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SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF MARIN

In re

IAN MICHAEL HALL, et al.,

DONIOUS SOMMONS, et al.,

DONTAYE HARRIS, et al.

Petitioners,

On Habeas Corpus.

SAN QUENTIN CONSOLIDATED WRIT PROCEEDING GROUP 1-3

Case Nos. SC212933, et al.

Case Nos. SC213244, et al.

Case Nos. SC213534, et al.

RESPONDENT'S BRIEF REGARDING EFFECTS OF *VON STAICH* DECISION

Date: November 30, 2020
Time: 1:30 p.m.
Judge: The Hon. Geoffrey M. Howard

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Plata v. Newsom
(N.D. Cal. Apr. 17, 2020) 445 F.Supp.3d 557 8

INTRODUCTION

This Court should stay the proceedings here until the *Von Staich* decision is final. Respondent is seeking review of the Court of Appeal's decision and, pending finality of the decision, this Court is not compelled by *Von Staich* to take any action. Indeed, absent a binding decision, this Court taking any action would necessarily result in wasted resources. This Court should instead allow the Court of Appeal decision to be fairly adjudicated, while CDCR continues working with the federal Receiver to offer alternative housing to medically high risk inmates. Even when the *Von Staich* decision becomes final, this Court should not decide the remedy for each individual petitioner because the Court of Appeal made clear this Court must defer to CDCR regarding how it will reduce San Quentin's population.

PROCEDURAL HISTORY

I. *HALL* LITIGATION

This Court consolidated 311[1] habeas corpus petitions from petitioners previously or currently housed at San Quentin. Petitioners allege their continued incarceration at San Quentin during the COVID-19 pandemic violates their right to be free from cruel and/or unusual punishment because the prison cannot safely house them without reducing the population by 50 percent. To address this claim, this Court intended to hold an evidentiary hearing in three phases. The first phase would address the underlying substantive constitutional claim; the second phase would address the petitioners' individual circumstances; and the third phase would address the remedies. On the eve of the first phase of the evidentiary hearing, the First District Court of Appeal issued a decision in *In re Von Staich* (Oct. 20, 2020, A160122) 56 Cal.App.5th 53 [2020 WL6144780, at *1] (*Von Staich*), in which a single prisoner at San Quentin alleged the same cruel and/or unusual punishment claim as the petitioners do here. This Court vacated the evidentiary hearing and directed the parties to brief the effect the *Von Staich* decision has on the current litigation.

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[1] Approximately 15 petitioners have either paroled or are no longer housed at San Quentin, and their petitions are therefore moot for the purpose of providing a remedy.

II. *Von Staich* Decision

The Court of Appeal held that CDCR and the Warden of San Quentin were deliberately indifferent to the risk of substantial harm to Von Staich, in light of his age and medical conditions, by failing to reduce the San Quentin population by half, as recommended by public health experts. (*Von Staich*, *supra*, 2020 WL6144780, at *15-16.) The court directed San Quentin to reduce its population to 1,775 prisoners through releases or transfers and noted its remedy would apply equally to all similarly situated prisoners at San Quentin. (*Id.* at *17, 19.) The court declared that CDCR had sole discretion, without interference from the court or Von Staich, to determine how to best effectuate the population reduction. (*Id.* at *17-18.) The court directed the parties to bring "[a]ny dispute that may arise regarding application of [the decision] . . . to the Marin County Superior Court." (*Id.* at *19.)

III. Petitioners' Contentions

Petitioners assert that *Von Staich* is binding on the parties here, acknowledge the decision is not yet final, but contend this Court should still "proceed to the next phase of these proceedings: determining the appropriate remedy for petitioners." (Petrs.' Opening Br. at pp. 4-6.) Specifically, petitioners contend this Court should determine the remedy for each individual petitioner, the remedy should be release, and this Court should not absolutely defer to CDCR in fashioning a remedy because transfers are neither an effective nor safe way to reduce the population by 50 percent. (See generally Petrs.' Opening Br.)

As explained below, this Court should hold the proceedings in abeyance until *Von Staich* is final. But when that decision becomes final, this Court should still decline petitioners' invitation to decide individual petitioner remedies because CDCR, in conjunction with the federal Receiver, should decide how to reduce San Quentin's population.

ARGUMENT

I. This Court Should Not Address the Remedies for Individual Petitioners and Should Hold the Proceedings in Abeyance Until the Remittitur in *Von Staich* Issues.

Petitioners contend this Court should continue addressing the remedy for individual petitioners while *Von Staich* is pending, and order the release of any or all of the 311 petitioner-

prisoners. (Petrs.' Opening Br. at p. 6.) As discussed below, it would be improper for this Court to decide every petitioner is entitled to release. In addition to following the appellate court's directive not to insert itself into CDCR's business of running its prisons, this Court should not take any immediate action because the *Von Staich* decision is not final. CDCR's petition for review is being filed today, November 16. On its own motion, the California Supreme Court initially extended its time to whether to grant or deny review until February 17, 2021. (*In re Von Staich* (Oct. 27, 2020, S265173), citing Cal. Rules of Court, rule 8.512(c).) Waiting fewer than three months to proceed with litigation in its natural posture is preferable to wasting judicial and State resources and inserting this Court into the minutiae of prison operations *Von Staich* denounced. (*Von Staich*, *supra*, 2020 WL 6144780, at *17.)

Indeed, the federal Receiver has proposed that CDCR offer over 8,000 high risk medical patients living in dorms the opportunity to move into a single cell, and CDCR is working with the Receiver to facilitate those movements when approved by appropriate public health and corrections experts. (Exh. 1, *Plata v. Newsom* (01-cv-1351-JST) Nov. 4, 2020 J. Case Management Statement, at p. 15.)[2] The petitioners' counsel in *Plata* acknowledge that large percentages of medically vulnerable inmates have declined offers to move from dorms to cells. (Exh. 2, *Plata v. Newsom* (01-cv-1351-JST) Oct. 20, 2020 J. Case Management Statement, at p. 13[3].) Such refusals, however, do not entitle petitioners to an individual remedies determination, much less release from prison.

This Court also does not gain any advantage by addressing individual petitioner remedies while *Von Staich* is pending. It is not certain *Von Staich* will remain good law; therefore, addressing individual remedies is premature and imprudent. For example, the appellate court granted relief for all similarly situated prisoners as San Quentin. (*Von Staich*, *supra*, 2020 WL 6144780, at *17.) But even assuming the decision stands, the requisite population reduction does

[2] Only 15 percent of the high-risk inmates with COVID-19 risk scores of 11 and above accepted an intra-institution transfer to close-cell-front housing, despite the move intending to primarily benefit the inmate. (Petrs.' Opening Br., Exh. 9, Oct. 21, 2020 Transferring COVID-19 High-Risk Patients to Safer Housing, at p. 9.)

[3] In exhibits 1 and 2, respondent cites to the original pagination of the document.

not necessarily reflect that the 311 petitioner-prisoners,[4] rather than 1,026 different prisoners, are the prisoners who should be removed from San Quentin. Nor should this Court attempt to make that decision. (*Ibid.*)

The salient point the Court of Appeal made regarding the remedy for the purported constitutional violation was that CDCR has complete discretion and control over how to provide the relief granted. (*Von Staich*, *supra*, 2020 WL 6144780, at *18 ["Respondents are free to employ the means they determine will most quickly achieve the necessarily population reduction"].) Allowing petitioners to present a litany of information to this Court about who is most worthy of being removed from San Quentin contradicts the appellate court's correct conclusion that courts are not the appropriate entity to review scientific facts. (*Id.* at *17.)

Likewise, there is no need for petitioners to identify those who are over age 60, eligible for parole, and have served at least 25 years of their sentences, or who are high risk to due to medical condition or age, for the purpose of deciding who is most worthy of a remedy.[5] (*Von Staich*, *supra*, 2020 WL 6144780, at *18.) And doing so is contrary to *Von Staich*: the appellate court directed CDCR to expand its early release programs to include inmates over age 60, eligible for parole, and who have served at least 25 years of their sentence for a violent offense <u>only if</u> CDCR could not otherwise reduce the population of San Quentin to no more than 1,775 inmates. (*Id.* at *19.) There has been no showing here that, if required, CDCR could not achieve the requisite reduction without including those identified inmates into the early release programs. Moreover, identifying those inmates is unnecessary because, beginning January 1, 2021, inmates aged 50 or over who have served at least 20 years on their sentence will be eligible for elderly parole consideration, which is the early release program the appellate court addressed. (Stats. 2020, ch. 334 (AB 3234) [extending elderly parole program to those 50 and older who have served minimum of 20 years].)

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[4] This Court recently issued two orders identifying a total of 200 additional petitioners and extending this Court's time to December 18, 2020, and January 8, 2021, respectively, to issue an order to show cause in those cases.

[5] Petitioners prepared a chart in response to this Court's November 9, 2020 order, categorizing the relevant prisoners based on age, years incarcerated, and medical and mental health concerns. Respondent will review the chart and provide a response, if necessary, no later than November 23, 2020.

More importantly, all evidence reflects that, despite the alleged lack of physical distancing, San Quentin is well-able to maintain the safety and security of its prisoners. Between August 27 and September 6, 2020, San Quentin never had more than eight inmates test positive for COVID-19 at a time; since September 7, San Quentin has experienced only one, two, or three inmates testing positive at a time. (Population COVID-19 Tracking, San Quentin Institution View, www.cdcr.ca.gov/covid19/population-status-tracking, as of Nov. 16, 2020.) This should be no surprise; the outbreak following the transfer of inmates from the California Institution for Men is "likely not the best predictor[] of how future outbreaks will unfold now that CDCR has implemented preventative measures . . . and learned from experience how to respond to and contain outbreaks." (Exh. 3, *Plata v. Newsom* (01-cv-1351-JST), July 19, 2020 Decl. of Anne Spaulding, MD, at p. 3.)

Lastly, as detailed in the Joint Case Management Statements, all aspects of testing, movement, and housing are continuously discussed and monitored by the federal Receiver and the *Plata* court.[6] (Exhs. 1-2.) This is not asserted to undermine this Court's power in these proceedings. Indeed, the appellate court noted that "the prompt response of an appellate court will enable the Marin County Superior Court to act with greater authority and more expeditiously than it otherwise might." (*Von Staich*, *supra*, 2020 WL 6144780, at *18.) The court made this statement in the section entitled "It is unnecessary to remand this case to the superior court," and the court was aware of the *Plata* proceedings and the consolidated proceedings in this Court. (*Id.* at *6-8.) Therefore, a fair reading of that statement is that the Court of Appeal's decision would allow this Court to vacate the evidentiary hearing, and address the remedy for the petitioner-prisoners here faster than the *Plata* court could. (*Id.* at *7.) Similarly, the court stating that this Court should resolve any disputes arising from *Von Staich* also fairly reads, consistent with the rest of the decision, that the parties should raise any disputes with this Court, rather than the appellate court. (*Id.* at *19.) This is presumably because superior courts are inherently structured

[6] It bears noting that the Court of Appeal in *Von Staich* mistakenly concluded that "this case and *Plata* address fundamentally different subjects." (*Von Staich*, *supra*, 2020 WL 6144780, at *7.) *Plata* pertains to the delivery of constitutionally adequate medical care and, contrary to the appellate court's belief, is not limited to impact of crowding on medical care. (*Plata v. Newsom* (N.D. Cal. Apr. 17, 2020) 445 F.Supp.3d 557, 560; see *Von Staich*, at *7.)

to timely address disputes between parties in a streamlined manner by a single judge, rather than needing to assemble three justices on the appellate court who regularly only preside over appellate arguments. Under any reading, there is no suggestion by the appellate court that this Court should take any action before the *Von Staich* decision was final.

In short, this Court should not take any action before the *Von Staich* decision is final. San Quentin's population will continue to decrease, CDCR and the federal Receiver will continue implementing COVID-19 mitigation strategies, and this Court can address any lingering issues in a few months based on the most current information at that time.

II. IF *VON STAICH* BECOMES FINAL, THIS COURT SHOULD NOT DECIDE THE REMEDY FOR EACH INDIVIDUAL PETITIONER BECAUSE THE COURT OF APPEAL MADE CLEAR THIS COURT MUST DEFER TO CDCR REGARDING HOW IT WILL REDUCE SAN QUENTIN'S POPULATION.

Petitioners urge this Court to decide that each individual petitioner's remedy is release. This Court should resist petitioners' suggestion because deciding that every petitioner is entitled to release would contradict the appellate court's decision and the deference owed to CDCR in managing its prisons. Regarding the remedy, the appellate court made clear its decision would apply to all similarly situated inmates at San Quentin, and that this Court should not insert itself into the mechanics of reducing the San Quentin population. (*Von Staich*, *supra*, 2020 WL 6144780, at *16 ["The remedy we provide will benefit all San Quentin inmates and provide CDCR latitude to determine how that happens"].) Accordingly, the court directed CDCR to "expedite the removal from San Quentin State Prison—by means of release on parole or transfer to another correctional facility administered or monitored by CDCR—of the number of prisoners necessary to reduce the population of that prison to no more than 1,775 inmates." (*Id.* at *19.)

Notably, the appellate court ordered the transfer, not the release, of Von Staich, and did not "order the *release* of . . . any inmate." (*Von Staich*, *supra*, 2020 WL6144780, at *18.) In doing so, the court also rejected Von Staich's request to "release . . . all San Quentin inmates whose age or health condition put them at enhanced risk of death or grave illness from exposure to COVID-19." (*Id.* at *17.) The court denied having the power to order those specific prisoners' release and opined "it would be inappropriate and unwise" to do so, for a few reasons. (*Ibid.*) The court

recognized determining a prisoner's vulnerability to COVID-19 "is far more fraught than petitioner imagines" because the determination is based on "scientific facts, not law." (*Ibid.*) More importantly, "attempting to decide the question would require [the court] to ignore the admonition that courts should not become 'enmeshed in the minutiae of prison operations.'" (*Ibid.*, quoting *Bell v. Wolfish* (1979) 441 U.S. 520, 562.) The Court of Appeal rightly recognized that CDCR is "best positioned to determine the inmates whose removal from San Quentin can be processed most expeditiously." (*Id.* at *18.)[7]

By characterizing the determination of a prisoner's vulnerability to COVID-19 as based on "scientific facts, not law," the appellate court made clear that neither petitioners' counsel nor this Court is equipped to determine which individual prisoners should be removed from San Quentin. Petitioners nonetheless assert this Court should not allow CDCR to meet its population reduction by transferring inmates to other institutions. (Petrs.' Opening Br. at pp. 12-19.) Petitioners do not provide current, relevant, or complete information in support of their arguments, and instead couch their concern with CDCR providing "mass transfers" of the type at the start of the pandemic that caused the deadly outbreak at San Quentin in the first place. (*Id.* at p. 12.)

Obviously, CDCR does not intend to conduct mass transfers of the same kind that were previously unsuccessful, and petitioners' attempts to suggest prisoner transfers of any kind are not safe or effective is not well taken. In the *Plata* class action, the parties in conjunction with the federal Receiver and the California Correctional Health Care Services, continue to adopt additional safety measures and modify those in place to reduce the spread of COVID-19. (Exh. 1 at p. 5.) For example, the federal Receiver has developed a movement matrix setting forth the required precautions before moving an inmate, including between prisons, and there have been no reported COVID-19 transmission events associated with such movements since the matrix went into effect on August 21, 2020. (*Id.* at p. 8; see also Petrs.' Opening Br., Exh. 20, COVID-19

[7] As of October 31, 2020, San Quentin housed: 724 inmates serving a determinate sentence; 385 inmates serving a second strike sentence; 333 inmates serving a third strike sentence; 748 inmates serving a sentence of life with the possibility of parole; one inmate serving a sentence of life without the possibility of parole; and 660 condemned inmates. (Exh. 4, CDCR Office of Research.) Of the then-total 2,851 inmates at San Quentin, 269 inmates are serving serious offenses, 266 inmates are serving neither serious nor violent offenses, and 848 inmates require sex offender registration. (*Ibid.*)

Screening and Testing Matrix for Patient Movement.) Indeed, transfers between institutions have been regularly occurring without incident. (Exh. 1 at p. 7; e.g., Exh. 2 at p. 5 [noting there were 884 inter-prison transfers between September 28 and October 11, and no COVID-19 transmission events occurred among the prisoners subjected to the movement matrix process]; Exh. 5, Redacted List of Offenders with an Institution-to-Institution Movement Between Oct. 26, 2020 and Nov. 1, 2020 [reflecting 397 inmate transfers between institutions in that week]; Petrs.' Opening Br., Exh. 9 at p. 9 ["CDCR is currently transferring hundreds of patients per week between institutions without incident"].) Thus, petitioners' suggestion that transfers will necessarily contribute to COVID-19 outbreaks is unfounded. (Petrs.' Opening Br. at pp. 14-15; see Exh. 1 at p. 17 [reflecting that the most recent COVID-19 outbreak at the California State Prison and Substance Abuse Treatment Facility (SATF) was linked to staff who worked with inmates in the kitchen and factory].)

Also lacking merit is petitioners' contention that there is no other institution that could safely house the number of San Quentin inmates needing to be transferred. (Compare Petrs.' Opening Br. at pp. 14-15 with Exh. 6, Nov. 11, 2020 Weekly Report of Population, at p. 2 [reflecting 10 prisons in total being under capacity by 5,562 inmates].) Excluding Deuel Vocational Institution which is set to close and the California Health Care Facility, there is no reason to conclude that the remaining 29 male prisons could not absorb the approximately 1,026 prisoners from San Quentin, which equates to a mere 36 inmates per prison. (Exh. 6 at p. 2.) Even omitting the prisons that are currently at more than 100 percent capacity, the remaining 10 prisons would only have to absorb 103 prisoners each. (*Ibid.*) That number would continue to decrease as San Quentin prisoners are naturally released through parole grants, transfer, and determinate terms ending, and through CDCR continuing to process early releases. (Exh. 1 at p. 5.) And contrary to petitioners' assertion, all prisons have identified quarantine and isolation space to be used in case of an outbreak. (Compare Petrs.' Opening Br. at pp. 15-16 with Exh. 2 at pp. 9-12.)

Further, petitioners' list of self-serving reasons not to transfer them from San Quentin is unpersuasive and undermines their Eighth Amendment claim. (Petrs.' Opening Br. at pp. 17-18.)

If San Quentin is too dangerous to petitioners' health for them to be housed there, as they allege, then they can be transferred, as the Court of Appeal held is in their best interest. Arguing they should not be transferred because it is stressful, their family will be unable to visit, and they will be unable to participate in programs that may support their bid for parole necessarily implies that petitioners view the foregoing factors as mutually exclusive and more important than their need to be free from San Quentin's alleged unsafe environment.[8] (*Ibid.*) Neither can be true. If their allegations are correct, petitioners must be stressed by remaining at San Quentin, and family visiting and most in-person programs are suspended at every prison. Moreover, petitioners do not get to have it both ways. Either San Quentin is so unsafe that their life depends on their removal from there, or it is only unsafe if they are going to be transferred.

Finally, there is no need for petitioners' counsel to be notified before a client is transferred; if the appellate court limited the court's role in the remedy, then certainly petitioners' counsel are not allowed to "investigate whether the proposed transfer sufficiently addresses the petitioner's pending constitutional claim." (Petrs.' Opening Br. at p. 2.) Providing otherwise would hinder prison operations and insert petitioners' counsel and this Court into the minutiae of those operations, contrary to *Von Staich*. In summary, the Court of Appeal declared that its remedy would apply to all similarly situated San Quentin prisoners, and CDCR is responsible for determining how to reduce San Quentin's population. This Court should reject petitioners' arguments that suggest otherwise.

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[8] The due process clause does not provide state inmates with a constitutionally protected liberty interest in transfers from one prison to another. (*Meachum v. Fano* (1976) 427 U.S. 215, 225.) As the Supreme Court has explained, "[c]onfinement in any of the State's [prisons] is within the normal limits or range of custody which the conviction has authorized the State to impose." (*Ibid.*)

CONCLUSION

This Court should stay the proceedings until the *Von Staich* decision is final, and allow CDCR to continue managing its prison operations under the scrutiny of the parties and the federal Receiver in *Plata*.

Dated: November 16, 2020

Respectfully Submitted,

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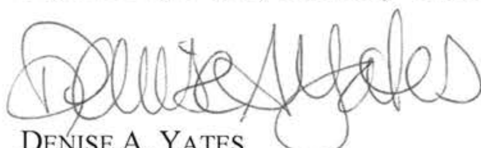

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DECLARATION OF SERVICE BY E-MAIL

Case Name: ***In re Ian Michael Hall, et al.*** **No.: SC212933, et al.**
In re Darious Sommons, et al.. **No.: SC213244, et al.**
In re Dontaye Harris, et al.. **No.: SC213534, et al.**

I declare:

I am employed in the Office of the Attorney General, which is the office of a member of the California State Bar, at which member's direction this service is made. I am 18 years of age or older and not a party to this matter.

On November 16, 2020, I served

RESPONDENT'S BRIEF REGARDING EFFECTS OF *VON STAICH* DECISION

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I declare under penalty of perjury under the laws of the State of California and the United States of America the foregoing is true and correct and that this declaration was executed on November 16, 2020, at San Francisco, California.

N. Newlin
Declarant

Signature

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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: November 5, 2020
Time: 1:30 p.m.
Crtrm.: 6, 2nd Floor

The parties submit the following joint statement in advance of the November 5, 2020 Case Management Conference.

I. POPULATION REDUCTION

Plaintiffs' Position: Further population reductions are necessary to minimize the risk of harm from COVID-19, particularly at prisons with primarily open-air, congregate living spaces, and among those at increased risk of harm if infected. As Defendants have acknowledged, reduced population contributes to fewer infections and deaths. *See* ECF No. 3469 at 3-4.

Unfortunately, as previously explained (*see* ECF No. 3417 at 2:14-3:2), the overall CDCR population reduction since March, while certainly helped by early release programs, has primarily resulted from natural releases and the suspension and limitation of intake.[1] Defendants have now stopped two of the three population reduction programs announced in July. As intake increases, and the number of early releases dwindles, CDCR's total population will increase.

Indeed, CDCR's population is already beginning to increase: the population totals for CDCR's Prisons and Camps on October 21 and 28 were, respectively, 7 and 75 people greater than the week before.[2] Significantly, these week-to-week net increases were the first reported since the initial CDCR COVID-19 patient was diagnosed in late March.[3]

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[1] The subsidiary role of early releases in population reduction is further illustrated by Defendants' recently provided data. They report that between July 1 and October 14, approximately 6,200 were released early, while a far greater number -- approximately 8,500 -- were released via their natural release date (ECF No. 3469 at 2:9-13), and at the same time, intake was prohibited until late August and since then has been, until the last three weeks, greatly limited.

[2] *See* "Institutions/Camps" totals (subpart A.I.1) at https://www.cdcr.ca.gov/research/wp-content/uploads/sites/174/2020/10/Tpop1d201021.pdf [October 21] and https://www.cdcr.ca.gov/research/wp-content/uploads/sites/174/2020/10/Tpop1d201028.pdf [October 28].

[3] *See* "Institutions/Camps" totals (subpart A.I.1) in 2020 Weekly Total Population

Given the large number of people in county jail awaiting transport to CDCR,[4] this dangerous increasing of population will likely continue unless the State re-starts early release programs.

We continue to be extremely disappointed that the State ended the early release program focused on those most vulnerable to severe complications or death if infected by COVID-19, and that so very few – less than 50 out of almost 6,600 eligible[5] – were released by that program when it was in effect. We are similarly disappointed the State excluded people from its COVID-19 high risk early release consideration if medical conditions changed such that they were no longer considered high risk, but refused to include people newly determined to be high risk based on pre-existing medical conditions that public health officials in July announced were serious risk factors for hospitalization or death from COVID-19. We are finally disappointed that the State has not released anyone from San Quentin since the October 20 state appellate decision requiring that prion's population to be substantially reduced due to the risk of harm from COVID-19.

Our disappointment with the State's very limited releases of those most at risk is deepened given what appears to be the inevitable next wave of COVID-19 infections. The

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Reports at https://www.cdcr.ca.gov/research/weekly-total-population-report-archive-2020/.

[4] CDCR on September 29 stated that nearly 8,000 people in county jails were awaiting transport to its reception centers (see ECF No. 3460 at 10:8-20), and surely many additional people were sentenced to state prison in the counties since then. For the most recent three weeks, *i.e.*, those starting October 19, October 26, and November 2, CDCR told us that it authorized intake of, respectively, 610, 428, and 680 people.

[5] *See* ECF No. 3460 at 4:9-6:6 (Defendants report that of 6,599 eligible for early release consideration under COVID-19 high-risk program, 45 determinately sentenced people were approved for release, and 12 indeterminately sentenced people were referred to the Governor for executive clemency consideration). We are not aware of the Governor granting any person in prison clemency since these referrals were made. Even if all referred were released, the main point would remain: surpassingly few of those most at risk of harm from COVID-19 were released by the State's program specifically enacted to release those people.

Governor warned of this next wave a month ago.[6] The United States as a whole is experiencing record-breaking numbers of infections, with no state reporting decreased numbers of infections.[7] California, as of the end of October, had an almost 20 percent increase in infections over the previous week.[8]

Defendants' Position: As of October 28, 2020, CDCR has experienced a population reduction of 23,049, representing a nearly 20 percent decrease in the size of the population, since the start of the COVID-19 public health crisis.[9] Between July 1 and October 28, 2020, 6,391 people were released from institutions and camps as a result of the COVID-19 early-release programs Defendants announced on July 10.[10] This represents 206 more early releases than those reported in the October 20 case management statement.[11] An additional 9,089 were released in accordance with their natural release dates during this

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[6] *See* Amy Graff, SFGATE, *Newsom warns second COVID-19 wave in other countries could hit California* (Oct. 5, 2020), https://www.sfgate.com/news/editorspicks/article/COVID-19-coronavirus-second-wave-California-fall-15623027.php.

[7] *See* New York Times, *The U.S. breaks its record, tallying over 99,000 new cases in a day* (Oct. 31, 2020), https://www.nytimes.com/live/2020/10/30/world/covid-19-coronavirus-updates#the-us-breaks-its-record-tallying-over-99000-new-cases-in-a-day (reporting that "nearly two dozen states are reporting their worst weeks for new cases — and none are recording improvements").

[8] *See* California Department of Public Health, COVID-19 Cases, California Cases, at https://public.tableau.com/views/COVID-19CasesDashboard_15931020425010/Cases?%3Aembed=y&%3AshowVizHome=no (last accessed Oct. 31, 2020) (showing as of October 31 an 18.4% "Weekly % Change" aka "Week-Over-Week % Change of New Cases").

[9] This figure is calculated by taking the difference between the total population in institutions and camps on February 26, 2020 and October 14, 2020. Weekly population reports can be found at https://www.cdcr.ca.gov/research/weekly-total-population-report-archive-2020/.

[10] *See* ECF No. 3389 at 2:4-5:4 and https://www.cdcr.ca.gov/covid19/expedited-releases/ for details regarding CDCR's COVID-19 early-release program announced on July 10, 2020.

[11] *See* ECF No. 3469 at 3:9-3:12.

1 period. As of October 28, CDCR's institutions and camps have a population of 94,293,
2 CDCR's lowest population in three decades.[12]https://word-
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[12] *See* October 28, 2020 population report at https://www.cdcr.ca.gov/research/wp-content/uploads/sites/174/2020/10/Tpop1d201028.pdf.

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2 mscc=1&wdp=2&uih=OneDrive&jsapi=1&jsapiver=v2&corrid=de8d08f3-df71-4e33-908c-
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6 CDCR continues to process early releases on a rolling basis through the 180-day
7 early-release program announced on July 10, which has accounted for the vast majority of
8 all early releases since then. This discretionary early-release program was implemented as
9 an added safety measure at a time when more comprehensive COVID-19 related policies
10 were still being developed. Since then, CDCR adopted additional significant safety
11 measures to reduce the spread of COVID-19, including, as described below, a drastic
12 reduction in intake from county jails, comprehensive testing, quarantine, isolation, and
13 movement protocols, policies regarding personal protective equipment, and plans for
14 COVID-19 testing of staff and incarcerated persons. CDCR continues to evaluate,
15 improve, and update these policies in close coordination with the Receiver.

16 CDCR has regularly provided early-release data to Plaintiffs' counsel and the public
17 after announcing the July 10 programs. The data shows that CDCR's early-release
18 programs are not merely subsidiary: between July 1 and October 28, 2020, early releases
19 accounted for over 41 percent of all releases from CDCR's institutions and camps during
20 that period.[13] Defendants have also been transparent about the fact that the early releases
21 are one of many safety measures CDCR implemented in response to COVID-19, and note
22 that Plaintiffs' list of disappointments (*see supra* pp. 2-3) lacks recognition of the logistics
23 of release and post-release processes and the impact on public safety.
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25

26 [13] As reported above and according to data compiled by CDCR's Office of Research,
27 6,391 people were released from CDCR's institutions and camps through its COVID-19 early-release programs between July 1 and October 28. 9,089 additional people were
28 released in accordance with their natural release dates. A total of 15,480 people were released during this period.

Plaintiffs' counsel receives several updates regarding intake and its mechanics each week through email and phone conferences, and they are aware of the planning, testing, quarantine, isolation, communication, and movement protocols involved in the intake process. Plaintiffs continue to disapprove of CDCR's efforts to provide relief to overpopulated county jails by restarting intake, but fail to acknowledge the impact on jails, courts, and local communities CDCR's intake policies have. At the October 21, 2020 case management conference, Plaintiffs' counsel had no response when the Court attempted to seek clarity on their conflicting positions on this issue (Tr. at 13:11-12), and appear to offer no further clarity on their position in this statement.

Additionally, Plaintiffs' commentary on the State's compliance with court directives in *In re Ivan Von Staich*, No. A160122, 2020 WL 6144780 (Cal. Ct. App. Oct. 20, 2020) is unhelpful and inappropriate. *In re Von Staich* is a separate, state court matter that currently remains pending. Defendants will not substantively comment on that litigation here except to note that, on its own motion, the California Supreme Court opened a case for appeal of this matter and extended its time for ordering review to and including February 17, 2020. Thus, the *In re Von Staich* order does not become enforceable until either the court denies a petition for review or the period expires for California Supreme Court review (on February 17, 2020), whichever occurs first.

Plaintiffs' counsel continue to omit mention of safety measures that have been created, executed, and improved over the past eight months or the beneficial impact they have had. Indeed, Plaintiffs have actively contributed to the development of safety protocols implemented by the Receiver and monitored CDCR's compliance with these protocols, many of which are mentioned on page four above and in sections below. These include, but are not limited to, aggressive testing strategies in each of CDCR's 35 institutions, contact tracing conducted by healthcare staff, quarantine and isolation protocols that surpass some Centers for Disease Control recommendations, a movement matrix that controls all movement of incarcerated people across the state, staff testing, protective-equipment guidance, and an ongoing collaboration between CDCR and the

counties regarding compliance with these standards in advance of intake.

Finally, Plaintiffs comment on the current size of CDCR's population. Although CDCR's population has increased by 82 people in the past two weeks since the last case management conference, it has reduced by nearly 20 percent since the beginning of March and still remains the lowest it has been in three decades.

II. TESTING AND TRANSFER PROTOCOLS

Plaintiffs' Position: CDCR continues to transfer large numbers of patients between prisons. Over the last several weeks, there have been on average approximately 500 such transfers per week. Testing and quarantining of those transferred, to reduce the risk of COVID-19 transmission, remain governed by CCHCS's August 19 "Movement Matrix."

We are not able at present to adequately monitor compliance with the Movement Matrix's testing and quarantine requirements. The best we can do is spot check individual patient records, and it is not possible to gain a systemic view of compliance doing that given the large numbers of people transferred. We also ask CCHCS regularly if it is aware of any COVID-19 transmission events associated with transfers; it says it is not aware of any such events. And while CCHCS says it believes prison staff are complying with the Matrix requirements, we believe it necessary—again remembering the San Quentin disaster resulting from transfers of positive patients into that prison, and the failure to properly quarantine them once they arrived—that objective information document compliance.

In this regard, CCHCS says its Transfer Registry, which we are told will comprehensively display compliance with Movement Matrix requirements for each transferred person, will be made available to us when "fully operational" or "completed." As of October 30, no date for this could be provided by CCHCS. We are not able to square this information with previous reports that the Transfer Registry had been implemented.

CCHCS also previously stated that it would modify an existing form in its Electronic Health Records System (EHRS) so that nurses before a transfer can document

1 that they checked that Movement Matrix requirements had been followed at the sending
2 prison. On October 30, CCHCS said it wanted to complete work on this project and
3 implement the revised form as soon as possible, but could not provide a date by which that
4 would happen.

5 *Defendants' Position*: Since the current iteration of the movement matrix went into
6 effect on August 21, 2020, DAI, CCHCS, and leadership teams at all institutions have held
7 meetings, conference calls, and training sessions to help staff understand and implement
8 the matrix. As directed by the matrix, movement is limited and controlled, and must be
9 pre-approved by CDCR headquarters, which is working in collaboration with CCHCS
10 (including Mr. Cullen and Dr. Bick). Additionally, there is continued enforcement of the
11 safety protocols requiring all county staff and incarcerated people arriving at CDCR on
12 intake buses to wear N95 masks. Further, CDCR and CCHCS continue to utilize measures
13 to track patient information for transfers. Staff at each prison have procedures and
14 processes in place to follow the requirements of the matrix. Further, on October 6, 2020,
15 CCHCS implemented an online registry to track all transfer information for incarcerated
16 persons. The registry is easily accessible, updateable, and contains comprehensive
17 information that allows staff to review medical and other important data before, during,
18 and after transfers. Finally, the prisons continue to offer comprehensive COVID-19 testing
19 for incarcerated people, and the specific protocols for each prison are outlined for Plaintiffs
20 during routine calls with CCHCS staff.

21 **III. INTAKE**

22 *Plaintiffs' Position*: CDCR doubled intake this week: from 338 the week of October
23 25, to 680 the week of November 1. As noted above, the State has at the same time ended
24 two of the three early release programs announced in July. If the State continues intake at
25 this pace, without conducting additional early releases, the population reduction achieved
26 in recent months will be slowly reversed.

27 *Defendants' Position*: CDCR accepted 445 incarcerated persons into custody from
28 county jail intake the week of October 18, and 338 incarcerated persons the week of

October 25, as follows:

Week of:	Number of Incarcerated Persons	Sending County	Receiving Institution
October 18	26	Humboldt	NKSP
October 18	28	Shasta	NKSP
October 18	41	Butte	NKSP
October 18	10	Plumas	NKSP
October 18	5	Modoc	NKSP
October 18	30	Napa	NKSP
October 18	22	Contra Costa	NKSP
October 18	40	Sutter	NKSP
October 18	74	Los Angeles	WSP
October 18	130	San Bernardino	WSP
October 18	39	Orange	CCWF
Total Week of October 18:	445		
October 25	44	El Dorado	NKSP
October 25	23	Shasta	NKSP
October 25	15	Colusa	NKSP
October 25	32	Yuba	NKSP
October 25	105	Tulare	WSP
October 25	52	San Luis Obispo	WSP
October 25	35	Los Angeles	CCWF
October 25	10	Kings	NKSP
Total Week of October 25:	338		

1 Each week, CDCR headquarters staff meet with leadership at the three reception
2 centers (NKSP, WSP, and CCWF) and CCHCS to evaluate current available space,
3 determine whether the institutions should permit intake the following week, and if so, how
4 much space is available to accommodate social distancing of newly arriving incarcerated
5 persons during the initial quarantine period.
6 For the week of November 1, CDCR has authorized intake as follows:
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Number of Incarcerated Persons	**Sending County**	**Receiving Institution**
100	San Joaquin	NKSP
50	Madera	NKSP
40	Mendocino	NKSP
100	Riverside	NKSP
50	Sacramento	NKSP
25	Sacramento	WSP
100	Fresno	WSP
100	Merced	WSP
50	Sonoma	WSP
25	Sacramento	WSP
40	San Diego	CCWF
Total Week of November 1:	680	

22 As Defendants have reported in previous Case Management Statements, CDCR is
23 working tirelessly to ensure that sending counties are complying with all intake protocols,
24 including testing of incarcerated persons in advance of transport and wearing of N95
25 masks by both incarcerated persons and transportation staff at all times during transport.
26 CDCR requires strict compliance with its protocol and has refused buses at intake on this
27 basis, two of which were refused this week.
28 CDCR also coordinates intake with the sending counties to ensure that it is spread

across multiple days within the week to better enable staff at the receiving institution to ensure social distancing during the intake process.

CDCR remains in communication each week with the California State Sheriffs' Association to determine which counties have the greatest need and are able to comply with CDCR's strict transfer protocol, and establishes priority for intake accordingly.

IV. QUARANTINE AND ISOLATION

Plaintiffs' Position:

A. Set Aside of Quarantine and Isolation Space

Plaintiffs continue to contest the adequacy of the quarantine and isolation space identified by Defendants at each prison in response to the Court order of July 22, ECF No. 3401 at 3-4. We raised our concerns with CCHCS on September 16, as described in several past Joint Case Management Conference Statements, based on (a) the plan to use congregate living environments with shared airspace for quarantine purposes, when experience has proven that such environments serve as incubators for uncontrolled viral spread, and (b) the plan to move patients to housing environments that many consider will render them susceptible to attack from other incarcerated people.

On October 27, we asked the Receiver to consider an additional question: whether the set-aside spaces at each prison include provisions for people who are about to be transferred or have been recently transferred (known as precautionary quarantine). This question has gained urgency as inter-prison transfers have steadily increased, averaging approximately 500 per week in recent weeks, and intake has climbed as well, with a planned 680 to enter CDCR from county jails the week of November 2.

CCHCS's own COVID-19 Screening and Testing Matrix for Patient Movement of August 19, 2020, requires people to be placed in precautionary quarantine pre- and post-transfer in celled housing (except for those prisons that have no cells). Each prison "shall maintain sufficient quarantine space to accommodate its historical average volume of transfers." (Definitions at 2.b.ii.) Plaintiffs asked whether such quarantine space has been set aside in accordance with this directive, and if so, whether it is considered included in

the set-aside space for outbreaks.

B. Development of Policies Related to Quarantine and Isolation

As reported at prior Case Management Conferences, Plaintiffs have asked the Receiver to consider developing three policies related to quarantine and isolation: (a) guidance regarding when people should be quarantined or isolated in a space other than the set-aside space, (b) procedures and time-frames for placing patients in isolation or quarantine once positive test results are received or information is received regarding an exposure, and (c) a directive to ensure that those placed in isolation due to symptoms who are pending a COVID-19 test results are kept separate from those who are lab-confirmed to have COVID-19. *See* ECF No. 3469 at 12. On October 30, CCHCS updated its policy regarding the preferential use of set aside space for isolation and quarantine, and stated that isolation of positive patients should happen immediately. No specific procedures for ensuring that were mandated. CCHCS on October 30 said that is developing a report that will measure compliance with key quarantine and isolation requirements. We hope this includes timeliness of placement. CCHCS also says that directives regarding separate isolation placement for symptomatic patients who are pending test results have been provided verbally to the prisons, and will be included in the next revision of the isolation guidelines set forth in the Movement Matrix.

C. Monitoring Use of Quarantine and Isolation Space

CCHCS provided us with the Outbreak Management Tool (OMT) for 10 prisons, as requested, and late last week provided access to a portal at which it says all prisons' OMTs will be accessible. We have engaged in productive discussions with CCHCS regarding best practices and our suggestions for OMT improvements. In our view, the OMTs should permit managers and executives to determine whether fundamental CCHCS public health directives regarding medical isolation and quarantine are being followed at the prisons, and

provide information from which we can monitor such compliance.[14] We have at CCHCS's invitation suggested revisions to the OMTs so they might better present this key information.

Defendants' Position: As discussed in the last joint statement, CDCR has completed its initial effort to set aside large amounts of previously identified isolation and quarantine space at the prisons. CDCR has continued to work with Plaintiffs, the Receiver, the *Coleman* Special Master, and the *Armstrong* Court Expert to ensure that appropriate isolation and quarantine space is reserved for class members of all three class actions and to modify reserved spaces and plans for quarantine and isolation as needed across the system.

On October 27, 2020, representatives from all three class actions met again to discuss isolation and quarantine space needs, with a focus on the needs of *Coleman* enhanced-outpatient class members. The *Plata* Receiver and the *Coleman* Special Master requested another follow-up meeting to take place on November 10. Similar efforts are underway through the *Armstrong* case to ensure that the potential needs of *Armstrong* class members are adequately covered.

V. SAFELY HOUSING MEDICALLY VULNERABLE PEOPLE

Plaintiffs' Position: People who live in open airspace congregate living areas in CDCR prisons are at higher risk of contracting COVID-19 than those housed in cells, and thousands of people living in those spaces currently are at heightened risk of severe illness or death from the virus, due to their age and/or medical condition. Since we filed our last Statement, the Receiver finalized his report entitled "Transferring COVID-19 High-Risk

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[14] CCHCS's public health directives are set forth in its web-based COVID-19 "Interim Guidance" (https://cchcs.ca.gov/covid-19-interim-guidance/), including in particular the "Definitions" section at the end of Appendix 13, the "COVID-19 Screening and Testing Matrix for Patient Movement" (revised August 19, 2020, and also known as the Movement Matrix).

Patients to Safer Housing" in which he addresses concerns about the medically vulnerable in open airspace living units. The Safer Housing Report recommends that CDCR "extend an offer to the over 8,200 patients with COVID-19 risk scores of 3 and above the opportunity to transfer into closed-front cells either at their existing institution or at another institution."

Plaintiffs support this recommendation, and Defendants have not objected to it. *See* ECF No. 3475 at 21. Indeed, Defendants have repeatedly affirmed that they are "committed to working with the Receiver to facilitate movements of medically high-risk patients from dorms to cells" to ensure safe housing "when such movement is recommended and approved by the appropriate public health and corrections experts." ECF No. 3469 at 15; *see also* ECF No. 3460 at 17, ECF No. 3448 at 16.

Unfortunately, progress towards implementing this recommendation has been limited. During our meeting with the Receiver's staff and Defendants on October 22, Mr. Kelso stated that his staff and Defendants would form a Working Group to plan for and to implement offering celled housing to medically vulnerable people, consistent with his Report. He indicated that this process would be undertaken "quickly," and that he was identifying CDCR custody and mental health staff to participate in this process. However, Plaintiffs learned on October 30 that the Working Group has not yet been formed. According to Vince Cullen, Director of Health Care Operations and Corrections Services, CCHCS is still assessing all prisons to ensure they have accurate information about the living spaces available. He reported that this process will not take months, but will also "not be ready next week."

Providing safer housing to those who are at highest risk of serious illness or death if they contract COVID-19 must be a priority, and the Plaintiffs urge Defendants and the Receiver to expedite this process. There will be, as the parties and the Court have recognized, challenges to implementation that include, but are not limited to, a reluctance on the part of many who have earned the right to live in less restrictive dorm housing to

move to a more restrictive cell.[15] Plaintiffs believe that there may be ways to incentivize movement to safer housing, and will welcome the opportunity to work with the Receiver and Defendants to develop and deploy strategies to make safer housing appealing to those who would benefit most from a move. As noted above, the next wave of infections is building now, and expediting the process is critical.

Defendants' Position: The Receiver has provided the parties with a final report on October 21, 2020 that proposes that CDCR should offer over 8,000 high risk medical patients living in dorms the opportunity to move into a single cell. The Defendants remain committed to working with the Receiver to facilitate movements of medically high-risk patients from dorms to cells, or any other movements, to safely house medically high-risk patients when such movement is recommended and approved by the appropriate public health and corrections experts.

VI. COVID-19 TESTING

Plaintiffs' Position:

A. Staff Testing

As previously reported, CCHCS took over authority for the staff testing program in August. On October 30, CCHCS distributed a revised "Employee Testing Guidance" to the parties. We are reviewing the revised Guidance and will send any concerns to CCHCS. Preliminarily, the revised Guidance appears to have increased the frequency of testing for employees at CHCF, CMF, and CCWF, and in medical inpatient units, from monthly to at least every two weeks (and weekly during an outbreak). It also increases the frequency of testing for transportation and hospital custody staff, from monthly to weekly, which we support. We are reviewing whether the revised Guidance's testing requirements are adequate for staff who work at jobs areas, such as kitchens and factories, that require

[15] As noted in our previous Case Management Conference Statement, Plaintiffs have distributed over 120 surveys to people who have been offered, and have declined, transfer to a cell, based on their elevated COVID risk factors. We have started to receive responses and are in the process of reviewing and compiling that information.

high levels of contact with incarcerated people and have been the source of a number of major outbreaks.

Regarding staffing for this program, CCHCS reports that as of October 5, it had assigned employee health RNs to each prison to conduct contact tracing onsite (this was previously done at Headquarters). CCHCS also reports that it will hire nurses to conduct the testing at each prison, and has stated it plans to have these nurses in place by the end of December. In the meantime, vendors continue to conduct employee testing.

Regarding Plaintiffs' monitoring, we still do not have access to employee testing data. The last update we received was in the July 27 Joint Case Management Conference Statement. *See* ECF No. 3405 at 8-10. CCHCS has said it is working on a reporting system for this data, and that reports for three prisons where some of the most vulnerable patients are incarcerated—CHCF, CMF, and CCWF—would be sent to us this week.

We support these developments and appreciate the steps CCHCS has taken to improve the staff testing program. But, seven months into this pandemic, we are disappointed that a comprehensive staff testing plan has yet to be fully implemented. Most significantly, CCHCS has reported that testing employees with symptoms of COVID-19—something we have been requesting since July, *see* ECF No. 3370, including in our motion, *see* ECF No. 3402 at 4-6—will not happen until CCHCS nurses are hired and trained to conduct onsite testing, which it estimates will not be completed until the end of December.

B. Incarcerated Population Testing

1. Patient Testing Policies

We have since June asked CCHCS to revise certain COVID-19 clinical guidelines regarding patient testing so that instead of language indicating a discretionary suggestion (e.g., "should"), words (e.g., "shall") be used that denote a directive mandate. We specifically were concerned about provisions related to serial re-testing of those quarantined who initially tested negative, and regular testing of those who work in areas with high levels of contact with staff or other incarcerated people.

With regard to serial re-testing, it appears the requested change will be made.[16] With regard to testing of essential workers who have high levels of contact with staff and others, no changes were made to the clinical guidelines, and there continues to be no mandated testing of these people despite multiple major COVID-19 outbreaks being directly attributable to such contact. On October 30, we again raised these concerns in relation to the most recent such outbreak, involving kitchen and factory workers at the California State Prison and Substance Abuse Treatment Facility (SATF). According to CCHCS, these workers were infected by staff and then seeded infections in multiple housing units, with approximately 400 people testing positive over the last 14 days. We believe CCHCS must require that prisons at specified intervals test workers who have high levels of contact with staff. On October 30, the Receiver said the issue would be considered.

2. Notification to Patients of Test Results

In early July we first raised concerns about inadequate patient notification and education regarding COVID-19 test results. CCHCS continues to work on implementing standardized templates that will notify patients of negative, inconclusive, or negative COVID-19 test results, and provide educational information. On October 30, CCHCS indicated it hoped to implement use of these templates by Thanksgiving. Meanwhile, and unfortunately, late, limited, and otherwise inadequate written notification of and education regarding test results continues.

Defendants' Position: Defendants note that Plaintiffs have raised issues in this section that appear to be directed to the Receiver's office and CCHCS. Defendants will not attempt to respond on their behalf, but remain committed to working with them in

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[16] On November 2, CCHCS's Chief Counsel wrote, as we understand it, that discretionary language ("should") would be replaced with mandatory language ("shall") in the Interim Guidance's "Testing for COVID-19 and Other Respiratory Pathogens" provision that currently reads "[s]erial retesting of housing unit inmates and others who are at potential exposure risk, who are quarantined, and initially test negative should be performed every 3-7 days until no new cases are identified."

addressing Plaintiffs' concerns.

VII. OIG Report on the Use of Face Coverings in CDCR

Plaintiffs' Position: On October 26, the Office of the Inspector General (OIG) released its second report in its review of CDCR's response to the COVID-19 pandemic. *See* Office of the Inspector General, *COVID-19 Review Series, Part Two: The California Department of Corrections and Rehabilitation Distributed and Mandated the Use of Personal Protective Equipment and Cloth Face Coverings; However, Its Lax Enforcement Led to Inadequate Adherence to Basic Safety Protocols* (Oct. 2020), available at: https://www.oig.ca.gov/wp-content/uploads/2020/10/OIG-COVID-19-Review-Series-Part-2-%E2%80%93-Face-Coverings-and-PPE.pdf. This report reviews CDCR's distribution and use of personal protective equipment (PPE). The OIG found that, although CDCR had provided PPE and communicated face covering and physical distancing requirements to staff and incarcerated persons, in practice, both frequently failed to adhere to mask-wearing requirements. *Id*. at 2. OIG staff directly observed this during their monitoring visits, *id.* at 22-30, and significant noncompliance was also reported by prison staff surveyed by the OIG, *id*. at 31.

Most troubling, the OIG concluded that the failure to follow face covering and physical distancing requirements "was likely caused at least in part by the department's supervisors' and managers' lax enforcement of the requirements." *Id*. at 2. The OIG noted that CDCR has referred only 7 employees (out of more than 63,000) for formal investigation or punitive actions for misconduct relating to face covering and physical distancing requirements since February 1, 2020. *Id.* at 2-3, 35. Even lower levels of progressive discipline were infrequent: "A sample of five prisons that employ a total of 10,382 staff showed that from February 1, 2020, to September 2, 2020, prison supervisors and managers had taken just 29 disciplinary actions—in a period spanning seven months—for noncompliance with the department's face covering or physical distancing requirements." *Id.* at 20-21. Of those 29, "almost all the actions taken were the lowest levels of the progressive discipline process: namely, verbal warnings and instances of

written counseling." *Id.* at 34. California Institution for Men, with 1,413 COVID-confirmed cases and 27 COVID-related deaths among the incarcerated population, "provided no documentation of any disciplinary actions." *Id.* at 2, 34. San Quentin, with 2,240 COVID-confirmed cases and 28 COVID-related deaths, "provided documentation of just one action." *Id.* at 2, 34-35.

The OIG also faulted CDCR and CCHCS for loosening face covering requirements in June 2020. *Id.* at 3, 36. Two memos released in June allowed staff and incarcerated persons to remove their face coverings when they were outside and able to maintain a distance of at least six feet from other individuals. *Id.* at 36-37.

Plaintiffs were deeply troubled by this report. In response to the OIG's recommendations, on October 27, CDCR and CCHCS issued a memorandum requiring staff to wear face coverings "at all times," with two exceptions: (1) when a staff member is alone in a hard-walled office, tower, or control booth, and (2) when a staff members is in the performance of their duties and is actively responding to an incident. In the latter incident, the staff member is permitted to remove their face covering while jogging/running to respond to an incident. The memorandum also provides that "corrective action shall be taken" whenever managers or supervisors observe noncompliance, and that managers and supervisors "shall document" the noncompliance in a tracking log. Finally, the memo calls for unannounced compliance visits to each prison.

We support these efforts, but remain concerned, as self-monitoring of compliance with the face covering and physical distancing policies has proven to be extremely difficult. We have previously sent reports to CDCR and CCHCS of staff not adhering to these policies; each time, we have been told that CDCR or CCHCS conducted audits and found no or limited issues. We believe that the OIG should conduct another review of CDCR's compliance with the mandatory mask requirement in the near future, given the likelihood of another wave of COVID-19 infections hitting the prisons in the near future. The Inspector General has informed us that upon request from the Court he would conduct a follow-up review in a few months in order to determine whether there is increased

1 compliance by staff with the mask wearing requirements.

2 *Defendants' Position*: On October 26, 2020, the OIG released a report focused on
3 CDCR's distribution of personal protective equipment (PPE) to its staff and incarcerated
4 persons during the COVID 19 pandemic. The report states that OIG monitored CDCR
5 institutions between May 19, 2020 and July 29, 2020 and that it conducted state-wide staff
6 surveys.

7 The report found that, despite early shortages, CDCR was generally able to procure
8 and maintain PPE supplies. Indeed, by April 9, CDCR delivered more than half of the
9 752,000 cloth face coverings it had purchased to its institutions. However, the report
10 further found that CDCR's enforcement of face covering and social distancing guidelines
11 was too lax and that not enough disciplinary action was employed, resulting in
12 noncompliance by staff and incarcerated persons.

13 On October 27, CDCR issued a memorandum updating the requirements regarding
14 the use of facial coverings and physical distancing, including strict enforcement protocols
15 and regular unannounced compliance audits to each institution. The memorandum
16 reminds "[a]ll departmental supervisors and managers [that they] are responsible for
17 ensuring subordinate staff consistently wear approved face coverings correctly and practice
18 physical distancing," and that failure to do so will result in corrective action. This
19 memorandum is attached as **Exhibit A**. Further, on October 28, CCHCS issued an
20 amended memorandum outlining enhanced entrance screening procedures that detail the
21 screening process, screener training, guidance for employees who are sick or denied
22 entrance to an institution, and regular submission of a proof of practice report to ensure
23 compliance with screening procedures, attached as **Exhibit B**.

24 In addition, Regional Healthcare Executives conducted random, surprise spot
25 checks at several institutions the week of November 2. Progressive discipline was initiated
26 for instances of noncompliance, in accordance with CDCR's October 27 memorandum.
27 Further, Secretary Allison and Mr. Kelso are jointly hosting a call with all wardens, CEOs,
28 and their management teams on Friday, November 6 to further reiterate the importance of

the mask wearing mandate and related discipline for noncompliance. Secretary Allison and Mr. Kelso are also in the process of creating a video with additional speakers which will stress the importance of mask wearing to staff. Thus, while CDCR is disappointed and concerned by the OIG's findings based upon monitoring that occurred before the end of July, it is taking every effort to ensure staff compliance with mask-wearing mandates and enhance policies to further safeguard the institution population as well as staff against the spread of COVID-19.

VIII. Prison-Specific Updates

Plaintiffs' Position: We continue to have weekly conferences with Regional Health Care Chief Executive Officers (CEOs) and their supervisor regarding COVID-related matters at individual prisons. We very much appreciate these discussions, including because we learn of positive initiatives, raise concerns about problems, and suggest opportunities for improvement.

Based on information received at the October 16 conference with the CEOs, we on October 20 reported to the Court that CIM would begin serial weekly testing of never-positive patients, as is being done at San Quentin, and the California Rehabilitation Center (CRC). *See* ECF No. 3469 at 17:16-22. We also reported that CIM had arranged for approximately 20 additional nurses, to implement such testing. *Id.*

On October 23, the Regional CEO said serial retesting did <u>not</u> start at CIM and that 20 additional nurses were <u>not</u> obtained there; CCHCS then said it would review the matter. On October 30, it was again stated that serial retesting of never-positive patients prison-wide, is not occurring at CIM, could not occur until additional nurses were hired, and that an experienced physician had been sent to the prison to determine those staffing needs.

That incorrect information was provided about serial weekly testing at CIM is unfortunate. That such retesting has not started is unacceptable. Serial retesting of never-positive patients occurs at San Quentin, CRC, and, we believe, Avenal. The COVID-19 outbreak at CIM is about to enter its eighth month. Almost 1,500 at the prison have been infected with the virus, resulting in 161 hospitalized (the largest such total among CDCR

prisons) and 27 deaths (sadly, the second highest among the state prisons). CIM has a very large number of medically vulnerable patients: only the California Health Care Facility (CHCF) and the California Medical Facility (CMF) have greater percentages of high risk medical patients.[17] CIM's number of medically vulnerable patients, and the continuing consequences from COVID-19 suffered by those at the prison (the two most recent deaths occurred in the last week), require that weekly retesting of never-positive patients start immediately.[18]

Defendants' Position: Defendants note that Plaintiffs have raised issues in this section that appear to be directed to the Receiver's office and CCHCS. Defendants will not attempt to respond on their behalf, but remain committed to working with them in addressing Plaintiffs' concerns.

IX. Updates on Medical Care Matters Not Directly Related to COVID-19

Plaintiffs' Position: A conference with CCHCS has been scheduled for November 6 to discuss in more detail what is being done about the thousands of delayed (many for months) Addiction Medicine physician appointments for patients with substance use disorders referred for Medication Assisted Treatment (MAT). *See* ECF No. 3469 at 19. We appreciate the opportunity to further discuss this important issue. In the last two weeks we have for the first time learned, via CCHCS responses to queries about particular patients, that a part of the problem is that some Addiction Medicine physicians, both at a local prison and headquarters, have reached their current patient load limit set by federal licensing requirements and thus cannot prescribe MAT for additional patients.

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[17] The most recent data provided by CCHCS, dated August 2020, shows that 65% of CHCF's population is designated medical high risk. At CMF and CIM, respectively, 53.9% and 49.6% of the population is so designated. Because CIM houses more people than CMF, the number of medical high risk patients housed there is greater than at CMF.

[18] We support the serial retesting program at CRC, but it is puzzling that CCHCS does it there but not at CIM. CCHCS data shows that only 4.6% of CRC's population is designated medical high risk, 23 patients have been hospitalized due to COVID-19 and, fortunately, none have died.

Defendants' Position: Defendants note that Plaintiffs have raised issues in this section that appear to be directed to the Receiver's office and CCHCS. Defendants will not attempt to respond on their behalf, but remain committed to working with them in addressing Plaintiffs' concerns.

DATED: November 4, 2020

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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: October 21, 2020 Time: 10:00 a.m. Crtrm.: 6, 2nd Floor

The parties submit the following joint statement in advance of the October 21, 2020 Case Management Conference.

I. POPULATION REDUCTION

A. Status

Plaintiffs' Position: Today, the California Court of Appeal ruled that the state's failure to provide adequate space to allow for distancing for people housed in San Quentin State Prison during the pandemic violated the Eighth Amendment. The Court ordered that the state expedite the removal from that prison, by means of release or transfer to another prison, the number of people necessary to reduce the population to no more than 1,775 (i.e., 50% of the June 2020 population). *See,* In re Von Staich, No. A160122 (Cal. Ct. App. Oct. 20, 2020) attached as Exh. 1.

Population reduction remains necessary to minimize the risk of harm from COVID-19, particularly among those at increased risk of harm if infected. As Defendants acknowledge below, reduced population contributes to fewer infections.

As previously explained (see ECF No. 3417 at 2:14-3:2), the overall CDCR population reduction since March, while certainly helped by early release programs, has primarily resulted from natural releases and the suspension and limitation of intake. As intake increases, CDCR's total population is likely to increase as well.[1]

The vast majority of early releases under the three programs CDCR announced in July took place in that month and early August. Since the October 6 Statement, in which CDCR announced the end of two of the three July programs, only 221 early releases have taken place.

Following the October 7 Case Management Conference, we asked Defendants to

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[1] CDCR recently stated that nearly 8,000 people in county jails are awaiting transport to its reception centers. As reported in Part III, below, more than 600 people are being received this week from county jails. If intake continues at such levels, it will soon enough off-set much of any continuing reduction achieved from natural and early releases.

have the new CDCR Secretary consider early release of people newly determined to have a Weighted COVID Risk Score qualifying them under the now-ended July Program that focuses on those at highest risk of severe complications if infected with COVID-19. Defendants have not substantively responded to this request, but the clear implication from their report below is that they will not do so, at least at present.

Defendants' Position: Since the start of the COVID-19 public health crisis, 23,131 incarcerated people were released from CDCR institutions and camps as of October 14, 2020.[2] CDCR experienced a population decrease of about 19.7% during this period. Between July 1 and October 14, 6,185 people were released from institutions and camps as a result of the COVID-19 early-release programs Defendants announced on July 10.[3] This represents 221 additional early releases since the October 6 case management conference statement.[4] An additional 8,498 people were released in accordance with their natural release date during this period. As of October 14, CDCR's institutions and camps have a population of 94,211.[5]

Responding to Plaintiffs' comment regarding the rate of population reduction above, Defendants note that CDCR started decreasing its population in late March. CDCR's population decreased by approximately 4,000 between mid-March and mid-April, over 5,000 more between mid-April and July, nearly 6,000 more in July, and over 5,000 more in August. To provide a visual of the rate of CDCR's population decrease this year, Defendants include the below graph. The population data in this graph is sourced from

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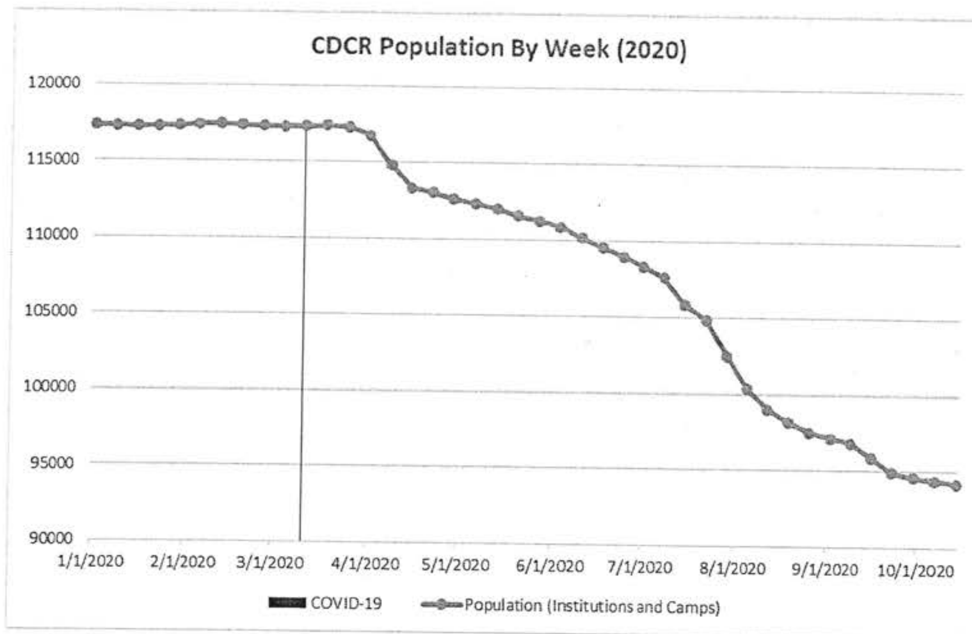
[2] This figure is calculated by taking the difference between the total population in institutions and camps on February 26, 2020 and October 14, 2020. Weekly population reports can be found at https://www.cdcr.ca.gov/research/weekly-total-population-report-archive-2020/.

[3] *See* ECF No. 3389 at 2:4-5:4 and https://www.cdcr.ca.gov/covid19/expedited-releases/ for details regarding CDCR's COVID-19 early-release program announced on July 10, 2020.

[4] *See* ECF No. 3460 at 4:3-4.

[5] See October 14, 2020 weekly population report at https://www.cdcr.ca.gov/research/wp-content/uploads/sites/174/2020/10/Tpop1d201014.pdf.

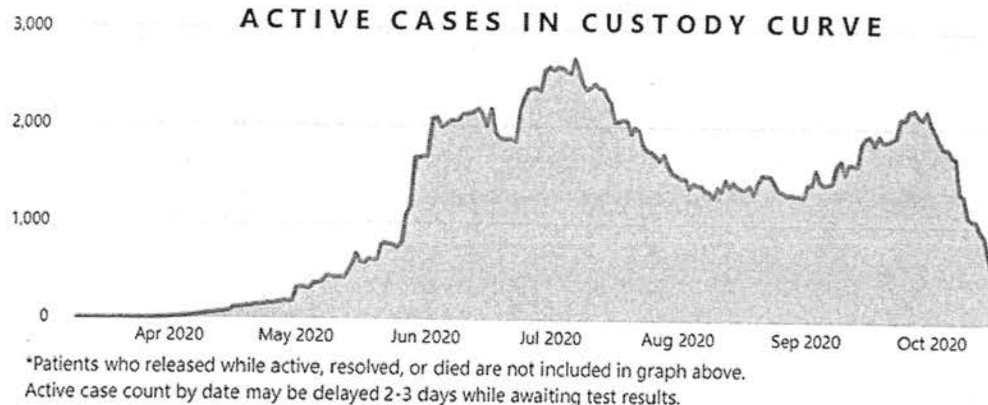
CDCR's weekly population reports from January 1 through October 14, 2020.



CDCR continues to process early releases on a rolling basis through the 180-day early-release program announced on July 10. CDCR implemented its discretionary early-release program as an added safety measure at a time when more comprehensive COVID-19-related policies were still being developed. Since then, CDCR has adopted additional significant safety measures to reduce the spread of COVID-19, including, as described in sections below, a drastic reduction in intake from county jails, comprehensive testing, quarantine, isolation, and movement protocols, policies regarding personal protective equipment, and plans for COVID-19 testing of staff and incarcerated people.

Because of the effectiveness of these policies, which CDCR continues to evaluate, improve, and update in close coordination with the Receiver, positivity rates and COVID-19-related complications and deaths have recently trended downwards. As of October 20, fewer than 500 incarcerated people statewide—or less than 1% of CDCR's current

population—are COVID-19-positive.[6] This is the lowest positivity rate CDCR has experienced since May. The below graph is a screenshot from page 4 of CDCR's Population COVID-19 Tracker taken on October 19, showing the number of positive COVID-19 cases among CDCR's incarcerated population between March 10 and October 19.



Early releases of medically high-risk people continue through the 180-day early-release program, which has accounted for the vast majority of all early releases since CDCR's COVID-19 early-release programs were announced on July 10. And, as set forth in section V below, the Receiver has indicated that new recommendations related to medically high-risk people are forthcoming.[7] In this context, CDCR continues to evaluate the need to resume the high-risk medical early-release program in addition to its other ongoing COVID-19 mitigation efforts.[8]

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[6] *See* CDCR's Population COVID-19 Tracking tool at https://www.cdcr.ca.gov/covid19/population-status-tracking/ (last visited on October 20, 2020).

[7] On October 14, the Receiver circulated a draft document to the parties titled "Report on Risks of COVID to High-Risk Patients." The current iteration of the report includes updates to recommended policies related to incarcerated people at a higher risk of experiencing complications if they contract COVID-19. The Receiver is accepting comments to this report until October 20.

[8] In the October 6 joint case management conference statement, Defendants reported that the high-risk medical early-release program, originally announced on July 10, had been (footnote continued)

CDCR continues to work with county jails to apply 12 weeks of positive programming credits to eligible people awaiting transfers to CDCR institutions. This includes identifying people eligible to receive these credits, calculating updated release dates following the application of credits, and providing release instructions for people who are released early as a result of the application of these credits.[9] As of October 9, 2020, CDCR had issued 965 release memoranda for persons incarcerated in county jails and awaiting transfer to CDCR.

II. TESTING AND TRANSFER PROTOCOLS

Plaintiffs' Position: CDCR continues to transfer large numbers of patients between prisons, with testing and quarantining to reduce the risk of COVID-19 transmission governed by CCHCS's August 19 "Movement Matrix." CDCR reports there were 514 such transfers between September 28 and October 4, and 370 between October 5 and 11. According to CCHCS, there have been "no COVID transmission events . . . among patients subjected to the movement matrix process."

Medical staff, before a patient is transferred between prisons, should check that a timely COVID test and other requirements of the Movement Matrix have been met. As noted previously, CCHCS rejected our suggestion that staff complete a checklist before patients get on a transportation vehicle to minimize the risk that a person is moved without the necessary quarantine period and a timely negative test. However, at the October 7 Case Management Conference, the Receiver explained that medical staff do use a checklist when people are transferred, and some prisons had modified it to include Matrix-related requirements. We then asked that the modified checklist be used at all prisons. CCHCS on October 16 denied our request. Instead, it stated that its "Nursing Program is cross

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suspended after the original list of people had been evaluated for early-release eligibility. *See* ECF No. 3460 at 6:6-10.

[9] *See* ECF No. 3460 at 8:1-9 for further explanation of this positive programming credit initiative.

referencing [the] current EHRS documentation 'pre-screening form' and will modify accordingly to ensure that the transfer matrix requirements are met." Plaintiffs have requested further information about this process.

In addition, to track transfers, CCHCS has developed a "Transfer Registry." Defendants indicate below that CCHCS implemented the Registry on October 6, and that it is easily accessible to staff. In response to questions we asked last week, CCHCS on October 16 said that on October 12 one session of training had been done with field staff about how the Registry works and that based on feedback received additional training will be developed by the end of this month. It is not clear to Plaintiffs the degree to which the Registry is fully operational, given that training is still being developed.

We also last week asked CCHCS about obtaining access to the Registry. Our question was not answered. We believe access to the Registry is necessary to adequately monitor compliance with the Movement Matrix.

Defendants' Position: Since the current iteration of the movement matrix went into effect on August 21, 2020, DAI, CCHCS, and leadership teams at all institutions have held meetings, conference calls, and training sessions to help staff understand and implement the matrix. As directed by the matrix, movement is limited and controlled, and must be pre-approved by CDCR headquarters, which is working in collaboration with CCHCS (including Mr. Cullen and Dr. Bick). Additionally, there is continued enforcement of the safety protocols requiring all county staff and incarcerated people arriving to CDCR on intake buses to wear N95 masks. Further, CDCR and CCHCS continue to utilize measures to track patient information for transfers. Staff at each prison have procedures and processes in place to follow the requirements of the matrix. Further, on October 6, 2020, CCHCS implemented an online registry to track all transfer information for incarcerated people. The registry is easily accessible, updateable, and contains comprehensive information that allows staff to review medical and other important data before, during, and after transfers. Finally, the prisons continue to offer comprehensive COVID-19 testing for incarcerated people, and the specific protocols for

each prison are outlined for Plaintiffs during routine calls with CCHCS staff.

III. INTAKE

Plaintiffs' Position: Plaintiffs remain concerned about the admission of additional people to CDCR prisons at this time. In compliance with Court's July 22 Order, the parties and the Receiver continue to meet and confer to ensure the space allocated for quarantine and isolation at each prison is adequate to respond to a COVID outbreak. Moreover, as set forth in § V., the Receiver recently issued a draft report urging Defendants to offer celled housing to all those considered medically vulnerable to COVID-19 who now live in dorms. Admitting additional people to the CDCR population before the quarantine and isolation allocation is finalized and these potential transfers are addressed could put pressure on already stressed quarantine space and result in further spread of the virus.

Defendants reopened intake to their facilities on August 24, admitting a total of 100 people the first week and 200 the following week. This "limited intake" would, according to Defendants, allow CDCR and CCHCS to test their processes, mitigate risk and ensure safety. *See* ECF No. 3436 at 10. Two weeks later, Defendants wrote, "CDCR expects to adopt a schedule for intake that will include some limited number of weeks for intake followed by one or two weeks of no intake, repeated for the foreseeable future. For instance, 3 weeks of intake, followed by a 1 or 2 week pause, then 3 weeks of intake." ECF No. 3449 at 11. However, Defendants have seemingly abandoned their measured approach to intake. Since September 20, Defendants have admitted between approximately 143 to 360 people each week. *See* ECF No. 3460 at 10-11. For the current week, Defendants say they plan to admit 610 people.

Defendants' Position: CDCR accepted 215 incarcerated persons into custody via county jail intake the week of October 4, and 322 incarcerated persons the week of October 11, as follows:

Week of:	Number of Incarcerated Persons	Sending County	Receiving Institution

October 4	132	Stanislaus	WSP
October 4	83	San Diego	NKSP
Total Week of October 4:	215		
October 11	25	Shasta	NKSP
October 11	145	Orange	NKSP
October 11	123	Kern	WSP
October 11	10	Kings	CCWF
October 11	6	Stanislaus	CCWF
October 11	12	Kern	CCWF
Total Week of October 11:	322		

Each week, CDCR headquarters meets with leadership from NKSP, WSP, and CCWF, as well as CCHCS, to determine whether the institutions should permit intake the following week, and if so, how much space is available such that social distancing of newly arriving incarcerated persons can safely be accomplished during the initial quarantine period. For the week of October 18, CDCR has authorized intake as follows:

Number of Incarcerated Persons	Sending County	Receiving Institution
30	Humboldt	NKSP
30	Shasta	NKSP
100	Butte	NKSP
10	Plumas	NKSP
10	Modoc	NKSP
50	Napa	NKSP
40	Contra Costa	NKSP
50	Sutter	NKSP
90	Los Angeles	WSP

160	San Bernardino	WSP
40	Orange	CCWF
Total Week of October 18:	610	

As Defendants have reported in previous Case Management Statements, CDCR is working tirelessly to ensure that sending counties are complying with all intake protocols, including testing of incarcerated persons in advance of transport and wearing of N95 masks by both incarcerated persons and transportation staff at all times during transport. CDCR requires strict compliance with its protocol. By way of example, a bus arrived at CCWF during the week of October 4, but the sending county had failed to provide CCWF with COVID-19 test results in advance of arrival for three incarcerated persons. Additionally, upon inspection of the bus at the vehicle sallyport, CCWF medical staff observed that the neither the sending county's transportation staff nor any of the incarcerated persons being transported were wearing N95 masks. Accordingly, the bus was not allowed to enter CCWF and the incarcerated persons were returned to the sending county.

CDCR also coordinates intake with the sending counties to ensure that it is spread across multiple days within the week to better enable staff at the receiving institution to ensure social distancing during the intake process.

CDCR remains in communication each week with the California State Sheriffs' Association to determine which counties have the greatest need and are able to comply with CDCR's strict transfer protocol.

IV. QUARANTINE AND ISOLATION

Plaintiffs' Position:

A. Set Aside of Quarantine and Isolation Space

Defendants have identified COVID-19 quarantine and isolation space at every prison to be used in the event of an outbreak, as ordered by this Court on July 22. ECF

No. 3401 at 3-4. Based upon information we received from Defendants on October 16, it appears that this space has been vacated, in compliance with the Court's orders on July 22 and September 22. ECF Nos. 3401 at 3-4 and 3460 at 2. On September 16, Plaintiffs requested modifications to that set-aside space, as allowed by the Court's order. *Id.* On October 15, CCHCS responded.

Plaintiffs' first ground for requesting modifications was that many of the quarantine set-asides are dorms or tiered cell blocks without solid doors -- exactly the sort of congregate living environments, with shared airspaces, that have allowed rapid and uncontrolled spread of the virus in the prisons. The Public Health Workgroup recognized that people exposed to the virus "must be separated from each other in single cells with solid doors." Several thousand people incarcerated in CDCR are presently quarantined in dorms or cells with barred or perforated doors, in direct contradiction to that guidance.

The response from CCHCS recognized these concerns but did not provide a clear response to how patients in prisons without solid-door celled quarantine space would be protected from an unreasonable risk of harm.

Plaintiffs' second ground for requesting modification was a concern that general population patients might refuse to move to isolation or quarantine space located on a sensitive needs yard, and vice versa, due to fears that they might experience violent reprisals from other incarcerated people as a result. People could refuse tests for the same reason. Multiple refusals could create a public health problem. CCHCS responded that isolation and quarantine space was akin to Administrative Segregation, where general population and sensitive needs populations are mixed. Finally, CCHCS provided specific responses to our institution-specific concerns and noted that, subsequent to Plaintiffs' September 16 letter, CDCR set aside additional beds for isolation and quarantine at some prisons. We then asked and received from CDCR a current draft of all set aside space. Plaintiffs will review the additional space and CCHCS's responses to determine whether we think our concerns have been adequately addressed.

B. Development of Policies Related to Quarantine and Isolation

As reported in the last two Case Management Conferences, Plaintiffs have asked the Receiver to consider developing two policies related to quarantine and isolation: (a) guidance regarding when people should be quarantined or isolated in a space other than the set-aside space, and (b) procedures and time-frames for placing patients in isolation or quarantine once positive test results are received or information is received regarding an exposure. *See* ECF No. 3448 at 12-13; ECF No. 3460 at 14.

Although CCHCS has provided responses to the above requests, plaintiffs are pursuing clarification.

We have also asked CCHCS to issue a directive to ensure that those placed in isolation due to symptoms who are pending a COVID-19 test results are kept separate from those who are lab-confirmed to have COVID-19. CCCHS on October 16 responded that this message has been provided to the field in regularly scheduled phone conferences, and will be addressed in the next iteration of the Movement Matrix.

C. Monitoring Use of Quarantine and Isolation Space

Plaintiffs must be able to adequately monitor the use of quarantine and isolation space, including to ensure that incarcerated people are not placed at risk of harm and so that we can determine whether to request that further space be set aside. CCHCS has developed a template—called an Outbreak Management Tool—that prisons will use on a daily basis to report on matters related to COVID-19, including information on numbers and housing locations of patients in quarantine and isolation. We sent CCHCS comments on a draft version of the template, and were told on October 2 that CCHCS is in the process of automating the tool, and that completed copies of these daily reports will be provided to Plaintiffs once they are in use at the prisons. On October 16, CCHCS said that work on a partially automated Tool was expected to be completed last week, would then be distributed to the prisons for feedback, and that it anticipated a partially automated version would be available by the end of this month.

While providing the above information, CCHCS did not last week respond to our question regarding when we will be provided access to the Outbreak Management Tool as

completed by the various prisons. We understand, including because weeks ago CCHCS provided us a copy of one, that the prisons are currently completing and forwarding the tool to regional and central office managers. Given that earlier this month CCHCS said we would be provided copies, it is not clear why we are not regularly receiving them. We believe access to this information is necessary for adequate monitoring and would significantly improve our understanding of outbreak response.

Defendants' Position: CDCR has completed its effort to set aside vast quantities of previously identified isolation and quarantine space at the prisons. As discussed at the last case-management conference, only one prison—California State Prison, Los Angeles County (LAC)—still needed to vacate its identified isolation and quarantine space. LAC completed that process on October 9, 2020, and all identified quarantine and isolation space is now either ready for occupancy or is already being used for quarantine or isolation.

Plaintiffs submitted a number of concerns about current isolation and quarantine reserves to the Receiver in September and the Receiver responded to those concerns on October 15, 2020. Additionally, the Receiver's office arranged a meeting on October 5 for the parties in *Plata*, *Coleman*, and *Armstrong* to further discuss isolation and quarantine issues with the Receiver, the *Coleman* Special Master, and the *Armstrong* Court Expert. The Receiver held a follow-up to that meeting on October 15, 2020. The focus of the October 15 meeting was ensuring that appropriate isolation and quarantine space would be available for enhanced-outpatient *Coleman* class members. Significant progress toward achieving that goal was made at the October 15 meeting, and the Receiver scheduled another follow-up meeting on October 27, 2020, to allow the parties to further discuss quarantine and isolation.

V. SAFELY HOUSING MEDICALLY VULNERABLE PEOPLE

Plaintiffs' Position: CDCR continues to house people in large congregate living

areas, including thousands who, based on age and/or their medical condition, are particularly vulnerable to severe illness or death from COVID-19.[10] In these dorms and open-cell-front living units, large numbers of people share airspace, including sleeping areas, bathrooms, and showers. The U.S. Centers for Disease Control and Prevention ("CDC") recently confirmed that COVID-19 can be spread by aerosolization, and the number and rate of infections in CDCR in the first seven months of the pandemic show that the virus spreads rapidly when introduced into dorms and open-cell-front housing. Because the risk of infection is so much greater in these environments, they are particularly dangerous for medically vulnerable people, placing them at heightened risk of severe illness or death.

In an effort to address this situation, the Receiver on October 14 circulated a Draft Report entitled, "Report on Risks of COVID to High-Risk Patients."[11] Recognizing the high risks of morbidity and mortality for people with COVID-19 risk-factors, he recommends that "CDCR extend an offer to the over 8,200 patients with COVID-19 risk scores of 3 and above who are currently housed in dorms or open-cell-front housing the opportunity to transfer into closed-front cells either at their existing institution or at another institution." Having consulted with our public health expert, Dr. Adam Lauring, Plaintiffs endorse this recommendation, and are continuing to discuss whether the CDCR should do more than extend an offer to those at high medical risk for COVID-19.

To date large percentages of medically vulnerable patients have declined offers to move from dorms to cells. Last week we mailed a questionnaire to each of these patients, in the hope of better understanding why they did not want to move and whether there are circumstances under which they would.

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[10] As noted in the previous Joint Case Management Conference Statement, celled housing has already been offered to a small number of medically vulnerable people in dorms, and the acceptance rate has been low.

[11] The parties have been invited to submit comments on the report by Tuesday, October 20.

Defendants' Position: The Receiver has provided the parties with a draft report that proposes that CDCR should offer over 8,000 HRM patients living in dorms the opportunity to move into a single cell. The Report is still awaiting further comments and the Defendants remain committed to working with the Receiver to facilitate movements of medically high-risk patients from dorms to cells, or any other movements, to safely house medically high-risk patients when such movement is recommended and approved by the appropriate public health and corrections experts.

Defendants note that Plaintiffs have raised issues in this section that appear to be directed to the Receiver's office and CCHCS. Defendants will not attempt to respond on their behalf, but remain committed to working with them in addressing Plaintiffs' concerns.

VI. COVID-19 TESTING

A. Staff Testing

Plaintiffs' Position: As reported in prior Joint Case Management Conference Statements, the Office of the Inspector General (OIG) in August reported significant problems with the entrance screening practices in CDCR. *See* ECF No. 3427 at 14-15; ECF No. 3436 at 18-19; ECF No. 3460 at 18; Office of the Inspector General, *COVID-19 Review Series, Part One: Inconsistent Screening Practices May Have Increased the Risk of COVID-19 Within California's Prison System* (August 2020), https://www.oig.ca.gov/wp-content/uploads/2020/08/OIG-COVID-19-Review-Series-Part-1-Screening.pdf. On October 8, CCHCS issued a memorandum to standardize the entrance screening practices at all prisons. The memorandum directs each prison to identify and submit a screening location for approval, provide training for employees conducting the screening, and regularly audit and report on compliance with screening procedures. We hope this will result in reliable, consistent screenings of all staff entering the prisons.

Regarding staff testing, CCHCS took over authority for staff testing in August, and on September 14, distributed its draft "Employee Testing Guidance" to the parties. Plaintiffs provided comments to CCHCS on September 23. On October 2, CCHCS said it

had reviewed our comments and would be providing responses, as well as a revised version of the Testing Guidance, the following week. On October 16, in response to our query, CCHCS stated it was still finalizing the revised Testing Guidance. CCHCS also reported it was finalizing an Employee Testing Budget Proposal, so that nursing staff could be hired to conduct onsite testing seven days a week. CCHCS reported that, currently, employee testing is still conducted by vendors, and is only done five days a week. CCHCS stated they anticipated nursing staff would be conducting employee testing by December 2020. As we have previously stated, we appreciate the steps CCHCS is taking to implement an effective staff testing program, but, seven months into the pandemic, regret that such necessary action was not taken by CDCR or CCHCS sooner.

Finally, in response to our request for reports on the staff testing completed in August and September at CHCF, CMF, and CCWF, CCHCS on October 16 stated that reports for staff testing are still being developed, and that no reports have been finalized. We acknowledge the difficulty of developing a comprehensive reporting system, but are eager to receive these reports, as we currently have no way to monitor whether and when employees have been re-tested.

Defendants' Position: On September 14, the Receiver's Office shared the employee testing guidance with the parties and requested comments, if any, by September 21. CDCR continues working closely with CCHCS to maintain the current staff testing procedures and to ensure a smooth and easy transition of the staff testing-responsibilities to CCHCS. CDCR also remains committed to continuing to work with CCHCS to answer any questions Plaintiffs might have about the status of and processes for staff testing until the transition to CCHCS has been completed.

B. Incarcerated Population Testing

Plaintiffs' Position:

1. Patient Testing Policies

The Receiver at the October 7 Case Management Conference said, as we understood it, that CCHCS would revise its patient testing policies so that serial retesting

1 was mandated in certain circumstances. We hope to soon see this and other revisions.
2 Another issue has recently arisen related to CCHCS's increasing reliance on a
3 particular Point of Care (POC, sometimes referred to as a rapid) antigen test. As we
4 understand it, this test is FDA-approved for use on symptomatic patients, but is widely
5 used, including by CCHCS, for those without symptoms. Earlier this month, five patients
6 without symptoms at the California Medical Facility (CMF) were declared to have
7 COVID-19 and placed in isolation due to positive POC tests. However, and fortunately,
8 CMF doctors ordered retests using the more traditional lab testing, and determined the
9 earlier results were false positives: none of the patients in fact were infected. We believe
10 CCHCS practices vary statewide as to whether POC positive results are confirmed by
11 subsequent lab tests, and that without confirming lab tests, placing patients into medical
12 isolation with others who are in fact infected is dangerous. Under current CCHCS policy,
13 people in isolation can be grouped and housed together. We asked CCHCS to implement a
14 mandate requiring lab retests of POC positive patients, and that such patients not be mixed
15 with others in isolation until confirming lab results are received. On October 16, CCHCS
16 said it uses the POC tests consistent with Centers for Disease Control and Prevention and
17 California Department of Public Health guidelines, but that as it "gain[s] more experience"
18 it "may modify" its approach.

19 **2. Reports and Monitoring of Serial Retesting**

20 CCHCS reports that work has been done on developing an automated reporting and
21 monitoring process regarding whether ordered serial retesting of patients is actually done,
22 but that further work has been deferred pending completion and release of the Transfer
23 Registry. We continue to hope that this can be completed soon.

24 **3. Notification to Patients of Test Results**

25 CCHCS on October 16 said initial testing of automated test result processes, using
26 standardized templates, has been completed and approved by its leadership, and the
27 processes are now undergoing final testing. It also provided copies of the standardized
28 templates, which are very well done We have asked that the notification template for

positive patients be modified to, among other things, explain that nurses will check blood oxygen levels, given the central importance of that check in the monitoring of COVID-19 patients.

Defendants' Position: Defendants note that Plaintiffs have raised issues in this section that appear to be directed to the Receiver's office and CCHCS. Defendants will not attempt to respond on their behalf, but remain committed to working with them in addressing Plaintiffs' concerns.

VII. Prison-Specific Updates

Plaintiffs' Position:

We continue to have a weekly conference regarding prison-specific COVID-related matters with the CCHCS Regional Medical Chief Executive Officers (CEOs) and the Deputy Director who supervises them. We have been able to raise concerns that have resulted in what we consider major improvements in COVID risk reduction measures and conditions for patients, highlight other concerns, and learn of initiatives undertaken at particular prisons.

For example, we believe the weekly conferences resulted in programs to serially test every week never-positive patients at the California Rehabilitation Center (CRC) and California Institution for Men (CIM), prisons where, despite large numbers of COVID infections for months, comprehensive retesting such as is being done at San Quentin and Folsom had not been instituted. At CIM, we learned that to implement serial testing, CCHCS in the last two weeks arranged for approximately 20 additional nurses, a laudable effort. The weekly conferences also resulted in patients on medical isolation and quarantine being offered some outdoor exercise at Salinas Valley State Prison, where some had been locked in their cells for weeks, even though other prisons, including the Correctional Training Facility located almost literally across the street, routinely provided outdoor exercise opportunities to those on isolation and quarantine.

Our questions at the conferences also revealed that at CIM, nearly 50 people who medical staff determined had been exposed to COVID-19 were quarantined together in a

gym, even though single cells with solid doors—which CCHCS mandates be used if available—were available. Further, the patients quarantined together came from four different housing units; the Regional CEO was not able to explain how this was consistent with the CCHCS mandates that if people are quarantined together they must have the same date and type of exposure. Subsequently, a number of people in the gym tested positive.

Similarly, we were able to confirm that at CRC this past summer people were quarantined in a particular dorm for months, with people from another dorm, with seemingly different exposure dates or sources, brought into same dorm. For weeks, new infections were repeatedly identified, with only four people remaining uninfected at the end of the quarantine period. The dorm acted as an incubator for COVID-19, and this unfortunate experience shows again why quarantine in single cells with solid cells must be done.[12]

Finally, we have learned via the conferences that a decision is expected shortly on whether to enter into a contract to study and test the ventilation systems in San Quentin's five-tier East, South, and West Block ventilation systems, as those systems relate to possible transmission of the virus that causes COVID-19. This is important because those units have peculiar ventilation, in which air in the building is drawn into each cell, a concern given that it is now recognized that the virus is in the air. We appreciate CCHCS's and CDCR's undertaking of this initiative.

Defendants' Position: Defendants note that Plaintiffs have raised issues in this section that appear to be directed to the Receiver's office and CCHCS. Defendants will not attempt to respond on their behalf, but remain committed to working with them in addressing Plaintiffs' concerns.

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[12] CRC has less than a handful of cells. CCHCS and CDCR have within the last two weeks installed tents at the prison, in which they intend to house, in cohorts of four or five, those who are at high risk of severe complications if infected with COVID-19 who are not yet infected. In that way, they hope to limit the spread of COVID-19 among those patients. Still, single cell quarantining cannot occur.

VIII. Updates on Medical Care Matters Not Directly Related to COVID-19

Plaintiffs' Position: We previously reported, and discussed at the October 7 Case Management Conference, that there are now approximately 4,700 patients who are ordered and receiving Medication Assisted Treatment (MAT) for a substance use disorder, and more than 6,000 patients awaiting the necessary addiction medicine physician appointment to be considered for such an order, with more than 80% of those appointments overdue. Many of those appointments are several months overdue.

On October 12 we asked CCHCS to begin providing us monthly data on overdue addiction medicine physician appointments. CCHCS on October 16 said it would do so starting at the end of November. We appreciate that this will be done.

Also on October 12 we asked CCHCS to take immediate action to increase the number of Addiction Medicine physician appointments currently provided, so that the backlog can be substantially reduced as soon as possible. Our concern about the backlog was heightened by our review of the records of a CCHCS patient who recently died. In May, the patient twice submitted written requests for care, describing his problems with heroin and asking for MAT so he could he could get help to "sober up." That same month, a primary care visit documented that he used heroin daily. On June 9, the patient was seen by a Licensed Clinical Social Worker, who determined he was at "high risk" for matters related to opioid use and ordered an Addiction Medicine physician appointment within 14 days. On June 11, that appointment was scheduled for June 25; however, it was then successively rescheduled to July 16, August 6, and then November 26. The records do not appear to include a reason why the appointment was repeatedly rescheduled; we believe it was due to the backlog.

On October 2, the patient was found unresponsive in his cell. Narcan was given with minimal improvement, apparently, and he was emergently transported to a local hospital. The hospital record reports that "a needle was found next to him" when found unresponsive in his cell, and state that patient had a "possible overdose" or "opioid overdose." The next day, the patient died.

1 *Defendants' Position:* Defendants note that Plaintiffs have raised issues in this
2 section that appear to be directed to the Receiver's office and CCHCS. Defendants will
3 not attempt to respond on their behalf, but remain committed to working with them in
4 addressing Plaintiffs' concerns.

5 DATED: October 20, 2020 HANSON BRIDGETT LLP

6
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19 DATED: October 20, 2020 PRISON LAW OFFICE

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EXHIBIT 3

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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

DECLARATION OF ANNE SPAULDING IN SUPPORT OF DEFENDANTS' RESPONSE TO PLAINTIFFS' PROPOSED ORDER RE: QUARANTINE AND ISOLATION SPACE

Judge: Hon. Jon S. Tigar

I, Anne Spaulding, declare:

1. I am currently an Associate Professor of Epidemiology with tenure at Rollins School of Public Health, Emory University. I am also an Associate Professor of Medicine at Emory School of Medicine, and an Adjunct Associate Professor at Morehouse School of Medicine. A copy of my curriculum vitae is attached as Exhibit A.

2. I obtained my M.D. degree from the Medical College of Virginia and my Master of Public Health degree from Johns Hopkins School of Public Health.

3. Through my career, I have gained significant experience in the field of correctional healthcare and public health. For example, I have served as a Staff Physician and as an Infectious

Disease Consultant for Fulton County Jail in Georgia; a Physician Consultant and an Infectious Disease Consultant for Georgia Correctional Health Care and the Medical College of Georgia; an Associate Statewide Medical Director for Georgia Correctional Health Care and the Medical College of Georgia; and a Medical Program Director for the Rhode Island Department of Corrections. I have also lectured on subjects related to correctional healthcare and public health at Johns Hopkins, Medical College of Georgia, Georgia Institute of Technology, and Brown University. I have also given talks and presentations at a number of national and international conferences and meetings on subjects related to correctional healthcare and public health. In fact, on July 14, 2020, I presented a webinar on COVID-19 via a contractor for the U.S. Department of State to leadership in the state and federal prisons of Mexico. The presentation included an extensive discussion about best practices for mitigating COVID-19 in correctional facilities.

4. I am familiar with the developing scientific literature regarding COVID-19, including the transmission and prevention of the virus.

5. Counsel for the California Department of Corrections and Rehabilitation (CDCR) have retained me to consult with CDCR regarding its response to the COVID-19 pandemic and to assist with litigation in this proceeding if necessary. I look forward to helping CDCR and look forward to meeting with other public health experts who are involved in this case and CDCR's response to the current pandemic.

6. I have carefully reviewed the information that is available from CDCR's patient tracker, which is found on CDCR's website.

7. I understand that the Receiver recently devised a methodology for estimating the amount of isolation and quarantine space that might be needed at each of California's thirty-five correctional facilities. I have reviewed that methodology, which states:

> To plan for the possibility of a large-scale outbreak of COVID-19, each facility in each prison shall identify space that will allow for rapid isolation and quarantine of impacted patients. Each facility shall identify its largest congregate living space. Each facility shall maintain empty beds equivalent to the capacity of its largest congregate living space or 20% of the current population of the facility, whichever is larger.

8. I am not aware of any other prison system using a formula like the one devised by

the Receiver for this purpose. And I agree with Plaintiffs' expert Dr. Adam Lauring in his assessment that there is no current consensus among the scientific community about how to determine exactly how much space is enough in a correctional institution for this purpose.

9. I understand that the Receiver based the methodology he devised for determining needed isolation and quarantine space on his experience during the pandemic with outbreaks of different sizes in the prisons, including four large outbreaks that have occurred—California Institution for Men, Chuckawalla Valley State Prison, and Avenal State Prison, and San Quentin. I have been informed that all four of those outbreaks occurred before CDCR started conducting extensive staff testing and at least one of those outbreaks—California Institution for Men—started before extensive testing of staff or incarcerated persons had commenced, and even before certain basic measures, such as mandatory mask wearing, had been implemented in the prisons. I have also been informed that one of those large outbreaks—San Quentin—appears to have been caused by an unfortunate decision to transfer residents from a prison with a very large active outbreak to a prison that previously had no known cases of COVID-19—a mistake that is unlikely to be repeated. Thus, these outbreaks, while informative, are likely not the best predictors of how future outbreaks will unfold now that CDCR has implemented preventative measures (such as mask wearing), taken steps to identify outbreaks sooner through extensive COVID-19 testing of incarcerated persons and staff, placed restrictions on the transfer of residents between institutions, and learned from experience how to respond to and contain outbreaks.

10. I agree that it is important to have space available for quarantine and isolation purposes in the event of an outbreak of COVID-19 in CDCR's prisons, but I disagree that the best way for determining the amount of space needed is to consider the size of outbreaks that occurred under circumstances that no longer exist. Additionally, I would like to discuss with CDCR and the Receiver other available options to ensure that space is available, such as rapid establishment of more beds via emergency structures.

11. It is significant that CDCR is now conducting regular staff and population testing because those measure will help CDCR to identify outbreaks while they remain small. If outbreaks are identified while they are still relatively small, fewer residents need to be isolated and

1 quarantined. Thus, the extensive testing that is now underway should reduce the amount of
2 reserved space needed for quarantine and isolation purposes.

3 12. I also understand that the goal of the Receiver's methodology "is to ensure to the
4 extent reasonably feasible that each institution has enough beds to handle the beginning phases of
5 an outbreak in order to significantly reduce the risk of it blossoming into a medium-sized or large
6 outbreak." This stated rationale does not seem to make sense because if outbreaks are caught in
7 their beginning phases, it should not be necessary to have isolation and quarantine space for
8 twenty percent of each prison's population, which is what the Receiver's methodology requires.

9 13. I also understand that some prisons have large numbers of residents who have
10 already contracted and recovered from COVID-19. People who have already contracted and
11 recovered from COVID-19 are very unlikely to contract it again in the following three months and
12 possibly longer. This is a significant fact because prisons that have large numbers of residents
13 who have already contracted and recovered from COVID-19 will likely need less space for
14 quarantine and isolation for some period following an outbreak.

15 14. A primary concern I have with the Receiver's methodology is that it may require
16 far more space to be set aside at a particular prison than is necessary. Reserving a large amount of
17 vacant housing space, rather than lowering the population density in each housing unit, may have
18 an unintended consequence of increasing the likelihood of transmission of infection in a facility.
19 Some of the reserved space called for under the Receiver's methodology might be better used to
20 spread out the population or to house medically high-risk patients. Setting aside an excessive
21 amount of space for isolation and quarantine might also force CDCR to unnecessarily transfer
22 residents between prisons in order to set aside the required amount of space if the Receiver's
23 methodology were mandated. Because inter-prison transfers can increase the risk of virus
24 transmission, transfers should be avoided if they are not necessary.

25 15. I have been advised that CDCR is considering a plan to set aside one entire housing
26 unit at each of its prisons for isolation and quarantine purposes and that these housing units would
27 have a minimum of 100 available beds. I would like to hear more details about this plan so that I
28 can better assess it, but it generally appears that a plan like this would comport with public health

guidance by reserving space at each institution so that incarcerated persons could be readily isolated in the early phases of an outbreak to prevent the outbreak from spreading. I understand that this plan would result in less reserved space than the Receiver's plan, which seems to require an excessive amount of reserved space at each prison based on an assumption that future outbreaks will look similar to the four very large outbreaks that have occurred so far.

16. I also believe that CDCR's plan will allow CDCR greater flexibility in how it utilizes available space at each of the prisons. I believe it is in the State's best interest to implement a quarantine and isolation plan that provides them with the utmost flexibility. The science surrounding COVID-19 is changing on a daily basis. We are constantly learning more about this novel coronavirus, and as we learn more, CDCR officials need the flexibility to react to the new science in real time. For instance, whereas the Centers for Disease Control and Prevention ("CDC") previously recommended that persons with laboratory-diagnosed COVID-19 be housed ideally in individual rooms, that guidance was changed on July 14, 2020, and the CDC now recommends using one large space to cohort COVID-19-positive individuals for medical isolation so as to conserve PPE and reduce the chance of cross-contamination within the facility.

I declare under penalty of perjury that I have read this document, and its contents are true and correct to the best of my knowledge. Executed on July 19, 2020, in Decatur, Georgia.

ANNE SPAULDING

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EXHIBIT 4

California Department of Corrections and Rehabilitation
Division of Correctional Policy Research and Internal Oversight
Office of Research
November 13, 2020

In-Custody Population at San Quentin State Prison by Sentence Type as of October 31, 2020	
In-Custody Population	**October**
Determinate Sentencing Law	724
Second Striker	385
Third Striker	333
Lifer	748
LWOP	1
Condemned	660
Total	2,851

In-Custody Population at San Quentin State Prison by Serious and Violent Status as of October 31, 2020	
In-Custody Population	**October**
Current Violent	1,698
Current Serious	269
Current Serious and Violent	618
No current Serious or Violent	266
Others	-
Total	2,851

In-Custody Population at San Quentin State Prison by Sex Registrant Status as of October 31, 2020	
In-Custody Population	**October**
Sex Registrants	848

Data Source: Offender Data Points Tableau
as of October 31, 2020

EXHIBIT 5

California Department of Corrections and Rehabilitation
Division of Correctional Policy Research and Internal Oversight
Office of Research
November 03, 2020

List of Offenders with an Institution-to-Institution Movement Between October 26, 2020 and November 1, 2020

CDCR Number	Inmate's Name	MH Level of Care	DDP Code	ADA Code	Tranfer Date	Tranfer from Location	Transfer to Location	Prior Bed Program	Bed Program
					10/29/2020	ASP	SCC		
					10/29/2020	ASP	SCC		
					10/29/2020	ASP	SCC		
					10/29/2020	ASP	SCC		
					10/29/2020	ASP	SCC		
					10/29/2020	ASP	SCC		
					10/29/2020	ASP	SCC		
					10/29/2020	CAC	CAL		
					10/29/2020	CAC	CAL		
					10/29/2020	CAC	CEN		
					10/29/2020	CAC	CVSP		
					10/30/2020	CAC	PVSP		
					10/28/2020	CAC	SAC		
					10/26/2020	CAC	SCC		
					10/26/2020	CAC	SCC		
					10/26/2020	CAC	SCC		
					10/26/2020	CAC	SCC		
					10/26/2020	CAC	SCC		
					10/26/2020	CAC	SCC		
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					10/26/2020	CAC	SCC		
					10/26/2020	CAC	SCC		
					10/26/2020	CAC	SCC		
					10/29/2020	CAL	CEN		
					10/26/2020	CAL	HDSP		
					10/26/2020	CAL	HDSP		
					10/30/2020	CAL	MCSP		
					10/30/2020	CCC	HDSP		
					10/27/2020	CCC	KVSP		
					10/27/2020	CCC	PBSP		
					10/30/2020	CCC	SAC		
					10/29/2020	CCC	SCC		
					10/29/2020	CCI	CAL		
					10/29/2020	CCI	HDSP		
					10/29/2020	CCI	HDSP		
					10/29/2020	CCI	KVSP		
					10/29/2020	CCI	KVSP		
					10/30/2020	CCI	PBSP		
					10/29/2020	CCI	SVSP		

CDCR Number	Inmate's Name	MH Level of Care	DDP Code	ADA Code	Tranfer Date	Tranfer from Location	Transfer to Location	Prior Bed Program	Bed Program
					10/30/2020	CEN	CAL		
					10/28/2020	CEN	HDSP		
					10/28/2020	CHCF	CMF		
					10/28/2020	CHCF	MCSP		
					10/29/2020	CHCF	MCSP		
					10/28/2020	CHCF	MCSP		
					10/29/2020	CHCF	MCSP		
					10/28/2020	CHCF	RJD		
					10/27/2020	CHCF	RJD		
					10/28/2020	CHCF	RJD		
					10/27/2020	CHCF	SAC		
					10/26/2020	CHCF	SAC		
					10/29/2020	CHCF	SVSP		
					10/26/2020	CIM	CAL		
					10/26/2020	CIM	CEN		
					10/29/2020	CIM	ISP		
					10/30/2020	CIM	PVSP		
					10/30/2020	CIM	SCC		
					10/30/2020	CIM	SCC		
					10/30/2020	CIM	SCC		
					10/30/2020	CIM	SCC		
					10/30/2020	CIM	SCC		
					10/30/2020	CIM	VSP		
					10/30/2020	CIM	VSP		
					10/27/2020	CIM	WSP		
					10/28/2020	CMC	CTF		
					10/28/2020	CMC	CTF		
					10/28/2020	CMC	KVSP		
					10/29/2020	CMC	LAC		
					10/27/2020	CMC	MCSP		
					10/27/2020	CMC	MCSP		
					10/27/2020	CMC	MCSP		
					10/27/2020	CMC	MCSP		
					10/27/2020	CMC	MCSP		
					10/27/2020	CMC	MCSP		
					10/27/2020	CMC	PVSP		
					10/27/2020	CMC	SAC		
					10/28/2020	CMC	SATF		
					10/28/2020	CMC	SATF		
					10/28/2020	CMC	SVSP		
					10/28/2020	CMC	SVSP		
					10/28/2020	CMC	SVSP		
					10/28/2020	CMC	SVSP		
					10/28/2020	CMC	SVSP		
					10/28/2020	CMC	SVSP		
					10/28/2020	CMC	SVSP		
					10/28/2020	CMC	SVSP		
					10/27/2020	CMC	VSP		
					10/27/2020	CMC	VSP		
					10/27/2020	CMC	VSP		
					10/29/2020	CMF	KVSP		
					10/29/2020	CMF	KVSP		
					10/30/2020	CMF	MCSP		
					10/30/2020	CMF	MCSP		
					10/30/2020	CMF	MCSP		
					10/30/2020	CMF	MCSP		
					10/30/2020	CMF	MCSP		
					10/26/2020	CMF	RJD		
					10/29/2020	CMF	RJD		

CDCR Number	Inmate's Name	MH Level of Care	DDP Code	ADA Code	Tranfer Date	Tranfer from Location	Transfer to Location	Prior Bed Program	Bed Program
					10/29/2020	CMF	RJD		
					10/26/2020	COR	KVSP		
					10/26/2020	COR	KVSP		
					10/26/2020	COR	KVSP		
					10/26/2020	COR	KVSP		
					10/26/2020	COR	KVSP		
					10/27/2020	COR	LAC		
					10/28/2020	COR	MCSP		
					10/28/2020	COR	MCSP		
					10/28/2020	COR	MCSP		
					10/26/2020	COR	MCSP		
					10/28/2020	COR	MCSP		
					10/28/2020	COR	MCSP		
					10/28/2020	COR	MCSP		
					10/28/2020	COR	MCSP		
					10/26/2020	COR	NKSP		
					10/29/2020	COR	RJD		
					10/29/2020	COR	RJD		
					10/29/2020	COR	RJD		
					10/29/2020	COR	RJD		
					10/28/2020	COR	SATF		
					10/28/2020	COR	SATF		
					10/29/2020	CRC	CIM		
					10/29/2020	CRC	KVSP		
					10/29/2020	CTF	CAC		
					10/29/2020	CTF	CMC		
					10/27/2020	DVI	CAL		
					10/27/2020	DVI	CAL		
					10/27/2020	DVI	CCC		
					10/27/2020	DVI	CCI		
					10/26/2020	DVI	CMF		
					10/26/2020	DVI	CTF		
					10/26/2020	DVI	CTF		
					10/26/2020	DVI	CTF		
					10/26/2020	DVI	CTF		
					10/26/2020	DVI	SAC		
					10/26/2020	DVI	SATF		
					10/27/2020	DVI	SCC		
					10/27/2020	DVI	SCC		
					10/27/2020	DVI	SCC		
					10/27/2020	DVI	SCC		
					10/26/2020	DVI	SOL		
					10/27/2020	FOL	CTF		
					10/29/2020	FOL	SAC		
					10/27/2020	FOL	SATF		
					10/27/2020	FOL	SOL		
					10/27/2020	FOL	SOL		
					10/27/2020	FOL	SOL		
					10/27/2020	FOL	SOL		
					10/27/2020	FOL	SOL		
					10/27/2020	FOL	SOL		
					10/27/2020	FOL	SOL		
					10/27/2020	FOL	SOL		
					10/29/2020	HDSP	CAL		
					10/27/2020	HDSP	KVSP		
					10/30/2020	HDSP	LAC		
					10/29/2020	HDSP	PBSP		
					10/27/2020	HDSP	SATF		
					10/27/2020	HDSP	SATF		

CDCR Number	Inmate's Name	MH Level of Care	DDP Code	ADA Code	Tranfer Date	Tranfer from Location	Transfer to Location	Prior Bed Program	Bed Program
AW7920	MURRAY, MATTHEW	GP	NCF		10/28/2020	HDSP	SVSP		
					10/29/2020	ISP	CAL		
					10/26/2020	ISP	CMF		
					10/28/2020	ISP	KVSP		
					10/28/2020	ISP	KVSP		
					10/28/2020	ISP	KVSP		
					10/28/2020	ISP	SATF		
					10/26/2020	ISP	SATF		
					10/28/2020	ISP	SATF		
					10/26/2020	KVSP	SAC		
					10/26/2020	KVSP	SVSP		
					10/29/2020	KVSP	WSP		
					10/30/2020	LAC	CAL		
					10/30/2020	LAC	CAL		
					10/30/2020	LAC	CAL		
					10/30/2020	LAC	CEN		
					10/30/2020	LAC	COR		
					10/30/2020	LAC	COR		
					10/30/2020	LAC	COR		
					10/30/2020	LAC	COR		
					10/30/2020	LAC	COR		
					10/30/2020	LAC	COR		
					10/30/2020	LAC	COR		
					10/26/2020	LAC	CTF		
					10/26/2020	LAC	CTF		
					10/29/2020	LAC	HDSP		
					10/28/2020	LAC	HDSP		
					10/28/2020	LAC	HDSP		
					10/29/2020	LAC	HDSP		
					10/29/2020	LAC	HDSP		
					10/28/2020	LAC	HDSP		
					10/29/2020	LAC	HDSP		
					10/28/2020	LAC	KVSP		
					10/30/2020	LAC	KVSP		
					10/30/2020	LAC	KVSP		
					10/30/2020	LAC	PVSP		
					10/30/2020	LAC	PVSP		
					10/30/2020	LAC	RJD		
					10/31/2020	LAC	RJD		
					10/30/2020	LAC	SOL		
					10/30/2020	LAC	SVSP		
					10/30/2020	LAC	SVSP		
					10/30/2020	LAC	SVSP		
					10/26/2020	MCSP	KVSP		
					10/30/2020	MCSP	LAC		
					10/29/2020	MCSP	SAC		
					10/29/2020	MCSP	SAC		
					10/29/2020	MCSP	SAC		
					10/29/2020	MCSP	SAC		
					10/29/2020	MCSP	SAC		
					10/29/2020	MCSP	SAC		
					10/29/2020	MCSP	SAC		
					10/29/2020	MCSP	SAC		
					10/29/2020	MCSP	SAC		
					10/29/2020	MCSP	SAC		
					10/29/2020	MCSP	SAC		
					10/28/2020	MCSP	SCC		
					10/27/2020	MCSP	SVSP		
					10/30/2020	MCSP	SVSP		

CDCR Number	Inmate's Name	MH Level of Care	DDP Code	ADA Code	Tranfer Date	Tranfer from Location	Transfer to Location	Prior Bed Program	Bed Program
					10/26/2020	NKSP	CAC		
					10/28/2020	NKSP	CAL		
					10/28/2020	NKSP	CAL		
					10/28/2020	NKSP	CAL		
					10/26/2020	NKSP	CCC		
					10/26/2020	NKSP	CCC		
					10/26/2020	NKSP	CCC		
					10/26/2020	NKSP	CCC		
					10/26/2020	NKSP	CCC		
					10/26/2020	NKSP	CCC		
					10/26/2020	NKSP	CCC		
					10/26/2020	NKSP	CCC		
					10/26/2020	NKSP	CCC		
					10/26/2020	NKSP	CCC		
					10/26/2020	NKSP	CCC		
					10/26/2020	NKSP	CCC		
					10/26/2020	NKSP	CCC		
					10/28/2020	NKSP	CEN		
					10/28/2020	NKSP	CEN		
					10/28/2020	NKSP	CEN		
					10/28/2020	NKSP	CEN		
					10/28/2020	NKSP	CMF		
					10/28/2020	NKSP	CMF		
					10/28/2020	NKSP	CTF		
					10/28/2020	NKSP	CTF		
					10/28/2020	NKSP	CTF		
					10/28/2020	NKSP	CTF		
					10/28/2020	NKSP	CTF		
					10/27/2020	NKSP	ISP		
					10/27/2020	NKSP	ISP		
					10/26/2020	NKSP	MCSP		
					10/26/2020	NKSP	MCSP		
					10/26/2020	NKSP	MCSP		
					10/26/2020	NKSP	MCSP		
					10/26/2020	NKSP	MCSP		
					10/26/2020	NKSP	MCSP		
					10/28/2020	NKSP	PVSP		
					10/28/2020	NKSP	PVSP		
					10/28/2020	NKSP	RJD		
					10/28/2020	NKSP	RJD		
					10/28/2020	NKSP	SAC		
					10/26/2020	NKSP	SCC		
					10/26/2020	NKSP	SCC		
					10/26/2020	NKSP	SCC		
					10/26/2020	NKSP	SCC		
					10/26/2020	NKSP	SCC		
					10/26/2020	NKSP	SCC		
					10/28/2020	NKSP	SOL		
					10/28/2020	NKSP	SOL		
					10/28/2020	NKSP	SOL		
					10/28/2020	NKSP	SOL		
					10/26/2020	NKSP	SVSP		
					10/28/2020	NKSP	VSP		
					10/28/2020	NKSP	VSP		
					10/28/2020	NKSP	VSP		
					10/26/2020	NKSP	WSP		
					10/30/2020	PBSP	CCC		
					10/28/2020	PBSP	CCI		
					10/26/2020	PVSP	CAL		

CDCR Number	Inmate's Name	MH Level of Care	DDP Code	ADA Code	Tranfer Date	Tranfer from Location	Transfer to Location	Prior Bed Program	Bed Program
					10/26/2020	PVSP	CAL		
					10/30/2020	RJD	CMF		
					10/28/2020	RJD	COR		
					10/28/2020	RJD	KVSP		
					10/31/2020	RJD	LAC		
					10/29/2020	RJD	MCSP		
					10/29/2020	RJD	MCSP		
					10/29/2020	RJD	MCSP		
					10/29/2020	RJD	MCSP		
					10/29/2020	RJD	MCSP		
					10/29/2020	RJD	PBSP		
					10/30/2020	RJD	SVSP		
					10/29/2020	RJD	SVSP		
					10/28/2020	SAC	CHCF		
					10/26/2020	SAC	CHCF		
					10/28/2020	SAC	CHCF		
					10/26/2020	SAC	CHCF		
					10/26/2020	SAC	CHCF		
					10/27/2020	SAC	CHCF		
					10/26/2020	SAC	CHCF		
					10/28/2020	SAC	CHCF		
					10/29/2020	SAC	HDSP		
					10/27/2020	SAC	KVSP		
					10/29/2020	SAC	NKSP		
					10/29/2020	SAC	NKSP		
					10/29/2020	SAC	SVSP		
					10/29/2020	SAC	SVSP		
					10/28/2020	SATF	CMF		
					10/28/2020	SATF	CTF		
					10/28/2020	SATF	CTF		
					10/27/2020	SCC	CAC		
					10/28/2020	SCC	CAL		
					10/30/2020	SCC	CAL		
					10/27/2020	SCC	CHCF		
					10/26/2020	SCC	DVI		
					10/26/2020	SCC	DVI		
					10/27/2020	SCC	KVSP		
					10/27/2020	SCC	MCSP		
					10/26/2020	SCC	RJD		
					10/29/2020	SCC	SAC		
					10/30/2020	SCC	VSP		
					10/28/2020	SOL	HDSP		
					10/30/2020	SOL	KVSP		
					10/30/2020	SOL	KVSP		
					10/29/2020	SOL	PBSP		
					10/26/2020	SQ	COR		
					10/26/2020	SVSP	HDSP		
					10/26/2020	SVSP	HDSP		
					10/26/2020	SVSP	HDSP		
					10/26/2020	SVSP	HDSP		
					10/26/2020	SVSP	HDSP		
					10/28/2020	SVSP	KVSP		
					10/28/2020	SVSP	KVSP		
					10/29/2020	SVSP	NKSP		
					10/28/2020	SVSP	SATF		
					10/29/2020	SVSP	WSP		
					10/29/2020	VSP	CIM		
					10/26/2020	VSP	CMF		
					10/26/2020	VSP	SCC		

CDCR Number	Inmate's Name	MH Level of Care	DDP Code	ADA Code	Tranfer Date	Tranfer from Location	Transfer to Location	Prior Bed Program	Bed Program
					10/26/2020	VSP	SCC		
					10/26/2020	WSP	CAC		
					10/26/2020	WSP	CAC		
					10/26/2020	WSP	CAC		
					10/28/2020	WSP	CAL		
					10/28/2020	WSP	CAL		
					10/28/2020	WSP	CAL		
					10/28/2020	WSP	CAL		
					10/27/2020	WSP	CCC		
					10/27/2020	WSP	CCC		
					10/27/2020	WSP	CCC		
					10/27/2020	WSP	CCC		
					10/27/2020	WSP	CCC		
					10/27/2020	WSP	CCC		
					10/27/2020	WSP	CCC		
					10/27/2020	WSP	CCC		
					10/27/2020	WSP	CCC		
					10/27/2020	WSP	CCC		
					10/27/2020	WSP	CCC		
					10/27/2020	WSP	CCC		
					10/27/2020	WSP	CHCF		
					10/30/2020	WSP	CMF		
					10/31/2020	WSP	CMF		
					10/27/2020	WSP	CMF		
					10/26/2020	WSP	COR		
					10/27/2020	WSP	CTF		
					10/26/2020	WSP	HDSP		
					10/26/2020	WSP	HDSP		
					10/26/2020	WSP	HDSP		
					10/26/2020	WSP	HDSP		
					10/26/2020	WSP	HDSP		
					10/27/2020	WSP	KVSP		
					10/27/2020	WSP	MCSP		
					10/27/2020	WSP	MCSP		
					10/27/2020	WSP	MCSP		
					10/27/2020	WSP	MCSP		
					10/26/2020	WSP	PVSP		
					10/26/2020	WSP	PVSP		
					10/26/2020	WSP	PVSP		
					10/29/2020	WSP	RJD		
					10/28/2020	WSP	SAC		
					10/27/2020	WSP	SCC		
					10/27/2020	WSP	SCC		
					10/27/2020	WSP	SCC		
					10/27/2020	WSP	SCC		
					10/27/2020	WSP	SCC		
					10/27/2020	WSP	SCC		
					10/27/2020	WSP	SCC		
					10/27/2020	WSP	SCC		
					10/26/2020	WSP	VSP		
					10/26/2020	WSP	VSP		
					10/26/2020	WSP	VSP		
					10/26/2020	WSP	VSP		

CSR #: STA303-110320-W
Data Source: SOMS as of November 2, 2020.

EXHIBIT 6

California Department of Corrections and Rehabilitation
Division of Correctional Policy Research and Internal Oversight
Office of Research
November 11, 2020

Weekly Report of Population
As of Midnight November 11, 2020

Total CDCR Population

Population	Felon/ Other	Change Since Last Week	Change Since Last Year	Design Capacity	Percent Occupied	Staffed Capacity
A. Total In-Custody/CRPP Supervision	97,753	+139	-26,935			
I. In-State	97,753	+139	-26,935			
(Men, Subtotal)	94,238	+148	-24,872			
(Women, Subtotal)	3,515	-9	-2,063			
1. Institution/Camps	94,340	+156	-23,384	89,663	105.2	126,442
Institutions	92,605	+217	-22,120	85,083	108.8	122,208
Camps(CCC, CIW, and SCC)	1,735	-61	-1,264	4,580	37.9	4,234
2. In-State Contract Beds	2,529	-19	-2,961			
Public Community Correctional Facilities	395	-1	-1,270			
Community Prisoner Mother Program	7	0	-17			
California City Correctional Facility	2,127	-18	-164			
3. Department of State Hospitals	240	-9	-80			
4. CRPP Supervision	644	+11	-510			
Alternative Custody Program	24	+2	-132			
Custody to Community Treatment Reentry Program	271	+3	-69			
Male Community Reentry Program	310	+7	-323			
Medical Parole	31	0	+6			
Medically Vulnerable Release	8	-1				
B. Parole	55,929	-228	+4,204			
Community Supervision	54,335	-229	+4,419			
Interstate Cooperative Case	1,594	+1	-215			
C. Non-CDCR Jurisdiction	2,853	-60	+1,765			
Other State/Federal Institutions	287	-4	-32			
Out of State Parole	745	-14	+13			
Out of State Parolee at Large	18	+1	+5			
DJJ-W&IC 1731.5(c) Institutions	17	0	-7			
County Jail	1,786	-43				
D. Other Populations	8,186	-44	+1,745			
Temporary Release to Court and Hospital	1,738	-26	+169			
Escaped	198	-2	0			
Parolee at Large	6,250	-16	+1,576			
Total CDCR Population	164,721	-193	-19,221			

This report contains the latest available reliable population figures from SOMS. They have been carefully audited, but are preliminary, and therefore subject to revision.

California Department of Corrections and Rehabilitation
Division of Correctional Policy Research and Internal Oversight
Office of Research
November 11, 2020

Weekly Report of Population
As of Midnight November 11, 2020

Weekly Institution Population Detail

Institutions	Felon/ Other	Design Capacity	Percent Occupied	Staffed Capacity
Male Institutions				
Avenal State Prison (ASP)	3,454	2,920	118.3	4,719
Calipatria State Prison (CAL)	3,000	2,308	130.0	3,451
California Correctional Center (CCC)	2,349	3,883	60.5	4,752
California Correctional Institution (CCI)	2,987	2,783	107.3	4,175
Centinela State Prison (CEN)	3,135	2,308	135.8	3,446
California Health Care Facility - Stockton (CHCF)	2,412	2,951	81.7	3,051
California Institution for Men (CIM)	2,136	2,976	71.8	4,450
California Men's Colony (CMC)	3,123	3,838	81.4	4,407
California Medical Facility (CMF)	2,040	2,361	86.4	2,981
California State Prison, Corcoran (COR)	2,942	3,116	94.4	4,476
California Rehabilitation Center (CRC)	2,225	2,491	89.3	3,514
Correctional Training Facility (CTF)	4,391	3,312	132.6	5,019
Chuckawalla Valley State Prison (CVSP)	1,898	1,738	109.2	2,578
Deuel Vocational Institution (DVI)	1,413	1,681	84.1	2,413
Folsom State Prison (FOL)	2,153	2,066	104.2	3,078
High Desert State Prison (HDSP)	3,353	2,324	144.3	3,461
Ironwood State Prison (ISP)	2,859	2,200	130.0	3,300
Kern Valley State Prison (KVSP)	3,627	2,448	148.2	3,622
California State Prison, Los Angeles County (LAC)	2,780	2,300	120.9	3,424
Mule Creek State Prison (MCSP)	3,906	3,284	118.9	4,207
North Kern State Prison (NKSP)	2,536	2,694	94.1	4,011
Pelican Bay State Prison (PBSP)	2,271	2,380	95.4	3,361
Pleasant Valley State Prison (PVSP)	2,820	2,308	122.2	3,535
RJ Donovan Correctional Facility (RJD)	3,617	2,992	120.9	4,038
California State Prison, Sacramento (SAC)	2,254	1,828	123.3	2,545
California Substance Abuse Treatment Facility (SATF)	4,413	3,424	128.9	5,157
Sierra Conservation Center (SCC)	3,073	3,836	80.1	4,570
California State Prison, Solano (SOL)	3,270	2,610	125.3	4,010
San Quentin State Prison (SQ)	2,801	3,082	90.9	4,226
Salinas Valley State Prison (SVSP)	2,804	2,452	114.4	3,509
Valley State Prison (VSP)	2,776	1,980	140.2	3,034
Wasco State Prison (WSP)	2,302	2,984	77.1	4,447
Male Total	91,120	85,858	106.1	120,967
Female Institutions				
Central California Women's Facility (CCWF)	2,009	2,004	100.2	3,068
California Institution for Women (CIW)	1,126	1,398	80.5	1,877
Folsom State Prison (FOL)	85	403	21.1	530
Female Total	3,220	3,805	84.6	5,475
Institution Total	94,340	89,663	105.2	126,442

Weekly Report of Population
As of Midnight November 11, 2020

Notes

- Felon/Other counts are felons, county contract boarders, federal boarders, state boarders, safekeepers, county diagnostic cases, Department of Mental Health boarders, and Division of Juvenile Justice boarders.
- Interstate Cooperative Cases are parolees from other states being supervised in California.
- Non-CDCR Jurisdiction are California cases being confined in or paroled to other states or jurisdictions.
- Welfare and Institution Code (W&IC) 1731.5(c) covers persons under the age of 21 who were committed to CDCR, had their sentence amended, and were incarcerated at the Division of Juvenile Justice for housing and program participation.
- Other Population includes inmates temporarily out-to-court, inmates in hospitals, escapees, and parolees at large.