ROB BONTA
Attorney General of California
MONICA N. ANDERSON
Senior Assistant Attorney General
DAMON MCCLAIN - 209508
Supervising Deputy Attorney General
RYAN GILLE - 262105
IRAM HASAN - 320802
Deputy Attorneys General
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 703-5500
Facsimile: (415) 703-58443
Ryan.Gille@doj.ca.gov

HANSON BRIDGETT LLP
PAUL B. MELLO - 179755
SAMANTHA D. WOLFF - 240280
LAUREL O'CONNOR - 305478
DAVID CASARRUBIAS - 321994
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
RITA LOMIO - 254501
RANA ANABTAWI - 267073
SOPHIE HART - 321663
LAURA BIXBY - 301148
1917 Fifth Street
Berkeley, California 94710
Telephone: (510) 280-2621
Facsimile: (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

Judge: Hon. Jon S. Tigar
Date: October 28, 2021
Time: 2:00 p.m.
Crtrm.: 6, 2nd Floor

The parties submit the following joint statement in advance of the October 28, 2021 Case Management Conference.

I. COVID-19 VACCINE

A. Patients

Plaintiffs' Position: As of October 26, 99% of CDCR's 99,345 incarcerated people had been offered vaccination against COVID-19, per the CCHCS Vaccine Registry.[1] 76,934, or 77% of the population, were fully vaccinated, and another 2,009, or 2%, had received a first dose. 19,328, or 20% of residents, had refused the vaccine.

CCHCS has also, as of October 22, identified approximately 14,000 patients eligible for a third or booster dose under current federal guidelines. These include approximately 3,200 immunocompromised patients who received two doses of an mRNA vaccine more than six months ago, and for whom a third dose was recommended in August. Essentially all these patients were offered a booster by mid-September; as of October 1 approximately 91% had accepted and received it. The remaining approximately 11,000 patients received two doses of the Pfizer vaccine more than six months ago, and thus are eligible for a booster pursuant to late September federal recommendations. Last week, it said it planned to offer a booster to all eligible Pfizer-vaccinated patients by October 31; as of October 22, CCHCS data indicated that more than 4,000 had been offered a booster.[2] We very much appreciate CCHCS's efforts.

Defendants' Position: Consistent with the most current public health guidance, CDCR/CCHCS issued a policy on August 20, 2021, regarding third booster doses of vaccine—just two days after the Centers for Disease Control and Prevention released its recommendation for administering booster shots. CDCR and CCHCS promptly started offering booster shots to eligible immunocompromised patients. CDCR and CCHCS have

[1] Those not yet offered are almost entirely either out-to-court (and thus housed in county jails) or new arrivals to CDCR Reception Centers.

[2] We anticipate that additional patients will be identified as eligible for, and offered, a booster given that on October 20 federal guidelines called for a booster for those who received the Moderna or Janssen vaccine.

since expanded booster-shot-eligibility criteria to include all non-immunocompromised patients who have received two doses of the Pfizer vaccine. According to data received from CCHCS on October 22, 7,195 currently eligible patients have been offered a booster shot, and 6,412 have accepted it.

Further, at the conclusion of the hearing on CCPOA's motion to intervene, counsel for the Receiver indicated that "we are developing a plan that we think effectively will require that all incarcerated persons becoming vaccinated, subject to religious and – and medical exemptions. That plan is still in development, but we will submit a plan to the court." (Oct. 14, 2021 Tr. at 15:24-16:3.) Defendants look forward to reviewing that plan with CCHCS prior to its submission to this Court.

B. Staff

Plaintiffs' Position: As of October 14, only 59% of prison staff statewide are fully vaccinated against COVID-19 (62% have received at least one dose). *See* Exhibit A to October 20, 2021 CCHCS Memorandum, attached hereto as Exhibit 1. The rates for custody staff are substantially lower: only 51% are fully vaccinated, with 52% having received at least one dose. *Id.*[3] Custody staff rates at a number of prisons are substantially lower than that. For example, at High Desert State Prison, a shockingly paltry 25% are fully vaccinated (27% have received a first dose); similarly, at Pelican Bay State Prison those rates are, respectively, 28% and 29%. *Id*.

On September 27, the Court ordered that Defendants implement the Receiver's recommendation requiring vaccination for all prison staff and certain incarcerated persons. Neither Defendants nor CCPOA, in opposing the order, disputed its public health basis, including that staff are the primary vector of infection, vaccination reduces the risk of infecting others, testing is an imperfect means to stop transmission, incarcerated people including the fully vaccinated remain at risk from COVID, and the August California

[3] That same document shows the fully / at least one dose vaccination rates for healthcare staff are 82%/85%; for administrative, maintenance and operations staff 67%/60%; and for contractor staff 37%/41%.

Department of Public Health vaccination requirement for certain prison staff leaves tens of thousands of the incarcerated at risk for exposure to infection from staff not required to be vaccinated.

The Court's order required the Receiver and Defendants to file a joint implementation plan by October 12. That plan as filed requires full vaccination by November 29. *See* ECF No. 3694 at 5. However, the Plan remains unimplemented. On October 20, the Receiver reported to the Court that Defendants have since refused to commit to the joint implementation plan, or to any date for implementation of the vaccination requirement, and requested the Court order the joint implementation plan (modified slightly to account for a delay in beginning implementation) be adopted. *See* ECF No. 3707. The Court has asked the parties to respond. We fully support the Receiver's request.

Defendants have filed a notice of appeal of the September 27 order, ECF No. 3693, and a motion to stay the order, ECF No. 3715.

As stated above, the California Department of Public Health (CDPH) in August mandated that all staff at two prions and certain staff at other prisons be fully vaccinated against COVID-19 by October 14, 2021. On October 21, CCHCS last week said this mandate applied to 20,229 staff. However, it did not provide the total number of such staff fully vaccinated, including because a then-existing state court order had temporarily restrained the CDPH mandate for California Correctional Peace Officer Association (CCPOA) members. The restraining order expired on October 22 and on that same date the state court denied a request by CCPOA members for a preliminary injection enjoining the CDPH mandate. CCHCS also informed us that staff subject to the CDPH mandate who are not fully vaccinated are required to wear N95 masks at all times when on prison grounds. We plan to ask how such staff will be identified each day and how the N95 mask requirement will be monitored.

Defendants' Position: Staff vaccination rates continue to improve. As of October

26, 65% of staff have at least one dose of the COVID-19 vaccine.

Plaintiffs are correct that Defendants did not dispute the Receiver's public health findings submitted in support of the August 4, 2021 Receiver's Report, however, the public health findings did *not* determine that "the August California Department of Public Health vaccination requirement for certain prison staff leaves tens of thousands of the incarcerated at risk for exposure to infection from staff not required to be vaccinated," as Plaintiffs misstate above. Nor could they, since the Receiver's Report, filed on August 4, 2021, predated the California Department of Public Health's (CDPH) orders pertaining to mandatory vaccination for prison staff. (*See* ECF No. 3657.) And, while Defendants agreed with the public health findings regarding COVID-19 that were included in the Receiver's report, Defendants were clear that they "do not agree with the conclusions the Receiver drew from these findings, namely, that the 'only method to ensure adequate protection and care for incarcerated persons is' to vaccinate all prison staff." (ECF No. 3660 at 19:23-20:2, *citing* ECF No. 3638 at 5.)

Moreover, as Defendants indicated in their Reply to the Order to Show Cause Re: Receiver's COVID-19 Vaccine Policy and at the September 24, 2021 hearing, neither Plaintiffs nor the Receiver submitted *any* evidence establishing that it is safer for an unvaccinated patient to be surrounded by vaccinated persons, rather than for that patient himself to be vaccinated; this fact has not and cannot be disputed. (*See* Defs. Reply re: Order to Show Cause re: Receiver's COVID-19 Vaccine Pol'y ("Defs.' Reply"), ECF No. 3673, at 12:23-28 ("the public health findings cited in the Receiver's report fail to support Plaintiffs' position that vaccinating *staff* is the *only* way to keep the incarcerated population safe from the threat of COVID-19 … Plaintiffs' position ignores not only the numerous layered safety measures that CDCR has implemented and enforces, but also the most direct means available of ensuring adequate safety of the incarcerated population—vaccinating all incarcerated people"), 13:20-22 ("Neither Plaintiffs nor the Receiver cite any public health guidance that identifies or supports such a strategy [of vaccinating those

who work near incarcerated persons] as providing more protection than the vaccination of all incarcerated people."); ECF No. 3686 (Sept. 24, 2021 Tr.) at 26:23-27:1 ("I don't think that there is any public health finding that says that a person who is unvaccinated is more safe if everybody around them is vaccinated than if he or she were vaccinated"), 29:22-30:1 ("the State is not disputing those public health findings. They are disputing the conclusion that the only way to protect … vaccinated and unvaccinated residents -- is to mandate vaccines for 40,000 employees on the record in front of it").)

Plaintiffs parrot the Receiver's improper and incomplete assertions in his October 20 filing, including that "Defendants have since refused to commit to the joint implementation plan, or to any date for implementation of the vaccination requirement." This statement omits half the story. Defendants already advised the Court on October 15 that "the deadlines set forth in the October 12, 2021 plan are no longer achievable and Defendants request clarification from this Court as to what deadlines, if any, now apply." (ECF No. 3703 at 3.) Moreover, and prior to the Receiver's October 20 filing, a Kern County Superior Court had specifically restrained the State from implementing a portion of its plan. (*See* Defendants' Request for Clarification, ECF No. 3703.) In response, the Court ordered Defendants and the Receiver to meet and confer over the timeframe for implementing the Court's September 27, 2021 order, and gave them 13 days to do so. The Court requested an update on those efforts at the next case management conference on October 28, 2021. (ECF No. 3705.) Defendants were in the process of meeting and conferring with counsel for the Receiver on implementation dates as instructed when the Receiver unilaterally terminated the discussions and filed a one-sided proposed order. (ECF No. 3708.)

Since that time, the Kern County Superior Court's temporary restraining order preventing implementation of the plan with respect to Bargaining Unit 6 employees specified in the August 19 CDPH Order has terminated, and the court subsequently denied CCPOA's request for a preliminary injunction. (*See* ECF No. 3710 at 4:20-25.) And as

stated in Defendants' Response to the Receiver's Report of Meet and Confer on Implementation Plan ("Defendants' Response"), Defendants explained to the Receiver's counsel that, in the absence of a court order mandating implementation of the vaccine plan by a date certain, the State could not unilaterally implement the plan and ignore the notice provisions and bargaining requirements set forth in applicable contracts between CDCR and the affected unions. (ECF No. 3710 at 3:18-24.) CDCR is therefore presently required to meet and confer with the affected unions per the terms of their contracts. (*Id.* at 3:21-22.) While the Receiver's unilateral termination of the meet-and-confer process unnecessarily halted implementation efforts, Defendants are prepared to proceed with implementation while complying with their bargaining obligations under state law prior to implementation. (ECF No. 3710 at 13-17.) Defendants and the Receiver restarted discussions on October 25, and Defendants remain hopeful that they will work out an implementation timeline that takes into account the reality of Defendants' obligations to its employees. With CCPOA's October 25, 2021 filing, however, the union contends that there must be meaningful time for bargaining over the effects of the plan before the plan may be implemented. (ECF No. 3712 at 3.) This position complicates Defendants' and the Receiver's efforts to reach agreement as to implementation deadlines, but counsel for the Defendants and Receiver are continuing to meet and confer.

II. VENTILATION

Plaintiffs' Position: The Receiver told a legislature committee in February, "If the coronavirus were designing its ideal home it would build a prison." *See* ECF No. 3548 at 7:10-12. One reason that's so is because the virus spreads by airborne aerosols and almost everyone in prison lives in crowded and poorly ventilated common air space housing units in which masks cannot be and are not worn for hours at a time, such as during hours of sleep. Most housing units have very little if any natural ventilation (if there are windows they almost always do not open). The electric mechanical ventilation systems at almost all prisons are designed to, in the heating mode, recirculate some portion of the air back to and

through each housing unit. Further, as described below, a good number of these ventilation systems do not work as designed, and need repair.

In sum, those who live and work in the units face significant risk of airborne transmission of COVID-19. A March 2021 report by independent experts CalPROTECT,[4] regarding a December 2020 review at the California Substance Abuse Treatment Facility and State Prison (SATF), identified "ventilation and air circulation" as a "key vulnerability related to COVID-19 control." Substance Abuse and Treatment Facility (SATF) Corcoran Site Visit Report**,** March 5, 2021, attached hereto as Exhibit 2, at 22. The report documented several concerns: wildly varying but generally relatively low air exchange rates between housing units; the use of inadequate filters; and the lack of routine maintenance (resulting in, among other things, inoperative exhausts, variable airflows, and unintended pressurizations leading to what it termed potential infection scenarios). *Id*. at 24-30.

Months ago, Defendants acknowledged that housing unit ventilation "plays a role in the health" of those incarcerated or who work in CDCR prisons. ECF No. 3566 at 19. CDCR thus at the end of 2020 undertook a project to install, where possible, MERV-13 filters for recirculated air in housing units, which as stated above is used during cold weather months. According to October 15 information from CDCR, all prison housing units Air Handling Units (AHUs) now have MERV-13 filters installed except for: (1) six prisons at which AHUs do not recirculate air; (2) two prisons which cannot accommodate MERV-13 filters due to system design (MERV-11 filters have been installed in one and are on order for the other); (3) two prisons at which the estimated installation of MERV-13 filters is said to be, respectively, October and November, 2021; and two (of 24) housing units at one prison, with the status of installation in those units not stated. The MERV-13

[4] CalPROTECT is a multidisciplinary team of experts in public health, medicine and infectious disease, behavioral science, environmental engineering, and economics from AMEND at UC San Francisco and UC Berkeley Schools of Public Health and Public Policy. *See* https://amend.us/calprotect.

filters must be promptly installed at the prisons and housing units that can use them. CDCR and CCHCS must monitor to determine whether the filters reduce the risk of airborne transmission during cold weather months.

CDCR also undertook in March a project to inspect and evaluate all housing unit ventilation systems, "focusing on whether the airflow is working the way it is supposed to." ECF No. 3566 at 20:2-4. An Executive Summary of the inspections and evaluations, and a "Summary of Performance Measures" were finally provided on August 31, and are attached as Exhibit 3. Shortly thereafter, CDCR provided additional data, and last month arranged an hour meeting with its headquarters person in overall charge of the project.[5]

CDCR, per the information provided, inspected and took measurements of all housing unit Air Handling Units (AHUs) and a small subset of cell and dorm air supply vents. Many serious problems were identified. The "Summary of Performance Measures" shows that the airflow of nearly one-third of AHUs was below 90% of design specifications.[6] At six prisons, nearly three-quarter or more of the AHUs failed to meet that standard, including two at which more than 90% failed to meet that mark. The data further shows that at four prisons, well under 20% of the airflow measurements taken at cells or dorms were at least 90% of design specifications, and at six other prisons only 50% to approximately 70% of measurements met that standard. In sum, CDCR's inspections and evaluations showed a need for repair or replacement of many housing AHUs and ventilation systems.

Despite these findings, CDCR has no overall program to repair or replace substandard AHUs or other ventilation system problems. The Executive Summary merely states that headquarters staff will assist in "prioritizing" repairs, but it was made clear during a October 5 discussion that any decision as to whether and when to make any repair

[5] The CDCR Director of Division of Facility Planning, Construction and Management.

[6] The data shows a total of 1,042 AHUs with airflow at least 90% of design were said to have airflow of at least 90% of design specifications and 490 which do not; 104 AHUs were pending airflow measurement.

has been left to each individual prison. While CDCR Facility Planning, Construction and Management Division (FPCM) have made visits to some of the prisons "to review repair procedures and priorities," there is no requirement that any repair be made, by any date. There are no plans to even ask if repairs have been completed, let alone a plan for post-repair inspections, airflow measurements, and evaluation.

We continue to believe that CDCR must assess not only whether AHUs are functioning as designed, but whether residents are safe from airborne spread of COVID-19 at current population levels (and, if not, what population each housing unit could safely support), so that CDCR can be better prepared in the event of a vaccine-evading variant or emergence of a similar airborne disease. *See* ECF No. 3592 at 15-17. In August, CCHCS said that CalPROTECT had completed visits and reviews, including we believe regarding housing unit ventilation, at 11 additional prisons in the first six months of this year. CCHCS said that CalPROTECT would provide a report regarding its site visits at the end of this year. We are hopeful this review will provide a more comprehensive assessment of the risk of airborne spread in CDCR's housing units.

Defendants' Position: CDCR has undertaken a significant effort to install MERV-13 filters in all appropriate housing units. As of October 15, 2021, Defendants have installed higher efficiency MERV-13 air filters in 602 housing units; only 29 others are still awaiting replacement. Eighty-nine additional housing units are served by AHUs that do not recirculate any interior air, so MERV-13 filters are unnecessary in those units. And 33 other housing units are served by AHUs that did not operate properly with MERV-13 filters installed, and required a lower efficiency filter such as a MERV-11.

Plaintiffs note above that "[t]he 'Summary of Performance Measures' shows that the airflow of nearly one-third of AHUs was below 90% of design specifications, and suggest that "CDCR's inspections and evaluations showed a need for repair or replacement of many housing AHUs and ventilation systems." It is important to understand, however, that there are two primary factors that determine the design specifications for a housing

unit AHU: (1) code requirements for minimum airflow (based on the floor area of the building and the number of occupants), and (2) the volume of airflow necessary to maintain the building's interior air temperature (normally driven by the type of AHU, the volume of exhausted air, and the exterior temperatures at the location). The volume of airflow needed to maintain interior temperatures is always larger than the code requirements for airflow. While the calculation will vary based on the building size and the AHU, an example from a 270-design cell housing unit at SATF indicates that approximately 2,000 Cubic Feet per Minute (CFM) of airflow is required by code and the AHUs serving that building are designed to produce 24,000 CFM of airflow. Due to the code required airflow being a smaller amount than the airflow needed to maintain temperature, an AHU that is performing below design specifications is likely still meeting code requirements but may be having difficulty in maintaining indoor air temperature during peak hot or cold weather events.

AHUs performing below the 90% level are one indicator that the institutions should perform preventive and reparative maintenance for these units. A poor performing AHU may not be maintaining appropriate interior temperature; repair requests for AHUs are normally generated by the building's inhabitants due to the interior temperature being too hot or too cold. Prison housing unit AHUs are operating 24/7 and in some extreme climatic zones within California. Given these operating conditions and the age of many of the AHUs, it is not surprising that repairs (or in extreme cases, replacement) are necessary in some instances.

Plaintiffs are mistaken that "CDCR has no overall program to repair or replace substandard AHUs or other ventilation system problems." CDCR's program for AHU repair or replacement is not a separate program but is a component of the larger maintenance program at each prison. AHU repairs are conducted by Plant Operations throughout the year based on either notification from the building's occupants that it is too hot or too cold, or based upon conditions identified during preventive maintenance. If

conditions are such that repair is not feasible or unlikely to improve the AHU's operation, prisons will utilize their facility maintenance budget for replacement of the AHU.

While Plaintiffs are correct that decisions as to whether and when to make repairs is within each institution's discretion, CDCR headquarters is heavily involved with setting expectations and providing assistance. The Division of Adult Institutions (DAI) discussed the inspection results at a Warden's meeting on September 1, 2021, emphasizing the need to address AHU performance issues. DAI will continue to emphasize these repairs at subsequent Warden's Meetings and during mid-year fiscal reviews. Facility Planning, Construction and Management Division (FPCM) staff have conducted conference calls with prison Plant Operations' staff dating back to July 2021 discussing inspection results and repair priorities. Beginning in September 2021, FPCM staff have been performing site visits specifically regarding ventilation to review repair procedures and priorities with Plant Operations staff. As of October 23, 2021, 17 of these site visits have occurred.

III. COVID-19 MONITORING

Plaintiffs' Position: Earlier this month we received information that at Wasco State Prison wheelchair users not known to have or to have been exposed to COVID-19 were being brought for showers into a unit housing those on quarantine due to exposure to others with active COVID-19, and, even more concerning, into an isolation unit housing those known have active COVID-19. On October 13, we asked CCHCS and CDCR whether this was true, and if so, to stop the practice because it wrongly risked infection of the people concerned. On October 20, CDCR responded, acknowledging that those not known to have been exposed to COVID-19 were brought into a quarantine unit for showers, but not addressing the question about people being brought into the isolation unit. We again asked for a response to that question. On October 21, CDCR replied, refusing to acknowledge whether disabled people had been brought into an isolation unit to shower, but stating that effective October 14 – the day after our initial query – the disabled people in the unit we said had been being brought to a COVID-19 isolation unit for showers were

brought to an entirely different building to shower. That CDCR staff, more than 18 months into the pandemic, could expose vulnerable people to the risk of COVID-19 infection in the way that occurred at Wasco bespeaks indifference to, or an inability to understand and implement, the most basic safeguards necessary when housing known active or suspected COVID-19 patients.

Defendants' Position: On October 13, 2021, Plaintiffs indicated they had received reports of wheelchair-using patients not on quarantine or isolation at Wasco being brought into quarantine and isolation spaces to use wheelchair-accessible showers. They referenced reports of wheelchair-using patients housed in Buildings B1 and B6, A-side, being brought to the B-side (quarantine in B1, and isolation in B6) for showers. Plaintiffs asked: "Can WSP confirm whether wheelchair-using patients are being brought into isolation and quarantine spaces in order to use wheelchair-accessible showers? If so, is this practice permitted by current policies on quarantine and isolation? Rather than unnecessarily exposing these patients by bringing them to isolation and quarantine spaces, are there alternative wheelchair-accessible showers that can be used? Or can these patients be moved elsewhere in the institution to more safely and easily access wheelchair-accessible showers?"

Defendants responded on October 20, 2021, and stated the following, in part:

> The B-side of FBB1, is currently used as intake for inmates as well as overflow for inmates with Americans with Disabilities Act (ADA) requirements, but is not a designated quarantine unit. We do not have cells for permanent wheelchair users (DPW) on the A-Side of any of our buildings. As a result, this inquiry is specifically related to intermittent wheelchair users (DPO).
>
> Upon review, it was discovered that the B-side of FBB1 was utilized last week to accommodate contact quarantine overflow when our designated quarantine building (Facility B Building #5) was at capacity. However, as of October 14, 2021, the remaining contact quarantine inmates were moved back into the designated quarantine building as space became available. Prior to last week, it was the practice of WSP-RC staff to bring DPO designated inmates from FBB1, A-side to FBB1, B-side to shower in order to ensure access to architectural accommodations including a shower ramp, shower

> chair, grab bars and a shower hose with shower wand. After the contact quarantine inmates were placed on the B-side of FBB1, staff continued to provide showers in this manner but cleaned and disinfected the showers in between each use. DPO-designated inmates are no longer brought into quarantine spaces to shower.

Plaintiffs' counsel responded the evening of October 20, 2021, and advised that the above response did not address their questions about Building 6, and asked further follow up questions related to the institution's practices relating to showering for wheelchair-bound patients in Building 6. Defendants responded the next day and advised "[t]here was a clerical error that occurred and the last response from WSP was missing." Defendants further explained:

> Per the direction of the Facility B Captain, effective Thursday, October 14, 2021, all DPO inmates housed in FBB6, A-side were to be escorted to FBB4, B-Side for showers. This direction was in effect until Monday, October 18, 2021, when contact quarantine inmates housed in FBB1, B-Side came off of quarantine and were re-housed elsewhere. Once FBB1, B-Side was emptied and sanitized, all DPO/DPW/DPM inmates housed in FBB6, A-Side were moved to FBB1, B-Side.
>
> FBB1, B-Side is currently used as intake for inmates as well as overflow for inmates with Americans with Disabilities Act (ADA) requirements, but is not a designated quarantine unit.
>
> Per Warden (A) Shirley, effective Monday, October 18, 2021, all Reception Center DPO/DPW/DPM inmates, will be housed in FBB1, B-Side, where there are 4 DPW cells and the building is designated for ADA. Once the DPO/DPW/DPM inmates are released from the 14 day quarantine, any who can be housed in dorms will be moved to dorms. Any who are not dorm qualified will remain in FBB1, B-Side until transferred.
>
> It should be noted FBB4, A-Side shower has been retrofitted with hand rails and a wheelchair ramp in order to house DPO/DPW/DPM inmates, however, WSP-RC is still awaiting approval from Plaintiff Attorneys in order to utilize this housing unit for ADA housing.

Thus, contrary to Plaintiffs' assertions above, Defendants did not refuse to answer any question. Moreover, Plaintiffs' accusations of "indifference to, or an inability to understand and implement, the most basic safeguards necessary" are unhelpful and

inaccurate. Mistakes can occur in a system the size of CDCR's, but to accuse Defendants of deliberate indifference for correcting a mistake immediately upon discovery does not demonstrate a reckless disregard.

IV. INTEGRATED SUBSTANCE USE DISORDER TREATMENT (ISUDT)

Plaintiffs' Position: As recently reported by the Receiver (*see* ECF 3668 at 10[7]), more than 12,000 incarcerated persons now receive Medication Assisted Treatment (MAT) for substance use disorders, typically opioid addiction. This number represents an approximately five-fold increase since the pandemic began in March 2020. We very much appreciate the efforts of CCHCS over the last 18 months to make MAT more widely available. We continue to believe the ISUDT program including MAT is necessary for adequate care, reduces morbidity and mortality, and changes many lives for the better.

For the Court's information, we have three main concerns regarding ISUDT which we have recently raised with CCHCS. First, there continues to be a large backlog of patients pending an initial addiction medicine provider appointment, which is necessary to begin MAT. As of 9/27/21, approximately 4,000 initial appointments were pending, with approximately 3,000 of those overdue, including about 600 ordered more than six months ago. CCHCS has implemented strategies to reduce this backlog, but "anticipates" it will not be "sufficiently addressed" until July 2022, perhaps sooner at some prisons. We continue to monitor these efforts, and when appropriate ask CCHCS to consider starting treatment immediately for particularly at-risk patients with pending initial appointments.

Second, group counseling and other non-MAT interventions continue to be unavailable for many ISUDT patients, including because of COVID-related precautions and restrictions. Data recently provided by CCHCS data shows that only about 60% of MAT-prescribed patients receive in-person groups or what is called "packet programming" (written handouts). Further, it was reported that more than 500 patients who had been receiving in-person groups or handouts were not able to get it due to COVID-related

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[7] The page reference here is to the ECF pagination.

quarantines. More broadly, we are concerned whether sufficient space and staff can be marshaled to provide in-person groups for the 12,000 current ISUDT patients then the 16,000 or more who eventually will be enrolled in the program. We will follow-up with CCHCS regarding these matters.

Finally, we are concerned about efforts to link MAT patients with MAT care in the community after parole or release. The Receiver recently reported (*see* ECF 3668 at 12) that just over 600 MAT-prescribed patients had been successfully linked to community providers upon release. That is greatly appreciated and important, but information received from CCHCS last week stated that nearly 450 such patients during this same period were released without being liked to a community provider. We will follow-up with CCHCS regarding the latter patients, including what might be done to increase the number of released patients with community providers.[8]

Defendants' Position: Defendants will continue to work closely with CCHCS in providing this critical and life-saving treatment to the incarcerated population and defer to CCHCS regarding its response to Plaintiffs' inquiries above.

V. PLAINTIFFS' RECENT SITE VISITS

A. Salinas Valley State Prison (SVSP) and California Medical Facility (CMF) Psychiatric Inpatient Programs

Plaintiffs' Position: On September 27, we wrote the Receiver and CCHCS regarding medical care in the Psychiatric Inpatient Programs (PIPs), based largely on site visits to those programs at Salinas Valley State Prison and California Medical Facility conducted, respectively, in June and July. As we explained, we believe there are major problems with medical care in those programs, including: inconsistent scheduling practices; no use of sick-call slips and a lack of standardized nurse triage practices; lack of

[8] CCHCS also confirmed last week that its policies provide for all MAT-prescribed patients to receive a 30-day supply of medication when paroling or released to community supervision, unless they are receiving Methadone, in which case they are referred to a Narcotics Treatment Program in the county in which they are released.

clear guidelines for follow-up with chronic care patients, many of whom could go months without provider encounters; and a lack of follow-up for patients said to have refused medical services.

We understand CCHCS is in the process of instituting a pilot program – the Specialized Beds Complete Care Model – to address certain deficiencies it identified in PIP care. The primary feature of the pilot is a daily group huddle between medical, mental health, and custody staff, and more communication between staff on different shifts. We appreciate this pilot, but as designed, it does not appear to address all deficiencies we reported.

As explained in our letter to the Receiver and CCHCS, we believe PIPs should be considered outpatient settings for purposes of medical care. This would mean medical staff in those units would be required to follow the same timeframes regarding appointments and care as their outpatient counterparts. This would, in our view, promote better continuity of care, and reduce the chance of patients not being seen by medical staff or receiving necessary care for months. As an alternative, we suggested the development of a Patient Registry for the PIPs that would track and require medical encounters take place for every patient in the PIP within a minimum time frame, e.g. every 30 days for chronic care patients and every 90 days for all other patients, or more often as needed.

We look forward to discussing our report and findings with CCHCS.

Defendants' Position: Defendants defer to CCHCS and its determination as to how best to address the issues Plaintiffs identify above. In addition, Defendants note that CMF has an ongoing initiative to ensure that PIP patients are seen timely for episodic and chronic care. CMF leadership is monitoring and actively engaging with PIP line staff in ensuring that PIP patient follow-ups are timely and scheduled in CERNER.

B. Substance Abuse Treatment Facility and State Prison, Corcoran (SATF)

Plaintiffs' Position: In August, Plaintiffs' counsel conducted a remote site visit, including phone interviews with patients and a video meeting with staff, at SATF. We requested this visit due to our growing concerns about staff misconduct at SATF. In May,

Plaintiffs' counsel in *Armstrong* sent CDCR and CCHCS a letter documenting deeply concerning social media posts by SATF medical staff, celebrating the brutal killings of disabled incarcerated people there. *See* ECF No. 3266 at 16, 75-78, Joint Case Status Statement, *Armstrong v. Newsom*, Case No. 4:94-cv-02307-CW (N.D. Cal. May 17, 2021). During a May 2021 *Armstrong* monitoring visit, counsel also heard and shared with CDCR and CCHCS reports of medical staff belittling patients and dismissing their concerns.

Unfortunately, the accounts we received during our interviews in August were consistent with those concerns. We heard numerous reports of dismissive and unprofessional behavior from nursing staff when people came to the clinic to obtain medications, request incontinence supplies, or otherwise seek help. For example, we heard reports of nurses telling patients to "get out of here" when they came to the clinic to request incontinence supplies, taunting patients when they requested medical grievances, giving patients too-small incontinence briefs and condom catheters and dismissing them when they asked for the appropriate size, and so frequently dismissing patients who requested hearing aid batteries that patients had begun severely restricting use of their hearing aids. We were also told by multiple patients that nurses will frequently inappropriately threaten people with or directly issue unwarranted Rule Violation Reports (RVRs). When we raised the issue with medical leadership at SATF during the site visit, they reported that they were not aware of any RVRs being issued by medical staff. However, according to documents produced by Defendants after the remote visit, medical staff at SATF issued 61 RVRs to patients between January 1, 2021 and August 17, 2021. All were issued by nursing staff, and four specific nurses were responsible for issuing 46 out of the 61 RVRs.

We raised these concerns with medical staff during a call on August 13, 2021, after our interviews, and in a written report on October 8, 2021. We appreciate the stated commitment of CCHCS Headquarters staff, the Regional Healthcare Executive, and the SATF CEO to addressing these issues. During our call on August 13, we were told: (1) the

CEO was following up personally with patients who had been the subject of advocacy letters from our office; (2) the nurses who had been identified as the authors of the social media posts had been placed on leave; (3) supervising registered nurses (SRN) had been directed to attend all IAC meetings; and (4) medical leadership had reiterated expectations of professionalism to clinic staff.

We appreciate these efforts, and hope to see substantial improvements at SATF at our next visit. Given the scope of the problems at SATF, however, we believe SATF will need to do more to create sustainable change. We encouraged leadership to identify a strong SRN and assign that person to the yard we identified as most problematic, and to require all SRNs spend more time in the medical clinics, supervising and modeling positive interactions with patients. We also encouraged leadership to proactively seek out confidential feedback from patients, especially those who have frequent interactions with medical staff. Finally, we requested CDCR and CCHCS review each of the 61 RVRs issued by medical staff at SATF, to determine whether any should be rescinded, and to specifically investigate the four nurses responsible for issuing 75% of the RVRs for misuse of the disciplinary process.

We plan to conduct another site visit to SATF soon to assess CDCR and CCHCS's efforts to address these problems.

Defendants' Position: Defendants are informed by CCHCS that SATF nursing leadership has addressed the SRN leadership functions and is implementing a plan to address leadership issues. The SATF CEO reviewed the 61 RVR's referenced by Plaintiffs and determined that all were appropriate and none should be rescinded. The nurses listed in the RVRs did submit their written findings (variance reports) of patient behaviors to custody, the custody review process for RVRs was followed at SATF, and the patient RVRs were subsequently issued through the custody RVR process. But as an additional precaution, the SATF Chief Nursing Executive is reviewing the nurses with the most frequent variance reports to custody. Additionally, SATF is continuing to conduct weekly

tours on all three watches and interacting with incarcerated persons in an effort to receive additional feedback.

DATED: October 26, 2021

HANSON BRIDGETT LLP

By: */s/ Samantha Wolff*
PAUL B. MELLO
SAMANTHA D. WOLFF
LAUREL O'CONNOR
DAVID C. CASARRUBIAS
Attorneys for Defendants

DATED: October 26, 2021

ROB BONTA
Attorney General of California

By: */s/ Iram Hasan*
DAMON MCCLAIN
Supervising Deputy Attorney General
RYAN GILLE
IRAM HASAN
Deputy Attorneys General
Attorneys for Defendants

DATED: October 26, 2021

PRISON LAW OFFICE

By: */s/ Steven Fama*
DONALD SPECTER
STEVEN FAMA
ALISON HARDY
SARA NORMAN
RITA LOMIO
RANA ANABTAWI
SOPHIE HART
LAURA BIXBY
Attorneys for Plaintiffs