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Attorneys for Plaintiffs

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

EASTERN DIVISION

RICHARD HART et al., individually and on behalf of all others similarly situated,

Plaintiffs,

v.

STEPHANIE CLENDENIN, Director of California Department of State Hospitals, in her official capacity et al.,

Defendants.

Case No.: 5:20-cv-1559 JGB (KKx)

DECLARATION OF PETER CHIN- HONG, M.D.

Date: TBD
Time: TBD.
Judge: Hon. Jesus G. Bernal
Courtroom: 7D

Compl. filed: 08/05/2020

I, Peter Chin-Hong, M.D., declare:

1. I have been retained by Plaintiffs as an expert witness in the above captioned matter.

Experience and Expertise

1. I am a physician and infectious diseases specialist. I am a professor at University of California, San Francisco (UCSF) School of Medicine as well as Associate Dean for Regional Campuses. I earned my medical degree from Brown University in 1997 and completed my residency/fellowship at UCSF in 2002, specializing in internal medicine and infectious diseases. Among other things, I also serve as Director of the UCSF Infectious Diseases/Immunocompromised Host and Transplant Infectious Diseases Program, and oversee training for pre-doctoral researchers. My curriculum vitae is attached as **Exhibit A.**

2. During COVID-19, I have been one of the leaders of institutional and community education around the disease. I have been part of numerous University initiatives including outreach to the Asian American community (via bilingual webinars, frequent KTSF Channel 26 appearances), and the Association of Black Cardiologists national webinars on the impact of COVID-19 on minority populations. I have had frequent appearances on local TV stations (NBC, ABC, CBS, Fox, KRON) and national TV (CNN, ABC, NBC, Fox business) and international TV (BBC, Sky UK, CNN India, Australian Broadcasting Network, DW Germany). I have made regular radio appearances, including BBC international, KQED and other PBS stations in San Francisco and Los Angeles. I have been solicited by numerous US and international print publications as well (San Francisco Chronicle, Mercury News, LA Times, Washington Post, New York Times, Wall Street Journal, Huffington Post (US, Canada, Australia), Guardia (UK), The Times (UK), The Mail (UK), South China Morning Post (HK), Sydney Morning Herald (Australia)). Clinically, I have been one of the senior COVID-19 clinicians at UCSF. In terms of COVID-19 research, I have been leading and

participating in teams looking at the impact of investigational agents such as remdesivir and convalescent plasma. In terms of managing risks during the COVID-19 pandemic, I have consulted with the San Francisco Opera, the San Francisco Public Defender's Office (to assist with juror safety) and with the State of Hawaii.

3. I served as an expert in *In re Ivan Von Staich*, a California state court case challenging the adequacy of the California Department of Corrections and Rehabilitation's response to a COVID-19 outbreak at San Quentin State Prison.

4. For this declaration, I reviewed documents including the Class Action Complaint, the declarations of DSH-Patton patients, relevant scientific research (including as cited herein), and policies, Protocols & Workflow documents, and data issued by the Department of State Hospitals[1].

SARS CoV2 Background

5. SARS CoV2 is the coronavirus that causes COVID-19. No one has prior immunity. Once a person has been exposed to the virus, they may show symptoms within as little as two days, and his condition might seriously deteriorate in as little as five days (perhaps sooner) after that. The effects of COVID-19 are very serious and can include severe respiratory illness, major organ damage, and, for a significant number of people – particularly those with chronic medical conditions and those over 50 years old – death.

6. COVID-19 is a respiratory virus and primarily spread through respiratory droplets. These droplets usually fall within 3 feet so that a physical distance of 6 feet is recommended to give a cushion of safety. There is likely aerosolization of droplets (making droplets smaller so they may linger longer in the environment) during shouting, screaming and singing, especially in an enclosed space that is a feature of much of DSH-Patton. This is of heightened concern in

[1] Materials on DSH's COVID-19 web site, including Related Links, at https://www.dsh.ca.gov/COVID-19/index.html.

mental health treatment facilities and other institutional settings where patients or detainees may cry out spontaneously or uncontrollably. There are number of examples of virus transmission in these sorts of circumstances.[2]

7. In congregate living facilities like DSH-Patton, outbreaks are also fueled by aerosols (smaller particles) that can remain suspended with virus in the air for far longer periods than regular droplets. This risk is made worse by poor ventilation systems, as appear to exist at DSH-Patton, and the dynamics of the psychiatric hospital settings that create an environment where virus is highly transmissible.

8. According to the U.S. Centers for Disease Control and Prevention (CDC), people with certain medical conditions are at increased risk of severe illness from COVID-19. These conditions include cancer, chronic kidney disease, chronic obstructive pulmonary disease, heart failure, coronary artery disease, cardiomyopathies, type 2 diabetes, sickle cell disease, immunocompromised state from a solid organ transplant, and obesity. There is evidence that other medical conditions might increase risk of severe illness from COVID-19 as well – for example, asthma, hypertension, neurologic conditions such as dementia, and type 1 diabetes.[3]

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[2] Hamner L, Dubbel P, Capron I, *et al.*, *High SARS-CoV-2 Attack Rate Following Exposure at a Choir Practice — Skagit County, Washington*, MMWR Morb Mortal Wkly Rep 2020; 69:606–610 (May 15, 2020), available at https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e6.htm#suggestedcitation; Asadi, S., Wexler, A.S., Cappa, C.D. *et al.*, *Aerosol emission and superemission during human speech increase with voice loudness*, Sci. Rep. 9, 2348 (2019), available at https://doi.org/10.1038/s41598-019-38808-z.

[3] CDC, *Coronavirus Disease-People with Certain Medical Conditions*, available at https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html.

9. In general, older persons, starting at age 50, are at greater risk for severe illness and death from COVID-19 infection.[4]

10. Certain race and ethnic groups have been shown to be at significantly elevated risk of severe illness requiring hospitalization and death – specifically, Black, Latinx, Native American, and Pacific Islander populations. Such risks are estimated to be two to four times higher than the White population.[5]

11. The Substance Abuse and Mental Health Services Administration ("SAMHSA"), an agency within the U.S. Department of Health and Human Services, has identified the high prevalence of CDC-identified risk factors among people with mental health conditions, and recommended that patients with mental health treatment needs be served in community placements to the greatest extent possible during the pandemic, with inpatient psychiatric treatment reserved for patients whose conditions are "life threatening."[6]

12. Other organizations, including the American Medical Association, have also highlighted the grave COVID-19 risks to people in psychiatric hospitals, and encouraged moving people with high-risk medical conditions or advanced age out of locked congregate facilities to protect them from the heightened risk of COVID-19 infection.[7]

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[4] Wei-jie Guan, Ph.D., Zheng-yi Ni, M.D., et al., Clinical Characteristics of Coronavirus Disease 2019 in China,

April 30, 2020, New England J. Med., 382:1708-1720 (Apr. 30, 2020), available at https://www.nejm.org/doi/full/10.1056/NEJMoa2002032.

[5] CDC, *Hospitalization and Death by Race/Ethnicity*, available at https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html.

[6] SAMHSA, *Considerations for the Care and Treatment of Mental and Substance Use Disorders in the COVID-19* (May 7, 2020), available at https://www.samhsa.gov/sites/default/files/considerations-care-treatment-mental-substance-use-disorders-covid19.pdf.

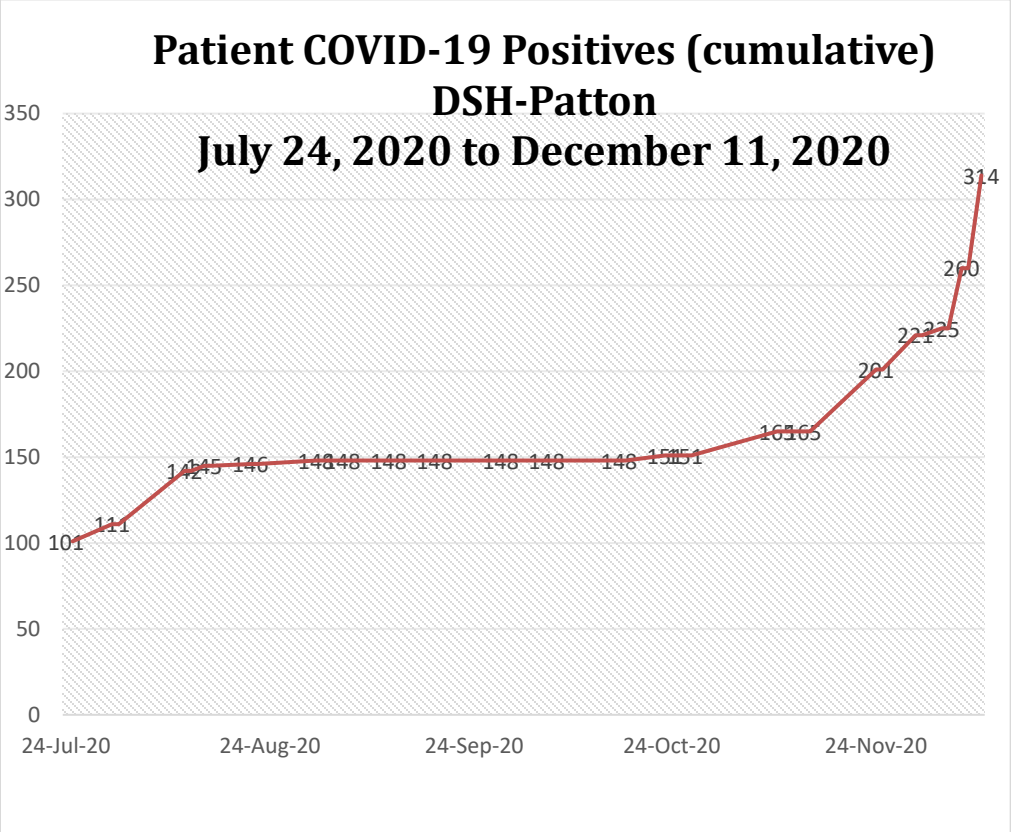
[7] American Medical Association, *AMA policy calls for more COVID-19 prevention for congregate settings* (Nov, 17, 2020), https://www.ama-assn.org/press-center/press-releases/ama-policy-calls-more-covid-19-prevention-congregate-settings; *see also* Judge

My Assessment

13. Since the summer, DSH has posted online, Monday through Friday, a daily tracking chart that shows patient and staff COVID-19 infections and deaths.[8] At my request, Plaintiffs' counsel assisted me in tracking the data posted on this web page and putting the data into a line graph showing the trend of new infections over time. Since May 16, 2020, more than 700 patients across the five DSH psychiatric hospital facilities have tested positive for COVID-19. Nearly half of those patient COVID-19 cases have been at one facility: DSH-Patton. Most alarming, 149 of the 314 positive patient cases reported at the facility have occurred in the last month (November 13 to December 11), including 89 positives in the most recent seven days alone. The graph below shows the data over time.

David L. Bazelon Center for Mental Health Law, *During the Pandemic, States and Localities Must Decrease the Number of Individuals In Psychiatric Hospitals, By Reducing Admissions and Accelerating Discharges*, available at http://www.bazelon.org/wp-content/uploads/2020/04/4-15-20-BC-psych-hospitals-statement-FINAL.pdf ("states, localities, and hospitals should take aggressive action to reduce the number of people confined in psychiatric hospitals" in light of the pandemic); World Federation for Mental Health, *COVID 19 – Greater Protection Needed in Psychiatric Hospitals* (June 1. 2020), available at https://wfmh.global/covid-19-greater-protection-needed-in-psychiatric-hospitals/ ("the WFMH calls on governments to develop clear policies and protocols to ensure greater protection against the increase in infection for patients within psychiatric hospitals where the situation is dire").

[8] DSH, Patient & Staff COVID-19 Tracking, available at https://www.dsh.ca.gov/COVID-19/Patient_and_Staff_COVID-19_Tracking.html.



14. One thing that is striking about this data is that, according to multiple patient reports, a significant number of housing units have been placed on quarantine status since early October 2020. Yet, even with quarantine protocols meant to prevent or slow transmission of the virus, the virus' transmission has accelerated rapidly in recent weeks.

15. The data suggest that the steps that DSH has taken to reduce the impact of COVID-19 at the facility are inadequate, or that the crowded congregate setting itself (without sufficient social distancing, poor ventilation, *etc*.) makes the facility unreasonably dangerous for patients at high-risk for severe COVID-19 illness, or (most likely) both.

16. My review reveals unreasonable risks of mass transmission and infection in a congregate setting like DSH-Patton, and a number of alarming deficiencies about how DSH-Patton is managing the situation. As discussed in greater detail below, DSH's response to the COVID-19 pandemic is inadequate to

protect DSH patients with one or more high-risk factors for severe illness and death from COVID-19.

A. Deficiency 1: DSH-Patton Has Crowded Living Conditions Where Adequate Social Distancing Is Impossible

17. Social distancing is the most elemental of all the precautions that must be taken to prevent or mitigate virus transmission, particularly in congregate settings like DSH-Patton. Without adequate social distancing, and even with other precautions, it is impossible to adequately protect people in congregate institutional settings from virus transmission. In the midst of an outbreak, measures like surveillance testing will not address the crisis without social distancing. It is like checking smoke alarms, but not evacuating, when a building is on fire.

18. The COVID-19 outbreaks at DSH-Patton illustrate this fact. It is impossible for patients to maintain adequate social distancing from other patients or staff in order to protect themselves from transmission of the virus. For months now, even as COVID-19 outbreaks among patients and staff have repeatedly occurred, patients have been required to spend significant time in crowded spaces with dozens of other people – including in shared day rooms, common day halls, and communal bathrooms. Patients have been required to eat in communal dining areas, to stand in crowded medication lines, and to use communal water fountains. Patients report that DSH has reduced or eliminated patient access to outdoor spaces, known to be far safer than indoor spaces when it comes to group gatherings.

19. DSH has itself recognized this risk, writing in their policy guidance document for DSH facilities including DSH-Patton that "Congregate living has the potential for rapid and widespread transmission of COVID-19."[9]

20. Public health officials have advised against these sorts of conditions in the general community, and even imposed bans on some of them (*e.g.*, indoor communal dining, operation of businesses except at greatly reduced capacity).

21. Even to the extent DSH confines people to their bedrooms rather than the 50+ person dayrooms and day halls, including for meals, the risks based on inability to socially distance persist. Consistent with the patients' declarations in this case, DSH's description of bedroom spaces makes clear that bedrooms are congregate spaces: "Within the units the Individuals are assigned to a small room which is similar to a college dorm. The number of Individuals assigned to a room is based on the size of the room (3-5 per room)."[10]

22. Among public health experts, there is general consensus that to meaningfully reduce the risk of virus transmission, congregate institutional settings should operate at no higher than 50% normal capacity. In my opinion, that guidance is absolutely necessary and if anything, overly permissive. The California Department of Public Health's December 3 Regional Stay at Home Order, now in effect in San Bernardino County (where DSH-Patton is located), states that "[i]n order to reduce congestion and the resulting increase in risk of transmission of COVID-19 in critical infrastructure retailers, all retailers may operate indoors at no more than 20% capacity."[11] (The December 6 supplemental

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[9] DSH, *COVID-19 Transmission-Based Precautions and Testing* at 10 (updated Nov. 23, 2020), available at https://www.dsh.ca.gov/COVID-19/docs/TransmissionBasedPrecautions_and_Testing.pdf.

[10] *DSH - Patton: Facilities*, available at https://www.dsh.ca.gov/Patton/Facilities.html.

[11] CDPH, Regional Stay at Home Order, Dec. 3, 2020, available at https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Regional-Stay-at-Home-Order-.aspx.

order allows for operation of grocery stores at no more than 35% capacity.[12]) There is no scientific basis for applying different measures regarding social distancing to congregate living facilities like DSH-Patton, especially in the face of ongoing and sustained viral transmission as is currently the case. Add patient living units (including dorms and bedrooms) should be operating at no more than 50% normal capacity to facilitate adequate social distancing.

23. I am informed that on or about December 7, 2020, DSH activated a surge capacity facility in Norwalk and would be transporting 43 female patients from DSH-Patton to this facility. DSH announced that the facility can be used to house up to 98 DSH patients in order to "provide more bed space at a state hospital for patients who test positive for COVID-19 or have been exposed to the virus."[13]

24. This surge capacity is necessary but far from sufficient. First, it is being used only *after* an untenable number of patients have tested positive at DSH-Patton, rather than being used proactively to facilitate adequate social distancing to mitigate the risk of virus transmission (as should be the case). Second, and in any event, the surge capacity for up to 98 patients is insufficient to facilitate adequate reduction of crowding in the DSH-Patton living areas to allow for necessary social distancing for patients.

B. Deficiency 2: DSH-Patton's Patient Living Areas Lack Adequate Ventilation to Mitigate Transmission Risk

25. Ventilation that allows for adequate air exchange is extremely important to mitigate the risk of virus transmission in indoor settings. Access to

[12] CDPH, Supplement to Regional Stay At Home Order, Dec. 6, 2020, available at https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Regional-Stay-at-Home-Order-.aspx.

[13] DSH, Temporary Use of Southern Youth Correctional Center, Norwalk, for COVID-19 Surge Capacity – FAQ, available at https://www.dsh.ca.gov/Metropolitan/docs/Norwalk_Facility_FAQ_English.pdf.

clean outdoor air is healthiest because it substantially dilutes viruses and other particles. If is necessary to monitor ventilation in indoor congregate settings and to ensure that it is adequate to address the risk of spread of COVID-19 in aerosols. Indeed, there have been several studies highlighting the risk of indoors COVID-19 transmission, even with social distancing, where there is inadequate ventilation.[14]

26. I have significant concerns about inadequate ventilation in the DSH-Patton patient living areas. The DSH protocols/policies that DSH has posted online do not adequately address ventilation needs to mitigate virus transmission risks.

27. Photographs of the DSH-Patton patient living and programming areas suggest that ventilation in these areas is compromised, including with little access to fresh air from outdoors, conditions that increase the risk of virus transmission.[15]

[14] The Lancet Respiratory Medicine, *COVID-19 transmission—up in the air*, 8:12, P1159 (Dec. 1, 2020), available at https://www.thelancet.com/journals/lanres/article/PIIS2213-2600(20)30514-2/fulltext#articleInformation; Kwon KS, Park JI, *et al.*, *Evidence of Long-Distance Droplet Transmission of SARS-CoV-2 by Direct Air Flow in a Restaurant in Korea*, J. Korean Med. Sci., 35(46):e415 (Nov. 2020), available at https://jkms.org/DOIx.php?id=10.3346/jkms.2020.35.e415; Agriland, *Research: Covid-19 can potentially spread over 8m in meat processing facilities* (Aug. 21, 2020), available at https://www.agriland.co.uk/farming-news/research-covid-19-can-potentially-spread-over-8m-in-meat-processing-facilities/.

[15] Source: https://www.dsh.ca.gov/Patton/Facilities.html.

28. Patients report that windows in the patient living area cannot be opened, and are instead locked and secured by metal.

29. This lack of airflow from the outside is inconsistent with public health guidance for indoor spaces where people congregate. It creates additional and unreasonable risks of mass transmission among DSH-Patton patients via

aerosolization and suspension of viral particles, as has been documented in multiple scientific studies.[16]

C. Deficiency 3: DSH-Patton Has Dangerous Quarantine Protocols That Put Patients at Unreasonable Risk of Infection and Harm

30. There have been extensive periods of quarantine based on exposure in multiple units at the DSH-Patton facility. Based on my review, I have significant concern as to the safety of how DSH is managing patient housing units that have potentially been exposed a COVID-19 positive staff person (or anyone else who is positive).

31. While some of DSH's quarantine practices reflect an effort to contain transmission of the virus from an impacted living unit to elsewhere, they suggest an indifference to the risks of the large number of not-yet-infected patients in those quarantined units by making conditions there *more* conducive to mass transmission.

32. For example, patients report that in many cases, even when units have been quarantined based on possible exposure, they have been still been required to eat in communal areas with many other patients. It could very well be the case that a small number of patients were infected by an identified virus exposure, and this practice has meant that they have been likely to further spread the virus to other patients who are not infected. This risk is reduced, but far from eliminated, even if people are confined to their multi-person "college dorm"-like bedrooms.

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[16]Lidia Morawska, Julian W. Tang, *et al.*, *How can airborne transmission of COVID-19 indoors be minimised?*, Environment International, Vol. 142, 105832 (Sept. 2020), available at https://www.sciencedirect.com/science/article/pii/S0160412020317876; Peter de Man, Sunita Paltansing, *et al.*, *Outbreak of Coronavirus Disease 2019 (COVID-19) in a Nursing Home Associated With Aerosol Transmission as a Result of Inadequate Ventilation*, Clinical Infectious Diseases (Aug. 2020), available at https://doi.org/10.1093/cid/ciaa1270.

33. Patients also report that when on quarantine, their access to the outdoors is restricted even beyond the generally limited outdoor access at the facility. Again, more time in the poor-ventilation indoor living areas only increases risk of virus transmission.

34. Congregate COVID-19 infection units create additional and unreasonable risk to patients. Multiple patients who have been infected describe being held in congregate dorm-like units filled with infected patients. This practice puts infected patients at even greater risk of bad health outcomes. For example, there is evidence that a COVID-19-infected person can be placed at further risk by being exposed to additional virus, as transmitted from other COVID-19 positive people. A COVID-19-infected person's condition can be made worse by exposure to other illness, including influenza or any other transmissible illness.[17]

35. DSH's internal guidance documents recognize this multiple-infection issue as well, noting that "[p]atient[s] can be infected with COVID-19 and other respiratory viruses such as Influenza and [Respiratory Syncytial Virus] at the same time."[18]

[17] Kim D, Quinn J, Pinsky B, Shah NH, Brown I. *Rates of Co-infection Between SARS-CoV-2 and Other Respiratory Pathogens*, Journal of the American Medical Association (JAMA), 323(20):2085–2086 (Apr. 2020), available at https://jamanetwork.com/journals/jama/fullarticle/2764787; Iacobucci Gareth, *Covid-19: Risk of death more than doubled in people who also had flu, English data show*, BMJ 2020; 370 :m3720 (Sept. 2020), available at https://www.bmj.com/content/370/bmj.m3720.

[18] DSH, *COVID-19 Transmission-Based Precautions and Testing* at 16 (updated Nov. 23, 2020), available at https://www.dsh.ca.gov/COVID-19/docs/TransmissionBasedPrecautions_and_Testing.pdf.

D. Deficiency 4: DSH-Patton Is Failing to Provide Adequate Patient Information and Education, Causing Enormous Stress and Compromising Transmission Prevention Efforts

36. Education on COVID-19 risks and prevention practices, and transparency about current institutional outbreaks and precautions, is extremely important to manage a COVID-19 outbreak. It is a fundamental ethical principle in health care to effectively communicate with patients about information that is relevant to their health and safety.

37. The materials I have reviewed point to a significant deficiency with respect to the lack of information and guidance being provided to patients. Patients consistently report that they are relying on TV news reports to find out about COVID-19 risks, precautions, etc. As one patient states, "I don't know what to believe. There is a lot of confusion about what is going on [about COVID-19]."

38. Several patients report that when their units are quarantined following an exposure, they are not informed of the quarantine (instead relying on happenstance and informal conversation with staff to find out what is happening). They are also not provided with adequate guidance about how to protect themselves from transmission, or how to monitor themselves for symptoms of infection.

39. The failure to ensure transparency and to provide important COVID-19 information to people in locked facilities like DSH-Patton causes enormous stress to those in confinement. It also substantially undermines transmission prevention efforts.

E. Deficiency 5: DSH-Patton's Practice of Allowing Staff Floating Unreasonably Increases Transmission Risks

40. Facility staff are a primary vector of transmission into locked congregate facilities, whether a psychiatric facility, a jail, a prison, or an

immigration detention center. At DSH-Patton, more than 100 DSH staff and non-DSH personnel working inside the facility have tested positive since early November 2020. Staff adherence to transmission precautions, and appropriate use of personal protective equipment (PPE) are absolutely essential to protect patients at the facility.

41. Staff floating across multiple units creates an unreasonable risk. The materials I have reviewed make apparent that DSH-Patton facility staff "float" among multiple units, either during a single shift or over sequential shifts in which they work overtime. Staff move between quarantine units where there is an identified exposure and non-impacted housing units, which creates an unnecessary risk of further spread.

42. The COVID-19 protocols/policies that DSH has posted do not adequately address the risks of staff floating through the facility, in and out of multiple patient living units, including between units that are quarantined and those that are not.

43. This staff floating practice has alarmed many DSH-Patton patients, and with good reason. For example, public health experts recently criticized San Quentin State Prison officials for allowing staff to work in multiple units at the prison, including medical isolation units and non-impacted dorms. The expert group identified this as "an enormous risk for the spread of COVID-19 between units," and concluded that "Staff Cohorting is a necessity" at the facility.[19]

44. The CDC guidance on correctional detention facilities similarly advises administrators to "make every possible effort to modify staff assignments to minimize movement across housing units and other areas of the facility. For example, ensure that the same staff are assigned to the same housing unit across

[19] AMEND & U.C. Berkeley Public Health, *Urgent Memo, COVID-19 Outbreak: San Quentin Prison* (June 15, 2020), available at https://amend.us/wp-content/uploads/2020/06/COVID19-Outbreak-SQ-Prison-6.15.2020.pdf.

shifts to prevent cross-contamination from units where infected individuals have been identified to units with no infections."[20]

45. This necessity applies no less at DSH-Patton as a congregate mental health facility, especially given the current mass outbreak. The risk of avoidable transmission across units is of added concern given that some people who have and can transmit the virus are asymptomatic. Effective cohorting helps to protect both patients and staff by reducing exposure across groups. It also makes contact tracing and quarantining more feasible when there is an outbreak.

F. Deficiency 6: DSH-Patton Staff Do Not Consistently Adhere to Face Covering Protocols, Which Unreasonably Increases Transmission Risks

46. Many patients report that facility staff do not adhere to good face covering practices, often not wearing masks properly or pulling their masks down from their face in DSH patient living areas.

47. Just as public health officials have imposed strict face covering requirements in public places across California, and just as store owners require employees to adhere to face covering requirements, DSH needs to do more to ensure that facility staff consistently adhere to public health guidance and mandates on this topic.

G. Deficiency 7: DSH-Patton Does Not Provide Adequate Access to Necessary Cleaning Supplies for Patients to Protect Themselves

48. Effective cleaning and disinfection practices in congregate facilities are important to reduce the risk of virus transmission and to reinforce good hygiene practices.

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[20] CDC Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities (updated Dec. 3, 2020), available at https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html.

49. Patients report problems with distribution of and access to cleaning and sanitizing supplies that are essential to combat transmission, particularly in a high-risk congregate setting like the DSH-Patton living areas.

50. Patients describe dirty and unsanitary surfaces in their living areas, as well as lack of access to sanitizing wipes, sanitizer, hand soap, and the like. They describe unduly restrictive practices in the distribution of these cleaning supplies. Such supplies should be placed inside the living areas for ready access, which appears often not to be the case.

H. Vaccination of Staff Will Not End the Risk of Mass Transmission and Infection Among DSH-Patton Patients

51. Public health officials and pharmaceutical companies have announced that distribution of COVID-19 vaccines are likely on the horizon. However, distribution and supply remain an enormous challenge to delivering vaccines to the public. There remain many unanswered questions as to the timeline and processes for vaccine administration. Two vaccine doses, spread several weeks apart, will likely be required for the vaccine to take full effect, which will add to any timeline of vaccine roll-out. Scientific evidence indicates that full protection may not exist until as long as 28 days after the second vaccine dose is administered. I understand that health care workers will likely be prioritized in some way for receipt of the vaccine, though the details remain unclear.

52. Vaccination of DSH staff will be an important step to address the terrible public health crisis but will not eliminate the heightened risks to DSH-Patton patients. First, and again, the timeline to full vaccination of health care workers generally, and DSH staff specifically, remains unknown and speculative. It should be expected that full vaccination will take a significant period of time due to the logistical challenges and the extended timeline to achieve protection against infection. In addition, public health experts recommend that staff vaccinations be

staggered, given the evidence of temporary side effects from the vaccine that could cause large workforce absenteeism.

53. Second, even if DSH staff receive vaccinations, there will continue to be other vectors for transmission into the DSH-Patton patient population, including (but not limited to) non-DSH personnel working at the facility, DSH-Patton patients transported outside for health appointments or other off-site activities, and new patient intakes.

54. Third, the durable protection from infection, illness, and particularly transmission that vaccination delivery may provide remains uncertain. The science is hopeful, but speculative.

55. In short, until public health data affirmatively demonstrate that the risk of COVID-19 transmission and severe illness has abated, there is no scientific basis for refraining from any and all available measures to prevent virus transmission, especially in congregate facilities like DSH-Patton.

I. DSH-Patton Patients Who Have Tested Positive for COVID-19 Are Still at Unreasonable Risk Even After Recovery

56. I understand that some of the plaintiffs in this case, and a significant number of other DSH-Patton patients who have risk factors for severe COVID-19 illness, have tested positive for COVID-19. It is important to note that immunity may be short-lived, setting the stage for potential reinfection even after recovery. In one recent study from UCLA, antibody levels fall substantially in as little as three months. Not all those who become infected develop antibodies in the first place, putting those at increased risk of reinfection. The proportion of the population with measurable antibodies supports this hypothesis. In one study published, by early June 2020 only 5% of the population in Connecticut and 24% of the population in New York had measurable antibodies, which is remarkable given the COVID-19 surge in the tri-state area of NY, NJ and CT at the time.

While much of the focus has been on keeping uninfected people from becoming infected, there is evidence that already infected patients could be exposed to additional virus, setting the stage for a recurring infection and further bad health outcomes. Even if this phenomenon is not widespread, the risk does remain and it is not known who may be impacted.

57. Even after someone in a high-risk congregate facility like DSH-Patton tests positive and (hopefully) recovers, it is important to protect them from risks of re-infection, including by addressing risks at the facility to the greatest extent possible and, whenever practicable, by moving them to a less dangerous setting where they can continue to receive appropriate services and supports.

J. Especially When Clinically Indicated Treatment Cannot Be Provided, It Is Difficult to Justify Confining Someone with Mental Health Needs in a Congregate Setting Where the Risk of COVID-19 Infection Is Unreasonably High

58. Those in a hospital setting are there to receive clinically indicated treatment – whether medical or mental health treatment, it should not matter.

59. I understand that treatment programming at DSH-Patton has been significantly reduced for several months now, with some programming put entirely on hold. The purpose of a psychiatric hospital is to provide necessary, clinically appropriate treatment to the patients it has. Where treatment is or cannot be delivered in a congregate health care facility (especially where the placement is on an involuntary basis, as it is at DSH-Patton), the elevated risk to health from COVID-19 in such a setting is hard to justify.

60. Without provision of clinically indicated treatment, an involuntary mental health treatment facility becomes little more than a detention facility, like a jail or a prison.

61. For patients who can do well in a less congregate or non-congregate setting, all available steps should be taken to move them there, both to address the elevated COVID-19 infection risk and to provide services to meet individual treatment needs. Under present conditions, no high-risk patient who can be appropriately served in a safer setting should confined in a congregate facility like DSH-Patton.

I declare under penalty of perjury that the foregoing is true and correct. Executed at San Francisco, California, on December 14, 2020.

Date: 12/14/20

Peter Chin-Hong

Peter Chin-Hong, M.D.