting the percentage of staff tested at each prison in recent weeks. Unfortunately, the data had not yet been validated so is of limited use. The data provided showed that, across all 35 prisons, only 77% of staff were tested (or were exempt because they tested positive within the previous 90 days) during the weeks of

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[19] Those eight prisons are California Rehabilitation Center, California Correctional Institution, High Desert State Prison, Salinas Valley State Prison, California Men's Colony, California State Prison, Los Angeles County, and Richard J. Donovan Correctional Facility.

December 6 and December 13, and only 68.3% were tested the week of December 20. However, CCHCS said this data does not account for staff who did not test because they were out sick or on vacation, and that adjusting for these absences could have a significant impact on the compliance rates reported. CCHCS said that it is currently addressing this issue through the data validation process. On January 8, CCHCS said that all prisons had submitted their validated data to headquarters, but they did not know when the validated data would be incorporated into a report and made available to Plaintiffs. Also on January 8, we asked whether such reports with validated staff testing data could be provided on a biweekly basis. CCHCS stated they would provide a response to these questions this week.

As described below, CCHCS and CDCR also recently provided the third set of biweekly reports of staff noncompliance with face covering and physical distancing requirements, which for the first time also included documentation of noncompliance with testing requirements. The logs document discipline taken for twelve staff members who failed to comply with mandatory testing policies in December at Mule Creek State Prison, two at the Substance Abuse Treatment Facility, and one at California Medical Facility. As stated previously, we believe that to adequately monitor compliance with the testing policies, we need both the logs reporting individual refusals to test (and corrective action taken) and reliable staff testing data for each prison.

Defendants' Position: CDCR continues to coordinate with the Receiver's Office and enforce the Memorandum on Employee Accountability for COVID-19 testing, which dictates that any employee who refuses to comply with mandatory COVID-19 testing shall not be permitted to enter the institution or facility and shall be placed on approved dock (without pay) until they comply with mandatory testing. Unwillingness to comply with mandatory staff testing shall be interpreted as a refusal. Concurrently, employees who refuse to comply with mandatory employee COVID-19 testing and who are not actively engaged in a request for reasonable accommodation shall also be subject to progressive discipline for their refusal to submit to the mandatory testing.

Further, beginning the week of January 4, 2021, staff at California State Prison, Lancaster, and California City Correctional Facility were first offered saliva testing as a new option. CDCR anticipates that the saliva test will be available at all institutions by the end of January 2021.

VIII. STAFF COMPLIANCE WITH FACE COVERING AND PHYSICAL DISTANCING REQUIREMENTS

Plaintiffs' Position: On December 31 and January 8, Defendants produced to Plaintiffs the third set of biweekly reports of staff noncompliance with face covering and physical distancing requirements, as directed by the Court.[20] *See* ECF No. 3492. As with the previous set of reports, CDCR and CCHCS produced separate logs, for custody and healthcare staff. No logs for custody staff were provided for four prisons; Defendants' counsel stated these prisons had no incidents to report.[21] Again, it is apparent from these logs that noncompliance with face covering and physical distancing policies continues: the logs document 50 incidents of noncompliance among medical staff and approximately 100 incidents among custody staff between December 16 and December 29. The majority of corrective action reported was in the form of verbal counseling.

We continue to believe Defendants should use also positive reinforcement and education to increase compliance. At the previous Case Management Conference, we raised the possibility of CDCR having Captains compare and in essence compete with each other regarding face-covering compliance in their facilities, and having CDCR supervisors ask incarcerated people about staff noncompliance. Defendants on January 12 said the idea of having Captains compete remains under consideration. With regard to asking incarcerated people, Defendants on January 12 said they believed the most effective

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[20] The report Defendants initially provided on December 31 omitted CDCR's logs for several prisons. Defendants produced a revised report with those logs on January 8.

[21] These prisons include Central California Women's Facility, California State Prison, Centinela, California State Prison, Solano, and Valley State Prison.

approach is to have Captains "talk with the population as they tour regarding all things related to COVID compliance and ask if the incarcerated persons have concerns." Defendants further asserted that this is already being done, and is the better approach because it does not make people uncomfortable. We disagree. As we explained in an email on January 13, we believe Captains should directly ask about staff face-covering compliance, and so too should Lieutenants and Sergeants. Having leadership directly ask about face coverings will help CDCR get more accurate information about compliance. It will also send a clear message to all staff and the incarcerated population that these policies are to be taken seriously.

In recent weeks, and as previously reported, we have sent CDCR detailed reports from incarcerated people regarding lack of compliance by staff with face-covering compliance at certain facilities at San Quentin and LAC. CDCR has said that it would review and investigate the San Quentin report, and we have asked for those results. We have not received a substantive response regarding the LAC report.

Defendants' Position: Defendants remain committed to enforcing mask wearing and social distancing statewide, and take allegations of non-compliance very seriously. As of November 23, 2020, all employees, contractors, and visitors working or performing duties at a CDCR institution, whether indoors and outdoors, must wear a procedure mask at all times, with only limited exceptions. Employees and contract workers are provided two procedure masks per shift, per day, upon entry to an institution. Visitors are also provided two procedure masks upon entry to the institution or facility and as needed throughout the day. Staff working a double shift will be provided additional masks for the next shift. Procedure masks are provided at the screening point (e.g., entrance gate or first pedestrian entrance). If staff, contractors, or visitors arrive without a mask, they will be required to put on a procedure mask prior to screening.

Defendants issued a memorandum updating and clarifying expectations for staff mask usage and physical distancing in a December 4, 2020 directive. Staff are required to review and acknowledge the directive via CDCR's training portal. A copy of that directive

was attached as Exhibit A to the December 9, 2020 case management conference statement (ECF No. 3501).

Defendants prepared and provided Plaintiffs with mask compliance logs on December 31, 2020, and on January 12, 2021, CCHCS responded to a number of Plaintiffs' counsel's questions pertaining to the logs. Finally, at the last Case Management Conference, this Court encouraged the parties to consider Plaintiffs' suggestions to further incentivize mask wearing: (1) have CDCR supervisors speak with incarcerated persons to inquire whether compliance with mask wearing is a problem in their housing unit and to encourage them to report noncompliance; and (2) ask CDCR captains to report compliance ratings to each other to create competition. Regarding Plaintiffs' first suggestion, CDCR believes it would be preferable for captains to speak with the population as they tour regarding all matters related to COVID-19 compliance, including adequacy of cleaning supplies, gloves, and how the population and staff are doing with mask wearing and physical distancing, including whether the population has any concerns. It is already CDCR's expectation that captains are speaking with staff and incarcerated persons during their tours, and this approach would not put the incarcerated population in an uncomfortable position. Regarding Plaintiffs' second suggestion, CDCR is currently considering whether and how to create competition among captains and yards to increase compliance.

IX. OFFICE OF THE INSPECTOR GENERAL AUDIT REPORT

The parties received the Office of the Inspector General's first audit report concerning CDCR's compliance with face covering and physical distancing requirements on January 13, 2021 (the date of this filing). The parties have not had an opportunity to review the report prior to the filing of this statement. The report is attached as **Exhibit 2**.

X. VENTILATION

Plaintiffs' Position: Adequate housing unit ventilation is a necessary component of COVID-19 risk reduction in prisons. We have raised questions and concerns about ventilation for months, including after CDCR in July asserted that a prison avoided a large-

scale outbreak last spring in part by adjusting housing unit Air Handling Units (AHUs) so that only outside air was used. *See* ECF No. 3397 at 6:2-5.

The use of outside air is a key ventilation risk reduction measure, as CDCR again recently recognized. *See* ECF No. 3520 at 19:1-2. On January 13, as this Statement was being finalized, CCHCS and CDCR provided information in which they suggested our previously stated facts regarding the limited amount of outside air used in prisons' AHUs was incorrect, implying (contrary to what had been previously indicated) that it only concerned a single prison, and in winter. They unfortunately did not provide a comprehensive statement of outside air use at all prisons in all seasons. We will ask for it, but continue to believe, based on information previously provided by CDCR, that housing unit ventilation in winter months at many prisons uses only 20% to 25% outside air, and an even smaller percentage when temperatures are below freezing.

As also previously reported (*see* ECF No. 3520 at 18:17-22), CDCR also issued a statewide memorandum, dated December 18, 2020, requiring all prison to try to use MERV-13 filters on housing unit AHUs instead of the commonly used MERV-8. According to the memorandum, using the MERV-13 will "reduce airborne transmission of COVID-19." However, the memorandum makes clear that AHUs may not be able to adequately operate with MERV-13 or any other filter besides the MERV-8, in which case the latter can continue to be used. On December 30, 2020, we asked CDCR to provide information as to each prison's efforts to upgrade its housing unit AHUs' MERV filters. On January 13, CDCR and CCHCS responded that even before the December 18 memo, seven prisons either partly or entirely used filters with an efficiency rating greater than MERV-8. They further explained that it would take all other prisons between 30 and 120 days to obtain MERV-13 filters. This timeframe suggests standard procurement have been used, despite the need to reduce airborne transmission of COVID-19.

We also on December 30 asked CDCR whether it would seek a report on "[i]nter-cell airflow patterns" at San Quentin, which a recently received report on that prison's cellblock ventilation specifically said was not analyzed (*see* ECF No. 3250 at 18:8-16).

On January 13, CCHCS and CDCR said they are still considering the underlying report.

Defendants' Position: On January 13, 2021, CDCR provided Plaintiffs with additional information in response to their inquiries pertaining to air filtration. As noted in the response, Plaintiffs' assertion that Air Handling Units (AHUs) in CDCR housing units use only approximately 20-25% outside air during summer months, and only 10-15% outside air in winter months is incorrect as that data only pertains to the design parameters of the AHUs at High Desert State Prison during heating operations only, and does not address the design parameters of AHUs at other CDCR prisons. The response also indicated that at least 7 prisons already utilized filters with an efficiency rating higher than MERV-8 prior to issuance of the December 18, 2020 memorandum. The first installation of MERV-13 filters to test whether sufficient airflow quantity can be maintained with the higher efficiency filter should occur in early February 2021.

XI. PRISON-SPECIFIC UPDATES

Plaintiffs' Position: Two patient deaths last week at RJD raised serious questions about whether ordered COVID-19 tests were being done.

On January 7, a 51 year old patient from RJD died at an outside hospital from what appears to be COVID pneumonia. He had a serious underlying medical conditions known to create a heightened risk of harm from COVID, a serious mental health condition, and was severely developmentally disabled. Prison medical doctors ordered COVID tests for the patient on December 11, December 18, and December 28, but none were ever done. On January 5, medical staff saw him emergently for shortness of breath, oxygen saturation in the low 40s, and sent him to an outside hospital, where he died two days later.

We immediately asked CCHCS about the death, and asked whether RJD has or had a problem completing orders for COVID testing. On the morning of January 8, CCHCS told us there was no problem with COVID testing at the prison.

Later on January 8, we were notified of the COVID-caused death of a 63 year old from RJD who died that same day. Medical records show the patient had multiple medical conditions known to create a heightened risk of harm from COVID, and a serious mental

health condition that resulted in a current determination of grave disability. On December 11 and then again on December 28, prison medical doctors had ordered that the patient be tested for COVID (with swabs to be done on December 14 and December 29) but neither was done. On January 5, medical staff responded emergently to the patient for shortness of breath; oxygen saturation was measured at 74%. The patient was sent to an outside hospital and died there three days later.

We then reviewed medical records for about two dozen patients, and CCHCS Dashboard information for RJD, all of which appeared to show that the prison had many, perhaps hundreds of orders for COVID testing in December that had apparently not been done, timely or otherwise. On January 10, we informed CCHCS of our concerns and, given the two patient deaths, asked them to urgently review whether there was a problem with ordered COVID tests not being done at RJD.

Defendants' Position: Defendants understand that CCHCS is in the process of reviewing Plaintiffs' concerns.

Video visitation was fully implemented at all 35 CDCR institutions by the end of 2020, and will be extended to conservation camps by early 2021. A more detailed article describing video visitation and its impact on the incarcerated population and their families is available at https://www.cdcr.ca.gov/insidecdcr/2020/12/30/cdcr-video-visits-reconnect-families/.

XII. MEDICAL CARE MATTERS NOT RELATED TO COVID-19

Plaintiffs' Position: On December 18, 2020, Judge Mueller at a *Coleman* status conference *sua sponte* extensively discussed a CDCR review of a recent suicide at the California Health Care Facility (CHCF). We subsequently received a copy of the CDCR review. In addition to identifying more than two dozen problems related to mental health care, the review determined there was incomplete emergency response documentation by medical staff, nursing staff failed to document required patient checks, and that it took staff eight minutes to activate 911 after the person was found unresponsive in his cell with a state-issued t-shirt wrapped around his neck (Judge Mueller mentioned this latter fact when

discussing the matter).

That these types of emergency medical response problems continue at CHCF is extremely troubling. Two and one-half years ago, in August 2018, we wrote the Receiver about both CHCF emergency response nursing documentation problems, and undue delays in activating 911 in what we called an extraordinarily large number of cases. At least partly in response to this report as well as similar concerns we reported at other prisons, CCHCS in 2019 launched an extensive re-tooling of its medical emergency response procedures and practices, particularly as done by nurses, and CHCF staff received special training on this in July 2019. For the same problems to now recur is concerning including because -- especially considering the other problems identified in the suicided review -- it indicates that staff acted as if the deceased deserved less care than would be accorded to a non-incarcerated person.

We believe CCHCS's and CDCR's mild response when staff delay activating 911 is a major cause of the continuing problems. In August 2018, we informed the Receiver that when the problem was identified the response was to train staff. But training seems to miss the mark when such staff has already been trained on the policy, and regardless of that the need to call 911 in emergency circumstances is known by just about every person above age ten, and probably many younger than that as well.

Defendants' Position: The emergency response to the suicide referenced in Plaintiffs' section above is still under review by institution leadership. As such, any further discussion would be premature and incomplete.

XIII. RESPONSE TO COURT'S DECEMBER 23, 2020 ORDER

Defendants' Position: At Plaintiffs' request, Defendants provided a detailed bullet-point outline of their responses to the Court's questions from the December 23, 2020 order to Plaintiffs' counsel on the morning of Saturday, January 9. Plaintiffs responded stating that they needed Defendants' full responses to provide their comments to the Court's questions. Defendants provided Plaintiffs with a copy of their full responses on Monday, January 11 when the parties exchanged portions of the joint CMC statement. Plaintiffs

also requested a copy of Defendants' supporting declaration, which Defendants provided the following morning. Plaintiffs did not provide their responses to the Court's questions to Defendants in advance of the joint filing. Defendants are therefore unable to address or respond to any of the points raised in Plaintiffs' responses to these questions, though Defendants will attempt to be prepared to do so during tomorrow's hearing.

A. The extent to which each institution has set aside enough cells with solid doors to comply with the Receiver's December 4, 2020 and December 18, 2020 guidance.

Defendants' Position: CDCR has made substantial progress to enable all prisons, including those with challenging designs, to appropriately quarantine and isolate inmates. All but a handful[22] of CDCR's prisons have reserved a substantial number of cells that give them the ability to comply with the Receiver's guidance provided on December 4 and 18, 2020, and CDCR is endeavoring to follow that guidance despite numerous challenges.

From July through September 2020, CDCR vacated and prepared a significant amount of space across the prison system that it reserved for isolation and quarantine under the Public Health Workgroup's guidance. Decl. Gipson Supp. Defs.' Opp'n ¶¶ 13-14; ECF No. 3508. In addition to that reserved space, CDCR made extensive efforts to identify other spaces that could potentially be used for isolation and quarantine at the prisons beginning last summer and continuing to the present. Decl. Gipson Supp. Defs.' Responses Ct.'s Questions re Pls.' Quarantine Mot. ¶ 2. Some of those spaces were comprised of additional cell and dorm housing that was vacated so that it could be available and ready for use if needed during an outbreak. *Id.* And some of those additional spaces were comprised of alternative spaces that had to be prepared and approved for occupancy, such as gyms, chapels, and tents. *Id.* Through its many efforts, CDCR has identified abundant additional space for quarantine and isolation at many prisons. *Id.* at ¶ 3. Much of the available space—both the originally reserved quarantine

[22] As discussed in more detail below, San Quentin, Folsom, California Rehabilitation Center, and California Health Care Facility were unable to substantially satisfy the Public Health Workgroup's recommendation for reserved quarantine and isolation space.

spaces and additional identified spaces—was presented to the Court with Defendants' opposition to Plaintiffs' motion. *See* Decl. Gipson Supp. Defs.' Opp'n, Ex. E; ECF No. 3508-5; Decl. Gipson Supp. Defs.' Responses Ct.'s Questions re Pls.' Quarantine Mot. ¶ 3.

The Receiver's guidance from December 4 and 18 recommends that patients exposed to COVID-19 should be quarantined in a cell with no more than two inmates per cell. Decl. Gipson Supp. Defs.' Responses Ct.'s Questions re Pls.' Quarantine Mot. ¶ 4, Ex. F. But the guidance provides that if an outbreak exceeds 200 positive cases or if the reserved quarantine cells are full, then "decisions about post-exposure quarantine practices and housing shall be committed to the discretion of the warden and CEO or their designees at the institution in consultation with CDCR and CCHCS regional and headquarters staff." *Id.* The Receiver's guidance from December 4 and December 18 does not specify an amount of reserved space for any particular prison, but it does seem to require that each prison have a substantial number of cells reserved for quarantine purposes. *Id.* Thus, each of the prisons that has substantial reserved cells—or that has additional cells that were later vacated and prepared for quarantine use—has capacity to comply with the Receiver's December 4 guidance until those cells are all occupied. In the event that reserved quarantine cells are all occupied by quarantining patients, those prisons can still follow the Receiver's guidance by then having their medical CEOs and Wardens consult with CCHCS and CDCR headquarters about how to handle any additional patients who need to be quarantined.

As reflected in the table that Defendants produced with their opposition to Plaintiffs' motion, 31 prisons have substantial quarantine-cell reserves, and each of them therefore has the ability to implement the Receiver's guidance. Decl. Gipson Supp. Defs.' Opp'n, Ex. E; ECF No. 3508-5. But as the Receiver's guidance recognized, "the high frequency and number of transfers increases patient COVID-19 fatigue which is resulting in a substantial increase in refusals, both refusals to transfer and refusals of COVID-19 testing." Decl. Gipson Supp. Defs.' Responses Ct.'s Questions re Pls.' Quarantine Mot. ¶ 4, Ex. F. Consequently, without resorting to forced cell extractions and forced moves,

CDCR cannot follow the Receiver's guidance in every instance. *Id.* at ¶ 5.

A case-by-case analysis of the circumstances at each prison is required to determine what compliance with the Receiver's guidance looks like as far as numbers of inmates quarantined in cells is concerned, and Defendants provide the following three examples to illustrate:

- For California State Prison-Corcoran, the Public Health Workgroup recommended that 40 beds be reserved. Decl. Gipson Supp. Defs.' Opp'n, Ex. E; ECF No. 3508-5. Corcoran exceeded that recommendation and reserved 100 cells. *Id.* Corcoran later identified an additional 252 cells that may be used for isolation or quarantine purposes during outbreaks. *Id.* Thus, under the Receiver's recent guidance, Corcoran could potentially place 352 post-exposure patients in a cell by themselves, or those same cells could accommodate up to 704 quarantined patients if double-celled. To the extent Corcoran's available quarantine cells are all occupied by patients on quarantine, Corcoran can still comply with the Receiver's guidance by having its medical CEO and Warden consult with CCHCS and CDCR headquarters on how best to quarantine additional patients.
- For Avenal State Prison, the Public Health Workgroup recommended that 248 beds be reserved for quarantine and isolation purposes. *Id.* Avenal was able to reserve 100 cells and 192 dorm beds in response to that recommendation. *Id.* Avenal's reserved cells can quarantine up to 200 patients under the Receiver's recent guidance. Although Avenal was not able to reserve 248 cell beds as recommended, it supplemented its cell space with 192 reserved dorm beds. *Id.* Furthermore, the Receiver's August guidance indicated that if a large portion of the population had already been infected by COVID-19, then less quarantine space is needed than was recommended by the Public Health Workgroup. Decl. Gipson Supp. Defs.' Opp'n, Ex. D at 1-2; ECF No. 3508-4 (CCHCS's guidance explained that a large number of resolved patients within

a prison expands options for cohorting patients, and that San Quentin likely needed less than the recommended space reserves due to the fact that a significant portion of its population had already been infected with COVID-19). This is an important consideration for Avenal, where 2,997 patients have contracted the virus, and Avenal's current population is about 3,327. Decl. Gipson Supp. Defs.' Responses Ct.'s Questions re Pls.' Quarantine Mot. ¶ __. To the extent Avenal's available quarantine cells are all occupied by patients on quarantine, Avenal can still comply with the Receiver's guidance by having its medical CEO and Warden consult with CCHCS and CDCR headquarters on how best to quarantine additional patients.

- The Public Health Workgroup recommended that California Correctional Institution (CCI) reserve 235 beds for quarantine and isolation. Decl. Gipson Supp. Defs.' Opp'n, Ex. E; ECF No. 3508-5. In response, CCI was able to reserve 124 cells and 154 dorm beds for isolation and quarantine. Decl. Gipson Supp. Defs.' Opp'n, Ex. E; ECF No. 3508-5. Under the Receiver's recent guidance, CCI can quarantine up to 248 patients in its reserved cells, which would satisfy the Public Health Workgroup recommendation. And to the extent that CCI's available quarantine cells are all occupied by patients on quarantine, CCI can still comply with the Receiver's guidance by having its medical CEO and Warden consult with CCHCS and CDCR headquarters on how best to quarantine additional patients.

Only four prisons either have no quarantine cells or only a small fraction of the number recommended by the Public Health Workgroup. They are San Quentin (63 cells), Folsom (99 cells), California Health Care Facility (92 negative pressure rooms/cells), and California Rehabilitation Center (no quarantine cells).[23] Decl. Gipson Supp. Defs.' Opp'n,

[23] The Receiver's December 4 guidance suggested that two additional prisons—

Ex. E; ECF No. 3508-5; Decl. Gipson Supp. Defs.' Responses Ct.'s Questions re Pls.' Quarantine Mot. ¶ 3.

B. What efforts have Defendants made "to find quarantine alternatives that satisfy the purposes of a post-exposure quarantine," at the seven institutions identified by the Receiver as lacking sufficient facilities or having a medical mission (ECF No. 3503 at 8.)

Defendants' Position: CDCR has made great efforts to enable all prisons, including those with challenging designs, to appropriately quarantine and isolate inmates. Decl. Gipson Supp. Defs.' Responses Ct.'s Questions re Pls.' Quarantine Mot. ¶ 6. Since last summer, CDCR has endeavored to identify alternative spaces that can be used for quarantine or isolation in the event of a large outbreak. *Id.* Many prisons have not only identified alternative spaces, but have also already obtained fire marshal approval and acquired bedding and storage units for the spaces to prepare them for occupancy. *Id.* Some of these spaces, including gyms, visiting areas, and chapels, are set forth in the table of isolation and quarantine space that Defendants presented with their opposition to Plaintiffs' motion. Decl. Gipson Supp. Defs.' Opp'n, Ex. E; ECF No. 3508-5. Other spaces not reflected in that document have also been identified and set aside at various prisons. Decl. Gipson Supp. Defs.' Responses Ct.'s Questions re Pls.' Quarantine Mot. ¶ 6, Ex. G. Also, CCHCS has indicated that it is in the process of undertaking a survey of all prisons to determine whether there is any additional space that can be used for isolation and quarantine. *Id.*

Additional information regarding the efforts of the seven specific prisons about which the Court inquired is provided below.

Avenal State Prison and Chuckawalla Valley State Prison—lack sufficient facilities to comply with the new guidance. Decl. Gipson Supp. Defs.' Suppl. Br. Ex. F. That was before the Receiver issued the supplemental guidance on December 18. As discussed below, with the addition of the December 18 guidance, Avenal and Chuckawalla have sufficient facilities, especially in consideration of the large portion of their populations that have already been infected with COVID-19, and additional identified space at each institution.

1. Avenal State Prison

The Public Health Workgroup recommended that Avenal reserve 248 beds for quarantine and isolation purposes. Decl. Gipson Supp. Defs.' Opp'n, Ex. E; ECF No. 3508-5. Avenal State Prison has reserved 100 cells for quarantine, which could be used to quarantine up to 200 patients under the Receiver's guidance. *Id.* In addition, Avenal has reserved dorm space sufficient to house 192 patients. *Id.* In May 2020, Avenal obtained fire marshal approval to use gyms in Facilities A and B as quarantine and isolation housing, and in July 2020, Avenal obtained fire marshal approval for gyms in Facilities C, D, and E. Decl. Gipson Supp. Defs.' Responses Ct.'s Questions re Pls.' Quarantine Mot. ¶ 7. Later, however, an issue was discovered with the Facility E gym fire panel. *Id.* This will require that Avenal develop and obtain approval from the fire marshal for a fire-watch process for that gym if Avenal needs to use it again. *Id.* These gyms, which can each house at least 50 patients, were fully prepared for occupancy with the installation of bedding and storage units, and were occupied during Avenal's outbreaks. *Id.*

Last summer, Avenal also obtained fire marshal approval to use three cells in Building 390A for quarantine or isolation, and Avenal obtained preapproval from the fire marshal to use visiting areas in Facilities A, B, C, E, and F in late October and early November 2020. *Id.* If the visiting areas are ever needed, they will be set up to house patients and final approval from the fire marshal will be obtained. *Id.* Each of the visiting areas can house about 32 patients. *Id.*

Like all of the prisons, Avenal has the ability to quickly install tents to provide additional housing if a large outbreak should occur. *Id.* A tent contractor has already visited Avenal's grounds to identify locations where tents will be installed, if needed, which should expedite the installation process. *Id.* The installation of tents can usually be accomplished within 72 hours. *Id.*

It is noteworthy that Avenal had several large outbreaks from May through October 2020. *Id.* at ¶ 8. As of January 12, CCHCS's patient tracker indicates that 3,001 patients at Avenal have been infected with COVID-19, and Avenal's current population is about

3,327.[24] *Id.* As CCHCS noted in its August 2020 recommendations concerning quarantine space, less space is required if a large portion of the population has already been infected by COVID-19. Decl. Gipson Supp. Defs.' Opp'n, Ex. D at 1-2; ECF No. 3508-4. During the recent surge of cases throughout the prison system (and the United States) that began in November, Avenal has not had another large outbreak, which suggests that CCHCS's guidance was correct. *Id.* In light of these facts and developments, Avenal has sufficient quarantine space.

2. Chuckawalla Valley State Prison

The Public Health Workgroup recommended that Chuckawalla Valley State Prison reserve 91 beds for quarantine and isolation purposes. Decl. Gipson Supp. Defs.' Opp'n, Ex. E; ECF No. 3508-5. Chuckawalla reserved 100 cells that can be used to accommodate up to 200 patients on quarantine under the Receiver's guidance. *Id.* Chuckawalla also reserved 192 beds in dorm settings for quarantine and isolation use. *Id.*

Like all prisons, Chuckawalla has reviewed its facilities to identify additional space that can potentially be used for isolation or quarantine in the event of a large outbreak and obtained fire marshal approval to use the spaces. Decl. Gipson Supp. Defs.' Responses Ct.'s Questions re Pls.' Quarantine Mot. ¶ 9. Chuckawalla has already obtained fire marshal approval to use the chapels and education rooms in Facilities A, B, C, and D. *Id.* In combination, those spaces accommodate up to 168 patients. *Id.* Chuckawalla also vacated offices in a decommissioned part of the Central Infirmary and turned the offices back into rooms for isolation or quarantine in the event of an outbreak. *Id.* Each of the twelve rooms can now house up to two inmates if needed. *Id.*

Additionally, Chuckawalla can easily and quickly add additional space for quarantine and isolation in the event of a large outbreak by installing tents. *Id.* A tent contractor has already reviewed the grounds at Chuckawalla and identified areas for tent

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[24] Even though many cases of COVID-19 in the prisons resolved as early as May 2020, CCHCS has advised that, to date, there are no confirmed cases of reinfection among the patient population in any prison. Decl. Gipson Supp. Defs.' Suppl. Br. ¶ 8.

installation so that the installation process can be expedited if the tents are ever needed. *Id.*

Chuckawalla has previously had several large outbreaks; in total, 1,742 patients at Chuckawalla have been infected with the virus since May 2020. *Id.* at ¶ 10. Chuckwalla's current population is about 1,845. *Id.* As CCHCS guidance indicates, less reserved space is needed for quarantine and isolation when a large portion of the population at a prison has already been infected. Decl. Gipson Supp. Defs.' Opp'n, Ex. D at 2; ECF No. 3508-4. Chuckawalla has not had another large outbreak despite the recent surge in cases across the system and nation. Decl. Gipson Supp. Defs.' Responses Ct.'s Questions re Pls.' Quarantine Mot. ¶ 10. Based on these developments and facts, Chuckawalla has sufficient quarantine space.

3. California Medical Facility

The Receiver's guidance leaves decisions about post-exposure quarantine housing at California Medical Facility (CMF) to the discretion of the medical leadership in recognition of its materially different mission. Decl. Gipson Supp. Defs.' Responses Ct.'s Questions re Pls.' Quarantine Mot. Ex. F. The Public Health Workgroup recommended that CMF reserve 162 beds for quarantine and isolation. Decl. Gipson Supp. Defs.' Opp'n, Ex. E; ECF No. 3508-5. CMF was able to move inmates in various locations throughout the prison so that it could reserve 158 cells and 36 dorm beds for quarantine and isolation. *Id.* The reduction in CMF's population has allowed it to recently set aside and use additional space for isolation and quarantine, including the following: Unit H2 (21 cells and five 8-person dorms); U-Wing (110 cells); D-Dorm (150 dorm beds); and an area in CMF's Psychiatric Inpatient Unit (64 cells). Decl. Gipson Supp. Defs.' Responses Ct.'s Questions re Pls.' Quarantine Mot. ¶ 11. Further, to create additional space for isolation or quarantine purposes, CMF has currently installed six tents with a total capacity of 100 patients. *Id.*

Currently, vaccinations are underway at CMF, and as of January 12, 1073[25] patients and 1029 staff had received their first dose of the COVID-19 vaccine. *Id.* at ¶ 12. As of January 12, about 583 patients at CMF had been infected with the virus, and nearly all of those infections occurred within the past 90 days. *Id.* As of January 12, the population at CMF was about 1,998, thus a significant portion of CMF's population has now either had one dose of the vaccine or already been infected with the virus. *Id.* In light of these facts and recent developments, CMF has sufficient quarantine space.

4. California Health Care Facility

The Receiver's guidance also leaves decisions about post-exposure quarantine housing at California Health Care Facility (CHCF) to the discretion of the medical leadership in recognition of its medical mission and unique operations. Decl. Gipson Supp. Defs.' Responses Ct.'s Questions re Pls.' Quarantine Mot. Ex. F. The Public Health Workgroup recommended that CHCF reserve 277 beds for quarantine and isolation. Decl. Gipson Supp. Defs.' Opp'n, Ex. E; ECF No. 3508-5. CHCF was able to reserve 92 negative pressure rooms and 100 tent beds for quarantine and isolation purposes. *Id.* And CHCF has the ability to install additional tents if needed. Decl. Gipson Supp. Defs.' Responses Ct.'s Questions re Pls.' Quarantine Mot. ¶ 13.

Furthermore, numerous inmates and staff are currently being vaccinated at CHCF and vaccinations are ongoing. *Id.* at ¶ 14. As of January 12, about 1,275[26] patients and 1,499 staff had received their first dose of vaccine, and 33 patients and 235 staff had received two doses of vaccine. *Id.* As of January 12, about 554 patients at CHCF had been infected with the virus, and the overwhelming majority of those infections occurred within the past 90 days. *Id.* As of January 12, the population at CHCF was about 2,389. *Id.* Thus, a significant portion of CHCF's population has either had at least one dose of the

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[25] An additional 331 patients were offered the vaccine but refused it.

[26] An additional 164 patients were offered the vaccine but refused it.

vaccine or already been infected. In light of these facts and recent developments, CHCF has sufficient quarantine space.

5. Folsom State Prison

CCHCS acknowledged that Folsom State Prison was one of the locations where setting aside quarantine and isolation space would be a challenge because of Folsom's design. Decl. Gipson Supp. Defs.' Opp'n, Ex. D at 2; ECF No. 3508-4. The Public Health Workgroup recommended that Folsom reserve 1,380 beds for quarantine and isolation. Decl. Gipson Supp. Defs.' Opp'n, Ex. E; ECF No. 3508-5. Folsom was initially able to reserve 44 cells and 28 dorm beds for quarantine and isolation. *Id.* Later, Folsom was able to set aside an additional 55 cells and 302 dorm beds for quarantine or isolation. *Id.* Folsom has also obtained fire marshal approval to use its visiting area as an alternative housing space, and during the large outbreak from August through October 2020, Folsom housed 70 patients in the visiting area. Decl. Gipson Supp. Defs.' Responses Ct.'s Questions re Pls.' Quarantine Mot. ¶ 15. Folsom could prepare the visiting area again for occupancy in about 24 hours. *Id.* Additionally, Folsom has the ability to install tents to supplement its quarantine and isolation space. *Id.* During the large outbreak at Folsom last summer, Folsom was able to quickly install multiple tents with capacity to house up to 180 patients. *Id.*

As a result of Folsom's large outbreak, 1,338 patients were infected with the virus. *Id.* at ¶ 16. As of January 6, Folsom's population was about 2,054. *Id*. Thus, a substantial portion of Folsom's population has already been infected with the virus. *Id.* Despite the recent surge in cases across the system, there are currently no active cases of the virus in Folsom's population. *Id.* As CCHCS's guidance indicates, the fact that a significant portion of the population was already infected with the virus reduces the need for quarantine and isolation space. Decl. Gipson Supp. Defs.' Opp'n, Ex. D at 1-2; ECF No. 3508-4. Based on these facts and developments, Folsom has sufficient isolation and quarantine space.

6. San Quentin State Prison

CCHCS acknowledged that San Quentin was one of the locations where setting aside quarantine and isolation space would be a challenge because of its design. Decl. Gipson Supp. Defs.' Opp'n, Ex. D at 2; ECF No. 3508-4. The Public Health Workgroup recommended that San Quentin reserve 1,550 beds for quarantine and isolation. Decl. Gipson Supp. Defs.' Opp'n, Ex. E; ECF No. 3508-5. San Quentin was able to reserve 108 gym beds, and has since set aside 63 additional cells in the Adjustment Center. *Id.* San Quentin also has the ability to quickly activate 69 beds in its three chapels. Decl. Gipson Supp. Defs.' Responses Ct.'s Questions re Pls.' Quarantine Mot. ¶ 17. San Quentin can also use its Prison Industry Authority building for additional space as it did during the large outbreak last summer, and San Quentin has experience quickly installing tents that can provide an additional 90 beds if necessary. *Id.*

According to CCHCS's patient tracker San Quentin's outbreaks have resulted in 2,151 infected patients. *Id.* at 18. As of January 6, San Quentin's population was about 2,652. *Id.* Thus, a substantial portion of San Quentin's population has already been infected with the virus. As CCHCS's guidance indicates, the fact that a significant portion of San Quentin's population was already infected with the virus reduces the need for quarantine and isolation space. Decl. Gipson Supp. Defs.' Opp'n, Ex. D at 1-2; ECF No. 3508-4. Despite the recent surge in cases across the system, there are currently only three active cases of the virus in San Quentin's population. Decl. Gipson Supp. Defs.' Responses Ct.'s Questions re Pls.' Quarantine Mot. ¶ 18. Based on these facts and developments, San Quentin has sufficient isolation and quarantine space.

7. California Rehabilitation Center

The Public Health Workgroup recommended that California Rehabilitation Center (CRC) reserve 187 beds for quarantine and isolation. Decl. Gipson Supp. Defs.' Opp'n, Ex. E; ECF No. 3508-5. CRC was able to reserve 155 dorm beds and was later able to set aside an additional 344 dorm beds. *Id.* CRC has also set aside its family visiting buildings, which provide 12 additional beds. Decl. Gipson Supp. Defs.' Responses Ct.'s Questions re Pls.' Quarantine Mot. ¶ 19.

Like all of the prisons, CRC has the ability to rapidly install tents if it needs more space. *Id.* During its previous large outbreak, CRC installed 30 twelve-person tents to provide extra housing capacity and safe locations for medically high-risk inmates. *Id.*

Since the beginning of the pandemic, about 1,866 patients at CRC have been infected with the virus, and CRC's current population is about 2,047. *Id.* at ¶ 20. Thus, a significant portion of CRC's population has already contracted the virus. Based on these facts and developments, CRC has sufficient isolation and quarantine space.

C. If Plaintiffs contend that the efforts identified in Paragraph 2 are insufficient, the basis for that contention and what more Plaintiffs propose should be done.

Plaintiffs' Position: The efforts identified in Paragraph 2 are insufficient. They consist primarily of (a) identification of additional quarantine and isolation space, overwhelmingly in congregate living settings (such as dorms, gym, and tents) that present high risk of transmission for people on quarantine; (b) reliance on the immunity derived from large numbers of people who have recovered from COVID-19 in some CDCR prisons; (c) phone calls with CCHCS to determine how to handle outbreaks that have grown out of control; and (d) vaccination at three prisons. While Plaintiffs welcome the vaccinations and the small number of additional cells identified for quarantine and isolation at some prisons, these efforts do not go nearly far enough.

There are 16 CDCR prisons where a large proportion of the population lives in dorms, pods, cells with perforated doors, or other common airspace: Avenal State Prison, California Correctional Center (CCC), California Medical Facility (CMF), California Rehabilitation Center (CRC), California State Prison-Los Angeles County (Lancaster), California State Prison-Solano, Calipatria State Prison, Central California Women's Facility (CCWF), Correctional Health Care Facility (CHCF), Folsom State Prison, Chuckawalla Valley State Prison (CVSP), Mule Creek State Prison, Richard J. Donovan Correctional Facility (RJD) (Facility E only), San Quentin State Prison, Sierra Conservation Center (SCC), and Valley State Prison (VSP). All of these prisons are

profoundly dangerous places to live during the pandemic.[27] *See* Joint Brief on Quarantine, ECF No. 3502, at 17 (people in prison dorms are 35 times more likely to contract COVID-19 than if they lived in cells). Defendants have consistently refused to take the most effective step to protect the people in these prisons from severe illness or death: population reduction sufficient to allow for social distancing and cell-based quarantine. *Id.* at 21 and n.16.

Defendants' decision not to reduce the population meaningfully has led inevitably to massive outbreaks because social distancing, generally recognized as an essential means to reduce transmission, is impossible, and because once people are exposed to the virus, they are all too often quarantined in dorms or other shared airspace that serve as incubators and not barriers to transmission. *Id.* at 14-22. Given this dire situation, the only routes to having adequate quarantine space in the 16 prisons identified above are (a) to wait for a massive outbreak that provides the survivors with some immunity to reinfection and the few remaining COVID-naïve people[28] with adequate access to the small number of solid-

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[27] The 19 other CDCR prisons, all of which have significant quantities of solid-door celled housing, are also dangerous places to live during the pandemic, but they do not have the significant risk factor at issue in this motion: they have adequate celled housing to provide quarantine without resort to shared airspace.

[28] Plaintiffs use the term "COVID-naïve" to mean people who have not previously tested positive for COVID-19 and are therefore vulnerable to infection. In focusing on this group, we might be undercounting the people who are susceptible to infection, because it is not currently known how long immunity lasts for those who recover from the virus. It is generally accepted that people within 90 days of infection have substantial immunity, but no data-based consensus has emerged on how much or how long immunity lasts after that point. The most cautious approach would be to consider all people in CDCR whose COVID-19 infections resolved more than 90 days ago as susceptible to reinfection and therefore to include them with the COVID-naïve group for these calculations. Plaintiffs choose not to do so at this point for two reasons: first, we do not have data regarding that group, and second, we concur with CCHCS that although we cannot be sure that this population cannot be reinfected after 90 days, the experience so far in CDCR, with tens of thousands of cases and no proven cases of reinfection, indicates that any reinfection in upcoming months will likely be extremely rare.

door cells available for quarantine, or (b) vaccinate the population. The former has happened at Avenal, with 330 remaining COVID-naïve people and 200 solid-door cell placements, and CVSP, with 103 COVID-naïve people and 200 solid-door cell placements. The latter option has been employed at two prisons to date,[29] CMF and CHCF. It must also be immediately undertaken at the remaining prisons.

Plaintiffs contend that Defendants' efforts are inadequate at the 12 prisons with substantial COVID-naïve populations, inadequate solid-door cell space for quarantine, and no current plan for vaccination:

Calipatria has 600 double-cell beds set aside with a COVID-naïve population of approximately 1985 living in shared air space[30] (perforated cell doors).

CCC has 200 double-cell beds set aside with a COVID-naïve population of approximately 642 living in shared air space.

CCWF has 200 double-cell beds set aside with a COVID-naïve population of approximately 1181 living in shared air space.

CRC has no cells set aside with a COVID-naïve population of approximately 121 living in shared air space.

Folsom has 99 cells set aside with a COVID-naïve population of approximately 702 living in shared air space.

Lancaster has 400 double-cell beds set aside with a COVID-naïve population of approximately 1254 living in shared air space (perforated cell doors).

Mule Creek has 200 double-cell beds set aside with a COVID-naïve population of

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[29] People at CCWF are also being vaccinated, but only in the two relatively small long-term care facilities at the prison in accordance with Phase 1A of the state's vaccination plan, and not the entire population.

[30] We estimate the COVID-naïve population housed in shared air space by taking the percentage of all people at the prison housed in shared air space and applying that percentage to the total number of COVID-naïve people at the prison.

approximately 842 living in shared air space.

RJD has 200 double-cell beds set aside with a COVID-naïve population of 554 approximately living in shared air space.

San Quentin has 63 cells set aside with a COVID-naïve population of approximately 412 living in shared air space.

SCC has 200 double-cell beds set aside with a COVID-naïve population of approximately 1302 living in shared air space.

Solano has 400 double-cell beds set aside with a COVID-naïve population of approximately 983 living in shared air space.

VSP has 287double-cell beds set aside with a COVID-naïve population of approximately 1093 living in shared air space.

People at these prisons are exposed to an unacceptable risk of harm and cannot be kept safe because there are too many people for the available celled housing in the event of an outbreak. Declaration of Adam Lauring, ECF No. 3504, at ¶ 6. Vaccination is the only acceptable path to safety.

In the weeks since briefing was completed in this matter, COVID-19 cases continue to grow and overwhelm community hospitals and a new, vastly more transmissible variant has been detected in the state. Plaintiffs no longer believe that the Receiver's supplemental guidance of December 18 will have a meaningful impact on the outbreaks in California prisons. There are four reasons for this change in our position. First, CDCR has been unable to determine, as a practical matter, how much is enough space to set aside under this direction. Second, the revision is tautological: it directs each prison to set aside enough quarantine space unless there isn't enough quarantine space, in which case the prison should do the best it can with the space it has available. It is difficult *not* to meet this standard in an outbreak, no matter the number of cells set aside, so long as the prison first fills up its quarantine cells. Third, Defendants cannot even meet this standard, as they persist in quarantining people in congregate spaces even where there are available solid-door cells. Joint Brief at 19-20. This failure continues to the present. For example, on

December 16, 2020, and again on January 5, 2021, Plaintiffs asked why patients quarantined in congregate living space at VSP had not been moved into available celled housing. On January 5, 2021, VSP had only 104 active COVID-19 cases and close to 250 vacant solid-door cell placements set aside for quarantine; under the Receiver's amended guidance, Defendants were required to move quarantined patients into the available cells. They did not do so; according to the CCHCS Regional Healthcare Executive, prison officials decided to quarantine people in their eight-person dorms in clear contradiction to the Receiver's direction.

The most important reason the Receiver's guidance is inadequate, however, is that it is grounded in the assumption that CDCR and the Governor can only do the best with what they have and make informed decisions in an impossible situation. That might be appropriate advice under normal circumstances but nothing about the pandemic is normal.

Given the inadequacy of CDCR's efforts to date, it is essential that the Court order the only remaining solution with any hope to save lives: vaccination. CDCR's incomplete or delayed efforts have failed to stop the virus from raging through the prison system. There is no reason to believe that will change with the measures they have proposed. The only alternative is to vaccinate the population immediately.

D. Whether Defendants refuse to comply or, despite their best efforts, cannot comply with any parts of the Receiver's current guidance, or any modifications to that guidance that might occur between now and the filing of the parties' January 13, 2021 case management statement.

Defendants' Position: Defendants do not refuse to comply with the Receiver's guidance and Defendants believe that substantial compliance with the guidance is achievable. Decl. Gipson Supp. Defs.' Responses Ct.'s Questions re Pls.' Quarantine Mot. ¶ 21. Defendants intend to continue to make all reasonable efforts to follow the guidance. *Id.* There have been instances where the new guidance has not been implemented correctly, and CDCR is working closely with CCHCS to quickly correct those mistakes and ensure that they are not repeated. *Id.* There have also been numerous instances where prisons have been unable to fully implement the new guidance because patients refuse to

move from their cells or refuse to be tested. *Id.* CDCR is working with CCHCS and is making every effort to educate such patients and convince them to protect themselves and others by moving to appropriate quarantine or isolation space. *Id.*

Since the Receiver issued his new guidance on December 4, 2020, CDCR has taken a number of steps to begin implementing the guidance. *Id.* at ¶ 22. Some of the more significant steps include the following:

- December 15, 2020—Meeting between the Division of Adult Institutions and CCHCS to clarify the Receiver's new guidance;
- December 18, 2020—Communication from Director Gipson to the prisons concerning the Receiver's supplemental guidance regarding quarantine;
- December 31, 2020—Meeting between CCHCS, the Division of Adult Institutions, and other officials regarding the implementation of the guidance;
- January 4, 2021—Meeting between Director Gipson and the Associate Directors in the Division of Adult Institutions regarding increasing efforts to ensure prisons are following the new quarantine guidance from the Receiver; and
- January 7, 2021—Meeting between CCHCS, the Division of Adult Institutions, the prisons' Chief Medical Executives, and the Regional Health Care Managers concerning the appropriate implementation of the Receiver's new guidance. *Id.*

These meetings ensure constant communication between and among CDCR and CCHCS headquarters and onsite leadership, and provide a productive and efficient forum to coordinate directives and discuss concerns, challenges, and areas of uncertainty. *Id.* at ¶ 23. CDCR and CCHCS continue to ensure open lines of communication as institutions work to implement the Receiver's guidance and refine their response to a constantly evolving pandemic..

E. The extent to which changes in science, public health guidance,

recommendations from the Receiver, or the state of the pandemic have changed the relief Plaintiffs seek.

Plaintiffs' Position: The disastrous nature of the cascading outbreaks in CDCR, the crisis of availability of hospital beds in the Central Valley and Southern California, and the slow progress of vaccination in the state have changed the relief Plaintiffs seek.

There has never been a more dangerous time for this pandemic: a new, more infectious strain of coronavirus has started to spread in California at the same time as case counts, infection rates, and the death toll set and break daily records and ICU beds are at zero capacity in many of the counties where prisons are located. But it is a hopeful time as well: health care workers and nursing home residents are being vaccinated every day by the thousands.

But although California has received over three million vaccine doses, the State has vaccinated just over 800,000. *See* https://www.bloomberg.com/graphics/covid-vaccine-tracker-global-distribution/; https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/VaccineDoses.aspx. In recognition of the slow roll-out, state guidelines were recently relaxed to allow vaccination of people in Phase 1B (including all incarcerated people) as long as vaccines have been made available to people in Phase 1A (including health care workers and residents of long-term care facilities). *See* https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Vaccine-Prioritization.aspx. Specifically, "[a]fter focused and appropriate efforts to reach the prioritized groups, vaccine providers may offer doses to people in lower priority groups when. . . [d]emand subsides in the current groups." https://covid19.ca.gov/vaccines/. The Governor today announced that people 65 and older should start to be vaccinated as well. https://www.msn.com/en-us/news/us/california-allows-everyone-65-and-older-to-get-covid-19-vaccine/ar-BB1cJ6Kj. People who are 65 and older are in the State's Phase 1B Tier Two along with all incarcerated people. https://covid19.ca.gov/vaccines/

The State's decision is consistent with the current thinking from national experts:

according to the CDC's vaccination guidelines, "[i]t is not necessary to vaccinate all individuals in one phase before initiating the next phase; phases may overlap," and "[d]ecisions about transitioning to subsequent phases should depend on supply, demand, equitable vaccine distribution, and local, state, or territorial context." https://www.cdc.gov/vaccines/covid-19/phased-implementation.html. Dr. Jerome Adams, the Surgeon General, has called for an immediate and significant expansion in vaccine administration: "Your headline today really should be, 'Surgeon General tells states and governors to move quickly to other priority groups' . . . . If the demand isn't there in 1a, go to 1b and continue on down." https://www.nytimes.com/2021/01/05/ world/the-us-surgeon-general-warns-not-to-let-priority-guidelines-slow-down-vaccinations.html. Indeed, the federal government on January 12 "instructed states . . . to immediately begin vaccinating every American 65 and older, as well as tens of millions of adults with medical conditions that put them at higher risk of dying from coronavirus infection," threatening that if they did not use the doses they have received quickly, they would lose them. https://www.nytimes.com/2021/01/12/us/politics/vaccine-states.html?action=click&module=Top%20Stories&pgtype=Homepage.

CDCR and CCHCS will shortly complete offering the vaccine to all people incarcerated in CMF, CHCF, and the skilled nursing facility and transitional care unit at CCWF, and to all staff, under Phase 1A of the State's vaccination plan. Plaintiffs have welcomed this accomplishment and expressed deep gratitude to the leaders who have made it happen. CDCR and CCHCS also plan to start vaccinating the rest of the population, based on COVID risk score, in Phase 1B of the State's plan; that process has not yet started and the timeframe for starting and completing the process is currently unknown. But the State still has ample unused doses of the vaccine and has been directed to expand the pool of people to be vaccinated to the next tier. Based on current direction from both CPDH and national experts, and given the extreme danger to people in CDCR facilities that Defendants have proven unable to mitigate, vaccination of all of the remaining people

in CDCR custody is an urgent necessity.[31]

Accordingly, the Court should order (a) Defendants and CCHCS to immediately begin to offer the vaccine to all people incarcerated in CDCR based on CCHCS's prioritization plan; (b) the Governor to provide adequate doses for these vaccinations; and (c) that people who are COVID-naïve and unvaccinated shall be quarantined only in solid-door cells as of February 1, 2021.

DATED: January 13, 2021

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[31] Plaintiffs seek this relief for all people in CDCR custody and not just the 12 prisons because inter-prison transfers, which could resume in large numbers at any time, can quickly reduce the efficacy of any prison-specific relief. Plaintiffs continue to support CCHCS's plan to prioritize those at higher risk from serious complications or death from COVID.

DATED: January 13, 2021

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EXHIBIT 1

Covid-19: Interim Guidance for

Health Care and Public Health Providers

COVID-19 SCREENING AND TESTING MATRIX FOR PATIENT MOVEMENT

1. *To reduce the likelihood of COVID-19 spreading from one location to another, movement shall be limited to that which is necessary for clinical care, medical isolation or quarantine, reduction of overcrowding, and seriouscustody concerns. Admission to PIP and MHCB shall be considered necessary transfers.*
2. *Institutions or 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 and Director, Health Care Operations or designees. Close coordination shall take place between sending and receiving 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.* ***These patients shall not be required to re-test or be quarantined for movement purposes during that timeframe.*** *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, CMC-West, 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	Sending jail: • Do not transfer inmates who are currently isolated or quarantined due to exposure. • Perform COVID screening and 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 N95 mask during transfer. Receiving reception center: • Quarantine all new arrivals for 14 days. • Screen all new arrivals for COVID-19 upon arrival and then daily while in quarantine. • Test all new arrivals for COVID-19 within 24 hours, again on day 5 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 shall be isolated as per interim guidance.	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.
From jail directly to Specialized Medical Beds (SMB)	• 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 N95 mask during transfer. • Quarantine all new arrivals for 14 days. • Screen all new arrivals for COVID-19 upon arrival and then daily while in quarantine. • Test all new arrivals for COVID-19 within 24 hours, again on day 5 and again prior to release from quarantine (day 12-14). • May release 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.	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.

TYPE OF MOVEMENT	COVID SCREENING AND TESTING STRATEGY	WHAT TO DO IF PATIENT REFUSES COVID TEST
From reception center to 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. • Perform COVID screening and test by PCR five days prior to scheduled transfer. • If PCR negative, screen for COVID and obtain rapid test on day of 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. • All inmates and transportation staff shall wear an N95 mask during transfer.	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.
Institution intake from reception center	• Quarantine patients 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.	Inmate to remain in quarantine for at least 21 days. Disposition to be determined in consultation with the Deputy Director, Medical Services or designee.
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	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. • Perform COVID screening and test by PCR five days prior to scheduled transfer. • If PCR negative, screen for COVID and obtain rapid test on day of 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. • All inmates and transportation staff shall wear an N95 mask during transfer. Receiving institution • Quarantine patients 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.	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.

TYPE OF MOVEMENT	COVID SCREENING AND TESTING STRATEGY	WHAT TO DO IF PATIENT REFUSES COVID TEST
Movement from one institution to another for OHU, CTC, SNF, or Hospice placement	**Sending institution** <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 N95 mask during transfer. <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. • Perform COVID screening and test by PCR five days prior to scheduled transfer. • If PCR negative, screen for COVID and obtain rapid test on day of scheduled transfer. • If PCR negative, COVID 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. **Receiving institution** <u>New arrivals who tested positive at sending institution:</u> • Isolate as per interim guidance. <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.	**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.

TYPE OF MOVEMENT	COVID SCREENING AND TESTING STRATEGY	WHAT TO DO IF PATIENT REFUSES COVID TEST
Movement within same institution • Release or move into STRH, LTRH, ASU, SHU • PIP/MHCB admission or discharge • CTC, OHU, Hospice admission or discharge • Mental health level of care change • DPP moves • DDP moves • All other routine mvmt	• Patients shall not be moved to or from an outbreak area at the same institution unless it is for purposes of isolation or quarantine. • No quarantine or testing required for movement within the same institution unless the patient will be moving into a large dorm (20 or more residents). If so, perform COVID screening and COVID-19 testing of the inmate within 5 days prior to this move. Only move the patient if the COVID screen and test are negative. • If movement is considered urgent or emergent, perform a rapid test and transfer within a day if COVID screen and test are negative. • Inmates who are symptomatic and/or test positive shall not be transferred and shall be isolated as per interim guidance.	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 Director, Medical Services or designee.
Admission to MHCB or PIP at another institution	Sending institution • Perform COVID screening and 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 N95 mask during transfer. Receiving institution <u>New arrivals who screened or tested positive at sending institution:</u> • Isolate as per interim guidance. <u>New arrivals who tested negative at sending institution:</u> • 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.	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.

TYPE OF MOVEMENT	COVID SCREENING AND TESTING STRATEGY	WHAT TO DO IF PATIENT REFUSES COVID TEST
Discharge from MHCB or PIP to another institution	**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. • Perform COVID screening and test by PCR five days prior to scheduled transfer. • If PCR negative, screen for COVID and obtain rapid test on day of 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. • All inmates and transportation staff shall wear an N95 mask during transfer. **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.	**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.
Transfer to DSH from CDCR	• Perform COVID screening and test by PCR five days prior to scheduled transfer. • 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. • All inmates and transportation staff shall wear an N95 mask during transfer.	Disposition to be determined in consultation with Deputy Director Mental Health or designee and DSH.
OMDH paroles to DSH	• Screen inmate and test for COVID 19 within 5 days of parole date. • Communicate results to DSH prior to inmate parole. • Transport inmate on the day of their parole to DSH. • All inmates and transportation staff shall wear an N 95 respirator during transfer.	Communicate information to DSH and transport the inmate on their date of parole.

TYPE OF MOVEMENT	COVID SCREENING AND TESTING STRATEGY	WHAT TO DO IF PATIENT REFUSES COVID TEST
DSH discharge to CDCR	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 N95 mask during transfer. 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 interim guidance.	DSH: Disposition to be determined in consultation with Deputy Director Mental Health or designee, DSH, the Deputy Director, Medical Services or designee. 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.
To MCCF, ACP, CCTRP, MCRP, fire campfire camp (unable to quarantine new arrivals)	• Do not transfer inmates who are currently quarantined due to exposure. • Quarantine inmate prior to transfer. • Screen for COVID-19 initially and then daily while in quarantine. • Test for COVID on day 12-14 of quarantine. • Inmate to remain in quarantine while awaiting results. • If inmate 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 N95 mask during transfer. • Inmates who are symptomatic and/or test positive shall be isolated as per interim guidance.	Do not transfer.

TYPE OF MOVEMENT	COVID SCREENING AND TESTING STRATEGY	WHAT TO DO IF PATIENT REFUSES COVID TEST
From MCCF, ACP, CCTRP, MCRP, CPMP, or fire camp to an institution (unable to quarantine prior to transport)	**All inmates and transportation staff shall wear an N95 mask during transfer.** **Receiving CDCR institution** • Quarantine inmate for 14 days upon arrival. • 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. **Inmates returning to an institution for urgent/emergent dental treatment** • 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.	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.
From one fire camp to another fire camp	• Perform symptom screening. • If screens negative, may transfer to new camp without testing. • If screens positive, transport to closest prison for COVID testing and either isolation or quarantine depending upon the results. • Inmate and staff shall wear N95 during transportation.	N/A
From fire camp to emergency room for treatment of minor injuries/conditions prior to same day release to fire camp.	• Inmate and staff shall wear N95 during transportation and while in the emergency department.	N/A
From fire camp to hospital for admission or other more serious condition	• When released, inmate shall be transported back to a prison for appropriate housing/ quarantine/testing. • All inmates and transportation staff shall wear an N95 mask during transfer.	N/A
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 N95 mask during transfer.	Inmates **cannot** be held beyond their parole date regardless of whether they agree to test or if the test is positive.

TYPE OF MOVEMENT	COVID SCREENING AND TESTING STRATEGY	WHAT TO DO IF PATIENT REFUSES COVID TEST
Out to court, same day return	Use videoconferencing to avoid out-to-court travel in all cases unless court refuses. • 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 N95 mask during transfer.	N/A
Out to court, at least one overnight stay in a jail or another prison.	Sending institution • Notify court in advance regarding any inmates who are currently isolated or quarantined due to exposure. Plan will be determined in consultation with the court. • For all other inmates, 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 and the court shall be notified. • All inmates and transportation staff shall wear an N95 mask during transfer. Receiving CDCR Institution • Manage like an intake from jail to reception center. • All inmates and transportation staff shall wear an N95 mask 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 5 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. Inmate to be placed in pre-transfer 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 court.
Out for clinical appointment, same day return	• Use "e-consult" and telemedicine whenever possible to avoid unnecessary offsite transportation. • All inmates and transportation staff shall wear an N95 mask during transfer. • Perform daily COVID screening for 14 days upon return. • Symptomatic inmates shall be isolated and tested as per interim guidance.	N/A
Return from outside hospitalizations and emergency department visits	Manage like an intake from jail to reception center • All inmates and transportation staff shall wear an N95 mask during transfer. • Quarantine for 14 days. • Screen for COVID-19 upon arrival and then daily while in quarantine. • Test for COVID-19 at 24 hours, again at day 5, and on day 12-14 of quarantine. • 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 shall be isolated as per interim guidance.	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.

ISOLATION AND QUARANTINE GENERAL PRINCIPLES

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

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

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

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

ISOLATION: GENERAL PRINCIPLES

Patients who are in isolation shall:

- Remain in their isolation location unless approved by clinical staff to move elsewhere
- Be medicated and fed in their isolation location
- Shall receive clinical care in their isolation location
- Shall not share showers or toilets with those who are not infected

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

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

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

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

1. Quarantine of Patients who have been Exposed to COVID-19
    a. These patients are at risk of being infected as a result of their exposure. Thus, they shall be separated from both the confirmed cases and from the symptomatic but not yet confirmed cases.
    b. For individual cases, the preference is for quarantine in a private room with a solid, closed door.
    c. Exposed persons shall not be housed in dorms with those who are not known to be exposed.
    d. If 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 14 days of quarantine and tested negative for COVID-19 by PCR. If testing is refused, quarantine shall be extended to 21 days.
    i. Any 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 2

STATE *of* CALIFORNIA

OIG | OFFICE *of the* INSPECTOR GENERAL

Roy W. Wesley, Inspector General
Bryan B. Beyer, Chief Deputy Inspector General

Independent Prison Oversight

Regional Offices

Sacramento
Bakersfield
Rancho Cucamonga

Face Covering and Physical Distancing Follow-up Monitoring

Introduction

In October 2020, the Office of the Inspector General (the OIG) issued a public report regarding the California Department of Corrections and Rehabilitation's (the department) compliance with face covering and physical distancing requirements for staff and incarcerated persons. The report identified frequent noncompliance by both staff and incarcerated persons, lax enforcement efforts by departmental supervisors and managers, and questioned the prudence of loosening of face covering requirements in June 2020. In response to the report, United States District Court Judge Jon S. Tigar invited the OIG to conduct follow-up monitoring at the department's prisons to observe and report whether staff and incarcerated persons have come into compliance with the department's current requirements. Below are the results of our monitoring activities through January 6, 2021.

Unannounced Monitoring Visits and Video Review

Our staff conducted unannounced visits at 17 prisons and two juvenile facilities. These visits focused on face covering and physical distancing compliance among staff and incarcerated persons. Our staff visited various locations throughout each prison visited. Additionally, where possible, we reviewed a sampling of video recordings from the prisons with usable footage. Although most staff, incarcerated persons, and youths adhered to the department's requirements, we still observed significant noncompliance at several prisons and juvenile facilities. Our most significant observations are detailed on the next page.

Based on our observations we assigned each prison two ratings, one for staff's compliance and one for the incarcerated population's compliance. The ratings are defined on the next page, at the end of the table.

Facility	Staff Face Covering Compliance	Incarcerated Population Face Covering Compliance
Avenal State Prison	Full Compliance	Full Compliance
California City Correctional Facility	Substantial Compliance	Full Compliance
California Correctional Center	Substantial Compliance	Significant Non-Compliance
California Health Care Facility	Partial Compliance	Significant Non-Compliance
California Institution for Men	Substantial Compliance	Substantial Compliance
California Medical Facility	Partial Compliance	Partial Compliance
California Men's Colony	Full Compliance	Substantial Compliance
California Rehabilitation Center	Full Compliance	Significant Non-Compliance
California State Prison, Sacramento	Substantial Compliance	Partial Compliance
California Substance Abuse Treatment Facility and State Prison, Corcoran	Substantial Compliance	Significant Non-Compliance
Calipatria State Prison	Full Compliance	Partial Compliance
Chuckawalla Valley State Prison	Full Compliance	Substantial Compliance
Pelican Bay State Prison	Full Compliance	Significant Non-Compliance
Salinas Valley State Prison	Substantial Compliance	Significant Non-Compliance
San Quentin State Prison	Substantial Compliance	Substantial Compliance
Valley State Prison	Full Compliance	Substantial Compliance
Wasco State Prison	Substantial Compliance	Substantial Compliance
N.A. Chaderjian Youth Correctional Facility	Substantial Compliance	Significant Non-Compliance
Ventura Youth Correctional Facility	Substantial Compliance	Full Compliance

Compliance Rating Definitions:

Full Compliance	All individuals observed in all locations were properly wearing face coverings
Substantial Compliance	Very few individuals observed without face coverings or improperly wearing face coverings
Partial Compliance	Several non-compliant individuals observed in the locations we visited within the facility, but the non-compliance was not widespread
Significant Non-Compliance	Several non-compliant individuals observed in more than one of the locations we visited within the facility, or many non-compliant individuals observed in one location

Significant Observations

Below are our staff's most significant observations from our visits focusing on face covering and physical distancing compliance, as well as from our staff during our other routine monitoring activities:

- **California Correctional Center (December 29, 2020):** The OIG observed staff announcing that incarcerated persons should "mask up" when the staff walked into the dormitory housing units. The OIG spoke with a lieutenant regarding this occurrence and the lieutenant informed us face coverings are not required for incarcerated persons in the dorm unless staff enter, or the incarcerated persons exit, the building. The OIG followed up with the warden, who reported that incarcerated persons in the dorms are expected to wear face coverings if they are off their own bunks. The warden also stated she had recently clarified her (and the department's) expectations with her managerial staff.
- **California Substance Abuse and Treatment Facility and State Prison, Corcoran (December 14, 2020):** The OIG observed multiple incarcerated persons working in the central kitchen wearing face coverings over their mouths only. The OIG did not witness any of the staff present (neither custody nor other kitchen staff) instruct the incarcerated culinary workers to properly don their face coverings. The OIG is concerned since the meals prepared and packaged by these individuals, who are not taking proper health and safety precautions, are disseminated throughout the institution and could potentially cause cross-contamination.
- **California Correctional Institution (week of January 4, 2021):** The OIG observed incarcerated persons in the isolation (housing COVID-positive persons) and quarantine (housing suspected COVID positive persons) units. The OIG observed that patients in the isolation unit did not have N95 masks. These incarcerated persons, who have been confirmed of having COVID, wore cloth face coverings, some wore bandanas, and some wore KN95 masks. In the quarantine units, patients wore cloth face coverings, including bandanas, but often improperly. Some patients wore no face covering until directed by staff to don a mask and some patients were not corrected at all as they walked through the common area. Additionally, during the course of our visit, OIG staff observed several other staff members and incarcerated persons failing to wear face coverings properly, or sometimes neglecting to don them at all.
- **California State Prison, Solano (January 5, 2021):**
    1. Many employees, probably more than half that we observed, appeared to have modified their N95 masks so that the straps of the mask looped around their ears rather than their heads. For another officer who was wearing her mask looped around her ears, we observed a noticeable gap between the officer's mask and her cheek and nose.
    2. Additionally, we observed many (probably more than a dozen) employees wearing their N95 masks incorrectly with the bottom loop dangling in front of their throats as opposed to being around their neck.
    3. We also observed at least two employees who were not wearing their masks at all, donning them only when they saw us.
    4. We observed about a dozen incarcerated persons not wearing masks while they were out on the exercise yard. Some of them were in very close proximity to others. A couple of them donned their mask when they saw us approaching; others did not. We did not observe correctional staff order any of them to put on their masks.

- **Multiple institutions:** We observed several staff members who had altered their N95 face coverings by refashioning the straps, seemingly to obtain a more comfortable fit, thus compromising the seal of the N95.

Review of Disciplinary Actions

Related to the department's face covering and physical distancing requirements, we requested and received copies of disciplinary actions taken by the department's prisons and youth facilities against staff, as well as corrective actions and rules violation reports issued by prisons to incarcerated persons from December 1 through December 29, 2020. The actions are summarized below by facility and type of action:

	STAFF					INCARCERATED POPULATION	
Prison	Verbal Counseling	Written Counseling	Letters of Instruction	Referrals for Investigation or Punitive Action	Punitive Actions	Corrective Counseling	Rules Violation Reports
Avenal State Prison	37	5	0	0	0	15	2
California City Correctional Facility	2	0	0	0	0	0	0
California Correctional Center	6	0	6	0	0	0	2
California Correctional Institution	6	2	1	0	0	0	0
California Health Care Facility	3	0	3	0	0	0	0
California Institution for Men	5	0	0	0	0	0	0
California Institution for Women	0	4	0	1	0	1	5
California Medical Facility	5	6	1	0	0	0	0
California Men's Colony	12	0	1	0	0	0	0
California Rehabilitation Center	23	0	0	0	0	7	2
California State Prison, Corcoran	13	4	1	0	0	0	0
California State Prison, Los Angeles County	6	0	0	0	0	0	2
California State Prison, Sacramento	31	0	0	0	0	1	0
California State Prison, Solano	0	0	0	0	0	0	0
California Substance Abuse Treatment Facility and State Prison, Corcoran	4	1	1	0	0	2	0
Calipatria State Prison	2	0	0	0	0	0	1
California State Prison, Centinela	0	2	0	0	0	1	0
Central California Women's Facility	0	0	0	0	0	0	1
Chuckawalla Valley State Prison	6	0	0	0	0	2	0
Correctional Training Facility	3	0	0	0	0	1	0
Deuel Vocational Institution	17	0	0	0	0	0	0
Folsom State Prison	8	1	1	0	0	0	1
High Desert State Prison	13	0	0	0	0	0	0
Ironwood State Prison	8	2	0	0	0	0	0
Kern Valley State Prison	6	3	0	0	0	0	0
Mule Creek State Prison	9	0	7	0	0	0	0
North Kern State Prison	8	0	0	0	0	0	0
Pelican Bay State Prison	8	0	0	0	0	1	1
Pleasant Valley State Prison	3	0	1	0	0	0	0
Richard J. Donovan Correctional Facility	3	23	1	0	0	1	0

	STAFF					INCARCERATED POPULATION	
Prison	Verbal Counseling	Written Counseling	Letters of Instruction	Referrals for Investigation or Punitive Action	Punitive Actions	Corrective Counseling	Rules Violation Reports
Salinas Valley State Prison	5	2	0	0	0	1	2
San Quentin State Prison	6	0	7	0	0	0	4
Sierra Conservation Center	9	4	1	0	0	3	1
Valley State Prison	0	0	0	0	0	0	0
Wasco State Prison	2	1	0	0	0	0	1
Totals	**269**	**60**	**32**	**1**	**0**	**36**	**25**
N.A. Chaderjian Youth Correctional Facility	1	0	0	1	0	70	4
O.H. Close Youth Correctional Facility	0	0	0	0	0	0	0
Pine Grove Youth Conservation Camp	0	0	0	0	0	0	0
Ventura Youth Correctional Facility	1	0	0	0	0	42	0
Totals	**2**	**0**	**0**	**1**	**0**	**112**	**4**

Self-Monitoring Documentation (Non-Compliance Tracking Logs)

On October 27, 2020, the department issued directives that regional health care executives and associate directors, or their designees, must conduct visits to observe compliance with face coverings and physical distancing within 30 days, and on a 120-day interval thereafter. The OIG requested documentation to support the completion of these compliance visits. However, for one prison, High Desert State Prison, the department failed to provide any documentation at all. Additionally, for another six prisons, the department provided documentation of compliance monitoring required by a May 11, 2020, memorandum to be completed by prison managers. The department did not provide documentation of visits required to be completed by regional health care executives and associate directors, or their designees. Specifically, the department did not provide the correct compliance monitoring checklists for the following prisons:

- California Correctional Center
- California Health Care Facility
- California Institution for Men
- California Rehabilitation Center
- California State Prison, Sacramento
- San Quentin State Prison

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

OAKLAND DIVISION

MARCIANO PLATA, et al.,

Plaintiffs,

v.

GAVIN NEWSOM, et al.,

Defendants.

CASE NO. 01-1351 JST

DECLARATION OF CONNIE GIPSON IN SUPPORT OF DEFENDANTS' RESPONSES TO COURT'S QUESTIONS RE PLAINTIFFS' QUARANTINE MOTION

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. In addition to setting aside and reserving space under the guidance of the Public Health Workgroup and the direction of the Court, CDCR made extensive efforts to identify additional spaces that can be used for isolation and quarantine at the prisons beginning last summer, and those efforts have continued to the present. Some of those spaces were comprised of additional cell and dorm housing that was vacated so that it could be available and ready for use if needed during an outbreak. And some of those additional spaces were comprised of alternative spaces that had to be prepared and approved for occupancy, such as gyms, chapels, and tents.

3. Through its many efforts, CDCR has identified abundant additional space for quarantine and isolation at many prisons. Much of the available space—both the originally reserved quarantine spaces and additional identified spaces—was attached as Exhibit E to my last declaration in support of Defendants' opposition to Plaintiffs' quarantine motion. As reflected in Exhibit E, 31 prisons have substantial quarantine-cell reserves, and each of them therefore has the ability to implement the Receiver's guidance. Only four prisons either have no quarantine cells or only a small fraction of the number recommended by the Public Health Workgroup. They are San Quentin (63 cells), Folsom (99 cells), California Health Care Facility (92 negative pressure rooms/cells), and California Rehabilitation Center (no quarantine cells).

4. The Receiver issued new guidance to CDCR regarding quarantine on December 4 and 18, 2020, by email. Attached as Exhibit F is the December 18 email, which contains both sets of guidance. As the Receiver's December 18 guidance recognized, "the high frequency and number of transfers increases patient COVID-19 fatigue which is resulting in a substantial increase in refusals, both refusals to transfer and refusals of COVID-19 testing."

5. For many weeks I have received reports from the prisons that some patients refuse to move to quarantine or isolation. CDCR is making every effort to educate such patients and to convince them to protect themselves and others by moving to appropriate

quarantine or isolation housing. To date, CDCR has not authorized forced cell extractions or forced moves of patients who should be quarantined or isolated. Consequently, it is extremely difficult to follow the Receiver's guidance when patients refuse to go to quarantine or isolation.

6. CDCR has made great efforts to enable all prisons, including those with challenging designs, to appropriately quarantine and isolate inmates. Since last summer, CDCR has endeavored to identify alternative spaces that can be used for quarantine or isolation in the event of a large outbreak. Many prisons have not only identified alternative spaces, but have also already obtained fire marshal approval and acquired bedding and storage units for the spaces to prepare them for occupancy. Some of these spaces, including gyms, visiting areas, and chapels, are set forth in Exhibit E to my last declaration in opposition to Plaintiffs' motion. But other spaces not reflected in that document have also been identified and set aside at various prisons. Attached as Exhibit G is a simplified draft of a working a document that my staff and I have been using to keep track of alternative spaces that can potentially be used for isolation and quarantine at various prisons. It reflects some spaces that are already set forth in Exhibit E, but it also describes additional spaces not reflected in Exhibit E. Furthermore, CCHCS has indicated that it is in the process of undertaking a survey of all prisons to determine whether there is any additional space that can be used for isolation and quarantine.

7. In addition to the space Avenal State Prison reserved for isolation and quarantine, which is reflected in Exhibit E to my last declaration, in May 2020, Avenal obtained fire marshal approval to use gyms in Facilities A and B as quarantine and isolation housing, and in July 2020, Avenal obtained fire marshal approval for gyms in Facilities C, D, and E gyms. Later, however, an issue was discovered with the Facility E gym fire panel. This will require that Avenal develop and obtain approval from the fire marshal for a fire-watch process for that gym if Avenal needs to use it again. These gyms, which can each house at least 50 patients, were fully prepared for occupancy with the installation of bedding and storage units, and were occupied during Avenal's outbreaks.

Last summer, Avenal also obtained fire marshal approval to use three cells in Building 390A for quarantine or isolation, and Avenal obtained preapproval from the fire marshal to use visiting areas in Facilities A, B, C, D, E, and F in late October and early November 2020. If the visiting areas are ever needed, they will be set up to house patients and final approval from the fire marshal will be obtained. Each of the visiting areas can house about 32 patients. Like all of the prisons, Avenal has the ability to quickly install tents to provide additional housing if a large outbreak should occur. A tent contractor has already visited Avenal's grounds to identify locations where tents will be installed, if needed, which should expedite the installation process. The installation of tents can usually be accomplished within 72 hours.

8. Avenal had several large outbreaks from May through October 2020. As of January 12, CCHCS's patient tracker indicates that 3,001 patients at Avenal have been infected with COVID-19, and as of January 6, Avenal's population was about 3,327. During the recent surge of cases throughout the prison system that began in November, Avenal has not had another large outbreak. Even though many cases of COVID-19 in the prisons resolved as early as May 2020, in a meeting on January 8, 2021, CCHCS's Director of Health Care Services, Dr. Bick, advised us that there are no confirmed cases of reinfection among the patient population at any prison.

9. Chuckawalla Valley State Prison's reserved isolation and quarantine space is reflected in Exhibit E to my last declaration. But like all prisons, Chuckawalla has reviewed its facilities to identify additional space that can potentially be used for isolation or quarantine in the event of a large outbreak and obtained fire marshal approval to use the spaces. Chuckawalla has already obtained fire marshal approval to use the chapels and education rooms in Facilities A, B, C, and D. In combination, those spaces accommodate up to 168 patients. Chuckawalla also vacated offices in a decommissioned part of the Central Infirmary, and turned the offices back into rooms for isolation or quarantine in the event of an outbreak. Each of the twelve rooms can now house up to two inmates if needed. Additionally, Chuckawalla can easily and quickly add additional space for

quarantine and isolation in the event of a large outbreak by installing tents. A tent contractor has already reviewed the grounds at Chuckawalla and identified areas for tent installation so that the installation process can be expedited if the tents are ever needed.

10. According to CCHCS's patient tracker, several large outbreaks have resulted in 1,742 patients at Chuckawalla being infected with the virus since May 2020. As of January 6, Chuckwalla's population was about 1,845. Chuckawalla has not had another large outbreak despite the recent surge in cases across the system that began in November.

11. In addition to the reserved isolation and quarantine spaces described in Exhibit E to my last declaration, the reduction in California Medical Facility's (CMF) population has allowed it to set aside and use additional space for isolation and quarantine, including the following: Unit H2 (21 cells and five 8-person dorms); U-Wing (110 cells); D-Dorm (150 dorm beds); and an area in CMF's Psychiatric Inpatient Unit (64 cells). Further, to create additional space for isolation or quarantine purposes, CMF has currently installed six tents with a total capacity of 100 patients.

12. Vaccinations are underway at CMF, and, as of January 12, about 1,073 patients and about 1,029 staff had received their first dose of the COVID-19 vaccine. According the CCHCS's patient tracker, as of January 12, about 583 patients at CMF have been infected with the virus, and nearly all of those infections occurred within the past 90 days. As of January 12, the population at CMF was about 1,998.

13. In addition to CHCF's 92 negative pressure room/cells, California Health Care Facility (CHCF) currently has tent capacity for up to 100 patients and it has the ability to add additional tents at any time if more space is needed.

14. Numerous inmates and staff are currently being vaccinated at CHCF and vaccinations are ongoing. As of January 12, about 1,275 patients and about 1,499 staff had received their first dose of vaccine, and about 33 patients and 235 staff had received two doses of vaccine. According to CCHCS's patient tracker, as of January 12, about 554 patients at CHCF have been infected with the virus, and the overwhelming majority of those infections occurred within the past 90 days. As of January 12, the population at

CHCF was about 2,389.

15. In addition to the isolation and quarantine space reserves described in Exhibit E to my previous declaration, Folsom State Prison has obtained fire marshal approval to use its visiting area as an alternative housing space. During the large outbreak from August through October 2020, Folsom housed 70 patients in the visiting area. Folsom could prepare the visiting area again for occupancy in about 24 hours. Additionally, Folsom has the ability to install tents to supplement its quarantine and isolation space. During the large outbreak at Folsom last summer, Folsom was able to quickly install multiple tents with capacity to house up to 180 patients.

16. According to CCHCS's patient tracker, 1,338 patients were infected with the virus during Folsom's outbreak. As of January 6, Folsom's population was about 2,054. Despite the recent surge in cases across the system, there are currently no active cases of the virus in Folsom's population.

17. In addition to the reserved isolation and quarantine space identified in Exhibit E to my last declaration, San Quentin State Prison also has the ability to quickly activate 69 beds in its three chapels. San Quentin can also use its Prison Industry Authority building for additional space as it did during the large outbreak last summer, and San Quentin has experience quickly installing tents that can provide at least an additional 90 beds if necessary.

18. According to CCHCS's patient tracker, San Quentin's large outbreak resulted in 2,151 patients becoming infected with the virus. As of January 6, San Quentin's population was about 2,652. Despite the recent surge in cases across the system, there are currently only three active cases of the virus in San Quentin's population.

19. In addition to the reserved isolation and quarantine space described in Exhibit E to my last declaration, California Rehabilitation Center (CRC) has also set aside its family visiting buildings, which provide 12 additional beds. And like all of the prisons, CRC has the ability to rapidly install tents if it needs more space. During its previous large outbreak, CRC installed 30 twelve-person tents to provide extra housing capacity and safe

locations for medically high-risk inmates.

20. According to CCHCS's patient tracker, since the beginning of the pandemic, 1,866 patients at CRC have been infected with the virus. As of January 6, CRC's population was about 2,047.

21. CDCR intends to comply with the Receiver's recent guidance, and I believe that substantial compliance with the guidance is achievable. I am aware that there have been instances where the new guidance has not been implemented correctly, and we are working closely with CCHCS to quickly correct those mistakes and ensure that they are not repeated. I am also aware that there have been numerous instances where prisons have been unable to fully implement the new guidance because patients refuse to move from their cells or refuse to be tested. We are working with CCHCS and making every effort to educate such patients and convince them to protect themselves and others by moving to appropriate quarantine or isolation space.

22. Since the Receiver issued his new guidance on December 4, 2020, CDCR has taken a number of steps to begin implementing the guidance. *Id.* at ¶ 22. Some of the more significant steps include the following:

- December 15, 2020—Meeting between the Division of Adult Institutions and CCHCS to clarify the Receiver's new guidance;
- December 18, 2020—Communication from Director Gipson to the prisons concerning the Receiver's supplemental guidance regarding quarantine;
- December 31, 2020—Meeting between CCHCS, the Division of Adult Institutions, and other officials regarding the implementation of the guidance;
- January 4, 2021—Meeting between Director Gipson and the Associate Directors in the Division of Adult Institutions regarding increasing efforts to ensure prisons are following the new quarantine guidance from the Receiver; and
- January 7, 2021—Meeting between CCHCS, the Division of Adult

Institutions, the prisons' Chief Medical Executives, and the Regional Health Care Managers concerning the appropriate implementation of the Receiver's new guidance. *Id.*

23. These meetings ensure constant communication between and among CDCR and CCHCS headquarters and onsite leadership, and provide a productive and efficient forum to coordinate directives and discuss concerns, challenges, and areas of uncertainty. CDCR and CCHCS continue to ensure open lines of communication as institutions work to implement the Receiver's guidance and refine their response to a constantly evolving pandemic.

I declare under penalty of perjury that I have read this document, and its contents are true and correct to the best of my knowledge. Executed on January 13, 2021, in Sacramento, California.

Connie Gipson,

EXHIBIT F

TO DECLARATION OF CONNIE GIPSON IN SUPPORT OF DEFENDANTS' RESPONSES TO COURT'S QUESTIONS RE PLAINTIFFS' QUARANTINE MOTION

Damon McClain

From: Barrow, Roscoe@CDCR <Roscoe.Barrow@cdcr.ca.gov>
Sent: Friday, December 18, 2020 7:54 AM
To: Lopes Matthew; Ed Swanson; Don Specter; Sara Norman; Steve Fama; Alison Hardy; Rana Anabtawi; Sophie Hart; Neill, Jennifer@CDCR; Renteria, Simone@CDCR; Stafford, Carrie@CDCR; Scofield, Bryant; Ferguson, Patricia@CDCR; Davis, Tamiya@CDCR; Ryan, Amanda@CDCR; Damon McClain; Kyle Lewis; Iram Hasan; Ryan Gille; Paul B. Mello; Samantha Wolff; Michael W. Bien; Lisa Ells; Thomas Nolan; Ernest Galvan; Martin Dodd; Jamie Dupree
Cc: Clark Kelso; Kirkland, Richard@CDCR; Toche, Diana@CDCR; Bick, Dr. Joseph@CDCR; Foss, Tammy@CDCR; Heintz, Lisa@CDCR; Gransee, Elizabeth@CDCR; Larson, Cheryl@CDCR; Saich, Lara@CDCR; Bauer, Heidi@CDCR; Clark, Jackie
Subject: FW: Statement on Quarantine

Sensitivity: Confidential

The Receiver has asked that I send you the following statement, providing an addendum to his statement communicated via my email of December 4 below:

On December 4, I issued the following statement on the use of quarantine space:

> 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.

Over the last two weeks, it has become apparent during our daily management calls with institutions that the attempts to comply with my December 4 quarantine statement at institutions now experiencing widespread outbreaks may be causing more harm than good. In particular, as the number of COVID-19 cases rises into the hundreds, the number of transfers necessary to comply with my statement creates a "churning" of patients that may contribute to the spread of COVID-19 throughout the institution which is contrary to the very purposes for quarantining. In addition, the high frequency and number of transfers increases patient COVID-19 fatigue which is resulting in a substantial increase in refusals, both refusals to transfer and refusals of COVID-19 testing. At many institutions, our patients are asking that we simply permit them to "hunker down" instead of moving.

Based on the above, I am adopting the following addendum to my December 4 quarantine statement:

> Addendum, 12-18-2020: At institutions experiencing a massive outbreak (defined as an outbreak where the number of COVID positive patients exceeds 200 or the number of patients who should be quarantined exceeds the total number of beds set aside at that institution for quarantine), decisions about post-exposure quarantine practices and housing shall be committed to the discretion of the warden and CEO or their designees at the institution in consultation with CDCR and CCHCS regional and headquarters staff.

Thank you very much.

Roscoe Barrow
Chief Counsel
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CCHCS Office of Legal Affairs; Building D
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CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

From: Barrow, Roscoe@CDCR
Sent: Friday, December 4, 2020 11:59 AM
To: Lopes Matthew <mlopes@pldolaw.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>; Simone Renteria <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; Kyle.Lewis@doj.ca.gov; Iram.Hasan@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>
Subject: Statement on Quarantine
Sensitivity: Confidential

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.

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CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

EXHIBIT G

TO DECLARATION OF CONNIE GIPSON IN SUPPORT OF DEFENDANTS' RESPONSES TO COURT'S QUESTIONS RE PLAINTIFFS' QUARANTINE MOTION

Institution	Gym	OSFM Occup.	Curr. Pop.	Bunk/Cots	Lockers/Tubs	Mattresses	OFSM Cleared Date Occupied	Date Occupied	Date Deactivated
ASP	Fac. A Gym	50	0	50	40	0	Y-SFM Cleared 5/21/2020	7/20/2020	8/24/2020
	Fac. B Gym	52	0	50	38	0	Y-SFM Cleared 5/21/2020	5/31/2020	10/18/2020
	Fac. C Gym	55	0	50	32	0	Y-SFM Cleared 6/3/2020	9/6/2020	9/22/2020
	Fac. D Gym	55	0	50	32	0	Y-SFM Cleared 6/3/2020	9/9/2020	10/18/2020
	Fac. E Gym	55	0	0	Need	0	Y-SFM Cleared 6/3/2020	9/21/2020	9/29/2020
	Visit -A	55	0	0	Need	0	Pending Approval	Currently No Need	
	Visit-B	32	0	0	Need	0	Pending Approval	Currently No Need	
	Visit-C	32	0	0	Need	0	Pending Approval	Currently No Need	
	Visit-D	32	0	0	Need	0	Pending Approval	Currently No Need	
	Visit-E	32	0	0	Need	0	Pending Approval	Currently No Need	
	Visit-F	32	0	0	Need	0	Pending Approval	Currently No Need	
	390-A	3	0	0	Need	0	Y	Currently No Need	
	Family Visitng	10	0	N/A	N/A	10	N/A	Currently No Need	
CCC	Fac. C	49	7	30 Bunks (60 beds)	30 Lockers	Y	Yes on 11/17/2020	12/31/2020	
CCI	Gym A								
	Gym B								
	Gym C								
	Gym D	56	0	56	N	N	Y	7/24/2020 & 11/22/2020	8/20/2020 & 12/15/2020
	Gym E	46	0	46	N	N	Y		
CCWF	Main yard gym	80	71	80	80	Y	Y	12/19/2020	
	~~Visit - A~~	15-20							
	~~Visit – B~~	15-20							
CEN	Fac. A	100	22	56	56	22	Y	12/21/2020	
	Fac. D	100	65	56	56	65	Y	12/21/2020	
CHCF	E–2A	20	0	15	8	N	Y	4/25/2020	10/17/2020
	E-2B	20	0	9	8	N	Y	4/25/2020	10/16/2020

Institution	Gym	OSFM Occup.	Curr. Pop.	Bunk/Cots	Lockers/Tubs	Mattresses	OFSM Cleared Date Occupied	Date Occupied	Date Deactivated
	E-3A	20	0	11	8	N	Y	4/25/2020	10/20/2020
	E-3B	20	0	10	8	N	Y	4/25/2020	9/12/2020
	E-4A	20		13	8	N	Y	4/25/2020	10/20/2020
	E-4B	20	0	10	8	N	Y	4/25/2020	9/5/2020
	E-5A	20	0	9	8	N	Y	4/25/2020	8/25/2020
	E-5B	20	0	8	8	N	Y	4/25/2020	9/5/2020
	Tent	100	0	100	0	100	Y	N/A	
CIM	Fac. C Gym	50	42	50	50	50	Y	4/11/2020	
	Fac. D Gym	No	Plans	to	occupy				
	Oak HU	72	0	0	0	0	Y	4/27/2020	
	redwood	No	Plans	to	occupy				
	Tent	10	0	10	0	N	Y	7/21/2020	
	Birch Hall	0		0	0	N	N		
CIW	Gym	32		32	32	32			
CMC	Chapel J	38	0	38	Y	Y		N/A	
CMF	Tent (6) 5-10 person, 1-50 person	120	41	100	100	100	Y	12/28/2020	
	Fac. A LD2	9	5	9	N	N	Y	12/22/2020	
	Fac. A MD2	9	6	9	N	N	Y	12/22/2020	
	Fac. A ND2	9	8	9	N	N	Y	12/22/2020	
	Fac. A PD2	6	0	6	N	N	Y		
CRC	Fac. D	78	3	78	0	N	Y	8/5/2020	
	Tents (80)	240	0	240	0	N	Y	10/12/2020	12/31/2020
	Fam. Visiting	12	0	12	0	N	Y	10/2/2020	
CTF	Fac. B BSZ1	24	15	24	N	Y	Y	12/22/2020	
	Fac. C GYM	56	9	56	N	Y	Y	8/28/2020	

Institution	Gym	OSFM Occup.	Curr. Pop.	Bunk/Cots	Lockers/Tubs	Mattresses	OFSM Cleared Date Occupied	Date Occupied	Date Deactivated
	Fac. C Chapel 1	14	0	14	N	Y	Y	12/5/2020	
	Fac. C Chapel 2	11	0	11	N	Y	Y	12/5/2020	
	Visiting	30	0	30	N	Y	Y	12/5/2020	
	Fac. C. Tents	104	20	104	Y	Y	Y	1/4/2021	
	Fac. B. Tents	104	99	104	Y	Y	Y	1/5/2021	
	GYM D	54	0	54	N	Y	Y	4/22/2020	
CVSP	Fac. A Chapel	30	0	0	0	0	Y	N/A	
	Fac. B Chapel	30	0	0	0	0	Y	N/A	
	Fac. C Chapel	30	0	0	0	0	Y	N/A	
	Fac. D Chapel	30	0	0	0	0	Y	N/A	
	A/B Visiting	64	0	0	0	0	Y	N/A	
	C/D Visiting	64	0	0	0	0	Y	N/A	
	Fam. Visiting	8	0	20	0	20	Y	4/1/2020	
FOL	Tents	180	0	180	N	N	Y	7/23/2020	11/1/2020
	Visiting	70	0	70	N	N	Y	7/23/2020	
KVSP	Fac. A	48	0	24	48	0	Y	N/A	
	Fac. B	48	0	24	48	0	Y	N/A	
	Fac. C	48	0	24	48	0	Y	N/A	
	Fac. D	48	0	24	48	48	Y	N/A	
LAC	Fac. B	24	0	24	24	24	Y	12/9/2020	12/23/2020
	Fac. C	24	0	24	24	0	Y		
	Fac. D	0	0	0	0	0	N		
MCSP	Central Service	10	4	10	N	Y	Y	12/22/2020	
	Fac. A Gym	100	58	100	N	Y	Y	11/25/2020	
	Fac. B Gym	100	43	100	N	Y	Y	11/25/2020	
	Fac. C Gym	99	0	99	20	Y	Y	11/25/2020	Vacant
	Fac. D Gym	100	0	100	N	N	Y	12/8/2020	Vacant
	Fac. E Gym	100	0	100	N	N	Y	11/25/2020	Vacant

Institution	Gym	OSFM Occup.	Curr. Pop.	Bunk/Cots	Lockers/Tubs	Mattresses	OFSM Cleared Date Occupied	Date Occupied	Date Deactivated
PVSP	Fac. A	36	0	36 ordered	ordered	ordered	Y		
	Fac. B	36	0	36 ordered	ordered	ordered	Y		
	Fac. D	36	0	36 ordered	36	36	Y		
RJD	Fac. B	100	0	75	Y	Y	12/13/2020	12/19/2020	
	Fac. C	100	0	0	Y	Y	12/13/2020	12/13/2020	
	Fac. D	100	42	74	Y	Y	12/13/2020	12/13/2020	
	Fac. E	100	0	86	N	Y	12/17/2020	N/A	
	Chapel Fac A	25	0	25	N	N	12/17/2020	N/A	
	Chapel Fac B	25	0	25	N	N	12/17/2020	N/A	
	Chapel Fac C	25	0	25	N	N	12/17/2020	N/A	
	Chapel Fac D	25	0	25	N	N	12/17/2020	N/A	
	Fac A Rec Room	49	0	49	N	N	12/17/2020	N/A	
SAC	Fac. B Gym	35	0	30	30	30	OSFM cleared-staged for occupancy if necessary	staged for occupancy if necessary	
SATF	Fac. A	46	0	46	40	40	Y	12/5/2020	12/28/2020
	Fac. F/G Gym	45	0	45	42	40	Y	12/5/2020	12/9/2020
	Fac. B Gym	45	0	45	N	N	Y	12/5/2020	12/28/2020
SCC	Fac. C Gym	100	10	100	N	N	Y	8/21/2020	
SOL	Fac. B Gym	150	46	150	Y	46	Y	6/10/2020	
	Fac. C/D	150	53	150	Y	53	Y	4/22/2020	
SQ	Lower Yard Gym	108	0	108	0	0	Y	4/15/2020	
	Tents (1)	90	0	90	0	0	Y	7/11/2020	8/4/2020
	PIA	250	0	250	0	0	Y	7/11/2020	7/7/2020
	Chapels	69	0	69	0	0	Y	7/11/2020	8/4/2020

Institution	Gym	OSFM Occup.	Curr. Pop.	Bunk/Cots	Lockers/Tubs	Mattresses	OFSM Cleared Date Occupied	Date Occupied	Date Deactivated
SVSP	Fac. C	56	0	56	56	56	4/8/2020	12/4/2020	12/17/2020
VSP	Fac. D Gym	80	4	80	N	N	Y	8/31/2020	
	Chapel 1	11	0	11	N	N	Y	12/5/2020	
	Chapel 2	11	0	11	N	N	Y	12/5/2020	