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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

PLAINTIFFS' NOTICE OF MOTION & MOTION FOR AN ORDER MODIFYING CDCR'S COVID-19 STAFF TESTING PLAN

Date:
Time:
Crtrm.: 6, 2nd Floor
Judge: Hon. Jon S. Tigar

NOTICE OF MOTION AND MOTION

PLEASE TAKE NOTICE that as soon as the matter may be heard by the above Court, Plaintiffs will and hereby do move, pursuant to Civil L.R. 7-1, for an order directing Defendants to modify CDCR's plan to test staff for COVID-19 to protect Plaintiffs against unreasonable risk of infection and harm.

This Motion is supported by the following Memorandum of Points and Authorities, the Proposed Order, the supporting declarations, and the entire record in this matter.

DATED: July 24, 2020

PRISON LAW OFFICE

By: */s/ Sophie Hart*

Donald Specter
Steven Fama
Alison Hardy
Sara Norman
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Sophie Hart
Attorneys for Plaintiffs

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

As the Receiver, this Court, and the parties have all recognized, staff are the most significant vector for spreading COVID-19 in the state prisons. *See* Declaration of Sophie Hart, ¶ 16 & Ex. H (Transcript of May 21, 2020 CMC); Joint Case Management Conference Statement (June 8, 2020), ECF No. 3345 at 3; Order Regarding Staff Testing for COVID-19 (June 11, 2020), ECF No. 3353 at 1; Order to Show Cause re: Baseline Staff Testing for COVID-19 (June 28, 2020), ECF No. 3366 at 1. As of July 23, 2020, more than 1500 CDCR employees had tested positive for COVID-19, with new cases reported daily. *See* Hart Decl., ¶ 14 & Ex. F (CDCR/CCHCS COVID-19 Employee Tracker).

In recognition of the risk that staff will continue to introduce and spread the virus in the prisons, this Court previously ordered Defendants to "produce a comprehensive plan for testing staff at all prisons in the California Department of Corrections and Rehabilitation." Order Regarding Staff Testing for COVID-19 (June 11, 2020), ECF No. 3353 at 2 (memorializing an order issued from the bench on June 9, 2020). Pursuant to the Court's order, Defendants provided the CDCR's interim plan to Plaintiffs on June 16. *See* Hart Decl., ¶ 2 & Ex. A. In writing and through the meet-and-confer process, Plaintiffs' counsel raised serious concerns regarding the plan—including that it did not call for baseline testing, testing of symptomatic staff, or sufficient testing during an active outbreak. *See* Hart Decl., ¶¶ 3-4, 9; Joint Case Management Conference Statement (June 8, 2020), ECF No. 3345 at 4-6; Joint Case Management Conference Statement (June 18, 2020), ECF No. 3356 at 6-7; Joint Case Management Conference Statement (July 1, 2020), ECF No. 3370 at 8-11.

Under threat of Court Order, Defendants agreed to modify their plan to conduct baseline testing at all prisons. *See* Order to Show Case re: Baseline Staff Testing for COVID-19 (June 28, 2020), ECF No. 3366 at 3-4; Defendants' Response to Order to Show

Cause Re: Baseline Staff Testing for COVID-19 (June 30, 2020), ECF No. 3368 at 2-3. In response to Plaintiffs' remaining concerns, on July 2, this Court directed Defendants to provide Plaintiffs a revised plan by July 16. *See* Civil Minutes (July 2, 2020), ECF No. 3374 at 1. Plaintiffs' counsel received the revised plan on July 15. *See* Hart Decl., ¶ 10 & Ex. B (CDCR July 7 Staff Testing Plan). The revised plan did not resolve or respond to Plaintiffs' concerns—it did not call for testing symptomatic staff, nor did it provide for sufficient testing during an outbreak. *See id.*

Plaintiffs again raised their concerns with the plan for staff testing during the July 16 Case Management Conference. The Court directed the parties to meet and confer, and Plaintiffs to file a motion by July 24 if the parties' disputes had not been resolved through the meet-and-confer process. *See* Civil Minutes (July 16, 2020), ECF No. 3393 at 2. The parties met and conferred on July 23, and Defendants thereafter produced a revised staff testing plan. *See* Hart Decl., ¶ 11 & Ex. C (CDCR July 23 Staff Testing Plan). Unfortunately, the parties were unable to reach an agreement on two significant issues: (1) testing of symptomatic staff and (2) the scope of the testing done during an outbreak. Having made every effort to raise and resolve these disputes with Defendants through the meet-and-confer process, Plaintiffs now turn to this Court for relief.

II. FACTUAL BACKGROUND

a. CDCR's Plan for Staff Testing Fails To Mitigate the Risk that Staff Will Spread COVID-19 in the State Prisons

A central component of an adequate COVID-19 testing strategy is to promptly identify symptomatic staff, and to perform comprehensive re-testing when a new case is identified. CDCR's plan falls short in both regards.

First, CDCR's plan does not call for testing symptomatic staff, so that appropriate outbreak investigations can be done at the prison. The U.S. Centers for Disease Control and Prevention ("CDC") advise that "[a]mong persons with extensive and close contact to vulnerable populations . . . , even mild signs and symptoms (e.g., sore throat) of a possible

SARS-CoV-2 infection should prompt consideration for testing." Hart Decl., ¶ 12 & Ex. D (CDC, Overview of Testing for SARS-CoV-2) (updated July 17, 2020). But, CDCR's plan states only that "[i]f a staff member has possible COVID-related symptoms, the staff member shall be directed to obtain a medical evaluation to determine whether he or she should be tested for COVID-19." *See* Hart Decl., ¶ 11 & Ex. C at 1 (CDCR July 23 Staff Testing Plan). In this regard, CDCR's plan appears to mirror a recommendation made by the CDC in their *Interim Considerations for SARS-CoV-2 Testing in Correctional and Detention Facilities*. Hart Decl., ¶ 13 & Ex. E (CDC, Interim Considerations for SARS-CoV-2 Testing in Correctional and Detention Facilities) (July 7, 2020). But, CDCR's plan is missing critical pieces: it does not require the employee to report a positive test, nor does it require any action if the employee does not seek a test on their own. *See id.* (recommending correctional facilities consider and address "staff who decline testing" and the reporting of results to the employer). Moreover, having implemented a staff testing program in the prisons, it is unreasonable to carve out those staff members who are most likely to be infected and to have spread the virus—those who report symptoms while at work.

A referral to an outside medical provider is insufficient. As Dr. Adam Lauring, an expert in infectious disease and COVID-19 prevention, explains in his declaration filed herewith, quickly testing symptomatic staff is key to preventing the spread of the virus in the prisons. *See* Declaration of Dr. Adam Lauring, ¶¶ 6-7. Prompt testing of symptomatic staff members is necessary so that public health officials can perform outbreak investigations and contact tracing, thereby stopping the virus from spreading. *Id.*; *see also* Hart Decl., ¶ 12 & Ex. D (CDC, Overview of Testing for SARS-CoV-2) (explaining that "[b]ecause of the potential for asymptomatic and pre-symptomatic transmission, it is important that contacts of individuals with SARS-CoV-2 infection be quickly identified and tested"). As Dr. Lauring explains, "[t]his is especially true in correctional settings, where the virus can spread rapidly once introduced." Lauring Decl., ¶ 6. Quickly

determining whether symptomatic staff have COVID-19 should be a central component of CDCR's testing strategy. But, the current plan simply outsources this function, with no assurance that the test will in fact occur or that a positive result will be reported. And, under CDCR's current plan, without a positive test result for a staff person, there is no requirement that the prison initiate testing to determine whether, and how far, the virus has spread.

Second, CDCR's plan for testing in the event of an outbreak is inadequate. When a new positive case is identified, CDCR's plan limits outbreak testing to the particular yard where the staff person worked, or incarcerated person lived. Specifically, the plan provides:

> For institutions that are organized by yard, initial testing can be limited to the yard where the positive inmate is housed or staff is assigned. If there are multiple yards at an institution, and those who have tested positive are clustered in one yard, serial testing should only occur among staff regularly assigned to that yard. It is not necessary to test staff across multiple yards as long as staff are not moving among buildings to provide services.

Hart Decl., ¶ 11 & Ex. C at 2 (CDCR July 23 Staff Testing Plan). The plan does not provide for any additional contact tracing of staff. *See id.*

As this Court stated in the June 28 Order to Show Cause, staff in CDCR are not cohorted to work on particular yards: "although the Receiver has recommended consideration of staff cohorting so that staff interact only with limited groups of inmates, no such cohorting has been implemented." Order to Show Case re: Baseline Staff Testing for COVID-19 (June 28, 2020), ECF No. 3366, n.2. Indeed, when public health experts visited San Quentin in the early stages of the outbreak in June, they reported that they had "learned about staff who were working in the Medical Isolation Unit (Adjustment Center) during the shift and were scheduled to work the next shift in the dorms." Hart Decl., ¶ 17 & Ex. I at 7 (SQ Amend Memo) (June 13, 2020). They noted that this presented "an enormous risk for the spread of COVID-19 between housing units." *Id.* And, even if staff

do not work on the same yard, they are likely to interact with each other during shift change, in carpools, and outside of work, as many staff members live and recreate in the same communities. *See id.* at 2-3 (noting "shared vanpools" were a potential source of staff-to-staff infections); Hart Decl., ¶ 18 & Ex. J at 24 (CMC Amend Report) (July 20, 2020) (noting that staff "[c]ommute with each other in 'vanpools' and/or often stay at nearby hotels during shift days").

In recognition of this reality, this Court previously stated: "the Court anticipates that all staff will be serially retested under Defendants' plan, without limitation to particular yards." Order to Show Case re: Baseline Staff Testing for COVID-19 (June 28, 2020), ECF No. 3366, n.2. Yet, CDCR has persisted in limiting outbreak investigations to a particular yard. Indeed, under Defendants' current plan, if a staff member tests positive, the other staff person he or she drove to work with that day, or had dinner with the night before, will only be tested by CDCR if they happen to work on the same yard. This policy is unreasonable, and presents a significant risk of harm to the Plaintiff class. *See* Lauring Decl., ¶¶ 8-9.

III. LEGAL ARGUMENT

a. The Court Should Order Defendants to Test Symptomatic Staff and Perform Appropriate Outbreak Investigations

This Court previously ordered Defendants to "produce a comprehensive plan for testing staff at all prisons in the California Department of Corrections and Rehabilitation to Plaintiffs by June 16, 2020." Order Regarding Staff Testing for COVID-19 (June 11, 2020), ECF No. 3353 at 2. Six weeks later, CDCR's plan remains insufficient to mitigate the risk that the virus will spread throughout a prison once it is introduced. It does not ensure that symptomatic staff will be tested, nor does it require that all staff will be re-tested in the event of an outbreak. Given the urgency of this issue—every prison has reported multiple positive staff cases—this Court should order Defendants to revise CDCR's plan to immediately address these issues. *See* Hart Decl., ¶ 14 & Ex. F (CDCR/CCHCS COVID-19 Employee Tracker).

This Court need not make a new finding of deliberate indifference to enter such an order. *See* Stipulation for Injunctive Relief and Order (June 13, 2002), ECF No. 68 at ¶ 29 and Order at p. 18; *see also* Findings of Fact and Conclusions of Law Re Appointment of Receiver (October 3, 2005), ECF No. 371. As the Court in *Coleman v. Newsom* has held, "once an Eighth Amendment violation is found and injunctive relief ordered, the focus shifts to remediation of the serious deprivations that formed the objective component of the identified Eighth Amendment violation." *Coleman v. Brown*, 28 F. Supp. 3d 1068, 1077 (E.D. Cal. 2014); *see also Coleman v. Brown*, 756 Fed. Appx. 677, 678-79 (9th Cir. 2018) (unpublished) (district court is entitled to rely on its previous rulings of deliberative indifference and "the persistence of objectively unconstitutional conditions satisfies the subjective 'deliberate indifference' inquiry" (citations omitted)).

Even if a new finding of deliberate indifference is necessary, that standard is met here. It is well established that "[a] prison official's 'deliberate indifference' to a substantial risk of serious harm to an inmate violates the Eighth Amendment." *Farmer v. Brennan*, 511 U.S. 825, 828 (1994); *see also Parsons v. Ryan*, 754 F.3d 657, 677 (9th Cir. 2014). As the Three Judge Court in this case observed in April, "Defendants themselves acknowledge that the virus presents a 'substantial risk of serious harm' and that the Eighth Amendment therefore requires them to take reasonable measures to abate that risk." Order Denying Plaintiffs' Emergency Motion to Modify Population Reduction Order (April 4, 2020), ECF No. 3261 at 9; *see also Helling v. McKinney*, 509 U.S. 25, 33 (1993) (recognizing that officials cannot be "deliberately indifferent to the exposure of inmates to a serious, communicable disease").

Failing to test symptomatic staff members, and failing to perform appropriate outbreak testing when a positive case is identified, places the Plaintiff class at unreasonable risk of harm. Lauring Decl., ¶¶ 6-9. Defendants have persisted in deliberate indifference to this risk. Plaintiffs have repeatedly raised these concerns with Defendants in writing, through the meet-and-confer process, and at the Case Management

Conferences. *See* Hart Decl., ¶¶ 3-4, 9; Joint Case Management Conference Statement (June 8, 2020), ECF No. 3345 at 4-6; Joint Case Management Conference Statement (June 18, 2020), ECF No. 3356 at 6-7; Joint Case Management Conference Statement (July 1, 2020), ECF No. 3370 at 8-11.

Yet, Defendants have refused to appropriately modify these provisions. The failure to do so, while simultaneously recognizing that staff are the *most significant vector* for spreading COVID-19 in the state prisons, constitutes deliberate indifference, and requires this Court's intervention.

b. The Requested Relief Meets the Requirements of the Prison Litigation Reform Act (PLRA)

Plaintiffs' proposed order satisfies the needs-narrowness-intrusiveness requirements of the Prison Litigation Reform Act. *See* 18 U.S.C. § 3626(a)(1)(A) ("The court shall not grant or approve any prospective relief unless the court finds that such relief is narrowly drawn, extends no further than necessary to correct the violation of the Federal right, and is the least intrusive means necessary to correct the violation of the Federal right."). Plaintiffs have proposed two discrete, targeted modifications to CDCR's staff testing plan. These changes are critical to mitigating the risk that staff will continue to spread COVID-19—a disease that has already taken the lives of 42 incarcerated people—in the prisons. *See* Lauring Decl., ¶¶ 6-9; Hart Decl., ¶ 15 & Ex. G (CDCR/CCHCS COVID-19 Patient Tracker).

IV. Conclusion

Plaintiffs respectfully request this Court order Defendants to modify CDCR's staff testing plan, to require prompt testing of symptomatic staff members, and re-testing of all staff in response to an outbreak, consistent with the public health recommendations of Plaintiffs' expert.

DATED: July 24, 2020

PRISON LAW OFFICE

By: */s/ Sophie Hart*

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UNITED STATES DISTRICT COURT

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MARCIANO PLATA, et al.,

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CASE NO. 01-1351 JST

DECLARATION OF ADAM LAURING, MD, PhD, IN SUPPORT OF PLAINTIFFS' MOTION FOR AN ORDER MODIFYING CDCR'S COVID-19 STAFF TESTING PLAN

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

I, Adam Lauring, declare as follows:

1. I am a physician and Associate Professor in the Division of Infectious Diseases and the Department of Microbiology and Immunology at the University of Michigan. I am board certified in infectious diseases and have a PhD in Molecular and Cellular Biology. In 2019, I became a Fellow of the Infectious Diseases Society of America, an honor given to individuals who have demonstrated excellence in the field. In 2020, I was elected to the Governing Council of the American Society for Virology. Attached as Exhibit A is a copy of my curriculum vitae. Further biographical details and qualifications are available at https://medicine.umich.edu/dept/microbiologyimmunology/adam-lauring-md-phd.

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

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

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

5. I have carefully reviewed the document titled "California Department of

Corrections and Rehabilitation COVID-19 Staff Testing Guidance," provided to me in its most recent form on July 24, 2020 by Plaintiffs' counsel. I also reviewed previous versions of this document, provided to me by Plaintiffs' counsel on June 27 and July 22, 2020.

6. To mitigate against the risk of a COVID-19 outbreak in a correctional setting, it is critical to quickly identify and test staff members with symptoms of COVID-19, so that appropriate outbreak investigations can be completed. Because COVID-19 can be transmitted by asymptomatic and pre-symptomatic carriers, it is vital that those exposed to the virus be quickly identified and tested. This is especially true in correctional settings, where the virus can spread rapidly once introduced.

7. In this regard, the CDCR's plan to direct symptomatic employees to seek a medical evaluation and referral for a test from a doctor is inadequate. To ensure an outbreak investigation is promptly completed, if the staff member is at work when they report or develop symptoms, the CDCR should immediately test that person. If the staff person reports symptoms from home, the CDCR should direct the employee to obtain a test, and report the result to the CDCR so that it can initiate contact tracing and other measures designed to inhibit transmission of the virus. If a symptomatic employee declines to be tested, or is unable to obtain a test, the CDCR should assume the staff member has COVID-19 and initiate outbreak investigation testing.

8. Currently, the CDCR staff testing plan only requires retesting staff who are regularly assigned to the yard where an employee who tests positive works. This does not account for the contact that employee may have in working on different yards, mingling with other staff during shift change, in carpools to and from the prison or socializing with other staff.

9. Once a staff person tests positive, it is crucial that CDCR re-test all staff. Limiting re-testing to a particular yard where the positive staff person is regularly assigned will not prevent the spread of the virus to other yards if staff are not cohorted to work on

particular yards, or if staff from different yards regularly interact with one another at or outside of work. Failure to implement such a comprehensive testing plan will create an unnecessary and unreasonable risk of additional infections and consequent disease.

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

Executed this 24th day of July, 2020, in Ann Arbor, Michigan.

Adam Lauring, M.D., Ph.D.

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UNITED STATES DISTRICT COURT

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MARCIANO PLATA, et al.,

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Defendants.

CASE NO. 01-1351 JST

DECLARATION OF SOPHIE HART IN SUPPORT OF PLAINTIFFS' MOTION FOR AN ORDER MODIFYING CDCR'S COVID-19 STAFF TESTING PLAN

I, Sophie Hart, declare as follows:

1. I am an attorney duly admitted to practice before this Court. I am a legal fellow at the Prison Law Office, counsel of record for Plaintiffs. I have personal knowledge of the facts set forth herein, and if called as a witness, I could competently so testify.

2. On June 16, 2020, Defendants' counsel emailed me and other members of the Plaintiffs' counsel team a copy of CDCR's staff testing plan for COVID-19. A true and correct copy of that document is attached hereto as **Exhibit A**.

3. On June 17, 2020, I sent Defendants' counsel a list of questions and concerns regarding the plan. The document I sent included the observation that "we believe it is likely that staff on different yards interact with each other during shift change, and outside of work -- many staff live and recreate in the same communities, even if they do not work on the same yard. We strongly encourage CDCR to test and retest all staff when there is a new case, not just staff on a particular yard."

4. On June 23, 2020, I wrote to Defendants' counsel, requesting a response to our June 17 questions regarding the staff testing plan by June 25, 2020, and to schedule a meet and confer the following Monday (June 29, 2020) to discuss our concerns. I did not receive a response to my request for a meeting.

5. On June 25, 2020, Defendants' counsel informed us that they hoped to send responses to Plaintiffs' June 17, 2020 comments on the staff testing plan the following day.

6. On June 26, 2020, I emailed Defendants' counsel, asking for a response to my request for a meet and confer. I did not receive a response.

7. On June 27, 2020, Defendants' counsel provided written answers to our June 17 comments on the staff testing plan.

8. On the evening of June 29, 2020, Defendants' counsel responded to our pending requests for a meet and confer, stating that they could meet with us regarding the staff testing plan on July 1 or 2. On June 30, 2020, Defendants' counsel emailed me and other members of the Plaintiffs' counsel team, stating that a meet and confer could be scheduled

for the next day, July 1, 2020, at 3:30 PM.

9. I sent Defendants a proposed agenda on the morning of July 1, 2020, including detailed comments on the staff testing plan. The written comments included the observation that "[t]he plan does not appear to call for testing staff who are symptomatic (though it calls for screening staff daily for symptoms). We believe symptomatic staff must be tested, so the prison can do appropriate contact tracing/outbreak investigations if the staff member tests positive." We also again observed that "[t]he plan states that this testing can be limited to the particular yard where the incarcerated person lives or staff member works who initially tested positive" but "staff are generally not cohorted to work on a particular yard. CDCR should expand this provision to call for all staff to be tested."

10. On July 15, 2020, we received a copy of CDCR's revised plan for staff testing. That plan was dated July 7, 2020. A true and correct copy of that document is attached hereto as **Exhibit B**.

11. I and other members of the Plaintiffs' counsel team met and conferred with Defendants regarding the revised staff testing plan on July 23, 2020. Following the meet and confer, Defendants provided a revised copy of CDCR's staff testing plan. A true and correct copy of that document is attached hereto as **Exhibit C**.

12. Attached hereto as **Exhibit D** is a true and correct copy of the Centers for Disease Control and Prevention ("CDC") *Overview of Testing for SARS-CoV-2*, dated July 17, 2020, available at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-overview.html.

13. Attached hereto as **Exhibit E** is a true and correct copy of the Centers for Disease Control and Prevention ("CDC") *Interim Considerations for SARS-CoV-2 Testing in Correctional and Detention Facilities*, dated July 7, 2020, available at: https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/testing.html.

14. Attached hereto as **Exhibit F** is a true and correct copy of the CDCR/CCHCS COVID-19 Employee Status Website, dated July 23, 2020, available at:

https://www.cdcr.ca.gov/covid19/cdcr-cchcs-covid-19-status.

15. Attached hereto as **Exhibit G** is a true and correct copy of the CDCR/CCHCS Population COVID-19 Tracker, which I downloaded from the CDCR/CCHCS website on July 24, 2020, available at: https://www.cdcr.ca.gov/covid19/population-status-tracking.

16. Attached hereto as **Exhibit H** is a true and correct copy of the cover page and pages 6-7 of the transcript of this Court's Case Management Conference on May 21, 2020.

17. Attached hereto as **Exhibit I** is a true and correct copy of the memorandum titled "Urgent Memo: COVID-19 Outbreak: San Quentin Prison," authored by public health experts at UCSF and UC Berkeley, and dated June 13, 2020. This memorandum was emailed to me by Roscoe Barrow, Chief Legal Counsel for California Correctional Health Care Services, on June 23, 2020.

18. Attached hereto as **Exhibit J** is a true and correct copy of the report titled "Evaluation of the April-May 2020 COVID-19 Outbreak at California Men's Colony," authored by public health experts at UCSF and UC Berkeley, and dated July 20, 2020. This memorandum was emailed to me by Roscoe Barrow, Chief Legal Counsel for California Correctional Health Care Services, on July 23, 2020.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct, and that this declaration is executed in Contra Costa County, California this 24th day of July, 2020.

/s/ Sophie Hart

Sophie Hart

Exhibit A

California Department of Corrections and Rehabilitation
COVID-19 Staff Testing Guidance

The following applies to all California Department of Corrections and Rehabilitation (CDCR) institutions, except for the California Medical Facility (CMF), Central California Women's Facility (CCWF), and California Health Care Facility (CHCF), identified by the Receiver, which provide skilled nursing level of care. These three institutions should follow the Skilled Nursing Facility (SNF) testing guidance issued by the California Department of Public Health (CDPH).

Testing does not replace or preclude other infection prevention and control interventions, including monitoring all staff and inmates for signs and symptoms of COVID-19, universal masking by staff and inmates for source control, use of recommended personal protective equipment, maintaining appropriate physical distancing, and environmental cleaning and disinfection. When testing is performed, a negative test only indicates an individual did not have detectable infection at the time of testing; individuals might have SARS-CoV-2 infection that is still in the incubation period or could have ongoing or future exposures that lead to infection.

Institutions without COVID-19 Cases

In institutions that currently do not have any newly diagnosed COVID-19 cases among inmates or staff within the last 14 days, CDPH recommends surveillance testing. The purpose of a surveillance testing strategy is to monitor the spread of the virus in order to isolate the virus and mitigate outbreaks.

CDPH recommends the institution implement surveillance testing of 10 percent of all staff every 14 days including staff from multiple shifts and various locations within the institution. The institution must ensure that a different cohort of staff are tested every 14 days.

In addition, specific testing is recommended for the following groups:

1) All employees who have not had a prior confirmed case of COVID-19 and who are regularly assigned to work in a Correctional Treatment Center, Outpatient Housing Unit, hospice, Psychiatric Inpatient Program, or Mental Health Crisis Bed shall be tested per the SNF testing guidance issued by CDPH.
2) All regularly assigned transportation staff who have not had a prior confirmed case of COVID-19 shall be tested at least once every month, with testing occurring throughout the month.

3) All staff who are regularly assigned to guarding duty at a community hospital, or equivalent, who have not had a prior confirmed case of COVID-19 shall be tested at least once every month, with testing occurring throughout the month.

4.) All regularly assigned culinary area staff who have not had a prior confirmed case of COVID 19 shall be tested once every month with testing occurring throughout the month.

NOTE: State may adjust the scope and frequency of staff testing based on community spread data and prevalence of the virus in the community.

Staff who test negative:

All staff should be screened for fever, respiratory symptoms, or other symptoms before entering any institution each day. To the extent possible, the institution should educate staff regarding the possible exposure of staff movement between multiple yards or buildings. Additionally, staff who are ill should stay home and notify their supervisor. Personnel who develop fever, respiratory symptoms, or other symptoms should be instructed not to report to work.

Staff who test positive:

Staff who test positive for COVID-19 and who have had NO symptoms shall be instructed to isolate themselves at home and shall not return to work until the following condition is met:

- At least 10 days have passed since the date of the positive COVID-19 diagnostic (federally approved Emergency Use Authorized molecular assay) test.

Staff who test positive for COVID-19, initially have no symptoms, but then develop symptoms during their 10-day home isolation period may return to work once the following conditions are met:

- At least 10 days have passed since symptoms first appeared; **AND**
- At least 3 days (72 hours) have passed since recovery, defined as resolution of fever without the use of fever-reducing medications; **AND**
- Improvement in respiratory symptoms[1] (e.g., cough and shortness of breath)

[1] It is possible that individuals may still have residual respiratory symptoms despite meeting the criteria to discontinue isolation. These individuals should continue to wear a facemask/cloth face covering when within 6 feet of others until symptoms are completely resolved or at baseline.

Staff should be provided information about how to appropriately isolate within their home. This includes the following recommendations:

Setup:

- A separate bedroom. If a bedroom must be shared with someone who is sick, consider advising the following:
  - Make sure the room has good air flow by opening the window and turning on a fan to bring in and circulate fresh air if possible.
  - Maintain at least 6 feet between beds if possible.
  - Sleep head to toe.
  - Put a curtain around or place other physical divider (e.g., shower curtain, room screen divider, large cardboard poster board, quilt, or large bedspread) to separate the ill person's bed.
- A separate bathroom **or** one that can be disinfected after use.

Equipment:

- A facemask (or if unavailable, a cloth face covering) should be worn by the infected person if there are others in the household or when healthcare or home care workers enter the house.
- Gloves for any caregivers when touching or in contact with the person's infectious secretions.
- Appropriate cleaning supplies for disinfecting the household.
- A thermometer for tracking occurrence and resolution of fever.

Services:

- Clinical care and clinical advice by telephone or telehealth.
- Plan for transportation for care if needed.
- Food, medications, laundry, and garbage removal.

When and how to seek care:

- If new symptoms develop or their symptoms worsen.
- If the infected person is going to a medical office, emergency room, or urgent care center, the facility should be notified ahead of time that the person has COVID-19; the person should wear a facemask (or if unavailable, a cloth face covering) for the clinical visit.
- Any one of the following emergency warning signs signal a need to call 911 and get medical attention immediately:
  - Trouble breathing
  - Bluish lips or face

- Persistent pain or pressure in the chest
- New confusion or inability to arouse
- New numbness or tingling in the extremities

Institutions with COVID-19 Cases

As soon as possible after one (or more) COVID-19 positive individual(s) (inmate or staff) is identified in an institution, serial retesting of all staff should be performed every 14 days until no new cases are identified in two sequential rounds of testing. The institution may then resume their regular surveillance testing schedule as outlined above.

For institutions which are organized by yard, initial testing can be limited to the yard where the positive inmate is housed or staff is assigned. If there are multiple yards at an institution, and the those who have tested positive are clustered in one yard, serial testing should only occur among staff in that yard. It is not necessary to test staff across multiple yards as long as staff are not moving among buildings to provide services.

If there are positive cases across multiple yards at any given institution, all staff across all yards should be tested every 14 days until no new cases are identified in two sequential rounds of testing. The institution may then resume their regular surveillance testing schedule as outlined above.

Staff who are pending a COVID test result and are asymptomatic can continue to work while wearing face coverings and utilizing appropriate PPE. All staff should be screened for fever, respiratory symptoms, or other COVID related other symptoms each time they enter any Institution.

Staff who test negative:

Staff who test negative and are asymptomatic can continue to work while wearing face coverings and utilizing appropriate PPE. All staff should be screened for fever, respiratory symptoms, or other COVID related other symptoms each time they enter any Institution. To the extent possible, the institution should limit staff movement among multiple yards to limit exposure. Additionally, staff who are sick should stay home. Personnel who develop fever, respiratory symptoms, or other symptoms should be instructed not to report to work and notify their supervisor.

Staff who test positive:

Staff who test positive for COVID-19 and who have had NO symptoms shall follow the instructions outlined above.

Retesting of a Previously Confirmed Positive Employee
An employee who has been confirmed positive by a diagnostic COVID-19 test shall not retest through either institutional surveillance, outbreak, or specialty assignment.

Testing of New Employees and Employees Returning from a Leave of Absence
All new employees of the institution or employees returning from a leave of absence (whether industrial or non-industrial) shall be tested for COVID-19. Testing should occur 48 hours prior to the start of or return to work date, unless documentation of prior positive diagnostic COVID-19 test is provided.

General Definitions:

1. Staff- for the purpose of this policy, any individual whose work assignment is to a particular institutional facility, including but not limited to, CDCR and California Correctional Health Care Services staff, registry, contract, Division Adult Parole Operations, Prison Industry Authority and Board of Parole Staff who interact with inmates.
2. New Employee- an employee who has not previously been assigned to a particular institution/worksite.
3. Leave of Absence- for the purposes of this policy is any employee who has not worked a shift within a consecutive 14 calendar day period. Vacations apply.

The California Department of Human Resources (CalHR) administrative time off (ATO) guidelines will be evaluated and applied. In unique situations, CDCR of CCHCS Human Resources designees will consult with CalHR.

This policy is subject to change as CDC guidelines, PPE availability and testing options change.

Exhibit B

California Department of Corrections and Rehabilitation
COVID-19 Staff Testing Guidance-July 7, 2020

The following applies to all California Department of Corrections and Rehabilitation (CDCR) institutions, except for the California Medical Facility (CMF), Central California Women's Facility (CCWF), and California Health Care Facility (CHCF), identified by the Receiver, which provide skilled nursing level of care. These three institutions should follow the Skilled Nursing Facility (SNF) testing guidance issued by the California Department of Public Health (CDPH). The SNF protocols are currently as follows:

> Regular surveillance testing requires testing 25 percent of staff every 7 days so that 100 percent of staff are tested each month. As soon as possible after one (or more) COVID-19 positive individuals (resident or staff) is identified in a facility, serial retesting of all staff should be performed every 7 days until no new cases are identified in two sequential rounds of testing; the facility may then resume their regular surveillance testing schedule.

Testing does not replace or preclude other infection prevention and control interventions, including monitoring all staff and inmates for signs and symptoms of COVID-19, universal masking by staff and inmates for source control, use of recommended personal protective equipment, maintaining appropriate physical distancing, and environmental cleaning and disinfection. When testing is performed, a negative test only indicates an individual did not have detectable infection at the time of testing; individuals might have SARS-CoV-2 infection that is still in the incubation period or could have ongoing or future exposures that lead to infection.

In all institutions, all staff should be screened for fever, respiratory symptoms, or other COVID-related symptoms each time they enter any institution. To the extent possible, the institution should limit staff movement among multiple yards to limit exposure. Additionally, staff who are sick should stay home. Personnel who develop fever, respiratory symptoms, or other COVID-related symptoms should be instructed not to report to work and notify their supervisor.

All Institution Baseline Staff Testing

CDCR is attempting to complete mandatory baseline staff testing (i.e., testing all staff) at all institutions by July 16, 2020. Efforts are being made to prioritize institutions with the highest numbers of laboratory-confirmed staff or inmate cases.

Institutions without COVID-19 Cases (Surveillance Testing)

In institutions that do not have any newly diagnosed COVID-19 cases among inmates or staff within the last 14 days, CDCR will follow CDPH recommendations regarding surveillance testing. The purpose of a surveillance testing strategy is to monitor the spread of the virus in order to isolate the virus and mitigate outbreaks.

Testing of 10 percent of all staff every 14 days including staff from multiple shifts and various locations within the institution will occur. The institution must ensure that a different cohort of staff are tested every 14 days. CDCR expects surveillance testing to be in place at applicable institutions by the July 30, 2020.

In addition, specific testing is recommended for the following groups:

1) All employees who have not had a prior confirmed case of COVID-19 and who are regularly assigned to work in a Correctional Treatment Center, Outpatient Housing Unit, hospice, Psychiatric Inpatient Program, or Mental Health Crisis Bed shall be tested per the SNF testing guidance issued by CDPH, which includes testing 25% of staff every 7 days, to ensure 100% of staff are tested each month.

2) All regularly assigned (i.e. staff assigned five days a week) transportation staff who have not had a prior confirmed case of COVID-19 shall be tested at least once every month, with testing occurring throughout the month.

3) All staff who are regularly assigned to hospital custody coverage and who have not had a prior confirmed case of COVID-19, shall be tested at least once every month, with testing occurring throughout the month.

4) All regularly assigned culinary area staff who have not had a prior confirmed case of COVID-19 shall be tested once every month with testing occurring throughout the month.

Institutions with COVID-19 Cases (Serial Testing)

As soon as possible, after one (or more) COVID-19 positive individual(s) (inmate or staff) is identified in an institution, serial retesting of all staff should be performed every 14 days until no new cases are identified in two sequential rounds of testing. The institution may then resume their regular surveillance testing schedule as outlined above. CDCR expects to be able to implement serial testing at applicable institutions by July 30, 2020.

For institutions that are organized by yard, initial testing can be limited to the yard where the positive inmate is housed or staff is assigned. If there are multiple yards at an institution, and those who have tested positive are clustered in one yard, serial testing should only occur among staff regularly assigned to that yard. It is not necessary to test staff across multiple yards as long as staff are not moving among buildings to provide services.

If there are positive cases across multiple yards at any given institution, all staff across all yards should be tested every 14 days until no new cases are identified in two sequential rounds of testing. The institution may then resume their regular surveillance testing schedule as outlined above.

Staff Testing Results

Staff who are pending a COVID test result:

Staff who are pending a COVID test result and are asymptomatic can continue to work while wearing face coverings and utilizing appropriate PPE. The exception to this is staff returning to their home institution after being redirected to an institution with a COVID outbreak, which is described below. All staff should be screened for fever, respiratory symptoms, or other COVID-related symptoms each time they enter any Institution.

Staff who test positive:

Staff who test positive for COVID-19 and who have had NO symptoms shall be instructed to isolate themselves at home and shall not return to work until the following condition is met:

- At least 10 days have passed since the date of the positive COVID-19 diagnostic (federally approved Emergency Use Authorized molecular assay) test.

Staff who test positive for COVID-19, initially have no symptoms, but then develop symptoms during their 10-day home isolation period may return to work once the following conditions are met:

- At least 10 days have passed since symptoms first appeared; **AND**
- At least 3 days (72 hours) have passed since recovery, defined as resolution of fever without the use of fever-reducing medications; **AND**
- Improvement in respiratory symptoms[1] (e.g., cough and shortness of breath)

Staff should be provided information about how to appropriately isolate within their home. (See Attachment A).

Testing of New Employees or Employees Returning from a Leave of Absence

All new institution-based employees or employees returning from a leave of absence shall be added into the testing cycles referenced above for COVID-19.

Testing off Staff Redirected to Assist with a COVID-19 Outbreak

All staff redirected to assist an institution that has of COVID-19 outbreak (staff or inmate), must be retested with a negative test result before returning to work in their home institution. As of 7/13/2020, this applies to staff redirected to San Quentin State Prison.

[1] It is possible that individuals may still have residual respiratory symptoms despite meeting the criteria to discontinue isolation. These individuals should continue to wear a facemask/cloth face covering when within 6 feet of others until symptoms are completely resolved or at baseline.

Next Steps

CDCR and CCHCS are working to hire a permanent Occupational Health Physician to advise and guide the Department's response to the pandemic, including any adjustments to the staff testing plan. In the interim, CDCR and CCHCS will be securing the services of a Licensed Occupational Medicine Specialist to fill this advisory role until the permanent position is filled. Based on these efforts, CDCR and CCHCS expect updates to this plan in the near future.

This policy is subject to change as CDC and CDPH guidelines are updated as well as PPE availability and testing options change.

Exhibit C

California Department of Corrections and Rehabilitation
COVID-19 Staff Testing Guidance-July 7, 2020

The following applies to all California Department of Corrections and Rehabilitation (CDCR) institutions, except for the California Medical Facility (CMF), Central California Women's Facility (CCWF), and California Health Care Facility (CHCF), identified by the Receiver, which provide skilled nursing level of care. These three institutions should follow the Skilled Nursing Facility (SNF) testing guidance issued by the California Department of Public Health (CDPH). The SNF protocols are currently as follows:

> Regular surveillance testing requires testing 25 percent of staff every 7 days so that 100 percent of staff are tested each month. As soon as possible after one (or more) COVID-19 positive individuals (resident or staff) is identified in a facility, serial retesting of all staff should be performed every 7 days until no new cases are identified in two sequential rounds of testing; the facility may then resume their regular surveillance testing schedule.

Testing does not replace or preclude other infection prevention and control interventions, including monitoring all staff and inmates for signs and symptoms of COVID-19, universal masking by staff and inmates for source control, use of recommended personal protective equipment, maintaining appropriate physical distancing, and environmental cleaning and disinfection. When testing is performed, a negative test only indicates an individual did not have detectable infection at the time of testing; individuals might have SARS-CoV-2 infection that is still in the incubation period or could have ongoing or future exposures that lead to infection.

In all institutions, all staff should be screened for fever, respiratory symptoms, or other COVID-related symptoms each time they enter any institution. If a staff member has possible COVID-related symptoms, the staff member shall be directed to obtain a medical evaluation to determine whether he or she should be tested for COVID-19. To the extent possible, the institution should limit staff movement among multiple yards to limit exposure. Additionally, staff who are sick should stay home. Personnel who develop fever, respiratory symptoms, or other COVID-related symptoms should be instructed not to report to work and notify their supervisor.

All Institution Baseline Staff Testing

CDCR is attempting to complete mandatory baseline staff testing (i.e., testing all staff) at all institutions by July 16, 2020. Efforts are being made to prioritize institutions with the highest numbers of laboratory-confirmed staff or inmate cases.

Institutions without COVID-19 Cases (Surveillance Testing)

In institutions that do not have any newly diagnosed COVID-19 cases among inmates or staff within the last 14 days, CDCR will follow CDPH recommendations regarding surveillance testing. The purpose of a surveillance testing strategy is to monitor the spread of the virus in order to isolate the virus and mitigate outbreaks.

Testing of 10 percent of all staff every 14 days including staff from multiple shifts and various locations within the institution will occur. The institution must ensure that a different cohort of staff are tested every 14 days. CDCR expects surveillance testing to be in place at applicable institutions by the July 30, 2020.

In addition, specific testing is recommended for the following groups:

1) All employees who have not had a prior confirmed case of COVID-19 and who are regularly assigned to work in a Correctional Treatment Center, Outpatient Housing Unit, hospice, Psychiatric Inpatient Program, or Mental Health Crisis Bed shall be tested per the SNF testing guidance issued by CDPH, which includes testing 25% of staff every 7 days, to ensure 100% of staff are tested each month.

2) Employees who have previously tested positive for COVID-19 and since recovered or resolved need only be tested in accordance with Centers for Disease Control's (CDC) recommendations for testing such individuals. Currently, the CDC recommends that individuals who have previously tested positive need not be tested again for at least three months, but that CDC guidance may change.

3) All regularly assigned (i.e. staff assigned five days a week) transportation staff who have not had a prior confirmed case of COVID-19 shall be tested at least once every month, with testing occurring throughout the month.

3) All staff who are regularly assigned to hospital custody coverage and who have not had a prior confirmed case of COVID-19, shall be tested at least once every month, with testing occurring throughout the month.

4) All regularly assigned culinary area staff who have not had a prior confirmed case of COVID-19 shall be tested once every month with testing occurring throughout the month.

NOTE: State may adjust the scope and frequency of staff testing based on community spread data and prevalence of the virus in the community.

Institutions with COVID-19 Cases (Serial Testing)

As soon as possible, after one (or more) COVID-19 positive individual(s) (inmate or staff) is identified in an institution, serial retesting of all staff should be performed every 14 days until no new cases are identified in two sequential rounds of testing. The institution may then resume their regular surveillance testing schedule as outlined above. CDCR expects to be able to implement serial testing at applicable institutions by July 30, 2020.

For institutions that are organized by yard, initial testing can be limited to the yard where the positive inmate is housed or staff is assigned. If there are multiple yards at an institution, and those who have tested positive are clustered in one yard, serial testing should only occur among

staff regularly assigned to that yard. It is not necessary to test staff across multiple yards as long as staff are not moving among buildings to provide services.

If there are positive cases across multiple yards at any given institution, all staff across all yards should be tested every 14 days until no new cases are identified in two sequential rounds of testing. The institution may then resume their regular surveillance testing schedule as outlined above.

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Staff who test positive:

Staff who test positive for COVID-19 and who have had NO symptoms shall be instructed to isolate themselves at home and shall not return to work until the following condition is met:

- At least 10 days have passed since the date of the positive COVID-19 diagnostic (federally approved Emergency Use Authorized molecular assay) test.

Staff who test positive for COVID-19, initially have no symptoms, but then develop symptoms during their 10-day home isolation period may return to work once the following conditions are met:

- At least 10 days have passed since symptoms first appeared; **AND**
- At least 3 days (72 hours) have passed since recovery, defined as resolution of fever without the use of fever-reducing medications; **AND**
- Improvement in respiratory symptoms[1] (e.g., cough and shortness of breath)

Staff should be provided information about how to appropriately isolate within their home. (See Attachment A).

Testing of New Employees or Employees Returning from a Leave of Absence

[1] It is possible that individuals may still have residual respiratory symptoms despite meeting the criteria to discontinue isolation. These individuals should continue to wear a facemask/cloth face covering when within 6 feet of others until symptoms are completely resolved or at baseline.

All new institution-based employees or employees returning from a leave of absence shall be added into the testing cycles referenced above for COVID-19.

Testing off Staff Redirected to Assist with a COVID-19 Outbreak

All staff redirected to assist an institution that has of COVID-19 outbreak (staff or inmate), must be retested with a negative test result before returning to work in their home institution. As of 7/13/2020, this applies to staff redirected to San Quentin State Prison.

Next Steps

CDCR and CCHCS are working to hire a permanent Occupational Health Physician to advise and guide the Department's response to the pandemic, including any adjustments to the staff testing plan. In the interim, CDCR and CCHCS will be securing the services of a Licensed Occupational Medicine Specialist to fill this advisory role until the permanent position is filled. Based on these efforts, CDCR and CCHCS expect updates to this plan in the near future.

This policy is subject to change as CDC and CDPH guidelines are updated as well as PPE availability and testing options change.

Exhibit D

Overview of Testing for SARS-CoV-2
Testing Overview

Updated July 17, 2020 Print

Note: This document is intended to provide guidance on the appropriate use of testing and does not dictate the determination of payment decisions or insurance coverage of such testing for people residing in the United States, except as may be otherwise referenced (or prescribed) by another entity or federal or state agency.

Summary of Changes

Revisions made on July 17, 2020

- Except for rare situations, a test-based strategy is no longer recommended to determine when an individual with SARS-CoV-2 infection is no longer infectious (e.g., to discontinue Transmission-Based Precautions or home isolation)

Revisions were made on July 2, 2020, to:

- Added screening to possible testing types
- Removed examples – please refer to setting specific guidance

This document provides a summary of considerations and current Centers for Disease Control and Prevention (CDC) recommendations regarding SARS-CoV-2 testing strategy. The CDC recommendations for SARS-CoV-2 testing have been developed based on what is currently known about COVID-19 and are subject to change as additional information becomes available.

Recommendations for Viral Testing, Specimen Collection, and Reporting

Authorized assays for viral testing include those that detect SARS-CoV-2 nucleic acid or antigen. Viral (nucleic acid or antigen) tests check samples from the respiratory system (such as nasal swabs) and determine whether an infection with SARS-CoV-2, the virus that causes COVID-19, is present. Viral tests are recommended to diagnose acute infection. Some tests are point-of-care tests, meaning results may be available at the testing site in less than an hour. Other tests must be sent to a laboratory to analyze, a process that may take 1-2 days once received by the lab. Testing the same individual more than once in a 24-hour period is not recommended.

For more information on testing for COVID-19 see the Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens and Biosafety FAQs for handling and processing specimens from possible cases.

Recommendations for Antibody Testing

CDC does not currently recommend using antibody testing as the sole basis for diagnosis of acute infection, and antibody tests are not authorized by FDA for such diagnostic purposes. In certain situations, serologic assays may be used to support clinical assessment of persons who present late in their illnesses when used in conjunction with viral detection tests. In addition, if a person is suspected to have post-infectious syndrome (e.g., Multisystem Inflammatory Syndrome in Children) caused by SARS-CoV-2 infection, serologic assays may be used.

Serologic assays for SARS-CoV-2, now broadly available, can play an important role in understanding the transmission dynamic of the virus in the general population and identifying groups at higher risk for infection. Unlike viral direct detection methods, such as nucleic acid amplification or antigen detection tests that can detect acutely infected persons, antibody tests help determine whether the individual being tested was previously infected—even if that person never showed symptoms.

Categories for SARS-CoV-2 Testing

This document describes five populations for which SARS-CoV-2 testing with viral tests (i.e., nucleic acid or antigen tests) is appropriate:

- Individuals with signs or symptoms consistent with COVID-19
- Asymptomatic individuals with recent known or suspected exposure to SARS-CoV-2 to control transmission
- Asymptomatic individuals without known or suspected exposure to SARS-CoV-2 for early identification in special settings
- Individuals being tested to determine resolution of infection (i.e., test-based strategy for Discontinuation of Transmission-based Precautions, HCP Return to Work, and Discontinuation of Home Isolation)
- Individuals being tested for purposes of public health surveillance for SARS-CoV-2

Generally, viral testing for SARS-CoV-2 is considered to be diagnostic when conducted among individuals with symptoms consistent with COVID-19 or among asymptomatic individuals with known or suspected recent exposure to SARS-CoV-2 to control transmission, or to determine resolution of infection. Viral testing is screening when conducted among asymptomatic individuals without known or suspected exposure to SARS-CoV-2 for early identification, and surveillance when conducted among asymptomatic individuals to detect transmission hot spots or characterize disease trends.

Recommended testing for individuals with signs or symptoms consistent with COVID-19

CDC recommends using authorized nucleic acid or antigen detection assays that have received an FDA EUA to test persons **with** symptoms when there is a concern of potential COVID-19. Tests should be used in accordance with the authorized labeling; providers should be familiar with the tests' performance characteristics and limitations.

Clinicians should use their judgment to determine if a patient has signs or symptoms compatible with COVID-19 and whether the patient should be tested. Most patients with confirmed COVID-19 have developed fever and/or symptoms of acute respiratory illness (e.g., cough) but some infected patients may present with other symptoms (e.g., altered smell or taste) as well. Clinicians are encouraged to consider testing for other causes of respiratory illness, for example influenza, in addition to testing for SARS-CoV-2 depending on patient age, season, or clinical setting; detection of one respiratory pathogen (e.g., influenza) does not exclude the potential for co-infection with SARS-CoV-2. Because symptoms and presentations may be different in children, consider referencing the CDC guidelines for COVID-19 in neonates and for Multisystem Inflammatory Syndrome in Children (MIS-C).

The severity of symptomatic illness due to infection with SARS-CoV-2 may vary from person to person. Among persons with extensive and close contact to vulnerable populations (e.g., healthcare personnel [HCP]), even mild signs and symptoms (e.g., sore throat) of a possible SARS-CoV-2 infection should prompt consideration for testing. Additional information is available in CDC's Interim Guidance on Testing Healthcare Personnel for SARS-CoV-2.

Recommended testing for asymptomatic individuals with known or suspected exposure to SARS-CoV-2 to control transmission

Testing is recommended for all close contacts of persons with SARS-CoV-2 infection. Because of the potential for asymptomatic and pre-symptomatic transmission, it is important that contacts of individuals with SARS-CoV-2 infection be quickly identified and tested.

- In areas where testing is limited, CDC has established a testing hierarchy; refer to the Interim Guidance on Developing a COVID-19 Case Investigation and Contact Tracing Plan for more information.

In some settings, broader testing, beyond close contacts, is recommended as a part of a strategy to control transmission of SARS-CoV-2. This includes high-risk settings that have potential for rapid and widespread dissemination of SARS-CoV-2 or in which populations at risk for severe disease could become exposed. Expanded testing might include testing of individuals on the same unit or shift as someone with SARS-CoV-2 infection, or even testing all individuals within a shared setting (e.g., facility-wide testing).

Recommended testing for asymptomatic individuals without known or suspected SARS-CoV-2 exposure for early identification in special settings

Certain settings can experience rapid spread of SARS-CoV-2. This is particularly true for settings with vulnerable populations in close quarters for extended periods of time.

Local, territorial, tribal, and state health departments can help with informed decision-making about testing at these or other settings. Before testing large numbers of asymptomatic individuals without known or suspected exposure, facility leadership should have a plan in place for how they will modify operations based on test results.

- Approaches for early identification of asymptomatic individuals include, initial testing of everyone in the setting, periodic (e.g., weekly) testing of everyone in the setting, and testing of new or returning entrants into the setting.

Recommended testing to determine resolution of infection with SARS-CoV-2

A test-based strategy, which requires serial tests and improvement of symptoms, could be considered for discontinuing Transmission-based Precautions or allowing HCP to return to work earlier than the symptom-based strategy. However, in most cases, the test-based strategy results in prolonged isolation of patients or work exclusion of HCP who continue to shed detectable SARS-CoV-2 RNA but are no longer infectious. A test-based strategy could also be considered for some individuals (e.g., those who are severely immunocompromised) in consultation with local infectious diseases experts if concerns exist for the individual being infectious for more than 20 days. In all other circumstances, the symptom-based strategy should be used to determine when to discontinue Transmission-Based Precautions or when HCP can return to work.

This strategy is described in the following documents:

- Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings
- Discontinuation of Isolation for Persons with COVID -19 Not in Healthcare Settings
- Assessing Criteria for Return to Work for Healthcare Personnel with Suspected or Confirmed COVID-19

Public health surveillance for SARS-CoV-2

Testing is a fundamental part of the United States SARS-CoV-2 Surveillance Plan, which uses multiple surveillance systems and epidemiology networks to monitor the progression and impact of SARS-CoV-2 spread in the United States.

Tests are used in community, outpatient, and hospital-based surveillance systems to identify cases of SARS-CoV-2 infection. These data help identify areas of ongoing circulation, determine trends in disease by location, provide insight into the impact of the disease over time and by location, and inform disease forecasts.

Last Updated July 17, 2020

Exhibit E

Interim Considerations for SARS-CoV-2 Testing in Correctional and Detention Facilities
Testing in Correctional & Detention Facilities

Updated July 7, 2020

These interim considerations are based on what is currently known about SARS-CoV-2 and COVID-19 as of the date of posting, July 7, 2020.

The US Centers for Disease Control and Prevention (CDC) will update these considerations as needed and as additional information becomes available. Please check the CDC website periodically for updated interim guidance.

Note: This document is intended to provide considerations on the appropriate use of testing and does not dictate the determination of payment decisions or insurance coverage of such testing, except as may be otherwise referenced (or prescribed) by another entity or federal or state agency. CDC is a non-regulatory agency; therefore, the information in this document is meant to assist correctional and detention facilities in making decisions rather than establishing regulatory requirements.

CDC offers considerations for correctional and detention facilities to plan, prepare, and respond to coronavirus disease 2019 (COVID-19). Testing to diagnose COVID-19 is one component of a comprehensive strategy and should be used in conjunction with a number of other prevention and mitigation activities described in the Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities. Testing symptomatic and asymptomatic individuals and initiating medical isolation for suspected and confirmed cases and quarantine for close contacts, can help prevent the spread of SARS-CoV-2, the virus that causes COVID-19, in correctional and detention facilities. This document describes testing strategies for correctional and detention facilities and provides considerations for implementing SARS-CoV-2 testing among persons incarcerated and staff.

Correctional and detention facilities can determine, in collaboration with state and local health officials, whether and how to implement the following proposed testing strategies. Implementation should be guided by what is feasible, practical, and acceptable, and be tailored to the needs of each facility. These considerations are meant to supplement—**not replace**—any state, local, territorial, or tribal health and safety laws, rules, and regulations with which facilities must comply.

Symptom screening and testing are strategies to identify individuals with COVID-19. COVID-19 contact tracing is an effective disease control strategy that involves investigating cases and their contacts—among incarcerated or detained persons (IDP). In the correctional setting this would typically include isolating index cases and placing contacts in quarantine. These strategies must be carried out in a way that protects privacy and confidentiality to the extent possible and that is consistent with applicable laws and regulations.

Any time a positive test result is identified, ensure that the individual is rapidly notified, connected to appropriate medical care, and medical isolation is initiated. Correctional and detention facilities should follow guidance from the Equal Employment Opportunity Commission when instituting and offering testing to staff, and when staff are preparing to return to work.

Types of COVID-19 tests

Viral tests are recommended to **diagnose current infection** with SARS-CoV-2, the virus that causes COVID-19. Viral tests evaluate whether the virus is present in a respiratory sample. Results from viral tests help public health officials identify and isolate people who are infected in order to minimize SARS-CoV-2 transmission.

Antibody tests are used to **detect a past infection** with SARS-CoV-2. CDC does not currently recommend using antibody testing as the sole basis for diagnosing current infection. Depending on when someone was infected and the timing of the test, the test may not find antibodies in someone with a current COVID-19 infection. In addition, it is currently not proven whether a positive antibody test indicates protection against future SARS-CoV-2 infection; therefore, antibody tests should not be used at this time to determine if an individual is immune.

CDC recommendations for SARS-CoV-2 testing are based on what is currently known about the virus. SARS-CoV-2 is new and what is known about it changes rapidly. Information on testing for SARS-CoV-2 will be updated as more information becomes available.

When testing might be needed

This document describes three scenarios when incarcerated or detained persons (IDP) or staff in correctional and detention facilities may need to have an initial SARS-CoV-2 viral test:

- Testing individuals with signs or symptoms consistent with COVID-19
- Testing asymptomatic individuals with recent known or suspected exposure to SARS-CoV-2 to control transmission
- Testing asymptomatic individuals without known or suspected exposure to SARS-CoV-2 for early identification

This document also outlines considerations for planning testing in correctional and detention facilities:

- Practical considerations for implementing broad testing for SARS-CoV-2 in correctional and detention facilities
- Checklist of considerations to help facilities make decisions about how and when to test broadly for SARS-CoV-2

These considerations are intended to provide evidence-based strategies for SARS-CoV-2 testing among IDP and staff who work in correctional and detention facilities. Depending on the context, specific testing considerations may be applied to IDP, correctional staff, or both.

Testing individuals with signs or symptoms consistent with COVID-19

Consistent with CDC's recommendations, individuals with COVID-19 signs or symptoms should be referred to a healthcare provider for evaluation for testing (including staff and IDP):

- One strategy to identify individuals with COVID-19 signs or symptoms is to conduct screenings such as temperature and/or symptom checking. These screenings are one tool correctional and detention facilities can use to help lower the risk of COVID-19 transmission. However, symptom screenings are not helpful for identification of individuals with COVID-19 who may be asymptomatic or pre-symptomatic.
- Symptom screening will also not prevent all individuals with COVID-19 from entering the facility.
- To identify individuals with symptoms, facilities should integrate temperature screening and symptom checking into their standard practices (i.e. IDP at intake, prior to discharge/release, or transfer, daily staff screening, and screening of volunteers and vendors upon entry) of correctional and detention facilities. Screenings should be conducted safely and respectfully and in accordance with any applicable privacy laws and regulations. See guidance on how to conduct screening for symptoms in Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities.

Staff

- All staff with suspected or confirmed COVID-19 should wear cloth face coverings (unless contraindicated), self-isolate at home, connect with appropriate medical care as soon as possible, and follow medical care and instructions.

Incarcerated or detained persons (IDP)

- All IDP with suspected or confirmed COVID-19 should be provided with cloth face coverings (unless contraindicated), be connected to appropriate medical care as soon as possible, and placed in medical isolation until medical care and instructions can be provided.

Testing asymptomatic individuals with recent known or suspected exposure to SARS-CoV-2 to control transmission

Testing is recommended for all close contacts [1] of persons with SARS-CoV-2 infection:

- Because of the potential for asymptomatic and pre-symptomatic transmission, it is important that contacts of IDP or staff with COVID-19 be quickly identified and tested.
- In areas where testing resources are limited, CDC has established a testing hierarchy for close contacts; refer to the Interim Guidance on Developing a COVID-19 Case Investigation and Contact Tracing Plan for more information.
- Contact tracing and case investigation can often be done in collaboration with local public health departments and disease investigation specialists.

Broader testing strategy beyond only close contacts

Congregate living or working conditions, such as correctional and detention facilities, have potential for rapid and widespread transmission of SARS-CoV-2. Performing contact tracing in correctional and detention settings may be resource-intensive and challenging (e.g., the number of close contacts of infected IDP who need to be followed in a housing unit with a dormitory-style sleeping area and shared restrooms and shower units may be large; outside public health staff conducting contact tracing may have limited access to correctional and detention facilities, and it may be necessary to conduct interviews with cases and close contacts over the phone). If contact tracing is not practicable, or if there is concern for widespread transmission following identification of new-onset SARS-CoV-2 infection among IDP or staff, facility management should consider **a broader testing strategy, beyond testing only close contacts within the facility to reduce the chances of a large outbreak.**

Practical considerations for implementing a broader testing strategy should include the availability of resources and the ability to act on results of testing. **The decision about testing strategies in correctional and detention facilities should be made in collaboration with state/local health departments.**

- Depending on facility characteristics and available resources, targeted (e.g., a specific housing unit) or facility-wide testing should be considered if a single IDP or staff member in the facility tests positive for COVID-19. Individuals testing positive on entry should be placed immediately into medical isolation and provided medical care. This circumstance would not trigger further widespread testing.

Quarantine and additional testing for close contacts

All persons who are close contacts to someone with COVID-19 (e.g., IDP and staff assigned to the housing unit where someone tested positive for SARS-CoV-2) should be provided with cloth face coverings (unless contraindicated), and the IDP should be placed in quarantine for 14 days after their last exposure.

Staff

Workers in critical infrastructure sectors may be permitted to work if asymptomatic after potential exposure to a confirmed case of coronavirus disease 2019 (COVID-19), provided the worker was not a close contact, and that worker infection prevention recommendations and controls are implemented. The staff member should wear a cloth face covering (unless contraindicated) at all times while in the workplace for 14 days after the last exposure (if not already wearing one due to universal use of cloth face coverings). Accordingly, management should consider requiring asymptomatic staff who have been identified as a close contact of a confirmed case to home quarantine to the maximum extent possible, while understanding the need to maintain adequate staffing levels of critical workers. If the contacted staff test positive, they should follow local health department and health care provider directions regarding isolation.

Incarcerated or detained persons (IDP)

If the IDP contact is tested for SARS-CoV-2 and tests positive, the IDP contact should be placed in medical isolation. Because correctional and detention facilities may not have enough space to provide an individual cell for each quarantined IDP, they may need to form cohorts of quarantined IDP who were exposed to SARS-CoV-2 at the same time. Some IDP in a quarantined cohort may be infected but not show symptoms or may not test positive. Infected persons may transmit SARS-CoV-2 to others

several days before the onset of symptoms, or even if they never develop symptoms. To prevent continued transmission of the virus within a quarantined cohort of people, re-testing of IDP who originally tested negative every 3 to 7 days could be considered. The specific re-testing interval that a facility chooses could be based on:

- The stage of the ongoing outbreak (i.e., more frequent testing in the context of escalating outbreaks, less frequent testing when transmission has slowed)
- The availability of testing supplies and capacity of staff to perform repeat testing without negatively impacting other essential health care services
- Financial resources to fund repeat testing, including procurement of testing supplies, laboratory testing services, and personal protective equipment (PPE)
- The capacity of on-site, contract laboratories or public health laboratories that will be performing the tests
- The expected wait time for test results (and resulting capacity for timely action based on the results)

Place any IDP who tests positive under medical isolation. If an IDP who tested positive was part of a quarantine cohort, restart the 14-day quarantine clock for the remainder of the cohort. See detailed guidance on recommendations for how to organize quarantine and medical isolation in correctional and detention settings in Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities.

Limitations of re-testing strategy include:

- Facilities may not have staff and testing capacity to organize testing of large number of IDP on a serial basis.
- Long waiting times for receiving large numbers of tests results may make frequent re-testing strategy impractical to implement.
- Frequent re-testing may cause the need for prolongation of the quarantine for the entire cohort if one individual is tested positive, and it may become challenging to find space to quarantine individuals in correctional or detention facilities.
- Frequent re-testing may become burdensome for IDP and increase proportion of individuals who refuse to be tested.

Practical considerations for implementing re-testing of quarantined individuals should include the availability of space, resources, potential limitations of this strategy and the ability to act on results. The decision about frequency of re-testing in correctional and detention facilities should be made in collaboration with state/local health departments.

Testing asymptomatic individuals without known or suspected exposure to SARS-CoV-2 for early identification

Correctional and detention facilities may consider testing asymptomatic individuals without known or suspected SARS-CoV-2 exposure in communities with moderate to substantial levels of community transmission. Practical considerations for implementing this strategy include the availability of resources, the results, and the ability for a coordinated response. The decision about testing strategies in correctional and detention facilities should be made in collaboration with state/local health departments. These testing strategies aim to reduce the risk of introducing SARS-CoV-2 into the correctional and detention setting (i.e., testing newly incarcerated or detained persons) and to reduce the risk of widespread transmission through early identification of infection among existing IDP and staff. Facilities in communities with moderate to substantial levels of community transmission can **consider** the following:

- Initial testing of all current IDP and all new IDP at intake before they join the rest of the population in the facility.
- Housing new IDP individually while test results are pending to prevent potential transmission. Some facilities may choose to implement a "routine intake quarantine" in which new IDP are housed separately for 14 days before being integrated into general housing.
- Testing for COVID-19 and reviewing results before transferring anyone to another facility or release, particularly if an IDP will transition to a congregate setting with persons at increased risk for severe illness from COVID-19. Refer to Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities for more information about transfer and release recommendations. Before an individual's projected transfer or release date, consider implementing a transfer, or release planning protocol (ideally in single cells) for 14 days to prevent COVID-19 from spreading to other facilities or the community.

Practical considerations for implementing broad-based testing for SARS-CoV-2 in correctional and detention facilities

For more information on testing procedures please see Performing Broad-Based Testing for SARS-CoV-2 in Congregate Settings.

Checklist of considerations to assist facilities in their decision-making process about how and when to test broadly for SARS-CoV-2

- ✓ Work with state/local health departments to help inform decision-making about broad-based testing in correctional and detention facilities.
- ✓ If a facility decides to implement broad-based testing, use viral tests with Emergency Use Authorization from FDA, and ensure that the manufacturers' instructions regarding sample collection and transport are strictly followed to maximize accuracy of results. Work with state/local health departments and laboratories to choose appropriate tests and needed supplies.
- ✓ If pursuing broad-based testing, strongly consider a program that includes testing for both IDP and staff.
  - SARS-CoV-2 infections or COVID-19 cases have been initially identified among staff in a number of facilities, before any cases appear among incarcerated or detained persons.
  - Because staff move between the facility and the community daily, the risks of introducing infection into the facility from the community and/or bringing infection from the facility back into the community is ongoing.
  - If there are operational, contractual, and/or legal reasons to refrain from testing staff within the facility or concerns about using facility resources/personnel to test staff, investigate options to work with community partners or state/local health departments to implement staff testing.

Planning for how the facility will modify operations based on test results

- Identify additional isolation spaces that can be used to house infected individuals identified during testing and additional quarantine spaces to house their close contacts. Consideration should also be made for isolation/quarantine spaces to meet other security or medical needs (e.g., Special Housing Unit, medical beds, mental health beds, Protective Custody, etc.)
- Given the potential for high numbers of asymptomatic infections, ensure that plans include isolation options to house large numbers of infected individuals and quarantine options to house large numbers of close contacts. For example, consider how the facility's housing operations could be modified for multiple test result scenarios (e.g., if testing reveals that 10%, 30%, 50% or more of incarcerated or detained persons test positive for COVID-19).
- Questions to consider and address in a testing plan for IDP include:
  - Will specific housing units/pods be designated for people who test positive?
  - How will the facility manage those who decline testing?
  - How often will broad-based testing be conducted? What will be the threshold/indicator for repeat testing?
  - If testing reveals that more IDP are positive than negative, will those who test negative be reassigned to different housing (rather than reassigning those who test positive)?
  - How will housing areas be systematically and thoroughly cleaned and disinfected if large numbers of positive individuals are identified and housing units are rearranged?
  - How will the facility manage the logistics of moving large numbers of people into different housing arrangements? (For example, where will incarcerated or detained individuals go while the housing units are being cleaned and disinfected, and how will positive and negative individuals be separated during this time?)
  - Will the facility use a test-based strategy or a time-based strategy to release asymptomatic infected persons from medical isolation? A test-based strategy or symptom-based strategy to release symptomatic infected persons from medical isolation? If choosing a test-based strategy, are adequate testing supplies and laboratory capacity available

medical isolation? If choosing a test-based strategy, are adequate testing supplies and laboratory capacity available to support the additional testing required? Will the facility use a mixed strategy (e.g., time-based/ symptom-based for most, but reserving the test-based strategy for those who are immunocompromised)?

- Who will report testing results to local or state health departments as required by state and local public health laws?

- If testing staff:
  - Can the employer legally mandate testing for staff? If not, how will the employer encourage testing? How will the employer manage staff who decline testing?
  - What entity will perform the testing, and how will results be reported to the employer and employee?
  - Who will report testing results from staff to local or state health departments as required by state and local public health laws?
  - How will adequate staffing levels be maintained if a large percentage of staff test positive? (See Guidance for Critical Infrastructure Workers.)
  - Will the health care provider (HCP) use a test-based strategy or a time-based strategy to determine when asymptomatic, infected staff can discontinue isolation and return to work?

Footnote

[1]Based on current knowledge, an individual is considered a close contact of someone with COVID-19 if they
a) have been within 6 feet of an infected person for at least 15 minutes starting from 48 hours before illness onset (or starting from 48 hours before the first positive test if asymptomatic) until the time the infected person meets criteria to end medical isolation or
b) have had direct contact with infectious secretions from someone with COVID-19 (e.g., have been coughed on) and were not wearing recommended PPE at the time of contact. Close contact can occur while caring for, living with, visiting, or sharing a common space with someone with COVID-19. Determination of close contact does not change if the infected individual is wearing a mask or cloth face covering.

Last Updated July 7, 2020

Exhibit F

CDCR/CCHCS COVID-19 Employee Status

Current number of active staff cases: 899

Updated July 23, 2020

Locations	Cumulative Confirmed		Staff Returned to Work
Avenal State Prison (ASP)	92		43
California City Correctional Facility (CAC)	10		4
Calipatria State Prison (CAL)	53		24
California Correctional Center (CCC)	10		7
California Correctional Institution (CCI)	112		17
Central California Women's Facility (CCWF)	15		6
Centinela State Prison (CEN)	72		22
California Health Care Facility (CHCF)	43		16
California Institution for Men (CIM)	112		68
California Institution for Women (CIW)	30		22
California Men's Colony (CMC)	6		2
California Medical Facility (CMF)	15		3
California State Prison, Corcoran (COR)	48		14
California Rehabilitation Center (CRC)	53		29
Richard A. McGee Correctional Training Center, Galt (CTC)	8		5
Correctional Training Facility (CTF)	2		2
Chuckawalla Valley State Prison (CVSP)	66		59
Deuel Vocational Institution (DVI)	10		2
Folsom State Prison (FSP)	5		4
High Desert State Prison (HDSP)	13		8
Ironwood State Prison (ISP)	105		76
Kern Valley State Prison (KVSP)	34		5
California State Prison, Los Angeles County (LAC)	63		46
Mule Creek State Prison (MCSP)	4		2
North Kern State Prison (NKSP)	94		15
Pelican Bay State Prison (PBSP)	7		2
Pleasant Valley State Prison (PVSP)	10		3
Richard J. Donovan Correctional Facility (RJD)	25		8
California State Prison, Sacramento (SAC)	9		8
Substance Abuse Treatment Facility (SATF)	25		8

Sierra Conservation Center (SCC)	7		2
California State Prison, Solano (SOL)	12		0
San Quentin State Prison (SQ)	251		78
Salinas Valley State Prison (SVSP)	14		2
Valley State Prison (VSP)	20		2
Wasco State Prison (WSP)	35		13
Northern California Youth Correctional Center (NCYCC)	5		2
OH Close Youth Correctional Facility (OH Close)	4		1
NA Chaderjian Youth Correctional Facility (NAC)	2		1
Ventura	1		1
CDCR/CCHCS Worksite Location —Los Angeles County	7		5
CDCR/CCHCS Worksite Location—Kern County	3		0
CDCR/CCHCS Worksite Location—Sacramento County	19		4
CDCR/CCHCS Worksite Location—San Bernardino County	8		2
CDCR/CCHCS Worksite Location —San Diego County	1		0
CDCR/CCHCS Worksite Location — San Joaquin County	2		2
CDCR/CCHCS Worksite Location – Santa Barbara County	1		0
CDCR/CCHCS Worksite Location – Stanislaus County	1		0
STATEWIDE TOTAL	**1544**		**645**

There have been three COVID-related staff deaths:
May 30 — staff member from California Rehabilitation Center
June 3 — staff member from Ironwood State Prison
July 13 — staff member from North Kern State Prison

Exhibit G

CDCR PATIENTS: CONFIRMED COVID-19 AND OUTCOMES

CONFIRMED — *Total Confirmed:* **7,313** — *New In Last 14 Days:* **1,035**

ACTIVE, IN CUSTODY	RELEASED WHILE ACTIVE	RESOLVED	DEATHS
1,975	202	5,094	42

Institution	Active in Custody	New In Last 14 Days
SQ	870	153
CCI	270	195
CCC	252	200
ASP	112	114
CIW	86	81
WSP	80	84
CIM	77	62
CRC	66	75
CVSP	50	0
ISP	31	11
CAL	20	22
CEN	17	10
COR	9	6
LAC	7	7
NKSP	7	2
HDSP	4	0
CHCF	3	1
CMF	3	3
KVSP	3	3
CCWF	2	2
FSP	1	1
PVSP	1	1
RJD	1	1
SAC	1	0

Institution	Released While Active
SQ	43
ASP	39
CIM	31
CCI	23
CCC	17
CVSP	17
WSP	17
CRC	9
CAL	3
ISP	2
LAC	1
CAC	0
CCWF	0
CEN	0
CHCF	0
CIW	0
CMC	0
CMF	0
COR	0
CTF	0
DVI	0
FSP	0
HDSP	0
KVSP	0

Institution	Resolved
SQ	1,197
CVSP	982
ASP	910
CIM	895
CRC	261
CCC	231
CIW	163
COR	154
LAC	127
CCI	84
WSP	31
CEN	16
ISP	16
CMC	11
SAC	4
NKSP	3
SVSP	3
CAC	1
CAL	1
FSP	1
SATF	1
SCC	1
SOL	1

Institution	Deaths
CIM	19
SQ	15
ASP	4
CVSP	2
CIW	1
COR	1
CAC	0
CAL	0
CCC	0
CCI	0
CCWF	0
CEN	0
CHCF	0
CMC	0
CMF	0
CRC	0
CTF	0
DVI	0
FSP	0
HDSP	0
ISP	0
KVSP	0
LAC	0

SELECTED FILTER: Active In Custody

Data Last Updated: Jul 23 2020 5:46PM

Confirmed | Confirmed Table View | Testing | Trended | Trended Table View | Institution View | Definitions | Version History

Exhibit H

PAGES 1 - 47

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

BEFORE THE HONORABLE JON S. TIGAR, JUDGE

MARCIANO PLATA, ET AL.,	)	
	)	
PLAINTIFFS,	)	NO. C-01-1351 JST
	)	
VS.	)	THURSDAY, MAY 21, 2020
	)	
GAVIN NEWSOME, ET AL.,	)	OAKLAND, CALIFORNIA
	)	
	)	FURTHER CASE MANAGEMENT
	)	CONFERENCE
DEFENDANTS.	)	
_____	)	

REPORTER'S TRANSCRIPT OF TELEPHONIC PROCEEDINGS

APPEARANCES:

FOR PLAINTIFFS:
PRISON LAW OFFICE
1917 FIFTH STREET
BERKELEY, CALIFORNIA 94710
BY: DONALD H. SPECTER, ESQUIRE
STEVEN FAMA, ESQUIRE
ALISON HARDY, ESQUIRE

FOR DEFENDANTS:
HANSON, BRIDGETT LLP
425 MARKET STREET, 26TH FLOOR
SAN FRANCISCO, CALIFORNIA 94105
BY: PAUL B. MELLO, ESQUIRE
SAMANTHA WOLFF, ESQUIRE

(APPEARANCES CONTINUED)

REPORTED BY:
DIANE E. SKILLMAN, CSR 4909, RPR, FCRR
OFFICIAL COURT REPORTER

TRANSCRIPT PRODUCED BY COMPUTER-AIDED TRANSCRIPTION

FOR DEFENDANTS:		DEPARTMENT OF JUSTICE OFFICE OF THE ATTORNEY GENERAL 455 GOLDEN GATE AVENUE, STE. 11000 SAN FRANCISCO, CALIFORNIA 94102
	BY:	DAMON G. MCCLAIN, DEPUTY A.G.
FOR INTERVENOR CCPOA:		MESSING ADAM & JASMINE, LLP 235 MONTGOMERY STREET, STE. 828 SAN FRANCISCO, CALIFORNIA 94104
(LISTENING)	BY:	GREGG M. ADAM, ESQUIRE
		CALIFORNIA CORRECTIONAL PEACE OFFICERS ASSOCIATION 755 RIVERPOINT DRIVE STE. 200 SACRAMENTO, CALIFORNIA 95605
(LISTENING)	BY:	DAVID A. SANDERS, ESQUIRE
FOR RECEIVER CLARK KELSO:		FUTTERMAN DUPREE DODD CROLEY MAIER 601 MONTGOMERY STREET, STE. 333 SAN FRANCISCO, CALIFORNIA 94111
	BY:	MARTIN H. DODD, ESQUIRE
ALSO PRESENT:		CLARK KELSO, RECEIVER

LET ME START WITH SOMETHING THAT I THINK IS A REAL POSITIVE, AND THAT IS TESTING. I APPRECIATE THE EFFORTS THAT THE DEFENDANTS MADE TO ANSWER THE COURT'S QUESTIONS REGARDING TESTING. I UNDERSTAND THAT CERTAIN INFORMATION SIMPLY WAS NOT AVAILABLE TO THEM. I THINK THAT FOR NOW I HAVE ENOUGH INFORMATION ABOUT THAT TOPIC, AND I'M GLAD THAT THE STATE'S EFFORTS TO PROVIDE THE RECEIVER WITH THE TESTS HE NEEDS HAVE PAID OFF.

I SEE THAT THE PLAINTIFFS NOTE THAT THERE IS NOW A DELTA BETWEEN THE TESTS THAT THE RECEIVER HAS ACCESS TO AND THE TESTS THAT THE RECEIVER WILL NEED GIVEN THE INTAKE LEVELS THAT ARE FORECAST AND SO FORTH. I'M GOING TO ALLOW THE RECEIVER TO THINK ABOUT WHAT HE WANTS TO DO WITH THOSE TESTS. I DON'T ANTICIPATE MAKING ANY ORDERS TODAY, AND THAT'S REALLY ALL I HAVE TO SAY ON THE SUBJECT OF TESTING.

MR. SPECTER, DO YOU WANT TO ADD ANYTHING?

MR. SPECTER: WELL, I WAS THINKING, ACTUALLY, NOW THAT THEY HAVE MORE TESTS AVAILABLE FOR A SMALLER POPULATION THAT THEY -- THAN THEY ANTICIPATED, WHETHER MR. KELSO WAS CONSIDERING USING SOME OF THOSE TESTS TO TEST THE STAFF.

AND THE REASON THAT IS, BECAUSE AS YOU PROBABLY HAVE SEEN THROUGH OUR CASE MANAGEMENT STATEMENT AND THE COVID TRACKER, THE VIRUS IS SPREADING AMONG INSTITUTIONS WHILE THE PRISONER POPULATION HAS BEEN LOCKED DOWN. SO IT SEEMS THAT THE VECTOR OF -- FUSION OF -- OR TRANSMISSION OF THE VIRUS IS RELATED TO

THE EMPLOYEES WHO COME IN AND OUT OF THE PRISON.

SO I WAS WONDERING WHAT MR. KELSO'S VIEWS ON THAT WERE.

THE COURT: WELL, THAT'S A GOOD QUESTION. BEFORE I TURN TO MR. KELSO OR ASK HIM TO RESPOND TO THAT, IS THERE ANYTHING, MR. MELLO OR MS. WOLFF, THAT THE DEFENDANTS WANT TO SAY ON THIS SUBJECT?

MR. MELLO: NO. I THINK YOUR HONOR'S STATEMENTS THAT THE RECEIVER SHOULD BE ALLOWED TO THINK ABOUT THAT AND CONSULT WITH US ON THAT MAKES SENSE TO US, YOUR HONOR.

THE COURT: MR. KELSO, WOULD IT BE APPROPRIATE FOR ME JUST TO ASK YOU TO RESPOND NEXT WEEK, GIVE THE PARTIES AN OPPORTUNITY TO MAKE WHATEVER PROPOSALS THEY WANT TO YOU FOR YOU TO CONSULT WITH YOUR STAFF AND -- I'M GOING TO COME BACK TO THE SUBJECT OF PUBLIC HEALTH EXPERTISE IN JUST A MOMENT.

WOULD IT BE APPROPRIATE FOR ME TO ASK YOU TO RESPOND TO THE PARTIES AND THEN WE CAN TAKE THAT UP NEXT WEEK?

MR. KELSO: YES, YOUR HONOR.

THE -- WE AGREE THAT AT THIS POINT THE MOST SIGNIFICANT RISK OF EXPOSURE COMES FROM STAFF. A COUPLE OF THOUSAND TESTS CERTAINLY DOESN'T GIVE US THE ABILITY TO TEST STAFF EVERYWHERE WE WOULD NEED TO. BUT IT MAY GIVE US THE OPPORTUNITY TO TEST STAFF AT SPECIFIED HIGH-RISK INSTITUTIONS, FOR EXAMPLE, OR AT THE BEGINNING OF WHAT MAY BE AN OUTBREAK.

AND MY STAFF IS ALREADY THINKING ABOUT ALONG THOSE LINES AS WELL AS WHETHER WE CAN TAKE -- AND IT MAY BE RELATED TO

THIS -- WHETHER WE CAN TAKE SOME ADDITIONAL STEPS TO PROTECT PATIENTS AT INSTITUTIONS WHERE OUTBREAKS MAY BE BEGINNING WHEN IT COMES TO -- OR DORMS, MORE PRECISELY, WHEN IT COMES TO EMPLOYEE COHORTING. THAT'S AN AWFUL TERM FOR WHAT I'M TRYING TO DESCRIBE HERE. I THINK --

(SIMULTANEOUS COLLOQUY)

THE COURT: I APPRECIATE YOUR --

MR. KELSO: -- IN THE CASES.

THE COURT: WHAT YOU ARE REFERRING TO IS THE IDEA THAT THERE SHOULD BE -- WHEN YOU SAY "EMPLOYEE COHORTING," THAT AN INDIVIDUAL STAFF MEMBER SHOULD INTERACT WITH AS FEW INMATES AS POSSIBLE OR -- MAYBE THAT'S NOT THE BEST WAY OF SAYING THAT, BUT THAT INMATES -- ACTUALLY, PROBABLY THE BETTER WAY IS, EACH INMATE SHOULD INTERACT WITH THE SAME STAFF MEMBERS AT A GIVEN ROLE OR POSITION TO THE GREATEST EXTENT POSSIBLE.

THAT'S WHAT YOU MEAN?

MR. KELSO: YES, YOUR HONOR. YOU HAVE STATED IT BETTER THAN I DID.

THE COURT: OKAY.

MR. KELSO: AND WE ARE STARTING TO THINK ABOUT THAT.

THE COURT: THESE TESTS -- IT MAY BE THAT MR. SPECTER'S SUGGESTION IS A GOOD ONE AND IT'S THE RIGHT ONE, AND IT SOUNDS LIKE MR. KELSO IS ALREADY THINKING ABOUT THAT. I WILL COME BACK TO THIS TOPIC IN JUST A SECOND.

Exhibit I

AMEND
CHANGING CORRECTIONAL CULTURE

Berkeley Public Health

Urgent Memo

COVID-19 Outbreak: San Quentin Prison

June 13, 2020

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

Background

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

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

Urgent needs and immediate actions required:

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

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

Minimum Recommended Leadership Team Positions:

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

- **Healthcare – Custody Coordination Leader.** This position would focus on partnering with Custody (and working closely with the Staff Healthcare Liaison Leader, described below) to review current housing on a daily basis, and to determine the appropriate way to cohort and house residents including developing quarantine areas (in partnership with the Environment of Care Leader). This position would also be responsible for ensuring that appropriate testing is done prior to any transfer of residents to other state facilities or to the community.

- **COVID-19 Testing Leader.** This position would be responsible for coordinating with the testing center (at this moment QUEST Diagnostics) including reaching out through public and private sources and coordinating with the state and local departments of public health to improve testing turnaround time, running the list with medical staff (and the Epidemiologist, described below) on a daily basis to determine who has – and who needs – testing, and coordinating contact tracing in response to testing results and reporting of symptoms throughout the facility.

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

sources of staff-to-staff infections such as shared vanpools. This position would also track daily staff movements in order to assist with contact tracing when needed.

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

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

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

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

- **Reception center** which currently houses ~500 persons. In the reception Center's "Badger Unit" where people from CIM were transferred, the fear and outrage are palpable – people are yelling throughout the housing unit due to discontent about the COVID-19 situation including intake of inmates from CIM and loss of privileges (thereby increasing the risk of COVID-19 spread throughout the tiers via respiratory droplets). It is hard to imagine that violent incidents will not erupt at some point soon further threatening the safety and health of residents and staff alike.

- **The Gymnasium**, which has been converted to a dorm. There is little to no ventilation in the housing unit creating high-risk for a catastrophic super spreader event. At a minimum, the gymnasium beds should be spread out more to ensure additional distance between residents and the second set of doors in the gymnasium dorm must be opened to ensure air turnover which may necessitate a second officer station for security reasons. This unit should be prioritized for closure if sufficient population reduction can be achieved.

- **HVAC - in all units above and in other housing areas** there is an immediate need to clean and turn on all fan and HVAC systems immediately (North Block, Gymnasium, Dorms) in order to maximize air exchange and ventilation as soon as possible – ideally in the next few days. Of note, the exhaust pumps and filters appear dirty on visual inspection, and require clearing and cleaning. Since maximizing ventilation and air exchange decreases COVID-19 transmission, doors and windows should be opened as much as possible (some have been welded shut - and must be remediated). If opening doors makes it difficult for officers to do their jobs then we would recommend that officer stations be rearranged or new ones set up so as to improve air exchange. Note that the important aspect is *air exchange*, not only the movement of air within the room. Fans that blow air around may help cool people, but they don't decrease rebreathing aerosols unless they filter the air or increase air exchange (diluting the aerosol).

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

   - **Liaise with testing laboratory to streamline testing,** including exploring observed self-collection of samples and alternate anatomic sites of testing (e.g. saliva, nares swabs)

   - **Improve testing turnaround time at QUEST or go through other laboratories that will be able to improve turnaround time (5-6 days or more is completely unacceptable).** As an example, CMC was able to respond rapidly to their outbreak with a turnaround testing time of 24 hours at some points in the outbreak. Large-scale testing with rapid receipt of results is essential to allow the medical team to minimize community spread. If tests are sent to

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

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

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

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

- **Of note, because testing time is so slow, little to no contact tracing can happen. Furthermore, patients cannot be appropriately housed based on test results when these results return 6 days later as a patient may have been exposed in the interim.** As a result, *entire units are put on lockdown status for the span of a quarantine*. In the long term, as this pandemic will last at least another year and likely longer, this will threaten long term goodwill between residents and staff and have profound mental health consequences for the population and staff alike.

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

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

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

Some suggestions for additional Quarantine and Medical Isolation space below:

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

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

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

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

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

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

For more information:

https://amend.us/covid

Exhibit J

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

Report | July 20, 2020

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

AMEND CHANGING CORRECTIONAL CULTURE
Berkeley Public Health

Note on Report

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

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

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

Source: Amend's Covid in California Prisons Program. https://amend.us/amends-covid-in-california-prisons-program/

Table of Contents

Purpose of this Assessment

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

We achieve this through the following guiding questions:

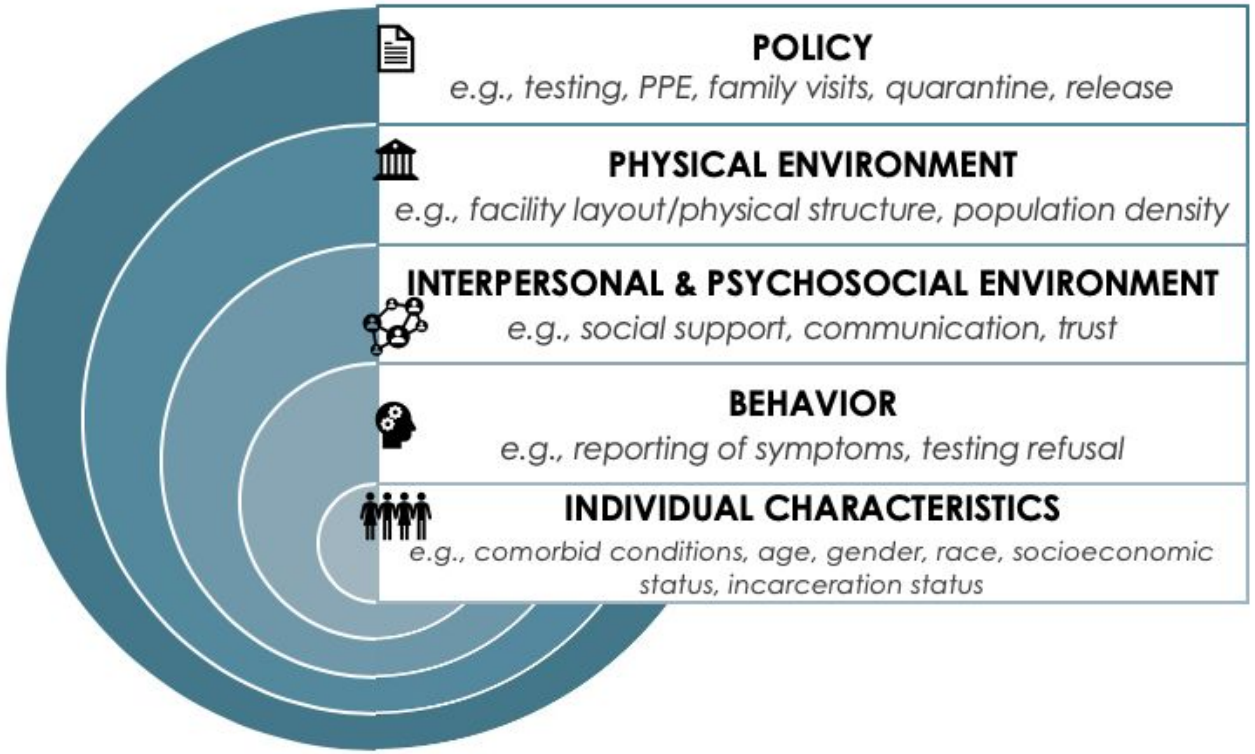
1. How was the April-May 2020 COVID-19 outbreak at California Men's Colony (CMC) contained?

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

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

Background: Guiding Health Framework

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



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

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

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

Background: Incarceration and Health

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

Incarcerated persons are at increased risk for:

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

Sources:
Massoglia, M., & Remster, B. (2019). Linkages between incarceration and health. *Public Health Reports, 134*(1_suppl), 8S-14S.
Incarceration and health: A family medicine perspective. American Academy of Family Physicians. (April 2017)[Accessible at: https://www.aafp.org/about/policies/all/incarcerationandhealth.html#statistics]

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

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

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

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

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

Background: Incarceration and COVID-19 in US

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

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

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

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

Between March 31-June 6, 2020:

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

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

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

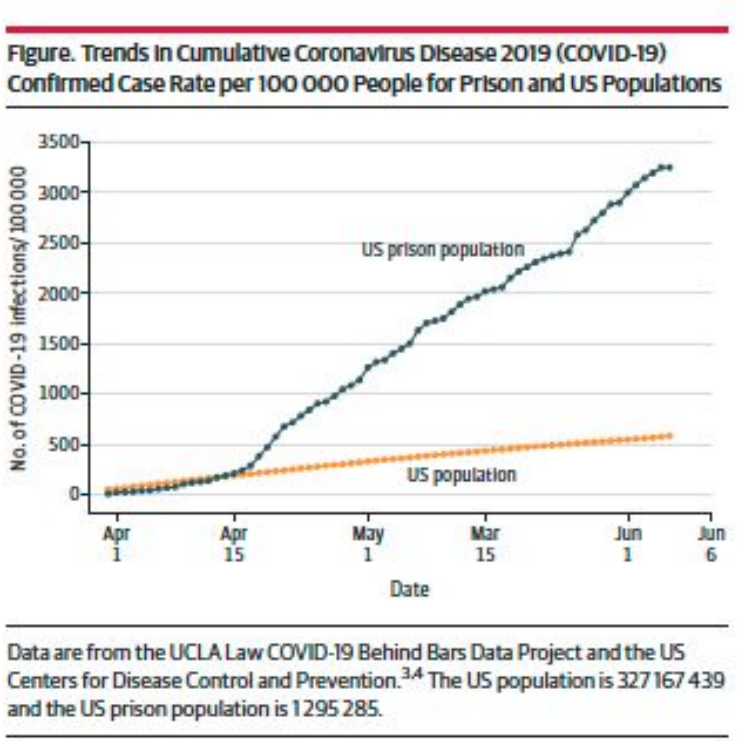


Figure 3: COVID-19 risk was initially lower in prisons but surpassed the US population on April 14, 2020. The mean daily case growth was 8.3% per day in prisons and 3.4% per day in the US population.

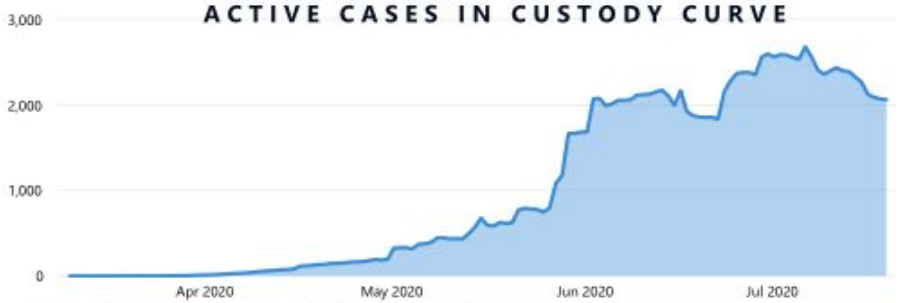
Source: Saloner, B., Parish, K., Ward, J. A., DiLaura, G., & Dolovich, S. COVID-19 Cases and Deaths in Federal and State Prisons. *JAMA*.

Background: Incarceration and COVID-19 in CA

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

CONFIRMED CASES: Cumulative Count

NEW IN LAST 14 DAYS	ACTIVE		RESOLVED	DEATHS
	CUSTODY	RELEASED		
1,322	2,058	185	4,683	39



*Patients who released while active, resolved, or died are not included in graph above.
Active case count by date may be delayed 2-3 days while awaiting test results.

On July 20, 2020:

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

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

CONFIRMED CASES : Rate Comparison

Cumulative Per 1,000 People

CDCR	California	United States
63.7	4.7	7.0

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

CONFIRMED CASES - COMPARISON Per 1,000 People

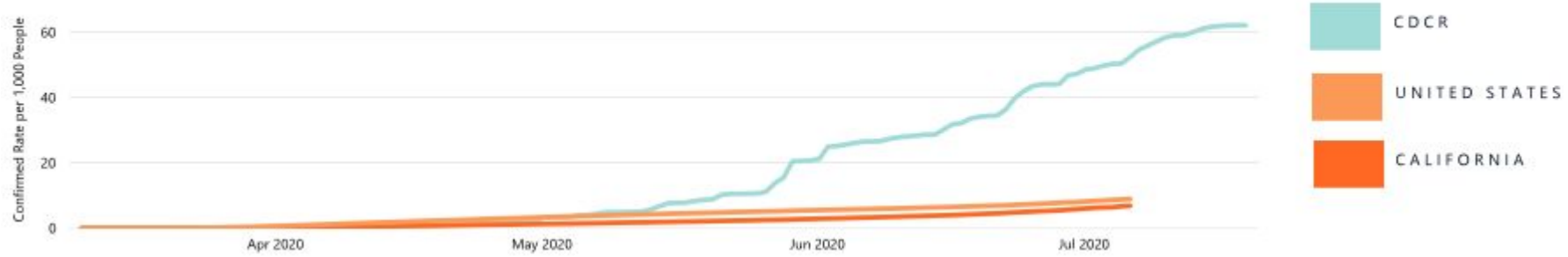


Figure 4: COVID-19 cases per 1,000 people incarcerated in CDCR far exceeds cases per 1,000 in the general California population as well as across the US

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

Background: Incarceration and COVID-19 Why is it so much worse?

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

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

Source: Preparedness, prevention, and control of COVID-19 in prisons and other places of detention: Interim guidance. World Health Organization. Regional Office for Europe. (March 15 2020)[Accessible at: https://www.euro.who.int/__data/assets/pdf_file/0019/434026/Preparedness-prevention-and-control-of-COVID-19-in-prisons.pdf?ua=1s]

Glossary: Key Terms & Critical Knowledge Gaps

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

Active Case	Modes of Transmission	Social Distancing
Recovered Case	Tests	Quarantine
Contact	Contact Tracing	Medical Isolation

Key Terms: Case Classification

Term	Definition	Critical Knowledge Gaps as of July 20, 2020
Active Case		SARS-CoV-2 transmission from pre-symptomatic and asymptomatic cases makes clear the importance of implementing measures that prevent spread by people who may be infectious and not be aware of their infection without testing ("silent spreaders"). Critical knowledge gaps include: • The relative proportions of pre-symptomatic, asymptomatic, and symptomatic SARS-CoV-2 among new infections • The relative infectiousness of symptomatic, pre-symptomatic, and asymptomatic persons (likelihood that they will infect others) • Relative efficacy of public health interventions that prevent pre/asymptomatic transmission (e.g., if pandemic is driven by undetected asymptomatic SARS-CoV-2 infections, new techniques in disease detection/prevention – i.e., beyond contact tracing, mass testing, and isolation of asymptomatic contacts – may be needed)
Symptomatic case	SARS-CoV-2 detected with symptom onset	
Pre-symptomatic case	SARS-CoV-2 detected before symptom onset	
Asymptomatic case	SARS-CoV-2 detected but symptoms never develop	

Resolved Case	SARS-CoV-2 infection resolved as assessed through either a *test-based strategy* (e.g., serial negatives) or *symptom-based strategy* (e.g., 10 days since symptoms first appeared & 24+ hours have passed *since last* fever without the use of fever-reducing medications & symptoms have improved)	• Test-based strategy is contingent on the availability of ample testing supplies and laboratory capacity as well as convenient access to testing
		• Determination of the resolution of clinical COVID-19 disease via the symptom-based strategy does not provide information on the duration of infectiousness, which could theoretically extend past the symptomatic period.
		• Knowledge of SARS-CoV-2 immunity among previously infected persons is needed:
		  ○ How long does protective immunity last?
		  ○ Does asymptomatic or mild SARS-CoV-2 infection confer full or partial immunity?
		  ○ Is it possible to be immune from reinfection but still asymptomatically transmit SARS-CoV-2 while in a carrier state (i.e., resolved and infectious)?

Sources:

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

Discontinuation of Isolation for Persons with COVID-19 Not in Healthcare Settings. Centers for Disease Control and Prevention. 2020 Jul 16. ttps://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html.

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

Key Terms: Contact

Term	Definition	Critical Knowledge Gaps as of July 20, 2020
Contact: characterized by proximity and duration		
Physical contact	Direct person-to-person contact	• Relative importance of varying levels of contact given confluence of other factors (e.g., population density, duration of exposure, air exchange)
Close contact	Contact of less than 6 ft for approximately 15 minutes or greater	
Proximate contact	Contact of greater than 6 ft in the same room for an extended period of time	

Source: Public Health Guidance for Community-Related Exposure. Centers for Disease Control and Prevention. 2020 Jul 16. https://www.cdc.gov/coronavirus/2019-ncov/php/public-health-recommendations.html

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

Key Terms: Modes of SARS-CoV-2 Transmission

Term	Definition	Critical Knowledge Gaps as of July 20, 2020
Direct: an infectious agent is transferred from a reservoir to a susceptible host by direct contact or droplet spread.		• Relative importance of droplet vs. vehicle vs. airborne spread in SARS-CoV-2 transmission in various settings • The frequency of airborne transmission • How often and why superspreading events occur
Contact	Occurs through direct person-to-person contact	
Droplet	Spray with relatively large, short-range aerosols produced by sneezing, coughing, or even talking. Droplet spread is classified as direct because transmission is by direct spray over a few feet, before the droplets fall to the ground	
Indirect: refers to the transfer of an infectious agent from a reservoir to a host by suspended air particles or inanimate objects (vehicles)		
Airborne	Smaller, longer-range aerosols nuclei that remain suspended in the air for long periods of time and blow over greater distances	
Vehicles	Vehicles (food, objects) that may passively carry a pathogen	

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

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

Key Terms: Testing Approaches

Term	Definition	Critical Knowledge Gaps as of July 20, 2020
Tests		
Viral RNA Tests	Identifies active COVID-19 case by detecting SARS-CoV-2 viral RNA at the moment specimen was taken	• Under what circumstances is individual vs. pooled (combining patient specimens in order to clear the entire group with one negative test or subsequently test the entire group if pooled results are positive) testing preferred to speed up and reduce cost of testing in prison settings? • Viral antigen tests confer advantages in speed of testing, but have decreased accuracy relative to viral RNA tests - under what circumstances would each test be available/preferred? • While antibody tests identify previous COVID-19 disease, what is their accuracy over what period of time (recent data suggests that antibodies wane in many individuals within a couple of months of infection. Does prior infection confer immunity? And if so, for how long? • Data on false negative rates post-exposure for a given testing type are still emerging, which will help to elucidate how early after exposure a test can reliably detect a positive case
Viral Antigen Tests	Identifies active COVID-19 case by detecting presence of viral protein at the moment specimen was taken	
Antibody Tests	Detects antibodies a person's immune system has made in response to the virus, indicating whether a person had been previously infected with COVID-19	

Source: Contact Tracing. Centers for Disease Control and Prevention. 2020 Jul 16. https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/contact-tracing.html
Note: *Information on this slide is dated as of July 20, 2020. Given the evolving knowledge of COVID-19, more accurate and up to date information may be available.*

Key Terms: Prevention and Control

Term	Definition	Critical Knowledge Gaps as of July 20, 2020
Contact Tracing	Technique used by health professionals to prevent the spread of infectious disease. In general, contact tracing involves identifying people who have an infectious disease (cases) and their contacts (people who may have been exposed) and working with them to interrupt disease transmission.	• Relative proportion of pre-symptomatic and asymptomatic cases who may be infectious and not be aware absent testing.
Social Distancing	Limiting face-to-face contact by keeping adequate space (~6 ft) between oneself and other people who are not from your "household" in both indoor and outdoor spaces. Should be practiced in combination with other everyday preventive actions to reduce spread of COVID-19, including wearing masks, avoiding touching face with unwashed hands, and frequently washing hands with soap and water for 20+ seconds.	• How many people constitute a "household"? (e.g., to what extent is social distancing possible in various environments and what are the highest risk situations where social distancing would have the largest impact (e.g., cells, dorms, showers, commissary) • No evidence about how much physical distancing measures within a shared living environment (e.g., pods within a shared dormitory) confer protection
Quarantine	Separates and restricts movement of people with credible exposure to determine COVID-19 status for quarantine period of up to 14 days	• Effectiveness of quarantine relies on (1) timing and accuracy of quarantine period, (2) capacity to follow quarantine procedure (without significantly exacerbating risk for other adverse health outcomes), (3) ability to quarantine individually, and (4) if a group is in quarantine together, ability to rapidly detect and isolate any infectious individuals • Current evidence to inform quarantine is limited and COVID-19 infection trends raise critical questions regarding implementation effectiveness
Medical Isolation	Separates people who have tested positive of COVID-19 from those who have not	• Risk of spread from probable cases of COVID-19 absent testing • Accuracy/availability of testing to identify positive cases

Sources:
Social Distancing. Centers for Disease Control and Prevention. 2020 Jul 16. https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/social-distancing.html
Is a 14-day quarantine effective against the spread of COVID-19?. The Centre for Evidence-Based Medicine. University of Oxford. 2020 Jul 20. https://www.cebm.net/covid-19/is-a-14-day-quarantine-effective-against-the-spread-of-covid-19/
Note: *Information on this slide is dated as of July 20, 2020. Given the evolving knowledge of COVID-19, more accurate and up to date information may be available.*

Pressing Takeaways and Why They Matter

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

1. **What is the relative importance of different modes of transmission in prisons?**
   - The World Health Organization released a statement acknowledging airborne (aerosol) transmission
   - Airborne transmission is serious threat in prisons and jails for superspreader events
   - The greater the potential for airborne transmission in a prison, the more critical the need for decarceration

2. **What is the relative proportion of pre-symptomatic, asymptomatic, and symptomatic SARS-CoV-2 among new infections?**
   - Some evidence that pre-symptomatic and asymptomatic cases account for nearly half of active cases in prisons
   - If pandemic driven by undetected asymptomatic infections, then current practices (e.g., verbal symptom screening, contact tracing) - while necessary - will be entirely insufficient to prevent and control spread in prisons
   - Bolsters critical need for decarceration

3. **Can people who have recovered from COVID-19 experience re-infection?**
   - Some evidence suggests that people who have recovered from COVID-19 are testing positive again
   - Resolved cases may not have protective immunity, which means incarcerated people and staff/custody could be re-infected and continue to spread the virus
   - Bolsters critical need for regular testing and decarceration

Methods: Data Sources

1. **Literature Review**
   Best practices for COVID-19 prevention and control

2. **Interviews with key stakeholders**
   E.g., Warden, CDCR's Public Health Officer, Receiver

3. **Group discussions**
   San Luis Obispo (SLO) Public Health Department (June 10, 2020)
   CMC administration
   Inmates Councils (East and West)
   The Gold Coats Program

4. **Direct observation and physical space assessment at CMC**
   Visit: June 11, 2020

5. **CDCR Administrative Reports & Records**

About California Men's Colony: Physical Infrastructure

East "cells" - Est. 1961

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

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

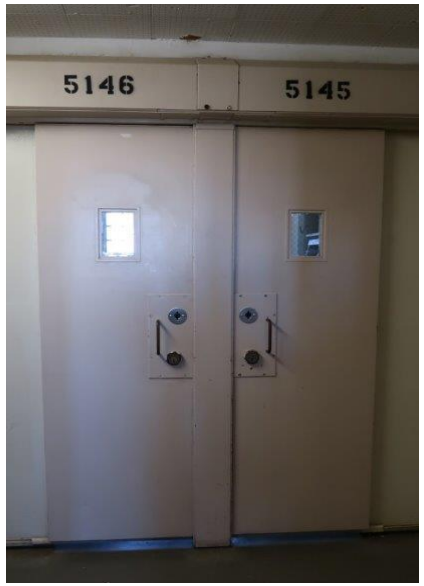


Figure. *Closed-door, single-unit cells in Medical Isolation area in Building C5*

West "dorms" - Est. 1954

Four independent facilities: E, F, G, M

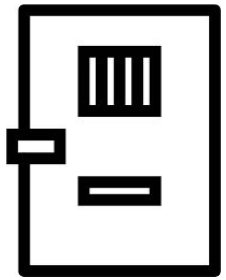
- Dormitories with approx. 30-50 individuals per unit with pods 6' apart comprised of max. 4 bunk beds each
- Security: Level I and II

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

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

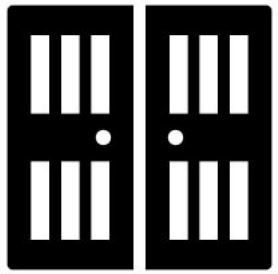
A Note on Physical Infrastructure in Prisons

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



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

Single or double occupancy cells with grilled doors and windows, which are located on solid-floor tiers



Single or double occupancy cells with grilled doors and no windows, located on solid-floor tiers

Small dorms (<100 individuals)

Large dorms (>100 individuals)

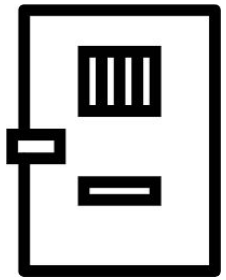
Multiple open tiers of cells with grilled or perforated metal doors and common airspace

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

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

About California Men's Colony: Physical Infrastructure

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



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

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

Small dorms (<100 individuals)

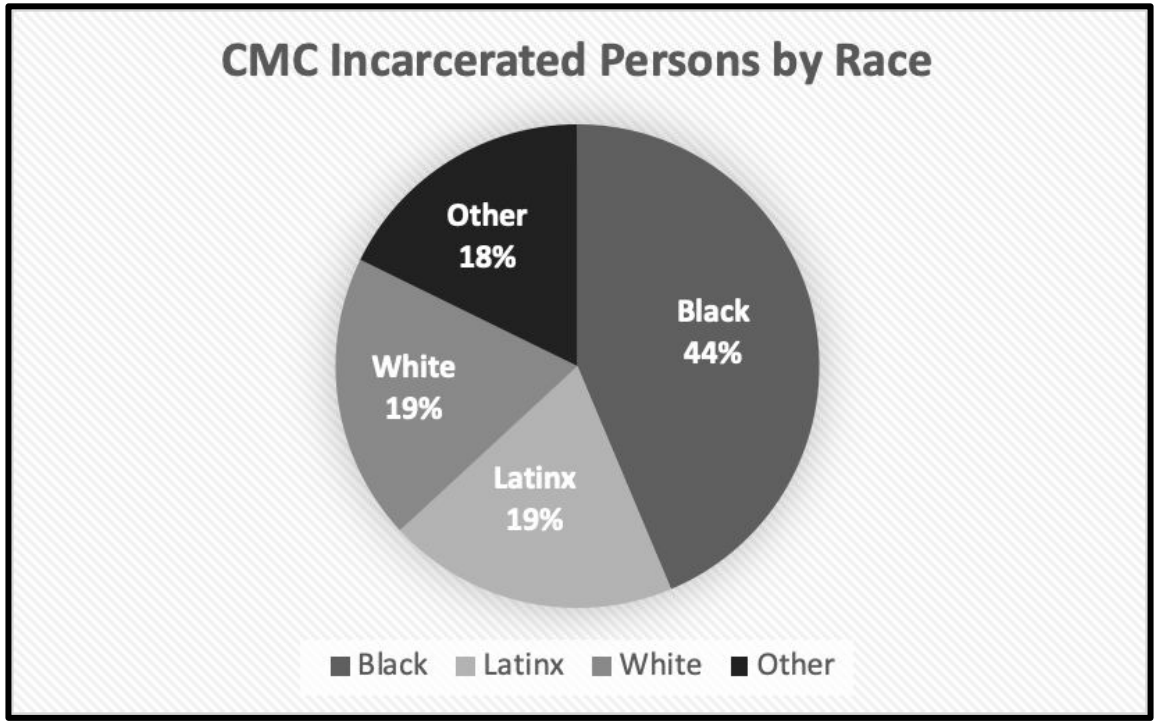
Relative likelihood of onward COVID-19 transmission within the unit*

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

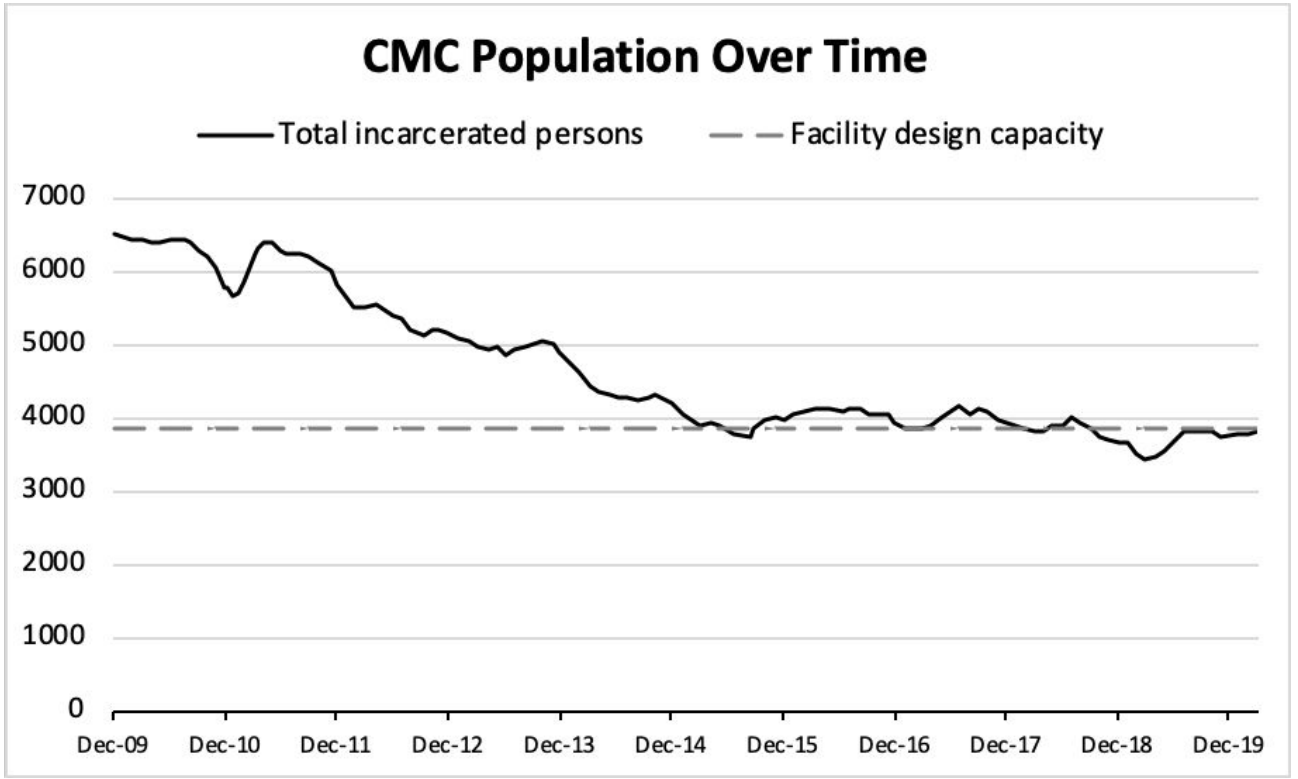
About California Men's Colony: Incarcerated People

Demographics of People Incarcerated at CMC:

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



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



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

About California Men's Colony: Incarcerated People

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

Characteristics of people incarcerated at CMC:

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

Population General Medical Risk Profile

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

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

Source: CDCR Dashboard, October 2019
*CDCR internal reporting June 2020; Rates are subject to change.

About California Men's Colony: Incarcerated People

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

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

Risk score, developed by CCHCS Quality Management Unit, computed by summing scores **(score = #)** across all persons with the following:
Age 65+ **(score = 4)**; pregnant **(1)**; moderate-severe persistent asthma **(1)**; cancer **(2)**; diabetes **(1)**; high-risk diabetes **(1)**; heart disease **(1)**; high-risk heart disease **(1)**; HIV/AIDS **(1)**; poorly controlled HIV/AIDS **(1)**; immunocompromised **(2)**; BMI 40+ **(1)**; on hemodialysis **(1)**; advanced liver disease **(2)**; having any of the following chronic conditions [hypertension, coccidioidomycosis, connective tissue disorder, dementia/Parkinson's disease, endocrine disorder, MS, Myasthenia Gravis, neurologic disorder, vasculitis] **(1)**
Data from **July 10, 2020**

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

About California Men's Colony: Staff/Custody

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

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

Characteristics of CMC Staff/Custody:

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

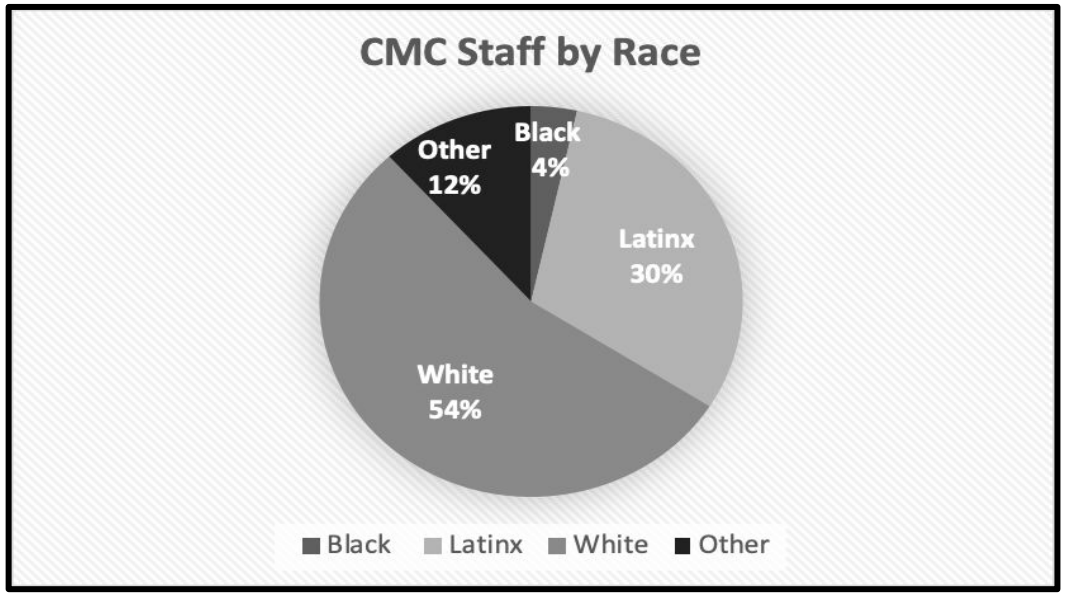


Figure. *CMC staff racial breakdown*

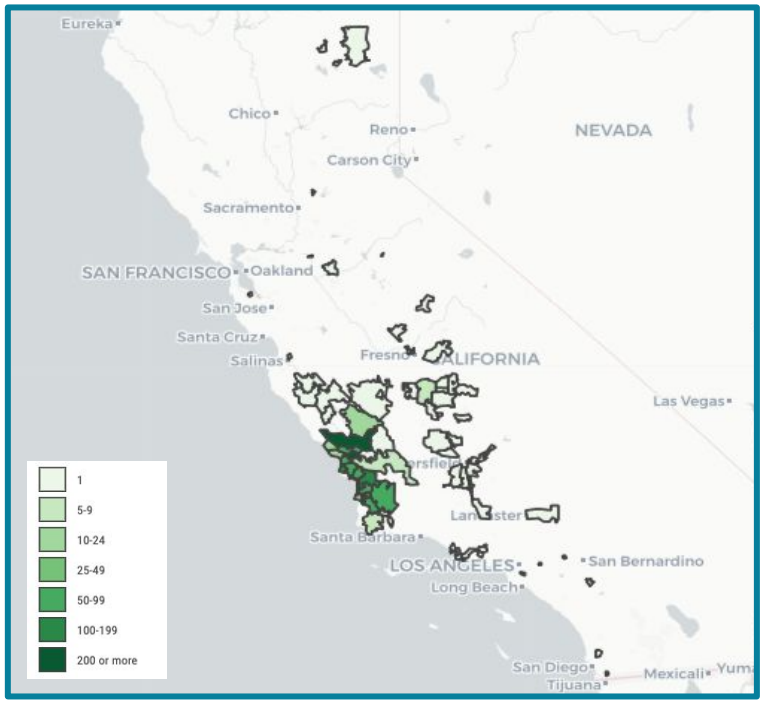


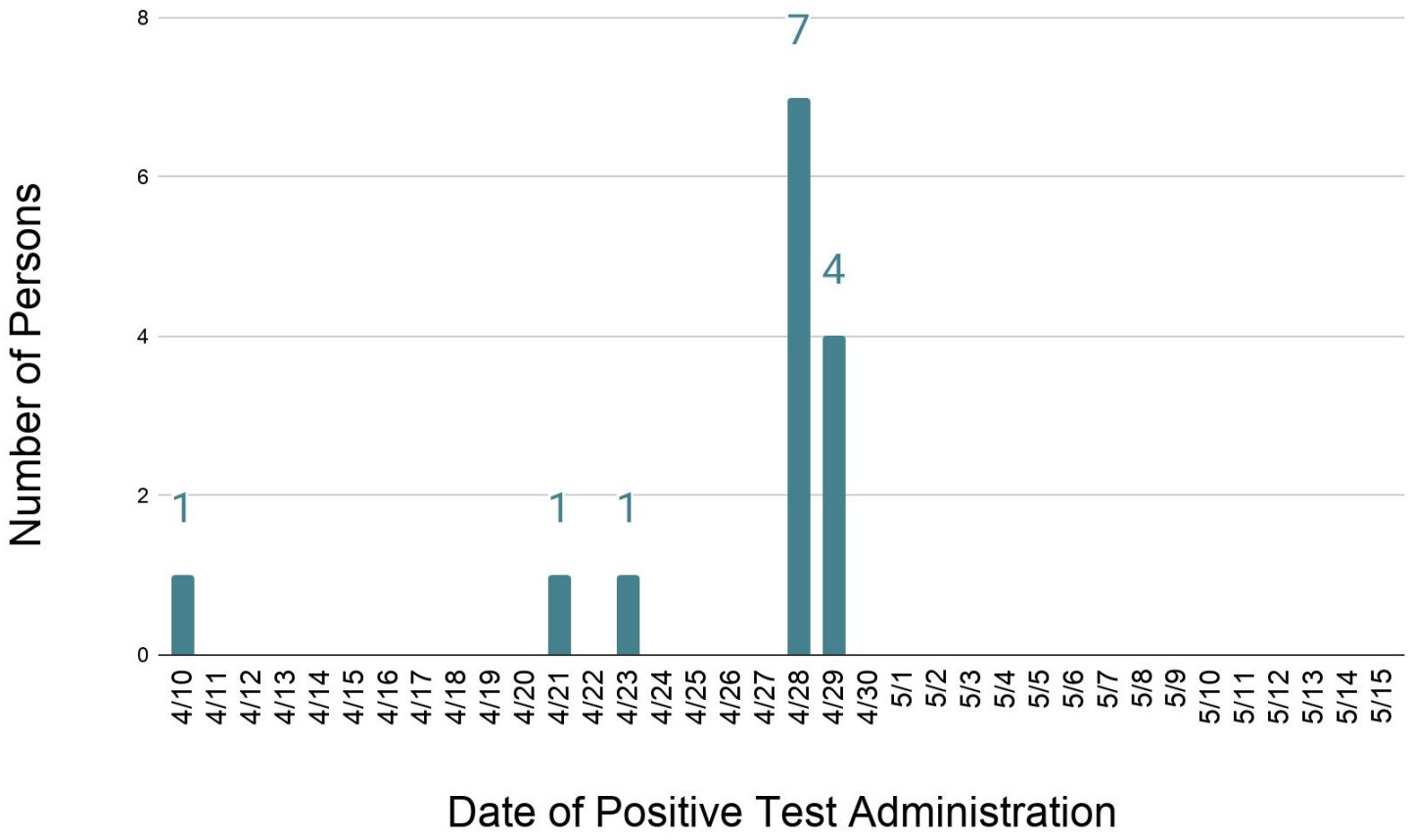
Figure. *Concentration of CMC staff by county of residence*

Staff/custody live and commute from various counties

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

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

Outbreak Characterization: Epidemic Curve



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

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

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

Source: San Luis Obispo County Department of Public Health

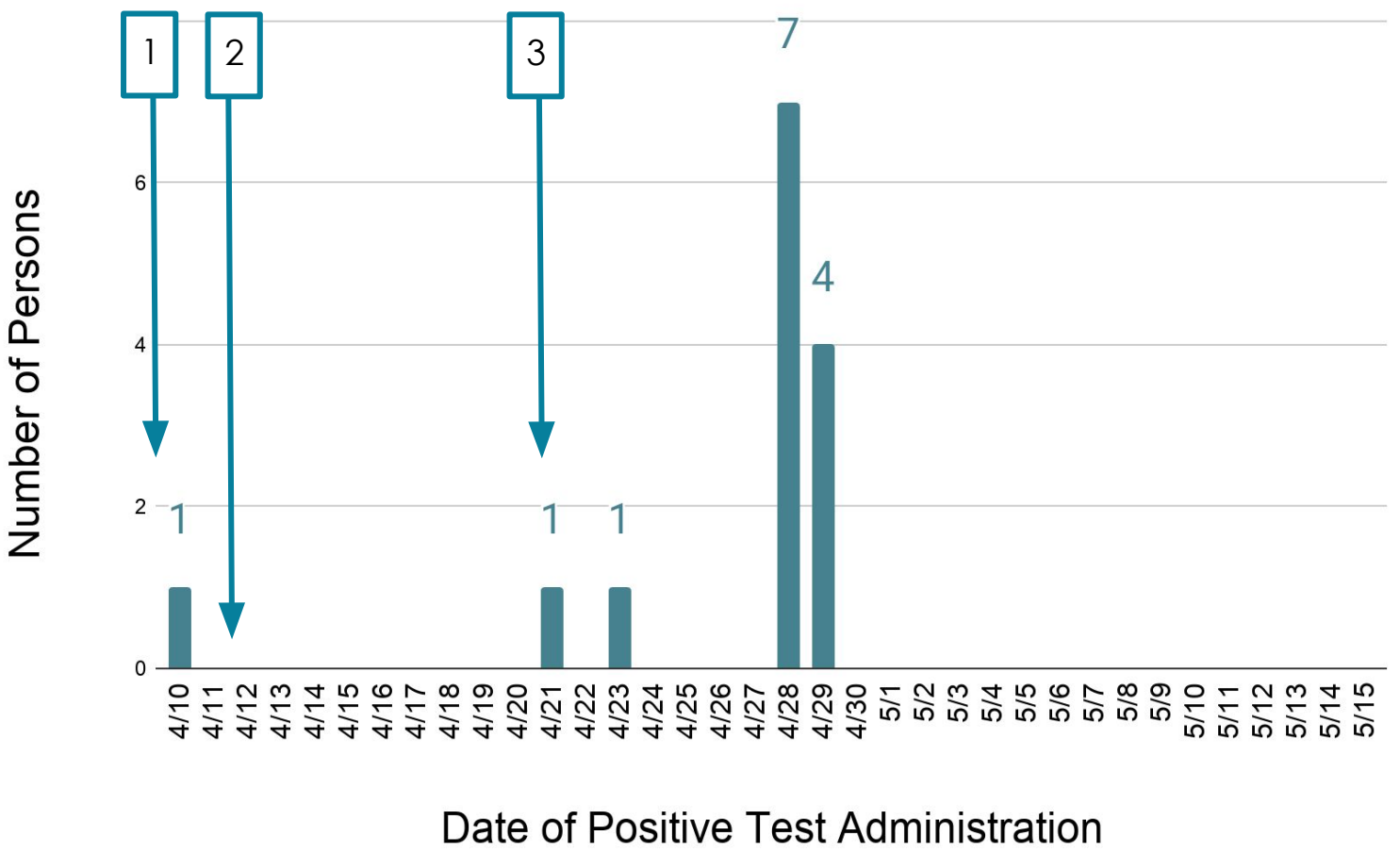
Outbreak Characterization: Introductions

1. **Person returning from court, previously at LA County Jail (East)**
   - April 6: Entered CMC and placed in isolation on C5, L1
   - April 10: Symptom onset and test collected
   - April 11: First positive test
   - April 24: Second positive test collected (result on April 28)
   - No epidemiologically linked onward transmission, but cannot rule out this possibility

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

3. **Symptomatic incarcerated person (East)**
   - Resided on C5, L3
   - April 21: Test collected
   - April 22: First positive test
   - Epidemiologically linked to 12 additional cases
     - 9 among incarcerated persons
     - 2 among custody
     - 1 among healthcare staff

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



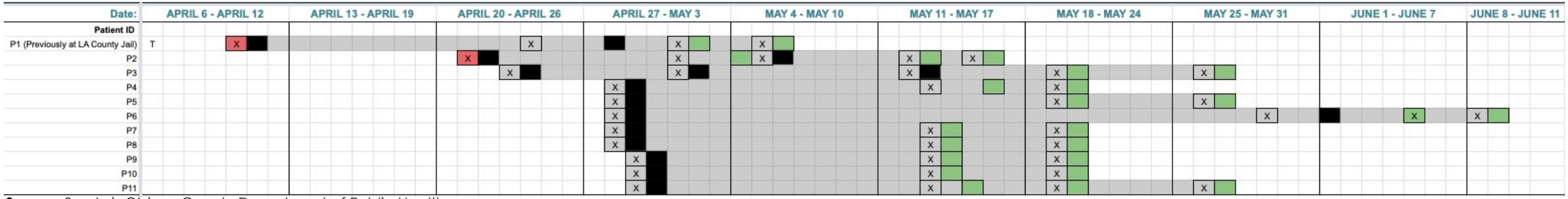
Outbreak Characterization: Testing Timeline for Positive Cases [April - June 2020]

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

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

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

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



Source: San Luis Obispo County Department of Public Health

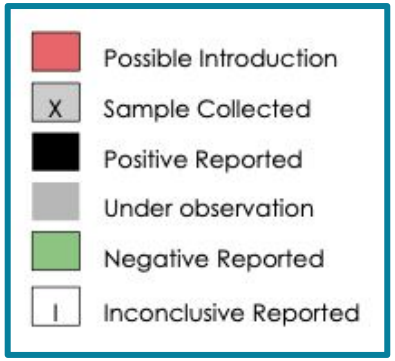


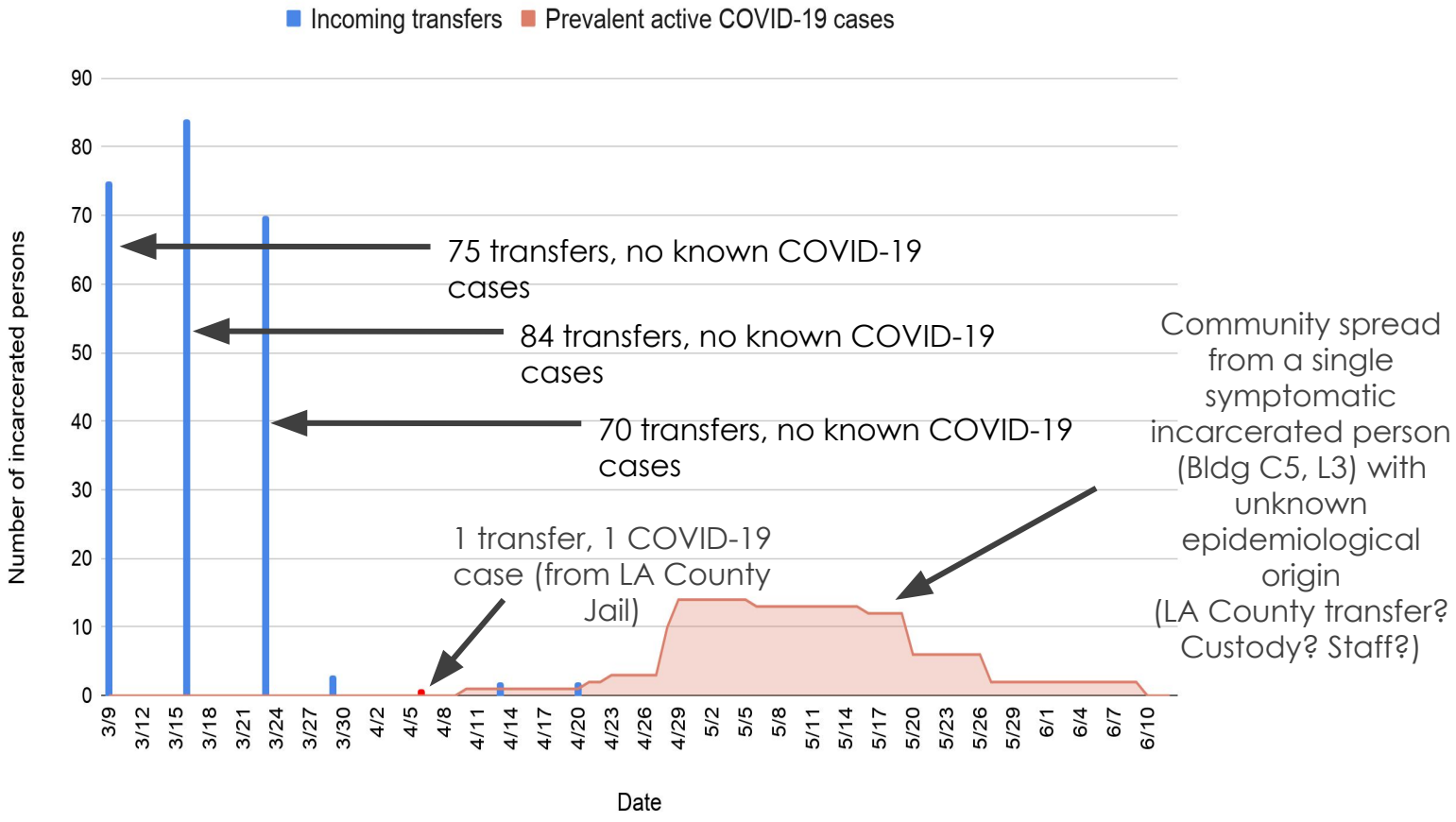
Figure: This timeline illustrates the testing process for positive cases among people incarcerated at CMC over the course of the outbreak. For example, row 1 documents the testing experience of the person returning from court and previously at LA County Jail. They arrived at CMC on April 6, 2020 and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

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

Onward Transmission with ~24 Hour Testing Turnaround

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

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

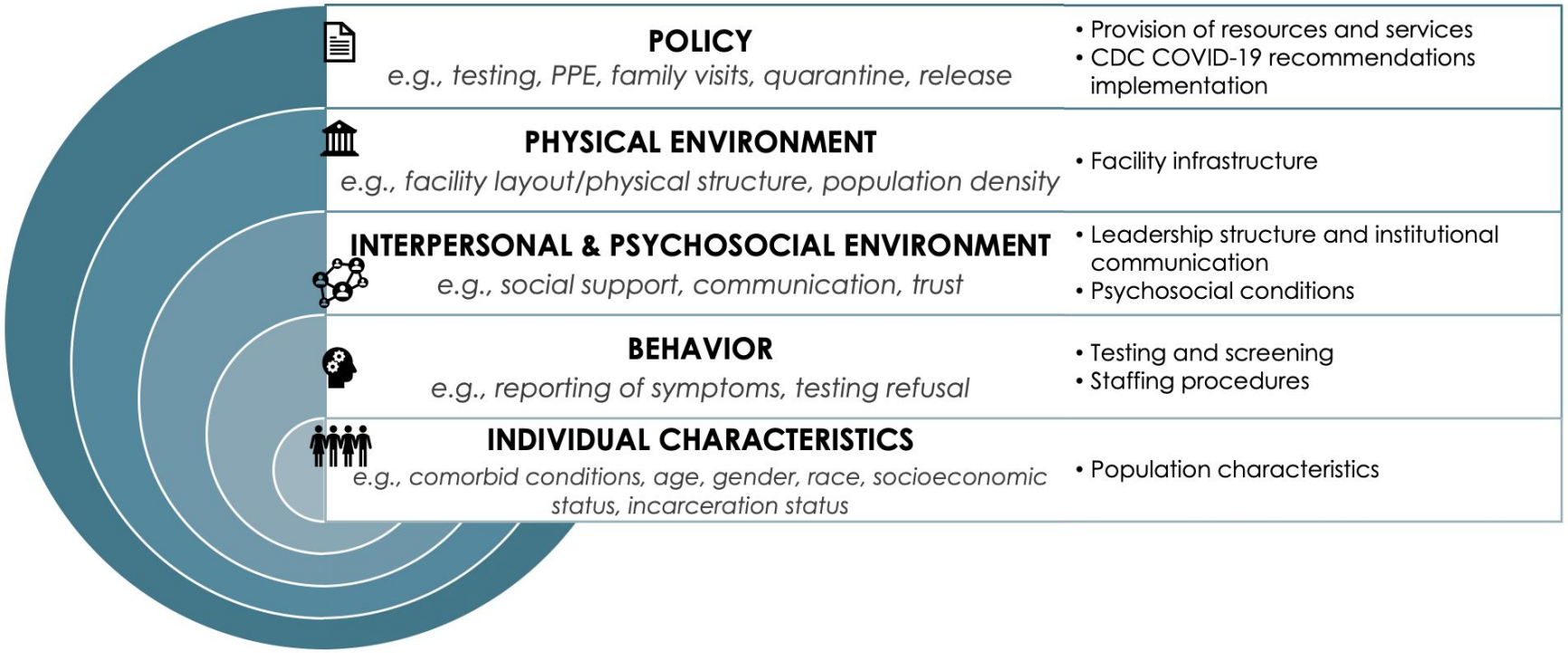


Source: CMC Medical

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

CMC Prevention and Control Efforts

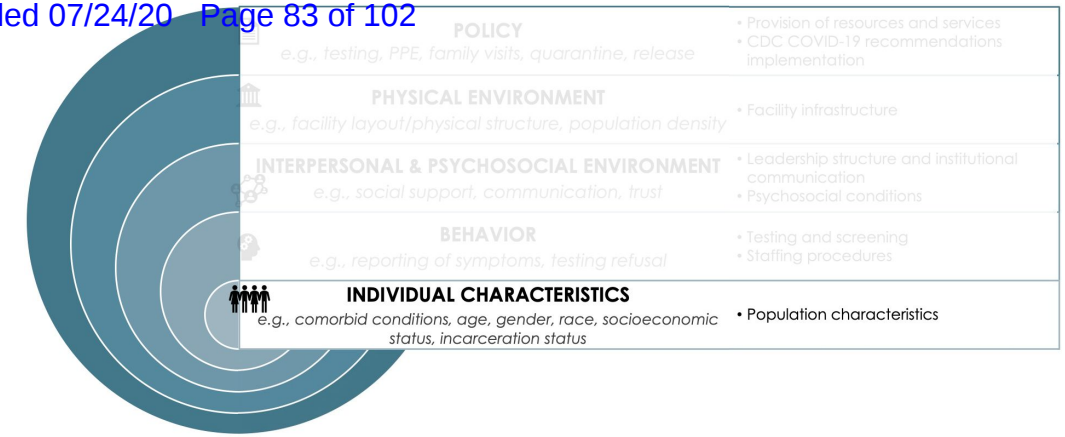
In this section, we examine the outbreak in the context of the **eight dimensions** of our guiding framework to understand, '*How was the April-May 2020 COVID-19 outbreak at CMC contained?*'



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

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

CMC Prevention and Control Efforts: Takeaways

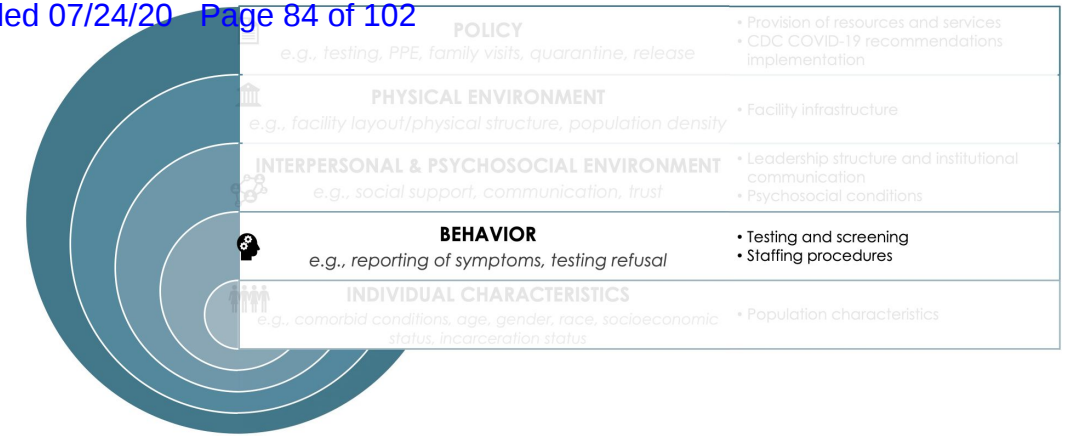


Population Characteristics that hindered efforts:

- **Underlying comorbid conditions among staff/custody and people incarcerated at CMC increase risk for severe COVID-19 related illness and death**
  - ~40% of people incarcerated at CMC are aged ≥50 and ~40% of staff/custody are aged ≥50
  - In the presence of comorbidities, even those of younger age may be at increased risk for severe illness and death

- **Staff/custody commute to and from CMC daily and can propel COVID-19 spread to both people incarcerated at CMC as well as surrounding communities.**
  - Given high housing costs in San Luis Obispo County, several staff/custody reside outside the county, as far as 141 miles away, and commute together to work in 'vanpools'
  - As a result, if infected, they could introduce COVID-19 to people incarcerated at CMC, other staff/custody, as well as to their home communities.

CMC Prevention and Control Efforts: Takeaways



Testing & Screening factors that facilitated efforts:

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

Testing & Screening factors that hindered efforts:

- **At initial stages of the outbreak, there were challenges identifying resources and responsibilities**
  - SLO Public Health Department was not the primary agency for testing
  - CMC Medical requested PPE supplies from Headquarters, but none were initially available
  - Statewide institutional staff testing was not announced until July 3, 2020

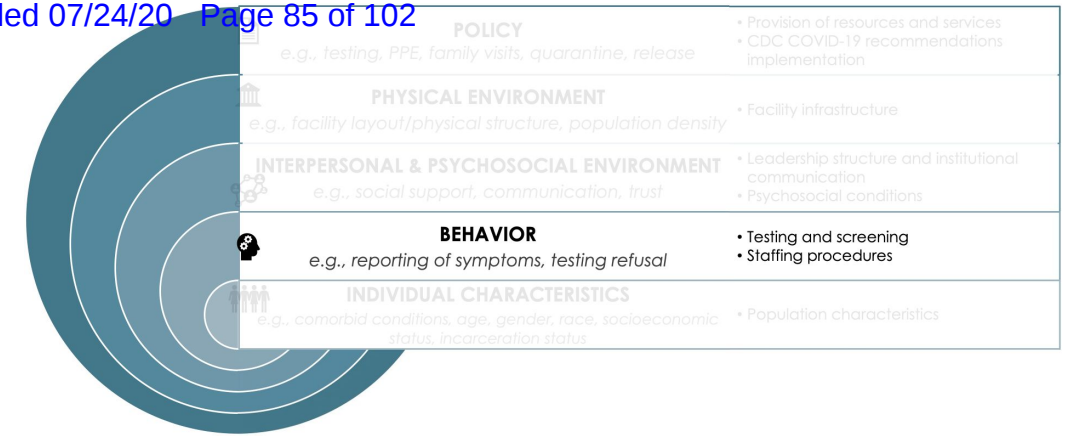
- **CMC's April-May strategy of symptom screening, contact tracing, and one-time testing (of negatives) are necessary but insufficient**
  - Symptom screening and contact tracing alone can identify those who are symptomatic, but will miss pre-symptomatic and asymptomatic individuals
  - One-time testing: Serial testing of negative cases may be needed since positive cases have been identified among those who previously test negative (false negatives, see box).

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

45% *of positive cases were asymptomatic or pre-symptomatic*

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

CMC Prevention and Control Efforts: Takeaways



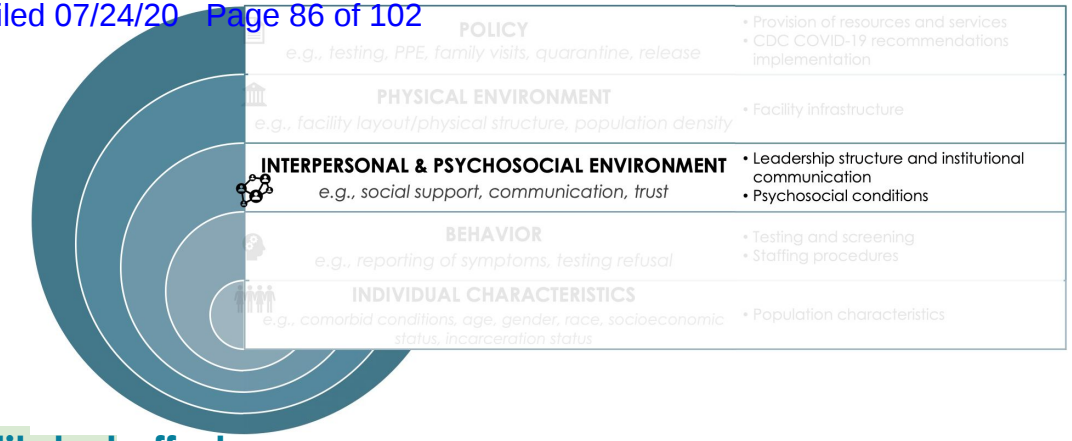
Staffing Procedures factors that facilitated efforts:

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

Staffing Procedures factors that hindered efforts:

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

CMC Prevention and Control Efforts: Takeaways



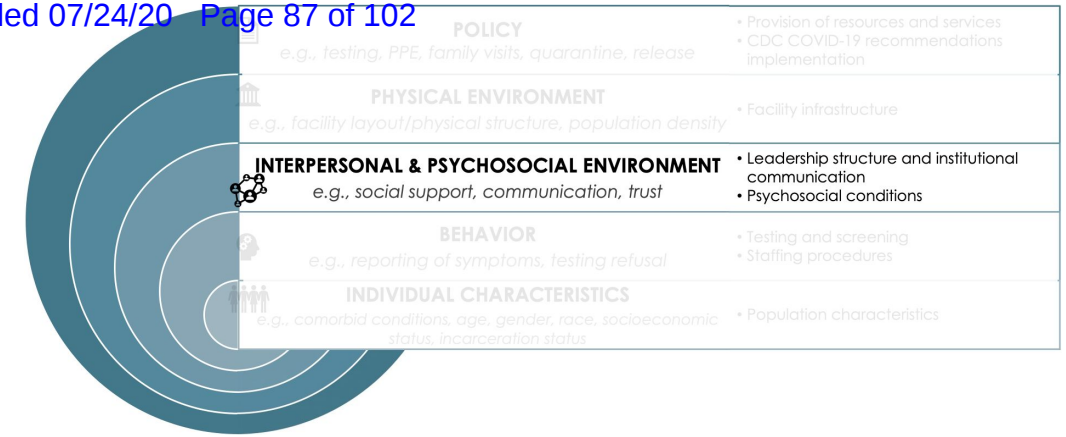
Leadership Structure & Institutional Communication factors that facilitated efforts:

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

Leadership Structure & Institutional Communication factors that hindered efforts:

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

CMC Prevention and Control Efforts: Takeaways



Psychosocial Conditions that facilitated efforts:

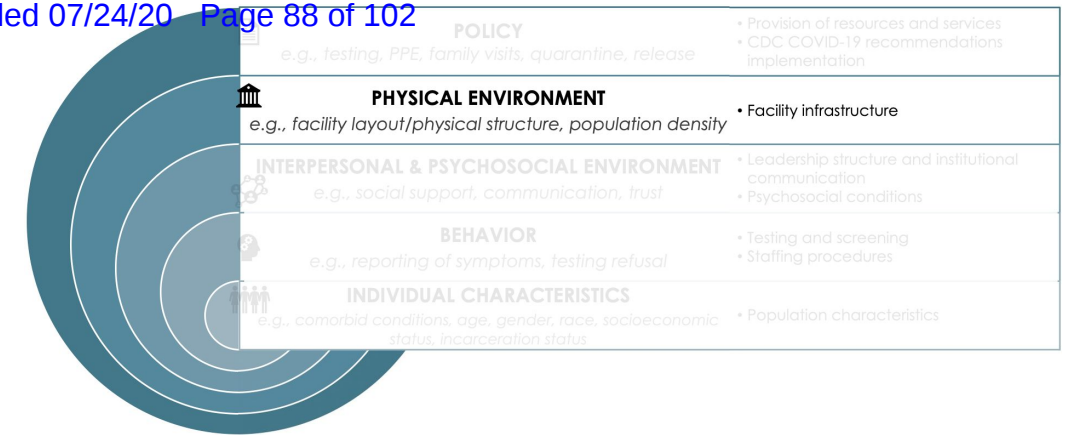
- **Despite the COVID-19 outbreak, CMC maintained some services that are essential for physical and mental health**
  - Many services switched to cell-side, including library and commissary services
  - Yard times, though reduced, were available (and re-opened for C yard)

Psychosocial Conditions that hindered efforts:

- **Ensuring mental health and care/treatment needs was challenging**
  - Need to socially distance undermined the ability to hold group therapy sessions
  - Staff reported being overworked, further exacerbating staff shortages
  - Incarcerated people reported communication lapses and loss of privileges, with potential mental health harms

- **The asymmetry of COVID-19 risk and power was noted by people incarcerated at CMC**
  - People incarcerated at CMC noted that once visitation was halted, the primary risk of virus introduction was from staff/custody
  - However, this risk was sometimes met with nonchalance by staff/custody (e.g., inconsistent mask use; ~50% re-testing refusal rate reported during April-May 2020 outbreak among staff, higher than re-testing refusal rates among incarcerated people)

CMC Prevention and Control Efforts: Takeaways



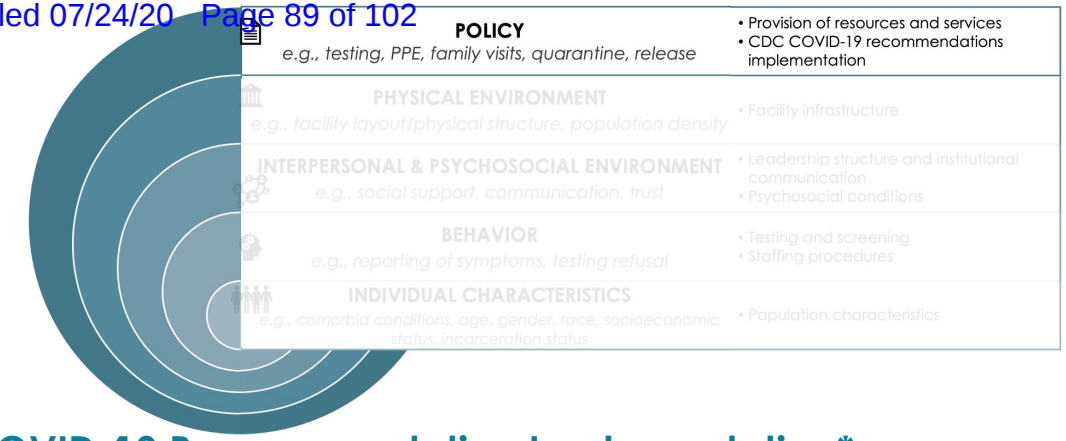
Facility Infrastructure factors that facilitated efforts:

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

Facility Infrastructure factors that hindered efforts:

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

CMC Prevention and Control Efforts: Takeaways



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

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

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

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

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

Summary Messages, CMC COVID-19 Outbreak

CMC established policies and procedures before the outbreak:

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

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

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

At the same time, CMC was lucky:

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

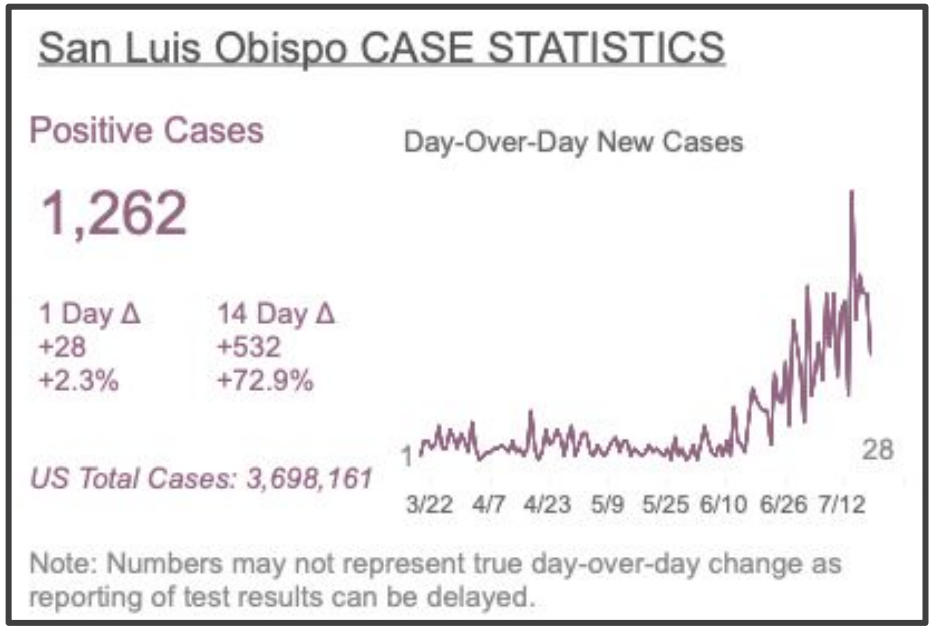


Figure: While prevalence of cases in SLO County was fortunately low during April-May outbreak, recent increases in prevalence since indicate higher risk of entry from the surrounding community. Similar concerns remain regarding COVID-19 prevalence in other counties from which custody/staff commute.

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

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

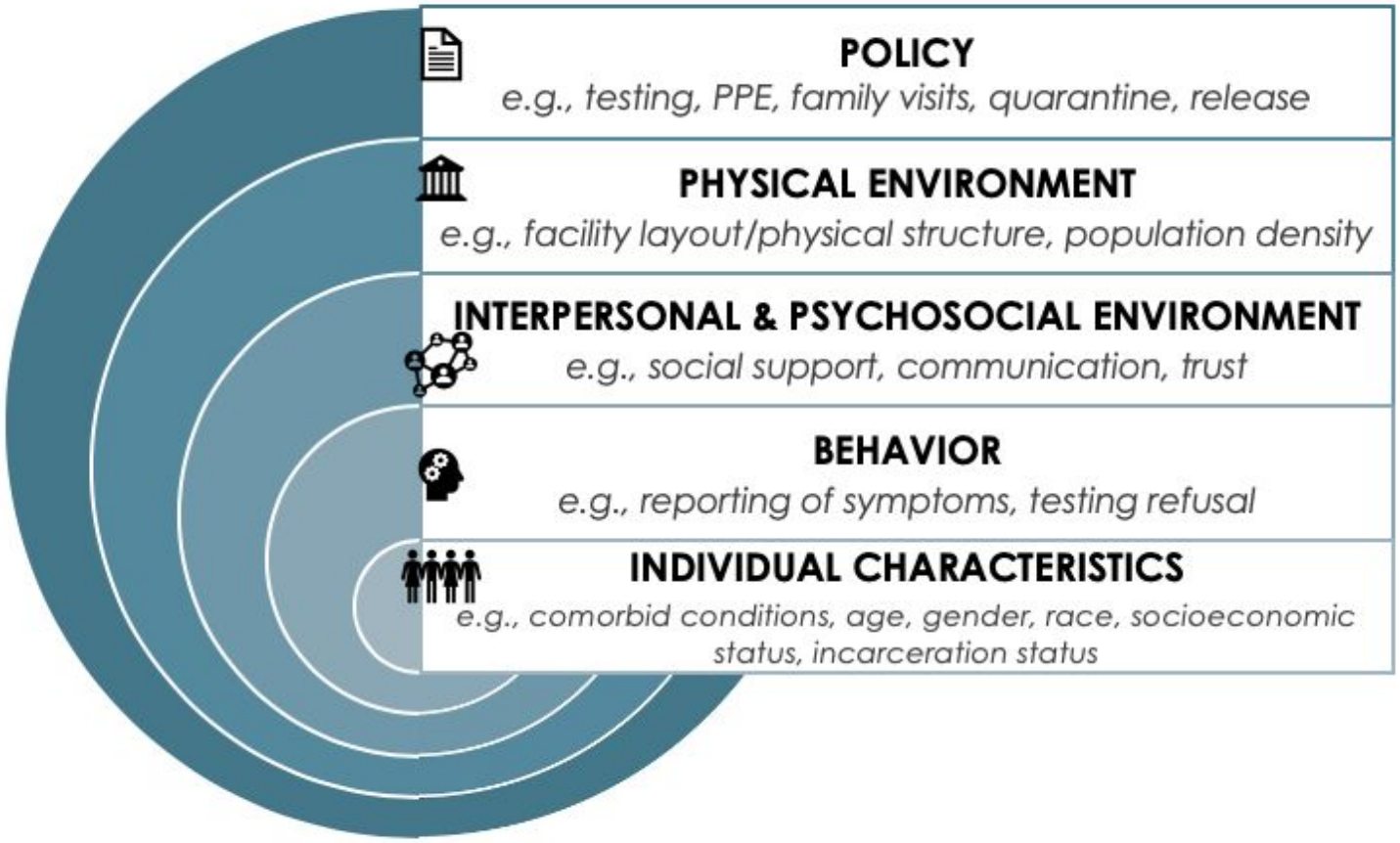
The U.S. Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO), UCSF Amend, and others have issued recommendations for COVID-19 prevention and control in jails, prisons, and detention centers. For example, CDC recommends **PREPARE-PREVENT-MANAGE**:

Sample of Existing Guidance

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

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

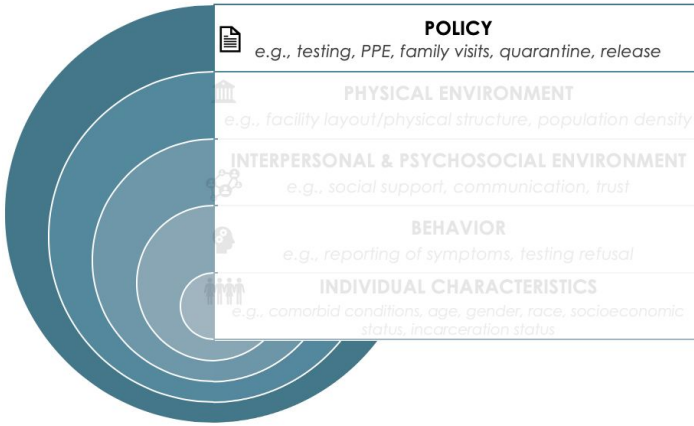
***New* and/or *Modified* Recommendations for COVID-19 Prevention:**
Based on CMC Assessment



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

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

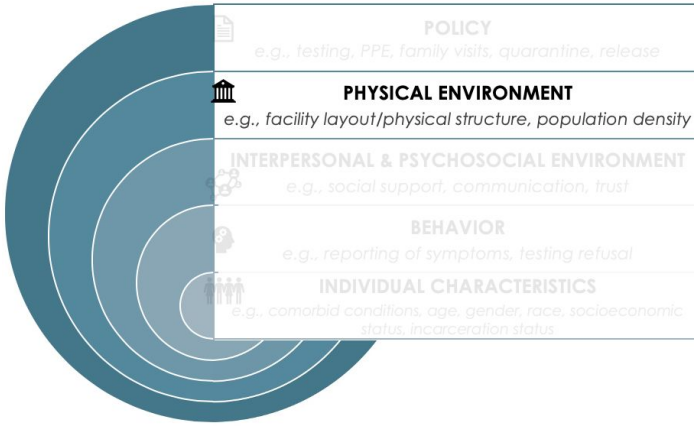
***New* and/or *Modified* Recommendations for COVID-19 Prevention:** Based on CMC Assessment



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

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

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



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

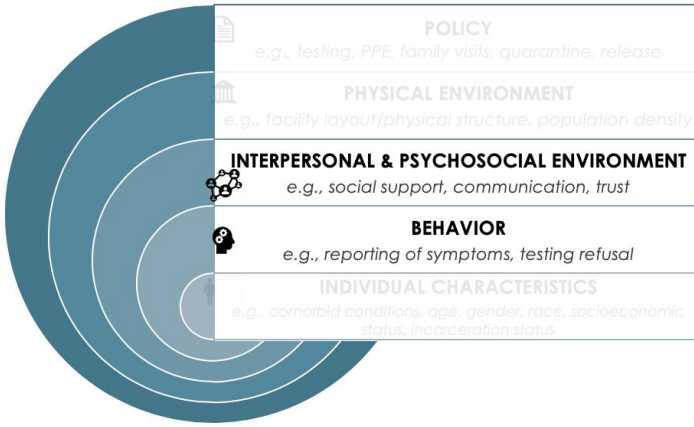
- **<u>The role of the physical space, including ventilation, in facilitating or preventing COVID-19 transmission has been dramatically underappreciated</u>**

  - ***Why is this important?*** Minimizing rebreathing of air to the maximum extent possible is essential to reduce the risk of direct and indirect COVID-19 transmission

  - ***How?***
    1. Implement decarceration strategy (slide 43)
    2. Categorize population density on basis of individuals in common air space (i.e., not separated by solid doors/walls w/ external ventilation)
    3. Channel air from the exterior through common areas then through cells/dorms to the exterior (seeking "positive pressure")
    4. Increase air exchange differentially to decrease rebreathing in least well ventilated units; Test all housing areas to determine level of rebreathing (CO_2 monitors)

- **<u>Ensure that new N95 masks (w/out one-way valves) are available and being used and frequently and effectively disinfected or replaced with new masks for both people who are incarcerated and staff/custody who have any contact with infected or exposed persons</u>**

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



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

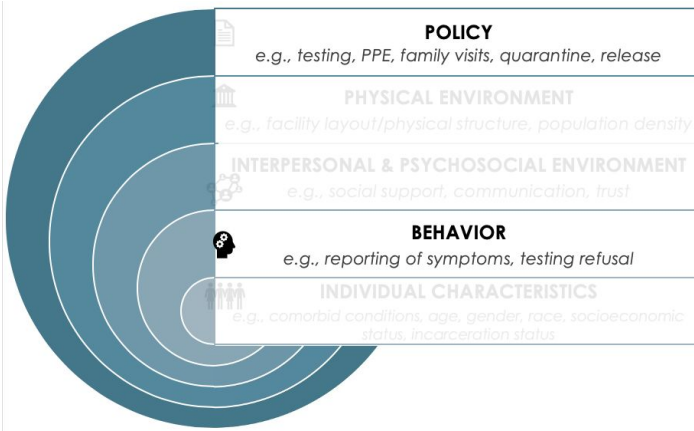
- **<u>The great risk that staff/custody pose to the safety and wellbeing of incarcerated people must be clarified</u>**

  - ***Why is this important?*** Staff/custody play an outsized epidemiological role in transmission, exposing people incarcerated throughout CDCR to COVID-19 from surrounding communities and facilitating spread to other communities

  - ***How?***
    1. Implement decarceration strategy (slide 43)
    2. Provide and require use of proper PPE and designated locations for quarantine/medical isolation (to protect incarcerated people, families of custody/staff, and surrounding communities)
    3. Minimize staff crossover between units as much as possible, *despite administrative & logistical constraints.* If crossover is unavoidable, a process of more frequent/rapid testing (prioritizing testing on the day of cross-over) should be triggered and those personnel should be closely monitored

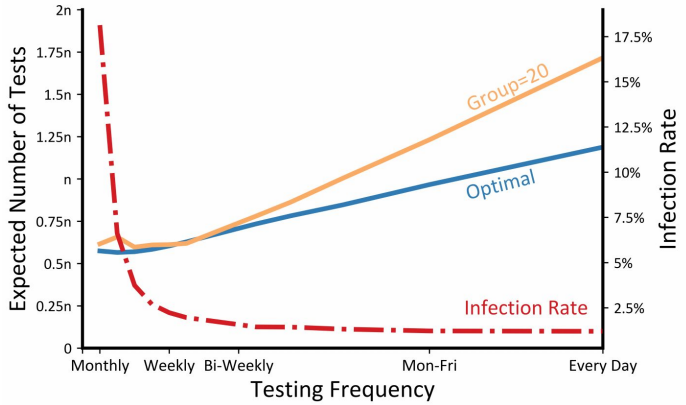
New and/or *Modified* Recommendations for COVID-19 Prevention:

Based on CMC Assessment



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

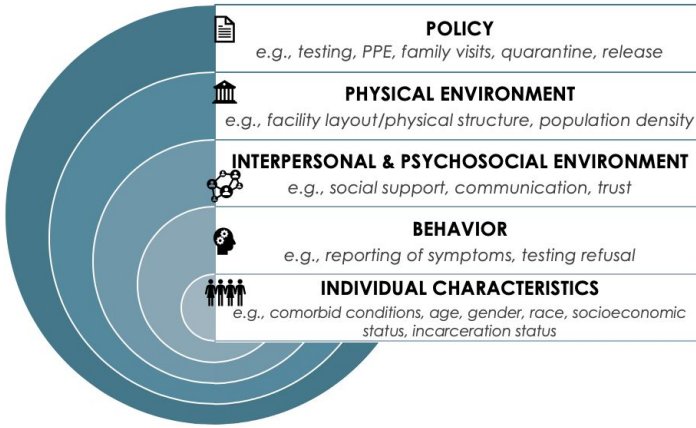
- ***Why is this important?*** Short turnaround times for results (≤24 hours) maximize efficiency, and CMC and SLO Public Health Department partnership on testing permitted evidence-based decision-making, minimizing onward COVID-19 transmission.
- ***How?***
  1. Implement decarceration strategy (slide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



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

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

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



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

- ***Why is this important?*** People in prisons are already deprived of liberty, exacerbating health and wellbeing challenges associated with imposition of further restrictive measures and loss of privileges (e.g., related to COVID-19, as well as other physical and mental health outcomes).

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

Sources: Amend's COVID in California Prisons Program. Urgent Memo, COVID-19: San Quentin Prison. https://amend.us/wp-content/uploads/2020/06/COVID19-Outbreak-SQ-Prison-6.15.2020.pdf
Preparedness, prevention, and control of COVID-19 in prisons and other places of detention: Interim guidance. World Health Organization. Regional Office for Europe. (March 15 2020)[Accessible at: https://www.euro.who.int/__data/assets/pdf_file/0019/434026/Preparedness-prevention-and-control-of-COVID-19-in-prisons.pdf?ua=1s]

Critical Areas of Uncertainty / Need for Future Work

- **Improve air exchange**: How can air exchange be maximized by improving ventilation, utilizing existing air flow systems, opening windows and doors, and leveraging other creative options?
  - Utilize CO_2 monitors in common spaces to identify where air exchange is poor

- **Cohorting**: Are there strategies that circumnavigate Union regulations and leadership hierarchies such that staffing plans can adhere to the cohorting model needed to reduce risk of transmission?
  - E.g., implementing decarceration strategy can also reduce risk of COVID-19 spread posed by (1) volume of staff entering prison daily; (2) staffing shortages; and (3) lack of staff cohorting

- **Quality of Life**: What are the associated physical/mental health consequences (and the relative transmission risks, if applicable) of various implementation models:
  - E.g., halting family visits, free video communication alternatives
  - E.g., halting outdoor time, organized sports, programming

- **Health Communication**: What are the best ways to engage with staff/custody to share COVID-19 information about their own health while simultaneously emphasizing their outsized epidemiologic role in bridging exposure risk between community and incarcerated populations?

- **Engagement**: How can people incarcerated throughout CDCR and their families be engaged as thought partners to provide expertise on their own healthcare needs, advise on implementation of COVID-19 prevention and control measures and distribute information?

Acknowledgments

California Men's Colony
Warden Josie Gastelo
Chief Deputy Warden Danny Samuel
CEO Teresa Macias
Dr. Johannes Haar
Lieutenant John Hill
Healthcare Staff and Custody
Inmates Councils East and West Chairmen
Gold Coats

San Luis Obispo Health Department
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California Department of Corrections and Rehabilitation
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Ms. Connie Gipson

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Dr. Brie Williams, UCSF
Dr. Stefano Bertozzi, UC Berkeley
Dr. David Sears, UCSF

Receiver Clark Kelso

The Honorable Judge Jon Tigar

AMEND
CHANGING CORRECTIONAL CULTURE

Berkeley Public Health

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

Appendix

AMEND CHANGING CORRECTIONAL CULTURE

Berkeley Public Health

CMC Prevention and Control Efforts - Additional Details

CDC COVID-19 recommendation implementation (Behavior & Policy)

Modes of transmission	Facilitates prevention/control efforts	Hinders prevention/control efforts
Direct - Contact *Occurs through direct person-to-person contact*	➔ Frequent cleaning and disinfection; mask use ➔ Physically distinct buildings allowed reduced transmission risks across units within prison - enables potential for isolation and quarantine to mitigate transmission	➔ Dormitories and pods exacerbated risks because of close, prolonged contact ➔ Poor mask fit could be improved ➔ Some transfers between facilities continued ➔ Staff/custody cohorting could not be mandated ➔ Daily volume of staff/custody movement in and out of facility
Direct - Droplet *Spray with larger, short-range aerosols that travel > few feet, before droplets fall*	➔ Good knowledge of mask and PPE use ➔ Social distancing measures in place (e.g., ground markers)	➔ Poor mask fit; inconsistent mask use among staff/custody ➔ Some transfers between facilities continued ➔ Staff/custody cohorting could not be mandated ➔ Daily volume of staff/custody movement in and out of facility
Indirect - Airborne *Smaller, longer range droplet (aerosols) nuclei that can suspend in the air for long periods of time and blow over great distances*	➔ Good knowledge of mask and PPE use ➔ Ability to medically isolate and quarantine in Building C5	➔ Dormitory and pods exacerbated risks because of close, prolonged contact ➔ Lack of mitigation strategies to prevent airborne risks compared to other transmission routes; strong need to improve air exchange through better ventilation and to systematically measure CO_2 levels ➔ Staff/custody cohorting could not be mandated ➔ Daily volume of staff/custody movement in and out of facility
Indirect - Vehicles *Vehicles (food, fomites) that may passively carry a pathogen*	➔ Frequent cleaning of common spaces; soap and sanitizer available for staff and people incarcerated at CMC	➔ Shared common spaces, such as stairwells and staff/custody stations, on East exacerbated risks; similarly, dormitories, pods, and common spaces exacerbated risks on West.

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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

[PROPOSED] ORDER RE: CDCR'S STAFF TESTING PLAN FOR COVID-19

As the Receiver, this Court, and the parties have all recognized, staff are the most significant vector for spreading COVID-19 in the state prisons. *See* Joint Case Management Conference Statement (June 8, 2020), ECF No. 3345 at 3; Order Regarding Staff Testing for COVID-19 (June 11, 2020), ECF No. 3353 at 1; Order to Show Cause re: Baseline Staff Testing for COVID-19 (June 28, 2020), ECF No. 3366 at 1. As of July 23, 2020, more than 1500 CDCR employees had tested positive for COVID-19, with new

cases reported daily. *See* CDCR, *CDCR/CCHCS COVID-19 Employee Status*, https://www.cdcr.ca.gov/covid19/cdcr-cchcs-covid-19-status (last updated July 23, 2020).

In recognition of the risk that staff will continue to spread the virus in the prisons, this Court previously ordered Defendants to "produce a comprehensive plan for testing staff at all prisons in the California Department of Corrections and Rehabilitation." Order Regarding Staff Testing for COVID-19 (June 11, 2020), ECF No. 3353 at 2 (memorializing an order issued from the bench on June 9, 2020). Having reviewed that Plan, and the parties' briefing regarding the Plan, this Court grants Plaintiffs' request for modification of that Plan.

IT IS HEREBY ORDERED:

1. Defendants shall modify the CDCR's COVID-19 staff testing plan to state that if a staff member reports symptoms while at work, the CDCR shall immediately test that person. If the staff person reports symptoms from home, the CDCR shall direct the staff person to obtain a test and report the results to the CDCR so that the CDCR can initiate contact tracing and other measures designed to inhibit transmission of the virus. If a symptomatic staff person declines to be tested, or is unable to obtain a test, the CDCR will consider that staff member to have COVID-19 and initiate outbreak investigation testing.

2. Defendants shall modify CDCR's COVID-19 staff testing plan to require re-testing of all staff, not just those assigned to a particular yard, in response to an outbreak.

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

IT IS SO ORDERED.

Dated: August __, 2020

_____

THE HONORABLE JON S. TIGAR
U.S. DISTRICT COURT JUDGE