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

18 MARCIANO PLATA, et al.,

19 Plaintiffs,

20 v.

21 GAVIN NEWSOM, et al.,

22 Defendants.

CASE NO. 01-1351 JST

**JOINT CASE MANAGEMENT
CONFERENCE STATEMENT**

Judge: Hon. Jon S. Tigar

Date: October 21, 2020

Time: 10:00 a.m.

Crtrm.: 6, 2nd Floor

1 The parties submit the following joint statement in advance of the October 21, 2020
2 Case Management Conference.

3 **I. POPULATION REDUCTION**

4 **A. Status**

5 *Plaintiffs' Position:* Today, the California Court of Appeal ruled that the state's
6 failure to provide adequate space to allow for distancing for people housed in San Quentin
7 State Prison during the pandemic violated the Eighth Amendment. The Court ordered that
8 the state expedite the removal from that prison, by means of release or transfer to another
9 prison, the number of people necessary to reduce the population to no more than 1,775
10 (i.e., 50% of the June 2020 population). *See, In re Von Staich*, No. A160122 (Cal. Ct.
11 App. Oct. 20, 2020) attached as Exh. 1.

12 Population reduction remains necessary to minimize the risk of harm from COVID-
13 19, particularly among those at increased risk of harm if infected. As Defendants
14 acknowledge below, reduced population contributes to fewer infections.

15 As previously explained (see ECF No. 3417 at 2:14-3:2), the overall CDCR
16 population reduction since March, while certainly helped by early release programs, has
17 primarily resulted from natural releases and the suspension and limitation of intake. As
18 intake increases, CDCR's total population is likely to increase as well.¹

19 The vast majority of early releases under the three programs CDCR announced in
20 July took place in that month and early August. Since the October 6 Statement, in which
21 CDCR announced the end of two of the three July programs, only 221 early releases have
22 taken place.

23 Following the October 7 Case Management Conference, we asked Defendants to
24

25 ¹ CDCR recently stated that nearly 8,000 people in county jails are awaiting transport
26 to its reception centers. As reported in Part III, below, more than 600 people are being
27 received this week from county jails. If intake continues at such levels, it will soon enough
28 off-set much of any continuing reduction achieved from natural and early releases.

1 have the new CDCR Secretary consider early release of people newly determined to have a
2 Weighted COVID Risk Score qualifying them under the now-ended July Program that
3 focuses on those at highest risk of severe complications if infected with COVID-19.
4 Defendants have not substantively responded to this request, but the clear implication from
5 their report below is that they will not do so, at least at present.

6 *Defendants' Position:* Since the start of the COVID-19 public health crisis, 23,131
7 incarcerated people were released from CDCR institutions and camps as of October 14,
8 2020.² CDCR experienced a population decrease of about 19.7% during this period.
9 Between July 1 and October 14, 6,185 people were released from institutions and camps as
10 a result of the COVID-19 early-release programs Defendants announced on July 10.³ This
11 represents 221 additional early releases since the October 6 case management conference
12 statement.⁴ An additional 8,498 people were released in accordance with their natural
13 release date during this period. As of October 14, CDCR's institutions and camps have a
14 population of 94,211.⁵

15 Responding to Plaintiffs' comment regarding the rate of population reduction above,
16 Defendants note that CDCR started decreasing its population in late March. CDCR's
17 population decreased by approximately 4,000 between mid-March and mid-April, over
18 5,000 more between mid-April and July, nearly 6,000 more in July, and over 5,000 more in
19 August. To provide a visual of the rate of CDCR's population decrease this year,
20 Defendants include the below graph. The population data in this graph is sourced from

21 _____
22 ² This figure is calculated by taking the difference between the total population in
23 institutions and camps on February 26, 2020 and October 14, 2020. Weekly population
24 reports can be found at [https://www.cdcr.ca.gov/research/weekly-total-population-report-
archive-2020/](https://www.cdcr.ca.gov/research/weekly-total-population-report-archive-2020/).

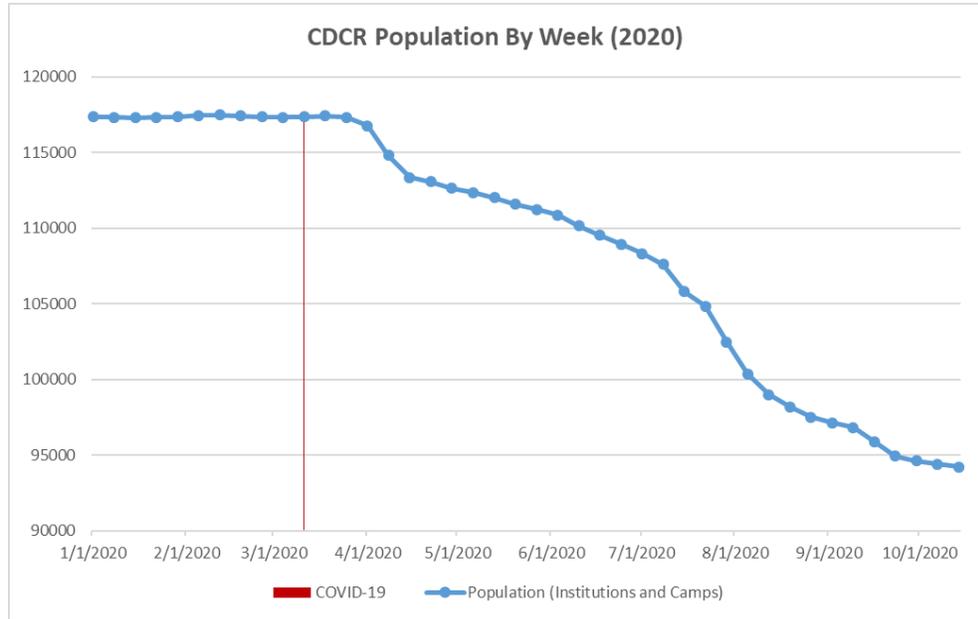
25 ³ See ECF No. 3389 at 2:4-5:4 and <https://www.cdcr.ca.gov/covid19/expedited-releases/>
26 for details regarding CDCR's COVID-19 early-release program announced on July 10,
27 2020.

28 ⁴ See ECF No. 3460 at 4:3-4.

⁵ See October 14, 2020 weekly population report at [https://www.cdcr.ca.gov/research/wp-
content/uploads/sites/174/2020/10/Tpop1d201014.pdf](https://www.cdcr.ca.gov/research/wp-content/uploads/sites/174/2020/10/Tpop1d201014.pdf).

1 CDCR’s weekly population reports from January 1 through October 14, 2020.

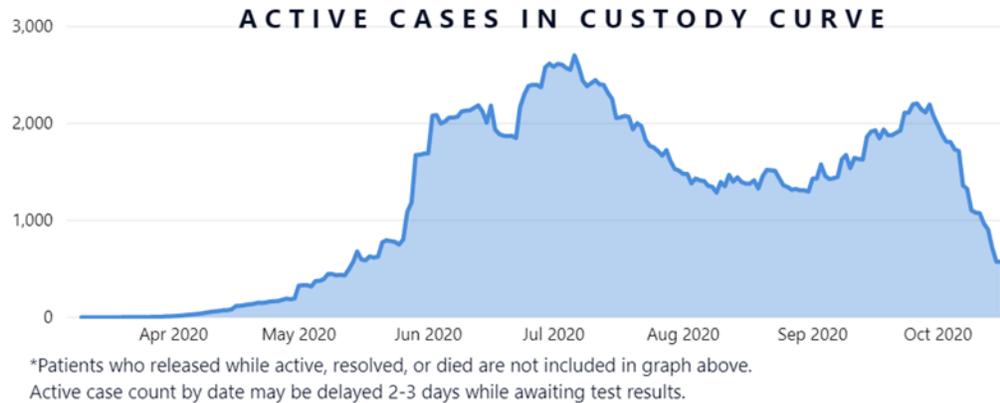
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CDCR continues to process early releases on a rolling basis through the 180-day early-release program announced on July 10. CDCR implemented its discretionary early-release program as an added safety measure at a time when more comprehensive COVID-19-related policies were still being developed. Since then, CDCR has adopted additional significant safety measures to reduce the spread of COVID-19, including, as described in sections below, a drastic reduction in intake from county jails, comprehensive testing, quarantine, isolation, and movement protocols, policies regarding personal protective equipment, and plans for COVID-19 testing of staff and incarcerated people.

Because of the effectiveness of these policies, which CDCR continues to evaluate, improve, and update in close coordination with the Receiver, positivity rates and COVID-19-related complications and deaths have recently trended downwards. As of October 20, fewer than 500 incarcerated people statewide—or less than 1% of CDCR’s current

1 population—are COVID-19-positive.⁶ This is the lowest positivity rate CDCR has
 2 experienced since May. The below graph is a screenshot from page 4 of CDCR’s
 3 Population COVID-19 Tracker taken on October 19, showing the number of positive
 4 COVID-19 cases among CDCR’s incarcerated population between March 10 and October
 5 19.



13 Early releases of medically high-risk people continue through the 180-day early-
 14 release program, which has accounted for the vast majority of all early releases since
 15 CDCR’s COVID-19 early-release programs were announced on July 10. And, as set forth
 16 in section V below, the Receiver has indicated that new recommendations related to
 17 medically high-risk people are forthcoming.⁷ In this context, CDCR continues to evaluate
 18 the need to resume the high-risk medical early-release program in addition to its other
 19 ongoing COVID-19 mitigation efforts.⁸

21

22 ⁶ See CDCR’s Population COVID-19 Tracking tool at
 23 <https://www.cdcr.ca.gov/covid19/population-status-tracking/> (last visited on October 20,
 2020).

24 ⁷ On October 14, the Receiver circulated a draft document to the parties titled “Report on
 25 Risks of COVID to High-Risk Patients.” The current iteration of the report includes
 26 updates to recommended policies related to incarcerated people at a higher risk of
 experiencing complications if they contract COVID-19. The Receiver is accepting
 comments to this report until October 20.

27 ⁸ In the October 6 joint case management conference statement, Defendants reported that
 28 the high-risk medical early-release program, originally announced on July 10, had been
 (footnote continued)

1 CDCR continues to work with county jails to apply 12 weeks of positive
 2 programming credits to eligible people awaiting transfers to CDCR institutions. This
 3 includes identifying people eligible to receive these credits, calculating updated release
 4 dates following the application of credits, and providing release instructions for people
 5 who are released early as a result of the application of these credits.⁹ As of October 9,
 6 2020, CDCR had issued 965 release memoranda for persons incarcerated in county jails
 7 and awaiting transfer to CDCR.

8 **II. TESTING AND TRANSFER PROTOCOLS**

9 *Plaintiffs' Position:* CDCR continues to transfer large numbers of patients between
 10 prisons, with testing and quarantining to reduce the risk of COVID-19 transmission
 11 governed by CCHCS's August 19 "Movement Matrix." CDCR reports there were 514
 12 such transfers between September 28 and October 4, and 370 between October 5 and 11.
 13 According to CCHCS, there have been "no COVID transmission events . . . among
 14 patients subjected to the movement matrix process."

15 Medical staff, before a patient is transferred between prisons, should check that a
 16 timely COVID test and other requirements of the Movement Matrix have been met. As
 17 noted previously, CCHCS rejected our suggestion that staff complete a checklist before
 18 patients get on a transportation vehicle to minimize the risk that a person is moved without
 19 the necessary quarantine period and a timely negative test. However, at the October 7
 20 Case Management Conference, the Receiver explained that medical staff do use a checklist
 21 when people are transferred, and some prisons had modified it to include Matrix-related
 22 requirements. We then asked that the modified checklist be used at all prisons. CCHCS
 23 on October 16 denied our request. Instead, it stated that its "Nursing Program is cross
 24

25 _____
 26 suspended after the original list of people had been evaluated for early-release eligibility.
 27 *See* ECF No. 3460 at 6:6-10.

28 ⁹ *See* ECF No. 3460 at 8:1-9 for further explanation of this positive programming credit
 initiative.

1 referencing [the] current EHRS documentation ‘pre-screening form’ and will modify
2 accordingly to ensure that the transfer matrix requirements are met.” Plaintiffs have
3 requested further information about this process.

4 In addition, to track transfers, CCHCS has developed a “Transfer Registry.”
5 Defendants indicate below that CCHCS implemented the Registry on October 6, and that it
6 is easily accessible to staff. In response to questions we asked last week, CCHCS on
7 October 16 said that on October 12 one session of training had been done with field staff
8 about how the Registry works and that based on feedback received additional training will
9 be developed by the end of this month. It is not clear to Plaintiffs the degree to which the
10 Registry is fully operational, given that training is still being developed.

11 We also last week asked CCHCS about obtaining access to the Registry. Our
12 question was not answered. We believe access to the Registry is necessary to adequately
13 monitor compliance with the Movement Matrix.

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

1 each prison are outlined for Plaintiffs during routine calls with CCHCS staff.

2 **III. INTAKE**

3 *Plaintiffs’ Position:* Plaintiffs remain concerned about the admission of additional
 4 people to CDCR prisons at this time. In compliance with Court’s July 22 Order, the
 5 parties and the Receiver continue to meet and confer to ensure the space allocated for
 6 quarantine and isolation at each prison is adequate to respond to a COVID outbreak.
 7 Moreover, as set forth in § V., the Receiver recently issued a draft report urging
 8 Defendants to offer celled housing to all those considered medically vulnerable to COVID-
 9 19 who now live in dorms. Admitting additional people to the CDCR population before
 10 the quarantine and isolation allocation is finalized and these potential transfers are
 11 addressed could put pressure on already stressed quarantine space and result in further
 12 spread of the virus.

13 Defendants reopened intake to their facilities on August 24, admitting a total of 100
 14 people the first week and 200 the following week. This “limited intake” would, according
 15 to Defendants, allow CDCR and CCHCS to test their processes, mitigate risk and ensure
 16 safety. *See* ECF No. 3436 at 10. Two weeks later, Defendants wrote, “CDCR expects to
 17 adopt a schedule for intake that will include some limited number of weeks for intake
 18 followed by one or two weeks of no intake, repeated for the foreseeable future. For
 19 instance, 3 weeks of intake, followed by a 1 or 2 week pause, then 3 weeks of intake.”
 20 ECF No. 3449 at 11. However, Defendants have seemingly abandoned their measured
 21 approach to intake. Since September 20, Defendants have admitted between
 22 approximately 143 to 360 people each week. *See* ECF No. 3460 at 10-11. For the current
 23 week, Defendants say they plan to admit 610 people.

24 *Defendants’ Position:* CDCR accepted 215 incarcerated persons into custody via
 25 county jail intake the week of October 4, and 322 incarcerated persons the week of
 26 October 11, as follows:

Week of:	Number of Incarcerated Persons	Sending County	Receiving Institution

1	October 4	132	Stanislaus	WSP
2	October 4	83	San Diego	NKSP
3	Total Week of October 4:	215		
4				
5	October 11	25	Shasta	NKSP
6	October 11	145	Orange	NKSP
7	October 11	123	Kern	WSP
8	October 11	10	Kings	CCWF
9	October 11	6	Stanislaus	CCWF
10	October 11	12	Kern	CCWF
11	Total Week of October 11:	322		
12				

Each week, CDCR headquarters meets with leadership from NKSP, WSP, and CCWF, as well as CCHCS, to determine whether the institutions should permit intake the following week, and if so, how much space is available such that social distancing of newly arriving incarcerated persons can safely be accomplished during the initial quarantine period. For the week of October 18, CDCR has authorized intake as follows:

	Number of Incarcerated Persons	Sending County	Receiving Institution
19	30	Humboldt	NKSP
20	30	Shasta	NKSP
21	100	Butte	NKSP
22	10	Plumas	NKSP
23	10	Modoc	NKSP
24	50	Napa	NKSP
25	40	Contra Costa	NKSP
26	50	Sutter	NKSP
27	90	Los Angeles	WSP
28			

1	160	San Bernardino	WSP
2	40	Orange	CCWF
3	Total Week of October	610	
4	18:		

5

6 As Defendants have reported in previous Case Management Statements, CDCR is

7 working tirelessly to ensure that sending counties are complying with all intake protocols,

8 including testing of incarcerated persons in advance of transport and wearing of N95

9 masks by both incarcerated persons and transportation staff at all times during transport.

10 CDCR requires strict compliance with its protocol. By way of example, a bus arrived at

11 CCWF during the week of October 4, but the sending county had failed to provide CCWF

12 with COVID-19 test results in advance of arrival for three incarcerated persons.

13 Additionally, upon inspection of the bus at the vehicle sallyport, CCWF medical staff

14 observed that the neither the sending county's transportation staff nor any of the

15 incarcerated persons being transported were wearing N95 masks. Accordingly, the bus

16 was not allowed to enter CCWF and the incarcerated persons were returned to the sending

17 county.

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

19 across multiple days within the week to better enable staff at the receiving institution to

20 ensure social distancing during the intake process.

21 CDCR remains in communication each week with the California State Sheriffs'

22 Association to determine which counties have the greatest need and are able to comply

23 with CDCR's strict transfer protocol.

24 **IV. QUARANTINE AND ISOLATION**

25 *Plaintiffs' Position:*

26 **A. Set Aside of Quarantine and Isolation Space**

27 Defendants have identified COVID-19 quarantine and isolation space at every

28 prison to be used in the event of an outbreak, as ordered by this Court on July 22. ECF

1 No. 3401 at 3-4. Based upon information we received from Defendants on October 16, it
2 appears that this space has been vacated, in compliance with the Court's orders on July 22
3 and September 22. ECF Nos. 3401 at 3-4 and 3460 at 2. On September 16, Plaintiffs
4 requested modifications to that set-aside space, as allowed by the Court's order. *Id.* On
5 October 15, CCHCS responded.

6 Plaintiffs' first ground for requesting modifications was that many of the quarantine
7 set-asides are dorms or tiered cell blocks without solid doors -- exactly the sort of
8 congregate living environments, with shared airspaces, that have allowed rapid and
9 uncontrolled spread of the virus in the prisons. The Public Health Workgroup recognized
10 that people exposed to the virus "must be separated from each other in single cells with
11 solid doors." Several thousand people incarcerated in CDCR are presently quarantined in
12 dorms or cells with barred or perforated doors, in direct contradiction to that guidance.

13 The response from CCHCS recognized these concerns but did not provide a clear
14 response to how patients in prisons without solid-door celled quarantine space would be
15 protected from an unreasonable risk of harm.

16 Plaintiffs' second ground for requesting modification was a concern that general
17 population patients might refuse to move to isolation or quarantine space located on a
18 sensitive needs yard, and vice versa, due to fears that they might experience violent
19 reprisals from other incarcerated people as a result. People could refuse tests for the same
20 reason. Multiple refusals could create a public health problem. CCHCS responded that
21 isolation and quarantine space was akin to Administrative Segregation, where general
22 population and sensitive needs populations are mixed. Finally, CCHCS provided specific
23 responses to our institution-specific concerns and noted that, subsequent to Plaintiffs'
24 September 16 letter, CDCR set aside additional beds for isolation and quarantine at some
25 prisons. We then asked and received from CDCR a current draft of all set aside space.
26 Plaintiffs will review the additional space and CCHCS's responses to determine whether
27 we think our concerns have been adequately addressed.

28 **B. Development of Policies Related to Quarantine and Isolation**

1 As reported in the last two Case Management Conferences, Plaintiffs have asked
2 the Receiver to consider developing two policies related to quarantine and isolation: (a)
3 guidance regarding when people should be quarantined or isolated in a space other than the
4 set-aside space, and (b) procedures and time-frames for placing patients in isolation or
5 quarantine once positive test results are received or information is received regarding an
6 exposure. *See* ECF No. 3448 at 12-13; ECF No. 3460 at 14.

7 Although CCHCS has provided responses to the above requests, plaintiffs are
8 pursuing clarification.

9 We have also asked CCHCS to issue a directive to ensure that those placed in
10 isolation due to symptoms who are pending a COVID-19 test results are kept separate from
11 those who are lab-confirmed to have COVID-19. CCHCS on October 16 responded that
12 this message has been provided to the field in regularly scheduled phone conferences, and
13 will be addressed in the next iteration of the Movement Matrix.

14 **C. Monitoring Use of Quarantine and Isolation Space**

15 Plaintiffs must be able to adequately monitor the use of quarantine and isolation
16 space, including to ensure that incarcerated people are not placed at risk of harm and so
17 that we can determine whether to request that further space be set aside. CCHCS has
18 developed a template—called an Outbreak Management Tool—that prisons will use on a
19 daily basis to report on matters related to COVID-19, including information on numbers
20 and housing locations of patients in quarantine and isolation. We sent CCHCS comments
21 on a draft version of the template, and were told on October 2 that CCHCS is in the
22 process of automating the tool, and that completed copies of these daily reports will be
23 provided to Plaintiffs once they are in use at the prisons. On October 16, CCHCS said that
24 work on a partially automated Tool was expected to be completed last week, would then be
25 distributed to the prisons for feedback, and that it anticipated a partially automated version
26 would be available by the end of this month.

27 While providing the above information, CCHCS did not last week respond to our
28 question regarding when we will be provided access to the Outbreak Management Tool as

1 completed by the various prisons. We understand, including because weeks ago CCHCS
2 provided us a copy of one, that the prisons are currently completing and forwarding the
3 tool to regional and central office managers. Given that earlier this month CCHCS said we
4 would be provided copies, it is not clear why we are not regularly receiving them. We
5 believe access to this information is necessary for adequate monitoring and would
6 significantly improve our understanding of outbreak response.

7 *Defendants' Position:* CDCR has completed its effort to set aside vast quantities of
8 previously identified isolation and quarantine space at the prisons. As discussed at the last
9 case-management conference, only one prison—California State Prison, Los Angeles
10 County (LAC)—still needed to vacate its identified isolation and quarantine space. LAC
11 completed that process on October 9, 2020, and all identified quarantine and isolation
12 space is now either ready for occupancy or is already being used for quarantine or
13 isolation.

14 Plaintiffs submitted a number of concerns about current isolation and quarantine
15 reserves to the Receiver in September and the Receiver responded to those concerns on
16 October 15, 2020. Additionally, the Receiver's office arranged a meeting on October 5 for
17 the parties in *Plata*, *Coleman*, and *Armstrong* to further discuss isolation and quarantine
18 issues with the Receiver, the *Coleman* Special Master, and the *Armstrong* Court Expert.
19 The Receiver held a follow-up to that meeting on October 15, 2020. The focus of the
20 October 15 meeting was ensuring that appropriate isolation and quarantine space would be
21 available for enhanced-outpatient *Coleman* class members. Significant progress toward
22 achieving that goal was made at the October 15 meeting, and the Receiver scheduled
23 another follow-up meeting on October 27, 2020, to allow the parties to further discuss
24 quarantine and isolation.

25 **V. SAFELY HOUSING MEDICALLY VULNERABLE PEOPLE**

26 *Plaintiffs' Position:* CDCR continues to house people in large congregate living
27
28

1 areas, including thousands who, based on age and/or their medical condition, are
2 particularly vulnerable to severe illness or death from COVID-19.¹⁰ In these dorms and
3 open-cell-front living units, large numbers of people share airspace, including sleeping
4 areas, bathrooms, and showers. The U.S. Centers for Disease Control and Prevention
5 (“CDC”) recently confirmed that COVID-19 can be spread by aerosolization, and the
6 number and rate of infections in CDCR in the first seven months of the pandemic show
7 that the virus spreads rapidly when introduced into dorms and open-cell-front housing.
8 Because the risk of infection is so much greater in these environments, they are
9 particularly dangerous for medically vulnerable people, placing them at heightened risk of
10 severe illness or death.

11 In an effort to address this situation, the Receiver on October 14 circulated a Draft
12 Report entitled, “Report on Risks of COVID to High-Risk Patients.”¹¹ Recognizing the
13 high risks of morbidity and mortality for people with COVID-19 risk-factors, he
14 recommends that “CDCR extend an offer to the over 8,200 patients with COVID-19 risk
15 scores of 3 and above who are currently housed in dorms or open-cell-front housing the
16 opportunity to transfer into closed-front cells either at their existing institution or at
17 another institution.” Having consulted with our public health expert, Dr. Adam Luring,
18 Plaintiffs endorse this recommendation, and are continuing to discuss whether the CDCR
19 should do more than extend an offer to those at high medical risk for COVID-19.

20 To date large percentages of medically vulnerable patients have declined offers to
21 move from dorms to cells. Last week we mailed a questionnaire to each of these patients,
22 in the hope of better understanding why they did not want to move and whether there are
23 circumstances under which they would.

24 _____
25 ¹⁰ As noted in the previous Joint Case Management Conference Statement, celled housing
26 has already been offered to a small number of medically vulnerable people in dorms, and
the acceptance rate has been low.

27 ¹¹ The parties have been invited to submit comments on the report by Tuesday, October
28 20.

1 *Defendants' Position:* The Receiver has provided the parties with a draft report
2 that proposes that CDCR should offer over 8,000 HRM patients living in dorms the
3 opportunity to move into a single cell. The Report is still awaiting further comments and
4 the Defendants remain committed to working with the Receiver to facilitate movements of
5 medically high-risk patients from dorms to cells, or any other movements, to safely house
6 medically high-risk patients when such movement is recommended and approved by the
7 appropriate public health and corrections experts.

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

12 **VI. COVID-19 TESTING**

13 **A. Staff Testing**

14 *Plaintiffs' Position:* As reported in prior Joint Case Management Conference
15 Statements, the Office of the Inspector General (OIG) in August reported significant
16 problems with the entrance screening practices in CDCR. *See* ECF No. 3427 at 14-15;
17 ECF No. 3436 at 18-19; ECF No. 3460 at 18; Office of the Inspector General, *COVID-19*
18 *Review Series, Part One: Inconsistent Screening Practices May Have Increased the Risk of*
19 *COVID-19 Within California's Prison System* (August 2020), [https://www.oig.ca.gov/wp-](https://www.oig.ca.gov/wp-content/uploads/2020/08/OIG-COVID-19-Review-Series-Part-1-Screening.pdf)
20 [content/uploads/2020/08/OIG-COVID-19-Review-Series-Part-1-Screening.pdf](https://www.oig.ca.gov/wp-content/uploads/2020/08/OIG-COVID-19-Review-Series-Part-1-Screening.pdf). On
21 October 8, CCHCS issued a memorandum to standardize the entrance screening practices
22 at all prisons. The memorandum directs each prison to identify and submit a screening
23 location for approval, provide training for employees conducting the screening, and
24 regularly audit and report on compliance with screening procedures. We hope this will
25 result in reliable, consistent screenings of all staff entering the prisons.

26 Regarding staff testing, CCHCS took over authority for staff testing in August, and
27 on September 14, distributed its draft "Employee Testing Guidance" to the parties.
28 Plaintiffs provided comments to CCHCS on September 23. On October 2, CCHCS said it

1 had reviewed our comments and would be providing responses, as well as a revised
2 version of the Testing Guidance, the following week. On October 16, in response to our
3 query, CCHCS stated it was still finalizing the revised Testing Guidance. CCHCS also
4 reported it was finalizing an Employee Testing Budget Proposal, so that nursing staff could
5 be hired to conduct onsite testing seven days a week. CCHCS reported that, currently,
6 employee testing is still conducted by vendors, and is only done five days a week. CCHCS
7 stated they anticipated nursing staff would be conducting employee testing by December
8 2020. As we have previously stated, we appreciate the steps CCHCS is taking to
9 implement an effective staff testing program, but, seven months into the pandemic, regret
10 that such necessary action was not taken by CDCR or CCHCS sooner.

11 Finally, in response to our request for reports on the staff testing completed in
12 August and September at CHCF, CMF, and CCWF, CCHCS on October 16 stated that
13 reports for staff testing are still being developed, and that no reports have been finalized.
14 We acknowledge the difficulty of developing a comprehensive reporting system, but are
15 eager to receive these reports, as we currently have no way to monitor whether and when
16 employees have been re-tested.

17 *Defendants' Position:* On September 14, the Receiver's Office shared the
18 employee testing guidance with the parties and requested comments, if any, by September
19 21. CDCR continues working closely with CCHCS to maintain the current staff testing
20 procedures and to ensure a smooth and easy transition of the staff testing-responsibilities to
21 CCHCS. CDCR also remains committed to continuing to work with CCHCS to answer
22 any questions Plaintiffs might have about the status of and processes for staff testing until
23 the transition to CCHCS has been completed.

24 **B. Incarcerated Population Testing**

25 *Plaintiffs' Position:*

26 **1. Patient Testing Policies**

27 The Receiver at the October 7 Case Management Conference said, as we
28 understood it, that CCHCS would revise its patient testing policies so that serial retesting

1 was mandated in certain circumstances. We hope to soon see this and other revisions.

2 Another issue has recently arisen related to CCHCS's increasing reliance on a
3 particular Point of Care (POC, sometimes referred to as a rapid) antigen test. As we
4 understand it, this test is FDA-approved for use on symptomatic patients, but is widely
5 used, including by CCHCS, for those without symptoms. Earlier this month, five patients
6 without symptoms at the California Medical Facility (CMF) were declared to have
7 COVID-19 and placed in isolation due to positive POC tests. However, and fortunately,
8 CMF doctors ordered retests using the more traditional lab testing, and determined the
9 earlier results were false positives: none of the patients in fact were infected. We believe
10 CCHCS practices vary statewide as to whether POC positive results are confirmed by
11 subsequent lab tests, and that without confirming lab tests, placing patients into medical
12 isolation with others who are in fact infected is dangerous. Under current CCHCS policy,
13 people in isolation can be grouped and housed together. We asked CCHCS to implement a
14 mandate requiring lab retests of POC positive patients, and that such patients not be mixed
15 with others in isolation until confirming lab results are received. On October 16, CCHCS
16 said it uses the POC tests consistent with Centers for Disease Control and Prevention and
17 California Department of Public Health guidelines, but that as it "gain[s] more experience"
18 it "may modify" its approach.

19 **2. Reports and Monitoring of Serial Retesting**

20 CCHCS reports that work has been done on developing an automated reporting and
21 monitoring process regarding whether ordered serial retesting of patients is actually done,
22 but that further work has been deferred pending completion and release of the Transfer
23 Registry. We continue to hope that this can be completed soon.

24 **3. Notification to Patients of Test Results**

25 CCHCS on October 16 said initial testing of automated test result processes, using
26 standardized templates, has been completed and approved by its leadership, and the
27 processes are now undergoing final testing. It also provided copies of the standardized
28 templates, which are very well done. We have asked that the notification template for

1 positive patients be modified to, among other things, explain that nurses will check blood
2 oxygen levels, given the central importance of that check in the monitoring of COVID-19
3 patients.

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

8 **VII. Prison-Specific Updates**

9 *Plaintiffs' Position:*

10 We continue to have a weekly conference regarding prison-specific COVID-related
11 matters with the CCHCS Regional Medical Chief Executive Officers (CEOs) and the
12 Deputy Director who supervises them. We have been able to raise concerns that have
13 resulted in what we consider major improvements in COVID risk reduction measures and
14 conditions for patients, highlight other concerns, and learn of initiatives undertaken at
15 particular prisons.

16 For example, we believe the weekly conferences resulted in programs to serially
17 test every week never-positive patients at the California Rehabilitation Center (CRC) and
18 California Institution for Men (CIM), prisons where, despite large numbers of COVID
19 infections for months, comprehensive retesting such as is being done at San Quentin and
20 Folsom had not been instituted. At CIM, we learned that to implement serial testing,
21 CCHCS in the last two weeks arranged for approximately 20 additional nurses, a laudable
22 effort. The weekly conferences also resulted in patients on medical isolation and
23 quarantine being offered some outdoor exercise at Salinas Valley State Prison, where some
24 had been locked in their cells for weeks, even though other prisons, including the
25 Correctional Training Facility located almost literally across the street, routinely provided
26 outdoor exercise opportunities to those on isolation and quarantine.

27 Our questions at the conferences also revealed that at CIM, nearly 50 people who
28 medical staff determined had been exposed to COVID-19 were quarantined together in a

1 gym, even though single cells with solid doors—which CCHCS mandates be used if
2 available—were available. Further, the patients quarantined together came from four
3 different housing units; the Regional CEO was not able to explain how this was consistent
4 with the CCHCS mandates that if people are quarantined together they must have the same
5 date and type of exposure. Subsequently, a number of people in the gym tested positive.

6 Similarly, we were able to confirm that at CRC this past summer people were
7 quarantined in a particular dorm for months, with people from another dorm, with
8 seemingly different exposure dates or sources, brought into same dorm. For weeks, new
9 infections were repeatedly identified, with only four people remaining uninfected at the
10 end of the quarantine period. The dorm acted as an incubator for COVID-19, and this
11 unfortunate experience shows again why quarantine in single cells with solid cells must be
12 done.¹²

13 Finally, we have learned via the conferences that a decision is expected shortly on
14 whether to enter into a contract to study and test the ventilation systems in San Quentin’s
15 five-tier East, South, and West Block ventilation systems, as those systems relate to
16 possible transmission of the virus that causes COVID-19. This is important because those
17 units have peculiar ventilation, in which air in the building is drawn into each cell, a
18 concern given that it is now recognized that the virus is in the air. We appreciate
19 CCHCS’s and CDCR’s undertaking of this initiative.

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

24 _____
25 ¹² CRC has less than a handful of cells. CCHCS and CDCR have within the last two
26 weeks installed tents at the prison, in which they intend to house, in cohorts of four or five,
27 those who are at high risk of severe complications if infected with COVID-19 who are not
28 yet infected. In that way, they hope to limit the spread of COVID-19 among those
patients. Still, single cell quarantining cannot occur.

1 **VIII. Updates on Medical Care Matters Not Directly Related to COVID-19**

2 *Plaintiffs' Position:* We previously reported, and discussed at the October 7 Case
3 Management Conference, that there are now approximately 4,700 patients who are ordered
4 and receiving Medication Assisted Treatment (MAT) for a substance use disorder, and
5 more than 6,000 patients awaiting the necessary addiction medicine physician appointment
6 to be considered for such an order, with more than 80% of those appointments overdue.
7 Many of those appointments are several months overdue.

8 On October 12 we asked CCHCS to begin providing us monthly data on overdue
9 addiction medicine physician appointments. CCHCS on October 16 said it would do so
10 starting at the end of November. We appreciate that this will be done.

11 Also on October 12 we asked CCHCS to take immediate action to increase the
12 number of Addiction Medicine physician appointments currently provided, so that the
13 backlog can be substantially reduced as soon as possible. Our concern about the backlog
14 was heightened by our review of the records of a CCHCS patient who recently died. In
15 May, the patient twice submitted written requests for care, describing his problems with
16 heroin and asking for MAT so he could he could get help to “sober up.” That same
17 month, a primary care visit documented that he used heroin daily. On June 9, the patient
18 was seen by a Licensed Clinical Social Worker, who determined he was at “high risk” for
19 matters related to opioid use and ordered an Addiction Medicine physician appointment
20 within 14 days. On June 11, that appointment was scheduled for June 25; however, it was
21 then successively rescheduled to July 16, August 6, and then November 26. The records
22 do not appear to include a reason why the appointment was repeatedly rescheduled; we
23 believe it was due to the backlog.

24 On October 2, the patient was found unresponsive in his cell. Narcan was given
25 with minimal improvement, apparently, and he was emergently transported to a local
26 hospital. The hospital record reports that “a needle was found next to him” when found
27 unresponsive in his cell, and state that patient had a “possible overdose” or “opioid
28 overdose.” The next day, the patient died.

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

5 DATED: October 20, 2020

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