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UNITED STATES DISTRICT COURTS
EASTERN DISTRICT OF CALIFORNIA
AND NORTHERN DISTRICT OF CALIFORNIA
UNITED STATES DISTRICT COURT COMPOSED OF THREE JUDGES
PURSUANT TO SECTION 2284, TITLE 28 UNITED STATES CODE

RALPH COLEMAN, et al., Plaintiffs, v. GAVIN NEWSOM, et al., Defendants.	Case No. 2:90-CV-00520-KJM-DB **THREE JUDGE COURT**
MARCIANO PLATA, et al., Plaintiffs, v. GAVIN NEWSOM, Defendants.	Case No. C01-1351 JST **THREE JUDGE COURT** **PLAINTIFFS' NOTICE OF EMERGENCY MOTION AND EMERGENCY MOTION TO MODIFY POPULATION REDUCTION ORDER; MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT**

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NOTICE OF MOTION AND MOTION

TO THE PARTIES AND ALL COUNSEL OF RECORD:

PLEASE TAKE NOTICE THAT as soon as the matter may be heard[1] before the Honorable Kim McLane Wardlaw, Kimberly J. Mueller, and Jon S. Tigar, the United States District Court Composed of Three Judges Pursuant to 28 U.S.C. § 2284, Plaintiffs move the Court to modify its order requiring the State of California to reduce the prison population to 137.5% of design bed capacity. Plaintiffs bring this motion under Federal Rule of Civil Procedure 60(b)(5) and the Prison Litigation Reform Act (PLRA), 18 U.S.C. § 3626.

Given the urgency, Plaintiffs request that the Court set an expedited briefing schedule and review this motion as soon as practicable. Plaintiffs waive any right to file a reply.

The motion is based on this Notice of Motion and Motion, the accompanying Memorandum of Points and Authorities, and the supporting declarations and associated documents, filed herewith.

MEMORANDUM OF POINTS AND AUTHORITIES

INTRODUCTION

California today is under a state of emergency due to the spread of the novel coronavirus and COVID-19, the deadly disease it causes. Like the rest of the country and the world, the State is bracing for the potentially catastrophic ravages of this pandemic. The Governor has taken significant steps to flatten the curve of new cases before hospitals are overwhelmed and the death toll skyrockets, as it has elsewhere. Declaration of

[1] This Court has previously instructed that "[a]ny other motions contemplated by the parties shall be filed with no hearing date notice on the motion. The Court will schedule the hearing date and briefing schedule after reviewing the moving papers." *See* Declaration of Ernest Galvan in Support of Plaintiffs' Emergency Motion, filed herewith, Exh. 1 (Transcript of Proceedings, Sept. 24, 2007, ECF No. 6519-1, at 99:25-100:2).

Michael Bien in Support of Plaintiffs' Emergency Motion ("Bien Decl."), filed herewith, ¶ 36, Exh. 22 (Newsom March 19, 2020 Executive Order N-33-20). The primary components of the Governor's actions have been to require social distancing to keep Californians at least six feet apart at all times and to prepare hospitals and health care workers for the coming surge in cases. *Id.*

Those steps have not been meaningfully implemented in the California Department of Corrections and Rehabilitation (CDCR) for one simple reason: the system is far too crowded. The prisons house tens of thousands of people in crowded dormitories where they live, sleep, and bathe within feet—sometimes inches—of each other. The prisons also house tens of thousands of the people most vulnerable to death or severe complications from COVID-19: the elderly and people with serious underlying medical conditions. These conditions pose an unacceptable risk of harm for people who live and work in CDCR as well as to the broader public: prison walls cannot stop the spread of pandemic disease. According to former CDCR Secretary Scott Kernan, California's prisons are "a tinderbox of potential infection as you go forward, especially if you are just watching what's going on around the world." Bien Decl. ¶ 34, Exh. 20 at 2. Another former corrections chief from Colorado sounded a similar warning: "I don't think people understand the gravity of what's going to happen if this runs in a prison.… You're going to see devastation that's unbelievable." Bien Decl. ¶ 57, Exh. 41 at 2.

It has been only 13 years since California prisons were under another state of emergency: the state had crowded its prison system beyond humane limits, with deadly results. On October 4, 2006, Governor Arnold Schwarzenegger proclaimed a State of Emergency because "the current severe overcrowding in 29 CDCR prisons has caused substantial risk to the health and safety of … the inmates housed in them …." Bien Decl. ¶ 44, Exh. 30. Among other significant harms, the Governor found, overcrowded prisons place people living in them at "increased, substantial risk for transmission of infectious illnesses." *Id.*

The State has since significantly reduced its prison population overall due to orders

from this Court, but not enough to prevent widespread sickness and death during the pandemic. It has taken no steps towards a targeted release of the most vulnerable populations. The *Coleman* class, people with serious mental illness, is uniquely vulnerable, both to the virus and to the increased isolation and reduced treatment and activities of CDCR's pandemic response. The current emergency is the inevitable result of the State's failure to learn the lessons from the emergency of 2006. The deadly promise of the prior overcrowding crisis will be realized today unless this Court acts swiftly to require the State to safely reduce the population in crowded congregate living spaces to a level that will permit social distancing and protect the medically vulnerable by releasing or relocating patients who are at low risk of criminal conduct but especially high risk of severe illness or death from COVID-19.

ARGUMENT

I. PROCEDURAL HISTORY

On August 4, 2009, after three weeks of testimony and argument, this Court imposed a population reduction order as a remedy for ongoing constitutional violations in the operation of the California state prison system. *See Coleman v. Schwarzenegger/Plata v. Schwarzenegger*, 922 F. Supp. 2d 882 (E.D. Cal., N.D. Cal. Aug. 4, 2009). This Court recounted the long history of the *Coleman* case, concluding that "[a]fter fourteen years of remedial efforts under the supervision of a special master and well over seventy orders by the *Coleman* court, the California prison system still cannot provide thousands of mentally ill inmates with constitutionally adequate mental health care." *Id.* at 898. Regarding the *Plata* case, this Court detailed the seven years of increasingly intrusive measures, including the imposition of a Federal Receivership, that had failed to address "fundamental constitutional deficiencies." *Id.* at 897. The Court concluded that overcrowding was the primary cause of the ongoing Eighth Amendment violations. *Id.* at 956, 897.

Consequently, this Court directed the State to submit a population reduction plan that would reduce the population of CDCR to 137.5% of design capacity within two years. *Id.* at 970. On January 12, 2010, the Court approved the State's plan, pursuant to which

CDCR would reach 137.5% of design capacity by January 2012. *See Coleman v. Schwarzenegger/Plata v. Schwarzenegger*, Nos. CIV-90-0520 LKK JFM P, C01-1351 TEH, 2010 WL 99000 (E.D. Cal., N.D. Cal., Jan. 12, 2010).

On May 23, 2011, the U.S. Supreme Court upheld this Court's population reduction order. *Brown v. Plata*, 563 U.S. 493 (2011). The Supreme Court observed the dramatic impact of overcrowding on the living conditions and quality of care in California prisons, and noted the "the severe impact of burgeoning demand on the provision of care" for *Coleman* and *Plata* class members. *Id.* at 517-18. In particular, extreme population pressures had led to "unsafe and unsanitary living conditions" in living quarters that were described as "breeding grounds for disease." *Id.* at 519-20. The Supreme Court affirmed this Court's finding by clear and convincing evidence that no relief short of a population reduction order would remedy the State's constitutional violations. *Id*. at 529; *see also* 18 U.S.C. § 3626(a)(3)(E)(ii). In doing so, the Supreme Court acknowledged that this Court's population reduction order might prove insufficient to remedy the constitutional violation, and thus explicitly directed that "the three-judge court must remain open to a showing or demonstration by either party that the injunction should be altered to ensure that the rights and interests of the parties are given all due and necessary protection." *Brown v. Plata*, 563 U.S. at 543.

Defendants subsequently returned to this Court, moving to vacate the Population Reduction Order on January 7, 2013. Plaintiffs filed a cross-motion seeking institution-specific population caps. This Court denied Defendants' motion, finding the State had failed to achieve a durable remedy to prison crowding. *Coleman v. Brown*, 922 F. Supp. 2d 1004, 1043 (E.D. Cal., N.D. Cal. Apr. 11, 2013). It also rejected Plaintiffs' motion, finding it premature because, at that point, the Defendants had not yet reached the prescribed population limit. This Court determined it was "best to wait and reassess the need for institution-specific caps, if they are needed, when defendants reduce the systemwide prison population to 137.5% design capacity, or at some other time deemed appropriate by the Receiver and Special Master." *Id.* at 1048.

II. OVERCROWDING OF MEDICALLY VULNERABLE PEOPLE AND THOSE HOUSED IN CONGREGATE LIVING AREAS CAUSES AN UNACCEPTABLE RISK OF HARM DURING THE GLOBAL COVID-19 PANDEMIC

A. COVID-19 Is a Deadly, Easily Transmissible Virus.

"On March 11, 2020, the World Health Organization announced that the COVID-19 outbreak can be characterized as a pandemic, as the rates of infection continue to rise in many locations around the world and across the United States." Bien Decl. ¶ 40, Exh. 26 (Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak ("National Emergency Proclamation")). As of March 24, 2020, there are 375,498 confirmed cases and 16,362 confirmed deaths worldwide. Bien Decl. ¶ 41, Exh. 27 (WHO, Coronavirus Disease (COVID-19) Outbreak Situation). Those numbers are expected to rise steeply—in fact, exponentially—as testing increases and the virus spreads. President Trump has declared a national emergency. Bien Decl. ¶ 40, Exh. 26 (National Emergency Proclamation). Last week, Governor Newsom projected "that roughly 56 percent of our population—25.5 million people—will be infected with the virus over an eight week period." Bien Decl. ¶ 42, Exh. 28 (March 18, 2020 Newsom Letter to Trump).

There is no vaccine for COVID-19, and there is no cure. Declaration of Marc Stern, M.D. in Support of Plaintiffs' Emergency Motion ("Stern Decl."), filed herewith, ¶ 4. No one has prior immunity. *Id.* It is easily transmissible—spreading "through droplets generated when an infected person coughs or sneezes, or through droplets of saliva or discharge from the nose." *Id.* It is believed "that a significant amount of transmission may be from people who are infected but asymptomatic or pre-symptomatic." *Id.* ¶ 5. Once a person has been exposed to the virus, she may show symptoms within as little as two days, and her condition might "seriously deteriorate in as little as five days (perhaps sooner) after that." *Id.*

The effects of COVID-19 are very serious and can include severe respiratory illness, major organ damage, and, for a significant number of people, death. Stern Decl.

¶¶ 6, 7, 13. The risk of death or serious illness is especially high for vulnerable populations, including people over the age of 50 and people, regardless of age, with "underlying health problems such as—but not limited to—weakened immune systems, hypertension, diabetes, blood, lung, kidney, heart, and liver disease, and possibly pregnancy." *Id.* ¶ 6. People infected with COVID-19, especially those in vulnerable populations, may require significant medical attention, including ventilator assistance for respiration and intensive care. *Id.* ¶ 7.

B. COVID-19 Will Spread Rapidly in the Prison Environment, and Incarcerated People Are at Particular Risk Due to Advanced Age, Serious Medical Conditions, and Crowded Congregate Living Spaces.

People in California prisons are at heightened risk of serious illness or death from COVID-19. Tens of thousands of people—a quarter of the total population of more than 121,000 people—are over the age of 50, a demographic particularly susceptible to the disease. Bien Decl. ¶ 43, Exh. 29 (CCHCS, Healthcare Services Dashboard at 27-28 ("CCHCS Healthcare Dashboard")); Bien Decl. ¶ 16, Exh. 6 (CDCR, Weekly Report of Population as of Midnight March 18, 2020). In addition, 14.7% spread across all institutions—or over 17,000 people—have a medical classification of "high risk," which also places them at higher risk of getting very sick or dying from the disease.[2] *Id.*; Bien Decl. ¶ 43, Exh. 29 (CCHCS Healthcare Dashboard); Bien Decl. ¶ 16, Exh. 6 (CDCR, Weekly Report of Population as of Midnight March 18, 2020). And tens of thousands more—regardless of age or medical history—are subjected to crowded, cramped, and

[2] "**High Risk:** Chronic care of complicated, unstable, or poorly-controlled common conditions (e.g., asthma with history of intubation for exacerbations, uncompensated end-stage liver disease, hypertension with end-organ damage, diabetes with amputation). Chronic care of complex, unusual, or high risk conditions (e.g., cancer under treatment or metastatic, coronary artery disease with prior infarction). Implanted defibrillator or pacemaker. High risk medications (e.g., chemotherapy, immune suppressants, Factor 8 or 7, anticoagulants other than aspirin). Transportation over a several day period would pose a health risk, such as hypercoagulable state. Case management is required." Bien Decl. ¶ 45, Exh. 31 (CCHCS, Health Care Department Operations Manual 1.2.14, Appx. 1, § (c)(3)(c)).

unsanitary conditions in congregate sleeping and living areas, as explained in more detail in the next section.

The World Health Organization ("WHO") has recognized that incarcerated people "are likely to be more vulnerable to the coronavirus disease (COVID-19) outbreak than the general population because of the confined conditions in which they live together." Bien Decl. ¶ 31, Exh. 17 at 1 (WHO Preparedness, prevention and control of COVID-19 in prisons and other places of detention ("WHO Prevention and Control of COVID-19 in Prisons")). The U.S. Centers for Disease Control and Prevention ("CDC"), in guidance on management of COVID-19 in correctional and detention facilities, has identified that COVID-19 presents a particularly heightened danger in correctional facilities because "incarcerated/detained populations have higher prevalence of infectious and chronic diseases and are in poorer health than the general population, even at younger ages." Bien Decl. ¶ 21, Exh. 7 at 13 (CDC Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities ("CDC Interim Guidance")). And, earlier this week, Scott Kernan, who served as the secretary of CDCR from 2015 to 2018, called California prisons "a tinderbox of potential infection as you go forward" and even more of a "petri dish" than cruise ships in terms of "the mass of humanity." Bien Decl. ¶ 34, Exh. 20 at 2 (Kernan: "I'm very concerned about my colleagues and the inmates and their families in jails and prisons across the country."). It is no surprise, then, that Clark Kelso, the *Plata* Receiver, stated:

> [W]e believe that a significant reduction in population at this time will be a clear benefit to us in opening up cells and beds, thereby facilitating increased social distancing within the prisons and a more flexible management of the remaining population to reduce the speed with which covid-19 will spread throughout CDCR institutions. From this perspective, I support an accelerated release program.

Bien Decl. ¶ 56, Exh. 40 at 1.

Similarly, Dr. Marc Stern, a physician who formerly served as the Assistant Secretary for Health Care at the Washington State Department of Corrections, observed that the level of crowding in California prisons "is very significant and worrisome from a

public health standpoint." Stern Decl. ¶ 12. Like the *Plata* Receiver, he recommends "immediately downsizing the population of these prisons, with priority given to those at high risk of harm due to their age and health status, and with the goal of allowing social distancing and recommended public health practices in all ongoing activities." *Id.* ¶ 15. Even with a constitutionally adequate prison healthcare system, incarcerated people in California "would still be at substantial risk of illness and death" because of their congregate living environment. *Id.* ¶ 19.

The disease already has breached the prison walls. Seven staff members at four different prisons and an incarcerated person at a fifth prison already have tested positive. Bien Decl. ¶ 47, Exh. 33 (CDCR, COVID-19 Preparedness: March 24, 2020 Update, showing the following affected prisons: California State Prison, Sacramento; California Institution for Men; Folsom State Prison; California Health Care Facility; and California State Prison, Los Angeles County). "The actual number of infections," of course, "is likely to be higher due to the testing shortage." Stern Decl. ¶ 3.

"The only way to control the virus is to use preventive strategies, including social distancing." Stern Decl. ¶ 4. Put simply, limiting person-to-person contact "is critical to saving lives." *Id.* ¶ 8. That is why Governor Newsom ordered "all individuals living in the State of California to stay home or at their place of residence" until further notice. Bien Decl. ¶ 36, Exh. 22 (Executive Department State of California, Executive Order N-33-20). And that is why the U.S. Centers for Disease Control and Prevention ("CDC"), in guidance on management of COVID-19 in correctional and detention facilities, named social distancing as "a cornerstone of reducing transmission of respiratory diseases such as COVID-19." Bien Decl. ¶ 21, Exh. 7 (CDC Interim Guidance). The CDC stated that social distancing requires people—including those who are asymptomatic—to remain at least **six feet** from each other at all times.[3] *Id.*

[3] The State of California also directs people to maintain six feet between themselves and people not in their household. *See* Bien Decl. ¶ 50, Exh. 36 at 8 (California Coronavirus

Recognizing the critical importance of social distancing and the difficulty of achieving it under existing conditions in correctional and detention facilities, international, state, and local jurisdictions have taken immediate steps to reduce the number of incarcerated people. Iran, for example, has temporarily released around 85,000 people from its prisons as of March 24, 2020. *See* Bien Decl. ¶ 22, Exh. 8 (March 18, 2020 Guardian article). States and counties across the United States have undertaken similar measures. For example, New Jersey will release up to 1,000 people from its county jails. *See* Bien Decl. ¶ 23, Exh. 9 (March 24, 2020 U.S. News & World Report article). Tennessee has similarly released 25 people from its county jails and plans to release dozens more, focusing on those who are particularly vulnerable to spreading the virus. *See* Bien Decl. ¶ 62, Exh. 46 (March 23, 2020 Nashville Scene article). Likewise, the Iowa Department of Corrections plans to expedite the release of 700 incarcerated people, and the North Dakota Parole Board has granted early release to 56 of the 60 people who applied for consideration this month. *See* Bien Decl. ¶ 60, Exh. 44 at 2 (March 25, 2020 Prison Policy Initiative report). Los Angeles, Denver, and Philadelphia all have instituted policies aimed at reducing jail populations, including reducing or delaying arrests and releasing individuals being held for drug offenses. *Id*.

In addition to maintaining physical distance, the CDC recommends that correctional facilities increase their disinfecting procedures and reinforce hygiene practices among staff and the incarcerated population. *See* Bien Decl. ¶ 21, Exh. 7 at 6 (CDC Interim Guidance). To meet these ends, the CDC stresses the need for adequate supplies of cleaning materials and personal protective equipment (PPE). *Id.* For example, correctional facilities should ensure that they have sufficient numbers of soap and sanitizer, respirators, face masks, and gloves, among other equipment to protect against the transmission of the virus. *Id.* The

(COVID-19) Response). Marin County, where San Quentin State Prison is located, similarly defined "Social Distancing Requirements" as including "maintaining at least six-foot social distancing from other individuals." Bien Decl. ¶ 48, Exh. 34 (Marin County shelter in place order).

CDC also recommends that "[f]acilities should make contingency plans for the likely event of PPE shortages during the COVID-19 pandemic." *Id.* at 4. With greater numbers of people who have been infected or exposed to the virus, more protective equipment will be required, increasing the likelihood of a supply shortage.

Once a person in prison has had close contact with an infected person, the CDC recommends that the person be placed in quarantine or medical isolation. *See* Bien Decl. ¶ 21, Exh. 7. "Close contact" occurs when a person directly contacts an infected individual, or when a person has been within six feet of an infected individual for an extended period of time. *Id.* The CDC suggests that an person who has been in close contact should "be quarantined in a single cell with solid walls and a solid door that closes" for a period of 14 days. Similarly, the WHO recommends that correctional facilities identify particular spaces "where suspect cases or confirmed cases not requiring hospitalization can be placed in medical isolation." *See* Bien Decl. ¶ 31, Exh. 17 (WHO Prevention and Control of COVID-19 in Prisons).

C. The Most Critical Prevention and Control Strategies—Social Distancing and Isolation to Prevent Transmission—Cannot Be Implemented in California Prisons Due to Existing Crowding and Space Constraints.

The Receiver appointed by the *Plata* Court to oversee medical care in CDCR (California Correctional Health Care Services, or CCHCS) has developed guidance to manage COVID-19 in CDCR's 35 institutions. Although many aspects of the guidance are well-reasoned, the most critical prevention and control strategies—social distancing and isolation to prevent transmission—simply cannot be implemented in California prisons due to existing overcrowding and space constraints. As a result, COVID-19 will be easily transmissible in the California prison system, and likely will infect a large number of people unless immediate action is taken.

CCHCS's guidance is outlined in two documents: The COVID-19 Interim Guidance for Health Care and Public Health Providers, dated March 2020, and a memo-randum regarding COVID-19 Guidance Regarding Field Operations, dated March 20,

2020. The cornerstone of the guidance—consistent with international, national, and state directives—is social distancing and isolation. For example, the guidance recognizes that "[s]ocial distancing strategies should be implemented as much as possible for all individuals" and recommends that individuals remain six feet apart and avoid congregating in groups of ten or more. Bien Decl. ¶ 11, Exh. 2 at 2-3 ("March 20, 2020 Memo"). But because most people in prison live in close quarters with others, both in crowded dorms and multi-person cells, this is simply impossible.

Approximately 46,265 people currently live in dorms in a California prison. *See* Bien Decl. ¶ 13, Exh. 3 ("Bed Audit"). This is nearly 40% of the entire prison population. Bien Decl. ¶ 16; *see also id*. ¶ 16, Exh. 6 (showing total in-custody population of 123,030 as of March 18, 2020). Dorm environments, where groups of people are gathered in close proximity to one another, are ripe for outbreak. The most recent data provided by the State shows that as of March 23, 2020, many dorms were well over capacity.[4] Indeed, as of March 23, 2020, 37,677 people live in dorms that are at or over 100% design capacity. Bien Decl. ¶ 17 & Exh. 6. Of those, 78% (29,401 people) live in dorms at or over 137.5% design capacity, including 13,458 people living in dorms at or over 175% design capacity. *Id*. Such conditions are a hotbed for infection, putting the lives of class members, staff, and thereby the outside community, at extreme risk.

Most alarming, 69% of the State's facilities (24 of 35 institutions) have dorms that are overcrowded. *See* Bien Decl. ¶ 20. The below photos illustrate conditions in Joshua Hall at the California Institution for Men ("CIM"), which has a design capacity of 80 people and was 161% overcrowded (housing 129 people) as of March 23, 2020. Declaration of Megan Lynch in Support of Plaintiffs' Emergency Motion ("Lynch Decl."),

[4] *See, e.g.*, Bien Decl. ¶ 13, Exh. 3 at 7, 4, 40 (Bed Audit showing that dorms at Central California Women's Facility (CCWF) meant to house 128 people often contain over 200 people, dorms at the California Correctional Center (CCC) are often close to 200% capacity, and dorms at the Substance Abuse Treatment Facility and State Prison, Corcoran ("SATF"), meant to house 63 people regularly house over 100 people); Lynch Decl., Exh. D (photograph of CCWF) & Exh. C (photographs of SATF dorms).

filed herewith, ¶¶ 4-9, Exh. A; Bien Decl. ¶ 13, Exh. 3 at 11 (Bed Audit). Joshua Hall houses a wide range of people who are classified as low security risk (Level II), including at least 28 people aged 60-69, 27 people aged 70-79, and seven people aged 80-90. *See* Bien Decl. ¶ 13, Exh. 3 (Bed Audit); Lynch Decl. ¶¶ 4-9. People also have a wide range of medical conditions, including diabetes, hypertension, hyperlipidemia, renal masses, atrial fibrillation, chronic kidney disease, chronic obstructive pulmonary disease, hepatitis C, hypothyroidism, hepatic fibrosis, unspecified systolic (congestive) heart failure, and HIV. Lynch Decl. ¶ 9. People in Joshua Hall are housed closely together both vertically (in bunk beds) and horizontally (with only between 25.5 and 48 inches between bunks). Declaration of Shira Tevah in Support of Plaintiffs' Emergency Motion ("Tevah Decl."), filed herewith, ¶ 5. People must traverse a narrow walkway between bunk beds each time they want to use the toilet, shower, or sink, as the bathroom is located in the center of a building with four separate wings. *Id.* ¶ 4. There is no way, then, that they can maintain a six-foot distance from other people.

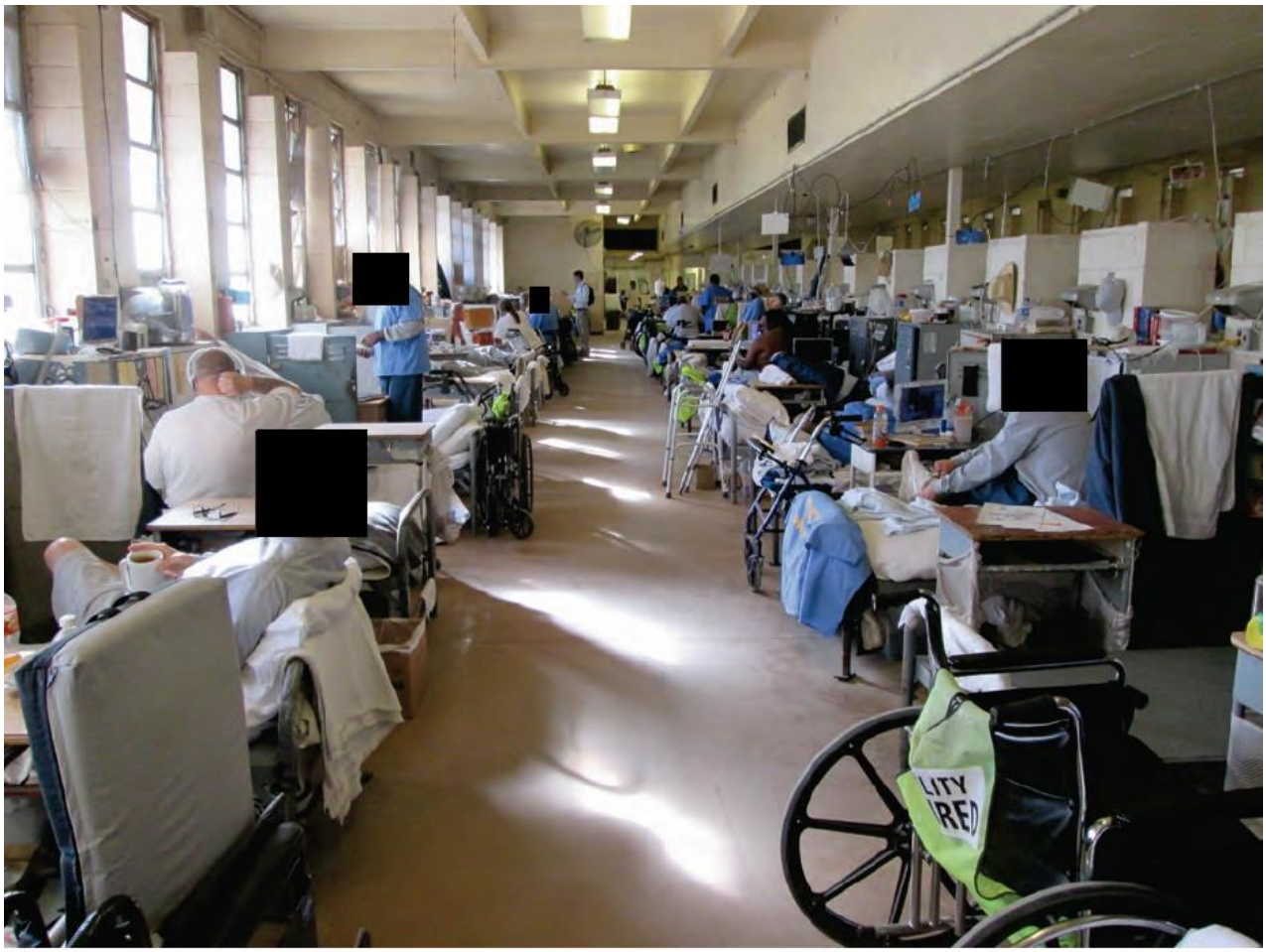
CIM, Facility A, Joshua Hall (Lynch Decl., Exh. A)

CIM, Facility A, Joshua Hall (Lynch Decl., Exh. A)

CIM, Facility A, Joshua Hall (Lynch Decl., Exh. A)

Even when dorms are at 100% capacity, social distancing is impossible. Dorm living requires people to sleep feet (and sometimes inches) from each other, and pass

through narrow walkways to access bathroom facilities and common areas. Elm Hall at CIM illustrates these conditions. Elm Hall houses a wide range of people who are minimum security (Level I), including at least 33 people aged 60-69, and 12 people aged 70-78. *See* Bien Decl. ¶¶ 13, Exh. 3 at 11 (Bed Audit); Lynch Decl. ¶ 14. People have a range of medical conditions, including asthma, dyslipidemia, fibrosis of liver, hypertension, seizures, advanced cirrhosis of liver, diabetes, hyperlipidemia, cirrhosis of liver, presence of automatic (implantable) cardiac defibrillator, cardiomyopathy, hypothyroid, disorder of lipoprotein metabolism, presence of coronary angioplasty implant and graft, ventricular fibrillation, unspecified viral hepatitis B without hepatic coma, chronic viral hepatitis C, and liver disease. Lynch Decl. ¶ 15. As of March 2, 2020, 27 people used a wheelchair, and seven people were designated as legally blind. *Id*. ¶ 12. All 156 beds in Elm Hall were occupied as of March 23, 2020. Bien Decl. ¶ 13, Exh. 3 at 11 (Bed Audit). Distance between beds ranges from 30-40 inches, and there is a narrow walkway between beds to get to and from the bathroom. Lynch Decl. ¶ 26.

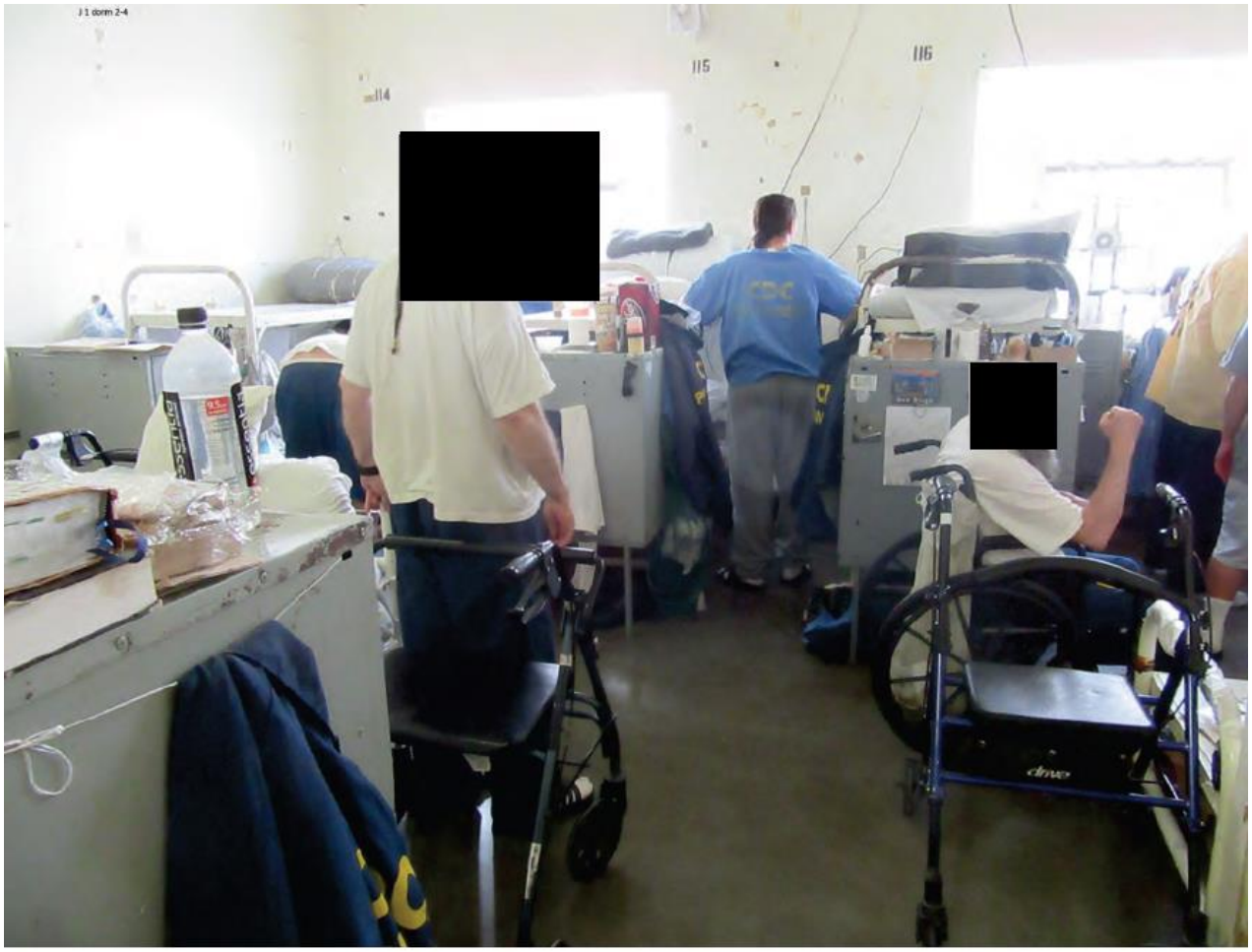


CIM, Facility D, Elm Hall (Lynch Decl., Exh. A)

Such living arrangements undermine and conflict with CCHCS's directive that "[c]ohorting vulnerable patients is not recommended as they are more susceptible to contracting and rapidly spreading the disease to other high-risk patients and are at high risk for developing serious complications or death related to the disease." March 20, 2020 Memo at 2.

These problems are not unique to CIM. As of March 23, 2020, J-1 dorm on Facility A at California Medical Facility ("CMF") was at 139% capacity, with 138 people living in a dorm designed to house just 92. *See* Bien Decl. ¶ 13, Exh. 3 at 15 (Bed Audit). J-1 houses a wide range of people who are Level II, including at least 35 people aged 60-69, and 12 people aged 70-79. *See id.*; Lynch Decl. ¶ 20. People housed there have a number of medical conditions, including diabetes, hyperkalemia, hypertension, hyperlipidemia,

atherosclerotic heart disease of native coronary artery without angina pectoris, disorder involving immune mechanism unspecified, and non-rheumatic aortic (valve) stenosis. Lynch Decl. ¶ 21. As of March 2, 2020, 19 people used a wheelchair. *Id*. ¶ 18. The below photo illustrates the crowded conditions in this unit. Lynch Decl. ¶ 31, Exh. B. Someone formerly incarcerated at CMF, who lived in J-1 and toured that unit again in November 2019, confirmed that it was and remains impossible to maintain a distance of six feet from other people in that unit. Declaration of Michael Brodheim in Support of Plaintiffs' Emergency Motion ("Brodheim Decl."), filed herewith, ¶ 7. The only way social distancing would be feasible would be if the bunk beds were moved six feet apart, all double bunks were replaced by single bunks, and people never moved from their beds, including to dress, bathe, use the toilet, or eat. *Id*.



CMF, J-1 Dorm (Lynch Decl. ¶ 31 Exh. B)

Combatting crowded conditions in the dorms is impossible, as there is simply nowhere to move people to allow necessary social distancing. The State's prison population currently is at 134.4% of design capacity. *See* Defs.' Mar. 2020 Status Report in Resp. to Feb. 10, 2014 Order, Coleman Doc. No. 6502 at 2 (Mar. 16, 2020). Every prison save three is over 100% capacity. *See id*., Exh. A (Coleman Doc. No. 6502-1). Many institutions greatly surpassed this mark. *See id.* (showing nearly a quarter of all institutions over 150% capacity, with SATF housing 1,862 more people than its overall design capacity, and Correctional Training Facility housing 1,795 more people than its capacity).

For these same reasons, it will be impossible to implement CCHCS's directive to "[p]romptly separate patients who are sick with fever and lower respiratory symptoms from well-patients." *See* Bien Decl. ¶ 11, Exh. 1 at 16 ("CCHCS Guidance"). CDCR already lacks adequate medical beds; according to the Plata medical experts, "some prisons do not have sufficient number of medical inpatient beds on site" to meet the needs of the population. *See* Joint Case Management Conference Statement, *Plata* Doc. No. 3163 at 17 (Oct. 29, 2019). CCHCS anticipates that overcrowding will impact the State's management of the virus. In particular, the guidance states that it may be necessary to cohort ill and healthy patients in the same dorm section and recommends that "[t]ape can be placed on the floor to mark the isolation section with a second line of tape 6 feet away to mark the well-patient section." Bien Decl. ¶ 11, Exh. 1 at 16. But, as noted above, social distancing is impossible in these dorm settings, where patients share bathroom facilities and common areas, and custody and healthcare staff must traverse throughout such units to provide meals, medical care, mental health treatment, and security checks.

Indeed, the CDC cautions against this very plan, warning that individuals under medical isolation should be housed "[s]eparately, in single cells with solid walls (i.e., not bars) and solid doors that close fully." *See* Bien Decl. ¶ 21, Exh. 7 (CDC Interim Guidance). If those settings are not available, the worst case scenario would still be to house people in multi-person cells "with an empty cell between occupied cells" or, in the

alternative, "[s]afely transfer individual(s) to another facility with available medical isolation capacity." *Id*. Again, given current population levels and space constraints, both the primary and alternative plans are not feasible in the California prison system.

The CCHCS guidance also directs that patients be isolated in airborne infection isolation rooms ("AIIR") or, alternatively, "a private room with a solid, closed door." Bien Decl. ¶ 11, Exh. 1 at 10-11, 15. But the guidance fails to identify whether AIIRs are available at every institution, and many cells throughout the State lack solid doors.

Finally, although the CCHCS guidance directs staff to limit their movement "between different parts of the institution to decrease the risk of staff spreading COVID-19," staffing shortages—which existed prior to the pandemic and will be exacerbated as more employees become ill and/or must work remotely—will require staff to move throughout facilities, even if just to provide basic necessities. *See* Bien Decl. ¶ 11, Exh. 1 at 15. Given the reality of CDCR's dense population, achieving the CCHCS's well-intentioned goal of "keep[ing] patients who are ill or who have been exposed to someone who is ill from mingling with patients from other areas of the prison" is impossible. *See id*. at 17-18.

D. The Impact of CDCR's Response to the Pandemic Will Be Borne by Its Most Vulnerable Populations, Such as People with Serious Mental Illness.

Responding to the pandemic within prison walls will require operational changes that disproportionately disadvantage populations about which this Court has expressed particular concern. In particular, CDCR's mental health population will suffer greatly due to the measures instituted to address the COVID-19 pandemic, such as restricted access to mental health treatment and expanded use of solitary confinement. The seriousness of the resulting harm underscores the need for urgent action by the Court.

Defendants already have substantially curtailed access to mental health care in response to the COVID-19 pandemic, including by closing access to hundreds of licensed inpatient psychiatric hospital beds. The Department of State Hospitals DSH suspended admissions of *Coleman* patients to its 336 licensed inpatient psychiatric hospital beds in

response to the COVID-19 pandemic. *See* Bien Decl. ¶ 34; *see also* Bien Decl. ¶ 14, Exh. 4 at 4 ("COVID-19 Mental Health Plan"). The remaining Psychiatric Inpatient Programs within CDCR prisons are already full, with long waitlists. *See* Bien Decl. ¶ 15, Exh. 5 (Psychiatric Inpatient Census and Pending List Report).

Indeed, CDCR's planned response to the COVID-19 pandemic will sharply limit its ability to provide mental health treatment to all patients in its custody at the same time that fear and anxiety will increase demand for mental health services. *See* Bien Decl. ¶ 14, Exh. 4 at 1. CDCR's plan acknowledges that asymptomatic patients housed in units or facilities that have been placed under quarantine due to risk of exposure will not receive mental health groups at all. *Id.* at 4. Given CDCR's dense housing, many or most units will likely experience rolling quarantines that disrupt or cease all group therapy for months.[5]

Moreover, vulnerable populations will suffer most from the isolation associated with social distancing. Absent a marked reduction in population, the only significant method for social distancing in CDCR will be placing general population prisoners into solitary confinement conditions. *See* Declaration of Craig Haney in Support of Plaintiffs' Emergency Motion ("Haney Decl."), filed herewith, ¶ 10 ("In penal settings, the social distancing that is now required in response to the COVID-19 Pandemic will most likely take the form of solitary confinement. Indeed, I have seen precisely this form of social distancing utilized as a matter of course in numerous correctional institutions throughout the country, where medical quarantines are conducted … by effective placing prisoners in solitary confinement."). The scientific literature on the serious harmful effects of solitary

[5] *Coleman* class members are disproportionately vulnerable to both contracting and experiencing severe harm from COVID-19. 13,415 of the people housed in CDCR's dorms have serious mental illness. Bien Decl. ¶ 59 & Exh. 43. One in four EOP patients currently live in CDCR's overcrowded dormitories, where they are unable to achieve social distancing. *Compare id.*, *with* Bien Decl. ¶ 46, Exh. 32 (total number of EOP class members in CDCR). *Coleman* class members are also disproportionately older than other prisoners; approximately 30% of the class is over the age of 50. Bien Decl. ¶ 55.

conditions in prison is consistent and alarming. *See* Haney Decl. ¶ 11. The *Coleman* court has recognized the particular dangers of solitary confinement to people with serious mental illness. *See* Apr. 10, 2014 Order, *Coleman* Doc. No. 5131 at 45-46.

The stakes could not be higher. Suicides in the CDCR are at record levels, leading the Secretary to acknowledge in October 2019 that the Department was experiencing an "inmate suicide crisis." *See* Bien Decl. ¶ 58, Exh. 42 (Oct. 8, 2019 SF Chronicle article). CDCR's 38 suicides in 2019 marked a tragic record. The rate of suicide in CDCR prisons in 2019 was 30.3 per 100,000, almost double the average national rate for prisons of 16 per 100,000. Bien Decl. ¶ 53-54 & Exh. 39 at 1 (2019 mid-year CDCR population data); *see also* Bien Decl. ¶ 61, Exh. 45 at p. 10, Table 10 (BJS report).

These stark realities underscore to need for urgent action to reduce the prison population. Only through a targeted population cap can CDCR mitigate the harm associated with its current COVID-19 prevention and mitigation measures.

E. Time Is of the Essence for any Effective Measures to Stem the Rapid Spread of COVID-19 to CDCR's Vulnerable Populations.

The State must act now if it is to stop the global COVID-19 pandemic from running rampant in its prison system and striking down the most vulnerable people in its custody. As Rick Raemisch, the former executive director of the Colorado Department of Corrections, recognized: "These prisons are bacteria factories. I don't think people understand the gravity of what's going to happen if this runs in a prison, and I believe it's inevitable. You're going to see devastation that's unbelievable." Bien Decl. ¶ 57, Exh. 41 at 2 (March 25, 2020 Pew Trusts report).

That is why correctional health expert Dr. Marc Stern warns that CDCR must

> immediately downsiz[e] the population of these prisons, with priority given to those at high risk of harm due to their age and health status, and with the goal of allowing social distancing and recommended public health practices in all ongoing activities. **To be effective in reducing the spread of the virus, these downsizing measures must occur now.** Currently, the prevalence of the virus in the prisons appears low, limited to a few prisons. This gives the California a critical window of opportunity to contain the virus before it

> permeates the prison system and becomes completely unmanageable.

Stern Decl. ¶ 15 (emphasis in original).

The sole measure Defendants have taken to reduce the prison population—the cessation of intake from the county jails, announced on March 24, 2020, *see* Bien Decl. ¶ 37, Exh. 23—will be inadequate to accomplish what Dr. Stern and CCHCS's own guidance say is needed. Through this pause in intake, CDCR's population will decrease by only a few thousand people a month. *See* Declaration of Thomas Hoffman in Support of Plaintiffs' Emergency Motion ("Hoffman Decl."), filed herewith, ¶ 13 n.8 (38,000 people released in 2018). This step is welcome but is neither fast nor targeted enough to bring relief when and where it is needed. Notably, to date, the State has announced no plans to modify any dorm housing to allow social distancing or release any medically vulnerable people. Without such action, the many people who live and work in California prisons are at serious risk.

III. THIS COURT SHOULD ORDER TARGETED RELIEF TO ADDRESS THE UNACCEPTABLE RISK OF HARM TO MEDICALLY VULNERABLE POPULATIONS AND PEOPLE HOUSED IN OVERCROWDED DORMS WHERE SOCIAL DISTANCING IS IMPOSSIBLE

A. The State Cannot "Properly Account for" Medically Vulnerable People and Those Housed in Congregate Settings under Its Current Population Reduction Measures

This Court, anticipating that the remedies ordered in 2009 might require adjustment over time, "retain[ed] jurisdiction over this matter … to consider any subsequent modifications made necessary by changed circumstances." 922 F.Supp.2d at 1004. Specifically, the Court recognized that the overall limit of 137.5% of capacity might prove inadequate: "Should the state prove unable to provide constitutionally adequate medical and mental health care after the prison population is reduced to 137.5% design capacity, plaintiffs may ask this court to impose a lower cap." *Id.* at 970 (footnote omitted). The 2009 remedial order, however sweeping, was only the "first stage of the court's attempt to bring the system into compliance with the Constitution's mandate." *Id.* at 964.

The Court's population reduction order was premised on the State's ability to "properly account for" the needs of particularly vulnerable populations, by maintaining them at lower populations as needed. *Id*. at 970 n.64. The Court recognized that some segments of the prison population might require more specific relief based on particularized needs:

> We recognize that certain institutions and programs in the system require a population far below 137.5% design capacity. We trust that any population reduction plan developed by the state in response to our opinion and order will properly account for the particular limitations and needs of individual institutions and programs.

Id. at 970 n.64. The Court acknowledged that the cap might need to be more targeted, and should the "single systemwide cap" prove to be "inadequate relief," further action might be needed. *Id*. at 964.

The U.S. Supreme Court also contemplated the possibility that modification of the cap would be warranted and more targeted relief necessary. The Court explained:

> The three-judge court … retains the authority, and the responsibility, to make further amendments to the existing order or any modified decree it may enter as warranted by the exercise of its sound discretion. "The power of a court of equity to modify a decree of injunctive relief is long-established, broad, and flexible." *N.Y. State Ass'n for Retarded Children, Inc. v. Carey*, 706 F.2d 956, 967 (C.A.2 1983) (Friendly, J.). A court that invokes equity's power to remedy a constitutional violation by an injunction mandating systemic changes to an institution has the continuing duty and responsibility to assess the efficacy and consequences of its order. *Id.* at 969-71. Experience may teach the necessity for modification or amendment of an earlier decree. To that end, the three-judge court must remain open to a showing or demonstration by either party that the injunction should be altered to ensure that the rights and interests of the parties are given all due and necessary protection.
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> * * *
>
> These [foregoing] observations reflect the fact that the three-judge court's order, like all continuing equitable decrees, must remain open to appropriate modification.

Brown v. Plata, 563 U.S. at 542-43, 545.

Indeed, in 2013, this Court counseled Plaintiffs to evaluate the necessity of further

relief *after* the State had complied with the population cap. At that time, the Court denied Plaintiffs' motion for additional relief in the form of institution-specific population caps on the following grounds: "Because defendants have not yet met the systemwide cap of 137.5%, it is difficult to determine whether that cap provides inadequate relief.… Accordingly, it is best to wait and reassess the need for [additional relief] when defendants reduce the systemwide prison population to 137.5% design capacity.…" April 11, 2013 Order, *Plata* Doc. 2590 at 61-62.

Now, more than five years after the State reached the numerical target of the overall population cap, it is indisputable that the cap is inadequate to permit the delivery of constitutional health care in the current crisis. It is therefore necessary to impose population caps specific to the most vulnerable populations.

B. Relief Should Be Targeted to These Specific Populations

There is a real and immediate risk that people living in California prisons will die or suffer serious medical injuries if Defendants do not make swift and targeted reductions to the prison population. In order to prevent the rapid spread of COVID-19 and protect medically vulnerable class members from severe illness or death, the Court should order Defendants to (1) significantly reduce the population in crowded congregate living spaces to a level that will permit social distancing, and (2) protect the medically vulnerable by releasing or relocating class members who are at especially high risk of severe illness from COVID-19.

To achieve population reductions in congregate living spaces, the Court should order Defendants to release to parole or post-release community supervision those class members who (a) are at low risk as determined by CDCR's risk assessment instrument or are serving a term for a non-violent offense; and (b) are paroling within the year. Within this group, people with six months or less to serve and people who are at high risk of severe illness from COVID-19 should be prioritized.

To protect the medically vulnerable, the Court should order Defendants to release or relocate class members who are at high risk of severe illness from COVID-19. According

to the Centers for Disease Control and Prevention, high risk individuals include: (a) people aged 65 and over; (b) people with chronic lung disease or moderate to severe asthma; (c) people who have heart conditions; (d) people who are immunocompromised (for example, due to cancer treatment, bone marrow or organ transplantation, immune deficiencies, poorly controlled HIV or AIDS, or prolonged use of immune-weakening medications); (e) people with severe obesity; (f) people with uncontrolled diabetes; (g) people with renal failure; (h) people with liver disease; and (i) people who are pregnant. *See* Bien Decl. ¶ 51, Exh. 37 (CDC statement re: higher risk people). Defendants can be given ample discretion in implementing this order, to release these vulnerable class members to parole or post-release community supervision and/or use the Governor's emergency powers to temporarily relocate them. *See generally* Bien Decl. 52, Exh. 38 ¶¶ 1-6 (Newsom March 4, 2020 Proclamation of a State of Emergency); Cal. Gov. Code § 8658.

C. An Order for Targeted Relief Is Warranted Under Rule 60(b)(5)

Federal Rule of Civil Procedure 60(b)(5) permits a party to move to modify an injunctive order if "applying it prospectively is no longer equitable." Fed. R. Civ. P. 60(b)(5); *see N.Y. State Ass'n for Retarded Children, Inc. v. Carey*, 706 F.2d 956, 967 (2d Cir. 1983). Under Rule 60(b)(5), the party seeking relief must show that: (1) modification is warranted due to a significant change in factual or legal circumstances, and (2) "the proposed modification is suitably tailored to the changed circumstance[s]." *Rufo v. Inmates of Suffolk Cty. Jail*, 502 U.S. 367, 393 (1992).

Modification of an existing injunction "must not create or perpetuate a constitutional violation," *Rufo*, 502 U.S. at 391, and the legal standard underlying the original injunction guides the court in molding the modification. *See generally id.* at 391-3 & nn.12, 13; *Sharp v. Weston*, 233 F.3d 1166, 1170-73 (9th Cir. 2000).

1. The Global Pandemic Constitutes a Changed Circumstance

The degree to which the coronavirus global pandemic has impacted every aspect of life in the United States and around the world cannot be overstated. At the time of this

writing, tens of millions of Americans, and all Californians, have been ordered to shelter in their homes except for essential needs. *See* Bien Decl. ¶ 50, Exh. 36. There have been hundreds of thousands of cases and at least 14,000 deaths reported globally. Stern Decl. ¶ 2. Health care facilities around the world have experienced or are bracing for an extraordinary influx of patients, as the virus sweeps through populations and strikes the most vulnerable as well as many others. *See id*. ¶7.

CDCR has recognized the magnitude of the crisis: all visiting and all educational, vocational, rehabilitative, religious, and volunteer programs in California prisons have been shut down, and all people entering the prisons are subjected to health screens. Bien Decl. ¶ 47, Exh. 33. The Governor has closed CDCR to all intake from county jails. Bien Decl. ¶ 37, Exh. 23 at ¶ 1 (Executive Order N-36-20, March 24, 2020).

At the time of the 2009 order, this Court expressed confidence that the "population reduction plan developed by the state in response to our opinion and order will properly account for the particular limitations and needs of individual … programs." 922 F.Supp.2d at 970 n.64. The State's planning clearly did not account for an emergency on this level. CDCR is far too crowded for the most basic and essential public health measure in the face of viral epidemic—social distancing—to be practiced in its many dormitory settings. Stern Decl. ¶ 8, 10-12; Brodheim Decl. ¶¶ 7, 9. The system is far too crowded to provide minimally adequate health care to the medically vulnerable who will contract COVID-19 with severe complications in large numbers. *See* Stern Decl. ¶¶ 6-7, 9, 17. The burden of the response to the virus, including severely restricted access to mental health treatment and expanded use of solitary confinement, disproportionately harms the most vulnerable people in the system, such as those with mental illness. *See supra*, Section II.D. In short, "incarcerated people in California state prisons are at an extraordinary risk of dying from the COVID-19 virus because the prisons are too crowded." Stern Decl. ¶ 13 (emphasis in original). These are significant factual changes warranting modification of this Court's 2009 prisoner release order.

2. A Targeted Population Reduction Order Would Directly Address the Needs of the Medically Vulnerable Population and Those Living in Congregate Settings and Would Therefore Be Tailored to the Changed Circumstances

The modification sought—an order requiring the State to reduce the prison population by releasing medically vulnerable people and reducing dormitory capacity to a level that will permit social distancing—is directly tailored to the risk of harm to the Plaintiff classes in the current coronavirus pandemic. The population reduction would allow necessary public health measures to be implemented and bring CDCR's capacity to care for its most vulnerable patients closer to a constitutional level of care. *See* Stern Decl. ¶¶ 16-17. The reduction also would allow CDCR to feasibly implement the *Plata* Receiver's own COVID-19 prevention and response guidelines, which are impracticable at current levels of crowding. *See supra* Section II.C. A reduced population would also facilitate the delivery of crucial mental health care, which has already been curtailed to a dangerous degree. *See supra* Section II.D. Without a targeted reduction, CDCR's overcrowding poses an unreasonable and substantial risk of harm to these populations.

D. The Requested Modifications Would Continue to Meet the PLRA's Requirements for a Prisoner Release Order

Under the PLRA, this Court should consider whether (1) it "has previously entered an order for less intrusive relief that has failed to remedy the deprivation of the Federal right," and (2) "the defendant has had a reasonable amount of time to comply with the previous court orders." 18 U.S.C. § 3626(a)(3)(A)(i), (ii). The Court also must find by clear and convincing evidence that "(i) crowding is the primary cause of the violation of a Federal right; and (ii) no other relief will remedy the violation." *Id.* § 3626(a)(3)(E).

The history of this case, the nature of the current public health crisis, and expert testimony demonstrate that a targeted release order from this Court is warranted and, indeed, is urgently necessary. Current conditions satisfy the PLRA's general standards for prospective relief, *see id.* § 3626(a)(1)(A), and the standards for issuing a prisoner release order, *see id.* § 3626(a)(3)(A), (E). Given the circumstances, this Court "is obligated to

act." *Coleman v. Schwarzenegger*, 922 F. Supp. 2d 882, 889 (E.D. Cal. 2009).

1. Less Intrusive Orders Have Failed to Remedy the Violation of Class Members' Right to Constitutionally Adequate Health Care.

In 2009, this Court ordered Defendants to reduce crowding in the prisons, in part to address the risk posed by the spread of infectious diseases. *See Coleman,* 922 F. Supp. 2d at 888, 931. The present crisis demonstrates that the 2009 order did not extend far enough to address the risk of serious harm to particular populations in CDCR's custody. By failing to limit extreme crowding in congregate living spaces or to impose specific population caps for aging and medically vulnerable populations, this Court's order was insufficient to address the extraordinary and immediate threats to health and well-being that these populations now face.

Both this Court and the Supreme Court cited the spread of infectious disease as a significant danger of prison overcrowding. In affirming this Court's population reduction order, the Supreme Court cited findings that "[o]vercrowding had increased the incidence of infectious disease" in the CDCR, and that crowded living quarters "where large numbers of prisoners may share just a few toilets and showers [were] 'breeding grounds for disease.'" *Plata*, 563 U.S. at 508-09, 519-20. The Supreme Court observed the connection between chronic overcrowding and the spread of infectious illness, noting that "[o]ne officer testified that antibiotic-resistant staph infections spread widely among the prison population and described prisoners 'bleeding, oozing with pus that is soaking through their clothes when they come in to get the wound covered and treated.' Another witness testified that inmates with influenza were sent back from the infirmary due to a lack of beds and that the disease quickly spread to 'more than half' the 340 prisoners in the housing unit …." *Id.* at 520 n.7 (internal citations omitted).

This Court too emphasized the dangerous connection between prison overcrowding and the spread of infectious disease. The Court observed that "crowding generates unsanitary conditions, overwhelms the infrastructure of existing prisons, and increases the risk that infectious diseases will spread." *Coleman*, 922 F. Supp. 2d at 931. In concluding

that prison crowding is a primary cause of the unconstitutional denial of adequate health care to CDCR's incarcerated population, this Court cited expert findings that "[u]ntil CDCR reduces its population, it will remain highly vulnerable to outbreaks of communicable diseases, including staph infections, tuberculosis and influenza." *Id.*

More than a decade after the Court's 2009 order, it is evident that the order did not fully remedy the dangers it sought to alleviate. Even after implementation of the population cap, crowding continues to prevent the State from implementing adequate measures to prevent the dangerous spread of infectious illness. Further population reduction measures are necessary—this time targeted directly at CDCR's overcrowded congregate living spaces and medically vulnerable population. *See id.* at 970 (noting that Plaintiffs may seek further relief "[s]hould the state prove unable to provide constitutionally adequate medical and mental health care after the prison population is reduced to 137.5% design capacity"); *see also Brown v. Plata*, 563 U.S. at 542-43, 545 ("The three-judge court … retains the authority, and the responsibility, to make further amendments to the existing order or any modified decree it may enter as warranted by the exercise of its sound discretion."). The *Plata* Receiver supports a further population reduction in response to the pandemic:

> [W]e believe that a significant reduction in population at this time will be a clear benefit to us in opening up cells and beds, thereby facilitating increased social distancing within the prisons and a more flexible management of the remaining population to reduce the speed with which covid-19 will spread throughout CDCR institutions. From this perspective, I support an accelerated release program.

Bien. Decl. ¶ 56, Exh. 40.

2. The State Has Had More than a Reasonable Amount of Time to Comply.

The State has had more than reasonable opportunity to devise and implement population reduction measures to eliminate the intolerable risk of serious harm or death due to the spread of infectious disease. Reasonableness, for these purposes, "must be assessed in light of the entire history of the court's remedial efforts." *Brown v. Plata*, 563

U.S. at 516.

Since the 2009 order from this Court, the State has had over a decade to reduce crowding and develop a constitutionally adequate healthcare system that can fulfill the function of protecting against the spread of communicable diseases. While COVID-19 presents unique risks and challenges, the prevention and management of infectious diseases is a well-established function of a prison health care system. Indeed, serious deficiencies in CDCR's ability to adequately address the risk of communicable disease were one of the problems that led the *Plata* Court to appoint a Receiver. *See* Findings of Fact and Conclusions of Law Regarding the Appointment of Receiver, *Plata* Dkt. No. 371, Oct. 3, 2005, at 18, 21-22. Years later, conditions in the prisons still expose prisoners to unacceptable risk of serious harm or death due to infectious disease. *See* Stern Decl. ¶¶ 8, 10-13.

The State has had ample time to address these deficiencies. *Cf. Brown v. Plata*, 563 U.S. at 514 (stating that Defendants "were given ample time to succeed" with regard to earlier orders, where Defendants had five years and 12 years to implement changes in the medical and mental health cases, respectively); *Coleman*, 922 F.Supp.2d at 918 (stating, in 2009, that Defendants had been given a reasonable amount of time to comply with the District Court's orders).

Moreover, the magnitude and urgency of the threat currently facing CDCR's incarcerated population simply does not lend itself to extended timeframes for further remedial efforts. According to Defendants, seven employees and one incarcerated person have already tested positive for COVID-19 in CDCR. Bien Decl. ¶ 47, Exh. 33. "The actual number of infections is likely to be higher due to the testing shortage." Stern Decl. ¶ 3. Without a swift and targeted reduction in the population, "[t]he conditions in CDCR's prisons will undoubtedly result in the rapid spread of the COVID-19 virus throughout the prisons." *Id.* ¶ 13. Defendants are well aware of the crowding in their prisons and the substantial elderly and medically vulnerable populations in their custody. Their failure to act more quickly to reduce the prison population in light of this unprecedented crisis is

troubling and constitutes further evidence of the need for urgent action by this Court.

3. Clear and Convincing Evidence Shows that Crowding Is the Primary Cause of the Deprivation of Constitutionally Adequate Health Care

There is no question that overcrowding is the primary reason class members are at heightened risk of a rapid and deadly spread of COVID-19 in California's prisons. The "primary" cause of a constitutional violation, for the purposes of a prisoner release order, is properly construed as "the foremost cause of the violation." *Brown v. Plata*, 563 U.S. at 525.

COVID-19 is spread between people who are in close contact with one another (within about six feet), through respiratory droplets when an infected person coughs or sneezes. *See* Bien Decl. ¶ 32, Exh. 18 (CDC Guidance); Stern Decl. ¶ 4. There is no vaccine or cure for COVID-19. Stern Decl. ¶ 4. No one has prior immunity. *Id.* The only way to control the virus is to stop it from spreading, primarily through social distancing. *Id.*

Social distancing is simply impossible in CDCR's overcrowded congregate living spaces. As Dr. Stern observed:

> To the extent that incarcerated people are housed in close quarters, unable to maintain a six-foot distance from others, and sharing or touching objects used by others, infectious diseases that are transmitted via the air or touch (like COVID-19) are more likely to spread, placing people at risk. This is especially true when, as in California, the number of incarcerated people is high and when large numbers of people are housed in open dormitories rather than one or two-person cells. For these reasons, if—but more likely when—COVID-19 is introduced into a prison, the risks of spread is greatly, if not exponentially, increased as already evidenced by spread of COVID-19 in two other congregate environments: nursing homes and cruise ships.

Id. ¶ 8; *see also* Brodheim Decl. ¶ 10 ("[M]ost people in the dorms at CMF are still living, showering, and sleeping within a few feet of each other most if not all of the time . . . ."); *supra* Section II.C.

Removing and isolating those with active symptoms will not stop the spread of this disease. First, isolating people who have symptoms of COVID-19 requires dedicated space in the prisons—many of which are still dangerously overcrowded. *See* Stern Decl. ¶ 11 ("[A] CDCR Institutional Bed Audit dated March 23, 2020 . . . shows that many of the CDCR dormitories are very crowded. For example, at Avenal State Prison, all people are housed in dormitories designed to house 50-100 people. Most of those dormitories are currently at 150% capacity. At the Central California Women's Facility, some of the dormitories are as much as 194% overcrowded."); *see also* Bien Decl. ¶ 13, Exh. 3 ("Bed Audit") Moreover, it is believed that people can transmit the virus without being symptomatic and, indeed, that a significant amount of transmission may be from people who are infected but asymptomatic or pre-symptomatic. Stern Decl. ¶ 5. Without immediately and significantly reducing the population in congregate living spaces, COVID-19 is very likely to spread rapidly throughout the prison system.

When it does, medically vulnerable people will get very ill very quickly. *Id.* ¶ 6-7. "Vulnerable people who are infected by the COVID-19 virus can experience severe respiratory illness, as well as damage to other major organs. Treatment for serious cases of COVID-19 requires significant advanced support, including ventilator assistance for respiration and intensive care support." Stern Decl. ¶ 7; *see also id.* ¶ 17.

CDCR's inpatient medical beds are already at capacity; indeed, before the COVID-19 outbreak, medical experts in *Plata* raised the concern "that some prisons do not have sufficient number of medical inpatient beds on site" to meet the needs of the prison population. *See* Joint Case Management Conference Statement, *Plata* Doc. No. 3163 at 17 (Oct. 29, 2019). Thus, it is unlikely that CDCR will be able to treat many of those who fall very ill from COVID-19 within the prison system, and an outbreak of COVID-19 in the prisons will almost certainly put significant additional pressure on community healthcare systems. Stern Decl. ¶ 7. If overloaded local health care systems are unable to absorb the outbreak, class members will die unnecessarily without life-saving treatment. *Id.*

4. Clear and Convincing Evidence Shows that No Other Relief Will Remedy the Violation

No relief other than a targeted prisoner release order will protect class members' constitutional rights to adequate health care. The only way to control the COVID-19 virus and limit its devastating effects is to implement preventive strategies such as social distancing. Stern Decl. ¶ 4. The only way to achieve social distancing in the crowded dorms is to significantly reduce the population in those units. *See id.* ¶ 16.

Specific populations (elderly people and those with chronic medical conditions) also face a heightened risk of serious harm or death due to the virus. Stern Decl. ¶ 17. The only reasonable way to protect those people from this imminent threat is to remove them from CDCR's crowded prisons—either by releasing them or relocating them in facilities in which they can be safely isolated. *See id.* ¶ 17. The State has announced that it will close the state prisons to intake for at least 30 days. *See* Bien Decl. ¶ 37, Exh. 23 (Newsom March 24, 2020 Executive Order N-36-20). This measure, while welcome, will not address the danger facing people in the prisons right now. The population reduction associated with closing the prisons to new intakes will occur only gradually over coming months, as people are released. But, as Dr. Stern explains, **"[t]o be effective in reducing the spread of the virus, … downsizing measures must occur now**" in the "critical window of opportunity to contain the virus before it permeates the prison system and becomes completely unmanageable." Stern Decl. ¶ 15 (emphasis in original).

The decision to halt intake does nothing to address crowding in congregate living spaces today or in the next few weeks—when the virus is likely to spread rapidly through the system—and it does not address the particular risks faced by elderly and medically vulnerable people in CDCR custody. It will not enable CDCR to contain the potential exponential growth of cases and serious complications, of morbidity and mortality. Nothing short of an immediate, targeted population reduction order will protect class members against the grave threat posed by COVID-19.

5. A Prisoner Release Order Would Be Narrowly Drawn, Would Extend No Further than Necessary, and Would Be the Least Intrusive Means to Correct the Current Constitutional Violations

This Court should issue a prisoner release order directed solely at CDCR's overcrowded congregate living spaces and medically vulnerable population. Such an order would be narrowly drawn, extend no further than necessary, and be the least intrusive means to avoid risk of catastrophic harm to the incarcerated population.

"Narrow tailoring requires a fit between the remedy's ends and the means chosen to accomplish those ends." *Brown v. Plata*, 563 U.S. at 531 (alterations and citation omitted). "The scope of the remedy must be proportional to the scope of the violation, and the order must extend no further than necessary to remedy the violation." *Id.* Here, a prisoner release order directed at CDCR's overcrowded congregate living spaces and medically vulnerable population would be tailored directly to the constitutional violations at issue. This Court's 2009 order did not limit the State's discretion in any way, allowing it to choose any methods it wished to relieve the unconstitutional conditions. Unfortunately, the State implemented population reduction in a manner that failed to adequately address the risk posed by COVID-19.

In light of this case history, the order sought would be narrowly drawn, extend no further than necessary to remedy the ongoing constitutional violations, and constitute the least intrusive means to that end. Even with an order directed at CDCR's overcrowded congregate living spaces and medically vulnerable population, the State would retain maximal discretion as to specific methods of implementation.

6. Public Safety Would Be Served by a Targeted Prisoner Release Order

In considering a population reduction order, the Court must give "substantial weight" to its impact on public safety. 18 U.S.C. § 3626(a)(1)(A). Far from having an adverse impact, a targeted prisoner release order would significantly enhance public safety in two ways.

First, without a targeted release, COVID-19 will spread like wildfire in CDCR's crowded prisons, quickly overwhelming hospital capacity and needlessly infecting thousands of staff and incarcerated people. Stern Decl. ¶¶ 13-17. This is because social distancing is impossible at many prisons and for the thousands of people living and working in them. *Id.* ¶ 8; Brodheim Decl. ¶ 11. Since social distancing is the primary means to slow the spread of the virus, the virus has the capacity to spread uncontained in CDCR absent immediate action. Stern Dec. ¶¶ 8, 13, 20.

Nearly 200,000 people live or work in CDCR prisons. *See* Bien Decl. ¶ 16, Exh. 6 (March 18, 2020 CDCR Weekly Offender Report); Bien Decl. ¶ 33, Exh. 19 (Dec. 2019 State Employee Demographics). Every day, 65,000 staff go home to their families and communities, *see id.,* and every month, several thousand incarcerated people are released after completing their sentences. Hoffman Decl. ¶ 13 n.8 (over 38,000 people release in 2018); Bien Decl. ¶ 63, Exh. 47 (Jan. 2020 CDCR Offender Data Points Report showing over 35,000 people released from custody in 2018). The influx to California communities of thousands of people with significant exposure to the virus will spread the damage caused by CDCR overcrowding to all Californians. Stern Decl. ¶ 16; Haney Decl. ¶ 9 ("prisons have only limited means of protecting incarcerated persons from contact with staff who regularly enter facilities after having been in the outside world. Staff members are at risk of having contracted COVID-19 and then transmitting it to all those inside the institutions, including staff and incarcerated persons"). The risk to public safety is extreme.

Second, the unchecked spread of COVID-19 within the prisons has serious potential to create panic and chaos that endangers the lives of incarcerated people and staff alike. In the words of former CDCR Secretary Scott Kernan, "It's a tinderbox of potential infection as you go forward, especially if you are just watching what's going on around the world… I know Italy and Brazil had serious violence and even escapes and murders in the jails as a result of COVID-19." Bien Decl. ¶ 34, Exh. 20 (March 23, 2020 KQED article). In addition, increased demands for mental health care caused by fear, stress and anxiety will

arise at the same time that the delivery of mental health care, access to inpatient hospitalization and suicide prevention measures are being limited. Deaths by suicide will increase.

The risk to public safety from reducing the population is minimal. The 2009 population reduction order resulted in significant decarceration without significant rise in crime. Hoffman Decl. ¶ 11; Bien Decl. ¶ 35, Exh. 21 (2015 Public Policy Institute of California report). Older and medically vulnerable people currently in the system pose minimal risk to the public. Hoffman Decl. ¶ 8. The same holds true with low security people already fully identified by CDCR's risk tool. Hoffman Decl. ¶ 10. CDCR can choose the lowest risk people to release in order to reduce the dorm population to a level that permits appropriate social distancing. This Court can implement the necessary population reduction in a manner that permits CDCR maximum latitude to select the release criteria. In the opinion of Thomas Hoffman, an experienced law enforcement leader and former Director of CDCR's Division of Adult Parole Operations, "CDCR can accelerate the reduction the prison population to address the COVID-19 pandemic without an adverse impact on public safety." Hoffman Decl. ¶ 12.

Governor Newsom, the Defendant in this case, has been clear that social distancing must be practiced by all Californians and that hospital facilities must be conserved for a threatened influx of extremely sick patients. *See* Bien Decl. ¶ 36, Exh. 22 (Newsom March 19, 2020 Executive Order N-33-20). Thus a targeted release order to enable social distancing where large groups must gather by necessity, and protect the most medically vulnerable by moving them from a place that cannot serve their needs, is necessary to fully implement the Governor's orders for all Californians.

In fact, California law calls for just such measures to be taken. Section 8658 of the California Government Code provides specific direction to CDCR in the case of emergencies like today's pandemic:

> In any case in which an emergency endangering the lives of inmates of a state, county, or city penal or correctional institution has occurred or is imminent, the person in charge of

> the institution may remove the inmates from the institution. He shall, if possible, remove them to a safe and convenient place and there confine them as long as may be necessary to avoid the danger, or, if that is not possible, may release them. Such person shall not be held liable, civilly or criminally, for acts performed pursuant to this section.

Under this law, the State *shall*, when possible, ensure that people held in custody be provided safe harbor as needed to avoid emergency. State law recognizes that the dangers involved in keeping people incarcerated in an emergency might constitute a greater risk to public safety than a carefully calibrated release.

It is true that "[w]henever a court issues an order requiring the State to adjust its incarceration and criminal justice policy, there is a risk that the order will have some adverse impact on public safety in some sectors," but "[t]he PLRA's requirement that a court give 'substantial weight' to public safety does not require the court to certify that its order has no possible adverse impact on the public." *Brown v. Plata*, 563 U.S. at 534. Any amorphous risks associated with a targeted order cannot stand in the way of ensuring that tens of thousands of people receive the minimally adequate care the Constitution mandates.

The PLRA's requirements are satisfied, as are the requirements for modification of the 2009 prisoner release order. This Court should modify the order to target the populations described above.

CONCLUSION

For the foregoing reasons, Plaintiffs respectfully ask the Court to issue an order modifying the 2009 population cap and requiring the State to reduce the population in crowded congregate living spaces to a level that will permit social distancing and protect the medically vulnerable by releasing or relocating class members who are at especially high risk of severe illness from COVID-19.

Respectfully submitted,

DATED: March 25, 2020

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UNITED STATES DISTRICT COURTS
EASTERN DISTRICT OF CALIFORNIA
AND NORTHERN DISTRICT OF CALIFORNIA
UNITED STATES DISTRICT COURT COMPOSED OF THREE JUDGES
PURSUANT TO SECTION 2284, TITLE 28 UNITED STATES CODE

RALPH COLEMAN, et al., Plaintiffs, v. GAVIN NEWSOM, et al., Defendants.	Case No. 2:90-CV-00520-KJM-DB **THREE JUDGE COURT**
MARCIANO PLATA, et al., Plaintiffs, v. GAVIN NEWSOM, Defendants.	Case No. C01-1351 JST **THREE JUDGE COURT** **DECLARATION OF THOMAS HOFFMAN IN SUPPORT OF PLAINTIFFS' EMERGENCY MOTION**

DECLARATION OF THOMAS HOFFMAN

I, Thomas Hoffman, declare:

1. I am a public safety executive who has been involved in California municipal and State law enforcement and corrections for over 42 years. During my career I served with the City of Inglewood Police Department (1975-1994), the City of West Sacramento Police Department (1994-2004), and as the Director of the California Department of Corrections and Rehabilitation's (CDCR) Division of Adult Parole Operations (DAPO) (2006-2009). Since August 2009 I have worked as a consultant on public safety, corrections, and parole issues.

2. While serving with the City of Inglewood Police Department (1975-1994), I promoted through the ranks from Officer to Captain, working in the areas of Operations, Investigations, Special Operations and Administration. I also served with the City of West Sacramento Police Department (1994-2004) serving as Captain, Deputy Chief of Police and as Interim Chief of Police.

3. In 2006, I was appointed to be the Director of the Division of Adult Parole Operations (DAPO) of the California Department of Corrections and Rehabilitation. DAPO is the arm of CDCR that is responsible for all parole operations. As Director, I was responsible for policy development, administration, and oversight of an organization of 2,400 sworn and 1,800 non-sworn employees charged with the day-to-day supervision of over 135,000 State parolees. During that time, DAPO was responsible for all programming provided to California parolees being released from prison. Furthermore, during my tenure as Director of DAPO, parole supervision became one of the most hotly debated public safety issues of our time. From 2006 to 2009, DAPO initiated the largest expansion in the number, scope and diversity of post-release rehabilitative programs in its history. During that time, DAPO was also responsible for the implementation of Jessica's Law (the highly controversial and complex sex offender management law), the development of a validated risk and needs assessment instrument (COMPAS/CSRA), and the development of the parole violation decision making instrument (PVDMI).

4. During my tenure at DAPO, I also personally directed the Division's strategy for the implementation of the recommendations of the California Expert Panel (2007) and the Rehabilitation Strike Force (2008). The California Expert Panel was a nationally renowned group of correctional professionals and academics who gathered to conduct an analysis of CDCR policies and practices, and to recommend areas for improvement. The Rehabilitation Strike Force was tasked with offering recommendations for the resources provided as part of AB 900, which provided funding for additional criminal justice facilities to California communities. The recommendations identified in these two reports often served as my personal "roadmap" when I considered a specific policy or strategy for implementing organizational change throughout my tenure as Director.

5. Upon my retirement from CDCR/DAPO in August 2009, I was engaged as a correctional/parole consultant by the Adult Parole Operations division of the Colorado Department of Corrections to facilitate the development of a parole violation decision making instrument. As was the case in California, this process was undertaken to ensure transparency, equity, and consistency in the remedies imposed by officers and supervisors in response to parole violations or criminal activity by those under their supervision.

6. Since my retirement from CDCR I have also served as an Executive Fellow with the Police Foundation, headquartered in Washington DC. The Police Foundation is a national non-profit, bipartisan organization with a commitment to improve American policing. In this capacity I have served as a primary point of contact for the Foundation's work on the implementation of AB 109 (California's 2011 "realignment" of the criminal justice system), parole reform, sentencing reform, and most recently, the debate about the militarization of the American police.

7. Since October 2012, I have also served as the Senior Public Safety Advisor for Californians For Safety and Justice (CSJ). CSJ is a foundation-funded non-profit organization that encourages the development of "smart justice" solutions for local, county and State organizations. In this capacity, I played a lead role in developing the campaign strategy for outreach and communication with local law enforcement leaders and others in

the successful Proposition 47 campaign in 2014. I am also working with the Fontana, Santa Barbara and San Luis Obispo Police Departments as they implement enforcement programs designed to improve the resources and services available for their Officers when they interact with mentally ill individuals, disabled veterans and homeless people in their communities.

8. As noted above, I am familiar with the tools available for addressing the public safety impacts of changes in the way people transition from incarceration to the community. There is a well-developed body of evidence regarding the risks that persons will re-offend during the first few years of release from prison. The California Department of Corrections and Rehabilitation publishes result recidivism statistics periodically. The last published set of data is for persons released in fiscal year 2014/2015.[1] The data follows these people for the three years after their release. This data shows that persons who are over 60 years old present dramatically lower risks of a new conviction within three years after release compared to other age groups.[2] This is consistent with the general consensus in the field of correctional risk assessment that people age out of criminal behavior. A person who engaged in criminal behavior in his twenties is very unlikely to return to such behavior after age 45. CDCR publishes demographic data showing that as of December 2018, approximately 8.4% of the in custody population, or approximately 10,600 people, were aged 60 or older, and of them approximately 5,000 people were age 65 or over.[3] The next lower age bracket, 55 to 59 years of age, also a generally low risk age group, numbered over 9,000 people.

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[1] *See* Recidivism Report for Offenders Released From the California Department of Corrections and Rehabilitation in Fiscal Year 2014-2015 (Recidivism Report), available at, https://www.cdcr.ca.gov/research/wp-content/uploads/sites/174/2020/01/Recidivism-Report-for-Offenders-Released-in-Fiscal-Year-2014-15.pdf.

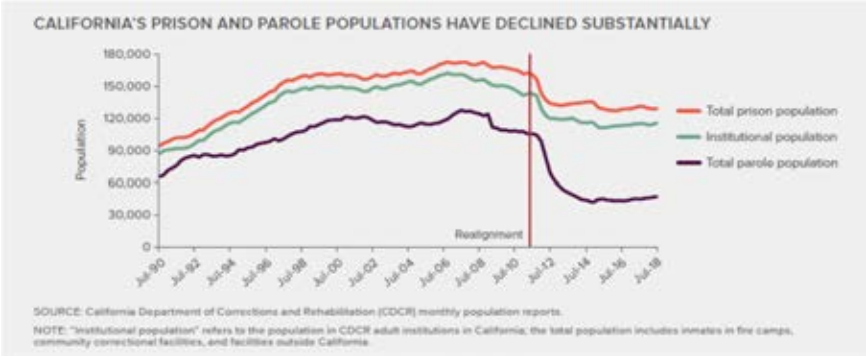
[2] *Id.* at viii, Persons over 60 have a three-year conviction rate of 20.5 percent compared to 59 percent for persons aged 20 to 24.

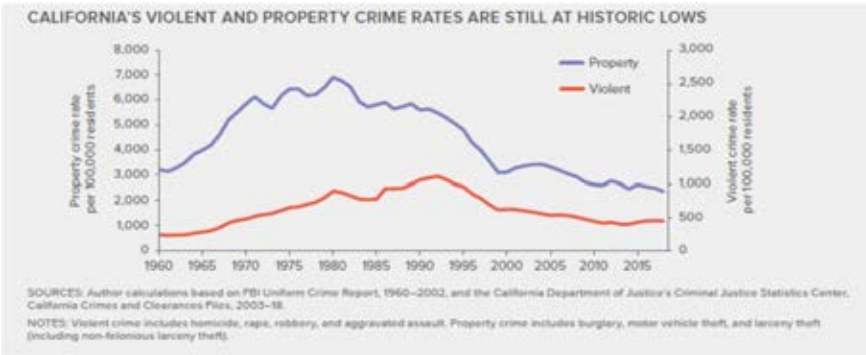
[3] California Department of Corrections, Offender Data Points: Offender Demographics for the 24-month Period Ending December 2018 (January 2020) (CDCR Demographics) at

9. The recidivism rates for "lifers," persons with indeterminate sentences are extremely low, regardless of age. Of the 688 lifers released in 2014-2015, sixteen individuals (2.3 percent) were convicted of a new crime, the majority of which were misdemeanors.[4]

10. California's tracking of risk assessment scores is also public.[5] CDCR reports that as of the end of 2018, 49.8% of its in custody population, or over 63,000 people, scored at a "Low Risk to Reoffend" on the California State Risk Assessment Score (CSRA).[6]

11. Much work has been done to study the public safety impact of California's post-2009 prison population reduction. Both violent and property crime rates have remained at historic lows during the same period in which the prisoner and parolee population dropped. To the left are two tables from a January 2020 report by the Public Policy Institute of California,[7] one showing the drop in and the prison and parole population, and the other showing the drop in crime rates.





page 20, available at https://www.cdcr.ca.gov/research/wp-content/uploads/sites/174/2020/01/201812_DataPoints.pdf.

[4] Recidivism Report, *supra* note 1, at viii, 19-20.

[5] CDCR Demographics, *supra* note. 3.

[6] *Id.* at 16.

[7] Public Policy Institute of California, "California continues to reshape its criminal justice

12. Based on my experience as a former peace officer, and former parole administrator, as well as my continued work in this field, it is my professional opinion that CDCR can accelerate the reduction the prison population to address the COVID-19 pandemic without an adverse impact on public safety.

13. In addition, it is my professional opinion that if CDCR does not act to prevent uncontrolled spread of COVID-19 inside the prisons, the consequences will be harmful to public safety. Movement of staff in and out of the prisons is necessary to their operation. The worse the infection rate is in the prisons, the more risk that staff will carry the virus out to the public. Similarly, even without any additional measures, there is a steady flow of people paroling and/or being released to Post Release Community Supervision.[8] Controlling the rate of infection inside the prison also prevents released prisoners from bringing the virus outside the prisons.

14. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration is executed at Folsom, California this 24th day of March, 2020.

Thomas Hoffman

system," January 2020, available at https://www.ppic.org/wp-content/uploads/californias-future-criminal-justice-january-2020.pdf.

[8] See CDCR Demographics, *supra,* note 3, at page 54 (over 38,000 individuals were released from custody in 2018).

12. Based on my experience as a former peace officer, and former parole administrator, as well as my continued work in this field, it is my professional opinion that CDCR can accelerate the reduction the prison population to address the COVID-19 pandemic without an adverse impact on public safety.

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UNITED STATES DISTRICT COURTS
EASTERN DISTRICT OF CALIFORNIA
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UNITED STATES DISTRICT COURT COMPOSED OF THREE JUDGES
PURSUANT TO SECTION 2284, TITLE 28 UNITED STATES CODE

RALPH COLEMAN, et al., Plaintiffs, v. GAVIN NEWSOM, et al., Defendants.	Case No. 2:90-CV-00520-KJM-DB **THREE JUDGE COURT**
MARCIANO PLATA, et al., Plaintiffs, v. GAVIN NEWSOM, Defendants.	Case No. C01-1351 JST **THREE JUDGE COURT** **DECLARATION OF CRAIG W. HANEY IN SUPPORT OF PLAINTIFFS' EMERGENCY MOTION**

DECLARATION OF DR. CRAIG W. HANEY, PHD

I, Craig W. Haney, declare as follows:

1. I am a Distinguished Professor of Psychology and UC Presidential Chair at the University of California Santa Cruz in Santa Cruz, California, where I engage in research applying social psychological principles to legal settings including the assessment of the psychological effects of living and working in institutional environments, especially the psychological effects of incarceration. I was a co-founder and co-director of the UC Criminal Justice & Health Consortium – a collaborative effort of researchers, experts and advocates from across the University of California system working to bring evidence-based health and healthcare solutions to criminal justice reform in California and nationwide.

2. I also have served as a consultant to numerous governmental, law enforcement, and legal agencies and organizations on jail- and prison-related issues. Those agencies and organizations include the Palo Alto Police Department, various California Legislative Select Committees, the National Science Foundation, the American Association for the Advancement of Science, the United States Department of Justice, the Department of Health and Human Services (HHS), the Department of Homeland Security, and the White House (under both the Clinton and Obama Administrations). In 2012, I testified as an expert witness before the Judiciary Committee of the United States Senate in a hearing that focused on the use and effects of solitary confinement and was appointed as a member of a National Academy of Sciences committee analyzing the causes and consequences of high rates of incarceration in the United States. My research, writing, and testimony have been cited by state courts, including the California Supreme Court, and by Federal District Courts, Circuit Courts of Appeal, and the United States Supreme Court.[1]

3. COVID-19 is a serious, highly contagious disease and has reached pandemic status. At least 375,498 people around the world have received confirmed diagnoses of COVID-19 as of

[1] For example, see *Brown v. Plata,* 563 U.S. 493 (2011).

March 24, 2020,[2] including 44,183 people in the United States.[3] At least 16,362 people have died globally as a result of COVID-19 as of March 24, 2020,[4] including 544 in the United States.[5] These numbers are predicted by health officials to increase, perhaps exponentially. For example, the CDC has estimated that as many as 214 million people may eventually be infected in the United States, and that as many as 21 million could require hospitalization.[6]

4. The COVID-19 Pandemic poses such a threat to the public health and safety in the State of California, that on March 4, 2020 Governor Gavin Newsom declared a statewide State of Emergency, and on March 19, 2020, he ordered all California residents to stay home or at their place of residence except to facilitate certain authorized necessary activities.[7] His office has estimated that, in the absence of taking appropriate steps to mitigate the spread of the virus, as many as 56% of all Californians will contract it.[8]

5. COVID-19 is a novel virus. There is no vaccine for COVID-19, and there is no cure for COVID-19. No one has immunity. Currently, the most effective ways to control the virus are to use preventive strategies, including social distancing, in order to maximize our healthcare capacity for a manageable number of patients. Otherwise, healthcare resources will be overwhelmed and the Pandemic will worsen.

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[2] World Health Organization, *Coronavirus disease (COVID-19) Outbreak*, https://www.who.int/emergencies/diseases/novel-coronavirus-2019

[3] Center for Disease Control and Prevention, *Coronavirus Disease 2019 (COVID-19): Cases in U.S.*, https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html.

[4] *Supra,* fn. 2.

[5] *Supra,* fn. 3.

[6] Sheri Fink, *Worst-Case Estimates for U.S. Coronavirus Deaths,* N.Y. TIMES (Mar. 18, 2020), https://www.nytimes.com/2020/03/13/us/coronavirus-deaths-estimate.html.

[7] Executive Department, State of California, Executive Order N-33-20, https://covid19.ca.gov/img/Executive-Order-N-33-20.pdf

[8] Office of the Governor, "Letter to President Donald Trump" (March 18, 2020), https://www.gov.ca.gov/wp-content/uploads/2020/03/3.18.20-Letter-USNS-Mercy-Hospital-Ship.pdf.

6. Social distancing presents serious challenges for everyone in every part of our society, but nowhere more than in penal institutions, where living conditions are unusually sparse and prisoners necessarily live in unescapably close quarters with one another.

7. Moreover, jails and prisons are already extremely stressful environments for the persons confined in them to live.[9] They can be psychologically and medically harmful in their own right, leaving formerly incarcerated persons with higher rates of certain kinds of psychiatric and medical problems.[10] Incarceration leads to higher rates of morbidity (illness rates) and mortality (i.e., it lowers the age at which people die).[11]

8. Prisons lack the operational capacity to address the needs of persons in custody in a crisis of this magnitude. These facilities are ill-equipped to provide incarcerated persons with ready access to cleaning and sanitation supplies, or to assure that staff sanitize all surfaces during the day. Most correctional facilities were already operating at or beyond the limits of their

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[9] Much of this evidence is summarized in several book-length treatments of the topic. For example, see: Haney, C., Reforming punishment: Psychological limits to the pains of imprisonment. Washington, DC: American Psychological Association (2006); Liebling, A., & Maruna, S. (Eds.), The effects of imprisonment. Cullompton, UK: Willan (2005); and National Research Council (2014). The Growth of Incarceration in the United States: Exploring the Causes and Consequences. Washington, DC: The National Academies Press. In addition, there are numerous empirical studies and published reviews of the available literature. For example, see: Haney, C., Prison effects in the age of mass incarceration. Prison Journal, 92, 1-24 (2012); Johns, D., Confronting the disabling effects of imprisonment: Toward prehabilitation. Social Justice, 45(1), 27-55.

[10] E.g., see: Schnittaker, J. (2014). The psychological dimensions and the social consequences of incarceration. Annals of the American Association of Political and Social Science, 651, 122-138; Turney, K., Wildeman, C., & Schnittker, J., As fathers and felons: Explaining the effects of current and recent incarceration on major depression. Journal of Health and Social Behaviour, 53(4), 465-481 (2012). See, also: Listwan, S., Colvin, M., Hanley, D., & Flannery, D., Victimization, social support, and psychological well-being: A study of recently released prisoners. Criminal Justice and Behavior, 37(10), 1140-1159 (2010).

[11] E.g., see: Binswanger, I., Stern, M., Deyo, R., et al., Release from prison: A high risk of death for former inmates. New England Journal of Medicine, 356, 157-165; Massoglia, M. Incarceration as Exposure: The Prison, Infectious Disease, and Other Stress-Related Illnesses. Journal of Health and Social Behavior, 49(1), 56-71; and Massolglia, M., & Remster, B., Linkages Between Incarceration and Health. Public Health Reports, 134(Supplement 1), 85-145 (2019); and Patterson, E. (2013). The dose-response of time served in prison on mortality: New York state, 1989-2003. American Journal of Public Health, 103(3), 523-528.

capacities to provide mental health or medical care. The demand for such services in this crisis will only grow, and already scarce treatment resources will be stretched even more.

9. In addition, prisons typically provide very limited access to telephonic or other forms of remote visiting. Yet precisely *these* ways of connecting to others will become critically important if contact visiting is limited. Furthermore, prisons have only limited means of protecting incarcerated persons from contact with staff who regularly enter facilities after having been in the outside world. Staff members are at risk of having contracted COVID-19 and then transmitting it to all those inside the institutions, including staff and incarcerated persons.

10. In penal settings, the social distancing that is now required in response the COVID-19 Pandemic will most likely take the form of solitary confinement. Indeed, I have seen precisely this form of social distancing utilized as a matter of course in numerous correctional institutions throughout the country, where medical quarantines are conducted in prison infirmaries or other housing units by effectively placing prisoners in solitary confinement.

11. Yet solitary confinement subjects people to a separate set of very serious harmful effects, ones that significantly undermine their mental and physical well-being. The scientific literature on the harmfulness of solitary confinement in jails and prisons is now widely accepted and the research findings are consistent and alarming.[12] This research has led a number of professional mental and physical health-related, legal, human rights, and even correctional organizations to call for severe limitations on the degree to which solitary confinement is employed—specifically limiting when, for how long, and on whom it can be imposed.[13]

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[12] These many studies have been carefully reviewed in a number of publications. For example, see: K. Cloyes, D. Lovell, D. Allen & L. Rhodes, Assessment of psychosocial impairment in a supermaximum security unit sample, Criminal Justice and Behavior, 33, 760-781 (2006); S. Grassian, Psychiatric effects of solitary confinement. Washington University Journal of Law & Policy, 22, 325-383 (2006); C. Haney, Restricting the use of solitary confinement. Annual Review of Criminology, 1, 285-310 (2018); C. Haney & M. Lynch, Regulating prisons of the future: The psychological consequences of solitary and supermax confinement. New York Review of Law & Social Change, 23, 477-570 (1997); and P. Smith, The effects of solitary confinement on prison inmates: A brief history and review of the literature, in Michael Tonry (Ed.), Crime and Justice (pp. 441-528). Volume 34. Chicago: University of Chicago Press (2006).

[13] For a list of these organizations and their specific recommendations, see: Haney, C. (2018)

12. I provided expert testimony to the single judge *Coleman v. Brown* court in 2013 on the threats to life and safety posted by long-term solitary confinement in California's adult prisons.[14] My testimony was based on many tours of California prisons, extensive in-depth interviews with numerous incarcerated persons and staff, as well as the review of many policies, procedures, and class member records.

13. After touring nearly all of the Security Housing Units, and other segregated settings in CDCR, I concluded then that the conditions that existed there created very serious risks to the lives and well-being of persons with mental illness. I further concluded that mentally ill prisoners could not be safely housed in CDCR's segregated units unless they were provided with a minimally adequate treatment program, including at least 10 hours of out of cell time per week in addition to clinically indicated treatment hours. In addition, I concluded that even with these minimal forms of amelioration, the conditions in CDCR's segregated units still posed a considerable risk of psychological harm. I urged that strict time limits on such confinement be applied.[15]

14. I am informed that after the 2013 trial, the single-judge *Coleman* court issued on order severely limiting the use of solitary confinement and/or segregated housing, and that the Special Master and the parties worked out new policies and standards for segregated housing that provide for greater access to treatment, out-of-cell time, access to exercise, time limits, and access to entertainment devices such as radios and televisions.[16]

Restricting the use of solitary confinement. Annual Review of Criminology, 1, 285-310; Haney, C., Ahalt, C., & Williams, B., et al. (2020). Consensus statement of the Santa Cruz summit on solitary confinement. Northwestern Law Review, in press.

[14] See Expert Declaration of Craig Haney Re CDCR Segregated Housing Units, Coleman Dkt. No. 4581 (filed May 6, 2013), available at http://rbgg.com/wp-content/uploads/Declaration-of-Craig-Haney-re-CDCR-Segregated-Housing-Units-5-6-13.pdf.

[15] Id. at Paragraphs 28 and 29.

[16] See Order of April 10, 2014 *Coleman* Dkt. No. 5131 (available at http://rbgg.com/wp-content/uploads/Coleman-Order-re-Use-of-Force-Disciplinary-Process-and-Improper-Use-of-Segregated-Housing-4-10-14.pdf); Defendants' Plans and Policies, *Coleman* Dkt. No. 5190 (available at https://rbgg.com/wp-content/uploads/Defendants_-Plans-and-Policies-Submitted-in-

15. Based on my many years of studying correctional systems and practices across the country, and especially in California, I know that ameliorative measures such as increased treatment and out of cell time will be among the first things that are suspended as the prison system diverts staff to address the Pandemic. I am sure that the CDCR will generally limit movement and contact, and shift more housing units to programs that are identical to the solitary confinement/segregation programs that I observed and critiqued throughout the system during my tours in 2013.

16. It is my opinion, that the result will be needless suffering and loss of life, unless immediate measures are taken to reduce the population of persons with serious mental illness in the CDCR system.

17. With these things in mind, it is my professional opinion that adult prisons must reduce their populations *urgently* in order to allow the necessary social distancing in response to the COVID-19 Pandemic.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on March __, 2020 at Santa Cruz, California.

_____

DR. CRAIG W. HANEY, PHD

Response-to-April-10-2014-and-May-13-2014-Orders-Dock.pdf).

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I declare under penalty of perjury that the foregoing is true and correct.

Executed on March 24, 2020 at Santa Cruz, California.

Craig W. Haney

DR. CRAIG W. HANEY, PHD

Response-to-April-10-2014-and-May-13-2014-Orders-Dock.pdf).

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UNITED STATES DISTRICT COURTS
EASTERN DISTRICT OF CALIFORNIA
AND NORTHERN DISTRICT OF CALIFORNIA
UNITED STATES DISTRICT COURT COMPOSED OF THREE JUDGES
PURSUANT TO SECTION 2284, TITLE 28 UNITED STATES CODE

RALPH COLEMAN, et al., Plaintiffs, v. GAVIN NEWSOM, et al., Defendants.	Case No. 2:90-CV-00520-KJM-DB **THREE JUDGE COURT**
MARCIANO PLATA, et al., Plaintiffs, v. GAVIN NEWSOM, Defendants.	Case No. C01-1351 JST **THREE JUDGE COURT** **DECLARATION OF SHIRA TEVAH PLAINTIFFS' EMERGENCY MOTION TO MODIFY POPULATION REDUCTION ORDER**

DECLARATION OF SHIRA TEVAH

I, Shira Tevah, declare:

1. I am an attorney licensed to practice before the courts of the State of California. I am a staff attorney at Disability Rights Advocates. From October 29, 2018 to March 6, 2020, I was a staff attorney at the Prison Law Office. I have personal knowledge of the facts set forth herein, and if called as a witness, I could competently so testify. I make this declaration in support of Plaintiffs' Emergency Motion.

2. On October 28-31, 2019, I participated in a monitoring tour of the California Institution for Men ("CIM"), under the *Armstrong v. Newsom*, Case 4:94-cv-02307-CW, lawsuit on behalf of people with disabilities in California prisons. The Prison Law Office serves as class counsel in *Armstrong*.

3. On October 30, 2019, I visited Joshua Hall at CIM's A-Facility. In Joshua Hall, I observed that people were housed in a dormitory setting and in bunk beds. I saw that the bunk beds were positioned closely together, and the dormitory was crowded. I observed that people's belongings were stored in every open space around the beds. I saw that people had very little space to move without coming into contact with other individuals or their belongings.

4. I observed that Joshua Hall has four separate wings of the building where people are housed in bunk beds. There are two wings on each side of the building, with shared toilets, showers, and sinks in the bathrooms in the center connecting each side. I observed that while there are some separate sinks that are specific to one side of the building, the toilets and showers are all shared between both sides. The two wings on each side are connected to each other in a U-shape on the far side; there is no wall or door separating them. I saw that each wing has a narrow pathway with bunk beds on the right and left sides. I observed that people housed in Joshua Hall must ambulate down the narrow pathway, passing by the other bunk beds, in order to access the central shared toilets, showers, or sinks.

5. While in Joshua Hall, I measured the distance between the bunk beds to determine if individuals using wheelchairs or walkers had enough space to maneuver. I found that the horizontal space between the bunk beds varied between beds. The smallest distance between beds that I measured was 25.5 inches, and the largest distance between beds that I measured was 48 inches.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct, and that this declaration is executed at Berkeley, California this 24th day of March, 2020.

/S/
SHIRA TEVAH

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UNITED STATES DISTRICT COURTS
EASTERN DISTRICT OF CALIFORNIA
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UNITED STATES DISTRICT COURT COMPOSED OF THREE JUDGES
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RALPH COLEMAN, et al., Plaintiffs, v. GAVIN NEWSOM, et al., Defendants.	Case No. 2:90-CV-00520-KJM-DB **THREE JUDGE COURT**
MARCIANO PLATA, et al., Plaintiffs, v. GAVIN NEWSOM, Defendants.	Case No. C01-1351 JST **THREE JUDGE COURT** **DECLARATION OF MARC STERN, M.D. IN SUPPORT OF PLAINTIFFS' EMERGENCY MOTION TO MODIFY POPULATION REDUCTION ORDER**

DECLARATION OF MARC STERN, M.D.

I, Marc Stern, declare as follows:

1. I am a physician, board-certified in internal medicine, specializing in correctional health care. I most recently served as the Assistant Secretary for Health Care at the Washington State Department of Corrections. I served for four years as a medical subject matter expert for the Officer of Civil Rights and Civil Liberties, U.S. Department of Homeland Security, and as a medical subject matter expert for one year for the California Attorney General's division responsible for monitoring the conditions of confinement in Immigration and Customs Enforcement (ICE) detention facilities. I am a court-appointed medical expert in the class action *Parsons v. Ryan*, CV-12-00601-PHX-ROS. Currently, I am the Medical Advisor for the National Sheriffs' Association on matters related to preventive measures responding to COVID-19. Additionally, in 2009, at the request of the California Receiver Clark Kelso, I toured 10 California State Prisons to assess whether or not the Receiver's assignment – to restore the delivery of health services within the California State Prisons – to constitutionally adequate levels – had been completed. I have been Attached as Exhibit A is a copy of my curriculum vitae.

2. COVID-19 is a serious disease that has reached pandemic status, and is straining the health care systems around the world. At least 330,000 people around the world have received confirmed diagnoses of COVID 19, including 33,400 people in the United States. At least 14,000 people have died globally as a result of COVID-19, including more than 400 in the United States. These numbers will increase, perhaps exponentially. Moreover, the numbers for the United States currently must be considered in light of nationwide shortages of COVID-19 tests, thus the actual numbers are likely significantly higher than those reported.

3. The California Department of Corrections and Rehabilitation (CDCR) reports that so far five employees and one incarcerated person have tested positive for COVID-19. https://www.cdcr.ca.gov/covid19/. The actual number of infections is likely to be higher due to the testing shortage.

4. COVID-19 is a novel respiratory virus. It is spread primarily through droplets generated when an infected person coughs or sneezes, or through droplets of saliva or discharge from the nose. There is no vaccine for COVID-19, and there is no cure for COVID-19. No one has prior immunity. The only way to control the virus is to use preventive strategies, including social distancing.

5. The time course of the disease can be very rapid. Individuals can show the first symptoms of infection in as little as two days after exposure and their condition can seriously deteriorate in as little as five days (perhaps sooner) after that. It is believed that people can transmit the virus without being symptomatic and, indeed, that a significant amount of transmission may be from people who are infected but asymptomatic or pre-symptomatic.

6. The effects of COVID-19 are very serious, especially for people who are most vulnerable. Vulnerable people include people over the age of 50, and those of any age with underlying health problems such as – but not limited to – weakened immune systems, hypertension, diabetes, blood, lung, kidney, heart, and liver disease, and possibly pregnancy.

7. Vulnerable people who are infected by the COVID-19 virus can experience severe respiratory illness, as well as damage to other major organs. Treatment for serious cases of COVID-19 requires significant advanced support, including ventilator assistance for respiration and intensive care support. An outbreak of COVID-19 could put significant pressure on or exceed the capacity of local health infrastructure. In the absence of a vaccine and a cure, a significant number of people who are infected with the virus will die. To the extent that the health care infrastructure is overloaded, people will die unnecessarily because necessary respirators and hospital facilities are unavailable.

8. Controlling the spread of the virus by limiting person to person contact is critical to saving lives. This is very challenging in prisons, because they are congregate environments, i.e. places where people live and sleep in close proximity. Social distancing in ways that are recommended by public health officials can be difficult, if not impossible in this environment. To the extent that incarcerated people are housed in close quarters, unable to maintain a six-foot distance from others, and sharing or touching objects used by others, infectious diseases that are

transmitted via the air or touch (like COVID-19) are more likely to spread, placing people at risk. This is especially true when, as in California, the number of incarcerated people is high and when large numbers of people are housed in open dormitories rather than one or two-person cells. For these reasons, if – but more likely when – COVID-19 is introduced into a prison, the risks of spread is greatly, if not exponentially, increased as already evidenced by spread of COVID-19 in two other congregate environments: nursing homes and cruise ships.

9. In addition to the increased risk from COVID-19 to *any* individual in the prisons, there is an especially increased risk of harm to the elderly and people with underlying health conditions. They are not only more likely to become seriously ill, but also, therefore, more likely to require transport to a community hospital.

10. California state prisons remain overcrowded, even after the Population Reduction Order upheld by the U.S. Supreme Court in *Brown v. Plata*, 563 U.S. 493 (2001). I have reviewed the Weekly Population Report posted on the website of the CDCR at https://www.cdcr.ca.gov/research/wp-content/uploads/sites/174/2020/03/Tpop1d200318.pdf. This report shows that the California state prisons remain at 130% of capacity. Among the 35 state prisons, all but four are over 100% capacity, and 19 are at or over 130% of design capacity, with eight over 150% capacity. Among the four which are below capacity, their occupancies are still high, from a public health standpoint: 90.9%, 96.2%, 97.3%, and 99.7%.

11. I visited 10 of the California state prisons in 2009, and have observed many of the large open dormitories, housing groups ranging from a half dozen to scores of incarcerated people. Additionally, I have reviewed photographs taken in 2019 and provided to me by plaintiffs' counsel of living areas and day rooms in four prisons: Central California Women's Facility, California Institution for Men, California Medical Facility, and the Substance Abuse Treatment Facility at Corcoran. I also reviewed a CDCR Institutional Bed Audit dated March 23, 2020 that shows that many of the CDCR dormitories are very crowded. For example, at Avenal State Prison, all people are housed in dormitories designed to house 50-100 people. Most of those dormitories are

currently at 150% capacity. At the Central California Women's Facility, some of the dormitories are as much as 194% overcrowded.

12. The level of crowding in the California state prisons, as evidenced by the population reports, the Institutional Bed Audit and the photographs I reviewed, is very significant and worrisome from a public health standpoint. These crowded conditions, particularly in the dormitories, make it virtually impossible to maintain social distance.

13. CDCR already has reported confirmed cases of COVID-19 in the prisons. The conditions in CDCR's prisons will undoubtedly result in the rapid spread of the COVID-19 virus throughout the prisons, absent significant and immediate interventions. In addition, prisons house a higher percentage than the community of people with underlying health conditions that put them at increased risk of serious complications (including death) from COVID-19. Therefore, based on the crowded conditions, coupled with the increased concentration of people with high risk of complications, including death, from COVID-19, **incarcerated people in California state prisons are at an extraordinary risk of dying from the COVID-19 virus.**

14. I have reviewed the CDCR's COVID-19 Preparedness webpage listing the precautions they report to have implemented in the prisons. See https://www.cdcr.ca.gov/covid19/. Even if fully implemented as described, these steps reduce, but to not eliminate significant risk compared to risk in the community. Further, according to CDCR's own plan, it will likely not be able to fully implement its measures. Indeed, according to the website, "staff and inmates are practicing social distancing strategies *where possible*…." and they will "[adjust] dining schedules *where possible*" (emphasis added.)

15. For these reasons, I recommend immediately downsizing the population of these prisons, with priority given to those at high risk of harm due to their age and health status, and with the goal of allowing social distancing and recommended public health practices in all ongoing activities. **To be effective in reducing the spread of the virus, these downsizing measures must occur now.** Currently, the prevalence of the virus in the prisons appears low, limited to a few prisons. This gives the California a critical window of opportunity to contain the virus before it permeates the prison system and becomes completely unmanageable.

16. There are two values to immediate downsizing. First, downsizing will reduce the density of congregation. This will allow people in prison to maintain better social distancing. The reduction in population will also make it easier for prison authorities to implement infection prevention measures such as: provision of cleaning supplies to residents; frequent laundering of towels and clothes; provision of soap for handwashing; frequent cleaning of transactional surfaces; frequent showers; etc. The reduction in population while implementing these enhanced measures helps prevent overloading the work of prison staff such that they can continue to ensure the safety of incarcerated people. For those people housed in dormitories, reducing the density will enable people to live in group settings with sufficient space to maintain six feet of distance from others. All these steps can slow or stop the spread of infection, to the benefit of residents and staff and, ultimately, the community at large.

17. Second, immediate downsizing that prioritizes residents who are elderly and those with underlying health conditions reduces the likelihood they will contract the disease. Individuals in these groups are at the highest risk of severe complications from COVID-19 and when they develop severe complications they will be transported to community hospitals. Prisons are integral parts of the community's public health infrastructure. Reducing the spread and severity of infection in a state prison slows, if not reduces, the number of people who will become ill enough to require hospitalization where they will be using scarce community resources (ER beds, general hospital beds, ICU beds) which also in turn reduces the health and economic burden to the local community at large.

18. In addition to recommending immediate downsizing, I also recommend that the prisons begin planning now to downsize further as conditions change. The change in conditions we need to anticipate is reduction in workforce (custody and health care staff) as workers respond to their personal needs (self-quarantine or isolation, caring for ill relatives, staying home with school-age children). Insufficient custody staffing poses an obvious risk to the safety of the institution. Insufficient health care staffing poses an obvious risk to the health of residents.

19. The risks to which incarcerated people at the 35 California state prisons are exposed stem from the congregate nature of their crowded environment and, for the elderly and

chronically ill, from their medical histories. Thus, even if the health care delivery system were constitutionally adequate, the incarcerated people living in these prisons would still be at substantial risk of illness and death.

20. Thus, in summary, reducing the number of individuals imprisoned in the 35 California State Prisons immediately, with plans made for further reductions as staffing levels change, is necessary for the health and safety of the prisons and our communities. This population reduction should begin with the most medically compromised, and continue until the population reaches the point that allows for social distancing and recommended public health practices in all activities.

Pursuant to 28 U.S.C. 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed this 24th day in March, 2020 in Tumwater, Washington.

Dr. Marc Stern

Exhibit A

MARC F. STERN, M.D., M.P.H., F.A.C.P.

March, 2020

1100 Surrey Trace Drive, SE
Tumwater, Washington 98501, USA

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SUMMARY OF EXPERIENCE

CORRECTIONAL HEALTH CARE CONSULTANT **2009 – PRESENT**

Consultant in the design, management, and operation of health services in a correctional setting to assist in evaluating, monitoring, or providing evidence-based, cost-effective care consistent with constitutional mandates of quality.

Current activities include:

- COVID-19 Medical Advisor, National Sheriffs Association (2020 -)
- Advisor to various jails in Washington State on patient safety, health systems, and related health care and custody staff activities and operations, and RFP and contract generation (2014 -)
- Consultant to the US Department of Justice, Civil Rights Division, Special Litigation Section. Providing investigative support and expert medical services pursuant to complaints regarding care delivered in any US jail, prison, or detention facility. (2010 -) (no current open cases)
- Physician prescriber/trainer for administration of naloxone by law enforcement officers for the Olympia, Tumwater, Lacey, Yelm, and Evergreen College Police Departments (2017 -)
- Consultant to the Civil Rights Enforcement Section, Office of the Attorney General of California, under SB 29, to review the healthcare-related conditions of confinement of detainees confined by Immigration and Customs Enforcement in California facilities (2017 -)
- Rule 706 Expert to the Court, US District Court for the District of Arizona, in the matter of Parsons v. Ryan (2018 -)

Previous activities include:

- Consultant to Human Rights Watch to evaluate medical care of immigrants in Homeland Security detention (2016 - 2018)
- Consultant to Broward County Sheriff to help develop and evaluate responses to a request for proposals (2017 - 2018)
- Member of monitoring team (medical expert) pursuant to Consent Agreement between US Department of Justice and Miami-Dade County (Unites States of America v Miami-Dade County, *et al.*) regarding, *entre outre*, unconstitutional medical care. (2013 - 2016)
- Jointly appointed Consultant to the parties in Flynn v Walker (formerly Flynn v Doyle), a class action lawsuit before the US Federal District Court (Eastern District of Wisconsin) regarding Eighth Amendment violations of the health care provided to women at the Taycheedah Correctional Institute. Responsible for monitoring compliance with the medical component of the settlement. (2010 - 2015)
- Consultant on "Drug-related Death after Prison Release," a research grant continuing work with Dr. Ingrid Binswanger, University of Colorado, Denver, examining the causes of, and methods of reducing deaths after release from prison to the community. National Institutes of Health Grant R21 DA031041-01. (2011 - 2016)
- Consultant to the US Department of Homeland Security, Office for Civil Rights and Civil Liberties. Providing investigative support and expert medical services pursuant to complaints regarding care received by immigration detainees in the custody of U.S. Immigration and Customs Enforcement. (2009 - 2014)
- Special Master for the US Federal District Court (District of Idaho) in Balla v Idaho State Board of Correction, et al., a class action lawsuit alleging Eighth Amendment violations in provision of health care at the Idaho State Correctional Institution. (2011 - 2012)
- Facilitator/Consultant to the US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, providing assistance and input for the development of the first National Survey of Prisoner Health. (2010-2011)
- Project lead and primary author of National Institute of Corrections' project entitled "Correctional Health Care Executive Curriculum Development," in collaboration with National Commission on Correctional Health Care. NIC commissioned this curriculum for its use to train executive leaders from jails and prisons across the nation to better manage the health care missions of their facilities. Cooperative Agreement 11AD11GK18, US Department of Justice, National Institute of Corrections. (2011 - 2015)

- Co-teacher, with Jaye Anno, Ph.D., for the National Commission on Correctional Health Care, of the Commission's standing course, *An In-Depth Look at NCCHC's 2008 Standards for Health Services in Prisons and Jails* taught at its national meetings. (2010 - 2013)
- Contributor to 2014 Editions of Standards for Health Services in Jails and Standards for Health Services in Prisons, National Commission on Correctional Health Care. (2013)
- Consultant to the California Department of Corrections and Rehabilitation court-appointed Receiver for medical operations. Projects included:
    - Assessing the Receiver's progress in completing its goal of bringing medical care delivered in the Department to a constitutionally mandated level. (2009)
    - Providing physician leadership to the Telemedicine Program Manager tasked with improving and expanding the statewide use of telemedicine. (2009)
- Conceived, co-designed, led, and instructed in American College of Correctional Physicians and National Commission on Correctional Health Care's Medical Directors Boot Camp (now called Leadership Institute), a national training program for new (Track "101") and more experienced (Track "201") prison and jail medical directors. (2009 - 2012)
- Participated as a member of a nine-person Delphi expert consensus panel convened by Rand Corporation to create a set of correctional health care quality standards. (2009)
- Convened a coalition of jails, Federally Qualified Health Centers, and community mental health centers in ten counties in Washington State to apply for a federal grant to create an electronic network among the participants that will share prescription information for the correctional population as they move among these three venues. (2009 - 2010)
- Participated as a clinical expert in comprehensive assessment of Michigan Department of Corrections as part of a team from the National Commission on Correctional Health Care. (2007)
- Provided consultation to Correctional Medical Services, Inc., St. Louis (now Corizon), on issues related to development of an electronic health record. (2001)
- Reviewed cases of possible professional misconduct for the Office of Professional Medical Conduct of the New York State Department of Health. (1999 – 2001)
- Advised Deputy Commissioner, Indiana State Board of Health, on developing plan to reduce morbidity from chronic diseases using available databases. (1992)
- Provided consultation to Division of General Medicine, University of Nevada at Reno, to help develop a new clinical practice site combining a faculty practice and a supervised resident clinic. (1991)

OLYMPIA BUPRENORPHINE CLINIC, OLYMPIA, WASHINGTON **2019 - PRESENT**

Volunteer practitioner at a low-barrier clinic to providing Medication Assisted Treatment (buprenorphine) to opioid dependent individuals wishing to begin treatment, until they can transition to a long-term treatment provider

OLYMPIA FREE CLINIC, OLYMPIA, WASHINGTON **2017 - PRESENT**

Volunteer practitioner providing episodic care at a neighborhood clinic which provides free care to individuals without health insurance until they can find a permanent medical home

OLYMPIA UNION GOSPEL MISSION CLINIC, OLYMPIA, WASHINGTON **2009 – 2014**

Volunteer practitioner providing primary care at a neighborhood clinic which provides free care to individuals without health insurance until they can find a permanent medical home; my own patient panel within the practice focuses on individuals recently released jail and prison.

WASHINGTON STATE DEPARTMENT OF CORRECTIONS **2002 – 2008**

Assistant Secretary for Health Services/Health Services Director, 2005 – 2008
Associate Deputy Secretary for Health Care, 2002 – 2005

Responsible for the medical, mental health, chemical dependency (transiently), and dental care of 15,000 offenders in total confinement. Oversaw an annual operating budget of $110 million and 700 health care staff.

- As the first incumbent ever in this position, ushered the health services division from an operation of 12 staff in headquarters, providing only consultative services to the Department, to an operation with direct authority and

responsibility for all departmental health care staff and budget. As part of new organizational structure, created and filled statewide positions of Directors of Nursing, Medicine, Dental, Behavioral Health, Mental Health, Psychiatry, Pharmacy, Operations, and Utilization Management.

- Significantly changed the culture of the practice of correctional health care and the morale of staff by a variety of structural and functional changes, including: ensuring that high ethical standards and excellence in clinical practice were of primordial importance during hiring of professional and supervisory staff; supporting disciplining or career counseling of existing staff where appropriate; implementing an organizational structure such that patient care decisions were under the final direct authority of a clinician and were designed to ensure that patient needs were met, while respecting and operating within the confines of a custodial system.
- Improved quality of care by centralizing and standardizing health care operations, including: authoring a new Offender Health Plan defining patient benefits based on the Eighth Amendment, case law, and evidence-based medicine; implementing a novel system of utilization management in medical, dental, and mental health, using the medical staffs as real-time peer reviewers; developing a pharmacy procedures manual and creating a Pharmacy and Therapeutics Committee; achieving initial American Correctional Association accreditation for 13 facilities (all with almost perfect scores on first audit); migrating the eight individual pharmacy databases to a single central database.
- Blunted the growth in health care spending without compromising quality of care by a number of interventions, including: better coordination and centralization of contracting with external vendors, including new statewide contracts for hospitalization, laboratory, drug purchasing, radiology, physician recruitment, and agency nursing; implementing a statewide formulary; issuing quarterly operational reports at the state and facility levels.
- Piloted the following projects: direct issuance of over-the-counter medications on demand through inmates stores (commissary), obviating the need for a practitioner visit and prescription; computerized practitioner order entry (CPOE); pill splitting; ER telemedicine.
- Oversaw the health services team that participated variously in pre-design, design, or build phases of five capital projects to build complete new health units.

NEW YORK STATE DEPARTMENT OF CORRECTIONAL SERVICES **2001 – 2002**

Regional Medical Director, Northeast Region, 2001 – 2002

Responsible for clinical oversight of medical services for 14,000 offenders in 14 prisons, including one (already) under court monitoring.

- Oversaw contract with vendor to manage 60-bed regional infirmary and hospice.
- Coordinated activities among the Regional Medical Unit outpatient clinic, the Albany Medical College, and the 13 feeder prisons to provide most of the specialty care for the region.
- Worked with contracting specialists and Emergency Departments to improve access and decrease medical out-trips by increasing the proportion of scheduled and emergency services provided by telemedicine.
- Provided training, advice, and counseling to practitioners and facility health administrators in the region to improve the quality of care delivered.

CORRECTIONAL MEDICAL SERVICES, INC. (now CORIZON) **2000 – 2001**

Regional Medical Director, New York Region, 2000 – 2001

Responsible for clinical management of managed care contract with New York State Department of Correctional Services to provide utilization management services for the northeast and northern regions of New York State and supervision of the 60-bed regional infirmary and hospice.

- Migrated the utilization approval function from one of an anonymous rule-based “black box” to a collaborative evidence-based decision making process between the vendor and front-line clinicians.

MERCY INTERNAL MEDICINE, ALBANY, NEW YORK **1999 – 2000**

Neighborhood three-physician internal medicine group practice.

Primary Care Physician, 1999 – 2000 (6 months)

Provided direct primary care to a panel of community patients during a period of staff shortage.

ALBANY COUNTY CORRECTIONAL FACILITY, ALBANY, NEW YORK **1998 – 1999**

Acting Facility Medical Director, 1998 – 1999

Directed the medical staff of an 800 bed jail and provided direct patient care following the sudden loss of the Medical Director, pending hiring of a permanent replacement. Coordinated care of jail patients in local hospitals. Provided consultation to the Superintendent on improvements to operation and staffing of medical unit and need for privatization.

VETERANS ADMINISTRATION MEDICAL CENTER, ALBANY, NY **1992 – 1998**

Assistant Chief, Medical Service, 1995 – 1998
Chief, Section of General Internal Medicine and Emergency Services, 1992 – 1998

Responsible for operation of the general internal medicine clinics and the Emergency Department.

- Designed and implemented an organizational and physical plant makeover of the general medicine ambulatory care clinic from an episodic-care driven model with practitioners functioning independently supported by minimal nursing involvement, to a continuity-of-care model with integrated physician/mid-level practitioner/registered nurse/licensed practice nurse/practice manager teams.
- Led the design and opening of a new Emergency Department.
- As the VA Section Chief of Albany Medical College's Division of General Internal Medicine, coordinated academic activities of the Division at the VA, including oversight of, and direct teaching in, ambulatory care and inpatient internal medicine rotations for medical students, residents, and fellows. Incorporated medical residents as part of the general internal medicine clinics. Awarded $786,000 Veterans Administration grant ("PRIME I") over four years for development and operation of educational programs for medicine residents and students in allied health professions (management, pharmacy, social work, physician extenders) wishing to study primary care delivery.

ERIE COUNTY HEALTH DEPARTMENT, BUFFALO, NY **1988 – 1990**

Director of Sexually Transmitted Diseases (STD) Services, 1989 – 1990
Staff Physician, STD Clinic, 1988 – 1989
Staff Physician, Lackawanna Community Health Center, 1988 – 1990

Provided leadership and patient care services in the evaluation and treatment of STDs. Successfully reorganized the county's STD services which were suffering from mismanagement and were under public scrutiny. Provided direct patient care services in primary care clinic for underserved neighborhood.

UNION OCCUPATIONAL HEALTH CENTER, BUFFALO, NY **1988 – 1990**

Staff Physician, 1988 – 1990

Provided direct patient care for the evaluation of occupationally-related health disorders.

VETERANS ADMINISTRATION MEDICAL CENTER, BUFFALO, NY **1985 – 1990**

Chief Outpatient Medical Section and Primary Care Clinic, 1986 – 1988
VA Section Head, Division of General Internal Medicine, University of Buffalo, 1986 – 1988

- Developed and implemented a major restructuring of the general medicine ambulatory care clinic to reduce fragmentation of care by introduction of a continuity-of-care model with a physician/nurse team approach.

Medical Director, Anticoagulation Clinic 1986 – 1990
Staff Physician, Emergency Department, 1985 – 1986

FACULTY APPOINTMENTS

2007 – present	Affiliate Assistant Professor, Department of Health Services, School of Public Health, University of Washington
1999 – present	Clinical Professor, Fellowship in Applied Public Health (previously Volunteer Faculty, Preventive Medicine Residency), University at Albany School of Public Health
1996 – 2002	Volunteer Faculty, Office of the Dean of Students, University at Albany
1992 – 2002	Associate Clinical/Associate/Assistant Professor of Medicine, Albany Medical College

1993 – 1997	Clinical Associate Faculty, Graduate Program in Nursing, Sage Graduate School
1990 – 1992	Instructor of Medicine, Indiana University
1985 – 1990	Clinical Assistant Professor of Medicine, University of Buffalo
1982 – 1985	Clinical Assistant Instructor of Medicine, University of Buffalo

OTHER PROFESSIONAL ACTIVITIES

2016 – present	Chair, Education Committee, Academic Consortium on Criminal Justice Health
2016 – present	Washington State Institutional Review Board ("Prisoner Advocate" member)
2016 – 2017	Mortality Reduction Workgroup, American Jail Association
2013 – present	Conference Planning Committee – Medical/Mental Health Track, American Jail Association
2013 – 2016	"Health in Prisons" course, Bloomberg School of Public Health, Johns Hopkins University/International Committee of the Red Cross
2013 – present	Institutional Review Board, University of Washington ("Prisoner Advocate" member),
2011 – 2012	Education Committee, National Commission on Correctional Health Care
2007 – present	National Advisory Committee, COCHS (Community–Oriented Correctional Health Services)
2004 – 2006	Fellow's Advisory Committee, University of Washington Robert Wood Johnson Clinical Scholar Program
2004	External Expert Panel to the Surgeon General on the "Call to Action on Correctional Health Care"
2003 – present	Faculty Instructor, Critical Appraisal of the Literature Course, Family Practice Residency Program, Providence St. Peter Hospital, Olympia, Washington
2001 – present	Chair/Co-Chair, Education Committee, American College of Correctional Physicians
1999 – present	Critical Appraisal of the Literature Course, Preventive Medicine Residency Program, New York State Department of Health/University at Albany School of Public Health
1999	Co–Chairperson, Education Subcommittee, Workshop Submission Review Committee, Annual Meeting, Society of General Internal Medicine
1997 – 1998	Northeast US Representative, National Association of VA Ambulatory Managers
1996 – 2002	Faculty Mentor, Journal Club, Internal Medicine Residency Program, Albany Medical College
1996 – 2002	Faculty Advisor and Medical Control, 5 Quad Volunteer Ambulance Service, University at Albany
1995 – 1998	Preceptor, MBA Internship, Union College
1995	Quality Assurance/Patient Satisfaction Subcommittee, VA National Curriculum Development Committee for Implementation of Primary Care Practices, Veterans Administration
1994 – 1998	Residency Advisory Committee, Preventive Medicine Residency, New York State Department of Health/School of Public Health, University at Albany
1993	Chairperson, Dean's Task Force on Primary Care, Albany Medical College
1993	Task Group to develop curriculum for Comprehensive Care Case Study Course for Years 1 through 4, Albany Medical College
1988 – 1989	Teaching Effectiveness Program for New Housestaff, Graduate Medical Dental Education Consortium of Buffalo
1987 – 1990	Human Studies Review Committee, School of Allied Health Professions, University of Buffalo
1987 – 1989	Chairman, Subcommittee on Hospital Management Issues and Member, Subcommittee on Teaching of Ad Hoc Committee to Plan Incoming Residents Training Week, Graduate Medical Dental Education Consortium of Buffalo
1987 – 1988	Dean's Ad Hoc Committee to Reorganize "Introduction to Clinical Medicine" Course
1987	Preceptor, Nurse Practitioner Training Program, School of Nursing, University of Buffalo
1986 – 1988	Course Coordinator, Simulation Models Section of Physical Diagnosis Course, University of Buffalo
1986 – 1988	Chairman, Service Chiefs' Continuity of Care Task Force, Veterans Administration Medical Center, Buffalo, New York
1979 – 1980	Laboratory Teaching Assistant in Gross Anatomy, Université Libre de Bruxelles, Brussels, Belgium
1973 – 1975	Instructor and Instructor Trainer of First Aid, American National Red Cross

1972 – 1975	Chief of Service or Assistant Chief of Operations, 5 Quad Volunteer Ambulance Service, University at Albany.
1972 – 1975	Emergency Medical Technician Instructor and Course Coordinator, New York State Department of Health, Bureau of Emergency Medical Services

REVIEWER/EDITOR

2019 – present	Criminal Justice Review (reviewer)
2015 – present	PLOS ONE (reviewer)
2015 – present	Founding Editorial Board Member and Reviewer, Journal for Evidence-based Practice in Correctional Health, Center for Correctional Health Networks, University of Connecticut
2011 – present	American Journal of Public Health (reviewer)
2010 – present	International Advisory Board Member and Reviewer, International Journal of Prison Health
2010 – present	Langeloth Foundation (grant reviewer)
2001 – present	Reviewer and Editorial Board Member (2009 – present), Journal of Correctional Health Care
2001 – 2004	Journal of General Internal Medicine (reviewer)
1996	Abstract Committee, Health Services Research Subcommittee, Annual Meeting, Society of General Internal Medicine (reviewer)
1990 – 1992	Medical Care (reviewer)

EDUCATION

University at Albany, College of Arts and Sciences, Albany; B.S., 1975 (Biology)

University at Albany, School of Education, Albany; AMST (Albany Math and Science Teachers) Teacher Education Program, 1975

Université Libre de Bruxelles, Faculté de Medecine, Brussels, Belgium; Candidature en Sciences Medicales, 1980

University at Buffalo, School of Medicine, Buffalo; M.D., 1982

University at Buffalo Affiliated Hospitals, Buffalo; Residency in Internal Medicine, 1985

Regenstrief Institute of Indiana University, and Richard L. Roudebush Veterans Administration Medical Center; VA/NIH Fellowship in Primary Care Medicine and Health Services Research, 1992

Indiana University, School of Health, Physical Education, and Recreation, Bloomington; M.P.H., 1992

New York Academy of Medicine, New York; Mini-fellowship Teaching Evidence-Based Medicine, 1999

CERTIFICATION

Provisional Teaching Certification for Biology, Chemistry, Physics, Grades 7–12, New York State Department of Education (expired), 1975

Diplomate, National Board of Medical Examiners, 1983

Diplomate, American Board of Internal Medicine, 1985

Fellow, American College of Physicians, 1991

License: Washington (#MD00041843, active); New York (#158327, inactive); Indiana (#01038490, inactive)

"X" Waiver (buprenorphine), Department of Health & Human Services, 2018

MEMBERSHIPS

2019 – present	Washington Association of Sheriffs and Police Chiefs
2005 – 2016	American Correctional Association/Washington Correctional Association
2004 – 2006	American College of Correctional Physicians (Member, Board of Directors, Chair Education Committee)
2000 – present	American College of Correctional Physicians

RECOGNITION

B. Jaye Anno Award for Excellence in Communication, National Commission on Correctional Health Care. 2019

Award of Appreciation, Washington Association of Sheriffs and Police Chiefs. 2018

Armond Start Award of Excellence, American College of Correctional Physicians. 2010

(First) Annual Preventive Medicine Faculty Excellence Award, New York State Preventive Medicine Residency Program, University at Albany School of Public Health/New York State Department of Health. 2010

Excellence in Education Award for excellence in clinical teaching, Family Practice Residency Program, Providence St. Peter Hospital, Olympia, Washington. 2004

Special Recognition for High Quality Workshop Presentation at Annual Meeting, Society of General Internal Medicine. 1996

Letter of Commendation, House Staff Teaching, University of Buffalo. 1986

WORKSHOPS, SEMINARS, PRESENTATIONS, INVITED LECTURES

It's the 21st Century – Time to Bid Farewell to "Sick Call" and "Chronic Care Clinic". Annual Conference, National Commission on Correctional Health Care. Fort Lauderdale, Florida. 2019

HIV and Ethics – Navigating Medical Ethical Dilemmas in Corrections. Keynote Speech, 14th Annual HIV Care in the Correctional Setting. AIDS Education and Training Program (AETC) Mountain West, Olympia, Washington. 2019

Honing Nursing Skills to Keep Patients Safe in Jail. Orange County Jail Special Training Session (including San Bernardino and San Diego Jail Staffs), Theo Lacy Jail, Orange, California. 2019

What Would You Do? Navigating Medical Ethical Dilemmas. Leadership Training Academy, National Commission on Correctional Health Care. San Diego, California. 2019

Preventing Jail Deaths. Jail Death Review and Investigations: Best Practices Training Program, American Jail Association, Arlington, Virginia. 2018

How to Investigate Jail Deaths. Jail Death Review and Investigations: Best Practices Training Program, American Jail Association, Arlington, Virginia. 2018

Executive Manager Program in Correctional Health. 4-day training for custody/health care teams from jails and prisons on designing safe and efficient health care systems. National Institute for Corrections Training Facility, Aurora, Colorado, and other venues in Washington State. Periodically. 2014 – present

Medical Ethics in Corrections. Criminal Justice 441 – Professionalism and Ethical Issues in Criminal Justice. University of Washington, Tacoma. Recurring seminar. 2012 – present

Medical Aspects of Deaths in ICE Custody. Briefing for U.S. Senate staffers, Human Rights Watch. Washington, D.C. 2018

Jails' Role in Managing the Opioid Epidemic. Panelist. Washington Association of Sheriffs and Police Chiefs Annual Conference. Spokane, Washington. 2018

Contract Prisons and Contract Health Care: What Do We Know? Behind Bars: Ethics and Human Rights in U.S. Prisons Conference. Center for Bioethics – Harvard Medical School/Human Rights Program – Harvard Law School. Boston, Massachusetts. 2017

Health Care Workers in Prisons. (With Dr. J. Wesley Boyd) Behind Bars: Ethics and Human Rights in U.S. Prisons Conference. Center for Bioethics – Harvard Medical School/Human Rights Program – Harvard Law School. Boston, Massachusetts. 2017

Prisons, Jails and Medical Ethics: Rubber, Meet Road. Grand Rounds. Touro Medical College. New York, New York. 2017

Jail Medical Doesn't Have to Keep You Up at Night – National Standards, Risks, and Remedies. Washington Association of Counties. SeaTac, Washington. 2017

Prison and Jail Health Care: What do you need to know? Grand Rounds. Providence/St. Peters Medical Center. Olympia, Washington. 2017

Prison Health Leadership Conference. 2-Day workshop. International Corrections and Prisons Association/African Correctional Services Association/Namibian Corrections Service. Omaruru, Namibia. 2016; 2018

What Would YOU Do? Navigating Medical Ethical Dilemmas. Spring Conference. National Commission on Correctional Health Care. Nashville, Tennessee. 2016

Improving Patient Safety. Spring Provider Meeting. Oregon Department of Corrections. Salem, Oregon 2016

A View from the Inside: The Challenges and Opportunities Conducting Cardiovascular Research in Jails and Prisons. Workshop on Cardiovascular Diseases in the Inmate and Released Prison Population. The National Heart, Lung, and Blood Institute. Bethesda, Maryland. 2016

Why it Matters: Advocacy and Policies to Support Health Communities after Incarceration. At the Nexus of Correctional Health and Public Health: Policies and Practice session. Panelist. American Public Health Association Annual Meeting. Chicago, Illinois. 2015

Hot Topics in Correctional Health Care. Presented with Dr. Donald Kern. American Jail Association Annual Meeting. Charlotte, North Carolina. 2015

Turning Sick Call Upside Down. Annual Conference. National Commission on Correctional Health Care. Dallas, Texas, 2015.

Diagnostic Maneuvers You May Have Missed in Nursing School. Annual Conference. National Commission on Correctional Health Care. Dallas, Texas. 2015

The Challenges of Hunger Strikes: What Should We Do? What Shouldn't We Do? Annual Conference. National Commission on Correctional Health Care. Dallas, Texas. 2015

Practical and Ethical Approaches to Managing Hunger Strikes. Annual Practitioners' Conference. Washington Department of Corrections. Tacoma, Washington. 2015

Contracting for Health Services: Should I, and if so, how? American Jail Association Annual Meeting. Dallas, Texas. 2014

Hunger Strikes: What should the Society of Correctional Physician's position be? With Allen S, May J, Ritter S. American College of Correctional Physicians (Formerly Society of Correctional Physicians) Annual Meeting. Nashville, Tennessee. 2013

*Addressing Conflict between Medical and Security: an Ethics Perspective***.** International Corrections and Prison Association Annual Meeting. Colorado Springs, Colorado. 2013

Patient Safety and 'Right Using' Nurses. Keynote address. Annual Conference. American Correctional Health Services Association. Philadelphia, Pennsylvania. 2013

Patient Safety: Overuse, underuse, and misuse…of nurses. Keynote address. Essentials of Correctional Health Care conference. Salt Lake City, Utah. 2012

The ethics of providing healthcare to prisoners-An International Perspective. Global Health Seminar Series. Department of Global Health, University of Washington, Seattle, Washington. 2012

Recovery, Not Recidivism: Strategies for Helping People Who are Incarcerated. Panelist. NAMI Annual Meeting, Seattle, Washington, 2012

Ethics and HIV Workshop. HIV/AIDS Care in the Correctional Setting Conference, Northwest AIDS Education and Training Center. Salem, Oregon. 2011

Ethics and HIV Workshop. HIV/AIDS Care in the Correctional Setting Conference, Northwest AIDS Education and Training Center. Spokane, Washington. 2011

Patient Safety: Raising the Bar in Correctional Health Care. With Dr. Sharen Barboza. National Commission on Correctional Health Care Mid-Year Meeting, Nashville, Tennessee. 2010

Patient Safety: Raising the Bar in Correctional Health Care. American Correctional Health Services Association, Annual Meeting, Portland, Oregon. 2010

Achieving Quality Care in a Tough Economy. National Commission on Correctional Health Care Mid-Year Meeting, Nashville, Tennessee, 2010 (Co-presented with Rick Morse and Helena Kim, PharmD.)

Involuntary Psychotropic Administration: The Harper Solution. With Dr. Bruce Gage. American Correctional Health Services Association, Annual Meeting, Portland, Oregon. 2010

Evidence Based Decision Making for Non-Clinical Correctional Administrators. American Correctional Association 139th Congress, Nashville, Tennessee. 2009

Death Penalty Debate. Panelist. Seattle University School of Law, Seattle, Washington. 2009

The Patient Handoff – From Custody to the Community. Washington Free Clinic Association, Annual Meeting, Olympia, Washington. Lacey, Washington. 2009

Balancing Patient Advocacy with Fiscal Restraint and Patient Litigation. National Commission on Correctional Health Care and American College of Correctional Physicians "Medical Directors Boot Camp," Seattle, Washington. 2009

Staff Management. National Commission on Correctional Health Care and American College of Correctional Physicians "Medical Directors Boot Camp," Seattle, Washington. 2009

Management Dilemmas in Corrections: Boots and Bottom Bunks. Annual Meeting, American College of Correctional Physicians, Chicago, Illinois. 2008

Public Health and Correctional Health Care. Masters Program in community–based population focused management – Populations at risk, Washington State University, Spokane, Washington. 2008

Managing the Geriatric Population. Panelist. State Medical Directors' Meeting, American Corrections Association, Alexandria, Virginia. 2007

I Want to do my own Skin Biopsies. Annual Meeting, American College of Correctional Physicians, New Orleans, Louisiana. 2005

Corrections Quick Topics. Annual Meeting, American College of Correctional Physicians. Austin, Texas. 2003

Evidence Based Medicine in Correctional Health Care. Annual Meeting, National Commission on Correctional Health Care. Austin, Texas. 2003

Evidence Based Medicine. Excellence at Work Conference, Empire State Advantage. Albany, New York. 2002

Evidence Based Medicine, Outcomes Research, and Health Care Organizations. National Clinical Advisory Group, Integrail, Inc., Albany, New York. 2002

Evidence Based Medicine. With Dr. LK Hohmann. The Empire State Advantage, Annual Excellence at Work Conference: Leading and Managing for Organizational Excellence, Albany, New York. 2002

Taking the Mystery out of Evidence Based Medicine: Providing Useful Answers for Clinicians and Patients. Breakfast Series, Institute for the Advancement of Health Care Management, School of Business, University at Albany, Albany, New York. 2001

Diagnosis and Management of Male Erectile Dysfunction – A Goal–Oriented Approach. Society of General Internal Medicine National Meeting, San Francisco, California. 1999

Study Design and Critical Appraisal of the Literature. Graduate Medical Education Lecture Series for all housestaff, Albany Medical College, Albany, New York. 1999

Male Impotence: Its Diagnosis and Treatment in the Era of Sildenafil. 4th Annual CME Day, Alumni Association of the Albany–Hudson Valley Physician Assistant Program, Albany, New York. 1998

Models For Measuring Physician Productivity. Panelist. National Association of VA Ambulatory Managers National Meeting, Memphis, Tennessee. 1997

Introduction to Male Erectile Dysfunction and the Role of Sildenafil in Treatment. Northeast Regional Meeting Pfizer Sales Representatives, Manchester Center, Vermont. 1997

Male Erectile Dysfunction. Topics in Urology, A Seminar for Primary Healthcare Providers, Bassett Healthcare, Cooperstown, New York. 1997

Evaluation and Treatment of the Patient with Impotence: A Practical Primer for General Internists. Society of General Internal Medicine National Meeting, Washington D.C. 1996

Impotence: An Update. Department of Medicine Grand Rounds, Albany Medical College, Albany, New York. 1996

Diabetes for the EMT First–Responder. Five Quad Volunteer Ambulance, University at Albany. Albany, New York. 1996

Impotence: An Approach for Internists. Medicine Grand Rounds, St. Mary's Hospital, Rochester, New York. 1994

Male Impotence. Common Problems in Primary Care Precourse. American College of Physicians National Meeting, Miami, Florida. 1994

Patient Motivation: A Key to Success. Tuberculosis and HIV: A Time for Teamwork. AIDS Program, Bureau of Tuberculosis Control – New York State Department of Health and Albany Medical College, Albany, New York. 1994

Recognizing and Treating Impotence. Department of Medicine Grand Rounds, Albany Medical College, Albany, New York. 1992

Medical Decision Making: A Primer on Decision Analysis. Faculty Research Seminar, Department of Family Practice, Indiana University, Indianapolis, Indiana. 1992

Effective Presentation of Public Health Data. Bureau of Communicable Diseases, Indiana State Board of Health, Indianapolis, Indiana. 1991

Impotence: An Approach for Internists. Housestaff Conference, Department of Medicine, Indiana University, Indianapolis, Indiana. 1991

Using Electronic Databases to Search the Medical Literature. NIH/VA Fellows Program, Indiana University, Indianapolis, Indiana. 1991

Study Designs Used in Epidemiology. Ambulatory Care Block Rotation. Department of Medicine, Indiana University, Indianapolis, Indiana. 1991

Effective Use of Slides in a Short Scientific Presentation. Housestaff Conference, Department of Medicine, Indiana University, Indianapolis, Indiana. 1991

Impotence: A Rational and Practical Approach to Diagnosis and Treatment for the General Internist. Society of General Internal Medicine National Meeting, Washington D.C. 1991

Nirvana and Audio–Visual Aids. With Dr. RM Lubitz. Society of General Internal Medicine, Midwest Regional Meeting, Chicago. 1991

New Perspectives in the Management of Hypercholesterolemia. Medical Staff, West Seneca Developmental Center, West Seneca, New York. 1989

Effective Use of Audio–Visual Aids. Nurse Educators, American Diabetes Association, Western New York Chapter, Buffalo, New York. 1989

Management of Diabetics in the Custodial Care Setting. Medical Staff, West Seneca Developmental Center, West Seneca, New York, 1989

Effective Use of Audio–Visuals in Diabetes Peer and Patient Education. American Association of Diabetic Educators, Western New York Chapter, Buffalo, New York. 1989

Pathophysiology, Diagnosis and Care of Diabetes. Nurse Practitioner Training Program, School of Nursing, University of Buffalo, Buffalo, New York. 1989

Techniques of Large Group Presentations to Medical Audiences – Use of Audio–Visuals. New Housestaff Training Program, Graduate Medical Dental Education Consortium of Buffalo, Buffalo, New York. 1988

PUBLICATIONS/ABSTRACTS

Borschmann, R, Tibble, H, Spittal, MJ, … Stern, MF, Viner, KM, Wang, N, Willoughby, M, Zhao, B, and Kinner, SA. *The Mortality After Release from Incarceration Consortium (MARIC): Protocolfor a multi-national, individual participant data meta-analysis.* Int. J of Population Data Science 2019 5(1):6

Binswanger IA, Maruschak LM, Mueller SR, **Stern MF**, Kinner SA**.** *Principles to Guide National Data Collection on the Health of Persons in the Criminal Justice System.* Public Health Reports 2019 134(1):34S-45S

Stern M. *Hunger Strike: The Inside Medicine Scoop.* American Jails 2018 32(4):17-21

Grande L, **Stern M.** *Providing Medication to Treat Opioid Use Disorder in Washington State Jails*. Study conducted for Washington State Department of Social and Health Services under Contract 1731-18409. 2018.

Stern MF, Newlin N. *Epicenter of the Epidemic: Opioids and Jails.* American Jails 2018 32(2):16-18

Stern MF. *A nurse is a nurse is a nurse…NOT!* Guest Editorial, American Jails 2018 32(2):4,68

Wang EA, Redmond N, Dennison Himmelfarb CR, Pettit B, **Stern M**, Chen J, Shero S, Iturriaga E, Sorlie P, Diez Roux AV. *Cardiovascular Disease in Incarcerated Populations*. Journal of the American College of Cardiology 2017 69(24):2967-76

Mitchell A, Reichberg T, Randall J, Aziz-Bose R, Ferguson W, **Stern M.** *Criminal Justice Health Digital Curriculum*. Poster, Annual Academic and Health Policy Conference on Correctional Health, Atlanta, Georgia, March, 2017

Stern MF. *Patient Safety (White Paper)*. Guidelines, Management Tools, White Papers, National Commission on Correctional Health Care. http://www.ncchc.org/filebin/Resources/Patient-Safety-2016.pdf. June, 2016

Binswanger IA, **Stern MF**, Yamashita TE, Mueller SR, Baggett TP, Blatchford PJ. *Clinical risk factors for death after release from prison in Washington State: a nested case control study*. Addiction 2015 Oct 17

Stern MF. Op-Ed on Lethal Injections. The Guardian 2014 Aug 6

Stern MF. *American College of Correctional Physicians Calls for Caution Placing Mentally Ill in Segregation: An Important Band-Aid*. Guest Editorial. Journal of Correctional Health Care 2014 Apr; 20(2):92-94

Binswanger I, Blatchford PJ, Mueller SR, **Stern MF**. *Mortality After Prison Release: Opioid Overdose and Other Causes of Death, Risk Factors, and Time Trends From 1999 to 2009*. Annals of Internal Medicine 2013 Nov; 159(9):592-600

Williams B, **Stern MF,** Mellow J, Safer M, Greifinger RB. *Aging in Correctional Custody: Setting a policy agenda for older prisoner health care.* American Journal of Public Health 2012 Aug; 102(8):1475-1481

Binswanger I, Blatchford PJ, Yamashita TE, **Stern MF.** *Drug-Related Risk Factors for Death after Release from Prison: A Nested Case Control Study*. Oral Presentation, University of Massachusetts 4th Annual Academic and Health Policy Conference on Correctional Healthcare, Boston, Massachusetts, March, 2011

Binswanger I, Blatchford PJ, Forsyth S, **Stern MF**, Kinner SA. *Death Related to Infectious Disease in Ex-Prisoners: An International Comparative Study*. Oral Presentation, University of Massachusetts 4th Annual Academic and Health Policy Conference on Correctional Healthcare, Boston, Massachusetts, March, 2011

Binswanger I, Lindsay R, **Stern MF**, Blatchford P. *Risk Factors for All-Cause, Overdose and Early Deaths after Release from Prison in Washington State Drug and Alcohol Dependence*. Drug and Alcohol Dependence Aug 1 2011;117(1):1-6

Stern MF, Greifinger RB, Mellow J. *Patient Safety: Moving the Bar in Prison Health Care Standards.* American Journal of Public Health November 2010;100(11):2103-2110

Strick LB, Saucerman G, Schlatter C, Newsom L, **Stern MF**. *Implementation of Opt-Out HIV testing in the Washington State Department of Corrections*. Poster Presentation, National Commission on Correctional Health Care Annual Meeting, Orlando, Florida, October, 2009

Binswanger IA, Blatchford P, **Stern MF**. *Risk Factors for Death After Release from Prison*. Society for General Internal Medicine 32nd Annual Meeting; Miami: Journal of General Internal Medicine; April 2009. p. S164-S95

Stern MF. Force Feeding for Hunger Strikes – One More Step. CorrDocs Winter 2009;12(1):2

Binswanger I, **Stern MF**, Deyo RA, Heagerty PJ, Cheadle A, Elmore JG, Koepsell TD. *Release from Prison – A High Risk of Death for Former Inmates*. New England Journal of Medicine 2007 Jan 11;356(2):157–165

Stern MF, Hilliard T, Kelm C, Anderson E. *Epidemiology of Hepatitis C Infection in the Washington State Department of Corrections.* Poster Presentation, CDC/NIH *ad hoc* Conference on Management of Hepatitis C in Prisons, San Antonio, Texas, January, 2003

Phelps KR, **Stern M**, Slingerland A, Heravi M, Strogatz DS, Haqqie SS. *Metabolic and skeletal effects of low and high doses of calcium acetate in patients with preterminal chronic renal failure.* Am J Nephrol 2002 Sep–Dec;22(5–6):445–54

Goldberg L, **Stern MF,** Posner DS. *Comparative Epidemiology of Erectile Dysfunction in Gay Men*. Oral Presentation, International Society for Impotence Research Meeting, Amsterdam, The Netherlands, August 1998. Int J Impot Res. 1998;10(S3):S41 [also presented as oral abstract Annual Meeting, Society for the Study of Impotence, Boston, Massachusetts, October, 1999. Int J Impot Res. 1999;10(S1):S65]

Stern MF. *Erectile Dysfunction in Older Men*. Topics in Geriatric Rehab 12(4):40–52, 1997. [republished in Geriatric Patient Education Resource Manual, Supplement. Aspen Reference Group, Eds. Aspen Publishers, Inc., 1998]

Stern MF, Wulfert E, Barada J, Mulchahy JJ, Korenman SG. *An Outcomes–Oriented Approach to the Primary Care Evaluation and Management of Erectile Dysfunction*. J Clin Outcomes Management 5(2):36–56, 1998

Fihn SD, Callahan CM, Martin D, et al.; for the **National Consortium of Anticoagulation Clinics**.* *The Risk for and Severity of Bleeding Complications in Elderly Patients Treated with Warfarin*. Ann Int Med. 1996;124:970–979

Fihn SD, McDonell M, Martin D, et al.; for the **Warfarin Optimized Outpatient Follow–up Study Group**.* *Risk Factors for Complications of Chronic Anticoagulation*. Ann Int Med. 1993;118:511–520. (*While involved in the original proposal development and project execution, I was no longer part of the group at the time of this publication)

Stern MF, Dittus RS, Birkhead G, Huber R, Schwartz J, Morse D. *Cost–Effectiveness of Hepatitis B Immunization Strategies for High Risk People*. Oral Presentation, Society of General Internal Medicine National Meeting, Washington, D.C., May 1992. Clin Res 1992

Fihn SD, McDonell MB, Vermes D, Martin D, Kent DL, Henikoff JG, and the **Warfarin Outpatient Follow–up Study Group**. *Optimal Scheduling of Patients Taking Warfarin. A Multicenter Randomized Trial.* Oral Presentation, Society of General Internal Medicine National Meeting, Washington, D.C., May 1992. Clin Res 1992

Fihn SD, McDonnell MB, Vermes D, Kent DL, Henikoff JG, and the **Warfarin Anticoagulation Study Group**. *Risk Factors for Complications During Chronic Anticoagulation*. Poster Presentation, Society of General Internal Medicine National Meeting, Seattle, May 1991

Pristach CA, Donoghue GD, Sarkin R, Wargula C, Doerr R, Opila D, **Stern M**, Single G. *A Multidisciplinary Program to Improve the Teaching Skills of Incoming Housestaff.* Acad Med. 1991;66(3):172–174

Stern MF. *Diagnosing Chlamydia trachomatis and Neisseria gonorrhea Infections*. (letter) J Gen Intern Med. 1991;6:183

Stern MF, Fitzgerald JF, Dittus RS, Tierney WM, Overhage JM. *Office Visits and Outcomes of Care: Does Frequency Matter?* Poster Presentation, Society of General Internal Medicine Annual Meeting, Seattle, May 1991. Clin Res 1991;39:610A

Stern MF. *Cobalamin Deficiency and Red Blood Cell Volume Distribution Width*. (letter) Arch Intern Med. 1990;150:910

Stern M, Steinbach B. *Hypodermic Needle Embolization to the Heart.* NY State J Med. 1990;90(7):368–371

Stern MF, Birkhead G, Huber R, Schwartz J, Morse D. *Feasibility of Hepatitis B Immunization in an STD Clinic*. Oral Presentation, American Public Health Association Annual Meeting, Atlanta, November 1990

EXPERT TESTIMONY

Pajas v. County of Monterey, *et al.* US District Court for the Northern District of California, 2019 (trial)

Dockery, *et al.* v. Hall *et al.* US District Court for the Southern District of Mississippi Northern Division, 2018 (trial)

Benton v. Correct Care Solutions, *et al.* US District Court for the District of Maryland, 2018 (deposition)

Pajas v. County of Monterey, *et al.* US District Court Northern District of California, 2018 (deposition)

Walter v. Correctional Healthcare Companies, *et al*. US District Court, District of Colorado, 2017 (deposition)

Winkler v. Madison County, Kentucky, *et al*. US District Court, Eastern District of Kentucky, Central Division at Lexington, 2016 (deposition)

US v. Miami-Dade County, *et al.* US District Court, Southern District of Florida, periodically 2014 - 2016

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UNITED STATES DISTRICT COURTS
EASTERN DISTRICT OF CALIFORNIA
AND NORTHERN DISTRICT OF CALIFORNIA
UNITED STATES DISTRICT COURT COMPOSED OF THREE JUDGES
PURSUANT TO SECTION 2284, TITLE 28 UNITED STATES CODE

RALPH COLEMAN, et al., Plaintiffs, v. GAVIN NEWSOM, et al., Defendants.	Case No. 2:90-CV-00520-KJM-DB **THREE JUDGE COURT**
MARCIANO PLATA, et al., Plaintiffs, v. GAVIN NEWSOM, Defendants.	Case No. C01-1351 JST **THREE JUDGE COURT** **DECLARATION OF MICHAEL BRODHEIM IN SUPPORT OF PLAINTIFFS' EMERGENCY MOTION**

DECLARATION OF MICHAEL BRODHEIM

I, Michael Brodheim, declare:

1. I am a Litigation Assistant at the Prison Law Office, counsel of record for *Coleman* and *Plata* Plaintiffs. I have personal knowledge of the facts set forth herein, and if called as a witness, I could competently so testify. I make this declaration in support of Plaintiffs' Emergency Motion.

2. I served 33 years in the custody of the California Department of Corrections. I was released from CDCR custody on July 23, 2015. While in CDCR custody, I lived in dormitories at the California Medical Facility (CMF) from 2000 to 2011.

3. Since my release from custody, I visited CMF once in November 2019, as a member of the Prison Law Office team monitoring compliance with the *Armstrong v. Newsom* Remedial plan. During that visit, I walked through many of the CMF housing units, including dormitories that I had once lived in.

4. Although I have not lived at CMF since July 2015, I observed during my November 2019 visit, that the conditions had changed very little since I had left, except that there were a few more single beds in some of the dorms than there had been before, in addition to the bunk beds. I believe were also more people using walkers and wheelchairs in the dorms than when I lived there. This made the dorms even more crowded than they had been before.

5. The dormitories I lived in at CMF were in units J-1, J-2, and J-3. "J" refers to the wing of the prison, and the numerals refer to the floor.

6. On each floor of J wing, there were multiple dormitories. As I recall, there was one 8-man dorm on each floor of J-Wing. The other dorms were 12-man dorms, except for the front dorm which had more than 20 men. The latter dorm also had its own shower. Each dorm, except for the 8-man dorm, had one or two single beds with the other beds being double-bunked. Only the larger dorm had a common area where people could congregate. There was no similar space in any of the other dorms. Every dorm had a room in one corner with a toilet and sink. The room was about the size of a small closet.

Often, people would use that room to bathe (taking what was called a "bird bath") and/or do their laundry.

7. In the J-1, J-2 and J-3 dormitories that I lived in, there were usually 8 men living in a room that measures roughly 20' x 20'. These men and I shared the one toilet and one sink that was located in the corner of the dormitory. There were four bunk beds in the dorms I lived in. Even if our beds had been six feet apart, which they were not, it would have been impossible to maintain a distance of six feet from each other while we were sleeping, as we all slept within a couple of 2-3 feet of each other on the upper or lower bunk. And whenever we left our beds to do any activities of normal life, including dressing, bathing, getting food, going to the bathroom etc, we came within six feet of each other.

8. Some of the people I lived with in the dorms used wheelchairs and/or walkers. This made the small room more crowded and more difficult to maintain distance between us.

9. We had to leave the dorm to take a shower. This was true for every dorm except the first, larger dorm, which had its own shower. In order to shower, we had to wait for the custody officer to unlock the door, which they did once an hour. We would have to walk down the hallway to get to the shower room. When I showered, I would be locked in the shower room (for about an hour), typically with about 5-10 other people. Two or three people would use the shower at one time. It would not have been possible to maintain social distance in the shower room, nor could I avoid passing people in my dorm on my way to the shower.

10. Below are some photos of J-1 dorm, where I lived in 2011. These photos were taken in April 2019 by plaintiffs' *Armstrong* auditing team. The conditions that these incarcerated people are living are very similar to the conditions in the dorm when I lived there.

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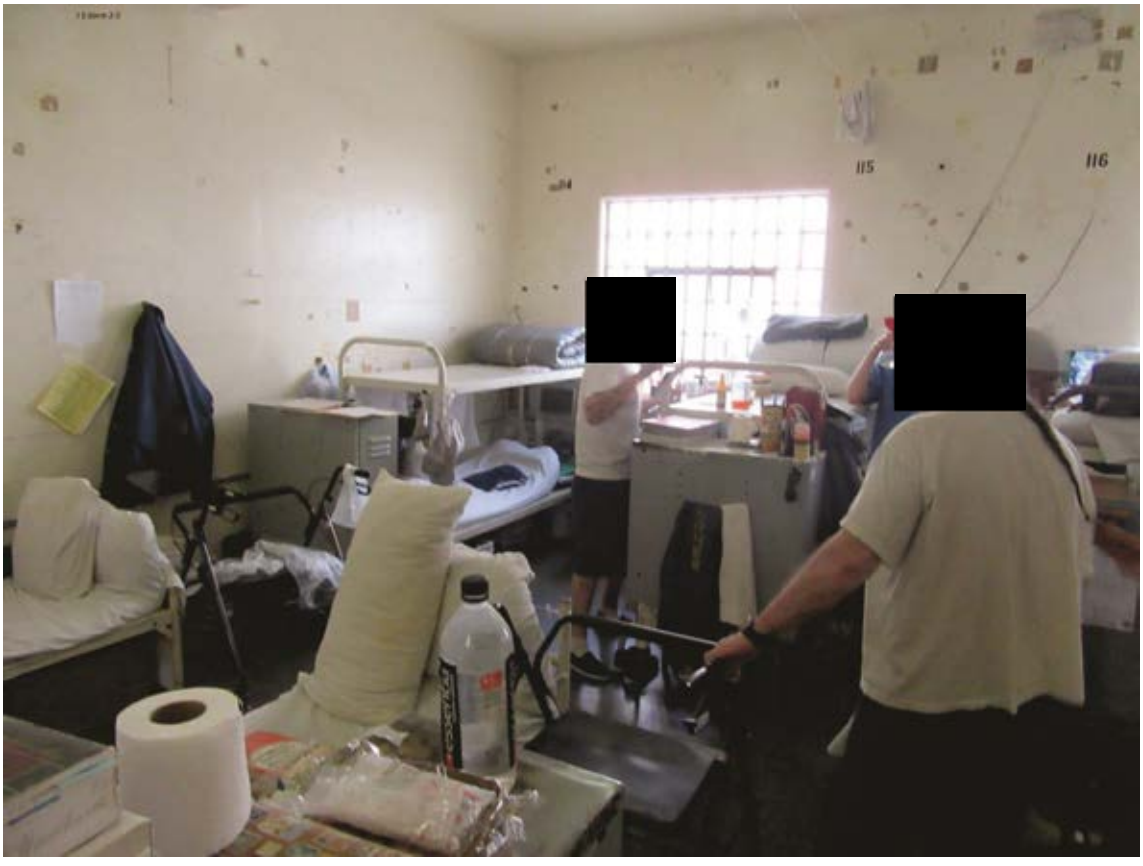
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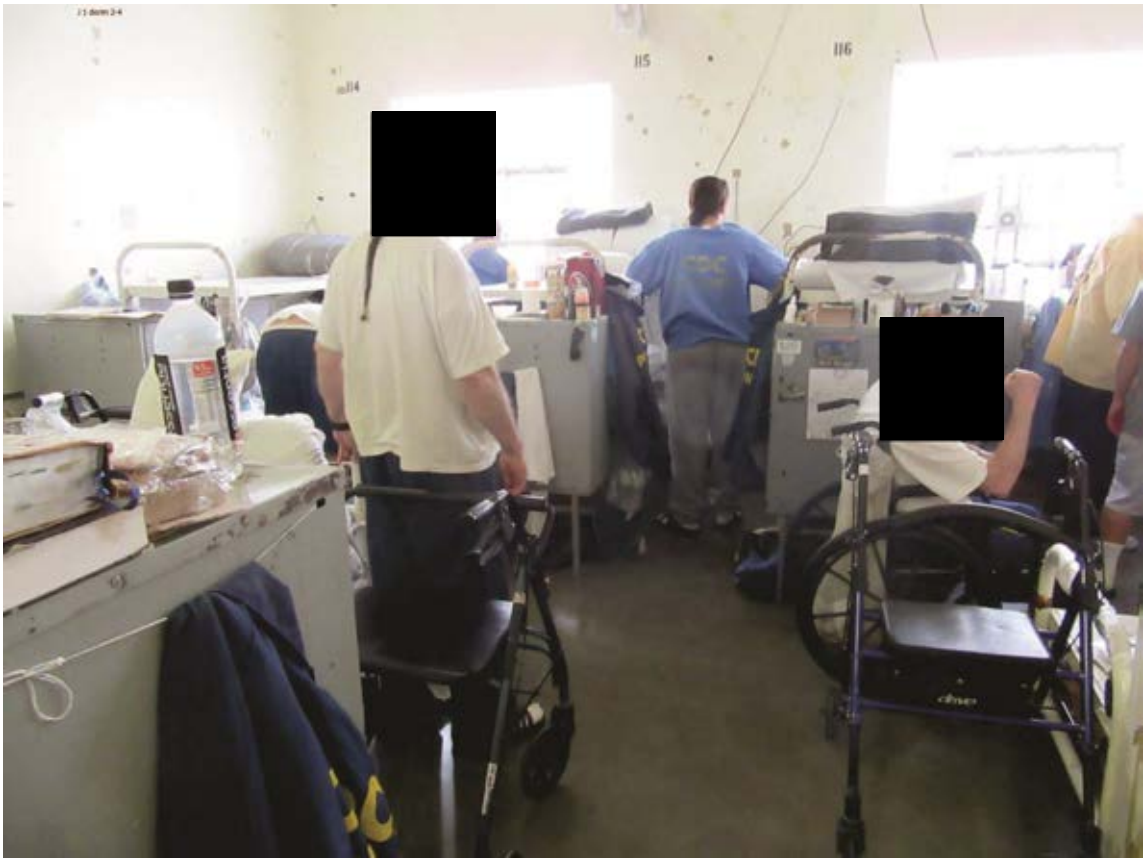

11. During my visit in November 2019, I observed that most people in the dorms at CMF are still living, showering, and sleeping within a few feet of each other most if not all of the time, just as they were when I lived there.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct, and that this declaration is executed at Berkeley, California this 24th day of March, 2020.

/s/
Michael Brodheim

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MARCIANO PLATA, et al., Plaintiffs, v. GAVIN NEWSOM, Defendants.	Case No. C01-1351 JST **THREE JUDGE COURT** **[PROPOSED] ORDER GRANTING PLAINTIFFS' EMERGENCY MOTION TO MODIFY POPULATION REDUCTION ORDER**

Before this Court is Plaintiffs' Emergency Motion to Modify the Population Reduction Order. This Court, having considered the briefing, relevant legal authority, and the record in this case, including the expert declarations, **GRANTS** Plaintiffs' motion.

The Court finds that the requested relief therein meets the requirements of 18 U.S.C. § 3626. In so doing, the Court finds that the relief is narrowly drawn, extends no further than necessary to ensure the protection of the federal constitutional and statutory rights of Plaintiffs, and is the least intrusive means necessary to accomplish those objectives. The Court also finds that previous orders for less intrusive relief failed to remedy the deprivation of Plaintiffs' rights, and Defendants have had a reasonable amount of time to comply with previous court orders. Finally, this Court finds that crowding is the primary cause of the violation of Plaintiffs' rights, and no other relief will remedy the violation of these rights.

IT IS HEREBY ORDERED that:

1. Defendants shall reduce the population density in crowded congregate living spaces to a level that will permit social distancing by releasing to parole or post-release community supervision those class members who (a) are at low risk as determined by CDCR's risk assessment instrument or are serving a term for a non-violent offense and (b) are paroling within the year. Within this group, people with six months or less to serve and people who are at high risk of severe illness from COVID-19 should be prioritized.
2. Defendants shall release or relocate class members who are at high risk of severe illness from COVID-19. High risk individuals include: (a) people aged 65 and over; (b) people with chronic lung disease or moderate to severe asthma; (c) people who have severe heart conditions; (d) people who are immunocompromised (for example, due to cancer treatment, bone marrow or organ transplantation, immune deficiencies, poorly controlled HIV or AIDS, or prolonged use of immune-weakening medications); (e) people with severe obesity; (f) people with uncontrolled diabetes; (g) people with renal failure; (h) people with liver disease;

and (i) people who are pregnant. *See* Bien Decl. ¶ 51, Exh. 37 (Centers for Disease Control and Prevention, *Coronavirus Disease 2019 (COVID-19): People Who are at Higher Risk*, https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/people-at-higher-risk.html (last updated March 22, 2020)). Defendants may release these high-risk class members to parole or post-release community supervision and/or use the Governor's emergency powers to temporarily relocate them. *See generally* Bien Decl. ¶ 52, Exh. 38 at ¶¶ 1-6 (Governor Newsom March 4, 2020 Proclamation of a State of Emergency); Cal. Gov't Code § 8658.

3. **In the alternative**, Defendants shall release to parole or post-release community supervision as many people as necessary to achieve safe social distancing and sufficient space for quarantines and isolations.
4. Defendants shall submit a plan to implement these orders to the Court on or before April 1, 2020.

IT IS SO ORDERED.

Dated: March __, 2020

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HON. KIM MCLANE WARDLAW
UNITED STATES CIRCUIT JUDGE
NINTH CIRCUIT COURT OF APPEALS

Dated: March __, 2020

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HON. KIMBERLY J. MUELLER
CHIEF UNITED STATES DISTRICT JUDGE
EASTERN DISTRICT OF CALIFORNIA

Dated: March __, 2020

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HON. JON S. TIGAR
UNITED STATES DISTRICT JUDGE
NORTHERN DISTRICT OF CALIFORNIA