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IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

MARCIANO PLATA, et al.,
Plaintiffs,
v.
EDMUND G. BROWN JR., et al.,
Defendants.

NO. C01-1351 TEH
ORDER GRANTING
PLAINTIFFS' MOTION FOR
RELIEF RE: VALLEY FEVER
AT PLEASANT VALLEY AND
AVENAL STATE PRISONS

This matter came before the Court on June 17, 2013, on Plaintiffs' motion concerning Valley Fever at Pleasant Valley State Prison ("PVSP") and Avenal State Prison ("ASP").

Plaintiffs' original motion requested an order for Defendants to:

- (1) expand their exclusionary factors so that no prisoners in the known at-risk groups of African-Americans, people of Filipino descent, Inuits, persons with diabetes, HIV, or any immunocompromised state are sent to Pleasant Valley and Avenal, and suspend the transfer of inmates without HIV test results to PVSP and ASP;
- (2) fully implement their exclusion of these same at-risk groups by ensuring that all such prisoners are transferred from Pleasant Valley and Avenal within 30 days; and
- (3) immediately request a health hazard evaluation and an epidemiological evaluation at Pleasant Valley and Avenal by the National Institute of Occupational Safety and Health and the Centers for Disease Control and Prevention.

Mot. at 10. Plaintiffs further requested a referral to the existing three-judge court "for an order suspending the transfer of all inmates into Pleasant Valley and Avenal" if these steps were not completed within 30 days. *Id.*

1 After Plaintiffs filed their motion, the Court ordered the Receiver to facilitate a meet-
 2 and-confer process that included the court experts. This process did not resolve the motion,
 3 but it did lead to the Receiver's promulgation of the following cocci exclusion policy on
 4 April 29, as revised on May 1 to include exclusion of inmates diagnosed with diabetes
 5 mellitus:

6 To reduce the risks associated with cocci disease at PVSP and
 7 ASP to a reasonable level, the following inmates shall be
 8 excluded from PVSP and ASP (except for those inmates who
 waive the application of this exclusion policy):

- 9 (1) inmates who, considering all available patient information,
 10 are at an increased risk for contracting cocci disease of 50
 percent or greater than baseline risk; and
- 11 (2) inmates who, considering all available patient information,
 12 would be at a significantly increased risk of morbidity
 and/or mortality from contracting cocci disease, which
 includes inmates who are
- 13 a. medical high-risk;
 - 14 b. HIV infected;
 - 15 c. immunocompromised;
 - 16 d. diagnosed with diabetes mellitus;
 - e. undergoing immunosuppressive chemotherapy; or,
 - f. pregnant.

17 Receiver's Resp. at 2. The first category would currently include African-American inmates,
 18 inmates of "other race" (non-White, non-Latino/Hispanic, and non-African-American), and
 19 inmates older than 55 years of age. *Id.* at 5, 10 To date, Defendants have refused to
 20 implement this policy. In their reply, Plaintiffs abandoned their original requests and now
 21 only "seek an order compelling defendants to immediately implement [the Receiver's]
 22 policy." Reply at 2.

23 The Court has carefully considered the parties' arguments, including those raised in
 24 Defendants' June 14, 2013 unsolicited response to the Receiver's latest tri-annual report, as
 25 well as reports filed by the Receiver and the court experts. For the reasons set forth below,
 26 the Court GRANTS Plaintiffs' motion by ordering Defendants to implement a modified
 27 version of the Receiver's exclusion policy within 7 days of the date of this order, with all
 28 transfers to be completed within 90 days of the date of this order.

1 **I. BACKGROUND**

2 This motion concerns coccidioidomycosis, commonly referred to as cocci or Valley
3 Fever, “an infectious disease caused by inhalation of a fungus (*Coccidioides*) that lives in the
4 soil of dry, low rainfall areas. It is spread through spores that become airborne when the dirt
5 they reside in is disturbed by digging, construction, or strong winds. There is no direct
6 person-to-person transmission of infection.” Court Medial Experts, *Coccidioidomycosis in*
7 *Cal. State Prisons*, May 23, 2013, at 2 (“Expert Report”).

8 While cocci infection can be asymptomatic, it can also result in serious illness and, in
9 the most extreme cases, death:

10 Approximately 60% of individuals who are infected with cocci
11 are asymptomatic. Patients who develop symptoms commonly
12 present after an incubation period of one to three weeks with
13 flu-like illness with fever, cough, headaches, rash, and muscle
14 aches; these symptoms typically last weeks to months. In the
15 majority of infections, resolution occurs without antifungal
therapy; however, a small proportion of patients fail to recover
and develop severe pulmonary or disseminated disease, affecting
soft tissues, joints, bones, and the meninges (the membranes
surrounding the brain and spinal cord). Illness may persist for
months or longer, and in some cases result in death.

16 *Id.*; see also Galgiani Decl. ¶ 7.¹ Approximately 10 percent of individuals infected with
17 cocci develop severe disease. Cal. Correctional Health Care Svcs. (“CCHCS”) Public Health
18 & Quality Mgmt. Units, *Coccidioidomycosis in Cal.’s Adult Prisons: 2006-2010*, Apr. 16,
19 2012, at 2 (Ex. B to Galgiani Decl.) (“Apr. 16, 2012 CCHCS Report”).

20 Severe disease or dissemination may develop in anyone, but
21 African-Americans, Filipinos, people with weak immune
22 systems, such as those with an organ transplant or who have
23 HIV/AIDS, and those with chronic illnesses such as diabetes and
24 chronic lung disease requiring oxygen, are at increased risk of
developing severe disease. Individuals with a prior history of
cocci are immune to subsequent infection; however, currently
there is no commercially available test to determine immunity. In
addition, there is no vaccination to protect against cocci infection.

25 Expert Report at 2.

26 _____
27 ¹Defendants do not dispute the qualifications of Plaintiffs’ expert, Dr. John Galgiani,
28 to opine on cocci-related issues. Nor, more broadly, do Defendants dispute any of the data
included in the Receiver’s reports, the court expert report, or Plaintiffs’ submissions.

1 Cocci is “endemic (native and common) to certain regions of the Southwestern United
2 States, Mexico, and South and Central America where the climate and soil conditions are
3 conducive to growth of the fungus. In California, most cases emanate from the southern San
4 Joaquin Valley.” *Id.* at 2. Eight prisons are located in California’s hyperendemic region:
5 ASP; PVSP; California Correctional Institution (“CCI”); California State Prison, Corcoran
6 (“COR”); Kern Valley State Prison (“KVSP”); North Kern State Prison (“NKSP”); the
7 Substance Abuse Treatment Facility and State Prison at Corcoran (“SATF”); and Wasco
8 State Prison (“WSP”). Apr. 16, 2012 CCHCS Report at 11. However, it is not disputed that
9 ASP and PVSP have the most severe cocci problems. For example, in 2011, 535 of the 640
10 reported cocci cases within the California Department of Corrections and Rehabilitation
11 (“CDCR”) – nearly 85% – occurred at these two prisons alone. Expert Report at 5.

12 Defendants first “identified significant increases in the number of inmate-patients
13 presenting with cocci, with deaths attributed to this disease,” at PVSP and ASP in 2005 –
14 eight years ago.² Nov. 20, 2007 CDCR/CCHCS memo to institution staff, “Exclusion of
15 Inmate Patients Susceptible to Coccidioidomycosis from Highest Risk (Hyperendemic) Area
16 Institutions,” at 1 (“2007 Exclusion Policy”) (Ex. A to Toche Decl.). At the Receiver’s
17 request, the California Department of Public Health (“CDPH”) conducted an investigation at
18 PVSP.

19 CDPH confirmed the outbreak, noting the occurrence of at least
20 166 cases of cocci at PVSP during 2005, including 29 (18%) who
21 were hospitalized, and four deaths. The rate of PVSP cocci cases
was 38 times the rate of cocci in residents of Coalinga, the city in
which PVSP is located, and 600 times the rate of Fresno County.

22 Apr. 16, 2012 CCHCS Report at 2. In January 2007, CDPH made final recommendations,
23 “including inmate and staff education, environmental controls, and relocation of the highest
24 risk groups to other prisons.” Expert Report at 3. CDPH recommended exclusion of high-
25 risk inmates as “the most effective method to decrease risk”:

27
28 ²The Stainer Declaration incorrectly states that Defendants first “became aware of a[n] increased infection rate of Valley Fever at PVSP and ASP” in 2006. Stainer Decl. ¶ 4.

1 Previous studies have suggested that the risk for extrapulmonary
 2 complications is increased for *persons of African or Filipino*
 3 *descent*, but the risk is even higher for *heavily immunosuppressed*
 4 *patients*. In this investigation, we found an increased risk among
 5 persons with chronic medical conditions, especially pulmonary
 conditions. *Prevention efforts are critical for these higher risk*
populations and may mitigate the risk, but physical removal of
these highest risk groups from highly endemic regions, if
possible, would be the most effective method to decrease risk.

6 Apr. 16, 2012 CCHCS Report at 7 (listing January 11, 2007 recommendations from CDPH)
 7 (emphasis added).

8 In response to the CDPH's draft report, PVSP "posted laminated signs in all medical
 9 clinics, inmate housing units and law libraries" regarding the "signs and symptoms" of cocci
 10 on December 5, 2006. Jan. 10, 2007 memo from PVSP Warden to CDCR Associate
 11 Director, General Pop. Level III/IV, Division of Adult Institutions, at 1 ("Jan. 10, 2007 PVSP
 12 Memo") (Ex. B to Stainer Decl.). PVSP also alerted staff "to signs and symptoms" by
 13 providing information in two issues of the "In-Service Training Bulletin." *Id.* In addition,
 14 PVSP transferred "inmates that are high risk due to pulmonary conditions and heavily
 15 immunosuppressed patients . . . out of the endemic region by September 21, 2006," and
 16 ordered that "[f]urther identified patients are to be transferred within 30 days of being
 17 identified."³ *Id.* Notably, although CDPH observed the increased risk for African-
 18 Americans and Filipinos, PVSP did not transfer these inmates out. PVSP also failed to
 19 implement CDPH's recommendation to increase ground cover throughout prison property,
 20 which was demonstrated to be effective at reducing airborne spores by military operations
 21 during World War II. Apr. 16, 2012 CCHCS Report at 7. The PVSP Warden described this
 22 recommendation as "not feasible" due to an initial cost that "could potentially exceed
 23 \$750,000, in addition to significant ongoing maintenance costs." Jan. 10, 2007 PVSP Memo
 24 at 1-2. "The Warden proposed soil stabilization as an alternative solution; however, neither

25 ³At oral argument and in the Stainer Declaration, Defendants described the transfer
 26 process as complex and burdensome. *E.g.*, Stainer Decl. ¶¶ 11-15. While the Court
 27 understands that "the transfer process is not as simple as identifying open beds at other
 28 institutions and transferring the at risk inmate into the open bed [because] CDCR must ensure
 that the open bed meets the inmate's safety, rehabilitative, and health care needs prior to
 finalizing the transfer," *id.* ¶ 15, the Court also understands from the Receiver that the CDCR
 routinely transfers hundreds or thousands of inmates on a weekly basis.

1 measure was implemented at that time.” Expert Report at 3; *see also* Jan. 10, 2007 PVSP
 2 Memo at 2 (recommending “application of a high-grade soil sealant product to control dust
 3 from the predominant wind direction,” which was estimated to cost \$110,000 per application
 4 and was “expected to have a useful life of five years and requires no ongoing maintenance
 5 other than reapplication”).

6 Following issuance of the CDPH recommendations, the Receiver convened a
 7 committee – consisting of his staff and public health, academic, and clinical cocci experts –
 8 to examine the problem further. In June 2007, the committee issued a report with 26
 9 recommendations. Dwight Winslow, *Recommendations for Coccidioidomycosis Mitigation*
 10 *in Prisons in the Hyperendemic Areas of Cal.*, June 2007 (Ex. D to Specter Decl.). CDCR
 11 and the Receiver did not adopt all 26 recommendations but did respond by:

- 12 1. Implementing cocci education programs for inmates and
 13 staff at CDCR prisons.
- 14 2. Canceling construction to expand PVSP.
- 15 3. Relocating inmates with medical conditions designated by
 16 the multidisciplinary committee as being high-risk for
 17 severe cocci from [all eight] institutions in the
 18 hyperendemic region.
- 19 4. Supporting the construction of a medical facility with
 20 dialysis beds in Stockton for the protection of patients
 21 with end-stage renal disease.

22 Expert Report at 4 (footnotes omitted). “[R]ecommendations related to environmental
 23 mitigation that had been shown to be effective were judged to be too costly and were not
 24 implemented.” *Id.* On November 20, 2007, a new cocci exclusion policy was adopted for all
 25 eight prisons in the hyperendemic area⁴ and included the following criteria:

- 26 Criteria a. All identified HIV infected inmate-patients
- 27 Criteria b. History of lymphoma
- 28 Criteria c. Status post solid organ transplant
- Criteria d. Chronic immunosuppressive therapy (e.g., severe
 rheumatoid arthritis)

⁴This policy replaced the exclusion policy adopted on August 3, 2006, which neither party included in the record on this motion. 2007 Exclusion Policy at 1.

1 Criteria e. Moderate to severe Chronic Obstructive Pulmonary
2 Disease (COPD) requiring ongoing intermittent or continuous
oxygen therapy

3 Criteria f. Inmate-patients with cancer on chemotherapy

4 2007 Exclusion Policy at 2. Inmates who had already been infected with cocci were not
5 covered by this policy. *Id.* at 1. The court experts concluded that “implementation of these
6 measures was ineffective in mitigating the coccidioidomycosis crisis.” Expert Report at 4.

7 In December 2008, CDCR’s Occupational and Public Health Section requested a
8 health hazard evaluation (“HHE”) from the National Institute for Occupational Safety and
9 Health (“NIOSH”), which is part of the federal Centers for Disease Control and Prevention
10 (“CDC”), to examine cocci cases among prison employees – not inmates – at PVSP and
11 ASP. *Id.* However, the State unilaterally cancelled the planned site visit by NIOSH, and the
12 agency subsequently closed out the request for an HHE. As NIOSH explained in a
13 December 2009 letter to CDCR:

14 We had planned a visit to both PVSP and ASP for May 18-20,
15 2009. However, our trip was cancelled the week prior at your
request. . . .

16 Shortly after we made plans for a site visit, a motion was made by
17 California’s Office of the Governor to have CDCR create an
advisory group that would decide whether or not pursuing the
18 HHE further would be valuable to the State of California. In June
2009, we learned that your Office of Risk Management, which
19 had overseen occupational health issues for the prison system,
was disbanded. You have since relocated to another position
20 within CDCR. This development along with the lack of support
from CDCR management precluded moving forward with the
HHE. We contacted the union leaders for the local California
21 Correctional Peace Officers Associations (CCPOA), who did not
support efforts to advance the HHE. . . .

22 Since we do not have the support of either CDCR management or
23 the local CCPOA unions, we are closing out your HHE request.

24 Dec. 4, 2009 letter from NIOSH to CDCR at 4 (Ex. E to George Reply Decl.).

25 In 2010, the Receiver refined the 2007 Exclusion Policy as part of the implementation
26 of a medical classification system policy. A “Valley Fever transfer list” was created to
27 identify “inmates who are at institutions within the Valley Fever hyperendemic area that need
28 to be transferred out. When an inmate is identified as meeting the medical classification

1 criteria by his or her physician, he or she is added to the transfer list.”⁵ Stainer Decl. ¶ 5. As
 2 of May 6, 2013, “PVSP has three [inmates] on the transfer list and there are no inmates
 3 waiting to transfer out of ASP.” *Id.*

4 In December 2011, soil stabilization was finally implemented on some of the unpaved
 5 surfaces at PVSP. Funding for this work was provided by the Receiver. Expert Report at 5;
 6 *see also* Receiver’s 23rd Tri-Annual Report at 30; Hysen Decl. ¶ 3.

7 In April 2012, the Receiver’s Public Health and Quality Management Units released a
 8 report that examined cocci between 2006 and 2010. Among other findings, the report noted
 9 that:

- 10 • Four institutions – PVSP, ASP, WSP, and NKSP – had cocci rates higher than rates in
- 11 the counties in which they are located, and none of these institutions “showed a
- 12 consistent decrease in rates” despite implementation of the measures described above;
- 13 • PVSP had a cocci rate that was 52 times higher, and ASP had a cocci rate that was
- 14 nearly 10 times higher, than the county with the highest rate in California;
- 15 • “PVSP had a cocci rate over 400 times the rate of the county in which PVSP is
- 16 located, and six times the rate of the adjacent mental health facility,” Coalinga State
- 17 Hospital (“CSH”);⁶
- 18 • For fiscal years 2008-09 and 2009-10, 355 inmates required outside hospitalization
- 19 because of cocci, at a cost of \$23.4 million per year;
- 20 • “PVSP and ASP experienced the highest costs for cocci in the system, corroborating
- 21 the disproportionate burden of disease in these institutions”; and
- 22 • From 2006 to 2010, 27 inmates died from cocci.

23
 24 ⁵The record does not include a list of the medical classification criteria used to place
 25 inmates on the Valley Fever transfer list, but presumably it is similar to the list of criteria
 contained in the 2007 Exclusion Policy.

26 ⁶One difference between PVSP and CSH “is that CSH has an air-conditioning system
 27 that can be shut off to outside air on dusty days, whereas PVSP has a swamp cooler system
 28 with 10 air exchanges per hour with outside air. CDCR did not investigate why PVSP had
 higher cocci rates than CSH. However, the Office of Facilities Management subsequently
 advised that changing the HVAC system at PVSP would be prohibitively expensive.” Expert
 Report at 6.

1 Apr. 16, 2012 CCHCS Report at 3-5. The Receiver also conducted a study of 36 inmate
2 deaths between 2006 and 2011 that were attributable to cocci and found that 97% were in the
3 hyperendemic region, 70% were African-American, and 76% had a comorbid condition (i.e.,
4 a serious illness like HIV or diabetes). Expert Report at 5.

5 Based on these troubling findings, Plaintiffs' counsel wrote a letter to the CDCR
6 Secretary and Receiver on September 6, 2012, requesting that further measures be taken to
7 address cocci at PVSP "and other prisons with high infection rates."⁷ Sept. 6, 2012 Letter
8 from Donald Specter to Matthew Cate, CDCR Secretary, and Clark Kelso, Receiver, at 2
9 (Ex. A to Specter Decl.). The letter led to a September 25, 2012 meeting between Plaintiffs'
10 counsel, CDCR executives, and the Receiver, as well as an agreement "to future meetings to
11 discuss mitigation measures." Toche Decl. ¶ 5.

12 On November 14, 2012, the Receiver – following consultation with the court experts –
13 recommended several possible actions that could be undertaken immediately.
14 "Recommendations for Immediate Response to Coccidioidomycosis in CDCR Prisons" (Ex.
15 C to Specter Decl.). The recommendations included suspending the transfer to PVSP and
16 ASP of African-Americans; persons with diabetes, HIV, or any other condition that caused
17 them to be in an immunocompromised state; and persons without HIV test results. *Id.* The
18 recommendations also included a suggestion to request assistance from NIOSH and CDC to
19 initiate a health hazard evaluation treating the inmates as if they were employees and to
20 examine whether the cocci cases at the two prisons showed any patterns that suggested
21 environmental causes. *Id.*

22 On December 3, 2012, CDCR formally requested assistance from CDPH – nearly six
23 years after CDPH made initial findings and recommendations that CDCR did not implement
24 in their entirety. Toche Decl. ¶ 6. On December 21, 2012, "CDCR requested that CDPH

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26 ⁷Plaintiffs' counsel also wrote to the court experts asking them to evaluate cocci-
27 related policies and procedures. Oct. 4, 2012 letter from Donald Specter to Court Experts
28 (Ex. B to Specter Decl.). As the Court subsequently clarified, however, "the appointment of
the Receiver superseded the provisions of the June 13, 2002 Order Appointing Experts that
allowed the parties to request evaluations from the court experts or to request that the experts
attend negotiations, mediation sessions, or court hearings." Mar. 21, 2013 Order at 2.

1 communicate with [CDC] and [NIOSH] to seek their assessment and recommendations on
2 Valley Fever.”⁸ *Id.* ¶ 7. However, it was not until April 23, 2013, at the request of the
3 Receiver, that CDPH requested immediate assistance from the CDC. Expert Report at 9.
4 “Within days, CDC and NIOSH staff contacted the Receiver to begin determining what
5 resources would be necessary and available for this analysis.” *Id.* Defendants’ counsel
6 represented at oral argument that these agencies were expected to issue preliminary findings
7 “any day now” and a final study in approximately six months.

8 Aside from the promulgation of the Receiver’s revised cocci exclusion policy, other
9 recent actions include investigation by the Receiver, CDCR, and CDPH into the potential use
10 of a licensed skin test to screen inmates for cocci immunity; this test is expected to gain FDA
11 licensing and be commercially available later this year. *Id.* at 7-8. Additionally, “[i]n or
12 around March 2013, CDCR attempted certain mitigation measures at PVSP and ASP,
13 including installing equipment on the doors at all housing units designed to keep out dust and
14 a finer air filter in one housing unit at each institution.” *Id.* at 8; Hysen Decl. ¶¶ 4-6.
15 Following testing of the new air filters in the two units, “in April 2013, CDCR authorized
16 installation of these higher efficiency filters for all remaining housing units at both PVSP and
17 ASP.” Hysen Decl. ¶ 4. At oral argument, Defendants’ counsel represented that such
18 installation had been completed. CDCR also expanded its education efforts in March 2013
19 by authorizing “distribution of additional pamphlets and posters to PVSP, ASP, and six other
20 neighboring institutions.” *Id.* ¶ 7; *see also* Stainer Decl. ¶¶ 17-21 (discussing ongoing
21 training and education efforts for both inmates and staff).

22 CDCR has also agreed to the Receiver’s request to transfer out of PVSP and ASP
23 inmates who meet the medical classification policy’s definition of “high risk.” Stainer Decl.
24 ¶ 6. These individuals include those with “end stage liver disease, hypertension with end
25 organ damage, cancer treated with chemotherapy, [and] coronary artery disease with prior
26

27 ⁸The record is not clear as to whether the request for assistance to NIOSH and CDC
28 followed the November 2012 recommendation to consider inmates as if they were
employees, or if the request included an evaluation as to employees only.

1 infarction.” *Id.* Approximately 600 medically high-risk inmates have been identified, and
 2 CDCR expects to complete transfer of these inmates by August 2013. *Id.* ¶ 10.

3 However, CDCR has refused to exclude the other inmates covered by the Receiver’s
 4 policy – most notably, diabetics and African-American and Filipino inmates⁹ – even after
 5 CDPH provided its formal commentary on April 4, 2013, that “[a] factor that probably
 6 contributed to the high rates in [PVSP and ASP] is housing populations of inmates at risk for
 7 severe cocci disease, *such as African Americans and persons with diabetes* or other chronic
 8 diseases.” Apr. 4, 2013 letter from Dr. Gil Chavez, State Epidemiologist and CDPH Deputy
 9 Director of Infectious Diseases, to Martin Hoshino, Acting CDCR Secretary for Operations,
 10 at 1 (“Chavez Letter”) (Ex. B to Toche Decl.). CDPH further concluded that:

11 *The populations/groups at risk for severe cocci factor can be*
 12 *addressed by reducing the number of inmates belonging to these*
 13 *groups in these prisons. The reality that the state prisons are*
 14 *already crowded means that moving all at-risk inmates out of*
 15 *these prisons is difficult and may not be feasible, but some further*
 16 *screening out of some high risk groups is advisable. . . . Further*
 17 *analyses of current data will likely show similar findings of these*
 18 *populations/groups at risk for severe disease as documented in*
 19 *past publications, and therefore it is probably of little additional*
 20 *value to carry out further data analyses to identify or clarify risk*
 21 *groups in these prisons at this time. . . . The populations at risk*
 22 *are well known and listed by the American Thoracic Society, but*
 23 *choosing only some categories to include in the updated policy*
 24 *will be difficult. If CDCR wants input into updating this policy,*
 25 *academic cocci experts should be invited.*

19 *Id.* at 2 (emphasis added).¹⁰

20 ⁹CDCR also objects to the inclusion of pregnancy on the list of exclusions because
 21 “[t]he only potential pregnant women at ASP and PVSP are employees, not inmates. Are
 22 you suggesting that all pregnant women in the hyperendemic region should move? This
 23 certainly appears overbroad.” May 8, 2013 letter from Diana Toche, Acting CDCR
 24 Undersecretary for Administration and Offender Services to Clark Kelso at 2 (“Toche
 25 Letter”) (Ex. B to George Reply Decl.). This objection is absurd. The policy clearly applies
 26 only to inmates, and the pregnancy exclusion will not apply to any inmates as long as PVSP
 27 and ASP remain designated as men’s prisons. The Court presumes that pregnancy was
 28 included in the policy because it is a recognized risk factor and to prevent Defendants from
 housing pregnant women at PVSP or ASP if they subsequently convert either institution to a
 women’s prison.

¹⁰The American Thoracic Society (“ATS”) criteria for increased risk include:
 “Patients with impaired cellular immunity, such as those with solid organ transplants, those
 with HIV infection, and those with chronic obstructive pulmonary disease, chronic renal
 failure, congestive heart failure, diabetes; patients receiving TNF inhibitors (medications
 used in the treatment of arthritis); Filipino and African-American men; and pregnant women

1 The court experts filed a timely report after reviewing all of the papers in this case.
2 They concluded that the measures taken to date by the CDCR and the Receiver have been
3 insufficient:

4 While CDCR transferred some medically high-risk patients,
5 conducted soil sampling and environmental mitigation measures
(in 2011 paid for by the Receiver), educated inmates and staff,
6 distributed dust masks,[FN] installed new door sweeps and higher
7 efficiency air filters, and created a program to measure wind
speeds, these efforts have been far from timely, thorough, or
effective.

8 [FN] Inmates were limited to one N95 mask per
9 month. These masks are intended to be used for no
more than 8 hours.

10 Expert Report at 11-12. They also agreed with Plaintiffs’ expert’s conclusion that cocci is
11 not always adequately treated:

12 [T]he plaintiffs’ expert, Dr. John Galgiani, an internationally
13 known cocci expert, stated in his declaration that his review of
14 four deaths related to cocci indicated that medical staff at prisons
15 in the cocci endemic zone are still slow to recognize the early
signs of illness, particularly in African-American men, and are
slow to begin timely and proper treatment for the disease. We
agree. We reviewed health records that raised similar concerns.

16 *Id.* at 12-13; *see also* Galgiani Decl. ¶¶ 18-19 (concluding that earlier diagnosis and
17 treatment might have prevented death in all four cases). The experts concluded their report
18 with seven recommendations:

- 19 1. Immediately implement a modified version of the
20 Receiver's May 1, 2013 Cocci Exclusion Policy at PVSP
21 and ASP. We recommend that all populations that meet
22 the American Thoracic Society criteria for increased risk
23 of severe cocci disease, including ethnicities at increased
24 risk for severe disease (e.g., African-Americans,
25 Filipinos), be included in the policy. We also recommend
26 that individuals whose HIV status is unknown (unless they
have refused testing after having been specifically
counseled about the risk of cocci) need to be transferred.
- 2. Institute environmental mitigation strategies known to be
effective to reduce exposure to cocci infection at Avenal
and Pleasant Valley State Prisons.

27 in the 2nd or 3rd trimester.” Expert Report at 14 n.31 (citing *An Official American Thoracic*
28 *Society Statement: Treatment of Fungal Infections in Adult Pulmonary and Critical Care*
Patients. (May 2010)).

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- 3. Upon completion of the CDC and NIOSH investigations convene a multidisciplinary working group to develop an action plan to address the recommendations of the reports.
- 4. As noted in the June 2007 report recommendations, if measures taken do not reduce cocci rates to near local community rates, close PVSP and ASP. Relocate PVSP and ASP inmates to institutions with rates of cocci equal or less than their local community rates.
- 5. Since 50% of deaths as well as 31% of cases that resulted in a hospital stay of 30 days or longer occurred at facilities in the endemic region other than PVSP and ASP, consider extending the exclusion criteria to those prisons with rates of cocci worse than their local community rates.
- 6. Provide training to all CDCR medical and nursing staff in recognition, diagnosis and treatment of cocci.
- 7. Establish an infectious disease consultative service (via direct physician participation, phone consultation or telemedicine) to assist medical staff in the management of patients with cocci.

Expert Report at 14-15.

II. DISCUSSION

A. The Requested Relief Is Not a “Prisoner Release Order” Under the PLRA

The Court first addresses Defendants’ argument that the Prison Litigation Reform Act (“PLRA”) bars this Court from entering an order to implement the Receiver’s policy because it is a “prisoner release order” that can only be issued by a three-judge court under 18 U.S.C. § 3626(a)(3)(B). The PLRA defines “prisoner release order” as “any order, including a temporary restraining order or preliminary injunctive relief, that has the purpose or effect of reducing or limiting the prison population, or that directs the release from or nonadmission of prisoners to a prison.” 18 U.S.C. § 3626(g)(4). Defendants contend that an order to implement the Receiver’s policy satisfies this definition because it “directs the release from or nonadmission of prisoners to a prison.”

However, at oral argument, Defendants conceded that an order to transfer any single inmate out of a prison to correct the violation of a constitutional right caused by something other than crowding – for example, because transfer was necessary for the inmate to obtain

1 appropriate medical care – would not be a “prisoner release order.” Counsel attempted to
 2 draw a distinction between transfer of a single inmate and a policy that would result in
 3 transfer of a large group of inmates. However, no such distinction can be drawn for purposes
 4 of analysis under the PLRA. Either a “transfer” is a “release from” a prison or it is not, and
 5 Defendants have now conceded that it is not.¹¹ Plaintiffs’ requested relief – which concerns
 6 only transfer and not release – therefore does not require consideration by a three-judge
 7 court.

8 Moreover, even absent Defendants’ concession, the Court would reject Defendants’
 9 arguments based on general principles of statutory construction. Statutory phrases are not
 10 construed in isolation; to the contrary, statutes must be read as a whole. *U.S. v. Morton*, 467
 11 U.S. 822, 828 (1984). In addition, “where a statute is susceptible of two constructions, by
 12 one of which grave and doubtful constitutional questions arise and by the other of which such
 13 questions are avoided, our duty is to adopt the latter.” *Gilmore v. California*, 220 F.3d 987,
 14 997 (9th Cir. 2000) (quotation marks and citations omitted). Likewise, “a statute should not
 15 be construed to displace courts’ traditional equitable powers ‘[a]bsent the clearest command
 16 to the contrary.’” *Id.* at n.12 (citation omitted). “Unless a statute in so many words, or by a
 17 necessary and inescapable inference, restricts the court’s jurisdiction in equity, the full scope
 18 of that jurisdiction is to be recognized and applied.” *Weinberger v. Romero-Barcelo*, 456
 19 U.S. 305, 313 (1982) (quotation marks and citations omitted).

20 Here, looking at the statute as a whole requires reading the definition of “prisoner
 21 release order” in conjunction with the requirements for entering one. One such requirement
 22 is that a three-judge court must determine, by clear and convincing evidence, that “crowding

23
 24 ¹¹Indeed, the California Penal Code appears to draw distinctions between a “transfer”
 25 and a “release.” For example, the Interstate Corrections Compact provides that: “Inmates
 26 confined in an institution pursuant to the terms of this compact shall at all times be subject to
 27 the jurisdiction of the sending state and may at any time be removed therefrom for *transfer* to
 28 a prison or other institution within the sending state, for *transfer* to another institution in
 which the sending state may have a contractual or other right to confine inmates, for *release*
 on probation or parole, for discharge, or for any other purpose permitted by the laws of the
 sending state; provided that the sending state shall continue to be obligated to such payments
 as may be required pursuant to the terms of any contract entered into under the terms of
 Article III.” Cal. Penal Code § 11189, Art. IV(c) (emphasis added).

1 is the primary cause of the violation of a Federal right,” before it can enter a prisoner release
2 order. 18 U.S.C. § 3626(a)(3)(E)(i).¹² Consequently, adopting Defendants’ interpretation of
3 “prisoner release order” would mean that a court could only order that prisoners be
4 transferred from one prison to another if overcrowding were the primary cause of the
5 violation of those prisoners’ rights, and not if any other reason were causing the violation.

6 Defendants have failed to point to anything in the legislative history that indicates an
7 intent to limit the protection of inmates’ constitutional rights in this manner – or, more
8 generally, any concern with transfers of inmates between prisons as opposed to release of
9 inmates from prison. To the contrary, “[s]ponsors of the PLRA were especially concerned
10 with courts setting ‘population caps’ and ordering the release of inmates as a sanction for
11 prison administrators’ failure to comply with the terms of consent decrees designed to
12 eliminate overcrowding.” *Gilmore*, 220 F.3d at 998 n.14.

13 More importantly, even if the legislative history did indicate Congressional intent to
14 limit courts’ ability to order inmate transfers in the manner suggested by Defendants, this
15 Court would still be barred from adopting Defendants’ interpretation. Although “Congress is
16 free to alter the standard that determines the scope of prospective relief for unconstitutional
17 prison conditions,” it can do so only “so long as the restrictions on the remedy do not prevent
18 vindication of the right.” *Id.* at 1002-03. It is easy to imagine circumstances – not caused by
19 crowding – where a transfer would be necessary to protect inmates’ constitutional rights: for
20 example, if specialized medical care were not available at a particular prison, or if one or
21 more inmates were illegally transferred in retaliation for exercising their First Amendment
22 rights. More starkly, imagine that a prison were so dilapidated that no one could predict
23 when the walls would crumble down, thus putting inmates’ lives at serious risk, but that
24 Defendants refused to transfer those inmates despite being aware of that risk, in clear
25 violation of the Eighth Amendment. In all of these cases, crowding would not be the cause

26 ¹²In addition, a prisoner release order can only be entered after “a court has previously
27 entered an order for less intrusive relief that has failed to remedy the deprivation of the
28 Federal right sought to be remedied through the prisoner release order” and “the defendant
has had a reasonable amount of time to comply with the previous court orders.” 18 U.S.C.
§ 3626(a)(3)(A)-(B).

1 (let alone the primary cause) of the constitutional violation, and adopting Defendants’
2 interpretation of “prisoner release order” would thus prevent any court – single-judge or
3 three-judge – from entering a transfer order. A single-judge court would be barred from
4 entering the order under 18 U.S.C. § 3626(a)(3)(B), which requires prisoner release orders to
5 be entered by a three-judge court. A three-judge court would likewise be barred under 18
6 U.S.C. § 3626(a)(3)(E)(i), which allows entry of a prisoner release order only if “crowding is
7 the primary cause of the violation of a Federal right.” This would prevent vindication of the
8 inmates’ constitutional rights and would therefore be impermissible.

9 Defendants’ proposed interpretation of “prisoner release order” must therefore be
10 rejected. This Court has the authority to order Plaintiffs’ requested relief if it finds that doing
11 so is warranted – the question to which this Court now turns.

12 **B. Plaintiffs Are Entitled to Relief**

13 As an initial matter, the Court notes that the procedural posture of this case has
14 changed since Plaintiffs filed their original motion. In between the motion’s filing and the
15 date of Plaintiffs’ reply brief, the Receiver promulgated a cocci exclusion policy, and
16 Plaintiffs now request only that the Court order implementation of the Receiver’s policy.
17 Defendants do not argue that the Receiver was acting beyond his authority in promulgating
18 the policy. The question before the Court is therefore whether Defendants should be ordered
19 to follow a policy adopted by the Receiver in the exercise of his authority as head of inmate
20 medical care.

21 Neither party briefed the legal standard that should apply in these circumstances. At
22 oral argument, Plaintiffs suggested that this question is governed by the Court’s September 6,
23 2007 order, which provided that “the Receiver can adapt, modify, eliminate, or create
24 [Policies and Procedures] as the Receivership progresses so long as the alternative Policies
25 and Procedures meet minimum Eighth Amendment standards.” Sept. 6, 2007 Order at 7.
26 Thus, Plaintiffs argued, any policy adopted by the Receiver should be enforced as long as it
27 is reasonable and complies with the Eighth Amendment. Defendants refused to suggest any
28 general standard but argued that, in this case, the policy would be barred because it is a

1 prisoner release order under the PLRA – an argument the Court rejected above – and would
2 also be subject to strict scrutiny as a race-based classification under *Johnson v. California*,
3 543 U.S. 499 (2005). On the latter point, Plaintiffs suggested that Defendants would not
4 have standing to raise the issue, but it logically follows from the Court’s September 6, 2007
5 order, which bars the Receiver from adopting policies that do not satisfy the Eighth
6 Amendment, that the Court should not enforce a policy if either party demonstrates that the
7 policy violates the Constitution. In this case, however, Defendants have not suggested, let
8 alone argued, that the policy would fail under strict scrutiny, and the Court therefore does not
9 reach that issue. Nonetheless, the Court observes that the exclusion policy under
10 consideration is based on risk and not race, and it is therefore distinguishable from the race-
11 based housing policy at issue in *Johnson*. Given the lack of briefing on this issue, and
12 because Plaintiffs are – as explained below – entitled to relief even under the most
13 burdensome standard, the Court does not now decide what standard generally governs the
14 Court’s review of Defendants’ objections to any of the Receiver’s policies.

15 The most onerous standard would require Plaintiffs to demonstrate that the Receiver’s
16 policy must be enforced because failure to do so would result in deliberate indifference under
17 the Eighth Amendment. A plaintiff is entitled to relief for an Eighth Amendment violation if
18 the defendant “knows that inmates face a substantial risk of serious harm and disregards that
19 risk by failing to take reasonable measures to abate it.” *Farmer v. Brennan*, 511 U.S. 825,
20 847 (1994). There is no question here that Defendants are aware of the substantial risk of
21 serious harm; indeed, Defendants admit that they “are aware that Valley Fever presents a
22 serious risk to inmate health,” Opp’n at 10, and it would be impossible to conclude that a
23 disease that, in its severe form, could lead to death does not present a risk of serious harm.
24 The only question is therefore whether Defendants’ current position fails “to take reasonable
25 measures to abate” it.¹³

26 ¹³Defendants spend much time arguing that their prior responses to the cocci problem
27 demonstrate that they are not deliberately indifferent. However, the relevant question is not
28 what Defendants have done in the past; only Defendants’ “current attitudes and conduct” are
at issue. *Farmer*, 511 U.S. at 845-46 (quotation marks and citation omitted). Moreover,
even if this Court were to consider Defendants’ past actions, it would also consider that the

1 As noted above, Defendants have agreed to transfer out of PVSP and ASP inmates
 2 who are classified as high risk under the current medical classification policy, and they have
 3 agreed to do so by August 2013. At oral argument, Defendants’ counsel stated that such
 4 inmates would also not be admitted or transferred into these two prisons, unless Defendants
 5 received a contrary recommendation from the CDC or NIOSH. In addition, Defendants have
 6 not contested the continued enforcement of the Valley Fever transfer list that existed prior to
 7 promulgation of the Receiver’s recent policy.¹⁴ The record is not clear on the medical criteria
 8 required to be put on this list, but the Court presumes, in the absence of any contrary
 9 evidence, that the criteria include at least those that were adopted in 2007 – i.e., inmates with
 10 HIV, a history of lymphoma, a history of solid organ transplant, or moderate to severe COPD
 11 requiring ongoing intermittent or continuous oxygen therapy; inmates undergoing chronic
 12 immunosuppressive therapy (e.g., inmates with severe rheumatoid arthritis); and inmates
 13 receiving chemotherapy treatment for cancer. 2007 Exclusion Policy at 2. Thus, Defendants
 14 have already agreed to transfer the majority of inmates who are at higher risk of severe cocci
 15 disease for medical reasons. The most notable exception is that Defendants have so far
 16 refused to exclude inmates who have been diagnosed with diabetes mellitus.¹⁵

17 Beyond diabetes, the major increased-risk categories identified by the Receiver that
 18 Defendants have refused to exclude are inmates older than 55 years of age and inmates who
 19 are non-White and non-Latino/Hispanic. Defendants ask that the Court do nothing at this
 20 time for these other groups and simply wait for “experts at the Centers for Disease Control
 21 and NIOSH to evaluate these institutions and issue appropriate recommendations.” Opp’n at

22
 23 Receiver was responsible for several of the actions for which Defendants claim credit, and
 24 that Defendants, for unexplained reasons, stopped NIOSH’s efforts to conduct health
 evaluations at PVSP and ASP in 2009.

25 ¹⁴It is not clear whether all inmates on the Valley Transfer list are also classified as
 high risk under the medical classification policy, but there is likely significant overlap.

26 ¹⁵Chronic renal failure and congestive heart failure are also not explicitly listed on the
 27 currently excluded conditions. *Compare* Expert Report at 4 n.11 (listing groups CDCR
 28 agreed to exclude) *with id.* at 14 n.31 (listing risk criteria identified by the American
 Thoracic Society). However, they may be part of the criteria used to determine whether an
 inmate is medically high-risk under the classification system.

1 14-15. They contend that “until these experts have had the opportunity to properly evaluate
2 the problem, any attempt by Plaintiffs to address this problem through exclusion of entire
3 classes of inmates is simply guesswork without much chance of success.” *Id.* at 14.

4 The record does not support Defendants’ conclusion. Far from being “simply
5 guesswork,” every medical expert who has presented evidence in this case – including the
6 Receiver’s medical team; Plaintiffs’ expert, Dr. John Galgiani, whom Defendants do not
7 contest is an expert on cocci; the court experts; and the State Epidemiologist, Dr. Gil Chavez
8 – has concluded both that (1) certain groups of individuals, including African-American and
9 Filipino males and persons with diabetes, are subject to higher risk of severe cocci and
10 (2) the only way to reduce that risk is to reduce the number of inmates in these groups who
11 are housed at PVSP and ASP.¹⁶ The experts also agree that waiting for environmental
12 evaluations by the CDC and NIOSH is likely to take months or years and are likely to lead to
13 “marginal” improvements at best.¹⁷ CDCR states that it is “currently in the process of

14 ¹⁶*E.g.*, Receiver’s 23rd Tri-Annual Report at 29 (noting that “the Receiver employs a
15 team of Public Health experts who have consulted with both the Court’s experts and public
16 health experts from the California Department of Public Health”); Galgiani Decl. ¶ 7
17 (“Persons at increased risk for disseminated disease include African-Americans and
18 Filipinos, those with immunocompromised conditions, and women in the third trimester of
19 pregnancy.”); *id.* ¶ 12 (failure to exclude “African-American prisoners . . . along with
20 Filipinos, Inuits, persons with diabetes, HIV, or any immunocompromising condition . . . will
21 keep these groups at risk of severe complication from new Valley Fever infection”); *id.* ¶ 13
22 (“[A]ll prisoners with chronic medical high risk conditions should be transferred immediately
23 to prisons outside the hyperendemic Valley Fever area because the risk to inmates with these
24 conditions of becoming infected with the form of Valley Fever that leads to serious
25 disseminated disease or death is unacceptably high from a public health standpoint.”); Expert
26 Report at 14 (recommending exclusion of “all populations that meet the American Thoracic
27 Society criteria for increased risk of severe cocci disease”); Chavez Letter at 1 (“A factor that
28 probably contributed to the high rates in these prisons is housing populations of inmates at
risk for severe cocci disease, such as African Americans and persons with diabetes or other
chronic diseases.”); *id.* at 2 (“The populations/groups at risk for severe cocci factor can be
addressed by reducing the number of inmates belonging to these groups in these prisons. . . .
The populations at risk are well known and listed by the American Thoracic Society, but
choosing only some categories to include in the updated policy will be difficult.”).

25 ¹⁷*E.g.*, Galgiani Reply Decl. ¶ 4 (“[T]he chance that [environmental abatement]
26 measures would reduce cocci risk is marginal at best, and in any event it would take many
27 years to determine whether such measures have any value.”); Chavez Letter at 2 (“Further
28 analyses of current data are probably of little additional value toward updating the screening
policy and will take months to carry out. Environmental issues are difficult to address and
will require additional studies and months to years before additional data are available, and
the efficacy of any environmental abatement/control effort implemented will be difficult to
assess.”); Expert Report at 12 (agreeing with Dr. Chavez).

1 identifying and working with nationally-recognized experts on Valley Fever to ensure that
2 any new policies and procedures will be scientifically justified, reasonable and within the
3 national standard of care.” Toche Decl. ¶ 14. However, they have presented no expert
4 testimony to date, nor have they presented any other reason to doubt the currently undisputed
5 medical opinion presented by the Plaintiffs, the Receiver, the court experts, and the State’s
6 own Department of Public Health.

7 Perhaps at one point, Defendants’ wait-and-see approach might have been reasonable.
8 Under current conditions, however, they are not. As the court experts concluded, “[w]hile it
9 is important to involve the public health expertise of the CDC to provide further guidance,
10 given the ongoing morbidity and mortality from cocci, further postponement of previously
11 made public health recommendations shows a callous disregard for patient health and
12 safety.” Expert Report at 12. An exclusion policy is now the only reasonable response:

The most disturbing aspect of defendant’s response to plaintiffs’ Valley Fever motion is that defendants have known since at least 2005 that they are dealing with a public health emergency because of the unfortunate regularity with which Valley Fever deaths are continuing to occur in these two prisons. Public health emergencies require immediate action, not waiting for further study. It is deeply troubling to me that CDCR proposes to deal with this public health emergency by relying on measures which either have not worked in the past or which are unsubstantiated mitigating strategies. In my opinion it will take many years to determine whether certain environmental abatement measures might lower the incidence of disseminated disease and death caused by the existing Valley Fever problem. From a public health standpoint, that is unacceptable. It would seem imperative that prisoners of high risk for serious complications be transferred and excluded from these two prisons as soon as possible.

22 Galgiani Reply Decl. ¶ 6. Defendants acknowledge the serious risk of harm presented by
23 cocci. In light of all of the undisputed medical testimony, waiting for the CDC and NIOSH
24 to complete their reports – which the experts conclude are likely not to be helpful at reducing
25 the risk of harm, especially in the short term – is simply not a “reasonable measure[] to
26 abate” that risk. *Farmer*, 511 U.S. at 847. This is even more true where, as here, the
27 recommendation to exclude inmates at higher risk of severe cocci was first specifically made
28 to Defendants over six years ago; recent studies by the Receiver have demonstrated that,

1 despite education and limited environmental measures, the problem has persisted; and
2 Defendants – for unexplained reasons – four years ago stopped a federal agency from
3 conducting the very study Defendants now say is required before any further action is taken.

4 Likewise, Defendants’ contention that education and training should be increased is a
5 necessary but not sufficient part of the solution. Defendants point to the court experts’ and
6 Dr. Galgiani’s conclusion that four deaths might have been avoided had medical staff at
7 PVSP and ASP diagnosed cocci and begun treatment at an earlier stage. Expert Report at 12-
8 13; Galgiani Decl. ¶¶ 18-19; Defs.’ Resp. to Receiver’s 23rd Tri-Annual Report at 15-17.
9 Rather than demonstrating that an exclusion policy is unnecessary, however, “[t]hese cases
10 show that it is critical that CDCR/CCHCS remove inmates at increased risk for severe cocci
11 disease from prisons in the hyperendemic region *and* improve the ability of clinicians to
12 diagnose and treat new and existing cocci infections.” Expert Report at 13 (emphasis added).
13 Defendants have presented no evidence that additional training would be a reasonable
14 solution in the absence of an exclusion policy, nor have they demonstrated that, even if
15 training were sufficient, inmates would not continue to face an unreasonable risk of harm
16 pending development and completion of such training.

17 The only remaining question is whether the Court should order that the Receiver’s
18 policy be implemented, or whether a different policy would be more reasonable. The
19 Receiver’s promulgated policy is based on statistical analyses of the inmate populations at
20 PVSP and ASP and seeks to exclude all groups of inmates who are at a greater than 50%
21 over baseline risk. This approach raises questions over how baseline and comparison groups
22 should be defined, whether and when the policy would be subject to revisions as data related
23 to cocci cases was updated, and why the exclusionary line should be drawn at 50% versus
24 any other figure.¹⁸ Upon careful consideration, and given Plaintiffs’ agreement at oral

25 ¹⁸The Receiver opted to draw the line at 50% because confidence intervals for
26 categories below 50% ranged from 1.1 to 1.6 or 1.7, meaning that “at the low end of the
27 confidence interval, there is only a 10% increased risk over baseline, which the Receiver
28 concluded is comparatively insignificant, particularly since the upper end of the confidence
intervals for categories above 50% (i.e., African-American, Other race, and Age > 55) are all
greater than 2.0 (i.e., double the risk of the baseline)) [sic], and at the lower end of the

1 argument that they would be satisfied with a policy based either on the Receiver’s analysis or
2 the more narrow risk factors noted by the American Thoracic Society, the Court agrees with
3 the court experts, who “acknowledge that [the Receiver’s] studies provide important
4 information towards better understanding the cocci epidemic at ASP and PVSP” but “believe
5 it is premature to use the findings to modify the list of high-risk populations specified in the
6 nationally accepted, peer-reviewed statement from the ATS.” Expert Report at 14. It may
7 well be that certain groups – for example, those over the age of 55 – face an increased risk of
8 severe cocci in California’s prisons even if they do not face that risk in the general
9 population. However, the Court cannot say that it would be the least intrusive remedy at this
10 time to broaden the policy beyond nationally recognized standards, particularly since none of
11 the other medical experts who have provided opinions in this case have suggested that older
12 inmates face an increased risk.¹⁹ Additionally, although Dr. Galgiani stated that he believed
13 African-American, Filipino, and Inuit inmates needed to be excluded from PVSP and ASP,
14 Galgiani Decl. ¶ 12, his declaration supports only the exclusion of African-American and
15 Filipino inmates; Inuits are not mentioned anywhere except in the cited paragraph and in the
16 preceding paragraph, where Dr. Galgiani notes his understanding “that the Receiver’s staff
17 has agreed that if the decision is made to exclude African-Americans from these two prisons,
18 Filipinos and Inuits should also be excluded,” *id.* ¶ 11.

19 Basing the exclusion policy on national standards also addresses Defendants’ first two
20 of four objections: (1) that the Receiver’s policy is ambiguous because it does not come with
21 an “accompanying procedure that would enable staff to consistently implement and apply the
22 same standards to each inmate-patient” and does not define subjective terms like
23 “significantly increased risk of morbidity and/or mortality from contracting cocci,” and
24 confidence intervals are 20%, 30% and 50% above the baseline, respectively.” Receiver’s
25 Resp. at 10. The Receiver also concluded that excluding African-American but not
26 Latino/Hispanic inmates was supported by a statistical analysis that “shows that African-
Americans, but no other racial group, had a significantly increased risk for disseminated
cocci” at PVSP and ASP. *Id.*

27 ¹⁹The court experts noted that cocci infection “is more common among older adults,
28 particularly those 60 and older,” Expert Report at 2, but did not comment on any increased
risk of severe disease.

1 (2) that the policy excludes all inmates with diabetes, but the Federal Bureau of Prisons only
 2 includes inmates who have Type I diabetes. Toche Letter at 1-2. The American Thoracic
 3 Society criteria include a list of medical conditions and easily identifiable characteristics
 4 such as race, and using such criteria as the basis for an exclusion policy should eliminate any
 5 confusion over how to apply the policy. Additionally, the American Thoracic Society does
 6 not draw a distinction between Type I and Type II diabetes and has concluded simply that
 7 individuals with diabetes – implicitly either Type I or II – are at heightened risk. Defendants
 8 have provided no justification for rejecting the conclusions of the ATS in favor of the policy
 9 adopted by the Federal Bureau of Prisons.

10 Defendants' third objection – that the Receiver's policy does not consider whether
 11 inmates have previously had Valley Fever or long-term exposure to it, *id.* at 2 – is the only
 12 one that warrants a modification to the policy.²⁰ “Individuals with a prior history of cocci are
 13 immune to subsequent infection,” Expert Report at 2, so any such individuals need not be
 14 transferred or excluded from the affected institutions. However, time spent in the
 15 hyperendemic region alone is not a sufficient criteria because “without a skin test, it is
 16 impossible to accurately determine if a specific individual has acquired immunity. For this
 17 reason, using time as a criterion for exclusion is not safe.” *Id.* at 12. If a licensed skin test
 18 becomes available, the Receiver should consider using that test as part of the exclusionary
 19 criteria. Until such a test is available, the only individuals who would otherwise be subject to
 20 the exclusion policy who should be exempt from transfer or exclusion are those who have
 21 previously been diagnosed with cocci.

23 **III. CONCLUSION**

24 In short, Defendants acknowledge that cocci presents a serious risk to inmate health,
 25 yet they propose to take no further action until receiving final recommendations from the

26 ²⁰The Court has already explained that Defendants' fourth objection – that the policy
 27 is overbroad because it includes pregnancy as a criteria for exclusion even though the two
 28 prisons in question only house male inmates, Toche Letter at 2 – is absurd. Pregnancy is one
 of the nationally accepted factors for increased risk, and including it in the policy is
 necessary in case Defendants ever decide to start housing female inmates at PVSP or ASP.

1 CDC and NIOSH at some unknown time, estimated to be approximately six months away.
2 All medical experts who have presented testimony in this case, including the State's own
3 epidemiologist, agree that this response is insufficient, both because further delay would be
4 unreasonable and because environmental evaluations are unlikely to have any short-term
5 effect, assuming that the agencies' recommendations are even implemented.²¹ The experts
6 further agree that the factors for increased risk of severe cocci are well-known and
7 undisputed, and that screening out high-risk inmates is an appropriate response. Indeed,
8 Defendants appear to recognize this, as they have agreed to transfer out and exclude inmates
9 who meet certain medical criteria for increased risk. At the same time, Defendants are
10 unwilling to exclude other inmates whom they know are at an increased risk of severe
11 disease, which may lead to death. Defendants have therefore clearly demonstrated their
12 unwillingness to respond adequately to the health care needs of California's inmate
13 population, which is particularly ironic given Defendants' insistence in other court filings
14 that they are now providing a constitutional level of care. In the absence of a court-ordered
15 exclusionary policy, inmates will continue to suffer unnecessary and unreasonable harm, thus
16 presenting the most recent example of how Defendants lack "the will, capacity, and
17 leadership to maintain a system of providing constitutionally adequate medical health care
18 services to class members." Feb. 14, 2006 Order Appointing Receiver at 7 (setting forth
19 criteria for ending the Receivership).

20 Accordingly, for the reasons discussed above, the Court hereby GRANTS Plaintiffs'
21 motion for relief by ordering Defendants to adopt a modified version of the Receiver's cocci
22 exclusion policy that reflects Defendants' agreement to transfer all inmates who are
23 classified as "high-risk" under the medical classification system and is consistent with the
24 factors identified by the American Thoracic Society as creating an increased risk of severe
25 cocci. Inmates who have previously been diagnosed with cocci shall be exempt from
26 exclusion. The Receiver will modify his exclusion policy consistent with this order, and

27
28 ²¹Given the history of this case, in which recommendations have been repeatedly
ignored, this is not a foregone conclusion.

1 Defendants shall implement the modified policy, within 7 days of the date of this order. All
2 inmates covered by the policy shall be transferred out of PVSP and ASP within 90 days of
3 the date of this order.

4 In addition, the Receiver will request the CDC, as part of its evaluation, to examine
5 the data compiled by the Receiver to determine whether the exclusionary list should be
6 expanded to include any other groups, including individuals over the age of 55, or whether
7 any groups covered by the ATS criteria need not be excluded from PVSP and ASP because
8 they are not empirically at increased risk for severe cocci within the CDCR. The Receiver
9 will have the authority to modify the exclusion policy if the American Thoracic Society
10 changes its criteria for increased risk, if the CDC or NIOSH recommends changes to the
11 policy, or if the Receiver’s data demonstrates that a group covered by the ATS standards
12 does not, based on empirical data, face a heightened risk in the CDCR population. Prior to
13 making any such modifications, the Receiver will first meet and confer with the parties. The
14 Court will resolve any disputes that cannot be resolved by the meet-and-confer process.

15 Finally, consistent with the court experts’ recommendation, IT IS FURTHER
16 ORDERED that all CDCR medical and nursing staff be provided with additional training in
17 the recognition, diagnosis, and treatment of cocci. The Receiver will immediately consult
18 with the court experts to develop such training and to discuss whether any interim measures
19 are necessary before such training has been completed. The Receiver will include a
20 discussion of the response to this order in his next tri-annual report.

21 The Court finds that the above relief is “narrowly drawn, extends no further than
22 necessary to correct the violation of the Federal right, and is the least intrusive means
23 necessary to correct the violation of the Federal right.” 18 U.S.C. § 3626(a)(1)(A).

24

25 **IT IS SO ORDERED.**

26

27 Dated: 06/24/13



THELTON E. HENDERSON, JUDGE
UNITED STATES DISTRICT COURT

28