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IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

SACRAMENTO DIVISION

| | |
|---|---|
| **RALPH COLEMAN, et al.,**<br>Plaintiffs,<br>**v.**<br>**GAVIN NEWSOM, et al.,**<br>Defendants. | 2:90-cv-00520 KJM-DB (PC)<br>**NOTICE OF MOTION AND MOTION TO MODIFY COURT ORDERS UNDER RULE 60(B)**<br>Judge: Hon. Kimberly J. Mueller<br>Hearing Date: Sept. 24, 2020 at 9:00 a.m.<br>Location: Robert T. Matsui U.S. Courthouse<br>Courtroom: 3, 15th Floor |

**TO THE COURT AND COUNSEL OF RECORD FOR PLAINTIFFS:**

**PLEASE TAKE NOTICE** that under Federal Rule of Civil Procedure 60, Defendants move for a modification of existing Court orders. Defendants request the matter be heard on September 24, 2020 at 9:00 a.m. in Courtroom 3, or at a date and time ordered by this Court, because other matters are currently set to be heard on that date in this matter, including in connection with a further quarterly status conference.

This motion is based on this Notice of Motion and Motion to Modify, the accompanying Memorandum of Points and Authorities, the Declarations of Clendenin, Warburton, Lewis, and Siegel, all pleadings and papers on file in this action, and such other matters as the Court may deem appropriate.

Dated: August 31, 2020

Respectfully Submitted,

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IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

SACRAMENTO DIVISION

**RALPH COLEMAN, et al.,**

Plaintiffs,

**v.**

**GAVIN NEWSOM, et al.,**

Defendants.

Case No. 2:90-cv-00520 KJM-DB (PC)

**DEFENDANTS' MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF MODIFY ORDERS UNDER RULE 60(b)**

Judge: Hon. Kimberly J. Mueller
Hearing Date: Sept. 24, 2020 at 9:00 a.m.
Location: Robert T. Matsui U.S. Courthouse
Courtroom: 3, 15th Floor

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## INTRODUCTION

This Court has a "continuing duty and responsibility to assess the efficacy and consequences of its orders," *Brown v. Plata*, 563 U.S. 493, 542 (2011), and must "formulate its orders to allow the State and its officials the authority necessary to address contingencies that may arise during the remedial process." *Id.* at 544. Given Defendants' constitutional duty to protect patients from harm, they understood that they had authority to take immediate action to respond to an emergency that poses an imminent threat to life and limb—including actions that temporarily restricted the transfer of class members to beds managed by the Department of State Hospitals (DSH) to prevent the introduction and spread of the highly-contagious COVID-19 virus into its facilities. The Court, however, recently stated that existing orders *require* DSH to delay such preventative measures, regardless of how exigent the circumstances. (ECF No. 6639 (finding that "Director Clendenin relied exclusively on discretionary authority granted her under state law and gubernatorial executive orders to close DSH hospitals to *Coleman* class members," but she "has not at any time been relieved of her duty to follow this court's orders to provide access to *Coleman* class members to the full complement of DSH hospital beds"); *id*. at 8 ("defendants here are subject to such remedial orders and may not act in violation of those orders without first seeking and obtaining necessary modifications" and that "[t]he emergency nature of the pandemic does not excuse this requirement"); *id*. at 9 ("Here, Director Clendenin acted unilaterally to suspend admission of *Coleman* class members to DSH beds in violation of multiple court orders"); *id*. ("Defendants did not seek modification of any of those orders, and the Director's discretionary authority, without more, is insufficient to support her violation of this court's orders," and "[t]his is particularly true where, as here, defendants made no effort to seek relief, however expedited, from this court under Rule 60"); *id*. at 9-10 ("Director Clendenin also violated the court's March 8, 2017 order requiring consultation with the Special Master before closing DSH inpatient beds to *Coleman* class members," as "[s]he notified him of her decision to suspend admissions the day the decision was made and she did not, as the order required, consult with him in any way about the decision").)

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To address the Court's concerns, Defendants collaborated internally and then raised this topic during a special, smaller meeting of the Special Master's weekly COVID-19 task-force meetings, which this Court established to provide a forum for the Special Master and stakeholders to debate and resolve issues like this one in the midst of an ongoing international pandemic. (Lewis Decl. ¶ 2.) Defendants also proposed separate more focused discussions with Plaintiffs' counsel and the Special Master. (*Id.*) To this end, Defendants on August 4 circulated a proposed stipulation with a framework for notification of emergent circumstances and follow-on discussion regarding actions taken by Defendants effecting a temporary change in the number and/or use of mental health beds for Coleman class members needing inpatient care, including patients at the Mental Health Crisis Bed, Intermediate Care Facility, or Acute Psychiatric Program levels of care. (*Id.* ¶ 3 & Ex. A.) The Special Master thereafter told Defendants that he believed the Court's orders concerning the notification process were controlling and should be examined first, and he declined to provide comments on the proposal for Defendants' consideration. (*Id.* ¶ 5.) Plaintiffs have not responded to the proposal. (*Id.* ¶¶ 4-5.) Defendants sought to avoid litigation.[1]

Defendants therefore bring this motion to modify the orders the Court believes constrain DSH's ability to make emergency decisions to save lives, absent sufficient "consultation" with the Special Master and this Court's permission. Under the Court's explanation of its past orders, DSH may not take life-saving actions in an emergency like it did in March 2020 without first *litigating* whether it may do so. That would effectively require some responses to be delayed until it is already too late to protect patients, including *Coleman* patients. And it places DSH in an untenable position: when exigencies require immediate life-saving actions that might deviate from past orders concerning bed plans, DSH must commit contempt to discharge its constitutional

/ / /

[1] Given the importance of being able to act rapidly in the face of an emergency to protect the health and safety of patients and staff in State facilities, Defendants are moving to modify orders concerning the bed change notification and consultation procedures. Nevertheless, Defendants welcome further negotiation with the Special Master and Plaintiffs to reach agreement concerning a bed change emergency notification process that provides sufficient flexibility and clarity for Defendants to manage inpatient beds at State facilities when confronted with emergency situations that threaten the welfare of patients and staff. (Lewis Decl. ¶ 6.)

duties. This conundrum extends beyond the current health crisis and obstructs the Defendants' ability to respond in a future emergency, be it earthquake, fire, or the next global contagion.

Recent events establish that prospective, strict application of inpatient bed-availability orders is no longer equitable, and so this Court should modify them under Federal Rule of Civil Procedure 60(b)(5) or (b)(6). Specifically, Defendants move to modify the Court's orders concerning DSH's inpatient-bed availability and transfers to create a workable framework that: (1) defines specific conditions that will allow DSH to take temporary, emergency actions without pre-approval litigation; (2) provides notice to the Special Master in advance when possible, or otherwise as soon as practicable, and in no event more than 48 hours after taking the actions, as well as establish procedures for him to evaluate the actions taken and determine whether class members were adversely affected; and (3) creates transparency for Plaintiffs to know the effect, if any, of DSH's action on their clients.

## FACTUAL AND PROCEDURAL BACKGROUND

### I. RECENT EVENTS REVEALING A NEED FOR MODIFICATION.

"We are living in unprecedented times. The spread of COVID-19 is a global crisis, a crisis that is heightened in the most vulnerable groups among us." (Three-Judge Court, No. 4:01-cv-01351, ECF No. 3261 at 1.) On March 19, 2020, the Governor of California issued an unprecedented Executive Order for all Californians to shelter in place to prevent the spread of COVID-19 and save lives. (Exec. Order No. N-33-20 (Mar. 19, 2020) https://www.gov.ca.gov/wp-content/uploads/2020/03/3.19.20-attested-EO-N-33-20-COVID-19-HEALTH-ORDER.pdf.) The Governor issued the order shortly after he declared a state of emergency on March 4, 2020. (Proclamation of State of Emergency (Mar. 4, 2020) https://www.gov.ca.gov/wp-content/uploads/2020/03/3.4.20-Coronavirus-SOE-Proclamation.pdf.)

In response, DSH temporarily suspended admissions and discharges to and from its facilities for 30 days to similarly shelter in place, and protect its patients, including 298 of whom were *Coleman* class members, and its staff. (Clendenin Decl. ¶¶ 14, 21.) DSH recognized that its regular daily practice of admitting and discharging patients from 58 county jails and 35 CDCR

prisons presented the most serious threat of introducing the virus into DSH's facilities. (Clendenin Decl. ¶ 26; Warburton Decl. ¶ 8.) DSH acted decisively and responsibly to immediately eliminate this dangerous vector and develop an emergency plan to treat patients as safely as possible during a pandemic for which worldwide public health experts then (and now) could not forecast a "horizon." (Clendenin Decl. ¶¶ 18, 21-22, 24, 26; Warburton Decl. ¶¶ 16-18.) DSH's decision to temporarily suspend patient admissions gave it valuable time to ensure it had sufficient personal protective equipment supplies, secure testing resources, identify and develop isolation space, and develop and implement protocols to safely admit and discharge patients, and treat the patients in DSH custody in an unprecedented and uncertain pandemic environment. (Clendenin Decl. ¶¶ 18, 21-22; Warburton Decl. ¶¶ 17-18.)

Before DSH suspended admissions, DSH's Director called the Special Master to advise him of DSH's planned response to the pandemic. (Clendenin Decl. ¶ 13; ECF No. 6565 at 3 (the Special Master stated in his April 2, 2020 report that "[o]n March 16, 2020, the Special Master received a phone call from the director of DSH, Stephanie Clendenin, notifying him that DSH would be suspending admissions of *Coleman* class members to their hospitals".) During that telephone call, the Special Master informed DSH's Director that he understood her decision—the Special Master did not question the Director's decision, let alone disapprove DSH's decision. (*Id.* ¶ 13; *see also* ECF No. 6565 at 4 (providing that the Special Master had teleconference meetings with Director Clendenin and her staff on March 17 and 18, 2020 regarding DSH's decision to halt admissions, without complaint.) DSH's chief counsel separately notified Plaintiffs' counsel. (Clendenin Decl. ¶ 14; ECF No. 6565 at 3, 38.) The suspension of *Coleman* admissions was temporary, lasting 30 days, and ended on April 16, 2020. (Hendon Decl. ¶¶ 8-9, ECF No. 6612-1.) And, at the time of the temporary suspension of admissions, there were no COVID-positive patients in DSH's care. (Clendenin Decl. ¶ 23.)

Smart, evasive, and early action by DSH paid dividends. DSH did not have a COVID-positive patient until two weeks after the suspension was lifted. (*Id.*) And, as of August 25, not one *Coleman* class member at DSH has tested COVID-positive so far during the entirety of the COVID-19 pandemic. (*See* Status Report, ECF No. 6841 at 6.) DSH's prudent and proactive

measures to protect patients were just some of the "numerous and significant measures the State of California has taken and continues to take in response to COVID-19." (Three-Judge Court, No. 4:01-cv-01351, ECF No. 3291 at 2.) And it was because of such measures that the Three-Judge Court in April 2020 rejected Plaintiffs' claims that "State officials" had been "deliberately indifferent to a substantial risk of serious harm to inmate health or safety." (*Id.* at 1-2.)

However, this Court—rather than credit DSH for taking steps to save and promote patients and staff's well-being in response to the pandemic—issued an order to show cause concerning whether the 30-day suspension of transfers constituted contempt because it violated a March 8, 2017 order, and bed plans indicating DSH would make 256 beds available to class members at Atascadero State Hospital (ASH) (*see* ECF No. 4199). (ECF No. 6572.) The Court ordered discovery and a trial, which has been continued several times based on the parties' joint representation that DSH is following Program Guide requirements for patient admissions that have been supplemented with additional COVID-19 protocols. (ECF Nos. 6600, 6622, 6676, 6734.) Although Defendants asked that the trial be taken off calendar given ongoing positive and transparent discussions with extensive data regarding patient referrals, admissions, and discharges provided during weekly COVID-19 task force sessions, the trial is now set for October 23, 2020. (ECF Nos. 6800 & 6807.) In subsequent proceedings, this Court clarified that existing orders do not permit Defendants to immediately respond to an emergency without first seeking relief under Rule 60, and engaging in a more robust pre-decisional negotiation process with the Special Master. (*See*, *e.g.*, ECF No. 6639 at 9-10 (finding that Director Clendenin "violated the court's March 8, 2017 order requiring *consultation* with the Special Master before closing DSH inpatient beds to *Coleman* class members," as "[s]he notified him of her decision to suspend admissions the day the decision was made *and she did not, as the order required, consult with him in any way about the decision*" (emphasis added)); ECF No. 6660 at 2 (providing that "with the exception of a temporary modification to include COVID-19 screening, the *Coleman* Program Guide requirements for transfer of class members to inpatient DSH hospital beds are in full force and effect unless and until they are modified by order of this court").)

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## II. RELIEF SOUGHT.

Defendants bring this motion to modify earlier orders to make explicit what DSH understood to be its authority to make reasonable, short-term adjustments to the number or use of mental health beds for class members at the Intermediate Care Facility (ICF)[2] level of care in the event of flood, fire, contagion, contamination, earthquake, active-shooter incident, hostage crisis, or other imminently dangerous circumstance beyond its control. Defendants propose that:

- DSH be permitted, in such circumstances, to advise the Special Master in advance when possible, or otherwise as soon as practicable, and in no event more than 48 hours after emergency action is taken;
- consistent with his existing powers and duties under the 1995 Order of Reference (ECF No. 640), the Special Master would review the action taken and, if the Special Master determined that a report was necessary, report to the Court on the effect, if any, on *Coleman* class members; and
- under the July 2019 modification to the Order of Reference (ECF No. 6230), the parties would have thirty days to file objections to, or move to modify, reject, or adopt, the report (*see*, *e.g.*, Lewis Decl. ¶ 3 & Ex. A).

This proposed modification would supersede existing procedures and enable the State to take immediate, temporary action to save lives; allow prompt evaluation, analysis, and reporting to the Court; and allow Plaintiffs' counsel to know whether their clients were affected.

1. Specifically, Defendants seek to modify the following orders to incorporate the proposed emergency protocols insofar as DSH bed usage may be implicated: March 8, 2017 order requiring that, where "an emergency situation precludes [a] meet and confer thirty days in advance, defendants shall consult with the Special Master immediately upon learning of the need to make any changes, additions or reductions in the number and/or use of inpatient beds or mental health crisis beds" and that "[a]s used in this order, consultation requires a conference in person or by telephone and not mere written notice or communication" (ECF No. 5573);

[2] DSH only provides care to *Coleman* class members at the ICF level of inpatient care.

2. December 15, 2017 order (ECF No. 5750) allowing transfer timelines to be suspended in "unusual circumstances" outside CDCR's control; and

3. April 24, 2020 order (ECF No. 6639) indicating that DSH Director Clendenin was required to seek modification of orders before DSH suspended admissions in response to the COVID-19 pandemic, and stating "defendants here are subject to remedial orders and may not act in violation of those orders without first seeking and obtaining necessary modifications," and that "[t]he emergency nature of the pandemic does not excuse this requirement."

For the reasons discussed below, this Court should grant Defendants' motion to modify these orders to allow for immediate, reasonable responses to emergency situations followed closely by notice to the Special Master and his review and analysis of the effect, if any, on the Plaintiffs' class.

**ARGUMENT**

Under Federal Rule of Civil Procedure 60(b)(5), a court may relieve a party from a final order when, among other things, the order's prospective application is no longer equitable. And under Rule 60(b)(6), courts may grant such relief for "any other reason that justifies relief." A motion for relief under either provision must be filed within a "reasonable time." Fed. R. Civ. P. 60(c)(1). Rule 60(b) codifies the courts' inherent authority to modify or vacate the prospective effect of their judgments. *United States v. Asarco Inc.*, 430 F.3d 972, 979 (9th Cir. 2005) (applying Rule 60(b)(5)); *Nicacio v. U.S. I.N.S.*, 797 F.2d 700, 706 (9th Cir. 1985) (applying Rule 60(b)(6)).

A court that issues an injunction mandating systemic changes to an institution has the continuing duty and responsibility to assess the efficacy and consequences of its order. *Brown v. Plata*, 563 U.S. at 542. Court-ordered institutional reform implicates "sensitive federalism concerns" because it intrudes on elected officials' ability to govern. *Horne v. Flores*, 557 U.S. 433, 447-50 (2009). Accordingly, district courts must take a "flexible approach" to requests to modify orders that dictate the state's core responsibilities. *Id.*; *Rufo v. Inmates of Suffolk Cty. Jail*, 502 U.S. 367, 384-85 (1992). As the Supreme Court has instructed, the district court "must

remain open" to altering an order to ensure that the rights and interests of the parties are protected. *Plata*, 563 U.S. at 543. This includes "[p]roper respect for the State and for its governmental processes." *Id*. A court must "formulate its orders to allow the State and its officials the authority necessary to address contingencies that may arise during the remedial process." *Id*. at 544.

The COVID-19 global pandemic has presented Defendants, and specifically DSH, and this Court with such a contingency. This epic public health crisis has forced the State to take unprecedented actions to safeguard the lives of Californians, especially those committed to its custody. As DSH's evidence unequivocally shows, and as current events around the country make clear, discharging this duty requires lightning-quick decision-making by state officials. It is beyond dispute that delay can result in catastrophic consequences.

## I. THE COURT SHOULD GRANT RULE 60(b)(5) RELIEF BECAUSE, IN LIGHT OF RECENT EVENTS, APPLICATION OF ITS ORDERS IS NOT EQUITABLE.

Under Rule 60(b)(5), Defendants, as the moving party, must first show a significant change either in factual conditions or in the law warranting modification of the Court's remedial orders. *Asarco Inc.*, 430 F.3d at 979 (citing *Rufo*, 502 U.S. at 384). This Court then determines whether the proposed modification is suitably tailored to resolve the problems created by the changed factual or legal conditions. *Id*. If changed circumstances have been shown, this Court cannot refuse to rescind or modify an injunctive order. *Horne*, 557 U.S. at 447.

Here, the COVID-19 pandemic has revealed that the injunction, as interpreted by recent court orders, is dangerously inflexible and should be modified to allow DSH to take immediate life-saving actions in time of emergency, just as it did in March 2020.

### A. The Court Should Modify Its Prior Orders to Allow DSH to Take Immediate Action to Protect Patients From Imminent Danger Without First Bringing a Motion.

Under the Supreme Court's flexible approach, modification of an order under Rule 60(b)(5) is appropriate when changed factual or legal conditions make compliance with the order substantially more onerous, when an order proves to be unworkable because of unforeseen

obstacles, or when enforcement of the order without modification would be detrimental to the public interest. *Rufo*, 502 U.S. at 384-85. A court does not need to find that the change in circumstances was both unforeseen and unforeseeable. "[L]itigants are not required to anticipate every exigency that could conceivably arise during the life of a consent decree." *Id.* at 385.

There can be no dispute that the COVID-19 pandemic constitutes not only a "substantially changed circumstance," but an extraordinary one that has fundamentally altered our nation's public health landscape. Indeed, the Three-Judge Court so concluded, explaining that Defendants are confronting an "unprecedented pandemic" that "the entire world was unprepared for." (Order at 9, Apr. 4, 2020, ECF No. 6574.)[3] Defendants are in the midst of fighting a "unique threat" that "could not have been foreseen only a few months ago," let alone years earlier when this Court entered its orders concerning inpatient-bed planning and availability. (*See id.* at 11.)

DSH's ability to immediately respond to this unprecedented public health emergency further changed when, in response to its good-faith actions to protect patients from infection, this Court concluded that those actions violated prior orders unrelated to exigencies, and instead, related to planning for bed availability while it was not under the press of a global emergency, and announced a new procedural requirement for emergencies. As explained below, a modification is warranted under Rule 60(b)(5) because the Court's order imposes a condition that is unworkable, onerous, and detrimental to the public interest.

**1. By Requiring DSH to Litigate Emergency Actions, the Court's April 24 Order Imposes an Unworkable Condition that Makes Compliance with Earlier Orders Substantially More Onerous and Interferes With DSH's Ability to Take Immediate Life Saving Measures.**

The Court's requirement that Defendants bring a Rule 60(b) motion before DSH may take immediate action in response to an unforeseen emergency, such as the COVID-19 global pandemic, should be modified because it is both unworkable and substantially more onerous.

[3] Plaintiffs conceded that the pandemic is a changed circumstance in their own Rule 60(b)(5) motion to modify the Three-Judge Court's population-reduction order. (Three-Judge Court, No. 4:01-cv-01351, ECF No. 3219 at 28-29.) The Three-Judge Court denied the motion because the alleged constitutional injury was unrelated to the basis of that order: the delivery of constitutionally adequate medical and mental-health care.

Compliance is unworkable because the required Rule 60 procedure will necessarily delay emergency responses that require temporary suspension of patient movement, and such delays will have catastrophic results. (Clendenin Decl. ¶¶ 22, 26; Warburton Decl. ¶¶ 7-14; Siegel Decl. ¶¶ 13-14.) An example here is helpful—at any time when a patient living, or employee working, on a unit tests positive for COVID-19, DSH would immediately quarantine those units, while it serially tests all patients and employees living and working on the unit to determine if additional patients or employees become positive for COVID-19. The patients and employees continue to be tested and the unit quarantined until it is determined that transmission is no longer occurring on the unit. When a unit is quarantined, DSH pauses patient admissions and discharges to the unit or units so that additional patients are not exposed to COVID-19. (Clendenin Decl. ¶ 27; Warburton Decl. ¶ 15.) Depending on the extent and location of the outbreak, that could halt admissions to the entire hospital. (Clendenin Decl. ¶ 27; Warburton Decl. ¶ 15.) DSH cannot wait to litigate through a Rule 60 motion, even on an expedited basis, whether it can continue to admit patients into its facilities—patient and staff lives are at stake. (Clendenin Decl. ¶¶ 26-27; Warburton Decl. ¶¶ 7-14.) The mandated delay stands in tension with DSH's constitutional obligations to keep patients reasonably safe from a substantial risk of serious harm, as well as the State's overarching responsibility for public health and safety.[4]

Moreover, DSH must be able to immediately respond to protect people in its custody while maintaining security of the institution in the event of an emergency, such as a pandemic, fire, earthquake, or hostage crisis, to name a few. (Clendenin Decl. ¶ 28.) For example, DSH-Napa was almost evacuated due to the 2017 life-threatening fires in Northern California, particularly in Napa County. (*Id.*) DSH could not wait for a court order to move *Coleman* patients out of a facility subject to a mandatory evacuation order, nor could it guarantee admission to such a facility under these emergency circumstances just to comply with a bed-planning order. (*Id.*) To hold otherwise would expose the patients under DSH's care to undue risk. *See Hook v. State of Ariz.*, 120 F.3d 921, 924-25 (9th Cir. 1997) (holding the district court abused its discretion by

[4] This includes Defendants' Eighth Amendment duty to incarcerated patients, as well as DSH's Fourteenth Amendment duty to civilly detained patients.

denying modification where the defendants presented evidence showing compliance with decree raised institutional security concerns).

The requirement to litigate first and await a written order makes compliance substantially more onerous—if not impossible. As explained below, some emergencies do not permit such delay. The Court's requirement would force DSH either to disobey the Court, or to delay and subject patients and others to dangerous—potentially deadly—conditions, pending the outcome of litigation. Consequently, the Court's existing orders could have the unintended effect of subjecting those in the State's care to unconstitutional conditions when Defendants need to take decisive action to avoid that result. Indeed, Plaintiffs during this pandemic have criticized Defendants for failing to act quickly enough. (*See, e.g.*, Three-Judge Court, No. 4:01-cv-01351, ECF No. 3219 at 29-30 (Plaintiffs argued that CDCR's suspension of intake was inadequate to address COVID-19, and Defendants "failure to act more quickly to reduce the prison population in light of this unprecedented crisis is troubling and constitutes further evidence of the need for urgent action by this [Three-Judge] Court"); *Plata v. Newsom*, No. 4:01-cv-01351, ECF No. 3256 at 6-7 ("The steps that Defendants have proposed to date—temporarily pausing intake from county jails, expediting the release of people who were scheduled to be released in the next 60 days, and relocating fewer than 600 people from a few dorms at three prisons to cells—do not adequately address the magnitude of the problem and the needs of medically vulnerable class members.").) Modification is necessary to resolve this tension. *See Reynolds v. McInnes*, 338 F.3d 1221, 1228 (11th Cir. 2003) (modification to consent decree warranted where, despite the defendants' good-faith efforts, compliance with provision would effectively "preclude best professional practices"); *see also Jackson v. Los Lunas Community Program*, 880 F.3d 1176, 1205 (10th Cir. 2018) (district court's finding that the defendants' obligations under injunction were "onerous" should suffice to show changed circumstances under either "onerous" or "unworkable" prongs of the *Rufo* analysis).

**2. Modification of the Order Is in the Public Interest.**

The Court's categorical restriction on DSH's ability to take immediate emergency action affecting patient movement and bed use without first litigating the issue, harms the public interest

in two critical ways. First, requiring DSH to litigate before responding to an emergency jeopardizes public health and safety, including the health and safety of *all* 6,000 DSH patients, DSH's non-*Coleman* custodial population, community hospitals, and the public at large. In custodial situations no less than elsewhere, there is a "paramount necessity" to protect against "an epidemic of disease." *Jacobson v. Massachusetts*, 197 U.S. 11, 27 (1905).

The consequences of even a brief delay in the face of an emergency, such as a pandemic, could be catastrophic. (*See* Clendenin Decl. ¶¶ 21-22, 26-27; Warburton Decl. ¶¶ 7-8, 16; Siegel Decl. ¶¶ 13-15.) Time is of the essence. Once contagion begins to spread in a congregate setting, it can become difficult to contain, given the proximity of patients to one another and the ease with which a disease can be transmitted among a confined population. (Warburton Decl. ¶¶ 9-10; Siegel Decl. ¶¶ 10-12.) Furthermore, geophysical and climatic events, such as an earthquake, brush fire, or flood, could pose emergent threats to the structures housing patients that demand immediate action to move patients or prevent the transportation or admission of additional patients into those beds. (Clendenin Decl. ¶ 28.) In these situations, DSH needs to act within hours, if not minutes, to adjust movement in efforts to protect patients and staff. (*Id.*)

Moreover, by a large margin, the majority of DSH's inpatients, or approximately 96-97 percent, are not *Coleman* class members but Californians living with serious mental illnesses. (*See* Clendenin Decl. ¶ 3.) Patients are sent to DSH from counties and superior courts all over the state; depending on the commitment type, they may be discharged back to the county, superior court, or county jail after treatment—raising additional potential opportunities for spread among vulnerable individuals within the State's custody between correctional and inpatient settings. (Clendenin Decl. ¶ 6; Warburton Decl. ¶¶ 8, 14.) "[T]o be clear, this is not (solely) about weighing health and safety against security and administrative efficiency; it is also about weighing health and safety against health and safety." *Swain v. Junior*, 961 F.3d 1276, 1293 (11th Cir. 2020). And, because staff return to their communities at the end of each workday, delays in responding to a pandemic may place their families and neighbors at risk, and ultimately could consume scarce healthcare resources both within and outside the custodial environment. (*See* Siegel Decl. ¶ 15; Warburton Decl. ¶ 13.) *See also* Bakersfield Californian, "Hospital

Staffing an Emerging Concern in Kern's COVID-19 Effort, July 13, 2020 (reporting on shortages of community hospital beds and staff).) In short, allowing contagion to be introduced into a DSH facility could have wide-ranging impact on communities throughout the state. (Siegel Decl. ¶¶ 14-15; Warburton Decl. ¶¶ 12-14.)

Second, the Court's restriction harms the public interest because it fails to give sufficient deference to the Governor and DSH officials in responding to public health emergencies at a moment of peril unrivaled in our lives. Such interference conflicts with state officials' core responsibilities to safely manage the populations entrusted to their care. As the Supreme Court has explained, in institutional-reform cases the public interest is harmed when a federal court's judgment impedes the democratic process by improperly depriving state officials of their designated legislative and executive powers. *Horne*, 557 U.S. at 448-50. Courts must remain attentive to the fact that "federal-court decrees exceed appropriate limits if they are aimed at eliminating a condition that does not violate [federal law] or does not flow from such a violation." *Id*. at 450 (internal quotation marks omitted). "[P]rinciples of federalism and simple common sense require the [district] court to give significant weight" to the views of governmental officials. *Frew ex rel. Frew v. Hawkins*, 540 U.S. 431, 442 (2004). State officials with "front-line responsibility" must be given "latitude and substantial discretion." *Id.*; *see also Sandin v. Conner*, 515 U.S. 472, 482-83 (1995) ("federal courts ought to afford appropriate deference and flexibility to state officials trying to manage a volatile environment [in a prison]"). Indeed, as the Three-Judge Court emphasized in April 2020 in the specific context of COVID-19, "Defendants have broad authority to voluntarily take steps that may prevent the life-threatening spread of COVID-19 within their prisons, and we recognize the deference that is due to prison authorities to determine which additional measures must be taken to avoid catastrophic results. (Three-Judge Court, No. 4:01-cv-01351, ECF No. 3261 at 13 (citing *Turner v. Safley*, 482 U.S. 78, 84-85 (1987).)

In its April 24 order, this Court concluded that its prior bed-planning orders conflicted with, and therefore vitiated, DSH's authority to respond to emergencies and how to handle its beds under state law and the Governor's executive orders. However, the determination is not so

simple. The fact that a state law conflicts with a federal injunction is insufficient legal justification to deny a needed modification of the injunction. *Valdivia v. Schwarzenegger*, 599 F.3d 984, 995 (9th Cir. 2010). In *Valdivia*, defendants sought to modify certain procedural aspects of an injunction to conform with changes to state law. *Id.* The Ninth Circuit explained that although the procedures were put in place to remedy a claimed constitutional violation, they were not necessary or required by the Constitution. *Id.* Therefore, as a matter of federalism, the district court was obligated to reconcile the state law with the injunction. *Id.* The court could not simply deny the modification based on the inconsistency. *Id.* So too, here, the requirement of bringing a motion under Rule 60 before taking emergency action is not required by the Constitution, and conflicts with the Governor's statutory authority to respond swiftly and decisively to emergencies.[5] The Court should grant this motion to modify DSH bed plan orders to reconcile its orders with state law.

"The Constitution principally entrusts the safety and the health of the people to the politically accountable officials of the States to guard and protect." *S. Bay United Pentecostal Church v. Newsom*, 140 S. Ct. 1613, 1613-14 (2020) (Roberts, C.J., concurring in denial of injunctive relief) (citing *Jacobson*, 197 U.S. at 38 (internal quotes and brackets omitted). When those officials "undertake[ ] to act in areas fraught with medical and scientific uncertainties," their latitude "must be especially broad." *Id.*; *Marshall v. United States*, 414 U.S. 417, 427 (1974). The "federal judiciary," in contrast, "lacks the background, competence, and expertise to assess public health and is not accountable to the people." *S. Bay United Pentecostal Church*, 140 S. Ct. at 1614. The judiciary has a vital role in assuring that constitutional requirements under the Eighth Amendment and Due Process Clauses are met for those under the State's care. But in the extraordinary and limited circumstances of a true emergency, the courts must allow leeway for the Executive's immediate response, in order that the underlying goals of such judicial oversight

[5] Under the California Emergency Services Act, the Legislature centralized authority to respond to state emergencies within the Governor and Governor's Office of Emergency Services. In an emergency, the Governor has "complete authority over all agencies of the state government . . . and all police power vested in the state," Cal. Gov. Code § 8627, and he may exercise his emergency authority to "suspend any statute prescribing the procedure for conduct of state business, or the orders, rules, or regulations of any state agency." Cal. Gov. Code § 8571.

not suffer due to inflexible formality. DSH's Director, appointed by the Governor and confirmed by the Legislature to oversee an executive department, must be able to take decisive action to protect its patients without first litigating such actions.

**B. The Requested Modification Is Suitably Tailored.**

Defendants' proposed modification is suitably tailored to the circumstances. It provides a procedural framework that reconciles the Court's overall remedial plan with the State's need to act quickly to protect life and limb in a true emergency.

DSH seeks only the authority to take immediate, temporary action affecting ICF bed usage in an emergency. DSH recognizes that the term for such temporary emergency action must be limited. State law provides a suitably defined, limited, and administrable starting point, through a longstanding provision that is designed to recognize true, severe emergencies whose circumstances require immediate action. Looking to state law for guidance is appropriate because "it is difficult to imagine an activity in which a State has a stronger interest, or one that is more intricately bound up with state laws, regulations, and procedures, than the administration of" those that have been committed to its care for serious mental illness. *Woodford v. Ngo*, 548 U.S. 81, 94 (2006) (internal quotes omitted).

California Government Code § 8558(b) defines "state of emergency" as:

> "conditions of disaster or of extreme peril to the safety of persons and property within the state caused by conditions such as air pollution, fire, flood, storm, epidemic, riot, drought, cyberterrorism, sudden and severe energy shortage, plant or animal infestation or disease, the Governor's warning of an earthquake or volcanic prediction, or an earthquake, or other conditions, . . . which, by reason of their magnitude, are or are likely to be beyond the control of the services, personnel, equipment, and facilities of any single county, city and county, or city and require the combined forces of a mutual aid region or regions to combat[.]"

Cal. Gov. Code § 8558(b). Because the Governor's general authority to take action in an emergency is grounded in state law, it is appropriate to tailor the definition of "emergency" to align with § 8558(b).

To facilitate the Special Master's monitoring, any action taken in response to an emergency should be closely followed with notice to the Special Master and an opportunity for post-hoc analysis of the emergency response. Circumstances such as a fire or earthquake requiring

evacuation of patients and staff require *immediate* action to save lives. These measures would be closely followed by efforts to safely rehouse displaced individuals considering case factors such as medical conditions, disabilities, mental health needs, and security concerns. (Clendenin Decl. ¶ 28.) Depending on the conditions on the ground, even working around the clock, this process could take one to two days. (*Id*.) Therefore, Defendants request that the Court modify its orders to direct DSH to notify the Special Master in advance when possible, or otherwise as soon as practicable, and in no event more than 48 hours of initiating any emergency action affecting ICF bed usage. Such notice would be followed by evaluation, analysis, and—if the Special Master determined it was necessary—a report containing recommendations consistent with the Special Master's existing powers and duties. And there is already a mechanism in place for the parties to file objections to, or move to modify, reject, or adopt, the Special Master's report. (*See* ECF No. 6230.) Thus, under DSH's proposed modification, the parties, the Special Master, and the Court will have a clear framework and process in place to implement, review, and adjust emergency actions.

**C. The Proposed Modification Is Consistent with the Constitution.**

Defendants' proposed modification does not create or perpetuate a constitutional violation. Even accepting arguendo the Court's prior conclusions that the Program Guide sets the objective requirements of the Eighth Amendment, a modification of DSH bed planning orders to allow emergency action is justified under *Jacobson*'s reasoning and consistent with the remedial scheme. The Eighth Amendment is "contextual and responsive to contemporary standards of decency," *Hudson v. McMillian*, 503 U.S. 1, 8 (1992), and "has been interpreted in a flexible and dynamic manner." *Gregg v. Georgia*, 428 U.S. 153, 171 (1976). And, individual liberties, "under the pressure of great dangers," may be reasonably restricted "as the safety of the general public may demand." *Jacobson*, 197 U.S. at 29. Indeed, limiting DSH's flexibility to take emergency action could perpetuate a different constitutional violation—namely, deliberate indifference to COVID-19's serious threat of harm. *See, e.g.*, *Wilson v. Williams*, 961 F.3d 829, 840 (6th Cir. 2020) (holding that COVID-19 represented an obvious objective risk of harm in the Federal Bureau of Prison's dormitory housing, but prison's six-part plan to mitigate the virus's

risk did not amount to deliberate indifference). Had DSH done nothing to mitigate the dangerousness of constant admissions and discharges, and experienced a rampant outbreak in its facilities, despite knowing about possible risks, it would have been accused of deliberate indifference. Modification is necessary—DSH cannot have its hands tied from acting in an emergency due to outdated orders unrelated to such exigent circumstances, and then be blamed for failing to act quickly or decisively enough to protect its patients.

In *Jacobson*, the Supreme Court determined that exigent circumstances threatening public health and safety can outweigh and even override constitutional rights. 197 U.S. at 27 (addressing an "epidemic of disease which threatens the safety of [a community's] members"); *see also Prince v. Massachusetts*, 321 U.S. 158, 166-67 (1944) ("The right to practice religion freely does not include liberty to expose the community or the child to communicable disease or the latter to ill health or death."); *Benner v. Wolf*, No. 20-cv-775, 2020 U.S. Dist. LEXIS 89425, at *11 (M.D. Pa. May 21, 2020) ("[T]he necessity of quick action by the State or the impracticality of providing a pre-deprivation process may mean that a post-deprivation remedy is constitutionally adequate.") (quoting *Logan v. Zimmerman Brush Co.*, 455 U.S. 422, 436 (1982)). The emergency magnifies the State's inherent police power, granting it more flexibility to take actions in pursuit of public health and safety. *See Jacobson*, 197 U.S. at 24-31. Thus, if the State's action has a "real or substantial relation" to the public health emergency, courts should find the action unconstitutional only if it is "beyond all question, a plain, palpable invasion of rights secured by the fundamental law." *Id*. at 31; *see also In re Abbott*, 954 F.3d 772, 784 (5th Cir. 2020) ("The bottom line is this: when faced with a society-threatening epidemic, a state may implement emergency measures that curtail constitutional rights so long as the measures have at least some 'real or substantial relation' to the public health crisis and are not 'beyond all question, a plain, palpable invasion of rights secured by the fundamental law.'" (quoting *Jacobson*)); *In re Rutledge*, 956 F.3d 1018, 1027 (8th Cir. 2020) ("[I]n the context of a public health crisis, a state action is susceptible to constitutional challenge only if it, 'purporting to have been enacted to protect the public health, the public morals, or the public safety, has no real or substantial relation

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to those objects, or is, beyond all question, a plain, palpable invasion of rights secured by the fundamental law.'" (quoting *Jacobson*)).

The Ninth Circuit agrees that the temporary denial of constitutional rights, including those under the Eighth Amendment, is reasonable in certain situations. For instance, in *Norwood v. Vance*, 591 F.3d 1062 (9th Cir. 2010), the Court recognized that the Eighth Amendment right to outdoor exercise may be temporarily denied where officials must quickly respond to violence threatening inmate safety. And in *Noble v. Adams*, 646 F.3d 1138, 1143-47 (9th Cir. 2011), a post-riot lockdown of prison that resulted in denial of Eighth Amendment rights was reasonable because prison officials have a duty to keep inmates safe. Further, the Ninth Circuit has recognized that Eighth Amendment remedies are flexible, permitting exceptions if unexpected circumstances make the remedy infeasible. *See Spain v. Procunier*, 600 F.2d 189, 199 (9th Cir. 1979) (affirming order requiring inmates to receive a specific quantity of outdoor exercise "unless inclement weather, unusual circumstances, or disciplinary needs made that impossible").

This Court has similarly recognized that flexibility in the remedial scheme is necessary to account for unforeseen circumstances and is consistent with the Eighth Amendment. The Court has also acknowledged that there must be exceptions—exceptions which have been adopted into the Program Guide. (*See, e.g.*, ECF No. 5610 (ordering the parties to develop rules for when periods may be excluded when gauging compliance with transfer timelines); *see also* ECF No. 5744 & ECF No. 5750 at 4 (adopting the parties' Program Guide Addendum).)

As this Court has observed, emergencies like the current pandemic do not "suspend the Constitution." (May 29, 2020 Hrg. Tr. at 31:23–24.) But that is not the end of the analysis. Rather, as explained in *Jacobson*, such circumstances shift the relevant legal standard, lowering the constitutional floor. Given the flexibility in both the Eighth Amendment and the remedial plan in this case, a modification that allows for a temporary emergency deviation from DSH's bed-plan requirements, including procedural safeguards, is not "beyond all question, a plain, palpable invasion rights secured by the fundamental law." *See Jacobson*, 197 U.S. at 31.

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## II. ALTERNATIVELY, DEFENDANTS ARE ENTITLED TO RELIEF UNDER RULE 60(b)(6).

Federal Rule of Civil Procedure 60(b)(6) is a "catch-all" provision that authorizes a court to relieve a party from a final order for any reason not covered by the other provisions of the rule. *Delay v. Gordon*, 475 F.3d 1039, 1044 (9th Cir. 2007). Rule 60(b)(6) enables courts to grant relief "whenever such action is appropriate to accomplish justice," but should only be applied in "extraordinary circumstances." *Liljeberg v. Health Servs. Acquisition Corp.*, 486 U.S. 847, 864 (1988). The moving party must generally demonstrate injury and circumstances beyond its control that prevented timely action to protect its interests. *United States v. Alpine Land & Reservoir Co.*, 984 F.2d 1047, 1049 (9th Cir. 1993).

Here, given Defendants' constitutional duty to protect patients from harm—including those who are *Coleman* class members and those who are not—DSH believed it had authority as part of the State's executive branch, as well as explicit authority under the March 8, 2017 order, to take immediate action to address an emergency that poses an imminent threat to life and limb. Yet, in this Court's recently announced view, DSH *must* delay before it can act, regardless of how exigent the circumstances. DSH could not have anticipated the current pandemic, let alone that the Court would limit its ability to immediately respond to it. And if another emergency arises in the future, manifest injustice would result if DSH cannot take immediate action to save life and limb exactly like it did in March 2020. *See Alpine Land & Reservoir Co.*, 984 F.2d at 1049 ("Rule 60(b)(6) has been used sparingly as an equitable remedy to prevent manifest injustice."). Because the pandemic has revealed how restrictive the Court's orders are in time of crisis, and because Defendants' proposed modification to those orders is "appropriate to accomplish justice," *see Liljeberg*, 486 U.S. at 864, the Court should grant modification under Rule 60(b)(6)'s catch-all provision.

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## CONCLUSION

The Court should grant Defendants' motion to modify bed plan orders. The modification would (1) allow the State to temporarily deviate from DSH bed plans in the event of an emergency without pre-approval litigation; (2) provide notice to the Special Master in advance when possible, or otherwise as soon as practicable, and in no cases more than 48 hours after taking emergency actions, and establish procedures for him to evaluate the actions taken and determine whether class members were adversely affected; and (3) report to the Court and Plaintiffs the effect, if any, of DSH's action on *Coleman* class members.

## CERTIFICATION

Defendants' counsel certifies that he reviewed the following orders relevant to this filing: ECF No. 1800, ECF No. 1855, ECF No. 1998, ECF No. 2236, ECF No. 3613, ECF No. 4199, ECF No. 5343, ECF No. 5573, ECF No. 5583, ECF No. 5610, ECF No. 5750, ECF No. 6600, ECF No. 6639, and ECF No. 6660.

Dated: August 31, 2020

Respectfully Submitted,

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IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

SACRAMENTO DIVISION

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| **RALPH COLEMAN, et al.,**<br>Plaintiffs,<br>**v.**<br>**GAVIN NEWSOM, et al.,**<br>Defendants. | 2:90-cv-00520 KJM-DB (PC)<br>**DECLARATION OF STEPHANIE CLENDENIN IN SUPPORT OF DEFENDANTS' MOTION TO MODIFY** |

I, Stephanie Clendenin, declare:

1. I am the Director of the California Department of State Hospitals (DSH). I have held this position since August 2019. I submit this declaration in support of Defendants' motion to modify orders under Federal Rule of Civil Procedure 60(b). I have personal knowledge of the statements in this declaration and could testify to them if called to do so.

2. Before being named DSH's Director, I served as the Acting Director since 2018 and DSH's Chief Deputy Director from 2015 to 2018.

3. DSH's Strategic Plan clearly sets forth the agency's mission: "[t]o provide evaluation and treatment in a safe and responsible manner, by leading innovation and excellence across a continuum of care and settings." DSH's values, also made clear by its Strategic Plan, include:

- safety ("Providing an environment where both patients and staff can interact without violence or coercion; a therapeutic and comfortable environment to live, work, and receive treatment");
- treatment ("Providing patient, employees, the public and stakeholders with care, compassion, and consideration. Intervening to improve someone's condition"); responsibility ("Being accountable for actions taken. An obligation to have integrity and do the right thing always. Following through on commitments. An obligation to be good stewards of public resources");
- empowerment ("Instilling confidence in others. Granting authority where appropriate to allow others to act based on upon personal and professional knowledge. Encouraging and rewarding innovative thinking");
- respect ("recognizing each person's value and treating them professionally and humanely. Being kind in engagements with others"); and
- communication ("Instilling confidence in others. Granting authority where appropriate to allow others to act based upon personal and professional knowledge. Encouraging and rewarding innovative thinking").

4. Currently, DSH treats the following types of patients: 1) those deemed incompetent to stand trial under California Penal Code section 1370; 2) those found not guilty by reason of insanity under Penal Code section 1026; 3) those deemed to be an offender with a mental health disorder under Penal Code sections 2962 and 2972; 4) patients determined to be sexually violent predators under Welfare and Institutions Code section, 6600, *et seq*.; 5) certain patients committed by civil courts for being a danger to themselves or others under the Lanterman-Petris-Short Act, Welfare and Institutions Code Section 5000, *et seq*.; 6) wards from the CDCR Division of Juvenile Justice transferred to DSH for treatment under Welfare and Institutions Code section 1756; and 7) inmates serving prison sentences who are transferred to DSH for treatment under

Penal Code section 2684, which may include *Coleman* class members. DSH provides treatment to its patients at five different facilities, but not every patient classification is treated at each facility.

5. At any given time before the COVID-19 pandemic, DSH's hospitals treated approximately 6,000 patients and employ nearly 12,000 staff. However, DSH currently treats fewer patients due to its work preparing isolation and admission/observation units as part of its pandemic response. DSH makes available 336 beds to treat clinically and custodially appropriate *Coleman* class members referred for intermediate inpatient care at three hospitals: DSH-Atascadero (256 beds), DSH-Coalinga (50 beds), and DSH-Patton (30 beds). In fiscal year 2018-2019, DSH hospitals treated a total of 10,002 patients.

6. *Coleman* class members account for just three percent of DSH's patients. The rest of DSH's patient population is made up of its other commitments—the majority, or approximately 23 percent, are incompetent to stand trial and committed to DSH under Penal Code section 1370. DSH's patients are sent from counties and superior courts all over the state and, depending on the commitment type, may be discharged to a conditional release program, back to the county, superior court, or county jail after treatment. DSH does not prioritize other patient classes over *Coleman* class members and can admit up to 336 clinically and custodially appropriate *Coleman* class members. At the time that DSH temporarily suspended admissions in March 2020 in response to the worldwide COVID-19 public health crisis, there were seven *Coleman* patients and 1,042 non-*Coleman* patients pending admission into DSH's facilities.

7. In my current position as Director, I oversee the overall management of DSH operations, including the treatment of *Coleman* class members at DSH facilities.

8. Based on my experience at DSH, I have knowledge of, among other things, DSH's policies for the treatment and transfer of *Coleman* class members.

9. I have reviewed and I am familiar with the Program Guide and the Court's orders relevant to DSH's provision of care to *Coleman* class members, and I understand DSH's obligations under the Court's remedial plans.

10. I am familiar with the Court's March 8, 2017 order and the requirements it places on the parties when making certain types of changes to prior bed plans. Specifically, the order states that "[u]ntil further order of court, defendants shall meet and confer with the Special Master at least thirty days before making any changes, additions, or reductions in the number and/or use of any inpatient beds or mental health crisis beds. If an emergency situation precludes such meet and confer thirty days in advance, defendants shall consult with the Special Master immediately upon learning of the need to make any changes, additions, or reductions in the number and/or use of inpatient beds or mental health crisis beds." The order defined the term "consult" as requiring "a conference in person or by telephone and not mere written notice or communication."

11. In an emergency, it is not possible to have an in-person meeting with the Special Master before having to change, add, or reduce the number or use of inpatient beds at DSH because the Special Master lives and works in Rhode Island. Accordingly, DSH's typical and expected practice, if possible, is to call the Special Master in an emergency situation to give him the notice required under the March 8, 2017 order.

12. In the past, DSH has provided the Special Master notice via email and telephone calls when units, including those treating *Coleman* class members, have been placed on quarantine and suspended from intake due to communicable diseases such as the flu or norovirus. The Special Master and Plaintiffs have never raised concerns about these notifications in the past, which DSH considered emergency circumstances.

13. On March 16, 2020, before DSH temporarily suspended admissions of *Coleman* patients to its hospitals to patient admissions, I called the Special Master to inform him that, due to the developing emergency caused by COVID-19, DSH needed to temporarily suspend almost all patient admissions to all of its hospitals, including the hospitals treating *Coleman* class members. During my telephone call with the Special Master, he informed me that he understood the decision. The Special Master did not indicate any disapproval of the decision or that DSH should reconsider its decision.

14. I am also aware that, after my conversation with the Special Master, DSH's Chief Counsel, Christine Ciccotti, called Plaintiffs' counsel, and sent a confirming email, to inform

them of DSH's emergency action. After both of these phone calls occurred, I issued the directive on March 16, 2020 temporarily suspending *Coleman* patient admissions for 30 days to ensure the health and safety of *Coleman* class members then in our hospitals, as well as all other patients and staff.

15. It was my understanding based on past conduct in prior emergency notifications, and my telephone conversation with the Special Master that I fulfilled the requirements of the March 8, 2017 order. It was not my understanding that "consultation," as used in the March 8, 2017 order, required that the Special Master approve DSH's decision on what steps it took to address an emergency.

16. It was not until several days after my conversation with the Special Master that I learned that he had concerns with DSH's temporary suspension of patient admissions.

17. In advance of the decision to suspend *Coleman* and other patient admissions, I also contacted the California Department of Corrections and Rehabilitation (CDCR) on March 15 and 16, 2020, and spoke with their executive leadership and General Counsel about DSH's decision to temporarily suspend admissions to its hospitals to almost all patient admissions. CDCR also did not object to DSH's emergency decision.

18. The physical layout of each of DSH's five hospital facilities make them particularly vulnerable to the spread of communicable diseases, including COVID-19. DSH's hospitals are mostly dormitory space with congregate sleeping, dining, bathroom, and gathering space. DSH's hospitals have limited space available to isolate patients who have contracted a communicable disease, such as COVID-19, or quarantine patients who have been exposed or are suspected of having a communicable disease. This was true before COVID-19, and remains true today, although DSH used the period of suspended admissions for each of its hospitals to identify and prepare available space for isolation of individuals who are under investigation for COVID-19 and for the treatment of individuals who are positive for COVID-19, to the extent necessary, obtain personal protective equipment, establish protocols, and obtain testing capacity. This is only a representative, and not exclusive list, of what DSH did to prepare during the time.

19. DSH's patient population is also particularly vulnerable to the more severe effects of communicable diseases, such as COVID-19. DSH treats many patients who are more vulnerable due to their age or co-morbid medical conditions.

20. Leading up to the decision to temporarily suspend admissions of almost all patient intake to DSH's hospitals, and thereafter, I, or my staff, have continuously consulted with medical and mental health experts within and outside DSH regarding the steps DSH needed to take to prepare for COVID-19 and the consequences of a potentially longstanding pandemic.

21. Based on my understanding of DSH, its hospitals, its population, my understanding of COVID-19, and my own and my staff's consultation with health experts, it was necessary to temporarily suspend admissions to DSH's hospitals to almost all patient admissions while DSH prepared its hospitals for COVID-19, to prevent the introduction and spread of COVID-19, and prevent harm to DSH's patients and staff, including the 298 *Coleman* class members in DSH's hospitals at the time of the temporary suspension.

22. It is my belief, based on my knowledge of COVID-19 and experience managing DSH's hospitals during this pandemic, as well as discussions with, and reports from, other state hospital systems across the country that experienced COVID-19 outbreaks, that immediate action was necessary and that a delay of even one day could have resulted in the introduction and spread of COVID-19 in DSH's hospitals. That situation could have led to a longer-term suspension of admissions and a decrease in DSH's ability to provide mental health care to its existing patients. The recent introduction and spread of COVID-19 at DSH-Patton—despite DSH's precautions—confirms that belief and supports the proactive and immediate decision DSH made to halt admissions of *Coleman* patients on March 16, 2020.

23. To the best of my knowledge, DSH did not have any confirmed COVID-19 positive patients in any of its hospitals when it temporarily suspended patient admissions and discharges. As of August 25, 2020, DSH did not have any confirmed COVID-19 positive patients in any of the units that treat *Coleman* class members. Indeed, DSH did not have its first confirmed COVID-19 positive patient until May 16, 2020, which was four weeks after DSH resumed

admissions of *Coleman* class members, and one week before it resumed admissions of its other patient classes.

24. It is not possible for DSH to predict, prepare, and respond to every possible emergency situation without it having an effect on operations as they exist during non-emergent times. DSH may have to take immediate action in the future to respond to a sudden emergency that threatens the health and wellness of its patient population and staff, and a delayed response could result in a tragic loss of health or life. DSH may need to make emergency decisions in the future to save lives, and needs the ability to make those decisions quickly without delaying for a meet-and-confer process or litigation.

25. Following the Court's April 24, 2020 and May 7, 2020 orders addressing DSH's temporary transfer suspension, it is my understanding that the Court expects DSH to not merely consult the Special Master before making an emergency decision to save lives, but DSH must also request permission from the Court to take emergency action that reduces the number or type of beds DSH provides to treat *Coleman* class members.

26. I am concerned that even on a shortened or expedited schedule, a formal request to the Court, or final approval from the Special Master, will hinder DSH's ability to respond proactively to emergencies and result in harm to its patients and staff. For example, before COVID-19, between January 2020 and February 2020, DSH hospitals received an average of approximately 10 *Coleman* admissions per week, and approximately 75 patient admissions per week overall. Each of those transfers presented a risk to introducing COVID-19 into a DSH facility at a time when DSH had not had an opportunity to prepare and plan for space to safely admit patients and respond to any patients who contract the disease. Given COVID-19's aggressive infectious nature, DSH was not prepared to appropriately mitigate the impacts of admitting a COVID-19 positive patient and the potential for a widespread outbreak in its facilities.

27. If DSH is not able to respond immediately to an emergency, there is a great risk of potential harm to DSH staff and patients, as well as the community. At any time when a patient living, or employee working, on a unit tests positive for COVID-19, DSH would immediately

quarantine those units, while it serially tests all patients and employees living and working on the unit to determine if additional patients or employees become positive for COVID-19. The patients and employees continue to be tested and the unit quarantined until it is determined that transmission is no longer occurring on the unit. When a unit is quarantined, DSH pauses patient admissions and discharges to the unit or units so that additional patients are not exposed to COVID-19. For example, if DSH had experienced a widespread COVID-19 outbreak at its hospitals it may have had to suspend admissions for a much longer period of time and greatly curtailed the amount of treatment available to patients already in its hospitals. This would have resulted in patients having to remain in county facilities longer. The same may be true for a future outbreak. Moreover, DSH is a forensic inpatient psychiatric hospital, and is not a community acute care hospital. DSH must transfer patients with severe COVID-19 symptoms to community hospitals for care as it does not have facilities equipped for that level of medical intervention. A severe outbreak could result in an increased number of hospitalizations in the community. And, a severe outbreak could expose more staff to COVID-19, decreasing staff levels in the hospital, and increasing exposure to members of the community who come in contact with staff members.

28. My concerns are not limited to COVID-19 or similar emergencies. They also extend to wildfires, earthquakes, hostage situations, and other similar events. Wildfires and earthquakes are both unpredictable and not uncommon to California. For example, in 2017, a wildfire nearly required the evacuation of Napa State Hospital. If one of DSH's hospitals was threatened by, or suffered such an event, it would have to quickly evacuate and relocate a substantial patient population with significant mental health needs. The relocation of the population would likely require around the clock work for a number of days, as DSH found sufficient space and resources for its patients based on their individual medical, mental health, security, and other needs. DSH would not be able to admit or discharge any patients in such a situation. DSH would need to act in hours, if not minutes, and would not have the time to seek leave of the Court before or simultaneously while it carried out a task as large and intricate as evacuating and relocating a state hospital.

29. I understand that DSH has obligations in this case. DSH and I remain committed to continuing to timely communicate any actions, emergent or otherwise, to the Special Master that affect the *Coleman* class and the reasons for those actions. As DSH has done throughout this litigation, it will cooperate with the Special Master and his team's monitoring of DSH's actions as they relate to the *Coleman* litigation.

30. By allowing DSH to make immediate decisions in the face of life threatening or significantly dangerous emergencies, I believe that Defendants' proposed notification procedures concerning inpatient bed program changes accomplishes the flexibility that DSH needs to safely address emergency circumstances. It does not require DSH to pause its emergency response and potentially lose valuable response time. At the same time, the proposal requires DSH to notify the Special Master in a short period of time after any decision is made to close or change the number of mental health beds available. I believe this will maintain transparency and communication with the Special Master in a manner and within certain time parameters to ensure collaborative and informed decision-making. It also provides clarity to me and DSH regarding what is expected of us in our emergency response actions.

I declare under penalty of perjury that the information in this declaration is true and correct to the best of my knowledge. Executed on August 31, 2020, Sacramento, California.

Stephanie Clendenin, Director

CF1997CS0003

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IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

SACRAMENTO DIVISION

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| **RALPH COLEMAN, et al.,**<br>Plaintiffs,<br>**v.**<br>**GAVIN NEWSOM, et al.,**<br>Defendants. | 2:90-cv-00520 KJM-DB (PC)<br>**DECLARATION OF KYLE A. LEWIS IN SUPPORT OF DEFENDANTS' MOTION TO MODIFY** |

I, Kyle A. Lewis, declare:

1. I am a Deputy Attorney General in the California Office of the Attorney General, representing Defendants in this matter. I submit this declaration in support of Defendants' motion to modify the Court's orders under Federal Rule of Civil Procedure 60(b). I have personal knowledge of the contents of this declaration and could testify to them if called to do so.

2. During an All Parties Meeting on July 23, 2020, Defendants proposed to the Special Master and Plaintiffs that the parties come to an agreement concerning Defendants' notification

or consultation of the Special Master or Plaintiffs before taking actions that impact *Coleman* patient transfer to, use of, or availability of inpatient care treatment beds at State facilities in response to emergency situations, including responses to viral outbreaks or other exigencies. Plaintiffs' counsel expressed willingness to listen to Defendants' proposal, and the Special Master was encouraged that the parties were keeping an open dialogue. Defendants agreed to circulate a proposed notification plan among the parties for review and further discussion.

3. On August 4, Defendants delivered a proposed emergency notification procedure concerning mental health program bed changes to the parties, and invited further dialogue concerning it. A true and correct copy of this document, titled "*Coleman* Emergency Notification Proposal," is attached as Exhibit A.

4. During an All Parties Meeting on August 13, the parties discussed Defendants' proposed bed change emergency notification process. The Special Master asked questions about Defendants' issues with the current orders governing notification and consultation. Plaintiffs said that they had not fully reviewed Defendants' proposal, but that they would do so and provide comments concerning it.

5. On August 14, Defendants sent correspondence to the Special Master and Plaintiffs following-up on the positive conversations held thus far concerning Defendants' proposal, and invited written comments so that the parties could further discuss the proposal during the upcoming COVID-19 Task Force meeting. That afternoon, the Special Master contacted defense counsel and stated that Defendants' draft should not be the starting point for discussions on this topic, and that the Court's order were controlling and should be examined first. The Special Master invited further conversation, but said that Defendants were free to file a motion seeking a modification to the Court's orders. To date, Defendants have received no comments from any party concerning the proposed bed change emergency notification process.

6. Given the importance of being able to act rapidly in the face of an emergency to protect the health and safety of patients and staff in State facilities, Defendants are moving to modify orders concerning the bed change notification and consultation procedures. Nevertheless,

Defendants welcome further negotiation with the Special Master and Plaintiffs to reach agreement concerning a bed change emergency notification process that provides sufficient flexibility and clarity for Defendants to manage inpatient beds at State facilities when confronted with emergency situations that threaten the welfare of patients and staff.

I declare under penalty of perjury that the information in this declaration is true and correct to the best of my knowledge. Executed on August 31, 2020, at San Francisco, California.

/s/ Kyle A. Lewis

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# Exhibit A

# *Coleman* Emergency Notification Proposal

Proposal:
A framework for notification of emergent circumstances and follow-on discussion regarding actions taken by Defendants that effect a temporary change in the number and/or use of mental health beds for *Coleman* class members at the Mental Health Crisis Bed (MHCB), Intermediate Care Facility (ICF), or Acute Psychiatric Program (APP) levels of care, and to which the parties can stipulate. This stipulation will govern future notifications, reduce the need for future litigation, provide clarity for the steps the parties must take, and encourage communication and collaboration between the parties and Special Master.

Framework:

(1) When Defendants determine there is an emergency circumstance that requires immediate action to protect the health and safety of *Coleman* class members and that action results in a temporary, short-term change in the number and/or use of mental health beds for *Coleman* class members at the MHCB, ICF, or APP levels of care, Defendants shall:

a. Contact the Special Master or his designee and Plaintiffs' Counsel before the action is taken, if feasible, but in no event more than 48 hours after the action is taken, by phone to describe the emergency situation, what actions Defendants are taking, and why such actions are necessary, to be followed by an email confirming the information provided by phone.

b. Defendants shall discuss the actions taken with the Special Master and Plaintiffs. This may be done in a COVID-19 Task Force meeting, workgroup, or other meeting, as needed, depending on the circumstances of the emergency and Defendants' response.

c. When Defendants, the Special Master, and Plaintiffs meet, Defendants shall update the parties on the status of the emergency, the current efforts taken to respond, why those efforts are reasonable, what next steps are planned, any effects on the existing bed plans and other *Coleman* remedial requirements (to the extent they are known at the time), and how Defendants plan to provide mental health care for *Coleman* class members during the emergency. The Special Master and Plaintiffs shall have the opportunity to ask questions, provide input, and request additional meetings or information.

d. An "emergency" is the existence of conditions of imminent peril to the safety of persons and property within the prison system caused by conditions such as air pollution, fire, flood, storm, epidemic, riot, drought, cyberterrorism, sudden and severe energy shortage, plant or animal

infestation or disease, the Governor's warning of an earthquake or volcanic prediction, or an earthquake, or other similar conditions. (*See e.g*. Gov. Code § 8558.) An emergency may also include the failure of critical building infrastructure (e.g. water and/or sewage systems), or outbreaks of disease or other circumstances in the institution or in the community that threaten the health and safety of the institution, its staff, or the people being held there. This list in not intended to be exclusive.

e. "Short-term" means a change in the number and/or use of generally 30 days or less. If it becomes apparent that the reduction in the number of beds or change in the use of mental health beds must continue for longer than 30 days, Defendants will immediately communicate the need and reason to the Special Master and the change will be discussed at the next scheduled monthly mission change meeting under the process utilized by the parties and the Special Master.

(2) If, after the parties meet as described above in section (1), , there is disagreement between the parties regarding the emergency action, the Special Master will review the action taken and report to the Court on the effect, if any, on *Coleman* class members. The parties would have 30 days to file objections to, or move to modify, reject, or adopt, the report.

(3) Nothing in this proposal will affect the current practices for planned changes to existing bed plans or the existing mission change process utilized by the parties and the Special Master.

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IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

SACRAMENTO DIVISION

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| **RALPH COLEMAN, et al.,**<br>Plaintiffs,<br>**v.**<br>**GAVIN NEWSOM, et al.,**<br>Defendants. | 2:90-cv-00520 KJM-DB (PC)<br>**DECLARATION OF K. WARBURTON IN SUPPORT OF DEFENDANTS' MOTION TO MODIFY** |

I, K. Warburton, declare:

1. I am the Medical Director and Deputy Director of Clinical Operations for the California Department of State Hospitals (DSH), a position I have held since November 2011. I submit this declaration supporting Defendants' motion to modify the Court's orders under Federal Rule of Civil Procedure 60(b). I have personal knowledge of the statements in this declaration and could testify to them if called to do so.

2. I received my Doctor of Osteopathic Medicine in 2001 from Midwestern University, and completed my general adult psychiatry residency at Maine Medical Center. I also completed a fellowship in forensic psychiatry at the University of California, Davis. I am licensed to practice medicine by the Osteopathic Medical Board of California, and board certified in Forensic Psychiatry and General Adult Psychiatry by the American Board of Psychiatry and Neurology. I am also currently an Associate Professor of Clinical Psychiatry at the University of California, Davis, School of Medicine.

3. Before becoming DSH's Medical Director, I worked as a psychiatrist in a number of different settings inside and outside of DSH. For example, I was an attending psychiatrist for the Sacramento County Jail, attending psychiatrist at Napa State Hospital, acting Senior Psychiatrist at Napa State Hospital, and Chief of Forensic Psychiatry at Napa State Hospital.

4. As the Medical Director and Deputy Director of DSH's Clinical Operations, I oversee the development and delivery of all clinical and medical care within DSH, the implementation and evaluation of treatment protocols and policies, and communication with other systems and experts to understand current standards and best practices. I also oversee the clinical response to emergencies and crises experienced by DSH's hospitals, such as the recent COVID-19 pandemic. I am also familiar with the different types of patients DSH admits and treats and the general demographic characteristics of those patients, including, but not limited to, clinical acuity and medical comorbidity. I am also familiar with the general physical characteristics of DSH's hospitals, including the treatment and living environments for the different groups of patients, and the particular risks that those spaces pose when infectious diseases are introduced into the environment.

5. I previously submitted a declaration in support of Defendants' response to the Court's April 3, 2020 order to show cause. At the time, DSH's temporary suspension of nearly all admissions and discharges in response to the early spread of COVID-19 in California was still in place. I still support the statements made in that declaration based on the facts and information available to me at the time. It is still my opinion that DSH's decision to temporarily suspend

admissions and discharges was the clinically appropriate decision under the circumstances and helped to prevent the spread of illness in DSH's population.

6. A number of factors changed since that time, allowing DSH to start admitting and discharging patients beginning on April 15, 2020, when DSH ended its temporary suspension of *Coleman* class member admissions. Specifically, COVID-19 testing became more available to DSH, and DSH used the time during the temporary suspension to prepare plans and space to safely admit patients. DSH was also able to partner with public health experts from the California Department of Public Health (CDPH) to develop plans for safe admissions and discharges and outbreak response. That collaborative work is ongoing.

7. Based on my experience as DSH's Medical Director and knowledge of its facilities, staff and patients, my research and understanding of COVID-19, my ongoing experience responding to the COVID-19 pandemic, my discussions with officials from other state hospital systems and review of information about those other systems, my opinion is that DSH requires flexibility to respond to emergencies that threaten the life and health of its patients and staff. In certain circumstances, DSH does not have time to delay decisions, such as the decision to temporarily suspend patient admissions and discharges, and wait for approval by the Special Master, Court, and Plaintiffs.

8. Even a short delay, while we wait for approval from the Special Master, Plaintiffs, and the Court, could have devastating effects on DSH's patient population. Before DSH's temporary admission suspension, it was admitting new patients to all of its hospitals from up to 58 county jails and 35 CDCR prisons on a daily basis. Without rapid widespread testing and sufficient isolation and quarantine space, each of those patients presented a potential vector for introducing COVID-19 into DSH. During the suspension of admissions, DSH adopted new admission protocols and prepared isolation and quarantine space to appropriately mitigate potential introduction of the disease. Now that admissions have resumed, even with these new protocols, DSH's population remains vulnerable to this highly infectious disease and DSH may need to take rapid and significant steps to prevent the spread of that disease. In these circumstances, DSH needs flexibility to make rapid decisions regarding patient admissions and

discharges to avoid the introduction of disease and possible illness and death. DSH and its medical officials are in the best position to make these decisions because they are familiar with DSH's overall population, overall hospital structure and policies, and capabilities in a crisis.

9. My experience, research, and ongoing consultation with CDPH have made me aware that introduction of COVID-19 and other highly contagious viruses into DSH's facilities has the potential to cause rapid disease spread, and a devastating loss of life in its susceptible patient population. DSH's patient population and the design of its physical facilities make it particularly vulnerable. DSH units are much larger than most other state hospitals, and most patients live in dormitory-style bedrooms with multiple other roommates. On DSH's units, most patient dining, bathroom, congregate, and bedroom space is shared by patients and patients cannot be separated to prevent COVID-19 spread. Even after DSH worked to identify space for quarantine and isolation, it remains limited due to the design of its physical facilities.

10. DSH's patient population includes a large number of patients with conditions that make them more vulnerable to the more severe effects of COVID-19 and other contagious diseases. A high percentage of DSH patients have complex medical co-morbidities, and a portion of the patient population is housed in skilled nursing facilities. Approximately 25 percent of DSH's nearly 6,000 patients are over the age of 60. And many of DSH's patients have serious mental illnesses that make it difficult for them to follow masking, hygiene, and social distancing requirements in its congregate setting.

11. Severe disease and loss of life are not the only harms that would result from DSH experiencing an outbreak in one of its facilities. An outbreak would also severely limit DSH's ability to provide mental health care to its patients. Already staff must wear personal protective equipment and patient movement has been significantly limited. An outbreak requiring isolation and quarantine would further reduce DSH's treatment milieu and the ability to deliver mental health care to patients. An outbreak also could require DSH to close an entire hospital to new admissions, cutting off access to additional patients from across the state who may need care.

12. The negative effects of an outbreak, from COVID-19 or another infectious disease, are not isolated to DSH, but also impact the surrounding community. DSH facilities are not

similar to acute medical care hospitals in the community. They are not designed to treat medical emergencies or psychiatric emergencies, such as those patients placed on a 72-hour hold for assessment under Welfare and Institutions Code section 5150 because they are a danger to themselves or others. DSH only provides routine primary medical care. Patients with more serious or emergent illnesses must be sent out to community hospitals. This would include those patients who experience the more severe effects of COVID-19. Those patients must be taken to a community acute care hospital for treatment. Moving the patients to community hospitals impacts community resources and risks infecting staff at the community hospital and transport staff. Comparisons of DSH facilities to community acute medical care hospitals and the guidance for managing COVID-19 for those hospitals are completely inaccurate and inappropriate.

13. It is also possible for the disease to spread out of DSH's facilities. DSH and its staff are taking extreme precautions to protect themselves and patients with daily screenings and the use of personal protective equipment, among other measures. However, its staff are still in close contact with patients and risk contracting the disease, and taking it home to their families and surrounding community.

14. If a facility is forced to close to admissions due to an outbreak at that location, DSH will likely also have to halt the admissions of new patients to that facility, including those referred to DSH by the counties and superior courts around the state, as DSH is the primary provider of inpatient mental health care for justice-involved persons with serious mental illness in California.

15. An immediate closure could be required of an individual unit or an entire hospital. At any time when a patient living, or employee working, on a unit tests positive for COVID-19, DSH would immediately quarantine those units, while it serially tests all patients and employees living and working on the unit to determine if additional patients or employees become positive for COVID-19. The patients and employees continue to be tested and the unit quarantined until it is determined that transmission is no longer occurring on the unit. When a unit is quarantined, DSH pauses patient admissions and discharges to the unit or units so that additional patients are not exposed to COVID-19. Depending on the extent of the positive cases, DSH may need to halt admissions and discharges to the entire hospital. For example, DSH-Patton is currently

experiencing a COVID-19 outbreak. As of August 28, 2020, the cumulative total of confirmed positive cases is 148 among patients and 135 positive cases among staff. The hospital is temporarily closed to all admissions except those that are required by state law and cannot be suspended and 6 of its units are on quarantine, including all of its admissions units. COVID-19 spread extremely fast at DSH-Patton and has been challenging to contain. The most effective measures at preventing illness are limiting the introduction of the disease, rather than trying to contain it once patients are already infected.

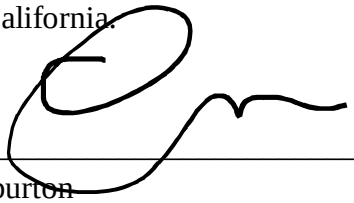
16. I am in regular contact with my colleagues in other states about COVID-19. We are sharing best practices, protocols, and information in real time. I am also regularly reviewing media and other reports about COVID-19's effects on other state hospital systems. Based on those conversations and my review, I believe that hospital systems that did not immediately limit or suspend patient admissions during the initial spread of COVID-19 in the United States experienced serious outbreaks and loss of life. For example, according to an April 17, 2020 NBC News report, at least 1,450 patients tested COVID-19 positive in state mental health facilities in 23 states.

17. To the best of my knowledge, DSH did not have any confirmed COVID-19 positive patients at the time it temporarily suspended admissions and discharges to DSH hospitals. DSH did not have its first confirmed COVID-19 positive patient until May 16, 2020, and as of August 25, 2020, none of DSH's *Coleman* class member patients test positive for COVID-19. To the best of my knowledge, DSH did not experience its first confirmed positive patient case until 4 weeks after DSH resumed admissions of *Coleman* class members, and one week before it resumed admissions of its other patient classes. I believe that DSH's temporary suspension of patient admissions prevented DSH from having confirmed positive cases for as long as it did. The suspension prevented transfers from vulnerable prison institutions and allowed DSH time to acquire testing capacity and to work in partnership with CDPH to develop and follow careful admission and discharge procedures. These essential measures have helped prevent and contain outbreaks throughout our system, including DSH's *Coleman* population.

18. The COVID-19 pandemic is not at an end and it does not appear that its threat will abate soon. With cases recently rising across the United States and in California, it remains critical that DSH be able to take immediate action, including closing admissions and discharges to its hospitals, to prevent widespread outbreak and emergencies that threaten the lives and well-being of its patients and staff, as well as its ability to provide mental health treatment to its current and future patients.

19. Despite the need to act quickly and decisively in this emergency, I understand the Court's concern with closing or limiting the number of beds available for patients in need of mental health care, and I remain committed to continuing to work with the Special Master and his experts regarding any actions we take in the face of this emergency and future emergencies that affect the beds available to treat *Coleman* class members in DSH. I also remain committed to work with the Special Master and his experts in the Task Force meetings and small group meetings during the COVID-19 pandemic to address this current ongoing emergency.

I declare under penalty of perjury that the information in this declaration is try to the best of my knowledge. Executed on August 31, 2020, Sacramento, California.



K. Warburton
*Original Signature Retained by Attorney*

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