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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

OAKLAND DIVISION

MARCIANO PLATA, et al.,

Plaintiffs,

v.

GAVIN NEWSOM, et al.,

Defendants.

CASE NO. 01-1351 JST

JOINT CASE MANAGEMENT CONFERENCE STATEMENT

Judge: Hon. Jon S. Tigar
Date: February 16, 2022
Time: 9:30 a.m.
Crtrm.: 6, 2nd Floor

The parties submit the following joint statement in advance of the February 16, 2022 Case Management Conference.

I. UPDATES REGARDING THE CURRENT COVID-19 OUTBREAK AND CDCR AND CCHCS'S COVID-19 RESPONSE

Plaintiffs' Position: Large COVID outbreaks continue in many prisons, with thousands of patients statewide isolated due to active infections or quarantined for exposure.[1] In recent weeks three incarcerated people and one staff member have died from COVID. The 15-day statewide modified program or lockdown imposed on January 9 because of widespread staff shortages and to hopefully limit the spread of the virus was twice-extended before ending on February 13. During that time, medical care was generally limited to essential services, and many appointments were postponed or canceled. That remains so even with the end of the statewide modified program, as all prisons currently are in Phase I of the CDCR / CCHCS RoadMap to Re-Opening, in which medical care is similarly restricted. It will take at least approximately one month before a prison can resume full programming, if there are no further outbreaks. In that regard, CCHCS data shows that large numbers of new cases continue to be identified, though fewer now than in previous weeks.

Most fundamentally, the massive current outbreak shows, again, the extreme vulnerability of CDCR-incarcerated people, and the prisons' medical delivery system, to the air-borne coronavirus. As the Receiver stated last year, "If the coronavirus were designing its ideal home, it would build a prison."[2] During this wave, twelve prisons

[1] As of February 9, nearly 3,000 patients with active COVID cases were on isolation, and approximately 23,400 others were quarantined, according to CCHCS data publicly posted or made available to us; even larger numbers of people had been isolated or quarantined each day for the previous three weeks.

[2] *See* Assembly Budget Subcommittee No. 5 on Public Safety, Monday, Feb. 8, 2021, available at https://www.assembly.ca.gov/media/budget-subcommittee-5-public-safety-20210208/video [at 1:38:25 et seq.].

experienced outbreaks in which more than 400 patients tested positive for COVID-19.[3] Thousands more patients were placed on quarantine at those prisons. In many cases the isolated and quarantined patients far surpassed the number of beds those prisons had previously set aside for COVID-19 isolation and quarantine purposes.

Mandating staff vaccinations is necessary to reduce the risk of infections and to reduce the frequency and breadth of outbreaks (and the consequent interruption of prison operations, including medical services). The State should also reduce the prison population to reduce crowding, so as to protect the particularly vulnerable, limit the number infected, and protect the medical delivery system. These actions are especially necessary now, given the possibility of future variants that may be more virulent and more contagious than prior variants.

Defendants below emphasize the low hospitalization rate among incarcerated persons, and assert without citation that "[t]his is undoubtedly the result of CCHCS's and CDCR's vaccination program and their efforts to provide vaccination boosters to the incarcerated population." Medical science, however, suggests that less severe disease among populations during the Omicron wave results from the variant's markedly reduced virulence as well as increased immunity brought about both by previous infections and vaccination—and that, as stated above, it is not known whether the next variant will induce more severe disease.[4]

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[3] According to CDCR's tracker, the following prisons reported outbreaks of at least 400 patients in January or February of this year: ASP, CCWF, CIM, CRC, CVSP, FOL, NKSP, MCSP, SCC, SATF, SQ, and WSP. *See* Cal. Dep't of Corr. & Rehab., *Population COVID-19 Tracking, CDCR Patients: COVID-19 By Institution*, https://www.cdcr.ca.gov/covid19/population-status-tracking/ (last accessed Feb. 9, 2022).

[4] *See* Alex Sigal, *Milder disease with Omicron: is it the virus or the pre-existing immunity?*, 22 Nature Review Immunology 69-71 (2022), at https://www.nature.com/articles/s41577-022-00678-4 ("Lower viral pathogenicity and higher population immunity do not have to exclude one another. Most likely both play a part in what is by now clear: Omicron leads to less severe disease at the population level.

Defendants below also assert that the hospitalization rate among CDCR incarcerated people during the Omicron wave is significantly lower than that among the general California population. However, CCHCS only reports patients hospitalized "for" COVID, using strict definitions for such, while statewide data, as we understand it, includes those hospitalized both "for" and "with" the virus. Further, even if the hospitalization rates were validly comparable, Defendants' assertion overlooks the fact that during the first year or so of the pandemic, COVID ravaged the CDCR population, infecting people at nearly six times the rate as in the community, with approximately one-half the population testing positive and more than 1,000 hospitalized.[5]

If the viral component is as important as it seems, then the question is, what kind of SARS-CoV-2 variant will we get next?").

[5] Defendants below also note that Plaintiffs' counsel met with five incarcerated people at Folsom State Prison (FOL) on February 3, to discuss refusals to test for COVID-19, and that testing rates at that prison have not yet improved. As we reported to Defendants on February 7, we learned from the incarcerated people that recent refusals to test for COVID-19 at FOL were largely the result of changes to isolation practices at the prison, which caused a loss of trust among many, including because of reasonable concerns about whether prison officials' actions were causing the virus to spread.

With regard to new isolation practices possibly spreading the virus, the residents explained that during the previous large outbreak, FOL used tents and temporary housing in the visiting room to house patients on isolation. This time, however, there were no tents, and, with hundreds testing positive for COVID-19 at once, a currently-occupied housing unit was used for those on medical isolation. Prison officials first moved people out of that unit to make space for the COVID-positive patients. The incarcerated people explained that some people in that building had been exposed to a COVID-positive staff member, and they were concerned that moving people from that building into other buildings spread the virus. While everyone was swabbed for COVID before they were moved, some people were moved out of that building before their test results came back, and received positive test results after they had been moved to other buildings.

Separately, people also reported that during the previous outbreak, people were told that if they tested positive, they would be moved to a tent or to visiting, and then would return to their same cell, with their same cellmate. By contrast, when this outbreak began, those assurances were not made, and people were concerned they would be permanently moved to an entirely different cell or building after their isolation period ended.

As we stated during the February 7 call, all of this underscores the fact that CDCR remains vulnerable to significant COVID-19 outbreaks due to the designs of the prisons

Defendants' Position:

A. Current COVID-19 Outbreak

The rate of COVID-19 cases in California's prisons spiked in January, just as they did across California and the entire country.[6] But COVID-19 cases among incarcerated people and staff have drastically decreased since January, again, mirroring trends throughout the United States. *Id.*

Significantly, the hospitalization rate among the incarcerated population remained exceedingly low during the Omicron surge. This is undoubtedly the result of CCHCS's and CDCR's vaccination program and their efforts to provide vaccination boosters to the incarcerated population. As of February 14, 2022, four patients were admitted to community hospitals, which constitutes a hospitalization rate for the incarcerated population that is slightly over 4 per 100,000. By contrast, on February 14, 2022, the New York Times reported that California's statewide COVID-19 hospitalization rate was significantly higher, at about 25 per 100,000.[7]

The hospitalization rate is a very important metric. In fact, there appears to be a developing consensus in the public health arena to pay less attention to case counts and more attention to the number of people who become seriously ill. "Omicron case count[] . . . numbers don't carry the same weight they used to. State and local health departments are preparing to explain that to the public and start reporting more meaningful

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(particularly those like FOL, where most housing units consist of large open-tiered cell blocks with non-solid cell fronts) and the size of the prison population, with too few cells readily available to quickly isolate positive patients.

[6] *See* Cal. Dep't Corr. & Rehabiliation, *Population COVID-19 Tracking, Trended Tab*, https://www.cdcr.ca.gov/covid19/population-status-tracking/ (last visited Feb. 10, 2022).

[7] *See* https://www.nytimes.com/interactive/2021/us/california-covid-cases.html (last visited Feb. 14, 2022).

data on the virus."[8] Experts also debate whether all hospitalization numbers or intensive care unit numbers would more meaningfully measure the severity of the Omicron variant. *Id*. Case counts "should be relied on only as broad indicators of the velocity and direction of the disease's transmission." *Id*. Experts instead advise that hospitalization numbers reflect the severity of an outbreak more accurately than case counts. *Id*.

As an infectious disease specialist at the University of California, San Francisco explained in November, "[w]e are not going to be able to eradicate cases of this virus . . . [w]hat is important to track is what impacts public health and impacts people's lives . . . which is getting sick."[9] She cautions against focusing resources on "chasing cases . . . instead of protecting people from illness." *Id*.

As discussed below and in previous statements, CDCR continues to vigilantly monitor trends in the virus and implement safety measures as needed to protect its incarcerated population and workers.

B. Modified Programming

The statewide modified program CDCR implemented on January 9, 2022 will continue through February 13, 2022. CDCR determined this to be a necessary public health measure to reduce incarcerated people's and staff members' risk of exposure to COVID-19. The downward trend in COVID-19 cases among both the incarcerated and staff populations is encouraging. CDCR continues to work closely with CCHCS and public health experts to reopen as safely and expeditiously as possible. CDCR is closely following the Roadmap to Reopening, which follows guidance from the Receiver and public health experts. The public can access an overview of the Roadmap at https://www.cdcr.ca.gov/covid19/reopening/, and can view each institution's current

[8] Modern Healthcare, *A Shift Away from Daily COVID Case Counts Has Begun* (Jan. 14, 2022), https://www.modernhealthcare.com/safety-quality/shift-away-daily-covid-case-counts-has-begun.

[9] ABC7 News, *UCSF Doctors Say Focus Should be on COVID Hospitalizations and Deaths, Not Case Counts* (Nov. 13, 2021), https://abc7news.com/florida-california-covid-vs-ca-cdc-data-hospitalizations/11234088/.

reopening phase under the "Reopening" tab on CDCR's COVID-19 Population Tracker at https://www.cdcr.ca.gov/covid19/population-status-tracking/. CCHCS and CDCR are currently exploring ways in which institutions may safely resume programming sooner than the current Roadmap allows. Any changes will be reflected in an updated version of the Roadmap.

C. Movement

Movement is conducted consistent with the current iteration of the Movement Matrix, which includes quarantine, testing, and isolation mandates for transfers between and within institutions. The Movement Matrix was revised on February 1, 2022 to adjust quarantine durations consistent with public health guidance. A current copy is available at https://cchcs.ca.gov/wp-content/uploads/sites/60/COVID19/Appendix13-PatientMovement.pdf. Institutions continue to quarantine and isolate incarcerated people as appropriate based on healthcare orders and the Movement Matrix.

Healthcare services are currently limited to essential clinical services, including urgent, emergent, and priority needs. Dayroom activity, canteen, and phone calls continue as long as physical distancing is maintained. Only one housing unit or dorm participates in recreation at a time to avoid mixing units. Education, vocation, Integrated Substance Use Disorder Treatment, and religious programs are being provided directly to incarcerated people in their housing units.

D. Face Coverings for the Incarcerated Population

Current CDCR policy continues to require institutions to provide appropriate face coverings to the incarcerated population, including at least two disposable procedure masks per week. Institutions are also to offer all incarcerated people one KN95 mask per week, which they may choose to wear for enhanced protection. Incarcerated people with work assignments in quarantine or isolation areas must be fit tested and wear N95 masks in those settings, and must be provided N95 replacements at the beginning of each work shift or as often as needed or requested.

E. Testing of the Incarcerated Population

CDCR enlisted Plaintiffs' counsel's assistance in persuading incarcerated people refusing to take COVID-19 tests in large numbers to comply with testing policies. CDCR facilitated a call between Plaintiffs' counsel and five incarcerated people at Folsom State Prison on February 3, 2022. It does not appear testing compliance among incarcerated people has improved at that institution yet.

F. Department Operations Center

The Department Operations Center continues to conduct daily calls with each institution to assess their needs and monitor their outbreak response. Incident command posts at each institution serve as healthcare and custody staff's central point for organizing local outbreak response efforts.

G. Intake

CDCR continues to monitor county jail intake on a daily basis. The evaluation process considers CDCR's current ability to transfer incarcerated people throughout the state, as well as backlogs at county jails. North Kern State Prison and Wasco State Prison have opened intake on a limited basis. Intake at the Central California Women's Facility will resume on a limited basis starting the week of February 14, 2022.

H. Visiting

CDCR suspended in-person visiting on January 9, 2022, for the safety of visitors, incarcerated people, and CDCR staff. Understanding this is a hardship for incarcerated people and their loved ones, CDCR expanded video visitation to Saturday and Sunday. Beginning February 14, 2022, institutional operations will be consistent with CDCR's Roadmap to Reopening Plan. Institutions in phase one will continue expanded video visitation and in-person visiting will resume for institutions as they progress to phases 2 two and three of the Roadmap.

I. Plaintiffs' Requests for Information

Plaintiffs sent numerous requests for information to CDCR, CCHCS, and the Receiver on January 26 and 28, 2022, which they describe throughout this statement.

Attached as **Exhibit 1** is a non-comprehensive chart summarizing Plaintiffs' requests since the last case management conference, and the status of CDCR, CCHCS, and the Receiver's response to each.

II. COVID-19 VACCINE

A. Patients

Plaintiffs' Position: We continue to appreciate the work to vaccinate and provide boosters to the resident population.

With regard to offering incentives to the unvaccinated, CCHCS previously informed us that it was sending surveys on the subject to a large number of such patients, which it intended to collect by the end of January. On January 28, we asked CCCHS to inform us how many survey responses had been received, the status of its staff tabulating results and making recommendations regarding incentives, and whether there was a date by which the Receiver will make a recommendation. On February 7, CCHCS replied, saying that it anticipates analysis of the survey, including number received and findings, will be completed by late February or early March. We believe this matter should be determined expeditiously.

Defendants' Position: Eighty-two percent of CDCR's incarcerated population—78,673 people—is fully vaccinated against COVID-19, and an additional two percent—1,576 people—is partially vaccinated. Currently, 72,058 incarcerated people are eligible for COVID-19 vaccine booster shots, 55,537 (77 percent of those eligible) accepted a booster shot, and 13,207 declined it. CCHCS began offering the Pfizer booster to eligible patients shortly after the United States Food and Drug Administration (FDA) granted emergency use authorization in late September, 2021, and began offering Janssen and Moderna boosters to eligible patients in the third week of October 2021, not long after the FDA released its emergency use authorization for those vaccines. Consistent with their efforts to follow the most up-to-date public health guidance throughout the pandemic, CDCR and CCHCS are preparing to offer fourth doses to eligible immunocompromised

incarcerated people in accordance with current public health guidelines. Healthcare staff continue to treat every patient encounter as an opportunity to encourage patients to accept the vaccine or a booster shot, as appropriate.

B. Staff

Plaintiffs' Position: Vaccinating and boosting prison staff, who are the primary vector of COVID infections in the prions, is the primary means to reduce the substantial risk of harm the virus poses to incarcerated people. Alarmingly, correctional officers, the largest single group among prison staff and those who have the most contact with residents, continue to have poor vaccination rates. According to the most recent data provided by CCHCS, only 61% of the approximately 21,400 correctional officers statewide were completely vaccinated. *See* Memorandum (January 21, 2022) at Attachment B, attached hereto as **Exhibit 2**. For example, at Mule Creek State Prison, only 50% of nearly 700 officers are completely vaccinated, and Mule Creek is but one of a half-dozen prisons where that rate is at least that low. *Id.* These prisons include California Correctional Center, High Desert State Prison, and Pelican Bay State Prison, where 40% or fewer officers are completely vaccinated. *Id.*

While this Court's order mandating COVID vaccination for all prison staff is stayed pending appeal, the California Department of Public Health (CDPH) August 19, 2021 order mandates vaccination for some staff, including all at the California Health Care Facility (CHCF) and California Medical Facility (CMF), unless they have been granted a religious or medical exemption. More specifically, the CDPH order requires vaccination or an exemption for approximately 38% of prison staff statewide. *See* **Exhibit 2** at Attachment A (showing 54,469 prison staff statewide) and Attachment C (showing 20,613 staff covered by the CDPH order).

The CDPH order shows that vaccine mandates work to improve vaccination rates: at CHCF and CMF, 85% and 81%, respectively, of all staff were completely vaccinated as of January 12. *See* **Exhibit 2** at Attachment A. These are highest rates among CDCR

prisons and well above the statewide prison staff average of 68%. *Id.*

We have serious concerns about the religious exemption or accommodation process being used by CDCR and CCHCS to excuse staff from the CPDH vaccination mandate. Data shows that as of early to mid-January, at least 1,165 staff subject to the mandate had been approved for a religious exemption, and 491 others had a request pending. *See* **Exhibit 2** at Attachments D (showing CDCR staff approved and pending religious accommodations) and E (showing that data for CCHCS staff). We are particularly concerned whether Defendants, when granting this very large number of religious accommodations, considered and properly determined whether doing so would impose an undue hardship on CDCR's functioning by increasing the risk of the spread of COVID in the prisons – surely not a "de minimis cost."[10] In our view, granting these accommodations substantially undermines the purpose and efficacy of the CDPH mandate and unreasonably endangers the health and safety of people incarcerated in CDCR, particularly at CHCF and CMF, where staff vaccination is mandatory. On January 26, we asked the Receiver to review and report on these religious accommodations, and to act if

[10] Under state and federal law, employees with sincerely held religious beliefs should be provided reasonable accommodations only if the accommodations do not impose an undue hardship. *See* Cal. Gov't Code § 12940(l); 42 U.S.C. § 2000e(j); *Cook v. Lindsay Olive Growers*, 911 F.2d 233, 241 (9th Cir. 1990). The "undue hardship" standard is not a high bar; it is met "whenever that accommodation results in 'more than a de minimis cost' to the employer." *Soldinger v. Nw. Airlines, Inc.*, 58 Cal. Rptr. 2d 747, 762 (Ct. App. 1996) (quoting *Ansonia Bd. of Educ. v. Philbrook*, 479 U.S. 60, 67 (1986)).

"The EEOC has released guidance explaining that . . . an employee's request for an exemption from a COVID-19 vaccination mandate can be denied . . . on the ground that such an exemption would pose an 'undue hardship' by burdening 'the conduct of the employer's business' through increasing 'the risk of the spread of COVID-19 to other employees or to the public.'" *Doe v. San Diego Unified Sch. Dist.*, 19 F.4th 1173, 1180 (9th Cir. 2021), *reconsideration en banc denied*, No. 21-56259, 2022 WL 130808 (9th Cir. Jan. 14, 2022) (quoting *What You Should Know About COVID-19 and the ADA, the Rehabilitation Act, and Other EEO Laws* at L.2 to L.3, U.S. Equal Emp. Opportunity Comm'n (Oct. 25, 2021), https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws#L).

the exemption process is not being properly applied. To date, no substantive response has been received.[11]

On January 28, we asked CCHCS and Defendants a number of other questions related to the application of the CDPH vaccination mandate. Defendants previously stated that staff newly hired or assigned to a position for which CDPH mandates vaccination have a grace period before they are required to comply. A February 14 response indicates there is no grace period for new hires, because vaccination records or a request for an exemption is required to be submitted as part of the hiring process. Unfortunately, no information was provided regarding staff who are already hired then newly assigned to a position for which CDPH mandates vaccination, as presumably happens when staff transfer between prisons. This remains an open concern: staff should not be newly assigned to a position for which vaccination is required unless they are in compliance with CDPH's mandate.

Separately, CCHCS reported that the number of its staff subject to the CDPH mandate for whom it has no information showing vaccination or whether an exemption had been granted or requested and against whom no discipline had been taken has been reduced from 480 to 72. We appreciate the attention to these staff members. As to the 72, CCHCS says three are new hires (which is puzzling, since it was explained that staff are required to comply with the CDPH mandate before being hired), 17 are pending or have been issued discipline action, and the remaining approximately 50 are "pending verification." This last group, while relatively small in number compared to the total CCHCS staff, is puzzling given that nearly three months have passed since the CDPH mandate compliance date.

We also asked CCHCS and CDCR about staff against whom they said progressive discipline had been taken for not complying with the CDPH mandate. Specifically, we

[11] Defendants provided revisions to this Statement (at 15:5-17:7) responding to Plaintiffs' concerns regarding the religious accommodations exemptions at 5:02 p.m. on the day of filing (February 14). Plaintiffs have not yet had an opportunity to review Defendants' position on this issue.

asked how many of their respective staff members had been issued a Letter of Instruction (LOI) for failure to comply, and what happened with those staff, including any further discipline. CCHCS reported 150 of its staff received LOIs. Of them, 92 are now fully vaccinated, 26 have pending or approved exemption requests, 16 have "separated" from CCHCS, six are on long term leave, seven are "still in process," and three have been served a notice of adverse action. We appreciate CCHCS's attention to the enforcement of the mandate. In sum, the process has resulted in further staff being vaccinated and extremely few leaving.

CDCR said it does not have the resources to gather the data that CCHCS provided regarding the number of staff issued LOIs and what became of them. This is not acceptable, because this review should be done in order to ensure adequate enforcement of the CDPH mandate. As a result, there is a major gap in information and an inability to assess whether CDCR is actually enforcing the CDPH mandate among its staff.

We also on January 28 asked CDCR and CCHCS to tell us whether efforts to confirm the vaccination status of contractor staff subject to the August 19 CDPH order, including the accommodation status of such staff, had been completed. On February 14, it was reported that 66 of approximately 1,360 contractor staff statewide are pending verification of compliance with the CDPH mandate, that staff not in compliance will be terminated, and that all contractor staff starting March 2 will be further checked for compliance with the December 2021 CDPH order requiring a booster shot.

Defendants' Position[12]*:* Seventy-one percent of CDCR's staff are fully vaccinated against COVID-19, and an additional one percent are partially vaccinated. CDCR and CCHCS's efforts to keep an accurate account of staff vaccinations continues. In addition to efforts reported in the January 19, 2022 statement (*see* ECF No. 3771 at 17-20), DAI

[12] Defendants note that the question of whether every worker entering CDCR's institutions must be vaccinated is pending before the Ninth Circuit. Defendants addressed their position on this topic in briefing filed with the Ninth Circuit, previous case management statements filed with this Court, and their briefing in response to this Court's order to show cause.

has reassigned three staff members at each institution to manually check the vaccination status and testing requirements for each worker entering the institution. This is a time-consuming process, but allows institutions to track workers who must test and who are not compliant with the CDPH vaccination requirement in the absence of an automated system. Additionally, it bears noting that prior to hire for positions subject to the CDPH vaccination mandate, CDCR candidates must submit proof of vaccination or complete a request for a religious accommodation or medical reasonable accommodation. Mask and testing requirements must be followed pending determination of the accommodation request. If an accommodation is denied, employees must follow the instructions for compliance provided in the denial letter within 14 days, similar to CCHCS's process.

Separately, on February 8, 2022, the Receiver provided the parties data showing compliance with the August 19, 2021 CDPH order for staff tracked in Telestaff, which includes all posted custody and nursing positions—approximately two thirds of all institutional staff, not including contractors. As shown in the yellow table in **Exhibit 3**, attached, more than 90 percent of Telestaff workers at all but five institutions complied with the August 19 CDPH order by being fully vaccinated. At least 88 percent of Telestaff workers complied by being fully vaccinated at four of the remaining five institutions, and 80 percent of Telestaff workers complied this way at the fifth. These numbers under report Telestaff workers' compliance with the CDPH order because they do not include staff who complied by receiving a medical or religious exemption.

Additionally, on January 25, 2022, CDPH extended the deadline for relevant workers to receive a booster shot from February 1, 2022 to March 1, 2022. *See* Cal. Dep't Pub. Health, *Adult Care Facilities and direct care Worker Vaccine Requirement* (Jan. 25, 2022), https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Adult-Care-Facilities-and-Direct-Care-Worker-Vaccine-Requirement.aspx. CDCR adopted this new deadline in a memorandum jointly issued with the Receiver to all custody and healthcare staff on January 28, 2022. A copy of this

memorandum is attached as **Exhibit 4**. The same memorandum extends the compliance deadline for all contract and registry workers subject to the August 19 and December 22, 2021 CDPH orders to March 1, 2022. After March 1, assignments for noncompliant contract and registry workers will be terminated.

With respect to religious accommodations from the vaccine requirement for workers subject to the CDPH vaccination order, CDCR and CCHCS are implementing the CDPH order, which provides that covered "[w]orkers . . . be exempt from the vaccination requirements . . . only upon providing the operator of the correctional facility or detention center a declination form, signed by the individual stating either of the following: (1) the worker is declining vaccination based on religious beliefs, or (2) the worker is excused from receiving any COVID-19 vaccine due to Qualifying Medical Reasons."[13] The CDPH order does not contemplate, and certainly does not require, covered employers to deny religious or medical exemption requests. Indeed, it specifies that exemptions are available upon submission of a declination form, so denying all religious requests as an undue burden, as Plaintiffs appear to advocate, would be at odds with the order itself. The CDPH order also specifies additional mitigation procedures that exempt employees must follow, including bi-weekly or weekly testing and wearing a surgical mask or higher, which procedures CDCR and CCHCS have ensured these employees meet or exceed. Accordingly, the state public health officer has determined, in imposing a vaccine and booster mandate for these workers, that availability of religious and medical exemptions is both appropriate and can be supported without undue risk or burden when paired with additional mitigation requirements for exempt workers.

Plaintiffs' apparent position—that CDCR and CCHCS should deny all religious exemptions—is at odds with the governing public health directive. Their reliance on a

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[13] *See* Cal. Dep't Pub. Health, *State and Local Correctional Facilities and Detention Centers Health Care Worker Vaccination Requirement* (Jan. 25, 2022), https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Correctional-Facilities-and-Detention-Centers-Health-Care-Worker-Vaccination-Order.aspx.

general statement from EEOC guidance fails to account for the specific facts governing this vaccine mandate, which is critical given the fact-specific nature of reasonable accommodation requests and the required interactive process with employees to address such requests. *See, e.g.*, *Enforcement Guidance on Reasonable Accommodation and Undue Hardship under the ADA*, General Principles, U.S. Equal Emp. Opportunity Comm'n (Oct. 17, 2002), https://www.eeoc.gov/laws/guidance/enforcement-guidance-reasonable-accommodation-and-undue-hardship-under-ada#undue ("Instead, undue hardship must be based on an individualized assessment of current circumstances that show that a specific reasonable accommodation would cause significant difficulty or expense.").[14] CDCR carefully evaluates each accommodation request it receives. Each initial decision regarding a request must pass a review before being finalized. When appropriate, requesting employees are engaged in the interactive process before a request is approved or denied. CDCR has a robust accommodation process that predates COVID-19, which it will continue to follow.

Finally, despite Plaintiffs' common refrain, repeated above, that vaccinating staff "is the primary means to reduce the substantial risk of harm the virus poses to incarcerated people," it bears repeating that this is inconsistent with the CDC's recommendations, which note that vaccines protect against serious illness, hospitalization and death for *oneself*, not for others. Indeed, the CDC states that "[c]urrent vaccines are expected to protect against severe illness, hospitalizations, and deaths due to infection with the

[14] Plaintiffs also oversimplify the legal landscape around this hotly contested issue, ignoring entirely the First Amendment implications involved. In *Fulton v. City of Philadelphia*, ___ U.S. ___ (2021), the U.S. Supreme Court recently held that policies that allow exceptions for non-religious reasons but do not allow exceptions for religious beliefs are subject to strict scrutiny under the First Amendment. All the recent appellate cases involving this issue, including the *Doe* case cited by Plaintiffs, were resolved on emergency injunction-pending-appeal postures. Accordingly, there is no case law applying current Supreme Court case law that establishes clearly that Plaintiffs' proposed approach of categorically denying all religious exemption requests is constitutional.

Omicron variant. *However, breakthrough infections in people who are vaccinated are likely to occur.* People who are up to date with their COVID-19 vaccines and get COVID-19 are less likely to develop serious illness than those who are unvaccinated and get COVID-19."[15] Thus, as Defendants have consistently stated, the most effective way to protect the incarcerated population from serious illness and death attributable to COVID-19 is for patients themselves to be vaccinated, particularly because even vaccinated staff can still become infected with the virus.

III. STAFF TESTING AND MASKING REQUIREMENTS

Plaintiffs' Position: After the last Case Management Conference, Plaintiffs consulted with a public health expert, Dr. Adam Lauring, and met with the Receiver and CCHCS regarding staff testing. The Receiver and CCHCS leadership also reported that they had met separately with the State and with a group of public health experts, to discuss staff testing policies. CCHCS thereafter proposed a revised plan for staff testing. Plaintiffs provided written comments, and CCHCS provided a further revised plan on February 11, as follows:

1. Test all unvaccinated, partially vaccinated, and booster eligible but not boosted staff at CHCF, CMF, and CCWF SNF twice weekly by POC or PCR testing, with results available to staff and EHP program within 24 hours. The interval of subsequent tests shall be between 48 and 72 hours. If staff return to the institution (e.g. from regular days off or vacation) and have not received a negative result within the past 72 hours, staff shall test on the day they return. Testing vendor will be onsite conducting testing 7 days per week with the same hours as currently.
2. At all remaining sites, test unvaccinated, partially vaccinated, and booster eligible but not boosted staff once weekly by POC or PCR testing, with results available to staff and EHP program within 24 hours. If staff return to the institution (e.g. from regular days off or vacation) and have not received a negative result within the past

[15] *See* https://www.cdc.gov/coronavirus/2019-ncov/variants/omicron-variant.html (last visited Feb. 14, 2022), emphasis added.

7 days, staff shall test on the day they return. Testing vendor will be onsite conducting testing 7 days per week with same hours as currently.

3. During outbreaks in the prison or nearby communities, based on clinical and public health consultation, we may transition to testing all staff, regardless of vaccination status, more than once per week, as determined by the specifics of the outbreak.

The Receiver requested the parties' responses to the plan by February 14. In general, we support the new plan. As we stated during the meet-and-confers, we appreciate in particular that the new plan would ensure results would be received no later than 24 hours after the test sample is collected. This would be a significant improvement; during the latest outbreak, test results for staff have taken 4-5 days to be received at many prisons, preventing CDCR and CCHCS from quickly identifying positive staff members.

We requested some revisions to the policy, to clarify that for those staff required to test "once weekly," the interval between tests should be between 5 and 7 days. We also requested that the requirement that staff test upon return from vacation or regular days off be clarified such that staff are required to test if they have not *tested* within the required interval and received a negative result (rather than just received a negative result within the required interval, which could mean they tested days prior).

During the meet-and-confer process, we also noted that the new plan gives significant discretion to the prisons to increase testing during outbreaks. We believe increased testing is necessary in outbreak situations, and explained that in order for us to do our due diligence as class counsel, if this policy is implemented, CDCR and CCHCS must provide us timely updates regarding whether and how testing policies have been modified at impacted prisons.

Finally, we also reiterated our position that enforcement of these requirements will be critical. As we have previously reported, CCHCS and CDCR face significant challenges in enforcing and monitoring staff testing rules. The most recent testing data we have received (for the week ending February 6) shows that substantial numbers

(approximately 30% statewide) of unvaccinated custody and nursing staff are not in compliance with testing requirements. *See* **Exhibit 5**. At four prisons (CHCF, CMF, RJD, and San Quentin), the compliance rate was below 60%. *Id.* CCHCS and CDCR have previously said that some staff may be incorrectly identified as noncompliant because they are sick or on leave, but they do not know precisely how many.

CCHCS and CDCR have also said that noncompliant staff are not currently prohibited from coming into the prisons, because CDCR and CCHCS do not enforce testing requirements in real time. Defendants below correctly note that a CCHCS "Staff Testing Analysis" Report dated January 23, 2021 and attached hereto as **Exhibit 6** concluded by recommending that "an 'on-grounds' process be implemented to ensure staff entering the institution have received COVID related testing consistent with current guidelines." **Exhibit 6** at 8; *see also id.* at 6-7 (recommending testing policies be enforced during entrance screening). However, we believe Defendants are incorrect in implying that such a process exists today. As we reported in the last Joint Case Management Conference Statement, we were told that CDCR and CCHCS *previously* stationed staff at the entrances to all prisons to screen staff, including for compliance with testing requirements. *See* ECF No. 3566 at 16. Staff who stated they had not recently been tested were given a rapid test. *Id.* That entrance screening was stopped in July 2021 (staff are now directed to self-screen for symptoms and exposure), at a time when active case counts had been very low for several weeks.[16] During a call on January 14, 2022, CCHCS and CDCR explained that compliance with testing requirements is currently monitored only retroactively—staff are reviewed each week for their compliance with the testing requirements during the previous week, and reportedly referred to the disciplinary process

[16] *See* Cal. Dep't of Corr. & Rehab., *Novel Coronavirus Disease 2019 (COVID-19) New Self-Screening Process*, https://www.cdcr.ca.gov/covid19/novel-coronavirus-disease-2019-covid-19-new-self-screening-process-and-elearning-course (July 12, 2021); Cal. Dep't of Corr. & Rehab., *Novel Coronavirus Disease 2019 (COVID-19) self-screening entrance process – updated*, https://www.cdcr.ca.gov/covid19/novel-coronavirus-disease-2019-covid-19-self-screening-entrance-process-updated (updated Jan. 3, 2022).

if they are identified as noncompliant.

During our February 8, 2022 meet and confer with CCHCS, the Receiver explained he was hopeful that with the revised policy (and in particular the quicker turnaround times for test results), improvements could be made to the system for enforcing testing requirements, but that CCHCS and CDCR had not yet decided how this would be done. We have requested another call with CCHCS and CDCR to discuss enforcement of staff testing requirements.

More generally, these enforcement challenges underscore the limitations of the staff testing program. Testing is an important risk reduction measure, but will not identify all active COVID-19 infections in staff. As the recent wave of outbreaks has make clear, with thousands of staff coming in and out of the prisons each day, the prisons remain incredibly vulnerable to outbreaks of COVID-19. Thus, while we support the revised staff testing policy, we continue to believe the State must adopt further measures—including mandatory vaccination policies—to mitigate the significant risk that staff will introduce and spread the virus in the prisons.

Defendants responded to the Receiver's proposed revised staff testing policy on February 14, stating that "CDCR would like to continue to meet and confer to clarify the services vendors can offer and how compliance measurement will improve with the new proposed plan. CDCR is unable to implement the plan without ironing out logistics in advance, and will continue to follow the existing policies in the meantime." Defendants' reluctance is concerning. We understand from the Receiver's office that the vendor(s) could do all that the new policy requires. Further, while we agree that it is necessary for CCHCS and CDCR to improve their systems for measuring and enforcing compliance with staff testing policies, determining how that will be done should not prevent adoption of the new policy. Most importantly, Defendants do not dispute the public health basis for the new policy, including the need to improve turnaround times for test results.

Defendants' Position: The Receiver provided the parties a report analyzing staff testing data on January 23, 2021. The report details the information required to accurately track staff testing rates, reasons for gaps in information, and recommendations for enhancing tracking systems. A copy of this report is attached as **Exhibit 6**. It concludes by recommending that "an 'on-grounds' process be implemented to ensure staff entering the institution have received COVID related testing consistent with current guidelines[,]" recognizing "[s]uch a process could be tremendously laborious[.]" *Id*. at 8. As described in the COVID-19 Vaccines section above, CDCR has already devoted staff to this task at each institution. CDCR disciplines noncompliant staff as soon as it discovers noncompliance.

Consistent with the multilayered approach CDCR adopted early in the pandemic, testing is not the only method for mitigating the spread of the virus. All workers entering CDCR's institutions, regardless of vaccination status, are currently expected to wear KN95 masks. Staff working in quarantine and isolation areas must be fit tested and wear N95 masks. KN95 and N95 masks are readily available at each institution. CDCR and the Receiver jointly issued this direction on January 24, 2022. *See* **Exhibit 7**, attached. Staff must follow testing policies in addition to adhering to these masking requirements. Currently, as the Court acknowledged at the January 24, 2022 case management conference, staff not fully vaccinated are required to test twice a week.

CDCR, in its continued effort to be transparent about its processes, alerted the Court and Plaintiffs to errors in data reported by CCHCS in November 2021. (*See* Supplemental Decl. Gipson Supp. Defs' Reply for Mot. Stay Order re: Mandatory COVID-19 Vaccinations Pending Appeal, ECF No. 3741-1 at 2-3.) Data validation has been one of CDCR and CCHCS's primary focuses since then.

On February 3, 2022, Defendants met and conferred with the Receiver regarding the Receiver's forthcoming staff testing policy. On February 8, 2022, the Receiver circulated a recommended testing policy for Defendants' and Plaintiffs' consideration. Defendants

met and conferred with the Receiver regarding the revised testing policy on February 10, 2022. During this meet and confer session, the Receiver explained the proposed policy is designed in part to detect infections sooner, particularly in light of current delays in receiving PCR test results, and reduce the significant resources currently devoted to tracking and verifying staff testing compliance. The Receiver also explained that the logistics of implementing the proposed plan had not yet been considered. That afternoon, the Receiver circulated a revised draft of the recommended testing policy. On February 14, 2022, after considering the most recent version of the Receiver's proposed staff testing policy, Defendants requested that meet and confer efforts continue to iron out the logistics of implementing the proposed staff testing plan before a new plan is implemented. In the meantime, Defendants intend to continue enforcing current policies.

Testing in accordance with the Movement Matrix continues to be successful. To date, no outbreak has been traced to movement conducted in accordance with the Matrix.

IV. VENTILATION

Plaintiffs' Position: Since last month's Case Management Conference, we asked CDCR and CCHCS questions regarding housing unit ventilation, and, separately, regarding the requirements of the December 8, 2021 joint CDCR/CCHCS memorandum (attached hereto as **Exhibit 8**), requiring air filtration units for indoor group activity areas.

Housing Unit Ventilation: On January 27, we asked for the current schedule for repairs and maintenance of about 140 housing unit Air Handling Units (AHUs) identified as still needing such action (*see* ECF No. 3771 at 24:22-25:6). On February 14, an updated schedule, current as of January 24, was provided. *See* Memorandum, February 14, 2022, attached hereto as **Exhibit 9**. It shows that AHU repairs and maintenance are not complete at nine prisons, with such work scheduled to be done at four by February 28 (including two previously scheduled to be completed by January 31), at four by March 31, and at one by April 30. We will continue to monitor this matter.

We also asked how the exhaust fans in quarantine housing units, or units housing multiple COVID-positive patients, are known to be operational, as a January 5, 2022 CDCR Memorandum requires them to be because, in CDCR's words, such fans "are especially critical" in those units (*see* ECF No. 3771 at Exhibit H). We specifically asked what process is used to determine if the fans are operational, and whether the January 5 memorandum requires cells with non-operational exhaust fans to be red-lined.

The February 14 response to our questions stated that operations staff are not inspecting exhaust fans daily, but that all staff and patients can ask for a fan to be repaired or replaced. *See* **Exhibit 9**. This is not adequate. The response does not explain how someone would know whether an exhaust fan is working. Given the "especially critical" importance of these fans, CDCR and CCHCS should at the least provide written educational information to the incarcerated population and staff that explains how to determine if a cell or living area exhaust fan is not working, advises that a non-working fan should be immediately reported, and states exactly how that should be done.[17]

Air Filtration Units For Indoor Group Activity Areas: We appreciate that CDCR and CCHCS, as Defendants report below, are working on a formal written procedure embodying the requirements of the December 8, 2021 joint memorandum, and have developed a tool for calculating the number of filtration units required for indoor group spaces. We also appreciate that CDCR and CCCHS say the prisons will use this tool, then submit results to headquarters which will verify them by the end of March, after which it will be provided to us. We will in the interim ask Defendants for a demonstration of the calculation tool.

We continue to have a major concern about the apparent lack of a plan to verify that air filtration units are actually placed where required by the joint memorandum. On January 19 and 26, we asked Defendants about this. Neither their February 10 responses

[17] Defendants revised the Statement to state that "CDCR has directed the prisons to conduct a one-time check of all housing unit living spaces to ensure that exhaust fans are operational" at 5:02 p.m. on the day of filing (February 14).

to our questions (*see* Memorandums, February 10, 2022, attached hereto as **Exhibit 10**) nor their presentation below address this concern. We continue to believe such self-monitoring and reporting is essential.

Finally, one of Defendants' February 10 memorandums troublingly suggests that air filtration units are not necessary if an indoor group space, such as a dayroom or dining hall, is used at less than full capacity, implying that "prior direction regarding distancing requirements" would suffice if the spaced has a reduced capacity. *See* **Exhibit 10**. This approach overlooks the fundamental fact that "distancing requirements" were born of the theory, now revised, that the primary vector of pathogen transmission causing COVID was large drops ejected during the most vigorous exhalation events, including coughing and sneezing. It is now widely accepted that the virus spreads through these droplets and, crucially, air-borne particles which can move far away from the infectious person and accumulate indoors over time.[18] Air filtration units should be placed in all group activity and program areas.

Defendants' Position: In addition to completing the system-wide air-filter-upgrade project, CDCR has continued to make progress on maintenance and repairs to air-handling units throughout the prison system. Defendants last reported that there were 140 units still in need of attention. That number has now been reduced to 116, and a schedule for the completion of that work has been updated and provided to Plaintiffs.

As Defendants reported last month, CDCR has issued a memorandum directing facilities staff to prioritize repairs to exhaust fans. Plaintiffs have expressed concerns about the identification of exhaust fans that are inoperable. If an exhaust fan stops working, facilities staff are typically notified right away of a need for the repair through requests from residents and staff who live or work in the relevant area. But to ensure that

[18] *See* EPA, *Indoor Air and Coronavirus (COVID-19)*, https://www.epa.gov/coronavirus/indoor-air-and-coronavirus-covid-19 (last accessed February 13, 2022).

any inoperable exhaust fans are identified, CDCR has directed the prisons to conduct a one-time check of all housing unit living spaces to ensure that exhaust fans are operational. If any exhaust fans are found to be inoperable, work orders will be submitted.

Throughout much of the pandemic, indoor group programs have either been suspended or run at reduced capacity to allow for better physical distancing in indoor spaces. On December 8, 2021, CDCR and CCHCS issued a memorandum concerning efforts to increase the capacity of indoor group programming back to normal levels. Among many requirements for increasing group programming capacity, the memorandum discussed a portable-air-filter requirement in spaces where increased-capacity groups will program. The memorandum also provided a process for calculating the number of portable filters required for a given group space. CCHCS and CDCR are currently in the process of developing a Health Care Department Operations Manual section to address the use of air filters.

At the last conference, Plaintiffs expressed concerns that prisons might not correctly calculate the number of portable air filters for a group space, and the Court requested that Defendants advise whether there is a way to routinize the calculation process. In Defendants' view, the December 8 memorandum already provides a routine process for making the calculations. But CDCR has now additionally developed a room-filter calculation tool that it has issued to the prisons. The room-filter calculator is a programmed spreadsheet that will automatically calculate the number of required air filters for a given room once certain measurements and data are added to the spreadsheet. The prisons have been directed to complete this spreadsheet for each of their spaces where air filters have been deployed to allow for an increase in group programming capacity in order to verify the accuracy of their previous calculations, and to return the completed spreadsheets to CDCR Headquarters by early March 2022. Headquarters staff will then review the spreadsheets to confirm that they were completed correctly and that the calculations are correct. It is anticipated that Headquarters' validation of calculations will

be completed by the end of March 2022, and CDCR will produce the information to Plaintiffs' counsel at that time.

V. IMPACT OF COVID-19 ON MEDICAL CARE SERVICES

Plaintiffs' Position: As stated in Part I, above, the statewide modified program has resulted in the postponement or cancellation of many medical appointments, and this will continue for weeks until prisons resume full programming. The number of backlogged Primary Care Provider (PCP) appointments statewide has ballooned to more than 8,000, according to CCHCS data as of January 31. This number does not include any appointments that were cancelled and then rescheduled for a future date, thus delaying care. We believe there are many such appointments.

The experience last month at California State Prison – Los Angeles County (LAC) illustrates how the current COVID surge restricts primary care appointments. As the Court knows, LAC for months has had a substantial backlog of PCP appointments, and, as we reported last month, had reduced it by approximately 1,000 in the last two and one-half months of 2021, and had robust plans, including extra clinics and providers, to promptly reduce it even more. *See* ECF No. 3771 at 26:8-15. However, CCHCS reports that the LAC backlog was only reduced by 127 appointments in January, explaining that a COVID outbreak "significantly impacted staffing and patient movement due to the quarantine of multiple housing units," resulting in the decision to prioritize emergent and urgent primary care appointments and use the special weekend and evening clinics – originally intended to reduce the PCP appointments backlog – to offer prophylactic medication to patients especially vulnerable to severe sickness or death if COVID-infected. We do not take issue with the decisions made, but report on them to emphasize how COVID outbreaks continue to result in primary care delays for many.

There also continue to be substantial number of backlogged specialty services appointments statewide. CCHCS reports that an abstract of information recently presented to its executives on this subject is being prepared for us. With regard to delayed cancer-

screening ultrasound exams for patients with advanced liver disease, we remain hopeful that this backlog (more than 800 as of early January) will be eliminated by CCHCS's plan to hold additional ultrasound clinics this month. We will check with CCHCS about this in March.

In early January, we reported medication delivery delays to patients at Richard J. Donovan Correctional Facility (RJD). CCHCS subsequently said delays occurred in the first week of the month, due to staffing shortages caused by COVID-19 outbreaks and the large amount of medication distributed at the prison. We subsequently reported further problems with medication delivery at the prison, including patient records stating that medication was not provided on multiple days due to "custody release issues" and not received at other times because the patient did not show up when in fact the patient had not been permitted to go to the medication line. CCHCS documents indicate a Headquarters Team then traveled to the prison to review medication operations. While we await a full written response from CCHCS regarding this, we are told that problems are now resolved, including by having nurses administer medication in housing units instead of from pill lines in the medical clinics.

Defendants' Position: The Receiver's office advised the parties on February 8, 2022 that it is exploring options for attracting consultants to help alleviate appointment backlogs, particularly in specialties like optometry and ophthalmology with the highest backlogs. And as possible, custody staff was hired or redirected to assist healthcare staff with their usual duties. For example, between January 1 and February 8, 2022, statewide custody staff logged approximately 935 hours (or roughly 117 eight-hour shifts) of suicide watch coverage. Defendants will continue to work with the Receiver and CCHCS to ensure the delivery of medical care services to patients to the full extent possible during the COVID pandemic and the recent spread of the Omicron variant.

VI. CALPROTECT REPORT

Plaintiffs' Position: The final CalPROTECT[19] report, resulting from that organization's multiple site visits to CDCR prisons in 2021, remains pending. On February 8, the Receiver indicated it would likely be a few weeks before a final report was issued. The draft report provided in January indicates that findings and recommendations will be made on a variety of COVID-related matters, including for example outbreak prevention and management, ventilation and air filtration, and preventing COVID transmission from staff. We look forward to receiving the final report, and to hearing what action CCHCS and CDCR will take in response to the findings and recommendations.

Defendants' Position: The parties received a draft of CalPROTECT's report evaluating CDCR's response to the pandemic and recommending certain mitigation measures in January 2022. The Receiver advised the parties in a February 8, 2022 meet and confer that the draft will be revised again before it is finalized. Defendants reserve discussion about the report until they review and evaluate a final version.

VII. DELEGATIONS

The parties were previously scheduled to meet and confer regarding the delegation of medical care at the California Rehabilitation Center (CRC) on February 24, 2022. In light of the current outbreak at CRC, Plaintiffs requested and the Receiver agreed to postpone this meet and confer to April 26, 2022.

[19] CalPROTECT, a special project of Amend at UCSF, is an initiative across University of California, San Francisco and University of California, Berkeley. CalPROTECT is comprised of a multidisciplinary team of academics and healthcare professionals with expertise in clinical medicine, public health, epidemiology, economics, environmental and exposure science, public policy, infectious disease, health systems, geriatrics, and palliative care. The CalPROTECT team is co-led by Dr. Brie Williams and Dr. Stefano Bertozzi.

DATED: February 14, 2022

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