DONALD SPECTER – 083925
STEVEN FAMA – 099641
MARGOT MENDELSON – 268583
PRISON LAW OFFICE
1917 Fifth Street
Berkeley, California 94710-1916
Telephone: (510) 280-2621

CLAUDIA CENTER – 158255
DISABILITY RIGHTS EDUCATION
AND DEFENSE FUND, INC.
Ed Roberts Campus
3075 Adeline Street, Suite 210
Berkeley, California 94703-2578
Telephone: (510) 644-2555

MICHAEL W. BIEN – 096891
JEFFREY L. BORNSTEIN – 099358
ERNEST GALVAN – 196065
THOMAS NOLAN – 169692
LISA ELLS – 243657
JENNY S. YELIN – 273601
MICHAEL S. NUNEZ – 280535
JESSICA WINTER – 294237
MARC J. SHINN-KRANTZ – 312968
CARA E. TRAPANI – 313411
ALEXANDER GOURSE – 321631
ROSEN BIEN
GALVAN & GRUNFELD LLP
101 Mission Street, Sixth Floor
San Francisco, California 94105-1738
Telephone: (415) 433-6830

Attorneys for Plaintiffs

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, et al.,

Plaintiffs,

v.

GAVIN NEWSOM, et al.,

Defendants.

Case No. 2:90-CV-00520-KJM-DB

PLAINTIFFS' RESPONSE TO DEFENDANTS' STRATEGIC COVID-19 MANAGEMENT PLAN

Judge: Hon. Kimberly J. Mueller

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INTRODUCTION

The Court's April 10, 2020 Order directed Defendants to develop a plan that:

> include[s] objectives and timelines for defendants' plans for housing of *Coleman* class members who are not being granted early release from the California Department of Corrections and Rehabilitation (CDCR), including those most at risk for COVID-19. It should provide for continuity of mental health care, including access to clinically indicated levels of mental health care and attendant programming as outlined in the Program Guide.

Order, ECF No. 6600 at 2 (Apr. 10, 2020).[1] This Court made clear that a unified, comprehensive approach with clear objectives and timeframes "is essential to protection and preservation of the vital interests at stake in this case." *Id.* at 2. But as explained in this Court's order from April 17, 2020, Defendants' Strategic COVID-19 Management Plan, ECF Nos. 6616, 6616-1 (Apr. 16, 2020) ("Strategic Plan"), does not meet those basic requirements. *See* Order, ECF No. 6622 at 2 (Apr. 17, 2020). Specifically, Defendants have failed to identify: (1) their objectives for housing *Coleman* class members who are not being granted early release from CDCR; (2) timelines for those objectives; and (3) a specific plan for housing medically vulnerable members of the *Coleman* class. *Id.*

The Strategic Plan itself is fundamentally deficient because it fails to address adequately the linchpin of the Federal Centers for Disease Control and Prevention ("CDC") guidance for correctional systems—physical distancing between individuals to prevent transmission of the disease, frequent hand washing and other hygiene measures, and sanitation. And even where Defendants discuss a low-on-the-CDC-list option (proposed by the *Plata* Receiver) of cohorting groups of eight individuals in dorm settings, they have failed to clearly endorse that plan, let alone develop steps or a timeline for implementing it. Notwithstanding this Court's rejection of a non-unified and piecemeal approach, *see* ECF No. 6600 at 1-2, Defendants still have not articulated what they hope to achieve to ensure class members are safe, and without that benchmark, they cannot know whether or when they will get to safe—for class members, non-class members, and CDCR

[1] Pagination references are to the ECF pagination.

clinical and custody staff.

I. Defendants May Finally Have Decided On A Social Distancing Plan, Including Adopting the Receiver's Cohorting Proposal.

Defendants' Strategic Plan skirts any meaningful response to the CDC's COVID-19 guidance for correctional systems, to achieve and maintain physical distancing between incarcerated people. *See* Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities, CDC Guidance (last visited Apr. 20, 2020) ("CDC Guidance"). For example,

- The CDC Guidance directs correctional systems to: "Make a list of possible social distancing strategies that could be implemented as needed at different stages of transmission density." CDC Guidance at 6.

  Defendants' opaque response is: "CDCR/CCHCS leadership have been considering, and continue to review and consider, all options to improve social distancing." Strategic Plan, ECF No. 6616-1, Attachment A at 3 (Apr. 16, 2020).

- The CDC Guidance states that correctional systems should "[e]xplore strategies to prevent over-crowding." CDC Guidance at 6.

  Defendants respond only that this is "[b]eing done on an ongoing basis." Strategic Plan, ECF No. 6616-1, Attachment A at 4 (Apr. 16, 2020).

- Correctional systems should "implement social distancing strategies to increase the physical distance between incarcerated/detained persons (ideally 6 feet between all individuals, regardless of the presence of symptoms)." CDC Guidance at 11,

  Defendants mention a number of ad hoc measures, including "encourag[ing]" social distancing, and referencing the Receiver's eight-person cohort proposal, which Defendants have not yet even endorsed, nor implemented. Strategic Plan, ECF No. 6616-1, Attachment A at 15 (Apr. 16, 2020).

- The CDC also recommends that correctional systems "[c]onsider additional options to intensify social distancing," CDC Guidance at 22,

  CDCR responds: "CDCR continues to move inmates out of dorm housing and educating [sic] the population about the importance of communal social distancing. CDCR and CCHCS continue to assess the institutions and determine what more needs to be done." Strategic Plan, ECF No. 6616-1, Attachment A at 40 (Apr. 16, 2020).

The main body of the Strategic Plan echoes this unwillingness to engage with the social distancing guidance, stating vaguely only that:

1 The [Department Operation Center]'s goal is to implement measures and strategies to protect inmates and staff during the COVID-19 pandemic, to
2 enhance social distancing in communal areas, and to review alternative housing options that may be used to increase physical distancing between
3 inmate cohorts in dorms where possible.

4 Strategic Plan, ECF No. 6616 at 7-8 (Apr. 16, 2020).

5 These responses link directly back to Defendants' fallback excuse for not having
6 affirmatively identified how to achieve a safe level of physical distancing: the "constantly
7 evolving" nature of the pandemic. *See, e.g.*, Strategic Plan, ECF No. 6616 at 7 (Apr. 16,
8 2020). But one component of the effort that has not changed since the initial guidance is
9 the need for physical distancing to minimize spread of the disease, as Defendants
10 elsewhere acknowledge. Strategic Plan, ECF No. 6616 at 11 (Apr. 16, 2020) ("Social
11 distancing is crucial in preventing the spread of COVID-19."). And in any event, as this
12 Court has noted, the evolving circumstances and need for flexibility to craft responses
13 against a changing backdrop are not reasons not to address this issue head-on. *See* Order,
14 ECF No. 6600 at 2 (Apr. 10, 2020) ("The adoption of a strategic plan that sets out specific
15 goals and objectives to be accomplished by a date certain is not inconsistent with the
16 flexibility defendants require to meet the significant challenges presented by the
17 coronavirus pandemic. Indeed, such a plan is essential to protection and preservation of
18 the vital interests at stake in this case.").

19 Of course, the *Plata* Receiver has proposed that Defendants adopt a plan to create
20 eight-person cohorts in the large dorms, with each cohort's sleeping space physically
21 separated by six feet in all directions from the sleeping space of other cohorts. *See* ECF
22 No. (Apr. 10, 2020). But in their Strategic Plan, Defendants could do no more than
23 equivocate as to their intent to implement the Receiver's proposal. Strategic Plan, ECF
24 No. 6616 at 11 (Apr. 16, 2020) ("Upon completion of all currently scheduled transfers
25 related to physical distancing, CDCR, in conjunction with the *Plata* Receiver, will assess
26 the population in the dorms and determine what additional steps need to be taken, if any.");
27 *Id.*, ECF No. 6616-1, Attachment A at 14 ("CDCR and CCHCS have defined housing
28 cohorts of 8 in dorm settings to increase social distancing in sleeping areas."); *Id.* at 15

1 ("Receiver memo of April 10, 2020, specifies that cohorts of 8 within dorms are sufficient
2 for social distancing.").
3 Defendants were given multiple opportunities at the April 17, 2020 hearing before
4 this Court to confirm that they actually are implementing the eight-person cohort plan, as
5 they represented to the *Plata* court at its April 16, 2020 hearing on Plaintiffs' COVID-
6 based emergency motion for relief for the *Plata* class. *See Plata v. Newsom*, N.D. Cal. No.
7 01-cv-01351-JST, ECF No. 3266 at 11 (Apr. 17, 2020) ("Defendants responded with an
8 unqualified commitment to implementing the Receiver's directive . . . ."). But before this
9 Court, Defendants only went so far as to say they are "examining" the Receiver's
10 cohorting proposal. Decl. of Michael W. Bien in Supp. of Pls' Response to Defs' Strategic
11 COVID-19 Management Plan ("Bien Decl."), ¶ 29.
12 And even if CDCR adopted the eight-person cohort concept, Defendants have never
13 addressed whether they intend or are even able to follow the CDC Guidance, and the
14 Receiver's matching recommendation, that each cohort be separated physically from every
15 other cohort by six feet in all directions. *See* CDC Guidance at 4, 11. Nor have they
16 explained what steps they intend to prevent transmission of the virus when eight-person
17 cohorts share bathrooms, *see* CDC Guidance at 19; Bien Decl., ¶ 3, Ex. B at 3 (March
18 2020 CDPH guidance warns that the virus may be "spread through the fecal-oral route,
19 including use of shared toilets in congregate settings"), and intermix for the purpose of
20 feeding, *see* CDC Guidance at 19, 21.
21 Defendants' failure to discuss or share the objectives and goals of their plans for
22 addressing the overcrowded dorms is especially troubling given initial reports received by
23 Plaintiffs' counsel over the past few days that CDCR is *increasing* rather than decreasing
24 the level of crowding in at least some dorms housing medically vulnerable persons. Bien
25 Decl., ¶ 15, Ex. N. Without any measurable goal on a large or small-scale to achieve true
26 physical distancing in its institutions—and without the necessary resources otherwise to
27 prevent and combat the disease—CDCR is still likely bound to experience severe, but
28 otherwise preventable, outbreaks.

In a filing this morning in *Plata*, Defendants again reversed course and stated in their Case Management Conference Statement that they have decided to follow the Receiver's guidance and have a plan to "fully implement the eight-person cohorts contemplated in the Receiver's plan." Joint Case Management Conference Statement, *Plata v. Newsom*, N.D. Cal. No. 01-cv-1351-JST, ECF No. 3294 at 11 of 19 (Apr. 20, 2020). They also promised to provide documents describing the details of their plan and a timeline for completion of the dorm moves to plaintiffs' counsel. Bien Decl., ¶ 25. As of the time of this filing, Plaintiffs' counsel has not received the documents. *Id.*

II. CDCR Has Not Taken Any Measures to Target Prevention Efforts to Protect the Medically Vulnerable in Its Care, or to Any Other Specific Population, and It Has No Intention of Doing So.

While Defendants have provided Plaintiffs a list of class members with at least one risk factor for COVID-19, Defendants' failure to create a plan for using that list to develop a safe housing plan for those "identified as medical vulnerable[] is of grave concern." Order, ECF No. 6622 at 3 (Apr. 17, 2020); *see also id.* & n.3 (directing the COVID-19 taskforce to give this issue "expedited consideration," i.e., give the task "the highest priority"). Defendants, however, have made clear that they do not intend to target COVID-related efforts to any particular population, including the medically vulnerable: "There are currently no plans to target specific portions of the population, such as *Coleman* class members or high risk inmates, for special movement or housing, except as detailed below in section III regarding the provision of Mental Health care." Strategic Plan, ECF No. 6616 at 9 (Apr. 16, 2020).

Defendants' refusal to target any population is puzzling and dangerous. Virtually all of the available guidance makes clear that systems should prioritize their efforts on the elderly and medically vulnerable, since they are disproportionately likely to experience severe COVID-19 based symptoms and/or death as a result of the disease. The CDC Guidance states that prisons must implement extra social distancing measures for quarantined patients at high-risk for medical complications. CDC Guidance at 20 ("If cohorting [of high-medical-risk quarantined individuals with low-medical-risk individuals]

is unavoidable, make all possible accommodations to reduce exposure risk for the higher-risk individuals. (For example, intensify social distancing strategies for higher-risk individuals.).”). CCHCS, the California Department of Public Health, and the Governor also recommend special measures for medically vulnerable patients. *See* COVID-19: Interim Guidance for Health Care and Public Health Providers, *Plata v. Newsom*, N.D. Cal. No. 01-cv-1351-JST, ECF No. 3274-6 at 19 (Apr. 3, 2020) (CCHCS guidance recommending that institutions place vulnerable patients in a “protective shelter in place”); Bien Decl., ¶ 17, Ex. P at 1-2 (California Department of Public Health guidance directing individuals over 65 years-old, individuals with serious chronic medical conditions like heart disease, diabetes, and lung disease, and individuals with compromised immune systems to reduce the risk from COVID-19 by practicing social distancing, both in and outside of the home); *id.*, ¶ 18, Ex. Q (California Executive Order N-27-20 issued on March 15, 2020, directing the state to focus on protecting the health and safety of vulnerable populations in assisted living facilities, who include older adults and those at higher risk for serious illness).

The information that CDCR provided for the *Coleman* class, when used in conjunction with the much more comprehensive information the Receiver has provided, contains individualized housing unit identifications, as well as specific COVID-19 vulnerabilities such as age, medical conditions, mental health level of care, and others. *See* Decl. of Ernest Galvan in Supp. of Pls’ Response to Defs’ Strategic COVID-19 Management Plan (“Galvan Decl ISO Pls’ Response”), ¶¶ 2, 10. These databases can be analyzed to show the specific housing units where large numbers of particularly vulnerable people live. *Id.* at ¶¶ 7 (Table 1, EOP dorms); 8 (Table 2, EOP Celled Units); 9 (Table 3, CCCMS in dorms); 11 (Table 4, EOP over age 65); 12 (Table 5, CCCMS over age 65); 17 (Table 9, units housing high medical risk); 18 (Table 10, units housing *Coleman* high medical risk). For example, the Receiver’s data shows the specific dormitories where *Coleman* class members aged 65 and older live. *Id.* ¶ 11 (Table 4, EOP aged 65 and older); ¶ 12 (CCCMS aged 65 and older). This information can be used to focus efforts on

1 housing units where vulnerable people reside. In addition, this data can be married with
2 CDCR's reports on design capacity and housing unit occupancy to focus efforts as
3 appropriate on units where vulnerable persons are crowded together, sharing small spaces
4 and facilities such as sinks, toilets, and showers. *Id.*, ¶¶ 4-5. That Defendants have not
5 already undertaken targeted efforts for vulnerable class members is alarming, and their
6 refusal to prioritize this population is inexplicable.

7 **III. The Piecemeal Measures Defendants Have Enacted Have Been Adopted Far**
8 **Too Slowly, Demonstrating the Lack of Urgency in Their Response to the Pandemic and Therefore to Address the Danger of the Pandemic Fully.**

9 Defendants have been on notice since January of the impending pandemic, yet
10 continue to implement, and apparently consider, only piecemeal and ad hoc preventative
11 and containment measures. The California Department of Public Health ("CDPH") began
12 issuing COVID-19-specific guidance to all licensed healthcare facilities in the state
13 beginning in January 2020. Bien Decl., ¶ 2 & Ex. A at 4 (January 23, 2020 guidance
14 document sent to all licensed California healthcare facilities, directing facilities to give
15 suspected COVID-19 patients surgical masks "as soon as they are identified," to place
16 them in an airborne infection isolation room, and healthcare personnel to "don gloves,
17 gown, goggles or a face shield, and a fit tested N95 or higher level respirator upon room
18 entry."); *id.* at ¶ 8 & Ex. G at 1 (January 27, 2020 guidance directing all healthcare
19 facilities to take steps to help evaluate "the capacity for California to respond to potential
20 expansion of [COVID-19]"); *id.* at ¶ 9 & Ex. H (January 31, 2020 guidance providing
21 updated information regarding COVID-19); *id.* at ¶ 10 & Ex. I (February 10, 2020
22 guidance notifying facilities of interim CDC guidance regarding COVID-19); *id.* at ¶ 11 &
23 Ex. J (February 19, 2020 guidance directing healthcare facilities to "have environmental
24 infection control procedures in place to prevent infections from spreading during
25 healthcare delivery"); *id.* at ¶ 12 & Ex. K (March 3, 2020 guidance notifying healthcare
26 facilities of updated CDC guidance regarding COVID-19 and recommending increasingly
27 intensive infection control measures and comprehensive planning for spread of the
28 disease); *id.* at ¶ 13 & Ex. L (March 8, 2020 guidance directing hospitals to provide a

1 survey identifying their surge capacity "[i]n anticipation of California potentially
2 experiencing a surge of COVID-19 patients").

3 Because Defendants operate a multitude of licensed facilities within CDCR, they
4 cannot claim they were unaware of this guidance when it was issued. In addition, CDPH
5 guidance from March 20, 2020—nearly a month before Defendants provided this Court
6 their incomplete Strategic Plan, and days after various California counties had issued
7 shelter-in-place orders—specifically instructed Defendants to achieve surge capacity in
8 their facilities immediately, and to rely on the most extreme estimates of their need for
9 beds and resources to combat the disease.[2] Bien Decl., ¶ 3, Ex. B at 9 ("**Health care**
10 **facilities need to enact their surge plans now** to create overflow space for screening,
11 triage, isolation, and transfer/discharge.") (bold in original); *id.* at 10 ("Large health care
12 systems must develop plans now to expand care delivery for extreme surge capacity and
13 work with the state with any identified barriers in staffing, capacity, or supplies and
14 equipment."); *id.* at 11 ("Similar to hospital preparations, outpatient clinics need to
15 repurpose their space and operations in order to meet the extreme estimates of patients
16 needing treatment, not conservative estimates."). As the guidance made clear, any
17 healthcare system needed to be prepared yesterday to meet the anticipated need for
18 physical space; given that Defendants still have not taken these measures, they are far too
19 late.

20 And Defendants should have understood the gravity of the guidance they began to
21 receive in January. CDCR has dealt with numerous outbreaks of infectious disease before:
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[2] Although the guidance is directed at healthcare facilities rather than correctional systems, CDCR has a vast healthcare system in place that must be ready to treat all the patients in the system. In addition, the impact of COVID-19 on the CDCR system is directly analogous to a healthcare system: CDCR, like a hospital, is a mostly-contained system with a limited amount of space and number of beds to house and care for those in its custody. The analogy is particularly apt at a time when physical space is at a premium and is the key component to preventing transmission of disease. In any event, the guidance promulgated by a California agency and directed specifically to CDCR's healthcare system put CDCR on notice months ago regarding what was and is to come.

Legionnaires' disease most recently at the California Health Care Facility in Stockton ("CHCF"), Bien Decl., ¶ 4, Ex. C; norovirus, *id.*, ¶ 14 & Ex. M; swine flu, *id.*, ¶ 16, Ex. O; Valley Fever, *see Plata v. Brown*, --- F. Supp. 3d ---, 2013 WL12436093 (June 24, 2013), influenza and antibiotic-resistant staph infections, *Brown v. Plata*, 563 U.S. 493, 520 n.7 (2011), to name a few. *See also* Strategic Plan, ECF No. 6616 at 7 (Apr. 16, 2020) ("CDCR and CCHCS have longstanding outbreak management plans in place to address communicable disease outbreaks such as influenza, measles, mumps, norovirus, and varicella . . . ."). CDCR should understand not only that infectious-disease outbreaks are serious, *see, e.g.*, *Brown v. Plata*, 563 U.S. at 520 n.7 (describing how inmates with influenza sent back to their housing unit due to a lack of beds in the infirmary quickly infected more than half of the 340 individuals in their unit), but also that this novel disease has characteristics that can allow it to devastate in ways Defendants have not seen before. And CDCR certainly did not need to wait for the Receiver to develop a plan for physical distancing. It cannot delay now in implementing his proposal.

IV. The Recent Outbreaks At CIM and LAC Are Case Studies in the Vast Expansion of COVID-19 Cases that May Soon Hit CDCR's Other Institutions, Particularly Those Housing Large Numbers of Individuals in Dorms, the Medically Vulnerable, and *Coleman* Class Members.

The lack of an appropriate plan to achieve social distancing and to protect the most medically vulnerable, especially those housed in crowded dorms, is evident in the outbreaks at the California Institute for Men ("CIM") and California State Prison Lancaster ("LAC"). The steep rate of infection in these two prisons makes them hot spots—like nursing homes—threatening the overall public health effort to "flatten the curve." CDCR COVID-19 patients from both CIM and LAC have required hospitalization at community hospitals, and the first death of a CDCR prisoner from COVID-19 was reported yesterday—a medically vulnerable elderly *Coleman* class member from CIM who had been housed in a crowded dorm. *See* Bien Decl., ¶ 25, Ex. T at 17 (Defendants' statement in April 20, 2020 *Plata* Joint Case Management statement).

The vast majority of the COVID-19 patients—and the first CDCR victim of the

disease—are *Coleman* class members. As of today, 87 of the 121, or 72%, of CDCR's COVID-19 patients are class members: 30 at CIM, 55 at LAC, 1 at CMC and 1 at CIW. Bien Decl., ¶ 26 & Ex. Y.

Prisons and jails nationwide continue to be major sources of virus infections. According to the New York Times, the Marion Correctional Institution in Ohio is now the largest source of infections in the country with 1,828 cases, almost three-quarters of the prison population. Four of the ten largest sources of infection in the United States are correctional facilities. Bien Decl., ¶ 23, Ex. S.

V. Defendants' Failure to Meet Specific Elements of the CDCR Guidance Relating to Staffing, Supplies, and PPE Only Reinforce the Obvious Need for Population Reduction Measures.

Defendants' Strategic Plan makes clear they are suffering from a severe lack of resources, including physical space, hygiene supplies, PPE, and staff, that can be remedied in the necessary timeframe only by reducing the population density in their system.

For example, as to space shortages:

- CDCR is already cohorting quarantined individuals, According to the CDCR guidance, however, "cohorting [of quarantined individuals] should *only be practiced if there are no other available options*." CDC Guidance at 15; Strategic Plan, ECF No. 6616-1, Attachment A at 24, 33 (Apr. 16, 2020) (emphasis added); *see also* CDC Guidance at 15 ("Facilities should make *every possible effort* to quarantine close contacts of COVID-19 cases individually." (emphasis added)).
- CDCR acknowledges that it mixes quarantined cohorts, including for feeding and sharing of bathrooms, contrary to CDC guidance. CDC Guidance at 19, 21. Strategic Plan, ECF No. 6616-1, Attachment A at 33, 37 (Apr. 16, 2020). at 33, 37.

As to staff shortages:

- The CDC guidance, and CDCR's response to the same, acknowledge that there are, and will be, ongoing staff shortages as a result of the COVID-19 pandemic, *see, e.g.*, CDC Guidance at 6-7; Strategic Plan, ECF No. 6616-1, Attachment A at 5-6 (Apr. 16, 2020), and those will occur on top of existing staffing shortages.
- Defendants already do not have sufficient custody staff to monitor individuals in medical isolation, nor are custody staff able to wear necessary PPE and limit their movement between different parts of their facilities. See CDC Guidance at 16 ("Custody staff should be designated to monitor [those in medical isolation] exclusively where possible. These staff should wear recommended PPE as appropriate for their level of contact with the

individual under medical isolation , , , and should limit their own movement between different parts of the facility to the extent possible."); Strategic Plan, ECF No. 6616-1, Attachment A at 26 (Apr. 16, 2020).

And as to shortages of PPE and sanitation and hygiene supplies:

- The CCHCS Receiver has issued two memoranda regarding the use of PPE in CDCR to combat COVID-19, and both acknowledge the current, and anticipated ongoing, lack of available PPE in the system. Bien decl., Exs. D, E. Due to the shortage, the memos advise that N95 and surgical masks should be used only in certain situations deemed highest priority. *Id.*

- Despite the ubiquity of recommendations by the CDC regarding the need for PPE to combat COVID-19, *see, e.g.*, CDC Guidance at 5, 7-8, 23-25, CDCR is already limiting the provision of PPE to a very small subset of the many people who work and live in CDCR. Strategic Plan, ECF No. 6616-1, Attachment A at 36 (Apr. 16, 2020) ("PPE is reserved for isolated individuals based on our current supply. Face coverings are available for staff and quarantined patients."). Their triaging of PPE in this manner underscores their already limited supply of critical PPE.

- Defendants state that they have an adequate supply of N95 masks only; their lack of reference to other types of PPE makes clear they do not have enough gloves, non-N95 masks, goggles, eye shields, and gowns or coveralls. *Id.* at 45-46. And even as to N95 masks, as noted above, Defendants are already limiting to whom they will provide the limited supplies they have.

- CDCR states that "alcohol-based disinfectants are not currently in use" for cleaning electronic products, strongly suggesting that CDCR does not have enough alcohol-based disinfectant to perform all necessary disinfection. CDC Guidance at 18; Strategic Plan, ECF No. 6616-1, Attachment A at 30 (Apr. 16, 2020).

- CDCR does not have no-touch trash receptacles available to those in medical isolation. CDC Guidance at 10. 17; Strategic Plan, ECF No. 6616-1, Attachment A at 13, 27 (Apr. 16, 2020).

- CDCR has not trained incarcerated people in use of PPE, in direct contravention of the CDC guidance, CDC Guidance at 8, 23-24, and despite relying on them for tasks that require use of PPE, such as laundry, cleaning, and sanitizing. Strategic Plan, ECF No. 6616-1, Attachment A at 43-44 (Apr. 16, 2020); *see also, e.g.*, *id.* at 11 (describing incarcerated peoples' roles in "cleaning high-traffic areas"); *id.* at 17 (describing ongoing PIA tasks as including "food production, . . . cleaning of healthcare spaces, and laundry."). CDCR also relies only on standard annual training for staff's use of PPE, providing no COVID-19-specific training, notwithstanding the unique characteristics of the disease. *Id.* at 8-9.

- CDCR will not have an adequate supply of cloth face coverings until April 30, more than six weeks after the World Health Organization declared the pandemic. Bien Decl., ¶ 7, Ex. F; *but see id.*, ¶ 25, Ex. T at 17 (Joint Case Management Statement, *Plata v. Newsom*, N.D. Cal. No. 01-cv-1351-JST, ECF No. 3294 at 8 (Apr. 20, 2020) ("[I]t is not known when each prison will receive [two cloth faces masks for each incarcerated person and custodial staff member]."). And even when they do arrive, cloth face coverings are

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an untested second-best alternative to PPE, including face masks. *See* Bien Decl., ¶¶ 5-6, Exs. D, E.

Even putting aside the inadequacies Defendants have acknowledged in their response to the CDC guidance, none of their responses address the many anecdotal reports Plaintiffs have received regarding the lack of supplies and PPE on yards and in facilities at various institutions, and the lack of replenishment of the same. Bien Decl., ¶ 24. The on-the-ground reality for more than one hundred thousand incarcerated people and the tens of thousands of CDCR clinical and custodial staff is critically different than what Defendants' broad assertions reveal. And putting different aspects of Defendants' plan together points to the large and dangerous gaps in their response. PPE *or* physical distance, if not both, along with adequate hygiene practices, is necessary to create physical barriers to transmission, given that there are no preventative or curative medical treatments available for COVID-19. But Defendants have not been able to provide or create adequate PPE or physical distance, and they have acknowledged they lack critical hygiene supplies and staff to try to even mitigate the gaps.

CONCLUSION

For the foregoing reasons, we ask the Court to require Defendants to identify concrete, measurable benchmarks, with dates certain for completion, to ensure they are prepared to address adequately the next institution-level and system-wide COVID-19 outbreaks that will occur in their system.

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1
CERTIFICATION

2 In preparing this filing, Plaintiffs' counsel reviewed the following orders of this
3 Court: Order, ECF No. 6600 (Apr. 10, 2020); Minute Order, ECF No. 6602 (Apr. 13,
4 2020); Order, ECF No. 6622 (Apr. 17, 2020).
5
6 DATED: April 20, 2020 Respectfully submitted,
7 ROSEN BIEN GALVAN & GRUNFELD LLP
8 By: */s/ Jessica Winter*
9 Jessica Winter
10 Attorneys for Plaintiffs
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25
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DONALD SPECTER – 083925
STEVEN FAMA – 099641
MARGOT MENDELSON – 268583
PRISON LAW OFFICE
1917 Fifth Street
Berkeley, California 94710-1916
Telephone: (510) 280-2621

CLAUDIA CENTER – 158255
DISABILITY RIGHTS EDUCATION
AND DEFENSE FUND, INC.
Ed Roberts Campus
3075 Adeline Street, Suite 210
Berkeley, California 94703-2578
Telephone: (510) 644-2555

MICHAEL W. BIEN – 096891
JEFFREY L. BORNSTEIN – 099358
ERNEST GALVAN – 196065
THOMAS NOLAN – 169692
LISA ELLS – 243657
JENNY S. YELIN – 273601
MICHAEL S. NUNEZ – 280535
JESSICA WINTER – 294237
MARC J. SHINN-KRANTZ – 312968
CARA E. TRAPANI – 313411
ALEXANDER GOURSE – 321631
ROSEN BIEN
GALVAN & GRUNFELD LLP
101 Mission Street, Sixth Floor
San Francisco, California 94105-1738
Telephone: (415) 433-6830

Attorneys for Plaintiffs

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, et al.,

Plaintiffs,

v.

GAVIN NEWSOM, et al.,

Defendants.

Case No. 2:90-CV-00520-KJM-DB

DECLARATION OF MICHAEL W. BIEN IN SUPPORT OF PLAINTIFFS' RESPONSE TO DEFENDANTS' STRATEGIC COVID-19 MANAGEMENT PLAN

Judge: Hon. Kimberly J. Mueller

1 I, Michael W. Bien, declare:
2 1. I am an attorney duly admitted to practice before this Court. I am a partner
3 in the law firm of Rosen Bien Galvan & Grunfeld LLP, counsel of record for Plaintiffs. I
4 have personal knowledge of the facts set forth herein, and if called as a witness, I could
5 competently so testify. I make this declaration in support of Plaintiffs' Response to
6 Defendants' Strategic COVID-19 Management Plan.
7 2. Attached hereto as **Exhibit A** is a true and correct copy of an all-facilities
8 guidance letter dated January 23, 2020 from the California Department of Public Health
9 ("CDPH") entitled "AFL 20-09: Health Update and Interim Guidance – 2019 Novel
10 Coronavirus (nCoV)" available at
11 https://www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/AFL-
12 20-09.pdf.
13 3. Attached hereto as **Exhibit B** is a true and correct copy of guidance from
14 March 20, 2020 from CDPH entitled "COVID-19 Health Care System Mitigation
15 Playbook", available at
16 https://www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/AFL-
17 20-23-Mitigation-Playbook.pdf.
18 4. Attached hereto as **Exhibit C** is a true and correct copy of a CDCR press
19 release dated April 24, 2019, last accessed on April 20, 2020, entitled "CDCR Starts
20 Chlorine Water Treatment Process at Stockton Correctional Facilities: Hyperchlorination
21 part of a larger plan to address *Legionella*" available at
22 https://www.cdcr.ca.gov/news/2019/04/24/cdcr-starts-chlorine-water-treatment-process-at-
23 stockton-correctional-facilities/.
24 5. Attached hereto as **Exhibit D** is a true and correct copy of a California
25 Correctional Health Care Services (CCHCS) memorandum to all CDCR staff dated
26 April 6, 2020 entitled "Staff Use of Personal Protective Equipment (PPE)."
27
28

1 6. Attached hereto as **Exhibit E** is a true and correct copy of a CCHCS
2 memorandum to all CDCR staff dated April 6, 2020 entitled "COVID-19 Personal
3 Protective Equipment (PPE) Guidance and Information."
4 7. Attached hereto as **Exhibit F** is a true and correct copy of a CCHCS
5 memorandum to all CDCR Wardens and Chief Executive Officers dated April 15, 2020
6 entitled CALPIA Cloth Face Barrier/Mask.
7 8. Attached hereto as **Exhibit G** is a true and correct copy of an all-facilities
8 guidance letter dated January 27, 2020 from the CDPH entitled "AFL 20-10: Healthcare
9 Facility Resources for the 2019 Novel Coronavirus (2019-nCoV)" available at , available
10 at https://www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/AFL-
11 20-10.pdf.
12 9. Attached hereto as **Exhibit H** is a true and correct copy of an all-facilities
13 guidance letter dated January 31, 2020 from the CDPH entitled "AFL 20-11: Updated
14 2019 Novel Coronavirus Information (2019-nCoV), Including Patient Under Investigation
15 (PUI) Guidance from the Centers for Disease Control and Prevention (CDC)" available at
16 https://www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/AFL-
17 20-11.pdf.
18 10. Attached hereto as **Exhibit I** is a true and correct copy of an all-facilities
19 guidance letter dated February 10, 2020 from the CDPH entitled "AFL 20-13: 2019 Novel
20 Coronavirus Interim Guidance for Risk Assessment and Health Management of Healthcare
21 Personnel with Potential Exposure" available at
22 https://www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/AFL-
23 20-13.pdf.
24 11. Attached hereto as **Exhibit J** is a true and correct copy of an all-facilities
25 guidance letter dated February 19, 2020 from the CDPH entitled "AFL 20-14:
26 Environmental Infection Control for the Coronavirus Disease 2019 (COVID-19)" available
27 at https://www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/AFL-
28 20-14.pdf.

1 12. Attached hereto as **Exhibit K** is a true and correct copy of an all-facilities
2 guidance letter dated March 3, 2020 from the CDPH entitled "AFL 20-17: Guidance for
3 Healthcare Facilities on Preparing for Coronavirus Disease 2019 (COVID-19)" available at
4 https://www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/AFL-
5 20-17.pdf.
6 13. Attached hereto as **Exhibit L** is a true and correct copy of an all-facilities
7 guidance letter to all hospitals dated March 8, 2020 from the CDPH entitled "AFL 20-18:
8 Hospital Surge Survey to Assess Capacity Regarding Coronavirus Disease 2019 (COVID-
9 19) and Reminder to Contact Medical Health Operational Area Coordination Office
10 (MHOAC)" available at
11 https://www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/AFL-
12 20-18.pdf.
13 14. Attached hereto as **Exhibit M** is a true and correct copy of a news article
14 dated January 14, 2008 from the Hanford Sentinel, by Eiji Yamashita, entitled "Virus
15 outbreak halts visits to 2 area prisons" available at https://hanfordsentinel.com/news/virus-
16 outbreak-halts-visits-to-2-area-prisons/article_d594bf2d-0b78-5dd5-8d12-
17 42271cb621b2.html.
18 15. Attached hereto as **Exhibit N** is a true and correct copy of an email dated
19 April 20, 2020 from Plaintiffs' counsel in *Armstrong v. Newsom*, Case No. C-94-2307-CW
20 currently pending in the Northern District of California, to CDCR counsel and the
21 *Coleman* Special Master entitled RE: Plaintiffs' Questions re: COVID-19 and Armstrong
22 Impacts.
23 16. Attached hereto as **Exhibit O** is a true and correct copy of a press release
24 issued by CDCR on May 3, 2009 entitled "Prison System Diagnoses First Probable Case
25 of Swine Flu (H1N1) Virus," available at:
26 https://www.cdcr.ca.gov/news/2009/05/03/prison-system-diagnoses-first-probable-case-of-
27 swine-flu-h1n1-virus/.
28

1 17. Attached hereto as **Exhibit P** is a true and correct copy of California
2 Department of Public Health ("CDPH") guidance dated March 16, 2020, entitled "Self-
3 Isolation for Older Adults and Those Who Have Elevated Risk," and available at:
4 https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/Self_Is
5 olation_Guidance_03.16.20.pdf. The CDPH guidance directs individuals over 65 years
6 old, individuals with serious chronic medical conditions like heart disease, diabetes, and
7 lung disease, and individuals with compromised immune systems to reduce the risk from
8 COVID-19 by practicing social distancing, both in and outside of the home.
9 18. Attached hereto as **Exhibit Q** is a true and correct copy of Executive Order
10 N-27-20 issued by Governor Newsom on March 15, 2020, available at:
11 https://www.gov.ca.gov/wp-content/uploads/2020/03/3.15.2020-COVID-19-Facilities.pdf.
12 Executive Order N-27-20 directs the state to focus on protecting the health and safety of
13 vulnerable populations in assisted living facilities, who include older adults and those at
14 higher risk for serious illness.
15 19. Attached hereto as **Exhibit R** is a true and correct copy of a document
16 entitled "COVID Monitoring Patient Registry" that was provided to me by co-counsel at
17 the PLO. This registry shows 120 of the 121 patients who have tested positive for
18 COVID-19. I am informed that the final patient, who is now deceased, was housed at CIM
19 when he tested positive and was a *Coleman* class member at the time of his death. Of the
20 120 patients on this registry, 87 (73%) are *Coleman* class members participating in the
21 MHSDS including 30 class members at CIM, 55 class members at LAC, one class member
22 at California Mens Colony (CMC) and one class member at California Institution for
23 Women (CIW).
24 20. On March 26, 2020, I attended a COVID-19 Task Force meeting in which
25 representatives for Defendants stated that CDCR was not testing any of its staff members
26 for COVID-19 and instead relied solely on staff members to self-report any illness.
27
28

1 21. On April 3, 2020, I attended a COVID-19 Task Force meeting in which
2 representatives for Defendants acknowledged that CDCR does not yet have access to rapid
3 COVID-19 testing to be used for incarcerated people.
4 22. On April 17, 2020, I appeared as counsel of record at a telephonic status
5 conference before this Court, during which representatives for Defendants stated that they
6 are "examining" the Receiver's cohorting proposal.
7 23. Attached hereto as **Exhibit S** is a true and correct excerpted section of a copy
8 of a news article dated April 20, 2020 from The New York Times entitled "Coronavirus
9 Live Updates: Southern States Move to Reopen as Outbreak Continues to Spread in Parts
10 of U.S.: *Cases surge in an Ohio prison, making it the top known U.S. hot spot*" last
11 accessed, April 20, 2020, available at
12 https://www.nytimes.com/2020/04/20/us/coronavirus-live-news.html#link-58dfe2ae.
13 24. I have received and reviewed numerous emails and letters from persons
14 incarcerated in CDCR and their family members concerning conditions in the prisons
15 during the past few weeks. In addition, attorneys from my office have conducted
16 telephone interviews with class members as part of their monitoring efforts in *Coleman*
17 and *Armstrong*. We have received numerous complaints about lack of access to soap,
18 sanitizer, masks, cleaning materials for showers, toilets, and other common surfaces and as
19 to the crowded conditions that preclude social distancing. I have also reviewed various
20 news reports and Facebook posts with information from persons purporting to be CDCR
21 staff concerning their lack of access to masks and gloves. I am aware of various efforts on
22 Facebook to locate and donate masks to CDCR prisons for use by staff and prisoners due
23 to shortages in CDCR supplies.
24 25. Attached hereto as **Exhibit T** is a true and correct copy of a Joint Case
25 Management Conference Statement filed today in *Plata v. Newsom*, Case No. 01-1351
26 JST, currently pending in the Northern District of California at, Dkt. No. 3294 (April 20,
27 2020). Today, April 20, 2020, during a *Plata* case management conference, counsel for
28 Defendants also promised to provide documents describing the details of their plan and a

timeline for completion of the dorm moves to Plaintiffs' counsel. As of the time of this filing, Plaintiffs' counsel has not received the documents.

26. 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 at San Francisco, California this 20th day of April, 2020.

/s/ Michael W. Bien
Michael W. Bien

EXHIBIT A

State of California—Health and Human Services Agency
California Department of Public Health

SONIA Y. ANGELL, MD, MPH
State Public Health Officer & Director

GAVIN NEWSOM
Governor

January 23, 2020 AFL 20-09

TO: All Facilities

SUBJECT: Health Update and Interim Guidance – 2019 Novel Coronavirus (nCoV)

All Facilities Letter (AFL) Summary

- This AFL provides information on the 2019 Novel Coronavirus (2019-nCoV)
- This AFL contains the latest Centers for Disease Control and Prevention (CDC) information on 2019-nCoV including infection control guidance, criteria for evaluation of Patients Under Investigation (PUIs), and recommendations for reporting, specimen collection, and testing. It is likely that CDC will update its guidance in the coming weeks, so please check for updates on CDC's 2019-nCoV webpage.
- At this time there are no confirmed 2019-nCoV cases in California.

Background

An outbreak of pneumonia of unknown etiology in Wuhan, China was reported to the World Health Organization (WHO) on December 31, 2019, and a novel coronavirus was soon identified as the cause. On January 21, 2020, CDC announced the first U.S. case in a traveler who had returned from Wuhan.

What is known:

- Limited person-to-person spread is occurring.
- Some healthcare workers in China have reportedly been infected.
- Although severe and fatal illness has been reported in some patients, many have had milder illness and do not require hospitalization.
- On January 21, 2020, CDC updated its interim travel health notice for people traveling to Wuhan, China from “Level 1, Practice Usual Precautions” to “Level 2, Practice Enhanced Precautions”.
- CDC has implemented symptom screening of travelers arriving from Wuhan, China at three United States airports (San Francisco International Airport, Los Angeles International Airport, and John F. Kennedy International Airport in New York); screening will soon expand to Atlanta Hartsfield-Jackson International Airport and Chicago O'Hare International Airport.

Center for Health Care Quality, MS 0512
P.O. Box 997377 ● Sacramento, CA 95899-7377
(916) 324-6630 ● (916) 324-4820 FAX
Department Website (www.cdph.ca.gov)

- Disembarking travelers with symptoms potentially consistent with 2019-nCoV infection are being referred for further evaluation at health care facilities.
- Asymptomatic travelers are given written instructions regarding steps to take if they become ill in the 14 days after arrival from Wuhan, including calling ahead to a health care facility and explaining that they have traveled from Wuhan.
- There is no vaccine or specific treatment for 2019-nCoV infection.
- An investigational new drug known as remdesivir may be requested via CDC for compassionate use in severely ill patients. Please contact the CDC Emergency Operation Center at 770-770-488-7100 to request remdesivir.

What is not yet known:

- Attack rate of the virus, or how easily and sustainably this virus spreads person-to-person.
- Incubation period of 2019-nCoV infections; current recommendations are based on the known incubation period of 2-14 days for other coronaviruses.
- Whether infected persons are infectious before they show clinical signs and symptoms.
- Spectrum of clinical illness associated with 2019-nCoV.

Recommendations for Healthcare Facilities

Although airports are screening travelers from Wuhan at entry, it is possible travelers who become ill in the days following their arrival may present for care at health care facilities in the community. The California Department of Public Health (CDPH) is encouraging all healthcare facilities to:

- Obtain a travel history for **all** patients presenting with fever and acute respiratory illness.
- Place signage, implement travel history screening at triage, and review procedures for immediately placing symptomatic patients with a positive travel history in a surgical mask and private room, ideally an airborne infection isolation room (AIIR), wherever possible.
- Immediately contact your local health department and your facility's infection preventionist if a patient may meet CDC's criteria for PUI.
- Review infection control guidance for potential 2019-nCoV patients. Ensure facility infection control policies are consistent with the CDC's Interim Infection Control Precautions for Patients Under Investigation for 2019-nCoV.
- Review procedures for collection of laboratory specimens for 2019-nCoV testing and laboratory biosafety guidelines; your local health department will work closely with the CDPH Viral and Rickettsial Disease Laboratory (VRDL) and the CDC to coordinate testing.

Criteria for a Person Under Investigation (PUI) for 2019-nCoV
Patients in the United States who meet the following criteria should be evaluated as a PUI in association with the outbreak of 2019-nCoV in Wuhan City, China.

Clinical Features	&	Epidemiologic Risk
Fever[1] (≥38°C/100.4°F) **and** symptoms of lower respiratory illness (e.g., cough, difficulty breathing)	and	In the last 14 days before symptom onset, a history of travel from Wuhan City, China. *– or –* In the last 14 days before symptom onset, close contact[2] with a person who is under investigation for 2019-nCoV while that person was ill.
Fever[1] (>38°C/100.4°F) **or** symptoms of lower respiratory illness (e.g., cough, difficulty breathing)	and	In the last 14 days, close contact[2] with an ill laboratory-confirmed 2019-nCoV patient.

[1]Fever may not be present in some patients, such as those who are very young, elderly, immunosuppressed, or taking certain fever-lowering medications. Clinical judgment should be used to guide testing of patients in such situations.

[2]Close contact is defined as—

a) being within approximately 6 feet (2 meters), or within the room or care area, of a novel coronavirus case for a prolonged period of time while not wearing recommended personal protective equipment or PPE (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection); close contact can include caring for, living with, visiting, or sharing a health care waiting area or room with a novel coronavirus case.*– or –*
b) having direct contact with infectious secretions of a novel coronavirus case (e.g., being coughed on) while not wearing recommended personal protective equipment.

Please contact your local health department **immediately** if a PUI is identified, or if patient's status as a PUI is uncertain.

The above criteria are intended to serve as guidance for evaluation and testing. Patients should be evaluated and discussed with the local public health department on a case-by-case basis if their clinical presentation or exposure history is equivocal (e.g., uncertain travel or exposure). Patients who meet PUI criteria should also be evaluated for common causes of respiratory infections and community-acquired pneumonia.

Testing for viral respiratory pathogens should be performed by molecular methods, e.g., multiplex viral respiratory testing via real reverse transcription polymerase chain reaction (RT-PCR); viral cultures should not be performed. Do not use rapid influenza diagnostic tests that are not RT-PCR based. At this time, positive results for another respiratory pathogen do not preclude testing for 2019-nCoV.

Infection Control Guidance for 2019-nCoV Infection
Although the transmission dynamics have yet to be determined, CDPH currently recommends a cautious approach to patients under investigation for 2019-nCoV. Such patients should be given a surgical mask to wear as soon as they are identified and should optimally be evaluated in an airborne infection isolation room (AIIR). If an AIIR is not available, and it is not possible to transfer the patient to a facility with an AIIR, the patient should be evaluated in a private room with the door closed, and healthcare personnel entering the room should use Standard, Contact, and Airborne precautions, plus eye protection; this means that healthcare personnel should don gloves, gown, goggles or a face shield, and a fit tested N95 or higher level respirator upon room entry.

Healthcare facilities should additionally implement procedures to minimize the number of healthcare personnel that interact with a PUI and ensure that potentially exposed healthcare personnel and patients can be identified if the PUI is confirmed to be infected with 2019-nCoV.

As healthcare employers, facilities are required to follow recommendations under the California Occupational Safety Health Administration's (Cal/OSHA) Aerosol Transmissible Diseases (ATD) Standard, Title 8 of the California Code of Regulations (CCR) Section 5199. Because 2019-nCoV meets the criteria for a novel aerosol transmissible pathogen (ATP) under the ATD Standard, employers must provide a powered air purifying respirator (PAPR) with a High Efficiency Particulate Air (HEPA) filter(s), or a respirator providing equivalent or greater protection, to employees who perform high hazard procedures on 2019-nCoV PUIs or confirmed cases.

Laboratory Biosafety for 2019-nCoV Infection
Laboratory workers should wear appropriate personal protective equipment (PPE), which includes disposable gloves, laboratory coat/gown, and eye protection when handling potentially infectious specimens.

Any procedure with the potential to generate fine-particulate aerosols (e.g., vortexing or sonication of specimens in an open tube) should be performed in a Class II Biological Safety Cabinet (BSC). Appropriate physical containment devices (e.g., centrifuge safety buckets; sealed rotors) should be used for centrifugation. Ideally, rotors and buckets should be loaded and unloaded in a BSC. Perform any procedures outside a BSC in a manner that minimizes the risk of exposure to an inadvertent sample release.

After specimens are processed, decontaminate work surfaces and equipment with appropriate disinfectants. Use any EPA-registered hospital disinfectant. Follow manufacturer's recommendations for use-dilution (i.e., concentration), contact time, and care in handling. All disposable waste should be autoclaved.

Virus isolation in cell culture and initial characterization of viral agents recovered in cultures of 2019-nCoV specimens are NOT recommended at this time.

Laboratories are also required to follow recommendations under the laboratory section of Cal/OSHA ATD Standard, Title 8 CCR Section 5199, found under subsection (f).

2019-nCoV Update Teleconference
CDPH is holding a teleconference with providers to discuss 2019-nCoV to discuss the status of this outbreak. Healthcare facilities and providers are encouraged to attend. The teleconference will be held:

- Date: Thursday, January 23, 2020
- Time: 12:00 P.M.
- Dial-in: 1-844-867-6167
- Access Code: 2633697

CDC Resources
Please refer to the following guidance for further information:

- Criteria to Guide Evaluation of Patients Under Investigation (PUI) for 2019-nCoV
- Interim Healthcare Infection Prevention and Control Recommendations for Patients Under Investigation for 2019 Novel Coronavirus
- Interim Laboratory Biosafety Guidelines for Handling and Processing Specimens Associated with 2019 Novel Coronavirus (2019-nCoV)

If you have any questions regarding the infection prevention and control of 2019-nCoV, please contact the CDPH Healthcare-Associated Infections (HAI) Program at novelvirus@cdph.ca.gov.

Sincerely,

Original signed by Sonia Y. Angell

Sonia Y. Angell MD MPH
State Public Health Officer and Director
California Department of Public Health

EXHIBIT B

COVID-19

HEALTH CARE SYSTEM MITIGATION PLAYBOOK

California Department of Public Health

March 2020

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VI. GLOSSARY

I. PURPOSE AND BACKGROUND

The purpose of this mitigation playbook is to provide a summary for a mitigation strategy in the State of California and the health care system. Each of the items listed in this playbook should have detailed operational plans to support them.

Novel Coronavirus (COVID-19)

The family of coronaviruses has been around for some time. Coronavirus Disease 2019, or COVID-19, the cause of the current outbreak that originated in China is a new member of this coronavirus family. CDC has assigned a scientific name to the virus, SARS-CoV-2.

The most common symptoms of COVID-19 include fever, cough, and respiratory symptoms. It is believed that most people – more than 80% – have moderate to no symptoms, while others experience a more complicated disease course, including pneumonia. COVID-19 appears to be more severe in older individuals and those with underlying chronic illnesses. Children seem to be less affected. Much is still to be determined about the virus, but based on multiple early reports, here are key characteristics of COVID-19 infection:

- **Incubation Period:** Estimated to be 2-14 days.
- **Mode of Transmission:** Evidence is building. Systems should ensure appropriate PPE is available for most critical patients where procedures occur frequently. Reports from around the world indicate most infections have occurred when a contagious individual has close contact with family, colleagues, or healthcare workers due to droplets which can spread up to 6 feet. Some evidence of spread has occurred through contact with surfaces contaminated with droplets, but this does not appear to be the primary mode of spread. Because the virus has been isolated in stool, there is concern for spread through the fecal-oral route, including use of shared toilets in congregate settings, but more data is needed on this. Similarly, there are some concerns about airborne transmission, but more data is needed on this.
- **Transmissibility:** The R_O is estimated to be between 2-4, depending on the cohort studied. This means that one infected person will *on average* spread the virus to 2-4 individuals.
- **Severity:** 80% of individuals with documented COVID-19 disease have a milder spectrum of asymptomatic to moderate illness. Different reports estimate the mortality rate to be between 2-3%. The mortality rate may be lower since asymptomatic individuals are less likely to seek care and get tested.
- **Convalescence:** The period after which an individual is clinically recovered and no longer capable of transmitting the virus is still to be determined. CDC has stated that viral shedding may occur for 15-30 days after onset of infection.

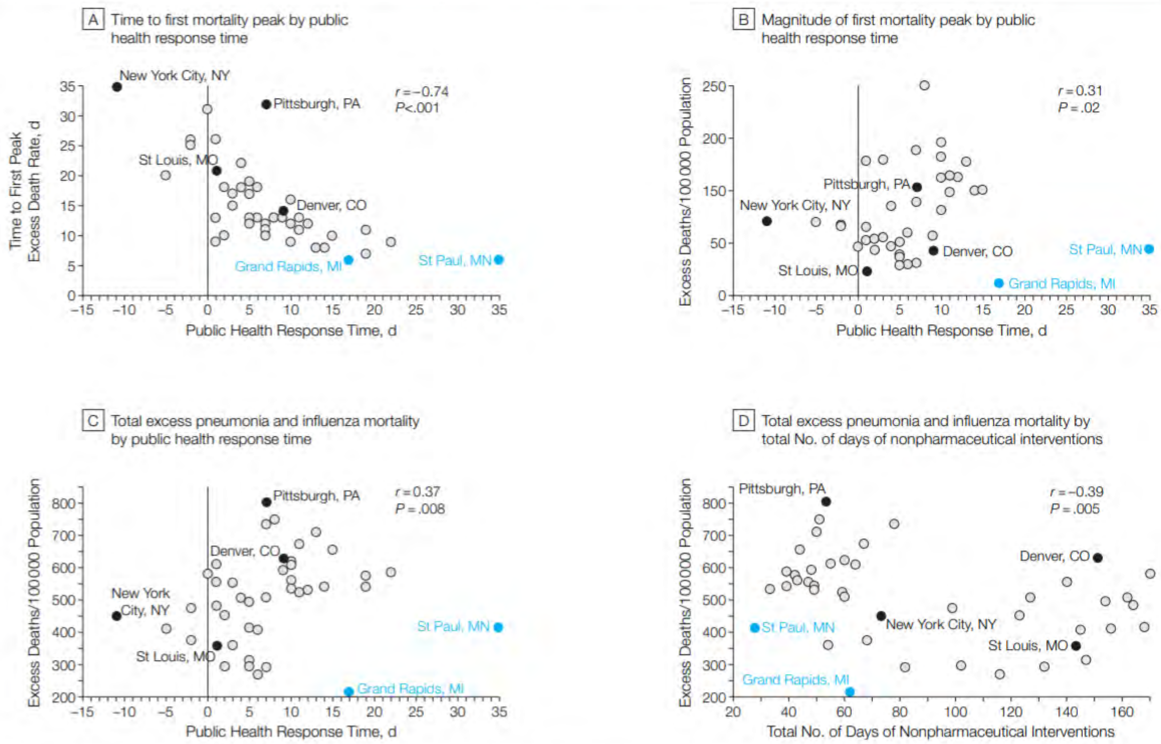
Pandemic Response Phases

In the early stages of a pandemic, key strategies include detecting cases using routine surveillance and epidemiologic investigations. As continued clusters of cases are identified and there is confirmation of human-to-human transmission in a given country, non-impacted countries attempt to contain the outbreak and limit any potential spread. This includes travel restrictions, screening, quarantine of any exposed individuals, and isolation of anyone who becomes ill. As continued implementation of case-based control measures becomes less effective, community interventions are used to limit the spread of disease in local geographic areas, including social distancing actions such as school closures or cancellation of events.

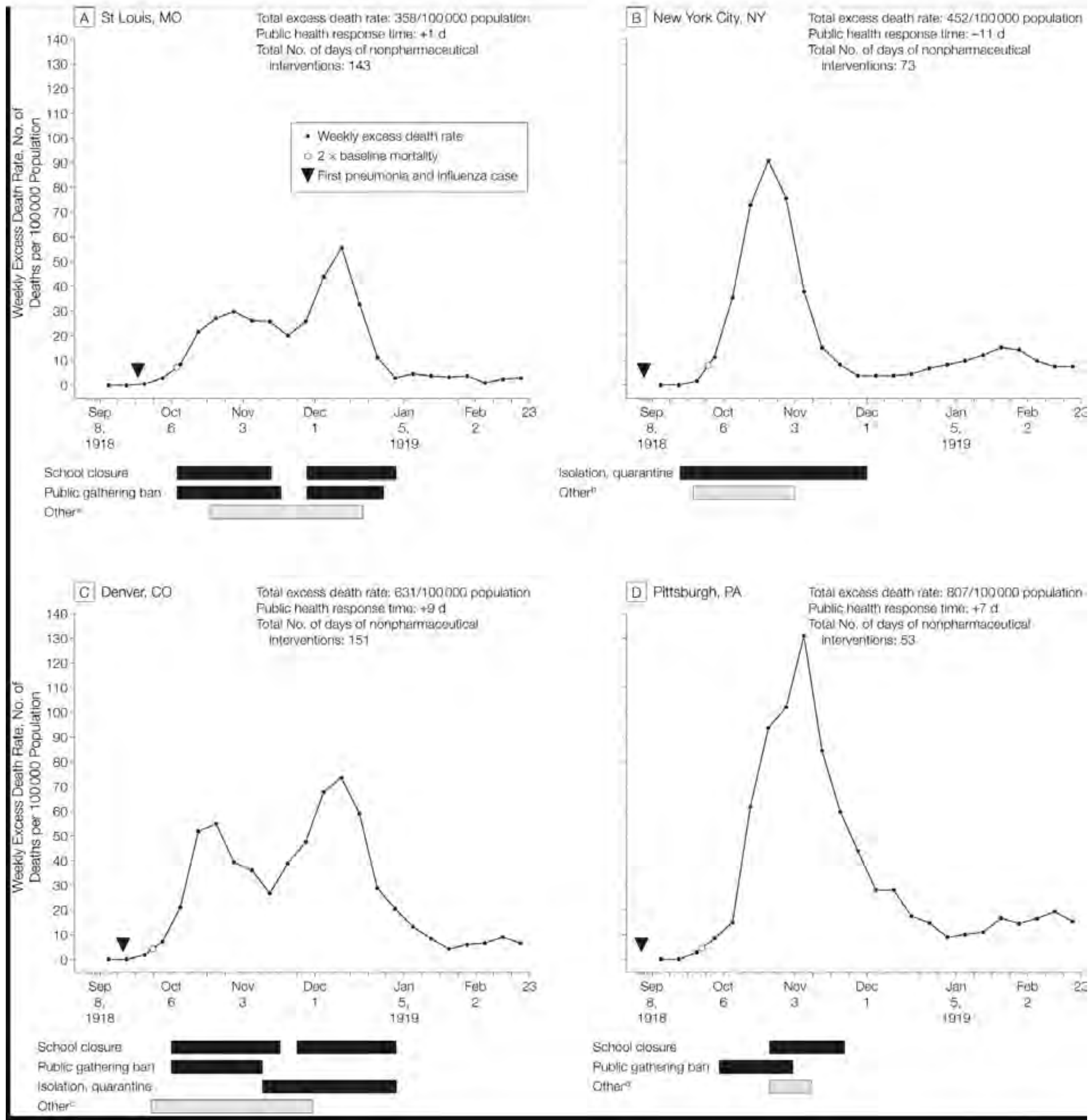
In a state as large as California, the transition from containment to mitigation phase is not homogenous. While many California communities are still working through containment-mitigation strategies, other communities are already in the mitigation phase due to widespread community transmission of COVID-19. Now that California has documented community spread and is progressing to the peak of the pandemic, disruption across social, economic, community and health care delivery environments will occur. California is now in a position where preparation of the healthcare system is essential and should not wait for the rapid surge in COVID-19 cases.

Cases are quickly increasing in multiple communities across the state, and there is a narrow window (7-10 days) in which to aggressively implement community interventions (closing schools, canceling large gatherings, and social distancing) in order to bend the epidemiologic curve or stretch it out. If aggressive community intervention actions are delayed, the interventions will have low or no impact. Studies[1,2] analyzing U.S. major city interventions and mortality rates from the Influenza Pandemic of 1918 clearly show that cities who delayed implementing early, aggressive community interventions suffered greatly, with substantially higher mortality. Even worse, those cities then suffered both the widespread illness *and* the burden of aggressive social distancing measures which were too late to be effective. Importantly, the lack of a vaccine or anti-viral treatments for COVID-19 has put the U.S. in a similar circumstance to 1918. This concept is vividly demonstrated by an analysis of response time of public health community interventions versus excess deaths from major U.S. cities in 1918:

Figure 1. Scatterplot of Public Health Response Time for 43 US Cities From September 8, 1918, Through February 22, 1919



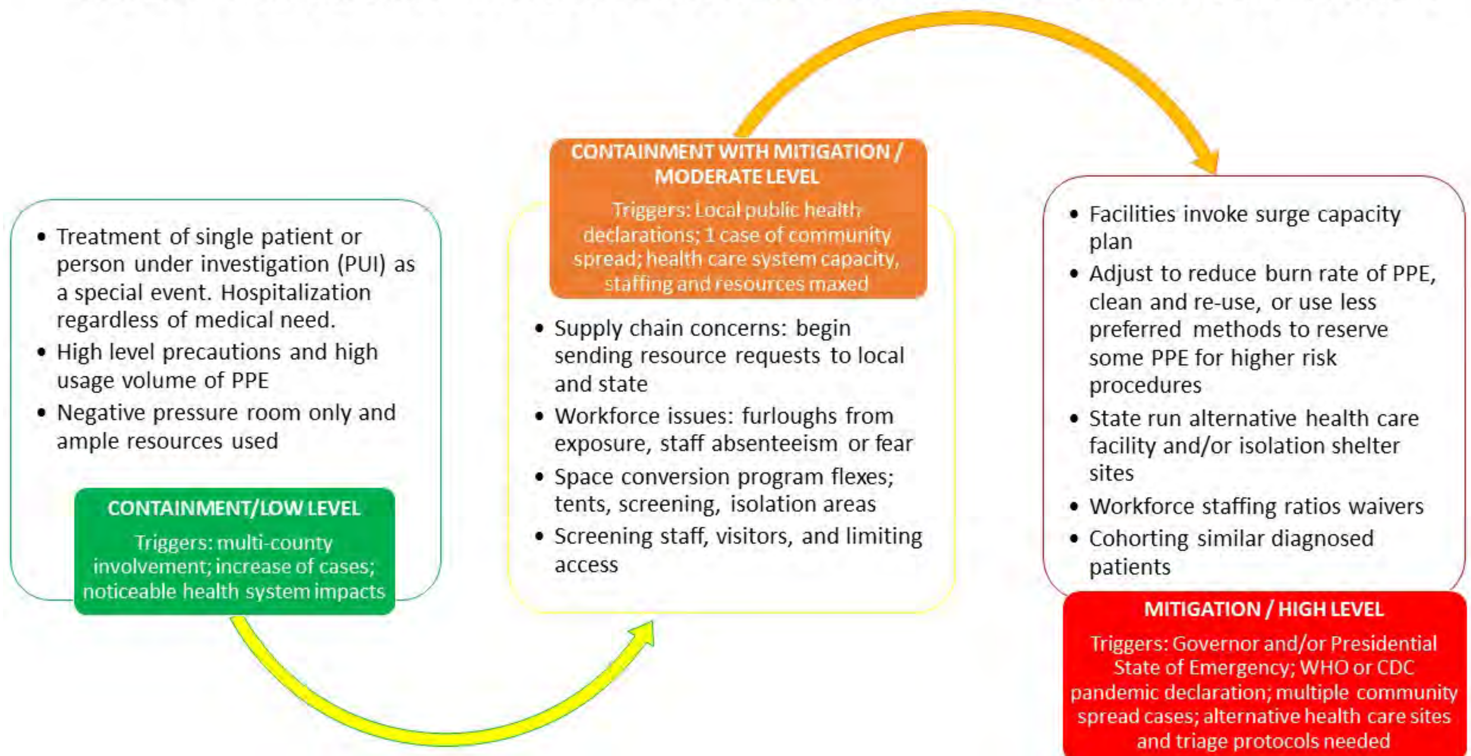
The 4 cities represented by black circles are discussed further in the text. The 2 cities represented by blue circles are outliers chosen to demonstrate that the associations shown are not perfect. The Spearman rank correlation coefficient was used.



Given that laboratory testing has not been available for widespread testing, and the case definition for testing was initially very restrictive and did not allow for testing for community spread, the reality is that infection already exists in many California communities but has been undetected because the vast majority of cases have a mild spectrum of illness. Therefore, the window for maximum impact of community interventions may have already passed in some communities. The movement to mitigation also signals the need to further engage the healthcare delivery system to prepare for a rapidly rising number of cases.

Containment to Mitigation Continuum

The strategies differ in each phase of response to an outbreak. Initially during an outbreak of any viral or bacterial strain, the goal is to contain it as much as possible. Actions taken under the containment phase may seem extraordinary or excessive to normal medical protocols and procedures, but they seek to stop the spread. Once the virus has demonstrated the ability to spread through a community, the health care delivery system then must shift its response activities to both contain the virus and prepare for mitigation of large-scale healthcare system impacts. It is this preparation to preserve space capacity, supply chain, and the staffing workforce that determines the health care facility's ability to handle the incoming healthcare needs during mitigation. This continuum is best described by the graphic below, which shows the potential triggers (catalysts) for health care facilities to shift and move to the next form of response.



Health Care System Mitigation: Key Considerations

- **SPACE:** Expand health care system surge capacity by using community sites (such as stadiums, gyms, churches, federal/state properties, community centers, etc.) as temporary government run health care facilities and/or isolation shelters.

- **STAFFING:** Recruit traveling, temporary staff and grant immediate California medical and licensure privileges; expand/alter scope of practice of RNs, LVNs, MAs and CNAs, as well as providers like NPs and PAs. Adjust staffing ratios in population based care settings and consolidate patients in cohorted spaces.

- **SUPPLIES:** Mitigate scarce resources through proper re-use, using expired or other mask models, and rationing supplies like personal protective equipment (PPE) to ensure the most high-risk situations for spread (i.e., aerosol-generating procedures) have the proper PPE to protect healthcare workers. Procure gurneys, IVs and other medical supplies for mass government run facilities now, so they are at the ready when it is time.

- **INFECTION CONTROL:** Provide "just in time" training for all levels of staff and adjust guidelines for specific facility types and supply chain situations.

- **COMMUNICATION:** Educate the public on patient triage systems in individual communities to guide infected individuals to the right level of care including: 1) self-isolation, 2) admission to local isolation shelter or state run health facility, and 3) hospitalization.

- **PARTNERSHIPS:** Develop partnerships between stakeholders, facilities, industries, and states to provide opportunities for mutual aid. Partner with local media to help educate the public on that community's triage system for symptomatic individuals.

- **LABORATORY TESTING:** Testing strategies during the shift from containment to mitigation initially focus on tracking the increasing number of infected individuals to determine when the health care system should rapidly increase their capacity. As the virus becomes widespread, testing becomes clinically focused and many patients will be presumed to be positive, similar to the peak of influenza season.

- **MEDICAL COUNTERMEASURES (MCM):** Work with health care delivery systems to procure, store, transport, and administer life-saving drugs, ventilators, other medical resources, and vaccines for COVID-19 as they become available.

- **MITIGATION STRATEGY BY PANDEMIC SEVERITY:** Each community or county may be in a different phase of the pandemic compared to a neighboring community, so it is imperative for each region to focus on mitigation steps specific to the phase they are experiencing.

II. Health Care Delivery System

Facility Capacity Management

General Considerations

Because it is unclear when California will reach the peak of the pandemic, the state needs to continue to identify and prepare for the number of hospital beds that may be needed as new infection rapidly increase over the coming weeks and months. Given that the health care system is already impacted by the current influenza season, this represents increased strain on the system. Reports from Italy's healthcare delivery system suggest that hospitals must prepare for rapid surge needs for ICU beds including making plans to convert operating rooms and other spaces to ICUs. Importantly, this surge will occur in the context of many hospitals already operating at or above capacity with overcrowded Emergency Departments (EDs) due in part to the demands of homelessness, behavioral health needs, and the opioid epidemic.

The increased demand for health care associated with a large novel coronavirus outbreak will require effective partnership across government and the entire continuum of health care, from hospitals to primary care, and must include cooperative strategies across our complex healthcare system. The likelihood that the impact will disproportionately burden certain regions of the state must also be anticipated, and plans made to shift patients and resources accordingly to ensure the entire state's healthcare delivery system remains strong.

Expansion of Health Care Capacity

The increased demand for health care should be addressed through a multifaceted approach, including expansion of existing hospital capacity, and expansion of the continuum of health care, and through the establishment of government-run alternate care sites, which may include state-run hospital facilities. Over the past several years, hospitals have been planning for increased capacity in the event of a public health emergency, with the assumption of the need for 15-20% immediate bed availability; however, most urban hospitals in the state have far less surge capacity. **Health care facilities need to enact their surge plans now** to create overflow space for screening, triage, isolation, and transfer/discharge, including conversion of outpatient space for inpatient use and using non-patient areas for patient care. In addition, facilities need to immediately implement patient education, phone advice, and treatment and triage algorithms to minimize unnecessary emergency department visits and admissions. Facilities also need policies and procedures to route patients with symptoms who may need testing away from congested emergency rooms, urgent care centers and clinics to locations (labs, community testing centers, etc.) where testing can be done without putting vital health delivery system assets at risk for undue infection burden.

Hospital surge plans are enacted in stages. The first step is to free up regular medical/ surgical beds and then to use program flexes to further expand the number of regular and ICU beds. As facilities across the state begin to report that they are at their bed capacity even with program flexes in place, and there is no ability to move patients to facilities within the region or the state, facilities will need waivers from both state and federal statutes to deliver additional patient care under modified conditions according to their surge plans. Because this situation will likely escalate quickly, potentially within hours or days, hospitals must solidify their plans now based on the most extreme potential numbers, not conservative estimates. This will ensure hospitals and local healthcare systems are prepared for a worst-case scenario. The State of California, and specifically the regulatory entities within Health and Human Services Agency, stand ready to assist and partner with healthcare facilities in this effort.

Health care facilities are well-versed in the ability to request program flexes to address health care needs in their facilities and routinely request such flexibilities during severe influenza seasons or during other local or state emergencies. CDPH has created a centralized structure through the Medical Health Coordination Center (MHCC) to quickly grant individual facility program flexes within 24 hours to allow triage of patients within tent structures on hospital property. As the impact worsens, CDPH will grant blanket program flexes to more quickly allow facilities to waive provisions of state regulations.

CDPH continues to monitor health care system capacity. Health care facilities should reach out to their Medical and Health Operational Area Coordinator to request resources from the county, region, state or federal government as needed. In addition, facilities should reach out to the Licensing and Certification District Office when they experience issues with their ability to deliver care or cannot meet the demand for care.

Large health care systems must develop plans now to expand care delivery for extreme surge capacity and work with the state with any identified barriers in staffing, capacity, or supplies and equipment. Additionally, sharing real-time creative solutions during this rapidly evolving pandemic will need to happen quickly among key leaders of large health care systems and public health.

The State of California recognizes that state and federal statutes will need to be waived when health care facility needs go beyond regulatory changes and require higher level modifications to existing laws governing care delivery such as scope of practice, movement between systems of care, transfer of patients, EMTALA, medical licensing of retired inactive or outside of California clinicians, use of supplies and equipment beyond manufacturer's recommended use, Medicaid or Medicare requirements, and liability and immunity protections, among others.

Expansion of Complementary Non-Hospital-Based Care

In order to relieve demands on hospitals, care will need to be augmented with additional outpatient services. Clinic hours may need to be extended to address patient needs. Long term care facilities may need to expand their role and accept additional patients who are discharged from the hospital but not yet able to go home. It is imperative that all health care providers, in all facility types, collaborate regionally to address any barriers to providing care and establish additional designated areas for care. Similar to hospital preparations, outpatient clinics need to repurpose their space and operations in order to meet the extreme estimates of patients needing treatment, not conservative estimates.

Establish Screening Areas

In order to reduce exposure at the health care facility while safely and quickly assessing patients to determine the level of care needed, implement the following:

- Establish separate screening areas, either on the health care facility property or in the community.
- Cohort patients in the screening area during assessment; screening areas for COVID-19 do not have to be a private room.
- Use the precaution level that is recommended by your institution.
- PPE must be changed between patients.
- Provide a 6 foot distance from other patients with reasonable privacy considerations.
- Record each patient screening with appropriate medical record documentation.
- Depending on the medical screening determination, transfer patient to 1) self-isolation at home, 2) centralized isolation shelter/urgent care facility; 3) hospital for admission.

Facility Access

In order to minimize unnecessary exposures, establish Safety Checkpoints at all portals of entry with the following provisions:

- Access to the medical facility should be limited to main portals of entry.
- Staff should be stationed at main portals of entry to conduct screenings.
- Patients who have a cough or shortness of breath should be directed to put on a mask before they are directed to the appropriate screening area.
- Visitors should be limited to one person, whether accompanying a patient to an appointment, or visiting a patient who is hospitalized.
- Restrict individuals with symptoms of upper respiratory infection from visiting.
- Instruct visitors and caregivers to wear a mask when outside the patient room and to clean hands before entering and leaving the patient room.
- Discourage visitors and caregivers from public locations within the medical facility (e.g. waiting room, cafeteria).

Move to Population-Based Care

During this pandemic, the demand for medical care will quickly exceed available resources to deliver that care. When staffing, supplies, and beds are scarce, the goal of health care becomes population-based care rather than individual care. Population based care means that resources are used to do the greatest good for the greatest number rather than providing all resources needed to treat each individual. Physicians will need to balance the obligation to save the greatest possible number of lives against the need to care for each individual. CDPH will work with experts to provide guidance on how to deliver care to ensure that ethical principles guide decisions to withdraw or withhold care.

Long Term Care Facilities Transfer/ Readmit/ Discharge Considerations

Patients with confirmed or suspected COVID-19 should not be sent to a long term care facility via hospital discharge, inter-facility transfer, or readmission after hospitalization without first consulting the local public health department. This will prevent the introduction of COVID-19 into a highly vulnerable population with underlying health conditions in a congregate setting. As discussed above, as the pandemic rapidly progresses, it will be necessary to designate certain long term care facilities as receiver sites for those with confirmed or suspected COVID-19; this would constitute community cohorting of COVID-19 patients requiring long term care but not hospital-level care. Regional healthcare systems should begin planning for this community-level cohorting now, as part of their overall triage system to direct individuals to the right level of care.

Emergency Medical Services (EMS)

Ambulance personnel should follow CDC guidelines for personal protective equipment (PPE). EMS personnel should have a designated area to doff their personal protective equipment and clean their ambulance between patients.

Medical facilities that have outside or specialized screening areas should direct EMS personnel to those locations for patient transport. Medical facility staff should meet ambulance personnel at a designated location outside the medical facility. The medical facility staff member should escort the patient and any accompanying family member to a designated COVID-19 evaluation and assessment area within the facility. When direct admit is possible, the patient and accompanying family member should be escorted to the designated inpatient setting.

Contingency plans for delays in ambulance transfer to receiving facility should also be made.

Health Care Workforce

Perhaps the most challenging aspect of expanding health care capacity during a pandemic is staffing. There will be shortages in the health care workforce as some workers become ill or are taken off duty because of exposure to individuals testing positive for COVID-19, while others may be fearful to come to work, need to care for sick parents or children, or have issues with childcare.

In addition, school closures can create a health care workforce shortage in a region, as it may result in health care staff needing to stay home to care for family members rather than being available to treat patients. Health care facilities need to develop back up staffing plans and may need to work with the Department of Social Services (DSS) to create provisions for onsite child care that meets DSS safety standards.

Because this is a national and global outbreak, securing mutual aid may be a significant challenge. Health care systems should use normal augmentations such as registries or increasing contract staff but as the need grows, this will likely be inadequate.

Health care facilities may need to rely on Medical Reserve Corps, volunteer staff, and even family members to assist with care. Facilities will need to examine administrative procedures to bring on staff quickly and determine both licensing, credentialing and privileging.

Health care facilities will need to work with the state to explore expanding scope of practice for licensed practitioners based on skill and experience and under the supervision of higher-level clinicians. Acute health facilities may also consider expediting credentialing for additional clinicians in the community that do not have hospital/admission privileges.

For non-patient care administrative staff, health care facilities should implement general recommendations for workplace social distancing, including flexible work sites (e.g. telecommuting), flexible work schedules (e.g. staggered shifts), replacing in-person meetings with teleconferences and restricting non-essential travel.

COVID-19 Patients and the Health Care Worker

If there is an exposure of an employee to a COVID-19 patient, the employee should self-monitor for symptoms of fever and a lower respiratory tract infection. If the employee does not have symptoms of fever or respiratory tract infection, the employee may continue to work. If the employee experiences any symptoms of fever and lower respiratory tract infection, they should be tested for influenza and COVID-19 and furloughed according to the same practices used for influenza during flu season. If the employee tests positive for COVID-19, follow guidance on criteria to determine when the employee may return to work.

Supply Chain

CDC and the World Health Organization are already reporting global shortages of critical supplies and equipment, in particular, of personal protective equipment (PPE) needed to ensure the safety of health care workers and in some cases the public.

To limit numbers of exposed health care workers and conserve PPE supplies, facilities should:

- Use dedicated or disposable patient-care equipment (e.g., blood pressure cuffs, stethoscopes).
- When facilities use reusable equipment, they must clean, disinfect, and sterilize (if needed) after use and according to manufacturer's instructions.
- Re-use masks and respirators by doffing, storing and cleaning correctly.
- Use expired surgical masks and N95 respirators and/or non-medical grade N95 respirators as a last resort if all other N95 supplies are exhausted.
- Minimize patient transfers to reduce opportunities for contamination both internally and externally.
- Triage areas for evaluation of persons presenting with fever and acute respiratory symptoms.
- Create entire units within the facility to care for hospitalized persons with suspected or confirmed COVID-19 infection.
- Have dedicated health care workers who practice extended use, reprocessing, and reuse of PPE, including respirators and eye protection.

Facilities should review CDC's PPE optimization strategies, available at https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html including options for extended use, reprocessing, and reuse of the various PPE components given current shortages of PPE. Extended use refers to the practice of wearing the same N95 respirator and eye protection for repeated close contact encounters with several different patients, without removing the respirator and eye protection between patient encounters. Health care workers should remove only gloves and gowns and perform hand hygiene between patients. This is typically done where multiple patients with the same infectious disease diagnosis are cohorted in the same area of the facility.

Facilities currently facing a shortage of N95 or other supplies, should contact their Medical Health Operational Area Coordinator (MHOAC); a MHOAC contact list is available at https://emsa.ca.gov/medical-health-operational-area-coordinator/ and the MHOAC Program Manual at https://www.cdph.ca.gov/Programs/CCLHO/CDPH%20Document%20Library/MedicalandHealthOperationalAreaCoordinationManual.pdf

Infection Control

Source Control: Additional Patient Considerations

Patients with minimal symptoms should be advised to home isolate and work restrict until well (resolution of fever for 24 hours, resolution of cough). These patients do not require testing. Evaluation by phone or video visit should be encouraged. Patients presenting to a medical facility with cough or shortness of breath should be immediately advised to wear a mask.

Personal Protective Equipment (PPE) and Isolation and Environmental Cleaning: General Considerations

Recommended PPE should be donned and doffed appropriately for patients suspected or confirmed to have COVID-19. Negative pressure rooms are not required for all suspect and confirmed COVID-19 patients but staff should at minimum take droplet precautions for any patients with respiratory symptoms while being evaluated and treated. During procedures or when providing treatment to critically ill COVID-19 patients, N95 respirators and other PPE should be used.

Those escorting patients with respiratory symptoms or suspected to have COVID-19 do not need to wear a mask, if the patient is masked. If the patient is unable to wear a mask, staff must put on a mask while escorting. Staff must wear full PPE if in direct contact (touching or providing care) with patients during transport.

- PAPR/CAPR or N95 Use and Additional Equipment:
    - Clean reusable components of PAPR/CAPR after each use.
    - Dispose of N95 after each use as per current infection prevention protocols.
    - Use disposable supplies if available; otherwise dedicate reusable supplies or equipment for patients suspected or confirmed to have COVID-19.
    - Reusable equipment must be cleaned routinely with hospital-approved disinfectant.
    - Rooms occupied by patients suspected or confirmed to have COVID-19 should be cleaned following protocols for routine daily and discharge cleaning.
    - Environmental services (EVS) should follow at minimum droplet and contact precautions with eye protection while performing daily and discharge protocols for cleaning of rooms occupied by patients suspected or confirmed to have COVID-19.
    - In general, rooms of discharged patients suspected or confirmed to have COVID-19 on droplet precautions need not be closed for 1 hour prior to cleaning. The exception is negative pressure rooms used by patients suspected or confirmed to have COVID-19 on airborne precautions due to aerosol-generating procedures; these must be closed for at least 1 hour prior to cleaning. However, the room may be cleaned without waiting for 1 hour if EVS staff wear a properly fitted N95 respirator.

- Initiate Airborne Precautions and wear PAPR/CAPR/N95 if performing or present in the room for high-risk procedures (intubation, bronchoscopy, sputum induction, suctioning, opening ventilator circuit, etc.) on patients suspected or confirmed to have COVID-19.
    - If available, perform high risk procedure in a negative pressure room; otherwise, a private room with closed door is adequate.
    - Conversion of rooms to negative pressure as possible
    - Limit high-risk procedures when impact to care is less obvious, i.e., nebulized medications without firm objective need, bronchoscopy when blind lavage will do, etc.

- Limit transport and movement of patients to medically necessary purposes.
    - Use alternative bedside procedures and imaging when possible.
    - Patient must be masked if ambulating outside the room or being transported for a procedure.
    - Staff need not wear mask or other PPE if patient is wearing mask during transport.

- Avoid unnecessary testing and routine periodic evaluation of patients in isolation
    - Decrease vital sign assessments to medically appropriate intervals to match clinical condition and improvement in condition.
    - Testing and imaging only when needed for clinical indications (e.g. diuresis, clinically evident bleeding, change in urine output, change in tidal volumes, oxygenation, etc.)
    - Utilize alternative diagnostic methods rather than resource- and staff-intense methods when appropriate (point of care ultrasound, etc.)

- Use remote interaction with patients in isolation as appropriate
    - 2-way intercom or phone
    - “Baby monitors” or other video monitors may suffice if patients unable to communicate
    - Remote telemonitoring equipment if available

Cohorting of COVID-19 Patients

- Patients with the same known respiratory disease/condition other than COVID-19 may be cohorted with local IP/ID guidance.
- Patients confirmed with COVID-19 may be cohorted with local IP/ID guidance.

Reusable Equipment and Environmental Cleaning

- Use disposable supplies if available; otherwise dedicate reusable supplies or equipment for patients suspected or confirmed to have COVID-19.
- Reusable equipment must be cleaned routinely with hospital-approved disinfectant following each use.

Visitation Restriction

Social distancing measures that decrease the amount of interaction between people can reduce virus transmission by decreasing the frequency and duration of social contact among persons of all ages. Social distancing should include medically screening visitors, limiting visitors, and possibly restricting visitors. It may also include restricting access to common areas like a recreation room, the cafeteria, and canceling outings and classes.

These measures can be common-sense approaches to limiting potential symptomatic and asymptomatic individual contact between people, which reduces person-to-person transmission; however, it can also quickly result in a decline of the patient's overall mental health. Isolation measures of this magnitude may save lives, but it is important to note that anxiety, depression and other mood disorders could ensue from this level of social isolation.

Removal of Remains

Mortuary and funeral home workers should always follow good biosafety practices. When handling human remains with known or suspected COVID-19 infection, workers must be protected from exposure to infected blood and body fluids or to contaminated objects and surfaces. Employers are responsible for following applicable OSHA requirements. Workers should use standard precautions to ensure protection from body fluids splashing or contaminating eyes, mouth, nose, hands or clothing.

At a minimum, mortuary workers should:

- Wear latex or nitrile, nonsterile gloves when handling potentially infectious materials.
- Wear heavy-duty gloves over the latex/nitrile gloves if there is a risk of cuts, puncture wounds or other injuries that break the skin.
- Wear a clean, long-sleeved fluid-resistant or impermeable gown to protect the clothing.
- Use a plastic face shield or a surgical mask and goggles to protect the face, eyes, nose and mouth from potentially infectious body fluids if there is a risk of splashing. If there is a risk of aerosol generation while handling human remains, use respiratory protection as specified in the OSHA general guidance.

Prompt cremation of remains from COVID-19 cases can avoid worker exposure. Embalming is allowed but an open casket should be discouraged to prevent mourners from touching the body.

III. Communications

There are over 11,169 health care facilities in over 30 different facility types in California that are licensed by CDPH, which underscores the challenges of consistent and timely communication. Note that this does not include the Veterans' Affairs health care system. In addition, there are thousands of other facilities like urgent cares, clinics and other ancillary health care facilities that are not licensed by CDPH.

CDPH will continue weekly All Facility Calls (AFCs) and add ad hoc AFCs or increase regular frequency as needed. CDPH will also continue weekly and ad hoc All Facility Letters (AFLs) with increased frequency as needed. CDPH will continue updating the CDPH web site for important updates and develop a more robust social media and radio presence. Most importantly, CDPH leadership will continue to keep the lines of communication open between health care facility leadership and stakeholders who represent the members of facility types, and be available and responsive to their evolving situational needs.

Similar to other pandemics, COVID-19 is not a singular event – it is a series of occurrences at different times, in different communities, over a sustained period of time. Messaging must be grounded in risk communication principles and based on the time and location of the events. The public must be informed about the potential threat, kept up to date in an environment of uncertainty, and provided relevant and usable information in a transparent manner. Additionally, health care providers and response personnel must be kept abreast of best practices, availability of resources and methods to ensure appropriate public care and safety. The effective use of crisis and emergency risk communication principles can help instill and maintain public confidence in the state and national public health system.

Recommended best practices include:

- Develop strategic public and stakeholder communications plan, adapting to the evolving situation.
- Identify credible spokesperson across multiple languages as needed.
- Develop and disseminate clear, plain-language COVID-19 communications, adapting messaging as the situation develops and evolves.
- Translate messaging to reach targeted and culturally appropriate populations.
- Utilize appropriate methods of communications, particularly social media and video messaging, to share information as it develops. Correct misinformation.

Public and Patient Outreach

Public Service Announcements with generalized recommendations about COVID-19 can serve as a useful tool to provide direction to patients to community screening areas and isolation shelters. It is important that the public has access to information about COVID-19 across all technological platforms. Outreach to the public can educate them on what to expect at screening and how to safely access care.

Communications should be developed to inform patients with potential infection to call first, before presenting to a clinic setting, and to visit a screening area first. All communication materials should be available in ADA compliant format in multiple languages as appropriate. Focus communications on the patient demographics who are at the highest risk and seek

communication avenues that reach the target audiences who are the most vulnerable to COVID-19.

Physician and Staff Education

Key groups to include in educational efforts include:

- Appointment and advice call center staff who field a variety of questions will require the development and training on FAQs.
- Front office and administrative staff need training on COVID-19 to reduce fears and enable them to properly handle suspected cases.
- Physicians should be familiar with triage workflows so they understand the new patient pathways through the health system and can refer patients appropriately.
- Physicians will need updates on reporting, epidemiology and outbreak information for their community and how to communicate with their local health department.
- Clinic directors will need timely information about business operations, staff and supply availability and what regulatory flexes are available.

IV. Laboratory Testing

There are 4 categories of lab testing: state public health lab diagnostic testing, local public health lab diagnostic testing, surveillance testing (by CDC or local public health lab), and commercial tests (multi-viral panels and point-of-care (POC) COVID-19 testing similar to POC flu tests).

As the pandemic progresses, public health labs will transition from testing all suspect cases to mostly testing for new COVID-19 strains; similar to influenza testing for virus mutations, testing will likely be conducted in outbreaks or high-risk or high-exposure settings, and specific instances (those re-infected with COVID-19, those in ICU, death). Like influenza surveillance for virus mutations, public health labs should plan for some form of surveillance testing for variant COVID-19 strains.

Criteria for Clinical Testing

Criteria for testing will continue to shift as the pandemic cycle follows its course. Hospitals and clinics should promulgate clinical guidelines for who should be tested regardless of federal guidelines. This may include:

- Patients who present with an influenza like syndrome (fever, cough, malaise)
- Patients who have a severe lower respiratory illness (pneumonia, ARDS) without another clear etiology
- Patients who have mild symptoms but are in close contact with individual(s) at high risk for complications of COVID-19

The need for testing diminishes once the community is saturated with cases. At that point, the focus on resources should be treatment for the patient. If a vaccine or other medical counter measure becomes available, then the need for testing will increase again.

Methods of Testing

CDPH encourages health care facilities to provide quick testing methods that reduces the amount of exposure to the facility. Designated "Drive By" testing locations on hospital or clinic property space is encouraged as to not bring in suspected or ill patients into the interior of the property. Staff conducting testing in these outdoor or tent screening environments should still follow proper PPE and infection control guidelines.

Mandatory Reporting

Commercial or POC testing results should be transmitted via Electronic Lab Report (ELR) to public health, which is normally used for other diseases including influenza. This automates the process of tracking new positive cases. Laboratories that are not yet participating in ELR should report to

their local health department. Clinicians are currently also mandated to report to their local health department per Title 17, Section 2500.

V. Medical Counter Measures (MCM)

In the context of the public health response to COVID-19, medical counter measures (MCMs) refer to FDA-regulated products used to prevent or treat the virus, including vaccines, antiviral medications for treatment or post-exposure prophylaxis (as used in influenza and HIV), and biologics (such as intravenous immunoglobulin used in measles and rabies). Additional supportive medical devices may also be needed such as ventilators or other respiratory or equipment support.

At this juncture, there are several groups actively working on developing a vaccine. Researchers are also testing a new antiviral under development (remdesivir), which can be requested on a compassionate use basis, as well as the efficacy of existing antiviral and anti-inflammatory agents. CDPH partners closely with the CDC to stay abreast of research on both vaccines and treatments, and will be developing a statewide plan to coordinate the distribution of any future vaccine via an algorithm that prioritizes high risk groups and critical responders. CDPH will work with the health care delivery system to procure, store, deliver and administer vaccines and drugs as needed.

VI. GLOSSARY

Term	Definition
Containment	Efforts made to prevent introduction of virus into a population including travel restrictions, quarantine of those with exposure, immediate isolation of new cases, aggressive contact tracing, etc.
Coronaviruses	A family of viruses known to cause a variety of diseases including the common cold, Severe Acute Respiratory Syndrome (SARS) and Middle East Respiratory Syndrome (MERS); when the virus mutates it can jump from animal to human hosts.
COVID-19	The name CDC adopted for the disease caused by SARS-CoV-2, the name of the novel coronavirus.
Mitigation	When it is recognized that widespread community transmission exists, and containment is ineffective, activities shift to lessening burden on healthcare system, protecting those most at risk, specific outbreak control, and slowing spread within populations.
N95 respirator	Respiratory protective device designed to achieve a very close facial fit and very efficient filtration of air borne particulars, the N95 designation means the respirator blocks at least 95 percent of very small particles (0.3 micron).
SARS-CoV-2	CDC adopted this as the scientific name of this novel coronavirus because it is closely genetically related to the corona virus that caused SARS.
Personal protective equipment (PPE)	Supplies such as masks, respirators, eye protections such as goggles and face shields, gowns and gloves, and other supplies that protect the healthcare workforce caring for infectious persons, first responders, and field staff.
Point of Care Testing (POC)	Medical diagnostic testing at or near the point of care.
R-naught (R_0)	Basic reproductive number; the average number of new infections caused by a typical infectious individual in a wholly susceptible population.
Strategic National Stockpile	The U.S. National repository of supplies including medical supplies such as antibiotics, vaccine, and personal protective equipment.
Population-based care	Resources are used to provide the greatest good for the greatest number rather than provided all resources needed to treat each individual; some may not receive care.

EXHIBIT C

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CDCR Starts Chlorine Water Treatment Process at Stockton Correctional Facilities

APRIL 24, 2019

Hyperchlorination part of a larger plan to address Legionella

STOCKTON – Since March, officials from the California Department of Corrections and Rehabilitation (CDCR), California Correctional Health Care Services, the California Department of Public Health San Joaquin County Public Health Services and the Centers for Disease Control have been working together to investigate the source of two confirmed cases of Legionnaires' disease at California Health Care Facility (CHCF) in Stockton.

Legionnaires' disease is a type of pneumonia caused by bacteria that grows in warm water. It is not contagious, but can be acquired when people breathe mists or vapors that contain the bacteria from contaminated water sources.

Environmental testing showed the presence of Legionella at CHCF and the neighboring N.A. Chaderjian and O.H. Close Youth Correctional Facilities. As a result, CHCF and the Northern California Youth Correctional Center (NCYCC) discontinued the use of potable water, installed self-filtering shower heads, stopped using yard misters and power washers, and shut off the drinking-water fountains and instant hot water dispensers. Bottled water is being provided to everyone who lives and works in the facilities and more self-filtering shower heads are on order.

As part of a comprehensive strategy to eliminate Legionella, a chlorine water treatment process called hyperchlorination began this morning, April 24, at CHCF and NCYCC, which includes the two juvenile facilities and a training center.

Hyperchlorination is the process used to disinfect water systems. It will take place between 7 a.m. and 5 p.m. seven days a week until all plumbed water supply lines and fixtures in the approximately 115 buildings at the Stockton facilities have been treated.

Follow-up environmental testing will be done to ascertain the effectiveness of the hyperchlorination.

CHCF has obtained five mobile shower trailers, some with eight shower units and some with 12. CHCF also has six ADA-compliant shower units that are wheelchair accessible with two showers for each unit. Bottled water will continue to be provided.

In addition to the inmate who passed away in March, one other inmate tested positive for Legionnaires' disease; he is in good condition after receiving treatment at the institution. There were 30 cases of pneumonia at CHCF tested for Legionnaires' disease with 27 of those being negative; one test result is pending. No cases of Legionnaires' disease have been reported at NCYCC.

CHCF provides medical and mental health care to inmates who have the most severe and long term needs. Opened in 2013, CHCF also provides inpatient and outpatient mental health treatment, has a diagnostic center, a dental clinic, a dialysis unit and provides services to inmate-patients needing or recovering from surgery. The facility also has a palliative care unit

and recently opened a memory care unit for inmate-patients with dementia. The Stockton facility houses nearly 2,700 inmates and employs approximately 4,000 people.

NCYCC consists of two active facilities, the N.A. Chaderjian Youth Correctional Facility and the O.H. Close Youth Correctional Facility, on a campus of several buildings in Stockton. The two facilities currently house, educate and rehabilitate 410 youth, aged 15-25. There are 767 people employed there.

FOR IMMEDIATE RELEASE

Wednesday, April 24, 2019

CONTACT: (916) 445-4950

###

EXHIBIT D

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

MEMORANDUM

Date: April 6, 2020

To: California Department of Corrections and Rehabilitation (CDCR) All Staff
California Correctional Health Care Services (CCHCS) All Staff

From:

Original Signed By
Connie Gipson
Director, Division of Adult Institutions
California Department of Corrections and Rehabilitation

Original Signed By
R. Steven Tharratt, MD, MPVM, FACP
Director of Health Care Operations and Statewide Chief Medical Executive
California Correctional Health Care Services

Subject: **STAFF USE OF PERSONAL PROTECTIVE EQUIPMENT (PPE)**

We understand the importance and urgency surrounding the availability and use of personal protective equipment (PPE), particularly masks, for CDCR/CCHCS staff and the incarcerated population. Our top priority is doing everything we can to provide appropriate protection to slow the spread of COVID-19 within our institutions.

We must face the reality that during this global pandemic, CDCR and CCHCS are not immune from the unprecedented demand for more PPE to protect those on the frontlines. While we are not the only organization impacted by this shortage, we are working every day to increase our supplies, including reusable barrier cloth masks manufactured by the California Prison Industry Authority (CALPIA). While we work to expand our supply, we all need to do our part to make sure that PPE, especially masks, are utilized in the most appropriate and efficient way possible. We need a mutual understanding of PPE and develop innovative solutions to help increase our supply.

See COVID-19 Personal Protective Equipment (PPE) Guidance and Information from CDCR/CCHCS Public Health.

PPE including "medical grade" masks (N95 and surgical) should only be used by both CDCR and CCHCS staff as recommended in the memo above. The Centers for Disease Control and Prevention (CDC) and California Department of Public Health (CDPH) issued guidance recommending face cloth covering in the general public and in close quarters. We understand that additional facial protection can potentially limit "droplet" transmission while also offering some peace of mind to our staff,

their families, stakeholders and our population. To help address this moment of need, CALPIA has started manufacturing two-ply, cotton, reusable barrier masks that we will start distributing to our population in quarantine settings this week. Distribution of the masks will begin for inmates in quarantine and medically fragile inmates. As CALPIA continues to expand the production of these masks, we will also make them available to the general population and staff who do not have access to face coverings as a precautionary measure as supply allows. CALPIA is making 800 masks per day between two locations and will continue to ramp up to full production to meet the expected needs.

CALPIA also began ramping up their brand new production of hand sanitizer, which has already started arriving at most institutions and locations. We are extremely grateful for CALPIA and our population workers providing these valuable services in such a short time frame.

FACE COVERINGS (REUSABLE BARRIER CLOTH MASKS)

While we continue internal production and procurement of PPE, CDCR and CCHCS will also follow the recently released guidance from The Joint Commission (TJC), a trusted health care accreditation organization, by allowing staff to bring in a personal supply of reusable barrier (cloth) masks and approved medical masks if supply is not readily available. Any personally provided mask must be appropriate for the workplace and cannot contain any inherently offensive logos, graphics or text. Designer face masks that have skulls, “gate keeper,” “punisher,” logos, etc. on them (motorcycle type) would not be appropriate and employees will not be permitted to wear while on duty. The Department assumes no responsibility for personally owned face coverings. Staff will be required to remove face coverings for identification purposes at entry points.

Recommended PPE as described should be utilized first; if recommended PPE is not available use the most comparable coverage.

EXPANDING SUPPLY

The CDCR and CCHCS procurement teams are rigorously searching for PPE supplies, especially masks, to purchase. If you have a lead, please send the information to COVID19@cdcr.ca.gov. We are looking into innovative solutions we may never have considered before, such as smaller supply vendors and more. Our top priority is the safety of all those who live and work in our facilities, and we are doing all we can to get you the protection you need.

Please continue to provide feedback to the local leadership at your facility, headquarters and the CDCR/CCHCS COVID-19 Department Operations Center.

We truly appreciate all of our staff working hard on the front lines as we are making unprecedented changes to our operations to keep everyone healthy and safe. There are sure to be changes over the next several weeks, and so we thank you for the flexibility, patience and support for that you all have provided to each other. We are all CDCR Strong.

EXHIBIT E

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

MEMORANDUM

Date:	April 6, 2020
To:	California Department of Corrections and Rehabilitation (CDCR) - All Staff California Correctional Health Care Services (CCHCS) - All Staff
From:	*Original signed by:* Heidi M. Bauer, MD MS MPH Public Health Epi/Surveillance Lead Public Health Branch *Original signed by:* Diane O'Laughlin, FNP-BC, DNP Headquarters Chief Nurse Executive Public Health and Infection Prevention
Subject:	**COVID-19 Personal Protective Equipment (PPE) Guidance and Information**

The purpose of this memo is to provide information and resources related to COVID-19 and the continuously evolving status personal protective equipment (PPE) supply availability. The information below is intended to guide the use of PPE as we move forward in responding to this pandemic. In-depth guidance is provided in the COVID-19: Interim Guidance for Healthcare and Public Health Providers.

TYPES OF MASKS

Filtering facepiece respirator N95: An "N95" is a type of respirator which removes at least 95 percent of particles from the air that are breathed through it. An N95 currently has two recommended uses:

- Staff person accompanying individuals with respiratory symptoms in a transportation vehicle.
- A staff person present during "aerosol producing procedures" on suspect or confirmed COVID-19 cases such as COVID-19 testing, CPR, etc. or providing high-contact patient care such as bathing someone confirmed to have COVID-19.

More information about N95 and surgical masks:

- Understanding the difference between N95 and Surgical Masks
- Proper use and disposal of PPE
- Facial hair and PPE use

Use of Privately Owned Masks and Respirators and Reusable barrier masks (cloth/washable): "The Joint Commission (TJC) issued a statement on March 31, 2020, supporting the use of standard face masks and/or respirators provided from home when health care organizations cannot provide access to protective equipment that is commensurate with the risk health care workers are exposed to amid the

P.O. Box 588500
Elk Grove, CA 95758

COVID-19 pandemic. The CDCR/CCHCS will follow the TJC recommendations for privately owned PPE, including N95 and surgical masks. Please wash reusable cloth masks between each use using hot water with regular detergent and dry completely on hot setting.

EXTENDING THE USE OF PPE (MEDICAL EQUIPMENT MASKS)

The CDC has put out guidance on extending the use of medical equipment masks. There is not an exact determination on the number of safe reuses for these masks and those decisions must be made based on a number of variables per CDC guidelines such as impact respirator function and contamination over time.

RESOURCES

The **COVID-19 Quick Guide Poster** follows Center for Disease Control (CDC) guidelines for COVID-19 management. This quick guide defines quarantine, who to isolate, COVID-19 case actions and how to perform appropriate surveillance during the COVID-19 pandemic. The COVID-19 Quick Guide Poster pairs with the Personal Protective Equipment (PPE) Guide Poster, number 2 below, to inform staff on what type of PPE they will need.

The **COVID-19 Protective Equipment (PPE) Guide Poster** adopts CDC guidelines as of March 29, 2020, which reflect the CDC's recommendations for optimizing PPE supplies (link below). The PPE guide poster reinforces 6 foot social distancing, and gives guidance for individuals who must be within 6 feet for a prolonged period of time of suspected/confirmed COVID-19 individuals.

A **COVID-19 Quick Reference Pocket Guide** is intended to keep on person as a resource for PPE, quarantine, isolation and surveillance.

The CDC's also provides recommendations for optimizing PPE supplies.

These resource tools, TJC statement on privately owned face masks, and current available supplies should all be considered when determining the type of PPE staff will use for the safety of staff and the population. Please place the posters in high traffic staff areas to remind staff of these key concepts for COVID-19 management. Please assure your staff is aware of these resource tools.

Thank you all for your cooperation, as we continue to work together to guard against the spread of COVID-19 and to keep our staff and patients protected.

EXHIBIT F

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

MEMORANDUM

Date: April 15, 2020

To: Wardens
Chief Executive Officers

From:

Original Signed By
Connie Gipson
Director, Division of Adult Institutions
California Department of Corrections and Rehabilitation

Original Signed By
R. Steven Tharratt, MD, MPVM, FACP
Director of Health Care Operations and Statewide Chief Medical Executive
California Correctional Health Care Services

Subject: **CALPIA CLOTH FACE BARRIER/MASK**

As an on ongoing effort to prevent further exposure of COVID-19, the following information is intended to provide guidance on the use of cloth masks by staff and inmates/patients who are performing day-to-day activities within our institutions. This guidance is not a substitute for health care and custody staff following current Centers for Disease Control and Prevention or county health department recommendations in dealing with suspected, quarantine or diagnosed patients. Staff and inmates/patients are required to wear a face barrier once a supply of two (2) face barriers/masks per correctional staff and inmate/patient has been delivered to the institution. Staff may bring in their own face coverings as previously communicated.

Staff working or performing duties on institutional grounds shall wear a cloth face covering at a minimum. In addition, maintaining social distancing requirements when moving about the institution for routine tasks is still recommended. These masks are not intended for direct patient care scenarios.

Inmates shall use a cloth face covering within the institution during the following activities:

- Any situation that requires movement outside of cell or while in a dorm setting
- During interactions with other inmates (ex: yard time, canteen, dayroom)
- Movement to and from for health care appointments
- Movement to and from medication administration areas

Wardens and Chief Executive Officers should work together in developing an informational directive to all staff and inmate/patients on this wear requirement. Institutions, CIM, LAC, CHCF, have received their masks and therefore this expectation is effective immediately.

If you have any questions, please email DOCCOVID19@cdcr.ca.gov.

EXHIBIT G

State of California—Health and Human Services Agency

California Department of Public Health

SONIA Y. ANGELL, MD, MPH
State Public Health Officer & Director

GAVIN NEWSOM
Governor

January 27, 2020 AFL 20-10

TO: All Facilities

SUBJECT: Healthcare Facility Resources for the 2019 Novel Coronavirus (2019-nCoV)

All Facilities Letter (AFL) Summary

This AFL requests health facilities to voluntarily complete a state-wide infection control resource assessment for coordinated emergency response planning, and includes materials for facilities to prepare for the 2019 Novel Coronavirus (2019-nCoV).

Background

Since the Centers for Disease Control and Prevention (CDC) announced on January 21, 2020 that the 2019 Novel Respiratory Syndrome Coronavirus had its first confirmed case in the United States, the California Department of Public Health (CDPH) sent out AFL 20-09 Health Update and Interim Guidance – 2019 Novel Coronavirus (nCoV), on January 23, 2020, to provide personal protective equipment (PPE) and infection control guidance to facilities.

As of January 24, 2020, there are confirmed cases in California. CDPH is requesting health facilities to assist in evaluating the capacity for California to respond to potential expansion of 2019-nCoV in California. CDPH requests that facility leadership complete the Facility Capacity to Respond to Potential 2019 Novel Coronavirus (2019-nCoV) survey by the end of day, Wednesday, January 29, 2020.

The questions are listed below so you can see the information we are requesting before you respond on behalf of your facility. Please note that designation of an individual as a facility's contact is voluntary. To every extent possible, personally identifiable information submitted will be kept confidential subject to the provisions of state and federal laws including, but not limited to, the California Information Practices Act of 1977, and only used for the purposes stated herein.

Health facility responses to these questions will greatly assist CDPH in understanding the capacity throughout the geographic regions of the state. This is only a gathering of

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information so that CDPH can better plan, communicate, and coordinate responses if needed.

List of questions on the survey:

1. Type of health facility
2. Name of health facility
3. In the event that you should have a Patient Under Investigation (PUI) tested or a confirmed case, please write in the cell/direct number and contact information of the administrator at your facility whom we can work with to coordinate a response. (Optional)
4. How many isolation rooms or private enclosed spaces do you have to isolate a patient?
5. How many airborne infection isolation (negative pressure) rooms do you have for symptomatic patients?
6. How many rooms do you have which could be converted to temporary negative pressure isolation rooms using portable high efficiency particulate air (HEPA) machines?
7. Do you have adequate staffing to handle a PUI, a confirmed case, or potential multiple cases?
8. Do you currently have adequate supplies (preferably up to 30 days of operational use) of personal protective equipment (PPE) for potential multiple cases?
    a. gloves
    b. gowns
    c. eye protection
    d. N95 respirators
    e. powered air purifying respirators (PAPRs) for PUI or confirmed case
9. Are there other spaces in your facility, such as a floor or nursing unit, that could be designated for the care of 2019-nCoV patients only, rather than placing them in airborne isolation rooms throughout the hospital, if the capacity for individual airborne isolation rooms is exceeded?
10. Does your hospital's onsite clinical laboratory have the capacity to perform multiplex polymerase chain reactions (PCR) for viral pathogens, e.g., Biofire?
11. Are there other factors or comments about your facility that are important for CDPH to know?

In addition to the above survey, we have also attached resources for your facility to prepare: Healthcare Facility Preparedness Checklist (PDF) and Air Changes Per Hour (ACH) Table (PDF).

Please contact your local health department **immediately** if a PUI for 2019-nCoV is identified, or if a patient's status as a PUI is uncertain. In addition, please report this as an unusual occurrence to your local CDPH Licensing & Certification District Office so they can communicate with the CDPH Medical and Health Coordination Center.

If you have any questions regarding the infection prevention and control of 2019-nCoV, please contact the CDPH Healthcare-Associated Infections (HAI) Program at novelvirus@cdph.ca.gov.

Sincerely,

Original signed by Heidi W. Steinecker

Heidi W. Steinecker
Deputy Director

Attachment:
Healthcare Facility Preparedness Checklist (PDF)
Air Changes Per Hour (ACH) Table (PDF)

EXHIBIT H

State of California—Health and Human Services Agency

California Department of Public Health

SONIA Y. ANGELL, MD, MPH
State Public Health Officer & Director

GAVIN NEWSOM
Governor

January 31, 2020 AFL 20-11

TO: All Facilities

SUBJECT: Updated 2019 Novel Coronavirus Information (2019-nCoV), Including Patient Under Investigation (PUI) Guidance from the Centers for Disease Control and Prevention (CDC).

All Facilities Letter (AFL) Summary

This AFL provides updated information on 2019-nCoV including updated CDC guidance for PUI.

The World Health Organization (WHO) has declared 2019-nCoV a Public Health Emergency of International Concern. China has reported a 26 percent increase of 2019-nCOV cases since January 30, 2020. Over 7,000 new cases worldwide have been reported within the past week. The CDC is taking progressive action to protect the public and decrease impact on the United States (US). The risk to the American public is still considered to be low.

Updated 2019-nCoV Information

- 2019-nCoV can be spread through person-to-person transmission
- Recent report from Germany confirms that the disease can be transmitted from an asymptomatic individual
- Screening with current laboratory tests is not effective in recognizing those who are incubating 2019-nCoV asymptomatically
- A negative result does not mean someone will not start to show symptoms or contract 2019-nCoV
- CDC does not recommend the use of face masks for the general public

For additional information, see the CDC 2019 Novel Coronavirus webpage.

Updated CDC PUI Guidance

The CDC Interim Infection Prevention and Control Recommendations for Patients with Known or Patients Under Investigation for 2019 Novel Coronavirus (2019-nCoV) in a Healthcare Setting webpage

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US Temporary Measures

A White House Briefing on January 31, 2020, announced that beginning at 5:00 p.m. Eastern Time on Sunday February 2, 2020, the US will implement the following temporary measures:

- Any US citizen returning to US from Hubei province in the previous 14 days will be subject to up to 14 days mandatory quarantine to ensure they receive proper health screening and medical care
- Any US citizen returning to the US from the rest of mainland China within the previous 14 days will undergo proactive entry health screening at a select number of ports of entry and up to 14 days of monitored self-quarantine to ensure they have not contracted the virus and do not pose a public health risk
- President Trump has signed a Presidential Proclamation temporarily suspending entry into the US of foreign nationals that pose a risk of transmitting 2019-nCoV
- Foreign nationals other than immediate family of US citizens and permanent residents who have traveled in China within the last 14 days will be denied entry into the US at this time

Reporting

If a PUI for 2019-nCoV is identified, or if a patient's status as a PUI is uncertain, health facilities must report this event, as required in Title 22 California Code of Regulations, to the local public health officer **immediately** and to your local CDPH Licensing & Certification District Office (DO), so the DO can communicate with the CDPH Medical and Health Coordination Center. See AFL 19-18 for additional information on the requirements of reporting outbreaks and unusual infectious disease occurrences.

If you have any questions regarding the infection prevention and control of 2019-nCoV, please contact the CDPH Healthcare-Associated Infections (HAI) Program at novelvirus@cdph.ca.gov.

Sincerely,

Original signed by Heidi W. Steinecker

Heidi W. Steinecker
Deputy Director

Resources

CDC PUI Guidance
CDPH 2019-nCoV webpage
Coronavirus Alert Poster– English (PDF)
Coronavirus Alert Poster – Spanish (PDF)
Coronavirus Alert Poster– Mandarin (PDF)

EXHIBIT I

State of California—Health and Human Services Agency

California Department of Public Health

SONIA Y. ANGELL, MD, MPH
State Public Health Officer & Director

GAVIN NEWSOM
Governor

February 10, 2020 AFL 20-13

TO: All Facilities

SUBJECT: 2019 Novel Coronavirus Interim Guidance for Risk Assessment and Health Management of Healthcare Personnel with Potential Exposure

All Facilities Letter (AFL) Summary

This AFL notifies health facilities that the Centers for Disease Control and Prevention (CDC) has released interim guidance on risk assessment and management of potential exposure of healthcare personnel (HCP) to the 2019-nCoV.

On February 8, 2020, the CDC released interim guidance to assist health facilities with assessment of risk, monitoring, and work restriction decisions for HCP with potential exposure to 2019-nCoV. Healthcare facilities should review the CDC's Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with 2019 Novel Coronavirus (2019-nCoV).

Risk Assessment

The CDC Interim Guidance includes risk assessment categories for health facilities to use when assessing the level of risk after a HCP has experienced potential exposure. Additionally, the interim guidance provides monitoring recommendations based on each risk assessment category. The HCP exposure risk factors described in the CDC interim guidance include, but are not limited to, the following:

- The duration of exposure (e.g., longer exposure time likely increases exposure risk)
- Clinical symptoms of the patient (e.g., coughing likely increases exposure risk)
- Whether the patient was wearing a facemask (which can efficiently block respiratory secretions from contaminating others and the environment)
- Whether an aerosol generating procedure was performed
- The types of personal protective equipment (PPE) used by HCP

Information on the 2019-nCoV remains limited; therefore, the CDC recommends that heath facilities use clinical judgment as well as the principles outlined in the CDC Interim Guidance when evaluating risk of exposure and management of potential exposure of HCP. Health facilities should use this guidance in coordination with their

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local public health department to assess risk, determine the need for work restrictions, and guide monitoring decisions.

Travel or Community Exposure
HCP with potential travel or community exposures to 2019-nCoV should have their exposure risk assessed according to the CDC Interim Guidance for travel or community-associated exposures. HCP who fall into the *high-* or *medium- risk* category described there should undergo monitoring as defined by their local public health authority and be excluded from work in a healthcare setting until 14 days after their exposure. Healthcare facilities should additionally consider work exclusion for HCP that returned from China before the CDC guidance became effective on February 3, 2020 and are still within the 14-day incubation period.

Communication
Since response and prevention planning for the 2019-nCoV is constantly changing as we learn more about this emerging disease, CDPH will host weekly All Facility Calls every Tuesday morning at 7:45 a.m. Depending on what new information develops, we will adjust these calls each week to be for all facilities, or only for specific facility types. Tomorrow's call will be geared toward hospitals only, but future calls will include all facilities. You will receive information for the call-in number via the California Health Alert Network (CAHAN) and meeting invitations from our Medical and Health Coordination Center (MHCC).

Again, if you have any questions regarding the infection prevention and control of 2019-nCoV, please contact the CDPH Healthcare-Associated Infections (HAI) Program at novelvirus@cdph.ca.gov.

Sincerely,

Original signed by Heidi W. Steinecker

Heidi W. Steinecker
Deputy Director

Resources

- Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with 2019 Novel Coronavirus (2019-nCoV).

- Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential 2019 Novel Coronavirus (2019-nCoV) Exposure in Travel-associated or Community Settings

EXHIBIT J

State of California—Health and Human Services Agency

California Department of Public Health

SONIA Y. ANGELL, MD, MPH
State Public Health Officer & Director

GAVIN NEWSOM
Governor

February 19, 2020 AFL 20-14

TO: All Facilities

SUBJECT: Environmental Infection Control for the Coronavirus Disease 2019 (COVID-19)

All Facilities Letter (AFL) Summary

This AFL notifies healthcare facilities of the Centers for Disease Control and Prevention (CDC) guidance regarding environmental infection control for Coronavirus Disease 2019 (COVID-19), formerly referred to as Novel Coronavirus (2019-nCoV).

Healthcare facilities should have environmental infection control procedures in place to prevent infections from spreading during healthcare delivery. Environmental infection control procedures, such as waste management, laundry, food service, and environmental cleaning, should align with the CDC's Interim Infection Prevention and Control Recommendations for Patients with Confirmed 2019 Novel Coronavirus (2019-nCoV) or Persons Under Investigation for 2019-nCoV in Health Care Settings.

For persons under investigation and patients managed with transmission-based isolation precautions for COVID-19, the CDC recommends the following environmental infection control measures:

- Dedicated medical equipment should be used for patient care.
- All non-dedicated, non-disposable medical equipment used for patient care should be cleaned and disinfected according to manufacturer's instructions and facility policies.
- Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly.
- Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for COVID-19 in healthcare settings, including those patient-care areas in which aerosol-generating procedures are performed.
    - Products with EPA-approved emerging viral pathogens claims are recommended for use against COVID-19.

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- If there are no available EPA-registered products that have an approved emerging viral pathogen claim for COVID-19 (at the facility), products with label claims against human coronaviruses should be used according to label instructions.

- **Management of laundry, food service utensils, and medical waste should also be performed in accordance with routine procedures.**

Refer to the CDC's Guidelines for Environmental Infection Control in Heatlh-Care Facilities and Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings for detailed information on environmental infection control. For the most recent COVID-19 information and guidance, please visit the CDC's Coronavirus Disease 2019 (COVID-19) webpage.

If you have any questions regarding the infection prevention and control of COVID-19, please contact the CDPH Healthcare-Associated Infections (HAI) Program at novelvirus@cdph.ca.gov.

Sincerely,

Original signed by Heidi W. Steinecker

Heidi W. Steinecker
Deputy Director

CDC Resources:

- Interim Infection Prevention and Control Recommendations for Patients with Confirmed 2019 Novel Coronavirus (2019-nCoV) or Persons Under Investigation for 2019-nCoV in Health Care Settings
- Guidelines for Environmental Infection Control in Health-Care Facilities
- Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings
- Coronavirus Disease 2019 (COVID-19)

EXHIBIT K

State of California—Health and Human Services Agency

California Department of Public Health

SONIA Y. ANGELL, MD, MPH
State Public Health Officer & Director

GAVIN NEWSOM
Governor

March 3, 2020 AFL 20-17

TO: All Facilities

SUBJECT: Guidance for Healthcare Facilities on Preparing for Coronavirus Disease 2019 (COVID-19)

All Facilities Letter (AFL) Summary

This AFL provides healthcare facilities new and updated COVID-19 guidance from the Centers for Disease Control and Prevention (CDC), which include:

- Interim guidance healthcare facilities should follow to prepare for community transmission of COVID-19
- Strategies to prevent spread in long-term care (LTC) facilities
- Use of N95 filtering facepiece respirators (N95s) that have exceeded their manufacturer-designated shelf life

CDC Guidance for Healthcare Facilities

Community transmission has been confirmed in California, although the extent of transmission remains unknown. California healthcare facilities should follow the CDC's Interim Guidance for Healthcare Facilities: Preparing for Community Transmission of COVID-19 in the United States to:

- Work with your local public health department to understand the impact and spread of the outbreak in your area.
- Designate staff who will be responsible for caring for suspected or known COVID-19 patients. Ensure they are trained on the infection prevention and control recommendations for COVID-19 and proper use of personal protective equipment.
- Monitor healthcare workers and ensure maintenance of essential healthcare facility staff and operations:
- Ensure staff are aware of sick leave policies and are instructed to stay home if they are ill with respiratory symptoms.
- Be aware of recommended work restrictions and monitoring guidance for staff exposed to COVID-19 patients.
- Instruct employees to check for any signs of illness before reporting to work each day and notify their supervisor if they become ill; In settings of widespread transmission, consider screening staff for fever or respiratory symptoms before entering the facility.

- Make contingency plans for increased absenteeism caused by employee illness or illness in employees' family members that would require them to stay home, including extending hours, cross-training current employees, or hiring temporary employees.
- When possible, manage mildly ill COVID-19 patients at home.

In addition to the general recommendations in the setting of community transmission, CDC provides guidance for specific health care settings including outpatient facilities, acute care inpatient facilities, and long term care facilities (LTC).

Additionally, for LTC facilities, the CDC released Strategies to Prevent the Spread of COVID-19 in Long-Term Care Facilities to provide general information to prevent spread of respiratory infections and to prepare to care for residents with COVID-19. California LTC facilities should continue to adhere to the CDC Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 (COVID-19) or Persons Under Investigation for COVID-19 in Healthcare Settings which recommends standard, contact, and airborne precautions, and use of eye protection.

Use of Expired N95 Respirators

The CDC also provided guidance for the "Release of Stockpiled N95 Filtering Facepiece Respirators Beyond the Manufacturer-Designated Shelf Life: Considerations for the COVID-19 Response." The CDC advised that certain N95 models past manufacturer-designated shelf life can be considered when responding to COVID-19; however, these N95 models should be used only as outlined in the CDC Strategies for Optimizing the Supply of N95 Respirators, and in compliance with State laws and regulations..

The California Division of Occupational Safety and Health (Cal/OSHA) developed and published interim guidance for the efficient use of respirator supplies. Facilities should refer to the Cal/OSHA Interim Guidance on Novel Coronavirus (COVID-19) for Health Care Facilities: Efficient Use of Respirator Supplies to ensure compliance with the aerosol transmissible disease (ATD) standard. For more information on stockpiled N95s, please refer to the joint CDPH-CAL/OSHA Frequently Asked Questions About Use of Stockpiled N95 Filtering Facepiece Respirators for Protection from COVID-19 Beyond the Manufacturer-Designated Shelf Life.

Program Flexibility for Alternative Spaces

CDPH encourages facilities to submit program flexibility requests to create alternative spaces on their property for screening patients. General acute care hospitals may refer to AFL 18-09 for more information on requesting temporary program flexibility for increased patient accommodations during a disease outbreak. Other healthcare facilities and providers may refer to this AFL guidance in requesting program flexibility for regulations applicable to their facility type.

Long Term Care Patient Transfer/Discharge/Readmits
CDPH asks that any hospital who receives a long term care resident transfer who becomes a PUI or confirmed case for COVID-19, first reach out to their local public health department for coordination before the patient is discharged, if the patient no longer requires hospitalization.

If you have any questions regarding the infection prevention and control of COVID-19, please contact the CDPH Healthcare-Associated Infections (HAI) Program at novelvirus@cdph.ca.gov.

Sincerely,

Original signed by Heidi W. Steinecker

Heidi W. Steinecker
Deputy Director

Resources

- CDC Interim Guidance for Healthcare Facilities: Preparing for Community Transmission of COVID-19 in the United States
- CDC Strategies to Prevent the Spread of COVID-19 in Long-Term Care Facilities
- CDC Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 (COVID-19) or Persons Under Investigation for COVID-19 in Healthcare Settings
- CDC Interim Guidance for Businesses and Employers to Plan and Respond to Coronavirus Disease 2019 (COVID-19), February 2020
- CDC Release of Stockpiled N95 Filtering Facepiece Respirators Beyond the Manufacturer-Designated Shelf Life: Considerations for the COVID-19 Response
- CDC Strategies for Optimizing the Supply of N95 Respirators
- Cal/OSHA Interim Guidance on Novel Coronavirus (COVID-19) for Health Care Facilities: Efficient Use of Respirator Supplies
- Frequently Asked Questions About Use of Stockpiled N95 Filtering Facepiece Respirators for Protection from COVID-19 Beyond the Manufacturer-Designated Shelf Life
- CDPH Novel Coronavirus (COVID-19) webpage
- CDC Coronavirus Disease 2019 (COVID-19) webpage
- AFL 18-09: Requesting Increased Patient Accommodations Including Medical Surge Tent Use

EXHIBIT L

State of California—Health and Human Services Agency

California Department of Public Health

SONIA Y. ANGELL, MD, MPH
State Public Health Officer & Director

GAVIN NEWSOM
Governor

March 8, 2020 AFL 20-18

TO: Hospitals

SUBJECT: Hospital Surge Survey to Assess Capacity Regarding Coronavirus Disease 2019 (COVID-19) and Reminder to Contact Medical Health Operational Area Coordination Office (MHOAC)

All Facilities Letter (AFL) Summary

This AFL requests that all hospitals voluntarily complete a state-wide resources survey on surge capacity. The California Department of Public Health (CDPH) is requesting that all hospitals complete the survey immediately.

This AFL reminds hospitals to contact their MHOAC with resource requests related to COVID-19.

Hospital Surge Survey

In anticipation of California potentially experiencing a surge of COVID-19 patients, CDPH is requesting that all hospitals complete an online survey on surge capacity. Hospital responses to these questions will greatly assist CDPH in assessing the California health care system's surge capacity. Additionally, this survey will assist CDPH in understanding hospitals current space, supply, and staffing situations, as well as future needs. This is only a gathering of information so that CDPH can better plan, communicate, and coordinate responses if needed.

CDPH requests that hospital leadership immediately complete the Hospital Surge Survey (https://www.surveymonkey.com/r/CDPHSurge).

If you have any questions regarding the Hospital Surge Survey, please contact CDPH by email at CDPH FacilityContactSurvey@CDPH.CA.gov.

For information on program flexibility, including the submission process for requesting a temporary program flexibility, see AFL-18-09 Requesting Increased Patient Accommodations Including Medical Surge Tent Use.

Center for Health Care Quality, MS 0512
P.O. Box 997377 • Sacramento, CA 95899-7377
(916) 324-6630 • (916) 324-4820 FAX
Department Website (www.cdph.ca.gov)

Medical Health Operational Area Coordination Office
In order to ensure adequate resources are available to meet the needs of your county/jurisdiction's operational area (OA) medical and health response system, the MHOAC coordinates all medical and health resources within, into, and out of your county/jurisdiction OA consistent with the California Public Health and Medical Emergency Operations Manual (EOM). The MHOAC uses the EOM as a guide to coordinate response among multiple jurisdictions and to access disaster medical and health service response at all levels of government and the private sector.

The MHOAC is responsible for managing disaster medical resources, including personnel, equipment, and supplies. Resource management includes assessing disaster medical response needs, tracking available resources, and requesting or providing mutual aid. The status of local available resources within the OA is assessed before requesting outside resources or submitting a resource request to the Region Disaster Medical Health Coordination/Specialist Program (RDMHC/S). Following an assessment of local resources, the MHOAC may request or provide mutual aid as conditions warrant. The MHOAC acts as the single-point ordering authority for OA medical health mutual aid requirements. If necessary, the MHOAC may also request the public health and medical Department Operations Center (DOC) or OA Emergency Operations Center (EOC) to be activated to support the public health or medical event.

If the MHOAC cannot fulfill a request using local sources, they may request public health and medical resources from outside of the OA via your RDMHC/S. If regional resources are inadequate or delayed, the RDMHC Program will forward the request to the State. If in-State resources are unable to fill the request in a timely manner, the State will request Federal assistance through the California Office of Emergency Services (Cal OES). Acting through Cal OES, the Governor will request Strategic National Stockpile (SNS) via the Department of Homeland Security. Please be aware that while every effort will be made to obtain resources as quickly as possible, requesting entities should anticipate that time from acceptance of a request to actual receipt of the resource may be 48-96 hours or longer, depending on the type and scope of the incident.

Please see the Medical Health Operational Area Coordination (MHOAC) Manual for more information.
(https://www.cdph.ca.gov/Programs/CCLHO/CDPH%20Document%20Library/MedicalandHealthOperationalAreaCoordinationManual.pdf#search=RDMHS)

For questions about infection control, please contact the CDPH Healthcare-Associated Infections Program at HAIProgram@cdph.ca.gov.

If you have any questions regarding the infection prevention and control of COVID-19, please contact the CDPH HAI Program at novelvirus@cdph.ca.gov.

Please remember to report to your district office if you have confirmed COVID-19 patients at your facility.

Sincerely,

Original signed by Heidi W. Steinecker

Heidi W. Steinecker
Deputy Director

Resources

- Hospital Surge Survey (https://www.surveymonkey.com/r/CDPHSurge)
- AFL-18-09 Requesting Increased Patient Accommodations Including Medical Surge Tent Use
- CDPH 5000 (PDF) - Program Flexibility
- CDPH 5000 A (PDF) - Temporary Permission for Program Flexibility for Increased Patient Accommodations
- Medical Health Operational Area Coordination (MHOAC) Manual (https://www.cdph.ca.gov/Programs/CCLHO/CDPH%20Document%20Library/MedicalandHealthOperationalAreaCoordinationManual.pdf#search=RDMHS)
- CDPH Coronavirus Disease 2019 (COVID-19) webpage

EXHIBIT M

https://hanfordsentinel.com/news/virus-outbreak-halts-visits-to-2-area-prisons/article_d594bf2d-0b78-5dd5-8d12-42271cb621b2.html

Virus outbreak halts visits to 2 area prisons

By Eiji Yamashita
Jan 14, 2008

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Four California prison facilities — including Avenal and Coalinga — remain closed to visitors after outbreaks of a stomach flu virus were confirmed over the past month, state prison medical officials said Monday.

Avenal State Prison had by far the largest number of inmates who came down with the contagious virus, according to the Department of Corrections and Rehabilitation.

CDCR spokesman Lt. Brian Parriott said 125 to 140 inmates were diagnosed with norovirus gastroenteritis infections in Avenal.

The outbreak at the Avenal prison was reported on Jan. 2, and the number of inmates showing symptoms has since gone down to 50, said Rachel Kagan, spokeswoman for California's prison medical receiver.

Outbreaks in other prisons appear contained, but the facilities remain closed to visitors while medical staff continue to try keeping the virus from spreading.

"Norovirus is nothing new to prisons or any sort of institutional living," Kagan said Monday.

The so-called cruise ship virus causes flu symptoms of fever, diarrhea and ...

Meanwhile, staff are restricting the movements of prisoners in the affected areas as they engage in "aggressive cleaning" to disinfect bunks and common areas at the state's four prisons, Kagan said.

The other prisons with confirmed outbreaks are:

* Pleasant Valley State Prison in Coalinga.

* Sierra Conservation Center in Jamestown.

* Deuel Vocational Institution in Tracy.

Pleasant Valley Prison is on lockdown status again this week after another outbreak of a stomach flu virus was suspected on Friday, Kagan said.

The report comes on the heels of the first outbreak involving 21 inmates reported in late December. On Friday, 20 other inmates experienced symptoms of stomach flu, prompting the officials to shut down the facility again while lab work is being done to confirm the outbreak.

"It was a conservative and early response," Kagan said. "The facility is closed until we can determine if it's norovirus and the extent of (the outbreak)."

The Sierra Conservation Center has been reopened after 55 inmates affected by the virus were treated and the facility disinfected.

An outbreak at Deuel Vocational Institution peaked at 35 cases, and inmates who aren't affected are again being allowed to move about, Kagan said. Inmates there began falling ill last week, causing a lockdown.

The lockdown has been partially lifted this week, Kagan said. But public health officials in San Joaquin County remain on alert because increased norovirus infections have been reported among civilians in the community, she said.

Four inmates at California Medical Facility in Vacaville also came down with diarrhea on Dec. 24, but norovirus has been ruled out, Kagan said. The facility was not closed, she added.

(Jan. 15, 2008)

0 comments

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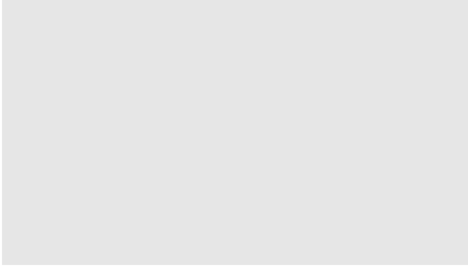

KCSO SWAT team called after suspect refuses to exit home

Updated Apr 17, 2020

Case 2:90-cv-00520-KJM-DB Document 6627 Filed 04/20/20 Page 75 of 150

+2

Inmates released on newly-adopted bail schedule

Updated Apr 17, 2020

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Apr 18, 2020

New managing editor, general manager named at Sentinel

Updated Apr 16, 2020

KCSO K-9 officer helps apprehend fleeing suspect after high-speed chase

Updated Apr 17, 2020

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Apr 14, 2020

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Man, teen arrested in connection to gang activity

Updated Apr 13, 2020

Virus outbreak halts visits to 2 area prisons

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EXHIBIT N

Greg Gonzalez

From: Thomas Nolan
Sent: Monday, April 20, 2020 7:48 AM
To: Davis, Tamiya@CDCR; Penny Godbold; Vincent Cullen; Russa Boyd; Beland, Bruce@CDCR; Powell, Alexander@CDCR; Meyer, Nicholas@CDCR; Ed Swanson; Ed Swanson [redacted]
Cc: [redacted]; Sean Lodholz; Armstrong Team - RBG only; Armstrong Team; [redacted]; Miranda, Teauna@CDCR; Fouch, Adam@CDCR; Bravo, Landon@CDCR; Annakarina De La Torre-Fennell; Michael Nunez; CDCR OLA Armstrong CAT Mailbox; Coleman Team - RBG Only; Coleman Special Master Team; Steve Fama
Subject: RE: Plaintiffs' Questions re: COVID-19 and Armstrong Impacts [IWOV-DMS.FID3579]

Hi Tamiya –

Our office has been contacted over the weekend by three different family members of class members or ADA workers at CMC-West about plans to add bunk beds and addition incarcerated individuals into the two ADA dormitories these. CMC West housing is entirely dormitory housing in old military barracks. On G-Yard at CMC West, Dorms 22 and 23 have long been designated ADA dorms because they have a level entrance and are located adjacent to the dining hall for the yard. Many of the individuals residing in these two dormitories are older and medically vulnerable. They would appear to be the individuals at CMC-West most vulnerable to Coronavirus, and it is hard to understand the logic of adding additional individuals and bunk beds into these dorms. These e-mails also raise serious and troubling concerns about the lack of cleaning supplies, and the institution's (or perhaps CDCR's) unwillingness to allow incarcerated individuals to use hand sanitizer, which we understand is now being made by PIA in large quantities, and about the fact that staff are not wearing protective masks that are now mandatory in many parts of the state.

We received the following report from the wife of an ADA worker at CMC West:

> [My husband] asked me to contact you about what is going on at the prison that will effect ADA inmates. According to him, there is a plan to extend the population of the dorm to house 15 additional men. My husband believes that this places ADA inmates in a more vulnerable position as far as potentially contracting the COVID-19 virus. He is under the thinking that the inmates there should be in as less contact as possible right now, and not being placed into bunk beds with other inmates. We both understand that their ability to recover from this virus wouldn't come with the best odds. My husband has stated that CMC had supplied building porters with extra cleaning supplies during the first day (after making a pledge to the media and public), but have not given anything extra since. **They have not given any extra soap or hand sanitizer out individually yet; haven't even made it available for purchase through the canteen. They made hand sanitizer available for two meals and then rescinded it, saying that it was for the staff and that it contained alcohol so it could not be utilized for inmates. It's important to note that the sanitizer was never given to inmates, but that a pump style bottle was set up and inmates could get some from there on their way to eat.** The point is that CMC-WEST is picking the wrong time to make a decision to expand the amount of people in the dorms. If the virus were to get in there, they are giving it more host and ability to be spread to men who already have underlining conditions.

We also received the following e-mail from a family member of someone in one of the ADA dorms at CMC-West:

> Contrary to your efforts to protect and preserve the lives of the elderly and those with chronic diseases, CDCR appears to have a completely different agenda. I am 74 years old and have been housed in building 22 at CMC-West for the past 7½ years. Buildings 22 and 23 are the 2 buildings that are used to house inmates with mobility impairments and chronic conditions. However, yesterday we were informed that, in the middle of a pandemic, the prison has decided to raise the population of the 2 buildings,

tomorrow. CMC-West has decided to raise the population of the buildings that house inmates who are at the greatest risk, from 45 to 60 by installing and utilizing bunk beds to facilitate this transition. They will take the military barracks stole dorm and create "makeshift" 4-6 man pods, though no barriers will be installed at all. So down the right side of the wall, it will be 2 to 3 (4 to 6 people) bunk beds in a row, approximately 4½ feet of space, 2 to 3 bunk beds in a row, space, and so on. This will be repeated for the left side of the wall as well. Inmates in the building raised the question of how this played any part in social distancing and were informed that CDCR only needed to practice social distancing outside of the buildings, not inside. Medical has also begun reducing and/or eliminating nebulizer treatments for inmates in their quest to protect staff and others. It is clear that CDCR has no idea what to do and continue to work out the kinks at the potential cost of the inmates. **The staff are not even wearing mask while people in society are continuously being directed to do so. I find this particularly troubling since the greatest chance we have of contracting this virus is through these very staff. While I applaud your efforts to send us home out the front door to our loved ones, it appears that CDCR's plan could potentially send us out of the back door.**

Several e-mails we received also pointed out that the dormitories at CMC West that house the dog training program are being allowed to maintain a reduced population size of 32 to 45 individuals in the dorm, even as the population in the ADA dorms is increased to 60. One relative concluded by saying "I guess the dogs and mentors out value the elderly."

We ask that CDCR look into and reconsider these plans, ensure that incarcerated individuals are given access to cleaning supplies and hand sanitizer (easily done safely in locations like entrances to dining rooms where the process can be observed), and ensure that staff wear protective masks.

Sincerely,

Tom Nolan

Thomas Nolan
Of Counsel

101 Mission Street, 6th Floor
San Francisco, CA 94105
[redacted] (cell)
(415) 433-6830 (office telephone)
(415) 433-7104 (fax)
tnolan@rbgg.com

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From: Davis, Tamiya@CDCR <Tamiya.Davis@cdcr.ca.gov>
Sent: Friday, April 10, 2020 2:42 PM
To: Penny Godbold <PGodbold@rbgg.com>; Vincent Cullen ; Russa Boyd ; Beland, Bruce@CDCR Powell, Alexander@CDCR ; Meyer, Nicholas@CDCR
Cc: Sean Lodholz ; Armstrong Team - RBG only <ArmstrongTeam@rbgg.com>; Armstrong Team <arm-plo@prisonlaw.com>; ; Miranda, Teauna@CDCR ; Fouch, Adam@CDCR ; Bravo, Landon@CDCR ; Annakarina De La Torre-Fennell ; Michael Nunez <MNunez@rbgg.com>; CDCR OLA Armstrong CAT Mailbox
Subject: RE: Plaintiffs' Questions re: COVID-19 and Armstrong Impacts [IWOV-DMS.FID3579]

Hello all:

Thank you for the productive call this morning. Attached please find a copy of email that went to people with tablets explaining accessibility features and the DRP memo regarding plan for broadcasting ADA compliant content on institutional television systems.

Take care and have a wonderful weekend.

Tamiya Davis
Attorney III, Class Action Team
Office of Legal Affairs
California Department of Corrections and Rehabilitation
Phone:
Cell:

From: Penny Godbold <PGodbold@rbgg.com>
Sent: Thursday, April 9, 2020 4:55 PM
To: Davis, Tamiya@CDCR < >; Cullen, Vincent@CDCR ; Boyd, Russa@CDCR >; Beland, Bruce@CDCR < >; Powell, Alexander@CDCR >; Meyer, Nicholas@CDCR >
Cc: ; Sean Lodholz < v>; Armstrong Team - RBG only >; Armstrong Team < Miranda, Teauna@CDCR >; Fouch, Adam@CDCR < >; Bravo, Landon@CDCR < ; Annakarina De La Torre-Fennell >; Michael Nunez >; CDCR OLA Armstrong CAT Mailbox >
Subject: RE: Plaintiffs' Questions re: COVID-19 and Armstrong Impacts [IWOV-DMS.FID3579]

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Hi Tamiya,
Thank you for providing the written responses to the questions we were unable to cover during the Tuesday call. We have some clarifying questions based on your answers and those are highlighted in yellow in the attached document.

In addition, we would like clarification on your comment regarding the last two questions: "Defendants request this to be meet and Confer item." Are you proposing these issues be discussed during the May meeting? We are hoping to have answers before that time.

Lastly, we would like to follow up on the outstanding requests for information that we discussed on Tuesday which include:

1. Clarity on the cell-feeing direction - It was unclear if this applied to dorms and what procedures for feeding were being used in dorm settings.
2. Isolation beds for DPW class members – DAI and CCHCS were going to talk after the Tuesday call to discuss whether there are enough DPW designated isolation beds at designated institutions, and particularly dorms with DPW class members, and develop a plan for if/when there is a need to isolate DPW class members and they cannot be housed appropriately.
3. Class members moved to nontraditional housing locations – at the end of the call, we asked for clarity on whether any Armstrong class members have been moved from dorms to gyms or other housing locations that are being used during the pandemic. We requested a list of class members who have been moved.
4. 128s for class members housed out of DPP placement
5. Field memo re DPP after sent on Friday
6. COVID-19 education/information provided to ADA workers
7. Copy of email that went to people with tablets explaining accessibility features
8. We request a copy memo to TV specialists regarding captioning

I think it's a good idea to move forward with the call tomorrow and we look forward to talking to you then.
Thanks,
-Penny

From: Davis, Tamiya@CDCR
Sent: Wednesday, April 08, 2020 3:09 PM
To: Penny Godbold <PGodbold@rbgg.com>; Vincent Cullen ; Russa Boyd ; Beland, Bruce@CDCR ; Powell, Alexander@CDCR >; Meyer, Nicholas@CDCR >
Cc: Sean Lodholz >; Armstrong Team - RBG only ; Armstrong Team Miranda, Teauna@CDCR ; Fouch, Adam@CDCR ; Bravo, Landon@CDCR ; Annakarina De La Torre-Fennell ; Michael Nunez <MNunez@rbgg.com>; CDCR OLA Armstrong CAT Mailbox
Subject: RE: Plaintiffs' Questions re: COVID-19 and Armstrong Impacts [IWOV-DMS.FID3579]

Hello all:

Attached please find written responses to your questions that were not addressed on yesterday's call.

Take care,

Tamiya Davis
Attorney III, Class Action Team
Office of Legal Affairs
California Department of Corrections and Rehabilitation
Phone:
Cell:

From: Penny Godbold <PGodbold@rbgg.com>
Sent: Thursday, April 2, 2020 2:04 PM
To: Davis, Tamiya@CDCR < ; Cullen, Vincent@CDCR < >; Boyd, Russa@CDCR ; Beland, Bruce@CDCR < >; Powell, Alexander@CDCR < Meyer, Nicholas@CDCR
Cc: Sean Lodholz >; Armstrong Team - RBG only >; Armstrong Team ; Miranda, Teauna@CDCR Fouch, Adam@CDCR < >; Bravo, Landon@CDCR >; Annakarina De La Torre-Fennell >; Michael Nunez <MNunez@rbgg.com>
Subject: RE: Plaintiffs' Questions re: COVID-19 and Armstrong Impacts [IWOV-DMS.FID3579]

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Hi Tamiya,

Thanks for your response. We are available for a call next Tuesday at 2 pm and we do understand that the situation is changing daily. The fact that the situation is changing daily is precisely why we hope to get answers to some of these questions sooner than Tuesday. It is also why we are concerned that any information that is approved by the Director tomorrow might be out of date by the time you share it on Tuesday. Thus, any information that you are able to share with us this week, especially with regard to our general questions, is much appreciated and will be received with the understanding that the situation is changing daily.

Thanks,
-Penny

From: Davis, Tamiya@CDCR >
Sent: Thursday, April 02, 2020 1:39 PM
To: Penny Godbold <PGodbold@rbgg.com>; Vincent Cullen ; Russa Boyd >; Beland, Bruce@CDCR >; Powell, Alexander@CDCR < >; Meyer, Nicholas@CDCR < >
Cc: ; Sean Lodholz < >; Armstrong Team - RBG only < >; Armstrong Team < >; ; Miranda, Teauna@CDCR < >; Fouch, Adam@CDCR < >; Bravo, Landon@CDCR < >; Annakarina De La Torre-Fennell < >; Michael Nunez <MNunez@rbgg.com>
Subject: RE: Plaintiffs' Questions re: COVID-19 and Armstrong Impacts [IWOV-DMS.FID3579]

Hi Penny,

We are diligently working on getting the information and answers to your questions below. I know I sound like a broken record when I say that the COVID-19 situation is fluid and has varying impacts to CDCR's operations that are literally changing on a daily basis. As you are aware, we have three institutions that have inmates that have tested positive to COVID-19. CDCR's focus is on containment and life-saving measures.

We want to ensure that the information we provide is accurate and current to the best of our ability. To do so, we need to make sure the Director has any opportunity to review and provide any up-to-date information. Additionally, some of these questions require input from multiple stakeholders including CHCHCS and OCE. We plan on providing the Director

the information tomorrow, and would like to propose to meet next Tuesday at 2 pm to provide you a thorough update and provide answers to your questions. Please let us know if that day and time works for Plaintiffs.

Thank you,

Tamiya Davis
Attorney III, Class Action Team
Office of Legal Affairs
California Department of Corrections and Rehabilitation
Phone: [redacted]
Cell: [redacted]

From: Penny Godbold <PGodbold@rbgg.com>
Sent: Wednesday, April 1, 2020 6:54 AM
To: Cullen, Vincent@CDCR <[redacted]>; Davis, Tamiya@CDCR <[redacted]>; Boyd, Russa@CDCR <[redacted]>; Beland, Bruce@CDCR <[redacted]>; Powell, Alexander@CDCR <[redacted]>; Meyer, Nicholas@CDCR <[redacted]>
Cc: [redacted]; Sean Lodholz <[redacted]>; Armstrong Team - RBG only <[redacted]>; Armstrong Team <[redacted]>; [redacted]; Miranda, Teauna@CDCR <[redacted]>; Fouch, Adam@CDCR <[redacted]>; Bravo, Landon@CDCR <[redacted]>; Annakarina De La Torre-Fennell <[redacted]>; Michael Nunez <MNunez@rbgg.com>
Subject: RE: Plaintiffs' Questions re: COVID-19 and Armstrong Impacts [IWOV-DMS.FID3579]

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Hi Vince and Tamiya,

I am just following up on this to see if Friday at 2 pm would work for a phone call to discuss.

Thanks,
-Penny

From: Penny Godbold
Sent: Tuesday, March 31, 2020 7:24 AM
To: Vincent Cullen <[redacted]>; Davis, Tamiya@CDCR <[redacted]>; Russa Boyd <[redacted]>; Beland, Bruce@CDCR <[redacted]>; Powell, Alexander@CDCR <[redacted]>; Meyer, Nicholas@CDCR <[redacted]>
Cc: [redacted]; Sean Lodholz <[redacted]>; Armstrong Team - RBG only <[redacted]>; Armstrong Team <[redacted]>; [redacted]; Miranda, Teauna@CDCR <[redacted]>; Fouch, Adam@CDCR <[redacted]>; Bravo, Landon@CDCR <[redacted]>; Annakarina De La Torre-Fennell <[redacted]>; Michael Nunez <MNunez@rbgg.com>
Subject: Plaintiffs' Questions re: COVID-19 and Armstrong Impacts [IWOV-DMS.FID3579]

Vince,

Thank you for the phone call updates regarding the developing situation with COVID-19 and the impact on *Armstrong* class members in CDCR. As of our call on Friday afternoon, our understanding is:

All Non-Essential Transfers of incarcerated people have been limited. This includes transfers of *Armstrong* class member with codes impacting placements.

> Non-Essential Transfers at this time include transfers out of the RC and transfers due to 1845 code changes
>
> Essential Transfers include, among other emergent concerns, those who are kicked out of Ad Seg as well as LOC changes. To the extent possible those class members will be housed at the prison where released from Ad Seg or the LOC. However, if they need to be transferred to a different prison, they will be.

Defendants have stated that for class members with a new or changed 1845 showing a DPP code that impacts placement, ADA Coordinators have been directed to interview those class members to determine what accommodations are needed and to document that interview and needed accommodations on a 128. You confirmed that you will notify us of who these class members are.

Thank you for providing this information. **For any class member who is housed inconsistent with their DPP code, we request that you please identify those class members and provide the 128 forms confirming that they were interviewed and what accommodations they will be provided, weekly. Please also identify any class members who are being held in more restrictive placements – RC, Ad Seg, etc. – due to a lack of available bed space and inability to transfer.**

In addition to the information about transfers, and the plan for provision of basic accommodations, we have many additional questions regarding the provision of accommodations during this time. I am also including CDCR, as many of the questions we have relate to custody functions. We would like to have a call this week to discuss these issues. I propose keeping the **Friday at 2 pm call**, but scheduling it for two-hours. Also, to the extent that some of these issues may be handled differently at different prisons, we may need to have additional calls with ADA staff from the institutions to determine what is happening on the ground:

General

- **General Movement:** Has the movement of incarcerated people within the prison been limited statewide? What about at individual prisons? For example, are people still attending chow, yard, etc.?
- **Bed distance:** What efforts have been made to allow social distancing for people in dormitories? We are especially concerned, given the high number of people with lower-lower restrictions, that it will be difficult to sufficiently spread out. (CDCR website says: "The incarcerated population has received information about social distancing, and staff and inmates are practicing social distancing strategies where possible, including . . . assigning bunks to provide more space between individuals.")
- **Dining procedures**: Are people still eating in the chow hall? If so, are ADA workers carrying trays for certain class members? If so, what safety precautions (e.g., PPE, increased sanitization) have been adopted to prevent the spread of the virus?
- **Shower program**: Has access to showers been limited for incarcerated people, including after toileting accidents?
- **Isolation beds**: Which beds in which prisons have been identified for use for isolation purposes? Which of those are able to house DPW class members? Which have accessible features, including grab bars? Are there accessible showers and toilets?
- **1824 process**: Is the 1824 process running as normal? Is the RAP meeting weekly? Where appropriate, are people being interviewed to gather more information regarding their 1824? How are those interviews being conducted?
- **ADA workers**: Have there been any changes to the ADA worker program? What steps are taken to ensure social distancing during the provision of accommodations, including scribing assistance, wheelchair pushing, cleaning bed areas, and sighted guide work? Have the workers received any PPE or extra soap or sanitizer? If ADA workers are not providing services, how are the accommodations being provided to class members now?

- **Housing officers**: Has custody staffing been reduced? If so, has that affected officers' ability to provide accommodations, including assistance with reading and writing?
- **ADA staff**: Are ADA Coordinators onsite? Are staff still performing all usual functions?
- **DME**: Any changes to the issuance, repair, and replacement of DME?
- **Fitness**: Have people with disabilities been instructed on safe exercise activities they can complete in their bed areas?

Blind and Low Vision Class Members

- **Written COVID-19 information:** What effective communication of COVID-19 information, including written information, posters, and information about free GTL and J-Pay services, was provided? (See March 23, 2020 letter from Plaintiffs regarding CMF) Was any material provided in braille, audio, or large print? (From CDCR website: "To keep members of our population informed, we have created and distributed fact sheets and posters in both English and Spanish that provide education on COVID-19 and precautions recommended by CDC, which expand upon those advised during cold and flu season.")
- **Audio description:** Is audio description being provided for any videos updating incarcerated people about the situation?
- **Sighted guide:** Have sighted guide procedures changed in light of COVID-19? If so, how?
- **COMS training**: Is COMS training being provided? If not, will existing contracts be extended? (We understand SATF's contract is through June 2020.)
- **Talking books**: Are talking books still being mailed into the institution? It appears they might not be, at least for SATF (http://www.fresnolibrary.org/tblb/ ("All Branches Closed. Thank you for your understanding.")). If that is the case, what are Defendants doing to ensure that blind people have access to audio materials?
- **Law library and auxiliary aids:** Do class members still have regular access to the law library, where auxiliary aids, including the Merlin, DaVinci, JAWS, and Braille typewriter, as well as the MaxiAids catalog, are located? If not, how are they able to access those devices? How are those devices being cleaned and sanitized? (From CDCR website: "Recreation and Law Library Services will continue to be available to the incarcerated population even if physical access is restricted due to safety and security measures.")
- **J-Pay accessibility features:** Has any training on the new text-to-speech or magnification features on the J-Pay tablets been provided to blind or low vision class members? (From CDCR website: "CDCR's electronic messaging provider for the incarcerated population, JPay, is providing reduced-priced emails to those incarcerated at the pilot institutions and free emails for those inmates who cannot afford it.")
- **In-cell OCE assignments:** What in-cell assignments are provided by OCE, and are they accessible to blind and low vision class members? (From CDCR website: "The Office of Correctional Education is working with institution principals, library staff, and teachers to provide in-cell assignments where possible in order for students to continue their studies, legal library access and educational credit-earning opportunities. For those in our incarcerated population who need supplementary academic support, CDCR has encouraged Disability Placement Program, Developmental Disability Program, and Every Student Succeeds Act staff to coordinate with the institution instructor to provide additional assistance to enrolled students where possible.")

Deaf, Hard of Hearing, and Low TABE Class Members

- **Sign language interpretation**: Have there been any changes to staff or contract interpreter availability? Are they on the same schedules? Are they still providing in-person services? What about the use of contractor interpreters?
- **Videophones and TDD**: How are these high-touch items being cleaned and sanitized? Have TDDs been tested to ensure they are functioning properly?
- **Captioned phones**: Have Defendants installed captioned telephones? (See November 27, 2019 and March 27, 2020 letters from Plaintiffs) (From CDCR website: "Institutions have been instructed to find opportunities to allow increased phone access for the incarcerated population so they may keep in touch with their support system")
- **Staff communication**: How is verbal information from wardens, associate wardens, captains, supervisors, and counselors being communicated to deaf people (whose primary form of communication is sign language or written notes)? Do Defendants now provide real-time captioning? (Secretary Diaz said in an address to the

incarcerated population on March 25, 2020: "I've given direction to the wardens of your particular institution to be over communicating with you either from the warden themselves associate wardens captains, supervisors, counselors to be communicating with you.")

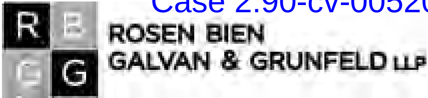
- **Biweekly captain/ADA meetings**: Have these meetings continued for D/deaf class members whose primary form of communication is sign language? At which institutions? Is social distancing being maintained?
- **Written materials**: What efforts are being made to effectively communicate written information to D/deaf people who use sign language or people with low TABEs? A Deaf person at San Quentin told us that he could not fully understand a written handout he had been given regarding COVID-19: "Some words I've never heard of or seen before."
- **J-Pay tablets**: Do educational videos, including Khan Academy distance learning videos, have captions? (We did not see captions during our February 2020 visit at SATF.)
- **Religious services**: How will chaplains be able to conduct individual religious counseling with D/deaf class members (both who rely on written notes and sign language)? Will televised religious services be provided in ASL and captions? (From CDCR website: "Chaplains will conduct individual religious counseling as appropriate while maintaining social distancing, and CDCR is working to provide televised religious services to the population.")
- **In-cell OCE assignments:** What in-cell assignments are provided by OCE, and are they accessible to D/deaf and low-TABE class members? (From CDCR website: "The Office of Correctional Education is working with institution principals, library staff, and teachers to provide in-cell assignments where possible in order for students to continue their studies, legal library access and educational credit-earning opportunities. For those in our incarcerated population who need supplementary academic support, CDCR has encouraged Disability Placement Program, Developmental Disability Program, and Every Student Succeeds Act staff to coordinate with the institution instructor to provide additional assistance to enrolled students where possible.")
- **Secretary video messages**: Will Secretary Diaz's video messages to the incarcerated population be provided in ASL? In simpler language? (From CDCR website: "CDCR Secretary Ralph Diaz will be releasing regular video message updates directly to the incarcerated population.")
- **Educational videos**: Will educational videos be provided in ASL? In simpler language? (From CDCR website: "We have also begun streaming CDC educational videos on the CDCR Division of Rehabilitative Programs inmate television network and the CCHCS inmate health care television network.")
- **Televisions in common areas**: Have Defendants installed larger televisions in common areas, so captions are clearly visible? (In SATF's dorms, for example, individual televisions do not receive the state-run television channels with important educational information.)
- **Daily Moth news**: Have Defendants considered making Daily Moth news clips available to D/deaf people in prison? (https://www.dailymoth.com/)
- **Headphones**: We understand that the Allowable Personal Property Schedule does not yet allow for headphones in some places, including the PSU. Have hard of hearing class members been informed that they can request headphones on an individual basis?

We look forward to speaking with you this week.

(Please forward to anyone I may have missed.)

Thanks,
-Penny

Penny Godbold



101 Mission Street, Sixth Floor
San Francisco, CA 94105
(415) 433-6830 (telephone)
(415) 433-7104 (fax)
pgodbold@rbgg.com

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EXHIBIT O

Prison System Diagnoses First Probable Case of Swine Flu (H1N1) Virus

MAY 3, 2009

Medical Receiver Calls for Halt to Visiting and Non-Essential Activities

SACRAMENTO – An inmate at Centinela State Prison in Imperial County has been diagnosed with a probable case of the H1N1 virus, commonly referred to as Swine Flu. This is the first probable case within the California Department of Corrections and Rehabilitation (CDCR). In response, CDCR and the court appointed Receiver over inmate medical care are taking all appropriate precautions to protect public health.

"The single probable case of H1N1 Influenza is mild and the infected inmate and his cell mate are confined to an appropriate setting and receiving appropriate care within Centinela State Prison," said Dr. Steven Ritter, California Prison Health Care Services Acting Chief Physician Executive. "We are closing visitation and non-essential activities at all of our institutions statewide as a precautionary measure according to our established protocol to protect the public, the staff, and the inmates. The continued well-being of the staff and inmates is essential in order to contain any further potential outbreaks and avoid additional exposure to the public at-large."

Effective today, CDCR has stopped all visiting and other non-essential activities including volunteer activities, special events, and other non-staff related inmate and youth programs at prisons, youth facilities, and community correctional facilities. Critical and legally mandated activities, such as attorney visits, medical and psychological evaluations, contract services such as Substance Abuse Programs, and court ordered social worker and other visits, will continue with added precautions.

"The Department takes the threat of a Swine Flu influenza outbreak very seriously, and is taking all precautions to limit possibilities of exposure and prevent any spread of the virus. The health and safety of the inmates in our care and the staff members who provide for their custody is our primary concern," said Scott Kernan, CDCR Undersecretary of Operations. "We have comprehensive plans in place to respond to natural disasters, pandemics, or any other issues that may arise. In anticipation of a confirmed case of Swine Flu, CDCR activated its Department Operations Center at Headquarters last week to ensure that all institutions are on stand by and prepared to respond."

CDCR has approximately 68,000 employees and oversees nearly 170,000 adult inmates and youth offenders. The Department has taken numerous steps to protect public health by posting and distributing information to educate inmates and staff on proven practices to stop the spread of this communicable viral infection. CDCR is working closely with state Department of Public Health, and local health departments, to curtail the spread of this virus.

EXHIBIT P

COVID-19 PUBLIC HEALTH GUIDANCE

Self-Isolation for Older Adults and Those Who Have Elevated Risk

March 16, 2020

This guidance is based on what is currently known about the transmission and severity of coronavirus disease 2019 (COVID-19). The California Department of Public Health (CDPH) will update this guidance as needed and as additional information becomes available.

This document is intended to be statewide guidance to help older adults and individuals who are at high risk for serious illness, this includes:

- Individuals over 65 years of age
- Individuals who have serious chronic medical conditions like:
    - Heart disease
    - Diabetes
    - Lung disease
- Individuals who have compromised immune systems

This guidance does not apply to people who work in essential services, such as hospital and health care workers, pharmacists, peace officers, firefighters, staff at skilled nursing facilities and residential care facilities for the elderly, and other essential workers.

Background

COVID-19 is a respiratory illness caused by a novel virus that has been spreading worldwide. Community-acquired cases have now been confirmed in California. We are gaining more understanding of COVID-19's epidemiology, clinical course, immunogenicity, and other factors as time progresses, and the situation is changing daily. CDPH is in the process of monitoring COVID-19, conducting testing with local and federal partners, and providing guidance and resources to prevent, detect and respond to the occurrence of COVID-19 cases in California.

At this time, community transmission of COVID-19 has occurred in California. All individuals should prepare for possible impacts of COVID-19 and take precautions to prevent the spread of COVID-19 as well as other infectious diseases, including influenza and gastroenteritis.

Illness Severity

The complete clinical picture with regard to COVID-19 is not fully understood. Reported illnesses have ranged from mild to severe, including illness resulting in death. Older people, those with compromised immune systems, and people with certain underlying health conditions like heart disease, lung disease and diabetes, for example, seem to be at greater risk of serious illness.

Measures for Older Adults and Those Who Have Elevated Risk

Individuals at elevated risk can take steps now to slow reduce the risk from infectious diseases, including COVID-19. CDPH recommends implementing the following steps:

- Remain at home until further guidance is issued.
    - Cancel any non-essential travel, appointments, etc.
    - For routine medical care, contact your health care provider to discuss rescheduling, if not urgent. Otherwise, discuss alternative provision of services, such as telehealth or in-home care.
    - If you are in need of medical care, and in consultation with your health care provider, make an appointment and visit your provider to get the necessary care. If you have an emergency and need immediate medical care, call 9-1-1.

- Continue with outdoor activities.
    - As long as you practice social distancing, we encourage you to continue your outdoor activities such as walks, runs and yardwork, to the extent your health allows it.

- Practice social distancing, both in and outside the home.
    - Maintain distance, at least six feet, between yourself and anyone who is coughing or sneezing.
    - Avoid handshaking, hugging or other intimate types of greetings—greet others with a wave, nod or bow instead.

- Stay in touch with others by phone, email, or other on-line tools (like Skype and Facebook).
    - Ask friends, family, neighbors, and other networks to do any essential grocery shopping, picking up medications, etc. Consider on-line ordering for food and other supplies.
    - Ask for help from friends, family, neighbors, community health workers, etc. if you become sick.
    - Identify friends, family, neighbors, and other networks who can provide you with care if your caregiver gets sick or otherwise adjusts their scheduled services.

- Identify Family, Friends, Neighbors, and Caregivers who can provide Support
    - Family, friends, neighbors, and caregivers who come to homes to provide support should be asymptomatic, meaning having no fever, cough, or other respiratory symptoms.
    - Family, friends, neighbors, and caregivers can support by knowing what medications your loved one or client is taking and seeing if you can help them have extra on hand; monitoring food and medical supplies (oxygen, incontinence, dialysis, and wound care) needed and creating a back-up plan; and stocking up on non-perishable food items to have on hand in your home.

- Have supplies on hand
    - Contact your healthcare provider to ask about obtaining extra necessary medications to have on hand.

- If you cannot get extra medications, consider using mail-order for medications.
- Be sure you have over-the-counter medicines and medical supplies (tissues, etc.) to treat fever and other symptoms.

- Have a plan for if you get sick
  - Consult with your health care provider for more information about monitoring your health for symptoms suggestive of COVID-19.
  - Stay in touch with others by phone or email. You may need to ask for help from friends, family, neighbors, community health workers, etc. if you become sick.
  - Watch for symptoms and emergency warning signs
    - Pay attention to potential COVID-19 symptoms including fever, cough and shortness of breath. If you develop symptoms, call your doctor or local public health department.
    - If you develop emergency warning signs for COVID-19, get medical attention immediately. In adults, emergency warning signs* include:
      - Difficulty breathing or shortness of breath
      - Persistent pain or pressure in the chest
      - New confusion or inability to arouse
      - Bluish lips or face
      - *This list is not all inclusive. Please consult your medical provider for any other symptom that is severe or concerning.

- Practice Hand washing
  - Wash hands frequently for at least 20 seconds.
  - Encourage hand washing by family and friends, particularly children.
  - Provide alcohol based hand sanitizers to supplement hand washing.
  - Avoid touching eyes, nose, or mouth with unwashed hands.
  - Clean frequently used devices, such as mobile phones.

- Use "respiratory etiquette"
  - Cover cough with a tissue or sleeve. See CDC's Cover Your Cough page for multilingual posters and flyers, posted at the bottom of webpage.
  - Provide adequate supplies within easy reach, including tissues and no touch trash cans.

- Clean and disinfect your home to remove germs: practice routine cleaning of frequently touched surfaces (for example: tables, doorknobs, light switches, handles, desks, toilets, faucets, sinks & cell phones) with common cleaning supplies

- See the Center for Disease Control and Prevention's guidance regarding the prevention of disease in homes and residential communities.

EXHIBIT Q

EXECUTIVE DEPARTMENT
STATE OF CALIFORNIA

EXECUTIVE ORDER N-27-20

WHEREAS on March 4, 2020, I proclaimed a State of Emergency to exist in California as a result of the threat of COVID-19; and

WHEREAS the impacts of COVID-19 are far-reaching in sectors throughout California; and

WHEREAS the most critical health and safety standards must be our state's highest priority at this time given the emergency associated with COVID-19; and

WHEREAS healthcare and other residential and non-residential facilities licensed by the state, and particularly those serving senior citizens and other vulnerable populations, will face significant challenges with respect to staffing and capacity as a result of COVID-19; and

WHEREAS it is imperative that monitoring and enforcement efforts among our state agencies, especially in these facilities and particularly those serving senior citizens and other vulnerable populations, are focused specifically on the safety of these populations and on compliance with the most critical protections for health and safety of all in these facilities; and

WHEREAS additional action and capacity are necessary to protect the health and safety of Californians receiving care in these critical facilities and in-home isolation; and

WHEREAS certain existing California state employees have skills, which can be immediately utilized in and to the benefit of these facilities, and in particular in those facilities providing services to senior citizens and other vulnerable populations; and

WHEREAS I find it necessary to redirect these staff pursuant to Government Code section 3100, which allows me to reassign state workers as necessary to protect the public during an emergency; and

NOW, THEREFORE, I, GAVIN NEWSOM, Governor of the State of California, in accordance with the authority vested in me by the State Constitution and statutes of the State of California, and in particular, Government Code section 8567, do hereby issue the following Order to become effective immediately:

IT IS HEREBY ORDERED THAT:

1. The Department of Social Services, the Division of Occupational Safety and Health, and the Department of Public Health, shall focus on those individuals who are most vulnerable and on the most serious health and safety issues at licensed facilities. Consistent with this directive:

i) licensing and enforcement staff shall focus on providing technical assistance and supporting compliance with core health and safety requirements for caregivers and the cared for;

ii) these Departments and Division, in consultation with the Health and Human Services Agency, shall immediately identify health and community care facilities, and other sites housing populations that are particularly vulnerable to COVID-19, including but not limited to senior citizens and individuals who require assisted-living services due to chronic health conditions;

iii) these Departments and Division shall redirect resources to facilities identified pursuant to (ii) of this section;

iv) staff from these Departments and Division shall have primary focus on providing technical assistance and support to have maximum effect to address the risk of COVID-19;

v) consistent with these requirements, staff shall focus enforcement activities where there are allegations of the most serious violations impacting health and safety.

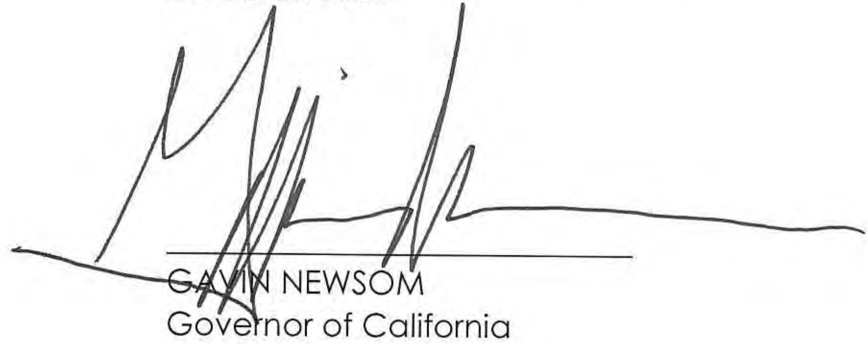
2. The Health and Human Services Agency shall develop alternatives, in consultation with counties and representatives of labor organizations and consumers, to leverage the in home supportive services programs, the adult protective services programs, the area agencies on aging and regional centers, and other programs to support the home isolation of vulnerable Californians, including seniors and those with serious chronic underlying health conditions.

3. To address increased demand for healthcare workers and first responders, Emergency Medical Services Authority, Department of Social Services, and the Department of Public Health shall authorize first responders, health and human services care providers and workers who are asymptomatic to continue working during the period of this emergency, subject to those responders, providers, and workers taking precautions to prevent transmission.

IT IS FURTHER ORDERED that as soon as hereafter possible, this Order be filed in the Office of the Secretary of State and that widespread publicity and notice be given of this Order.

This Order is not intended to, and does not, create any rights or benefits, substantive or procedural, enforceable at law or in equity, against the State of California, its agencies, departments, entities, officers, employees, or any other person. The State shall be immune from any liability resulting from implementation of this Order.

IN WITNESS WHEREOF I have hereunto set my hand and caused the Great Seal of the State of California to be affixed this 15th day of March 2020.



GAVIN NEWSOM
Governor of California

ATTEST:

ALEX PADILLA
Secretary of State

EXHIBIT R

COVID MONITORING

Patient Registry

Identification & Housing								
Current Institution	First Testing Institution	CDCR#	Last Name	Age	Care Team	Housing Facility	Cell Bed	MH LOC
CIM	CIM	[redacted]	[redacted]	39	[redacted]			
CIM	CIM	[redacted]	[redacted]	46	[redacted]	[redacted]	[redacted]	
CEN	CEN	[redacted]	[redacted]	60	[redacted]	[redacted]	[redacted]	
NKSP	NKSP	[redacted]	[redacted]	43	[redacted]	[redacted]	[redacted]	
CIM	CIM	[redacted]	[redacted]	32	[redacted]	[redacted]	[redacted]	
CIM	CIM	[redacted]	[redacted]	34	[redacted]	[redacted]	[redacted]	
CIM	CIM	[redacted]	[redacted]	54	[redacted]			
CIM	CIM	[redacted]	[redacted]	42	[redacted]	[redacted]	[redacted]	
CIM	CIM	[redacted]	[redacted]	61	[redacted]	[redacted]	[redacted]	

Institution(s): Multiple
Care Team(s): All
Housing/Facility: All

Report run: 4/20/2020 11:29:56 AM

COVID MONITORING

Patient Registry

Institution(s): Multiple
Care Team(s): All
Housing/Facility: All

Report run: 4/20/2020 11:29:56 AM

COVID MONITORING

Patient Registry

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Current Institution	First Testing Institution	CDCR#	Last Name	Age	Care Team	Housing Facility	Cell Bed	MH LOC
CIM	CIM	[redacted]	[redacted]	46	[redacted]	[redacted]	[redacted]	
CIM	CIM	[redacted]	[redacted]	53	[redacted]	[redacted]	[redacted]	
CIM	CIM	[redacted]	[redacted]	37	[redacted]	[redacted]	[redacted]	
CIM	CIM	[redacted]	[redacted]	29	[redacted]	[redacted]	[redacted]	
CIM	CIM	[redacted]	[redacted]	68	[redacted]	[redacted]	[redacted]	
CIM	CIM	[redacted]	[redacted]	61	[redacted]	[redacted]	[redacted]	
CIM	CIM	[redacted]	[redacted]	37	[redacted]	[redacted]	[redacted]	
CEN	CEN	[redacted]	[redacted]	36	[redacted]	[redacted]	[redacted]	
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Institution(s): Multiple
Care Team(s): All
Housing/Facility: All

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COVID MONITORING

Patient Registry

Institution(s): Multiple
Care Team(s): All
Housing/Facility: All

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COVID MONITORING

Patient Registry

Identification & Housing								
Current Institution	First Testing Institution	CDCR#	Last Name	Age	Care Team	Housing Facility	Cell Bed	MH LOC
CIM	CIM	[redacted]	[redacted]	51	[redacted]	[redacted]	[redacted]	
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CIM	CIM	[redacted]	[redacted]	60	[redacted]	[redacted]	[redacted]	
SATF	SATF	[redacted]	[redacted]	37	[redacted]	[redacted]	[redacted]	
CIM	CIM	[redacted]	[redacted]	63	[redacted]			
CIM	CIM	[redacted]	[redacted]	58	[redacted]	[redacted]	[redacted]	
CIM	CIM	[redacted]	[redacted]	48	[redacted]	[redacted]	[redacted]	

Institution(s): Multiple
Care Team(s): All
Housing/Facility: All

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COVID MONITORING

Patient Registry

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Care Team(s): All
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Current Institution	First Testing Institution	CDCR#	Last Name	Age	Care Team	Housing Facility	Cell Bed	MH LOC
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CIM	CIM	[redacted]	[redacted]	60	[redacted]	[redacted]	[redacted]	
CIM	CIM	[redacted]	[redacted]	37	[redacted]	[redacted]	[redacted]	
CIM	CIM	[redacted]	[redacted]	57	[redacted]	[redacted]	[redacted]	
CIM	CIM	[redacted]	[redacted]	45	[redacted]	[redacted]	[redacted]	
CIM	CIM	[redacted]	[redacted]	52	[redacted]			CCCMS
LAC	LAC	[redacted]	[redacted]	63	[redacted]	[redacted]	[redacted]	CCCMS
LAC	LAC	[redacted]	[redacted]	51	[redacted]	[redacted]	[redacted]	CCCMS

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Housing/Facility: All

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Care Team(s): All
Housing/Facility: All

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CIM	CIM	[redacted]	[redacted]	35	[redacted]	[redacted]	[redacted]	CCCMS
CIM	CIM	[redacted]	[redacted]	54	[redacted]	[redacted]	[redacted]	CCCMS
CIM	CIM	[redacted]	[redacted]	26	[redacted]	[redacted]	[redacted]	CCCMS
CIM	CIM	[redacted]	[redacted]	57	[redacted]	[redacted]	[redacted]	CCCMS
CIM	CIM	[redacted]	[redacted]	54	[redacted]	[redacted]	[redacted]	CCCMS
CIM	CIM	[redacted]	[redacted]	48	[redacted]	[redacted]	[redacted]	CCCMS
CIM	CIM	[redacted]	[redacted]	33	[redacted]	[redacted]	[redacted]	CCCMS
CIM	CIM	[redacted]	[redacted]	43	[redacted]	[redacted]	[redacted]	CCCMS
CIM	CIM	[redacted]	[redacted]	58	[redacted]	[redacted]	[redacted]	CCCMS

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Care Team(s): All
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CIM	CIM	[redacted]	[redacted]	39	[redacted]	[redacted]	[redacted]	CCCMS
CIM	CIM	[redacted]	[redacted]	51	[redacted]	[redacted]	[redacted]	CCCMS
CIM	CIM	[redacted]	[redacted]	50	[redacted]	[redacted]	[redacted]	CCCMS
CIM	CIM	[redacted]	[redacted]	37	[redacted]	[redacted]	[redacted]	CCCMS
CMC	CMC	[redacted]	[redacted]	74	[redacted]	[redacted]	[redacted]	CCCMS
CIM	CIM	[redacted]	[redacted]	40	[redacted]			CCCMS
CIM	CIM	[redacted]	[redacted]	35	[redacted]	[redacted]	[redacted]	CCCMS
CIM	CIM	[redacted]	[redacted]	41	[redacted]	[redacted]	[redacted]	CCCMS

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Care Team(s): All
Housing/Facility: All

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CIM	CIM			58				CCCMS
CIM	CIM			22				CCCMS
CIM	CIM			69				CCCMS
CIM	CIM			27				CCCMS
CIM	CIM			57				CCCMS
CIM	CIM			73				CCCMS
CIM	CIM			64				CCCMS
CIM	CIM			27				CCCMS
CIM	CIM			32				CCCMS

Institution(s): Multiple
Care Team(s): All
Housing/Facility: All

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CIM	CIM	[redacted]	[redacted]	53	[redacted]	[redacted]	[redacted]	CCCMS
CIM	CIM	[redacted]	[redacted]	39	[redacted]	[redacted]	[redacted]	CCCMS
LAC	LAC	[redacted]	[redacted]	36	[redacted]	[redacted]	[redacted]	EOP
LAC	LAC	[redacted]	[redacted]	41	[redacted]	[redacted]	[redacted]	EOP
LAC	LAC	[redacted]	[redacted]	38	[redacted]	[redacted]	[redacted]	EOP
LAC	LAC	[redacted]	[redacted]	38	[redacted]	[redacted]	[redacted]	EOP
LAC	LAC	[redacted]	[redacted]	50	[redacted]	[redacted]	[redacted]	EOP
LAC	LAC	[redacted]	[redacted]	52	[redacted]	[redacted]	[redacted]	EOP

Institution(s): Multiple
Care Team(s): All
Housing/Facility: All

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Care Team(s): All
Housing/Facility: All

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LAC	LAC			46				EOP
LAC	LAC			45				EOP
LAC	LAC			59				EOP
LAC	LAC			50				EOP
LAC	LAC			58				EOP
LAC	LAC			38				EOP
LAC	LAC			32				EOP
LAC	LAC			31				EOP
LAC	LAC			33				EOP

Institution(s): Multiple
Care Team(s): All
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Identification & Housing								
Current Institution	First Testing Institution	CDCR#	Last Name	Age	Care Team	Housing Facility	Cell Bed	MH LOC
LAC	LAC	[redacted]	[redacted]	35	[redacted]	[redacted]	[redacted]	EOP
LAC	LAC	[redacted]	[redacted]	50	[redacted]	[redacted]	[redacted]	EOP
LAC	LAC	[redacted]	[redacted]	55	[redacted]	[redacted]	[redacted]	EOP
LAC	LAC	[redacted]	[redacted]	50	[redacted]	[redacted]	[redacted]	EOP
LAC	LAC	[redacted]	[redacted]	63	[redacted]	[redacted]	[redacted]	EOP
LAC	LAC	[redacted]	[redacted]	63	[redacted]	[redacted]	[redacted]	EOP
LAC	LAC	[redacted]	[redacted]	53	[redacted]	[redacted]	[redacted]	EOP
LAC	LAC	[redacted]	[redacted]	65	[redacted]	[redacted]	[redacted]	EOP
LAC	LAC	[redacted]	[redacted]	55	[redacted]	[redacted]	[redacted]	EOP

Institution(s): Multiple
Care Team(s): All
Housing/Facility: All

Report run: 4/20/2020 11:29:56 AM

COVID MONITORING

Patient Registry

Institution(s): Multiple
Care Team(s): All
Housing/Facility: All

Report run: 4/20/2020 11:29:56 AM

COVID MONITORING

Patient Registry

Identification & Housing								
Current Institution	First Testing Institution	CDCR#	Last Name	Age	Care Team	Housing Facility	Cell Bed	MH LOC
LAC	LAC			62				EOP
LAC	LAC			62				EOP
LAC	LAC			58				EOP
LAC	LAC			59				EOP
LAC	LAC			68				EOP
LAC	LAC			19				EOP
LAC	LAC			22				EOP
LAC	LAC			26				EOP
LAC	LAC			30				EOP

Institution(s): Multiple
Care Team(s): All
Housing/Facility: All

Report run: 4/20/2020 11:29:56 AM

COVID MONITORING

Patient Registry

Institution(s): Multiple
Care Team(s): All
Housing/Facility: All

Report run: 4/20/2020 11:29:56 AM

COVID MONITORING

Patient Registry

Identification & Housing								
Current Institution	First Testing Institution	CDCR#	Last Name	Age	Care Team	Housing Facility	Cell Bed	MH LOC
LAC	LAC	███	███	36	███	███	███	EOP
LAC	LAC	███	███	42	███	███	███	EOP
LAC	LAC	███	███	45	███	███	███	EOP
LAC	LAC	███	███	27	███	███	███	EOP
LAC	LAC	███	███	29	███	███	███	EOP
LAC	LAC	███	███	25	███	███	███	EOP
LAC	LAC	███	███	24	███	███	███	EOP
LAC	LAC	███	███	28	███	███	███	EOP
LAC	LAC	███	███	30	███	███	███	EOP

Institution(s): Multiple
Care Team(s): All
Housing/Facility: All

Report run: 4/20/2020 11:29:56 AM

COVID MONITORING

Patient Registry

Institution(s): Multiple
Care Team(s): All
Housing/Facility: All

Report run: 4/20/2020 11:29:56 AM

COVID MONITORING

Patient Registry

Identification & Housing								
Current Institution	First Testing Institution	CDCR#	Last Name	Age	Care Team	Housing Facility	Cell Bed	MH LOC
LAC	LAC	[redacted]	[redacted]	66	[redacted]	[redacted]	[redacted]	EOP
LAC	LAC	[redacted]	[redacted]	35	[redacted]	[redacted]	[redacted]	EOP
LAC	LAC	[redacted]	[redacted]	40	[redacted]	[redacted]	[redacted]	EOPMod
LAC	LAC	[redacted]	[redacted]	64	[redacted]	[redacted]	[redacted]	EOPMod
LAC	LAC	[redacted]	[redacted]	49	[redacted]	[redacted]	[redacted]	EOPMod
LAC	LAC	[redacted]	[redacted]	58	[redacted]	[redacted]	[redacted]	EOPMod
LAC	LAC	[redacted]	[redacted]	74	[redacted]			EOPMod
LAC	LAC	[redacted]	[redacted]	60	[redacted]	[redacted]	[redacted]	EOPMod
LAC	LAC	[redacted]	[redacted]	35	[redacted]	[redacted]	[redacted]	EOPMod

Institution(s): Multiple
Care Team(s): All
Housing/Facility: All

Report run: 4/20/2020 11:29:56 AM

COVID MONITORING

Patient Registry

Institution(s): Multiple

Care Team(s): All

Housing/Facility: All

Report run: 4/20/2020 11:29:56 AM

COVID MONITORING

Patient Registry

Identification & Housing								
Current Institution	First Testing Institution	CDCR#	Last Name	Age	Care Team	Housing Facility	Cell Bed	MH LOC
LAC	LAC	[redacted]	[redacted]	49	[redacted]	[redacted]	[redacted]	ICF
LAC	LAC	[redacted]	[redacted]	37	[redacted]	[redacted]	[redacted]	ICF
CIW	CIW	[redacted]	[redacted]	30	[redacted]	[redacted]	[redacted]	MHCB

Institution(s): Multiple
Care Team(s): All
Housing/Facility: All

Report run: 4/20/2020 11:29:56 AM

COVID MONITORING

Patient Registry

Institution(s): Multiple
Care Team(s): All
Housing/Facility: All

Report run: 4/20/2020 11:29:56 AM

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The New York Times https://nyti.ms/2VhmBKE

LIVE UPDATES Updated 4 minutes ago

Coronavirus Live Updates: Southern States Move to Reopen as Outbreak Continues to Spread in Parts of U.S.

As the virus overwhelms the health care system, people with other illnesses are struggling to find treatment. A $450 billion deal to aid taxpayers and businesses stalls in Congress amid a dispute over testing.

RIGHT NOW South Carolina allowed retail shops to open on Monday with social distancing guidelines, and the governors of Georgia and Tennessee announced plans to ease restrictions on businesses in their states in the coming days.

Here's what you need to know:

- Several states in the South are moving to reopen businesses.
- Cases surge in an Ohio prison, making it the top known U.S. hot spot.
- The outbreak is continuing to worsen in some parts of the U.S.
- The outbreak's collateral damage includes people whose other illnesses go untreated.
- Oil plummets as storage capacity runs low, and a quirk in pricing wipes out one benchmark.
- A W.H.O. director warns that manufacturing and distributing a vaccine could be difficult.
- Cuomo says 478 more people died in New York, the lowest single-day toll in two weeks.

More live coverage:

World **U.S.** **New York** **Business**

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“While I am not extending the ‘safer at home’ order past the end of April, we are working directly with our major metropolitan areas to ensure they are in a position to reopen as soon and safely as possible,” he said in a statement. “Social distancing works, and as we open up our economy it will be more important than ever that we keep social distancing as lives and livelihoods depend on it.”

Cases surge in an Ohio prison, making it the top known U.S. hot spot.

More than 600 cases involving inmates and staff members at the Cook County Jail in Chicago have been tied to the coronavirus. Shannon Stapleton/Reuters

A state prison in Ohio is now the largest reported source of virus infections in the United States, according to a New York Times database, continuing a trend of fast-moving outbreaks behind bars.

Ohio officials said Sunday that at least 1,828 inmates — almost three-quarters of the prison population — had tested positive at the Marion Correctional Institution, a minimum- and medium-security prison about an hour’s drive north of Columbus. That’s more than the number of known cases at a meatpacking plant in South Dakota and an aircraft carrier docked in Guam.

About one out of five confirmed virus cases in Ohio is now connected with the state’s prison system, according to statewide figures. The Department of Rehabilitation and Correction said that as of Sunday, at least 2,400 inmates in the system had tested positive, and seven had died of either confirmed or suspected Covid-19 infections.

No deaths have been reported among the prisoners in Marion, but one staff member at the facility has died, and 103 employees have tested positive. The prison announced its first positive case, of an employee, on March 29.

Despite warnings from health officials and attempts to release some inmates to avoid outbreaks, jails, prisons and detention centers have emerged as major coronavirus spreaders. As of Monday, four of the 10 largest-known sources of infection in the United States were correctional facilities, according to Times tracking data.

And even those numbers are most likely a vast undercount, because some state and local agencies have not released information about cases behind bars, and others, including the federal Bureau of Prisons, are not testing everyone who falls ill. In contrast, the Ohio corrections department said it was testing aggressively inside prisons where the virus has been confirmed, extending tests even to prisoners who were not showing symptoms.

At the Cook County Jail in Chicago, more than 600 cases involving inmates and staff members have been tied to the virus, and four inmates have died. At one point last week, that jail was the top-known source of U.S. infections, but other sources have since surpassed it.

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And an outbreak at a correctional facility in Goldsboro, N.C., caused cases to spike in Wayne County. More than half of the inmates at the Neuse Correctional Institution — 458 — have tested positive for the virus, county officials said. There have now been 575 cases in the county and six deaths.

The outbreak is continuing to worsen in some parts of the U.S.

A medical worker took a sample at a coronavirus testing center in Chelsea, Mass., on Monday. Steven Senne/Associated Press

Although there have been encouraging signs that the outbreak is beginning to level off in some places, the threat of the virus is continuing to grow in some states and regions.

Even in areas where the number of new cases is beginning to flatten, it is doing so at a very high level: New York, which reported its fewest new cases in a month and its lowest one-day death toll in more than two weeks, still reported 4,726 new cases and 478 new deaths on Monday. And the country has added more than 25,000 new cases a day for the past week.

But in some regions, there are signs that things are getting worse, not better.

Massachusetts has been particularly hard-hit in recent days. It reported 1,705 new cases on Sunday, bringing its total to 38,077, and 146 new deaths, which brought the death toll to 1,706. “We’re right in the middle of the surge now,” Gov. Charlie Baker, a Republican, said Sunday on “Face the Nation” on CBS.

Los Angeles County reported 81 deaths on Saturday, its highest one-day death toll.

“In this last week, we have doubled the number of deaths that occurred among L.A. County residents,” Barbara Ferrer, the county’s director of public health, said in a statement on Saturday. Fewer deaths were reported Sunday — 24 — but county officials noted that nearly 1,000 new cases had been identified in the previous 48 hours.

There have been significant workplace-based clusters in Iowa, Kansas, Minnesota, North Dakota, South Dakota, Tennessee and other states, suggesting that the pandemic is just beginning to sink into some communities.

Nursing homes and prisons also continue to be hot spots.

The outbreak’s collateral damage includes people whose other illnesses go untreated.

EXHIBIT T

XAVIER BECERRA
Attorney General of California
DAMON MCCLAIN - SBN 209508
Supervising Deputy Attorney General
NASSTARAN RUHPARWAR - 263293
Deputy Attorney General
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 703-5500
Facsimile: (415) 703-3035
Damon.McClain@doj.ca.gov

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

Attorneys for Defendants

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

Attorneys for Plaintiffs

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA, OAKLAND DIVISION

MARCIANO PLATA, et al.,

Plaintiffs,

v.

GAVIN NEWSOM, et al.,

Defendants.

CASE NO. 01-1351 JST

JOINT CASE MANAGEMENT CONFERENCE STATEMENT

Date: April 20, 2020
Time: 2:00 p.m.
Crtrm.: 6, 2nd Floor
Judge: Hon. Jon S. Tigar

1 The parties submit the following joint statement in advance of the April 20, 2019
2 Case Management Conference.

3 **I. PLAINTIFFS' STATEMENT**

4 As of 8:00 a.m. this morning, 121 patients statewide have tested positive for COVID-19:
5 60 at the California Institution for Men (CIM) (all from Facility D, we believe), 55 at California
6 State Prison – Los Angeles County (LAC) (all from Facility D, almost or perhaps all from a single
7 housing unit in that Facility, we believe), two at Centinela State Prison, and one each at the
8 California Institution for Women, California Men's Colony, North Kern State Prison, and the
9 Substance Abuse Treatment Facility and State Prison. There has been one patient death from
10 COVID-19, on April 19, 2020.

11 **A. Defendants' plan to implement the Receiver's directive to facilitate distancing.**

12 Plaintiffs seek further information regarding Defendants' intent to implement the
13 Receiver's April 10, 2020 Directive (Receiver's Directive) (ECF 3273-2) to create in the prison
14 dormitories eight-person housing cohorts, each separated by a distance of at least six feet in all
15 directions. Defendants before this Court last week unequivocally indicated that they would
16 implement this Directive, "and explained that they have already moved some individuals from
17 dormitory housing into gymnasiums to increase physical distancing in the dorms." Order, ECF
18 3291 at 11. They further stated that the aspiration was to complete the process in the following
19 week.

20 That same day, in response to Judge Mueller's Order requiring Defendants to submit a
21 strategic plan for achieving compliance with the U.S. Centers for Disease Control and Prevention
22 (CDC) *Interim Guidance on Management of Coronavirus Disease (2019) (COVID-19) in*
23 *Correctional and Detention Facilities* ("CDC Guidance"), the CDCR filed a COVID-19 Plan that
24 is inconclusive as to whether they will implement the Receiver's Directive. That Plan states
25 "CDCR, in conjunction with the Plata Receiver, will assess the population in the dorms and
26 determine *what additional steps need to be taken, if any*" after completing already-scheduled
27 transfers. CDCR COVID Plan at 6, *Coleman v. Newsom*, Case No. 2:90-CV-00520-KJM-DB,
28 ECF No. 6616 at 11 ("Strategic Plan") (emphasis added).

In light of these inconsistent positions, Plaintiffs seek the following information from Defendants:

First, do Defendants intend to comply with the Receiver's Directive to create housing cohorts?

Second, if Defendants intend to comply with the Receiver's Directive, Plaintiffs request that Defendants provide the "activation schedule" that Defendants' counsel referenced during the April 16, 2020 motion hearing. That schedule should include an explanation of the methodology Defendants intend to use to house people at high risk due to COVID-19. Plaintiffs request that this schedule include all of the dormitories, including any existing or established in re-purposed space (e.g., gyms) in each of the 35 facilities and indicate whether each dormitory has been or will be reorganized to incorporate the eight-person cohort plan, with six-foot separation, and the final date by which Defendants intend to complete this transition for each dormitory.

Third, Defendants must provide photos or video-recorded site visits of each of the newly configured dormitories, in which staff measure the distances between cohorts, and document access to programs, bathrooms and showers, medical/mental health services, and meals.

Finally, if Defendants do not intend to fully implement the Receiver's Directive, Plaintiffs request that Defendants provide details on their alternative plan to effect physical distancing in the prison dormitories.

B. People at higher risk for severe illness or death from COVID-19.

In their Strategic Plan, Defendants stated that they do not intend to target COVID-related efforts to any particular population, including the medically vulnerable: "There are currently no plans to target specific portions of the population, such as *Coleman* class members or high risk inmates, for special movement or housing, except as detailed [elsewhere in the Plan] regarding the provision of Mental Health care." Strategic Plan at 4 (*Coleman* ECF 6616 at 9). Defendants' filings in this Court likewise do not indicate any plan to specially-house the medically vulnerable.

Plaintiffs remain concerned by Defendants' decision to not target any COVID-19 efforts to the medically vulnerable people in their custody. The Receiver's office has recognized the

importance of taking steps to protect these patients. In its April 3 *COVID-19: Interim Guidance for Health Care and Public Health Providers*, CCHCS instructed that prisons may consider placing these vulnerable patients on a "protective shelter in place":

> During the COVID-19 pandemic, CCHCS institutions may implement additional measures to protect vulnerable patients who are at increased risk for severe COVID-19 disease (e.g., single-cell or protected housing area, limited movement, separate dining and yard time, and telemedicine services). Patients in protective shelter in place should be educated regarding their risk and how to protect themselves, early symptom recognition and request for medical attention, and the availability of testing for COVID-19.

See April 3 Guidance at 18 (ECF 3274-6 at 19).

Defendants apparently have not adopted this recommendation. On April 8, CCHCS and Defendants provided Plaintiffs a spreadsheet of patients considered more vulnerable to COVID-19 complications. The spreadsheet showed that many of these individuals remained housed in crowded dorms. For example, CIM's Alder Hall housed 71 people who were classified as "high risk" medical, over the age of 50, and/or had conditions that made them vulnerable to severe illness from COVID-19. Alder Hall is the locus of a COVID-19 outbreak: at least 22 people were housed there prior to testing positive for COVID-19. ECF 3284-2 ¶ 5. Tragically, one CIM patient has recently died from COVID-19 complications, s*ee* Cal. Dep't of Corr. & Rehab., *California Institution for Men Inmate Dies from Complications Related to COVID-19* (April 19, 2020), https://www.cdcr.ca.gov/news/2020/04/19/california-institution-for-men-inmate-dies-from-complications-related-to-covid-19/, and medical records indicate he had been housed in Alder Hall. In addition, those records indicate the patient had risk factors, including age and underlying medical conditions, which made him especially vulnerable to COVID-19.

According to the April 7, 2020 Bed Audit, Alder Hall was at 112% capacity (ECF 3284-2 at 27), with 112 people in a space designed for 100 beds. Thus, sixty-three percent (63%) of the 112 people in this dorm were considered vulnerable to COVID-19 complications. As of April 8, there were also 71 medically vulnerable people (70% of that dorm's population) in Cedar Hall,

where at least 5 people were housed prior to testing positive for COVID-19 (ECF 3284-2 ¶ 7).[1] And, there were 83 medically vulnerable people (74% of that dorm's population) in Spruce Hall, where at least 6 people have tested positive for COVID-19 (ECF 3284-2 ¶ 6).

CIM is not the only prison in the state housing medically vulnerable people in crowded dormitories. For example, data provided by the Receiver indicates that California Medical Facility has five dorms that house 92, 84, 70, 70, and 61 people designated "high risk medical" in dorms that are, respectively, 129%, 134%, 142%, 116%, and 114% of design capacity. And, at California State Prison Solano, a dorm houses 57 such people in a dorm at 162% of design capacity. Valley State Prison houses 63 and 71 people in dorms who have at least one COVID-19 risk factor; these housing units are up to 133% of design capacity. Similarly, at the Substance Abuse and Treatment Facility there are 47 and 46 people housed in dorms who have at least one COVID-19 risk factor; those units are up to 141% of design capacity.

These figures demonstrate that Defendants have knowingly housed medically vulnerable people in a situation that puts them at a serious risk of harm and in one recent case, death. As stated above, Defendants have no plan to specially protect these individuals through physical distancing in their housing units. In monitoring Defendants' response to COVID-19 the Court should direct that those at medically high risk be housed in a manner that protects them from infection to the fullest extent possible.

C. Medical care related to COVID-19.

The changes to medical services, and Plaintiffs' monitoring, caused by the COVID-19 pandemic, described in the April 13, 2020 Case Management Conference Statement, continue. On April 14th, the Receiver's Chief Medical Executive and Chief of Corrections Services held an hour-long phone conference to answer questions Plaintiffs' regarding COVID-19. Defendants counsel participated in the conference. Plaintiffs have asked for a similar session this week to address questions and concerns that remain unresolved. The Receiver has not yet replied whether

[1] Plaintiffs understand that the Cedar Hall dorm has since been converted to a kind of infection control unit for patients who have tested positive for COVID-19.

1 a conference will be scheduled. Among the questions and concerns Plaintiffs hope to discuss with
2 Receiver are:

3 a. Medical Isolation

4 i. Criteria for release from medical isolation: CCHCS said its "priority" last
5 week was reconsideration of the criteria for when COVID-19 patients
6 would be considered recovered and thus can be released from medical
7 isolation. Currently, no CDCR COVID-19 patient has been determined to
8 be recovered and released from isolation; one patient has been on isolation
9 for 30 days and others have been on that status for approximately three
10 weeks.

11 ii. Outdoor time for those on medical isolation: None of the dozen patients on
12 medical isolation at LAC and CIM were offered outdoor time, CCHCS said
13 last week, even though it also said there was no medical or public health
14 reason they could not be, so long as they did not mix with those not on
15 medical isolation. CCHCS guidance to the prisons is currently silent
16 regarding outdoor time for those on medical isolation, even though it has
17 specifically said those on quarantine can be provided outdoor exercise so
18 long as they do not mix with others. CCHCS said it would pass along
19 Plaintiffs' request that the prisons be told that medical isolation patients can
20 be offered outdoor time to those currently revising the directives and
21 guidance given to the prisons.

22 iii. Question about cell-housing of medical isolation patient at LAC: A class
23 member reported that although he did not have COVID-19 he was double-
24 celled with a person who was positive for the virus. Plaintiffs have asked
25 CCHCS for information to determine if the class member's report is correct.

26 b. Testing

27 i. Availability of tests and timely test results: CCHCS said last week its
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supply of test kits was fairly stable. It reported 1400 COVID-19 test kits statewide, roughly distributed equally among the prisons except for re-allocations made to CIM and LAC given the outbreaks at those prisons. CCHCS said it had not heard of any problems in obtaining tests in the near future. CCHCS said the test results turn-around time was 48-72 hours, except at Pelican Bay State Prison (PBSP), where it was taking six days (currently, seven PBSP patients have been tested).

ii. Rapid tests: CCHCS said it expected to hear last week whether it would obtain rapid COVID-19 testing developed and being sold by Abbott Labs.

iii. Surveillance testing of non-symptomatic persons: CCHCS sometime in the last two weeks, apparently in partnership with an outside entity, offered COVID-19 testing to non-symptomatic people housed in LAC's D-2, the locus of a large outbreak. As a result, more than 20 persons have been diagnosed with COVID-19. CCHCS has said it will attempt similar surveillance testing at CIM, given the large outbreak at that prison's Facility D.

c. Personal Protective Equipment for staff

i. CCHCS said last week that its supplies of masks for healthcare and other staff was stabilizing. It stated it had received approximately 10,000 N95 or Nk95 masks, and some of those had been distributed to CIM and LAC. CCHCS said it did have issues with gowns, but did not provide further information.

d. Cloth face barriers for incarcerated persons and staff

i. On April 16, 2020, CDCR and CCHCS executives issued a memo stating that incarcerated persons and staff are required to wear a cloth face barrier "once a supply of two (2) face barriers/masks per correctional staff and inmate/patient has been delivered to the institution." CDCR last week

1 stated that it is manufacturing 20,000 cloth face coverings per day for use
2 by incarcerated persons and staff. However, it is not known when each
3 prison will receive the supply necessary to trigger the requirement that cloth
4 face barriers be worn.

5 e. Availability of community hospital beds for COVID-19 patients in need of
6 inpatient or other advanced care including ICU placement

7 i. CCHCS last week said it has not had and does not anticipate problems with
8 hospital admissions in the Los Angeles area. There may be concerns if
9 patients need hospitalization in areas referred to as "medical deserts." For
10 example, the hospital in Crescent City, California, which is the nearest one
11 to PBSP, has only eight ICU beds.

12 **II. DEFENDANTS' STATEMENT**

13 Defendants' statement describes the additional measures CDCR has taken since the
14 filing of Defendants' opposition to Plaintiffs' emergency motion on April 13, 2020 (ECF
15 No. 3272 et seq.). In particular, this statement discusses the steps CDCR has taken in
16 response to the Receiver's directives from April 10 and April 12, 2020, to mitigate the
17 risks of COVID-19 in CDCR's institutions, including the creation of eight-person cohorts
18 for inmates housed in dorm settings.

19 First, however, Defendants must raise a concern about the potential for orders
20 related to CDCR's response to the COVID-19 pandemic issued in *Coleman v. Newsom*,
21 No. 2:90-cv-0520 KJM DB (E.D. Cal.) to conflict with orders issued about that subject in
22 *Plata*. While the *Coleman* case focuses on a particular subset of correctional health care—
23 mental health care—the potential for conflicting orders related to correctional health care
24 more generally is emerging. For example, in its recent ruling denying Plaintiffs'
25 emergency motion, this Court concluded that it could not order the injunctive relief
26 requested by Plaintiffs—which included a request for an order requiring CDCR to develop
27 and implement a plan to minimize the spread of the COVID-19 virus to the incarcerated
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1 population in California's state prisons—because Defendants have not been deliberately
2 indifferent. (ECF No. 3291.) By contrast, on April 10, the *Coleman* Court, after
3 acknowledging the same robust response to the COVID-19 crisis that this Court
4 considered, concluded that CDCR's efforts were insufficient,[2] and ordered the following:

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> Good cause appearing, defendants will be directed to file, not later than 5 p.m. on Thursday, April 16, 2020, a strategic plan for achieving compliance with the U.S. Centers for Disease Control and Prevention (CDC) Interim Guidance on Management of Coronavirus Disease (2019) (COVID-19) in Correctional and Detention Facilities (CDC Guidance), to the maximum extent defendants currently maintain is possible.

9 (*Coleman,* ECF No. 6600 at 1-2; *see also* ECF No. 6622 at 1-2.) It is difficult to reconcile
10 these two orders. And the situation becomes more ambiguous upon considering the fact
11 that many of the CDC recommendations concern subjects that fall directly under the
12 Receiver's responsibility.

13 As this Court is aware, on February 14, 2006, it issued an order appointing the
14 Receiver, which divested the Secretary of CDCR from control of the medical delivery
15 system and placed the day-to-day management of it in the control of the Receiver. (ECF
16 No. 473 at 4.) Under that order, the Receiver shall "exercise all powers vested by law in
17 the Secretary of CDCR as they relate to the administration, control, management,
18 operation, and financing of the California prison medical health care system." (*Id.*) And
19 although some institutions' medical delivery has been delegated back to CDCR, the
20 Receiver retains control of the administrative functions of CDCR's medical services.
21 Thus, CDCR cannot enter into agreements about how to provide medical care to "high
22 risk" patients or on how to provide physical-distancing measures for medical purposes
23 without the approval of the Receiver.

24 On April 16, Defendants complied with the *Coleman* Court's order, which required
25 them to file a plan with the Court. The strategic plan filed in *Coleman* sets forth a

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[2] The *Coleman* Court did not, however, explicitly find that CDCR's response to the pandemic constituted deliberate indifference under the Eighth Amendment or otherwise violated the Constitution.

comprehensive summary of the measures that have already been presented to this Court, plus additional actions CDCR has taken regarding the provision of mental health care to address the needs of patients with mental illnesses. (*Coleman,* ECF No. 6616.) However, upon "initial review," the *Coleman* Court found the plan (not limited to the mental health components)—which was developed in close cooperation with the Receiver—to be problematic. (*Coleman,* ECF No. 6622 at 2 (noting that the Court's review "suggest[ed] an absence of specific goals and objectives and no identification of the expected duration of the plan or aspects thereof").)

The *Coleman* Court has allowed for additional briefing regarding the plan before it takes the plan under formal review. (*Id.* at 2.) It is unclear what additional orders the *Coleman* Court will make concerning CDCR's response to the pandemic. To support CDCR's preference for a holistic approach to addressing inmates' health needs and to mitigate the potential for conflicting orders, Defendants request that this Court and the *Coleman* Court address this issue through the Court's normal coordination mechanism.

While there is no doubt that the *Coleman* Court's jurisdiction fully encompasses CDCR's continuing provision of adequate mental health care in its institutions, Defendants believe that the determination of the adequacy of CDCR's measures to mitigate the medical risks of COVID-19 in its institutions falls squarely in the purview of this Court. In its April 10 order, the *Coleman* Court acknowledged that coordination between the two cases is desirable, and going forward, Defendants are optimistic that coordination can prevent the issuance of any conflicting orders.

A. CDCR Has Taken Significant Additional Steps to Improve Physical Distancing in its Institutions.

Defendants have rapidly begun to implement the Receiver's April 10 plan to improve physical distancing in the dorms by transferring numerous inmates out of dorms and into other locations, including celled housing and gyms. Although additional transfers are still needed, CDCR anticipates that by activating gymnasiums for occupation, and by

fully utilizing vacant cells in various locations, it will be able to fully implement the eight-person cohorts contemplated in the Receiver's plan.

1. Dorm transfers have commenced.

Officials at all prisons with dorms have been directed to determine the reductions in their dorm populations that will be required to create the eight-person cohorts described in the Receiver's plan, and CDCR has moved quickly to conduct the required transfers. In their opposition to Plaintiffs' emergency motion, Defendants described an initial phase of inmate transfers from dorms to improve physical distancing, which included the following transfers:

- 361 inmates from California Rehabilitation Center to CSP Corcoran; and
- 300 inmates from Chuckawalla Valley State Prison to Ironwood State Prison;
- 226 inmates from CSP Solano to Deuel Vocational Institution;
- 143 inmates from Sierra Conservation Center to camps;
- 100 inmates from Substance Abuse Treatment Facility to CSP Corcoran;
- 57 inmates from Chuckawalla Valley State Prison to CSP Corcoran;
- 52 inmates from California Correctional Center to camps;
- 43 inmates from Folsom State Prison B Facility to Female Community Reentry Facility.

The last of these transfers were completed last week, and the total number of inmates transferred in this first phase was about 1,282.

To create the space in the dorms required to implement the Receiver's plan for eight-person cohorts, however, additional transfers from some of the dorms are required. On April 17, 2020, CDCR presented to the Receiver an initial proposal to comply with the Receiver's plan. The Receiver sought additional information and CDCR therefore submitted a modified proposal to the Receiver for approval this morning—April 20, 2020. That modified proposal includes following additional dorm transfers:

- 175 inmates from Substance Abuse Treatment Facility to CSP Corcoran;

- 76 inmates from Substance Abuse Treatment Facility to California City Correctional Facility;
- 133 inmates from Correctional Training Facility to CSP Corcoran;
- 180 inmates from Chuckawalla Valley State Prison to Ironwood State Prison;
- 95 inmates from San Quentin to CSP Corcoran;
- 76 inmates from California Rehabilitation Center to CSP Corcoran;
- 57 inmates from CSP Solano to California City Correctional Facility;
- 19 inmates from CSP Solano to Deuel Vocational Institute;
- 50 inmates from Central California Women's Facility to Female Community Reentry Facility; and
- 38 inmates from Correctional Institution for Women to Female Community Reentry Facility.

If the Receiver approves these transfers on April 20, then CDCR should be able to complete them within about two weeks. CDCR anticipates that once these transfers are completed, nearly all dorms should have sufficient space to implement eight-person cohorts in accordance with the Receiver's plan. But it is possible that as CDCR works through this process it will identify a few remaining transfers that might be needed to fully implement eight-person cohorts in every dorm, in which case CDCR will promptly seek the Receiver's approval and conduct any such transfers as soon as possible.

2. CDCR has begun to activate gyms for housing as needed.

At this time, nineteen potential gymnasium sites have been identified. The State Fire Marshal, whose inspections are still underway, has approved occupancy at twelve gyms. The activation of gyms also requires that cots and lockers be moved into those locations for the inmates who will be housed there. CDCR has already acquired 600 cots and has ordered an additional 500 cots. And CDCR is in the process of surveying its need for additional lockers.

CDCR has already activated some approved gyms. To date, 108 inmates have been

moved into gyms at San Quentin, and 21 inmates have been moved into a gym at California Institution for Men (that number will likely be increased to 50 inmates this week). CDCR anticipates that two gyms at CSP Solano will be activated this week and that 128 inmates will be housed in them. CDCR has the ability and resources to activate more gyms, and will continue to do so as the need arises.

3. Appropriate physical distancing is being achieved in the dorms.

All institutions with dorms have been directed to determine how their dorms can be arranged to comply with the Receiver's eight-person-cohort plan, and to the extent their dorm populations allow it, those prisons have been directed to begin implementing the cohort plan. A number of dorm locations have already completed implementing eight-person cohorts. And rather than use the cohort model, a number of dorm locations were able to separate all inmates by at least six feet.

CDCR is in the process of surveying these efforts and has compiled some rough numbers concerning dorm areas that have achieved appropriate physical distancing. CDCR offers the following rough numbers to demonstrate that the process of ensuring appropriate physical distancing in the dorms is well underway. When considering these numbers, it is important to note that the dorm locations vary greatly from institution to institution. Some dorm areas house as few as ten inmates and others house well over 200 inmates. To date, it appears that about 135 dorm areas have implemented eight-person cohorts and about 67 dorm areas have been able to separate all inmates by at least six feet. Additionally, CDCR anticipates that over the next week an additional 88 dorm areas will be able to implement eight-person cohorts, and eight additional dorm areas will be able to separate all inmates by at least six feet. CDCR anticipates that within about the next three weeks, the remaining dorm areas (approximately 55) will achieve either eight-person cohorts or six-foot distancing for all inmates.

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B. Steps Taken at California Institution for Men and CSP Los Angeles County to contain the spread of COVID-19

1. Status of positive COVID-19 cases and hospitalizations among the inmate population

As of April 18, 2020, at 5:30 p.m., a total of 115 inmates at CDCR's 35 institutions have tested positive for COVID-19. Out of those 110 inmates, 59 are housed at California Institution for Men (CIM) and 50 are housed at CSP Los Angeles County (LAC).[3] At CIM, the majority of the inmates who tested positive were previously housed in Dorm D10. The other inmates who tested positive were also housed in Facility D dorms. Similarly, all inmates who tested positive at LAC were housed in Facility D at that institution before testing positive.

As of April 19, 2020, seven inmates from CIM and one inmate from LAC were hospitalized for COVID-19-related symptoms.

2. CIM's and LAC's continuing efforts to contain the spread of COVID-19

As described in prior briefings relating to Plaintiffs' emergency motions filed in the Three-Judge Panel and this case, to contain the spread of COVID-19, CDCR has been isolating inmates with COVID-19-related symptoms and quarantining inmates who have had contact with a COVID-19-positive individual.

a. Measures taken by CIM to contain the spread of COVID-19

In addition to the previously described measures, CIM has had a thorough and detailed plan in place to contain the spread of COVID-19 since the early stages of the COVID-19 pandemic. For example, during the second week in March, CIM's healthcare and custody leadership started mapping out a plan to ensure that CIM would have sufficient supplies and buildings available to house quarantined or isolated inmates. In addition, as soon as the first staff members and inmates tested positive, CIM immediately began its contact tracing investigations and placed inmates who had contact with COVID-

[3] In addition, as of April 18, 2020, two inmates at CEN, one inmate at CIW, one inmate at CMC, one inmate at NKSP, and one inmate at SATF have tested positive.

1 19 cases into quarantine. Further, after receiving the first positive test from an inmate,
2 CIM set up an outdoor tent clinic where patients with COVID-19-related symptoms could
3 be evaluated without risking exposure to inmates receiving treatment for other issues.

4 In addition, CIM set up an Incident Command Post, which was staffed seven days a
5 week, to monitor patient information, supplies, and staff resources to consistently manage
6 the effects of the ongoing pandemic. As part of the Incident Command Post, CIM
7 conducts a daily call (except for weekends and holidays) with various healthcare and
8 custody staff, including the Warden, the Associate Warden for health care, the Chief
9 Executive Officer, the Chief Medical Executive, the Chief Nurse Executive, and various
10 captains to discuss COVID-19-related topics.

11 All CIM inmates who display COVID-19-related symptoms are tested for COVID-
12 19 and housed individually in cells while awaiting their test results. If the tests return
13 positive, the inmates are sent to a dorm where they will be housed with other inmates who
14 tested positive. If the test results are negative, the inmates do not go straight back into
15 their old housing units. Instead, as a matter of precaution, they are housed in a separate
16 unit together with other inmates who tested negative and are monitored for COVID-19-
17 related symptoms for 14 days before they return to their housing units.

18 Inmates who have had contact with a person infected with COVID-19 are
19 quarantined and monitored together in dorms. As of April 18, 2020, approximately 1,200
20 inmates at CIM are quarantined. Nurses and physicians perform surveillance screenings of
21 all inmates in isolation or on quarantine for COVID-19-related symptoms at least twice per
22 day.

23 With respect to face coverings, all CIM inmates who are isolated or quarantined
24 have received at least three cloth masks. Inmates who tested positive are required to wear
25 cloth masks at all times. Healthcare staff who evaluate inmates are required to wear a cap,
26 a face shield, and a N95 mask. Inmates are required to wear their cloth masks during those
27 evaluations. Custody staff who walk around the institution are also required to wear
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surgical or cloth masks. (For further details about face coverings, Defendants refer to heading D., *infra.*)

b. Measures taken at LAC to contain the spread of COVID-19

Similar to CIM, LAC reacted quickly after the first inmate in Facility D tested positive for COVID-19. Custody and health care immediately isolated the inmate and began working together to establish protocols and methods to keep all inmates and staff safe. Further, LAC has set up an incident command center and reduced the staff footprint by increasing telework options with alternating onsite and telework schedules for primary care providers.

Staff members at LAC conduct additional rounds to ensure the safety and well-being of inmates who are placed on modified program. Inmates with complaints of cough, fever or shortness of breath are tested for COVID-19. In addition, inmates with respiratory symptoms or complaints such as sore throat, runny nose, sneezing, loss of smell, feeling feverish, or chest congestion are considered for COVID-19 testing as well. Staff members conduct additional rounds to ensure the safety and well-being of inmates on modified program. Further, cloth masks have been provided to all inmates at LAC and LAC is in the process of providing cloth masks to all staff members.

Also, to determine the prevalence and the manner of the spread of COVID-19 at LAC's housing unit D2 (where the majority of the inmates who tested positive were located previously), the prison commenced surveillance testing of all quarantined inmates who were asymptomatic last week. According to California Correctional Health Care Services, as of April 18, out of 51 inmates who were tested, 21 were positive, 18 were negative, and 12 results were pending. An additional 47 inmates still need to be tested.

3. Passing of released CIM inmate at a congregate living facility in Los Angeles County

On April 11, 2020, a 63-year old inmate who was released on parole (not an early release) from CIM on April 3, 2020, to a congregate living center in Los Angeles County, was found dead at the living center. Prior to his release, the inmate was quarantined

because he had been in contact with a COVID-19 positive person. According to the California Correctional Health Care Services, the inmate did not have any symptoms upon release, and the Los Angeles County Public Health Department was notified of the inmate's release and of his quarantine status. He died at the living center of apparent respiratory failure and his post-mortem testing was positive for COVID-19. Los Angeles County is performing a contact investigation at the living center. The inmate had other serious medical conditions at the time of his death.

4. Passing of a current CIM inmate

On April 19, 2020, a 60-year old inmate from CIM passed away from what appear to be complications related to COVID-19. The exact cause of death has not yet been determined. The inmate was at an outside community hospital at the time of his death. He was sent to the hospital on April 16, 2020, from CIM's quarantined D10 dorm after he became hypoxemic with a fever.

C. Updates on CALPIA's production and supply of hand sanitizer and masks, and new face covering policies

The California Prison Industry Authority (CALPIA) plans to ship 11,880 bottles of hand sanitizer next week. Starting in May, CALPIA plans to produce 50,000 32-ounce bottles of hand sanitizer per month, which will be shipped on a weekly basis.

In addition, CALPIA continues to produce 22,000 washable cloth barrier masks per day. The cloth masks are being distributed to all institutions for inmate and staff use. On April 10, 2020, CDCR issued a memorandum to notify all institutions that the cloth masks will be issued to all inmates, starting with three cloth masks per inmate for immediate distribution, with a later distribution of two additional cloth masks per inmate. The memorandum also noted that each facility needed to prepare for an increased demand for laundry services in light of the need to wash the masks regularly.

On April 15, 2020, California Correctional Health Care Services issued a memorandum that provided guidance on the use of the cloth masks. The memorandum

1 clarified that the cloth masks are not intended for direct patient-care scenarios. The
2 memorandum advised that staff members who are working or performing duties on
3 institutional grounds shall (at a minimum) wear a cloth face covering. It also stated that
4 inmates shall use a cloth face covering within the institution during the following
5 activities: any situation that requires movement outside of cell or while in a dorm setting;
6 during interactions with other inmates (ex: yard time, canteen, dayroom); movement to and
7 from health care appointments; and movement to and from medication administration
8 areas. These requirements are effective as soon as each institution receives a supply of two
9 face barriers/masks for each correctional staff member and each inmate.

10 DATED: April 20, 2020 XAVIER BECERRA
11 Attorney General of California
12
13 By: */s/ Damon McClain*
14 DAMON MCCLAIN
15 Supervising Deputy Attorney General
NASSTARAN RUHPARWAR
16 Deputy Attorney General
Attorneys for Defendants
17
18
19 DATED: April 20, 2020 HANSON BRIDGETT LLP
20
21 By: */s/ Paul Mello*
22 PAUL B. MELLO
SAMANTHA D. WOLFF
23 Attorneys for Defendants
24
25
26
27
28

DATED: April 20, 2020

PRISON LAW OFFICE

By: *[/s/ Steven Fama]*
STEVEN FAMA
Attorneys for Plaintiffs

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DONALD SPECTER – 083925
STEVEN FAMA – 099641
MARGOT MENDELSON – 268583
PRISON LAW OFFICE
1917 Fifth Street
Berkeley, California 94710-1916
Telephone: (510) 280-2621

CLAUDIA CENTER – 158255
DISABILITY RIGHTS EDUCATION
AND DEFENSE FUND, INC.
Ed Roberts Campus
3075 Adeline Street, Suite 210
Berkeley, California 94703-2578
Telephone: (510) 644-2555

MICHAEL W. BIEN – 096891
JEFFREY L. BORNSTEIN – 099358
ERNEST GALVAN – 196065
THOMAS NOLAN – 169692
LISA ELLS – 243657
JENNY S. YELIN – 273601
MICHAEL S. NUNEZ – 280535
JESSICA WINTER – 294237
MARC J. SHINN-KRANTZ – 312968
CARA E. TRAPANI – 313411
ALEXANDER GOURSE – 321631
ROSEN BIEN
GALVAN & GRUNFELD LLP
101 Mission Street, Sixth Floor
San Francisco, California 94105-1738
Telephone: (415) 433-6830

Attorneys for Plaintiffs

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, et al.,

Plaintiffs,

v.

GAVIN NEWSOM, et al.,

Defendants.

Case No. 2:90-CV-00520-KJM-DB

DECLARATION OF ERNEST GALVAN IN SUPPORT OF PLAINTIFFS' RESPONSE TO DEFENDANTS' STRATEGIC COVID-19 MANAGEMENT PLAN

Judge: Hon. Kimberly J. Mueller

1 I, Ernest Galvan, declare:

2 1. I am an attorney duly admitted to practice before this Court. I am a partner
3 in the law firm of Rosen Bien Galvan & Grunfeld LLP, counsel of record for Plaintiffs. I
4 have personal knowledge of the facts set forth herein, and if called as a witness, I could
5 competently so testify. I make this declaration in support of Plaintiffs' Response To
6 Defendants' Strategic Covid-19 Management Plan.

7 2. This Court noted in the order of April 17, 2020 (Dkt. No. 6622) that
8 "defendants have provided plaintiffs and the Special Master a detailed list of all class
9 members with at least on COVID-19 risk factor." I am informed and on that basis believe
10 that the "detailed list" the Court referred to is a spreadsheet emailed by CDCR attorney
11 Nicholas Weber to the Special Master and counsel on April 7, 2020, titled "Coleman Class
12 Members with at least one COVID-19 Risk Factor.xlsx." The spreadsheet contains the
13 following column headings:

14–21

Institution
CDCNumber
FirstName
LastName
CellBed
MentalHealth Level of Care
COVID-19 Risk Factors

22

23 3. The "Coleman Class Members with at least one COVID-19 Risk
24 Factor.xlsx." contains entries for 17,825 class members.

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1 4. On March 23, 2020, and April 8, 2020, we also received from CDCR
2 counsel a PDF document titled "Institutional Bed Audit By Bed Program." This document
3 includes information regarding each housing unit, including design capacity, occupied
4 count and level of overcrowding, in the format illustrated below:
5

ASP - Avenal State Prison Male Only II PF

Facility Name	Housing Area Name	Facility Building ID	Type of Bed	Design Bed Count	Overcrowd Bed Count	Medical Bed Count	Total Capacity	Occupied Count	Empty Bed Count	O/C %
ASP-Facility A	110	A 110 1	270 Dorm	68	68	0	136	96	40	141%
		A 110 2	270 Dorm	62	62	0	124	97	27	156%
	120	A 120 1	270 Dorm	68	68	0	136	107	29	157%
		A 120 2	270 Dorm	62	62	0	124	99	25	160%
	130	A 130 1	Dorm	100	100	0	200	148	52	148%
	140	A 140 1	270 Cell	50	50	0	100	50	50	100%
		A 140 2	270 Cell	50	50	0	100	94	5	188%
ASP-Facility A Total				**460**	**460**	**0**	**920**	**691**	**228**	**150%**

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11 5. If the Institutional Bed Audit by Bed Program were produced in a sortable
12 Excel or .CSV spreadsheet rather than as a PDF, it could be efficiently married up with the
13 April 7, 2020 list of *Coleman* class members so that the parties could focus on
14 concentrations of vulnerable class members in already overcrowded units. On April 19,
15 2020, my colleague, Jessica Winter, asked CDCR Counsel for such a sortable version of
16 the Institutional Bed Audit. In the interim, I manually entered the Design Bed Count and
17 Occupied Count information into a working copy of the April 7, 2020 spreadsheet for
18 *Coleman* class members living in dormitories, and for EOP class members in dorm and
19 celled units. Due to the large number of celled units housing non-EOP *Coleman* class
20 members, it was not practicable to manually enter the capacity and occupancy data for
21 them. This gap can likely be filled, however, when we receive a sortable version of the
22 Institutional Bed Audit report.
23 6. Nevertheless, with the working copy of the April 7, 2020 spreadsheet that
24 includes the manually entered crowding information, it is possible to focus on particular
25 housing units based on the number of vulnerable *Coleman* class members housed there. In
26 all of the examples below, I believe that the housing information is substantially correct,
27 although there may be errors introduced by the manual entry process.
28

1 7. The April 7, 2020 spreadsheet identifies 3,566 *Coleman* class members at the
2 Enhanced Outpatient Level (EOP) level of care who have at least one COVID-19 risk
3 factor. Based on the Institutional Bed Audit data, approximately 846 of these EOP patients
4 live in dormitory settings. The snapshot of the data below shows that over 700 of these
5 patients are concentrated in twenty housing units, nine of which are overcrowded For this
6 and all subsequent tables, I am informed and on that basis believe that some of the
7 dormitory units listed below, such as those at VSP, SATF, RJD and MCSP, are subdivided
8 into smaller units, but are reported in the Institutional Bed Audit report as one unit.

9 **Table 1, Top 20 Dorms By Population of EOP Patients with At Least One COVID-19 Risk Factor (Sources:**
10 **April 7, 2020 *Coleman* class spreadsheet, April 7, 2020 Inst. Bed. Audit).**

Housing Unit	Design Capacity	Occupied Count	O/C %age	# of Persons
VSP-A 001 1 II EOP	128	157	123%	71
VSP-A 002 1 II EOP	119	158	133%	63
SATF-G 001 2 II EOP	96	120	125%	57
CCWF-B 508 1 EOP	48	44	92%	57
SATF-G 001 1 II EOP	80	93	116%	52
SATF-F 003 1 II EOP	80	113	141%	47
SATF-F 003 2 II EOP	96	132	138%	46
SQ-B 002 1 II EOP	100	92	92%	42
SQ-B 001 1 II EOP	100	90	90%	31
SATF-G 003 2 II EOP	48	64	133%	24
MCSP-D 018D1 II EOP	30	29	97%	22
RJD-E 023B1 II EOP	30	30	100%	21
SATF-G 003 1 II EOP	40	50	125%	21
RJD-E 023D1 II EOP	30	27	90%	21
RJD-E 023A1 II EOP	30	29	97%	20
MCSP-D 018B2 II EOP	36	34	94%	20
RJD-E 023C1 II EOP	30	28	93%	19
MCSP-D 018D2 II EOP	36	31	86%	19
MCSP-D 018A1 II EOP	30	26	87%	19
MCSP-D 018A2 II EOP	36	32	89%	18
RJD-E 023A2 II EOP	36	31	86%	18
Grand Total				**708**

26 8. Based on the Institutional Bed Audit data, approximately 2,689 EOP patients
27 with at least one COVID-19 risk factor live in celled housing. (This number and the EOP
28

1 dorm number above, 846, do not add up to the full 3,566 EOP patients because housing
2 unit information is missing for some patients in the April 7, 2020 spreadsheet.) The top 30
3 celled housing units for EOP patients with at least one COVID-19 risk factor are listed
4 below. The majority of these celled units are overcrowded.

5 **Table 2, Top 30 Celled Units By Population of EOP Patients with At Least One COVID-19 Risk Factor**
6 **(Sources: April 7, 2020 *Coleman* class spreadsheet, April 7, 2020 Inst. Bed. Audit).**

Housing Unit	Design Capacity	Occupied Count	O/C %age	# of Persons
CMC-D 007 3 II EOP	100	100	100%	60
CMC-D 007 2 II EOP	100	97	97%	55
CMC-D 008 3 III EOP	100	99	99%	48
MCSP-B 007 1 III EOP	50	84	168%	48
CMC-D 008 2 III EOP	100	98	98%	47
RJD-A 002 1 III EOP	50	72	144%	46
RJD-A 001 1 III EOP	50	73	146%	44
CMF-A M 2 II EOP	38	69	182%	43
RJD-C 015 1 IV EOP	50	57	114%	42
CMF-A N 3 II EOP	38	66	174%	41
RJD-A 001 2 III EOP	50	75	150%	41
CMF-A N 1 II EOP	37	57	154%	41
MCSP-A 005 1 IV EOP	50	64	128%	40
MCSP-B 006 1 III EOP	50	68	136%	40
CMF-A N 2 II EOP	36	69	192%	40
LAC-D 004 1 IV EOP	50	78	156%	39
CMC-D 008 1 III EOP	100	91	91%	39
LAC-D 003 1 IV EOP	50	73	146%	39
CMF-A M 1 II EOP	37	72	195%	38
COR-03AA004 1 II EOP	50	78	156%	38
LAC-D 002 1 IV EOP	50	56	112%	38
CMF-A L 2 II EOP	38	72	189%	38
RJD-C 014 1 IV EOP	50	67	134%	36
RJD-A 002 2 III EOP	50	85	170%	36
RJD-C 014 2 IV EOP	50	74	148%	35
RJD-C 015 2 IV EOP	50	60	120%	34
MCSP-B 006 2 III EOP	50	80	160%	34
COR-03AA004 2 II EOP	50	67	134%	32
CIW-A SCU 1 EOP	47	61	130%	32
KVSP-C 008 1 IV EOP	32	44	138%	30
CHCF-E 301B1 EOP	40	44	110%	30
Grand Total				**1244**

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1 9. The April 7, 2020 spreadsheet includes 13,408 persons at the Correctional
2 Clinical Case Management System (CCCMS) level of care with at least one COVID-19
3 risk factor. Approximately 5,202 of these CCCMS patients are identified as living in
4 dormitory housing. The top 30 dormitory units by number of CCCMS patients with at
5 least one COVID-19 risk factor are listed below. All but one are overcrowded.
6
7 **Table 3, Top 30 Dormitory Units By Population of CCCMS Patients with At Least One COVID-19 Risk Factor (Sources: April 7, 2020 *Coleman* class spreadsheet, April 7, 2020 Inst. Bed. Audit).**
8

Housing Unit	Design Capacity	Occupied Count	O/C %age	# of Persons
CCWF-B 507 1 GP	128	203	159%	63
CCWF-D 513 1 GP	128	207	162%	58
CCWF-D 514 1 GP	128	212	166%	58
CCWF-C 511 1 GP	128	216	169%	56
VSP-C 002 1 II PF	128	213	166%	55
CCWF-D 515 1 GP	128	216	169%	55
VSP-C 004 1 II PF	128	207	162%	53
CCWF-C 510 1 GP	128	226	177%	53
SATF-G 002 1 II EOP	80	148	185%	51
VSP-B 004 1 II PF	128	221	173%	50
VSP-D 004 1 II PF	128	201	157%	50
VSP-D 002 1 II PF	128	196	153%	49
CIM-A AH 1 Angeles	80	147	184%	48
SATF-G 002 2 II EOP	96	179	186%	47
VSP-D 001 1 II PF	128	223	174%	46
VSP-C 001 1 II PF	128	210	164%	46
VSP-D 003 1 II PF	128	209	163%	45
CIM-D EH 1 Elm	156	145	93%	44
VSP-B 001 1 II PF	118	188	159%	43
VSP-C 003 1 II PF	128	210	164%	43
VSP-B 003 1 II PF	128	217	170%	42
VSP-B 002 1 II PF	128	213	166%	41
CCWF-A 501 1 R/C	127	220	173%	39
CIM-D MH 1 Magnolia	100	131	131%	37
CCWF-C 509 1 GP	128	172	134%	36
CIM-A JH 1 Joshua	80	128	160%	35
CCWF-B 506 1 GP	128	158	123%	35
CCWF-A 502 1 R/C	128	224	175%	35
CIM-A CH 1 Cleveland	80	141	176%	34
CMF-A J 2 III PF	76	87	114%	34
Grand Total				**1381**

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10. The April 7, 2020 spreadsheet does not specify age or other risk factors in a way that allows a focused approach on those at greatest risk. All risk factors are listed in one text field, "COVID-19 Risk Factors," separated by commas, in a way that does not lend itself to analysis. On April 8, 2020, the *Plata* Receiver provided the Prison Law Office with a more complete spreadsheet that included all members of the *Coleman* class, their COVID-19 risk factors, housing locations, and types of housing. This spreadsheet was produced with the filename "20.04.08 PLO High Risk Population2.xlsx." This spreadsheet has the following column headings:

PID
CDCNumber
Institution
LastName
FirstName
Age
Gender
Medical Risk Level
Health Conditions
Other High Risk Factors
Pregnant
Race
Ethnicity
Facility
CellBed
BedType
BedSecurityLevel
ClassScore
Incarceration Date
Estimated Release Date
ReleaseType
CountyofCommitment
Mental Health Level of Care
In Mental Health Program in Last
TABE
DPP Codes
DDP Codes
CSRA
OffenseCategory
OffenseGroup
SexReg

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9
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11
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Sentence_Months
Substance_Abuse
Criminal_Thinking
Social_Isolation
Criminal_Personality
Anger
Educational_Problems
Employment_Problems
Criminal_Peers
Criminal_Opportunity
Leisure_Recreation
Financial
Residential_Instability

11. The April 8, 2020 Receiver's spreadsheet is much more effective for performing the granular review that the Court has directed because it includes housing factors such as BedType (either Dorm, 270 Dorm, 180 Cell, or Cell), and BedSecurityLevel, as well as separate columns for age, and the Receiver's four-level Medical Risk scale. Using the Receiver's data (coupled with the Institutional Bed Audit) it is possible to focus in on categories such as age. For example, below are the dormitory units that house EOP patients who are 65 and older.

Table 4, Dormitory Units By Population of EOP Patients Aged 65 or Older (Sources: April 8, 2020 Receiver spreadsheet, April 7, 2020 Inst. Bed. Audit).

DORMNAMES	Dorm Design Capacity	Dorm Occ. Count	O/C Percent	# of Persons
RJD-E 023D1	30	27	90%	10
RJD-E 023C1	30	28	93%	6
VSP-A 001 1	128	157	123%	5
SATF-G 001 1	80	93	116%	4
RJD-E 023B1	30	30	100%	4
MCSP-D 018D1	30	29	97%	4
CHCF-C 301B1	48	48	100%	3
SQ-B 001 1	100	90	90%	3
MCSP-D 018A1	30	26	87%	3
MCSP-D 018A2	36	32	89%	3
VSP-A 002 1	119	158	133%	3
CCWF-B 508 1	48	44	92%	3

DORMNAMES	Dorm Design Capacity	Dorm Occ. Count	O/C Percent	# of Persons
SATF-G 003 1	40	50	125%	2
CHCF-C 301A1	44	44	100%	2
MCSP-D 018C2	36	32	89%	2
RJD-E 023D2	36	32	89%	2
MCSP-D 018B2	36	34	94%	2
RJD-E 023A2	36	31	86%	2
RJD-E 023A1	30	29	97%	2
SATF-G 003 2	48	64	133%	1
CHCF-C 305B1	44	43	98%	1
RJD-E 023B2	36	36	100%	1
MCSP-D 018D2	36	31	86%	1
CHCF-C 306B1	44	44	100%	1
SATF-F 003 1	80	113	141%	1
MCSP-D 018C1	30	29	97%	1
SATF-F 003 2	96	132	138%	1
CHCF-C 304B1	44	40	91%	1
MCSP-D 018B1	30	29	97%	1
SATF-G 001 2	96	120	125%	1
Grand Total				**76**

12. Again using the Receiver's data, the table below shows the dormitory units containing the highest numbers of CCCMS patients aged 65 and older.

Table 5, Dormitory Units with CCCMS Patients Aged 65 or Older (Sources: April 8, 2020 Receiver spreadsheet, April 7, 2020 Inst. Bed. Audit).

DORMNAMES	Dorm Design Capacity	Dorm Occ. Count	O/C Percent	# of Persons
CIM-A AH 1 Angeles	80	147	184%	18
CMF-A J 2 III PF	76	87	114%	13
CIM-A CH 1 Cleveland	80	141	176%	12
CCWF-B 505 1 GP	119	53	45%	11
CIM-A JH 1 Joshua	80	128	160%	10
CMF-B DC 1 II PF	100	129	129%	10
VSP-B 004 1 II PF	128	221	173%	9
SOL-D 024 1 II GP	100	162	162%	9
SATF-G 002 1 II EOP	80	148	185%	9

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DORMNAMES	Dorm Design Capacity	Dorm Occ. Count	O/C Percent	# of Persons
CIM-A MH 1 Mariposa	80	132	165%	9
CMF-A J 3 III PF	76	108	142%	8
CIM-A BH 1 Borrego	80	141	176%	8
VSP-C 004 1 II PF	128	207	162%	8
CHCF-C 305A1 OHU	44	44	100%	8
CIM-D EH 1 Elm	156	145	93%	8
CHCF-C 305B1 OHU	44	43	98%	7
CHCF-C 304A1 OHU	44	43	98%	7
VSP-B 001 1 II PF	118	188	159%	7
CIM-A SH 1 Sequoia	80	134	168%	7
VSP-C 002 1 II PF	128	213	166%	7
CHCF-E 304A1 OHU	88	84	95%	7
CMF-A R 1 III PF	26	40	154%	7
CMC-F 020 1 II PF	45	86	191%	7
Grand Total				**206**

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13. The Receiver's April 8, 2020 spreadsheet includes the entire *Coleman* class, 35,979 individuals, as well as persons who have been in the Mental Health Services Delivery System (MHSDS) within the past year, plus non-*Coleman* class members identified with Medical Risk Levels of High 1 and High 2. Although the terms High 1 and High 2 are not defined in the spreadsheet, the Receiver's publicly available operations manual defined "High Risk" as including: "Chronic care of complicated, unstable, or poorly-controlled common conditions (e.g., asthma with history of intubation for exacerbations, uncompensated end-stage liver disease, hypertension with endorgan damage, diabetes with amputation). Chronic care of complex, unusual, or high risk conditions (e.g., cancer under treatment or metastatic, coronary artery disease with prior infarction). Implanted defibrillator or pacemaker. High risk medications (e.g., chemotherapy, immune suppressants, Factor 8 or 7, anticoagulants other than aspirin)." (Chapter 1.2.14, Appendix 1 (c)(3)(C), available at https://cchcs.ca.gov/wp-content/uploads/sites/60/HC/HCDOM-ch01-art2.14.pdf).

1 14. The Receiver's April 8, 2020 spreadsheet shows that of the 35,979 persons
2 identified as belonging to the *Coleman* class, 12,187 (34%) reside in dormitories, and
3 23,096 (64%) reside in cells. Three individuals are listed as residing in "Rooms", and the
4 remaining 693 class members have no housing identified in the spreadsheet.
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Table 6, Coleman Class Member Housing (Sources: April 8, 2020 Receiver spreadsheet, April 7, 2020 Inst. Bed. Audit).
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Housing	# of Persons	% of Persons
DORMS	**12,187**	**33.87%**
Dorm	11,163	31.03%
270 Dorm	1,024	2.85%
CELLS	**23,096**	**64.19%**
180 Cell	3,720	10.34%
270 Cell	9,401	26.13%
Cell	9,975	27.72%
Room	**3**	**0.01%**
Room	3	0.01%
	693	**1.93%**
	693	1.93%
Grand Total	**35,979**	**100.00%**

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17 15. The Receiver's April 8, 2020 spreadsheet allows the housing breakdown to
18 be filtered to show only those *Coleman* class members identified with Medical Risk Levels
19 High 1 and High 2.
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Table 7, Coleman High 1 and High 2 Medical Risk Level Housing (Sources: April 8, 2020 Receiver spreadsheet, April 7, 2020 Inst. Bed. Audit).

Housing	# of Persons	% of Persons
DORMS	**2,697**	**31.23%**
Dorm	2,594	30.04%
270 Dorm	103	1.19%
CELLS	**5,718**	**66.21%**
180 Cell	654	7.57%
270 Cell	2,000	23.16%
Cell	3,064	35.48%
Room	**1**	**0.01%**
Room	1	0.01%
	220	**2.55%**
	220	2.55%
Grand Total	**8,636**	**100.00%**

16. The Receiver's April 8, 2020 spreadsheet shows that approximately 7,319 persons identified as being Medical Risk Levels High 1 and High 2, including *Coleman* and non-*Coleman* class members, reside in dormitories.

Table 8, High 1 and High 2 Medical Risk Level Housing (Coleman and non-Coleman) (Sources: April 8, 2020 Receiver spreadsheet, April 7, 2020 Inst. Bed. Audit).

Housing	# of Persons	% of Persons
DORMS	**7,319**	**40.09%**
Dorm	6,639	36.37%
270 Dorm	680	3.73%
CELLS	**10,474**	**57.38%**
180 Cell	1,010	5.53%
270 Cell	3,788	20.75%
Cell	5,676	31.09%
Room	**5**	**0.03%**
Room	5	0.03%
	457	**2.50%**
	457	2.50%
Grand Total	**18,255**	**100.00%**

1 17. The Receiver's April 8, 2020 spreadsheet shows that the top twenty
2 dormitory housing units by number of persons with Medical Risk Levels High 1 and High
3 2, including *Coleman* class members and non-*Coleman* class members, includes 11
4 housing units at CIM, four at CMF, and four at Solano State Prison.

5 **Table 9, Top 20 High 1 and High 2 Medical Risk Level Housing Units (Coleman and non-Coleman) (Sources:**
6 **April 8, 2020 Receiver spreadsheet, April 7, 2020 Inst. Bed. Audit).**

DORMNAMES	Dorm Design Capacity	Dorm Occ. Count	O/C Percent	# of Persons
CIM-A BH 1 Borrego	80	141	176%	112
CIM-A SH 1 Sequoia	80	134	168%	111
CIM-A CH 1 Cleveland	80	141	176%	111
CIM-A LH 1 Laguna	80	138	173%	110
CIM-A MH 1 Mariposa	80	132	165%	109
CIM-A JH 1 Joshua	80	128	160%	99
CIM-A AH 1 Angeles	80	147	184%	98
CIM-A OH 1 Otay	80	130	163%	95
CMF-B DC 1 II PF	100	129	129%	92
CIM-D EH 1 Elm	156	145	93%	91
CMF-B DD 1 II PF	88	118	134%	84
CMF-A J 3 III PF	76	108	142%	70
CMF-A J 1 III PF	92	107	116%	70
CIM-D JH 1 Juniper	100	136	136%	66
CMF-A J 2 III PF	76	87	114%	61
SOL-D 024 1 II GP	100	162	162%	57
CIM-D SH 1 Spruce Hall	100	117	117%	56
SOL-C 016 1 II GP	100	167	167%	56
SOL-D 019 1 II GP	100	149	149%	55
SOL-C 015 1 II GP	68	103	151%	54
Grand Total				**1657**

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23 18. Filtering the same list of the top twenty dormitory housing units by number
24 of persons with Medical Risk Levels High 1 and High 2 to remove non-*Coleman* class
25 members changes the focus to a partly overlapping set of institutions shown in the table
26 below, including CIM and CMF, as in the overall list above, but adding CCWF, VSP,
27 SATF, CHCF, and MCSP.
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1 **Table 10, Top 20 Dormitory Units By Number of Coleman Class Member High 1 and High 2 Medical Risk Level Patients (Sources: April 8, 2020 Receiver spreadsheet, April 7, 2020 Inst. Bed. Audit).**

DORMNAMES	Dorm Design Capacity	Dorm Occ. Count	O/C Percent	# of Persons
CCWF-B 508 1 GP	48	44	92%	50
CIM-A AH 1 Angeles	80	147	184%	36
CIM-A JH 1 Joshua	80	128	160%	33
CIM-D EH 1 Elm	156	145	93%	33
CIM-A CH 1 Cleveland	80	141	176%	31
VSP-A 001 1 II EOP	128	157	123%	29
CMF-B DC 1 II PF	100	129	129%	29
CIM-A BH 1 Borrego	80	141	176%	28
CMF-A J 2 III PF	76	87	114%	28
CIM-A MH 1 Mariposa	80	132	165%	28
CIM-A LH 1 Laguna	80	138	173%	25
CCWF-B 505 1 GP	119	53	45%	25
SATF-G 002 1 II EOP	80	148	185%	24
SATF-G 001 1 II EOP	80	93	116%	24
CMF-A J 3 III PF	76	108	142%	24
CHCF-C 301B1 OHU	48	48	100%	24
CMF-A A 3 ICF	40	37	93%	24
CIM-A SH 1 Sequoia	80	134	168%	23
MCSP-D 018D1 II PF	30	29	97%	23
VSP-A 002 1 II EOP	119	158	133%	23
CHCF-C 304B1 OHU	44	40	91%	23
VSP-B 001 1 II PF	118	188	159%	23
CMF-A J 1 III PF	92	107	116%	23
Grand Total				**633**

21 I declare under penalty of perjury under the laws of the United States of America
22 that the foregoing is true and correct, and that this declaration is executed at San Francisco,
23 California this 20th day of April, 2020.

25 */s/ Ernest Galvan*
Ernest Galvan