No. 21-16696

IN THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

MARCIANO PLATA, *et al.*,

Plaintiffs-Appellees,

v.

GAVIN NEWSOM, ET AL.,

Defendants-Appellants,

J. CLARK KELSO,

Receiver-Appellee.

On Appeal from the United States District Court for the Northern District of California (Case No. 4:01-cv-01351-JST)

BRIEF OF *AMICUS CURIAE* AMERICAN COLLEGE OF CORRECTIONAL PHYSICIANS IN SUPPORT OF PLAINTIFFS-APPELLEES

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Case **Page(s)**

Other Authorities

INTEREST OF *AMICUS CURIAE*[1]

The American College of Correctional Physicians, formerly known as The Society of Correctional Physicians, was founded in 1993. Its purpose is to support the interests of the providers who care for those incarcerated in correctional facilities of all types. This includes jails, juvenile facilities, and state and federal prisons. ACCP's members have dedicated their medical careers to ensuring those incarcerated receive the quality of medical, mental, and dental care mandated by the United States Constitution. ACCP members are united through the goal of improving public health by examining issues specific to the incarcerated and identifying solutions for medical professionals. ACCP meets those goals through education, advocacy, networking, and avenues of communication. ACCP therefore has a strong interest in promoting public health and reducing the spread of COVID-19, particularly in

[1] *Amicus* certifies that no party's counsel authored this brief in whole or in part, no party or party's counsel contributed money intended to fund this brief, and no person other than *Amicus*, its members, and its counsel contributed money intended to fund this brief. Pursuant to Federal Rule of Appellate Procedure 29(a)(2), all parties have consented or stated that they have no objection to the filing of this brief.

correctional facilities, where surges in COVID-19 infection affect both ACCP members and their patients.

INTRODUCTION

The United States is in an unprecedented and ongoing public health crisis as it battles COVID-19—a battle that can be won only with widespread vaccination. SARS-CoV-2, the causative agent of COVID-19, has wreaked havoc in communities across the country, taxed hospitals to the point of rationing care, upended the lives of countless families, and killed over 853,000 Americans, including more than 77,000 Californians. As of this filing, California alone is currently averaging more than 108,000 new cases each day.[2]

The dangers and upheaval caused by COVID-19 are particularly acute in correctional facilities: as of January 20, there are nearly 5,500 active cases among people incarcerated in California's correctional facilities, and nearly 250 people have died.[3] ACCP's extensive review of the medical literature demonstrates that COVID-19 vaccines authorized or approved by the U.S. Food and Drug Administration are safe and effective, and that the widespread use of those vaccines is the best way

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[2] *See Tracking COVID-19 in California*, California ALL (last updated Jan. 20, 2022), https://bit.ly/3ns3T2p.

[3] *Population COVID-19 Tracking*, Cal. Dep't of Corrections & Rehabilitation (last updated Jan. 20, 2022), https://bit.ly/3zZKL0t.

to keep COVID-19 from spreading within carceral settings. This Court should therefore defer to the fact-finding below and affirm the district court's well-reasoned opinion requiring vaccination among workers with access to California's correctional facilities.

ARGUMENT

I. COVID-19 Poses a Grave Danger to the Health of People Who Are Incarcerated.

COVID-19 presents a severe risk to public health. Although most people infected with the virus will experience mild to moderate symptoms, individuals with COVID-19 can become seriously ill or die at any age. As of January 20, 2022, there have been more than sixty-seven million confirmed cases of COVID-19 in the United States,[4] leading to more than 3,919,000 hospitalizations[5] and more than 853,000 deaths—more than twenty-three times the number of people in the United States who die from influenza in the average year.[6]

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[4] *COVID Data Tracker*, CDC, https://bit.ly/3Du7Glz (last visited Jan. 20, 2022).

[5] *COVID Data Tracker Weekly Review*, CDC (Jan. 14, 2022), https://bit.ly/3EYAdAb.

[6] *See Disease Burden of Flu*, CDC (Oct. 4, 2021), https://bit.ly/3ocAuZA.

Californians account for more than six million of those COVID-19 cases, and over 77,000 Californians have died from COVID-19.[7] And incarcerated Californians account for more than 59,000 cases; nearly 250 incarcerated Californians have died.[8] To put these numbers in perspective, approximately 18% of Californians overall have contracted COVID-19 over the course of the pandemic,[9] while the number of incarcerated Californians who have contracted COVID-19 is more than 60% of the current incarcerated population.[10] The proportion of incarcerated youth who have COVID-19 *on the date of this filing* (approximately 20%) is higher than the proportion of Californians who have had it at any point since the beginning of the pandemic.[11] Put

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[7] *See Tracking COVID-19 in California*, *supra* note 2.

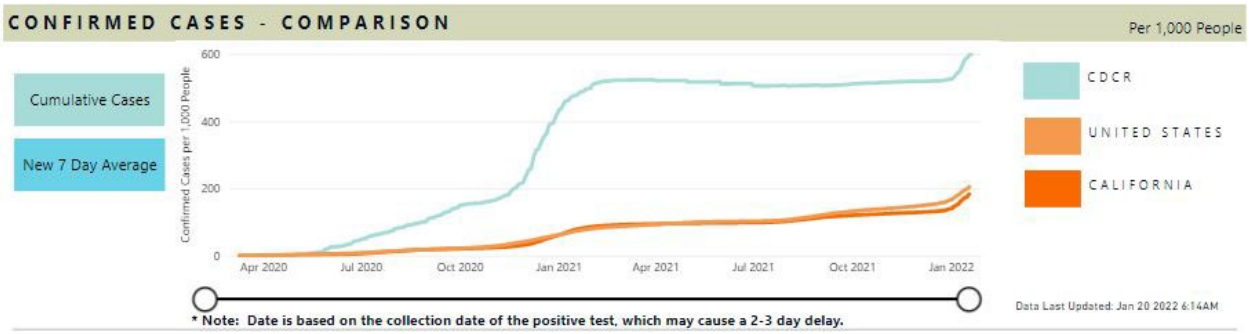
[8] *Population COVID-19 Tracking*, *supra* note 3.

[9] *Compare Tracking COVID-19 in California*, *supra* note 2 (listing 6,997,710 cases in California), *with QuickFacts: California*, U.S. Census Bureau, https://bit.ly/3FqPREi (last visited Jan. 20, 2022) (listing California population as 39,237,836).

[10] *Compare Population COVID-19 Tracking*, *supra* note 3 (listing 59,815 CDCR patients), *with id.* at CDCR Vaccination Tracker tab (listing total CDCR patient population as 98,651).

[11] *Compare Pandemic Response at DJJ*, Cal. Dep't of Corrections & Rehabilitation, https://bit.ly/3AfaAKb (last visited Jan. 20, 2022) (reporting that as of January 19, 2022, there are 134 active cases among youth in the Department of Juvenile Justice), *with* Byrhonda Lyons, *COVID cases triple in California juvenile prisons*, Cal Matters (Jan. 12,

another way, Californians who are incarcerated in state facilities have been more than three times as likely to contract COVID-19 than Californians in general:[12]



As these numbers indicate, SARS-CoV-2 is highly transmissible. The original strain was more contagious than the flu, and the Delta variant of SARS-CoV-2, the leading strain until recent weeks, is more than twice as contagious as previous variants.[13] The surging Omicron variant—which now accounts for more than 99.5% of new cases in the United

2022), https://bit.ly/3GuujrA (noting that about 650 individuals are incarcerated in California's juvenile justice system).

[12] *See Population COVID-19 Tracking*, *supra* note 3.

[13] *Delta Variant: What We Know About the Science*, CDC (Aug. 26, 2021), https://bit.ly/3plAmcy; Apoorva Mandavilli, *C.D.C. Internal Report Calls Delta Variant as Contagious as Chickenpox*, N.Y. Times (July 30, 2021), https://nyti.ms/3EtJXTb.

States—appears to be more contagious still.[14] Crucially, more than 50% of the spread of the virus may be from individuals who have no symptoms at the time of transmission.[15]

The disproportionate rate of COVID-19 among incarcerated persons is unsurprising, because "[r]esidential institutions have long been associated with an increased risk of infectious diseases."[16] Correctional institutions, like cruise ships and nursing homes, "can be considered high risk for amplifying infectious diseases such as COVID-19, because the conditions that prevent disease dissemination are nearly impossible to achieve."[17] Indeed, correctional institutions present even higher risks than cruise ships, the original COVID-19 hot spots, because correctional

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[14] *Omicron Variant: What You Need to Know*, CDC (last updated Dec. 20, 2021), https://bit.ly/327xwyr; *COVID Data Tracker: Variant Proportions*, CDC (last visited Jan. 20, 2022), https://bit.ly/3snnhk7.

[15] *Science Brief: Community Use of Masks to Control the Spread of SARS-CoV-2*, CDC (last updated Dec. 6, 2021), https://bit.ly/30inWYx.

[16] Mary Devereaux Hutton et al., *Tuberculosis in Nursing Homes and Correctional Facilities: Results of a 29-State Survey*, CDC, at 2 (Nov. 1990), https://bit.ly/3I51ySJ; *see also, e.g.*, Joseph A. Bick, *Infection Control in Jails and Prisons*, 45 Clinical Infectious Diseases 1047 (2007), https://bit.ly/3qrND34.

[17] Philip D. Sloane, *Cruise Ships, Nursing Homes, and Prisons as COVID-19 Epicenters: A 'Wicked Problem' With Breakthrough Solutions?*, 21 J. Am. Med. Dirs. Ass'n 958 (July 2020), https://bit.ly/3KfJBmC.

staff function as "a vector of disease transmission between the community and incarcerated individuals because they are in the community for a large percentage of their time, [but] pierc[e] the membrane of the prison daily as they go to and from work."[18] Correctional staff are thus "an avenue for COVID-19 to enter the prison, whether at the beginning of a pandemic or during successive waves."[19]

As a result, "staff members' COVID-19 prevalence . . . ha[s] a direct relationship on the prevalence of COVID-19 among incarcerated individuals."[20] Transmission among staff in correctional facilities has been a major factor in the spread of COVID-19 to people incarcerated.[21] Indeed, one comprehensive analysis of federal prisons concluded that "rising case rates inside federal prisons have been driven increasingly by

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[18] Danielle Wallace et al., *Is There a Temporal Relationship Between COVID-19 Infections among Prison Staff, Incarcerated Persons and the Larger Community in the United States?*, 18 Int'l J. Env't. Rsch. Pub. Health 6873 (June 26, 2021), https://bit.ly/3I2ttmk.

[19] *Id.*

[20] *Id.*

[21] Laura Hawks et al., *COVID-19 in Prisons and Jails in the United States*, 180 JAMA Internal Med. 1041 (Apr. 28, 2020), https://bit.ly/3fqrpZb ("[P]eople who are incarcerated will be at higher risk of exposure, as correctional officers and other staff frequently leave the facility and then return.").

infections among staff, rather than among incarcerated people."[22] In California, in the first ten days of January alone, the number of California prison employees testing positive for COVID-19 increased by 212%, to more than 3,800.[23]

Even those who recover from COVID-19 may experience debilitating symptoms lasting for several months or more after the acute phase of infection. A systematic review of forty-five studies found that 73% of infected individuals experienced at least one long-term symptom.[24] Another, more recent systematic review of fifty-seven studies found that more than half of COVID-19 survivors experienced post-acute sequelae

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[22] Alix M.B. Lacoste et al., *Fast, frequent, and widespread: COVID-19 outbreaks inside federal prisons*, UCLA Law COVID Behind Bars Data Project, at 2 (Nov. 2021), https://bit.ly/34DQY6L.

[23] Richard Winton, *More than 3,800 California prison staffers have coronavirus amid massive surge this month*, L.A. Times (Jan. 10, 2022), https://lat.ms/3zZ5uBy.

[24] Tahmina Nasserie et al., *Assessment of the Frequency and Variety of Persistent Symptoms Among Patients With COVID-19: A Systematic Review*, JAMA Network Open (May 26, 2021), https://bit.ly/3qocFkk; *see also* Karen B. Jacobson et al., *Patients With Uncomplicated Coronavirus Disease 2019 (COVID-19) Have Long-Term Persistent Symptoms and Functional Impairment Similar to Patients with Severe COVID-19: A Cautionary Tale During a Global Pandemic*, 73 Clinical Infectious Diseases e826 (Feb. 6, 2021), https://bit.ly/3FD32Ch ("'Long COVID' has been reported in 87% of hospitalized patients two months post-infection and in 53% of non-hospitalized patients 125 days after diagnosis.").

(that is, chronic complications of an acute condition) six months after recovery, including difficulty concentrating, generalized anxiety disorder, general functional impairments, and fatigue or muscle weakness.[25] Studies also indicate that COVID-19 is associated with increased risk of adverse neurological and psychiatric outcomes.[26]

People incarcerated in California are more likely than the rest of the population to have comorbidities that put them at higher risk for severe outcomes: for example, the rates of asthma and HIV among people incarcerated in California are twice as high as those among Californians in general.[27] What's more, transmission in carceral settings carries additional consequences beyond the risk of infection: when prisons are

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[25] Destin Groff et al., *Short-term and Long-term Rates of Postacute Sequelae of SARS-CoV-2 Infection: A Systematic Review*, 4 JAMA Network Open e2128568 (Oct. 13, 2021), https://bit.ly/3qskBjR.

[26] Maxime Taquet et al., *6-month neurological and psychiatric outcomes in 236379 survivors of COVID-19: a retrospective cohort study using electronic health records*, 8 The Lancet Psychiatry 416 (Apr. 6, 2021), https://bit.ly/3DXTbGo.

[27] Heather Harris, *Severe COVID-19 Infections May Threaten California's Prisons*, Pub. Pol'y Inst. of Cal. (Mar. 27, 2020), https://bit.ly/3ns3gWm; *see also, e.g.*, Elizabeth M. Viglianti et al., *Mass Incarceration and Pulmonary Health: Guidance for Clinicians*, 15 Annals Am. Thoracic Soc'y 409, 409–12 (Jan, 30, 2018), https://bit.ly/3rvWosf (identifying lung-related conditions that disproportionately affect incarcerated persons).

facing outbreaks, they are likely to cancel visitation and order lockdown of facilities, leading to significant isolation and detrimental psychological effects.[28] COVID-19 therefore poses a grave danger to the health and safety of people who are incarcerated above and beyond the already significant risk faced by the general public.

II. Vaccines Provide a Safe and Effective Way to Help Reduce Transmission of COVID-19 in Carceral Settings.

COVID-19 vaccines are safe. Before FDA authorized/approved, and the Centers for Disease Control and Prevention recommended use of, the COVID-19 vaccines in the population, scientists conducted extensive clinical trials. FDA, CDC, and their advisory committees then conducted rigorous reviews of the data, and they continue to monitor the vaccines'

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[28] *See* Stephen Stock et al., *San Quentin Prison Faces New COVID Outbreak, Sparking Fears of 2020 All Over Again*, NBC Bay Area (last updated Jan. 14, 2022), https://bit.ly/3trIU3E; Natalie Hanson, *San Quentin, state prisons locked down amid COVID outbreak*, Marin Indep. J. (last updated Jan. 12, 2022), https://bayareane.ws/3npyddI; *see also* Lucy Wainwright & Donna Gipson, *The Impact of Lockdown to Mental Health: A Summary of Patient Views*, EP:IC, https://bit.ly/3zYt2Xt (finding that 84% of patients in closed prisons in the United Kingdom reported deteriorating mental health during COVID-19 lockdown); ACCP, *Restricted Housing of Mentally Ill Inmates*, https://bit.ly/3noyePc ("Many patients with mental illness, such as depression, can be expected to worsen as a result of isolation imposed by restricted housing.").

safety.[29] A study of more than six million people who received the Pfizer or Moderna vaccines found that serious side effects are very rare.[30] Further, a study concluded that there is no increased risk for mortality among recipients of any of the COVID-19 vaccines, and that vaccine recipients had lower non-COVID-19 mortality risks than did unvaccinated people.[31]

COVID-19 vaccines are also effective. First, each of the three vaccines greatly reduces the likelihood of contracting SARS-CoV-2. The Pfizer, Moderna, and J&J/Janssen vaccines have been found to be 91.3%, 90%, and 72% effective against infection by prior variants, respectively,

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[29] *Benefits of Getting a COVID-19 Vaccine*, CDC (last updated Jan. 11, 2022), https://bit.ly/3H6BsiF; Nicola P. Klein et al., *Surveillance for Adverse Events After COVID-19 mRNA Vaccination*, 326 JAMA 1390 (Sept. 3, 2021), https://bit.ly/3F1XQYM; *COVID-19 vaccine safety surveillance*, FDA (Dec. 7, 2021), https://bit.ly/3y1dDET.

[30] Klein et al., *supra* note 29.

[31] Stanley Xu et al., *COVID-19 Vaccination and Non–COVID-19 Mortality Risk — Seven Integrated Health Care Organizations, United States, December 14, 2020–July 31, 2021*, 70 Morbidity & Mortality Weekly Rep. 1520, 1520–24 (Oct. 29, 2021), https://bit.ly/3D1ZRn4. Although the CDC recently recommended the Pfizer or Moderna vaccines over the J&J/Janssen vaccine, the CDC's advisory committee made clear that "receiving any vaccine is better than being unvaccinated." Press Release, CDC, *CDC Endorses ACIP's Updated COVID-19 Vaccine Recommendations* (Dec. 16, 2021), https://bit.ly/3yzUTfJ.

including the most common variants at the time of the district court's decision.[32] And studies uniformly demonstrate that COVID-19 vaccine regimens that include a booster are effective even against the novel Omicron variant, which has a higher immune evasion than its predecessors.[33] (For comparison, the flu vaccination reduces the risk of flu illness by between 40% and 60%.[34]) In California, as the following chart demonstrates, between January 3 and January 9, 2022, people who were unvaccinated were 4.1 times more likely to contract COVID-19 than people who were fully vaccinated:[35]

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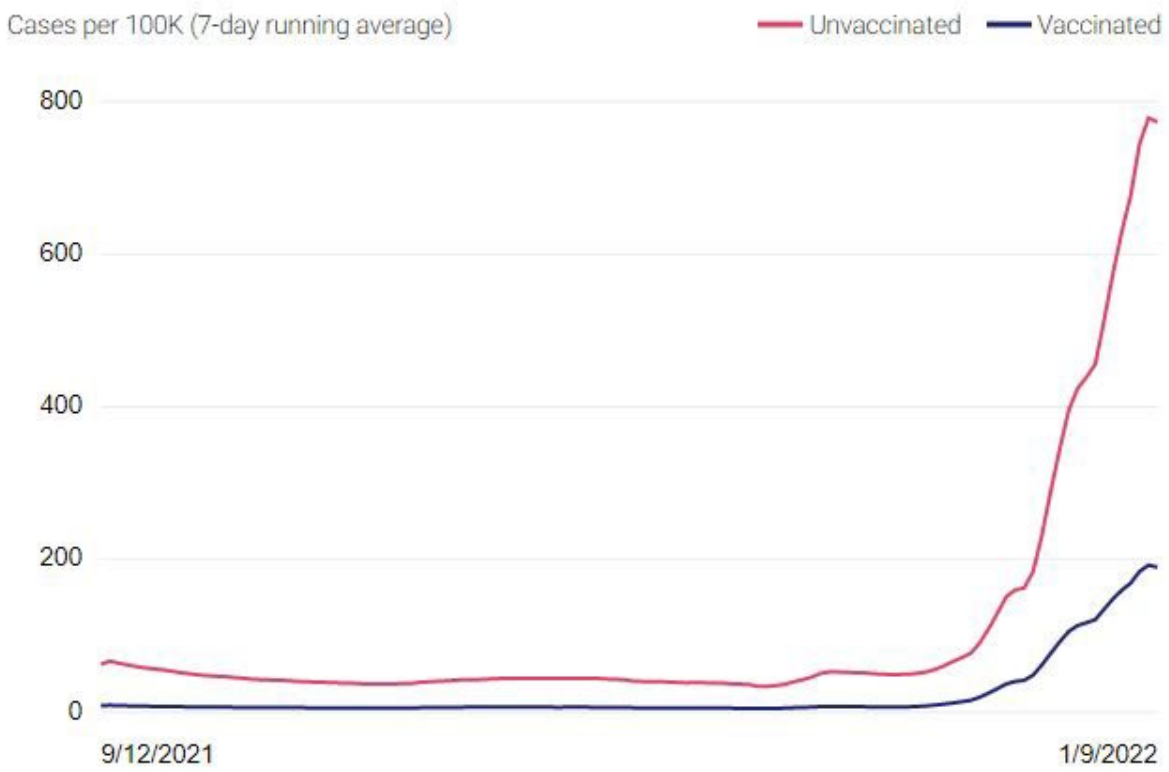
[32] Kathy Katella, *Comparing the COVID-19 Vaccines: How Are They Different?*, Yale Med. (updated Jan. 10, 2022), https://bit.ly/307jEU5. Scientists are still learning about how effective the vaccine is against the Omicron variant.

[33] *See, e.g.*, Sara Oliver, *Updates to the Evidence to Recommendation Framework: Pfizer-BioNTech Vaccine Booster Doses in 12–15 Year Olds*, CDC (Jan. 5, 2022), https://bit.ly/3zROHAl (collecting recent studies). The uncontrolled spread of the virus in areas with low immunization rates, however, certainly raises the risk that a fully vaccine-resistant strain will one day emerge.

[34] *Vaccine Effectiveness: How Well Do Flu Vaccines Work?*, CDC (last visited Jan. 20, 2022), https://bit.ly/3HifLMP.

[35] *See Tracking COVID-19 in California*, *supra* note 2.

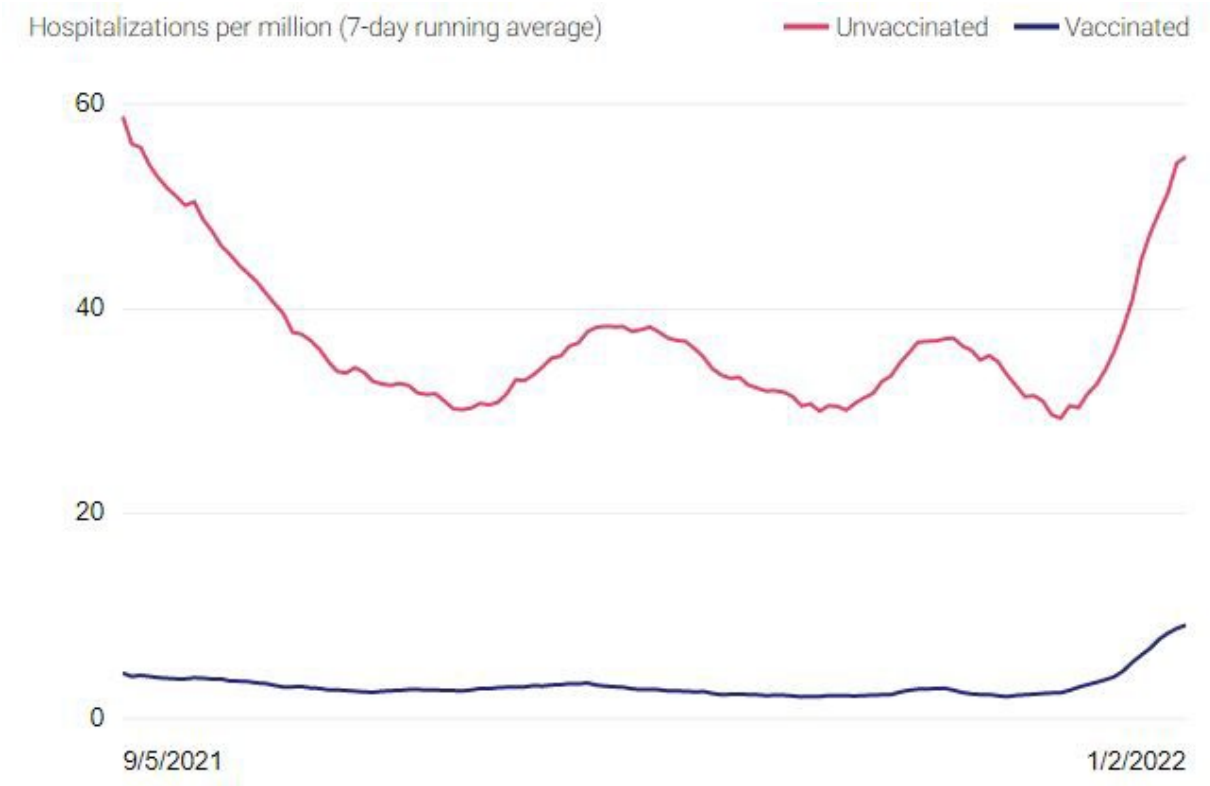


Second, each of the three vaccines is even more effective against serious illness and death. Studies have estimated the Pfizer, Moderna, and J&J/Janssen vaccines as 95.3%–97%, 95%, and 86% effective against severe disease, respectively.[36] The vaccines are likewise highly effective against hospital admissions, "even in the face of widespread dissemination of the delta variant."[37] And although research into the

[36] Katella, *supra* note 32.

[37] Sara Y. Tartof et al., *Effectiveness of mRNA BNT162b2 COVID-19 Vaccine Up to 6 Months in a Large Integrated Health System in the USA: A Retrospective Cohort Study*, 398 Lancet 1407, 1407 (Oct. 4, 2021), https://bit.ly/3ouPvqS.

effect of Omicron is ongoing, preliminary results suggest that the Pfizer vaccine remains 70% effective against hospitalization, even before a booster dose.[38] As this chart reflects, between December 27, 2021, and January 2, 2022, Californians who were unvaccinated were 6 times more likely to be hospitalized with COVID-19 than those who were fully vaccinated:[39]



[38] Shirley Collie et al., *Effectiveness of BNT162b2 Vaccine against Omicron Variant in South Africa*, New Eng. J. Med., Correspondence (Dec. 29, 2021), https://bit.ly/3qrESpW.

[39] *See Tracking COVID-19 in California*, *supra* note 2.

And across the country, as of November 27, 2021, the age-adjusted rate of COVID-19-associated hospitalizations in unvaccinated adults was more than 17 times that of fully vaccinated adults.[40]

Even vaccinated people who are hospitalized for COVID-19 have a significantly lower risk of death than do unvaccinated people. A study found that, among patients hospitalized with the Delta variant, "[t]he crude risk for COVID-19-related death in fully vaccinated persons was sevenfold lower than that among unvaccinated COVID-19 patients."[41] Although research regarding vaccine efficacy against the Omicron variant is still developing, initial reports suggest that vaccination, including a booster, remains efficacious against severe disease, and lowers a person's risk of dying from COVID-19 at every step.[42] In

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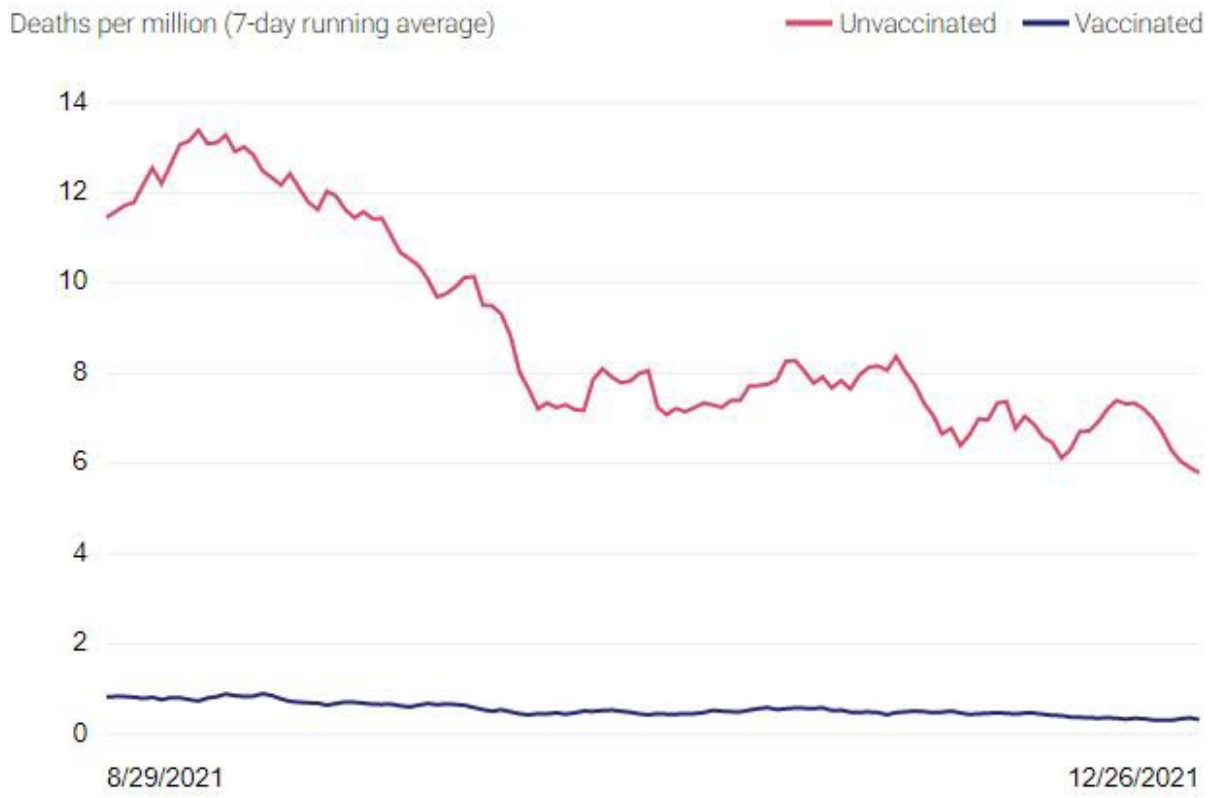
[40] *See Rates of laboratory-confirmed COVID-19 hospitalizations by vaccination status*, CDC (last updated Jan. 13, 2022), https://bit.ly/3oIwsZ4.

[41] Allison L. Naleway et al., *Incidence of SARS-CoV-2 Infection, Emergency Department Visits, and Hospitalizations Because of COVID-19 Among Persons Aged ≥12 Years, by COVID-19 Vaccination Status — Oregon and Washington, July 4–September 25, 2021*, 70 Morbidity & Mortality Weekly Rpt. 1608, 1609 (Nov. 19, 2021), https://bit.ly/3F05RwX.

[42] *See* Carl Zimmer & Sheryl Stolberg, *New Studies Raise Hopes That Vaccines Prevent Severe Disease From Omicron*, N.Y. Times (Dec. 15, 2021), https://nyti.ms/3H3uCd4.

California, between December 20 and December 26, 2021, people who were unvaccinated were 17.8 times as likely to die from COVID-19 as fully vaccinated people:[43]



Third, although still developing, evidence suggests that those who are fully vaccinated are contagious for shorter periods than unvaccinated people. A study found that viral loads of the Delta variant declined more rapidly in infected people who had been vaccinated, indicating that vaccinated people are contagious for shorter periods of time than

[43] *See Tracking COVID-19 in California*, *supra* note 2.

unvaccinated people.[44] Moreover, it logically follows that unvaccinated people pose a higher risk of transmission than do those who are vaccinated, because they are more likely to contract COVID-19 in the first place. Thus, vaccination protects not only people who are vaccinated, but also those they encounter.

III. The More Staff Who Get Vaccinated, The Safer Carceral Settings Become.

The more carceral workers who get vaccinated, the closer we are to slowing the spread of the virus and creating a safer environment. As the American Medical Association has explained, "[t]he only way to truly end this pandemic is to ensure *widespread* vaccination."[45] "By limiting viral spread, vaccination also minimizes opportunities for the introduction of more infectious variants through random mutation."[46] Widespread

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[44] Po Ying Chia et al., *Virological and serological kinetics of SARS-CoV-2 Delta variant vaccine breakthrough infections: a multicentre cohort study*, Clinical Microbiology & Infection (Nov. 22, 2021), https://bit.ly/3ENkd4a.

[45] Press Release, American Medical Ass'n, *AMA, AHA, ANA urge vaccinations as U.S. reaches 750,000 COVID-19 deaths* (Nov. 4, 2021), https://bit.ly/3C07CIS (emphasis added).

[46] *Vaccination to Prevent COVID-19 Outbreaks with Current and Emergent Variants — United States, 2021*, CDC (July 27, 2021), https://bit.ly/3oFcakp.

vaccination is the only practical way to push the effective reproduction rate of the SARS-CoV-2 virus below one, the rate at which endemic transmission begins to die out.

Widespread vaccination reduces the likelihood of infections among both vaccinated and unvaccinated people. During the wave of Delta infections, "states with high vaccination rates (>70% of the population) . . . report[ed] lower numbers of vaccine breakthrough cases as well as hospitalizations and deaths from COVID-19."[47] An analysis found that "[i]n the presence of high community prevalence of Covid-19, nursing homes with low staff vaccination coverage had higher numbers of cases and deaths than those with high staff vaccination coverage."[48] Widespread vaccination is particularly important for people who cannot get vaccinated due to age or medical condition, as well as immunocompromised people, who remain particularly susceptible to

[47] Carlos del Rio et al., *Confronting the Delta Variant of SARS-CoV-2, Summer 2021*, 326 JAMA 1001, 1002 (Aug. 18, 2021), https://bit.ly/3bVL5Cj.

[48] Brian E. McGarry et al., *Nursing Home Staff Vaccination and Covid-19 Outcomes*, New Eng. J. Med., Correspondence (Dec. 8, 2021), https://bit.ly/3pQ7O9H.

infection even after vaccination.[49] This is particularly critical in carceral settings, where people who are at high risk—or for whom vaccination may not be effective—are unable to choose to socially distance themselves from unvaccinated corrections officers and other prison workers, with whom they come into close contact. Contrary to California's argument, App. Br. at 36–37, simply permitting, or even requiring, people who are incarcerated to receive the vaccine is not sufficiently protective if they are forced to closely encounter workers with low vaccination rates on an ongoing basis.

History has shown that vaccine requirements are critical to achieving the degree of vaccination necessary to curb or eradicate infectious disease. Countries or states that mandated smallpox vaccination saw 10 to 30 times fewer smallpox cases than those that declined to do so.[50] Before compulsory school vaccination laws were in place throughout the United States, states with strict vaccination requirements had incidence

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[49] Katherine Lontok, *How Effective Are COVID-19 Vaccines in Immunocompromised People?*, Am. Soc'y for Microbiology (Aug. 12, 2021), https://bit.ly/3F24HBh.

[50] Rajaie Batniji, *Historical Evidence to Inform COVID-19 Vaccine Mandates*, 397 Lancet 791 (Feb. 27, 2021), https://bit.ly/3Fl2ykM.

rates of measles less than half those of states that did not.[51] But as a result of increased vaccine hesitancy, 2019 saw "the greatest number of [measles] cases reported in the U.S. since 1992."[52] While such outbreaks predominantly affect vaccine-hesitant individuals or their children, they can also harm vaccinated individuals or those too young to receive the vaccine: 13% of measles cases in 2019 were among infants too young to receive the vaccine, and 11% had received one or more shots (but may not have yet received the full regimen).[53]

Like other infectious diseases, COVID-19 spreads in communities with fewer vaccinated individuals, even if they are within or adjacent to communities with a higher proportion of vaccinated individuals. The more people who share a workspace who are vaccinated, the better protected all workers—vaccinated and unvaccinated alike—will be.

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[51] Kevin M. Malone & Alan R. Hinman, *Vaccination Mandates: The Public Health Imperative and Individual Rights*, in Law in Public Health Practice 262, 269 (1st ed., 2003), https://bit.ly/3BUviyg.

[52] *Measles Cases and Outbreaks*, CDC (updated Jan. 3, 2022), https://bit.ly/3ffkJ00.

[53] Manisha Patel, et al., *National Update on Measles Cases and Outbreaks—United States, January 1–October 1, 2019*, 68 Morbidity & Mortality Wkly. Rep. 893 (Oct. 11, 2019), https://bit.ly/3qiROOF.

California suggests that a vaccine requirement will lead corrections officers to simply quit en masse, resulting in staffing shortages and a less safe environment for people incarcerated. But even if that parade of horribles were to occur—although it has not in the institutions already covered by vaccination requirements, *see* 2-ER-50—California misses the broader point. The high number of COVID-19 infections among corrections officers is *itself* causing a staffing shortage, as the District Court noted, 1-ER-14, one that will not abate until the vaccination rate is sufficiently high. It is the unchecked spread of COVID-19, rather than vaccination requirements, that poses the major risk to staffing levels at carceral facilities and the safety of those residing there.

IV. Widespread Vaccination Is the Most Effective Way to Protect People Who Live and Work in Carceral Settings from COVID-19.

The statistics on COVID-19 vaccine efficacy speak for themselves. No other measure has been shown to reduce the risk of infection, hospitalization, and death to the degree that vaccination does. The science is clear: no arguments against the need for vaccination are medically valid, other than to accommodate a medical contraindication.

Natural immunity—the immunity against SARS-CoV-2 that develops following recovery from infection—is not an adequate substitute for vaccination.[54] Infection, unlike vaccination, carries a significant risk of death or serious illness. Moreover, vaccination better protects previously infected people against reinfection. Although research into Omicron is still developing, studies of prior variants have shown that unvaccinated people are at least twice as likely to become reinfected as are vaccinated people.[55] And studies show that the COVID-19 vaccines "can be given safely to people with evidence of a prior SARS-CoV-2 infection."[56]

The district court's order appropriately includes all workers in correctional facilities, including those who are unlikely to come into close

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[54] *See* Catherine H. Bozio et al., *Laboratory-Confirmed COVID-19 Among Adults Hospitalized with COVID-19-Like Illness with Infection-Induced or mRNA Vaccine-Induced SARS-CoV-2 Immunity — Nine States, January–September 2021*, 70 Morbidity & Mortality Weekly Rep. 1539 (Nov. 5, 2021), https://bit.ly/3kvoBwR (finding 5.49 times higher odds of laboratory-confirmed COVID-19 among previously infected, unvaccinated patients than among fully vaccinated patients).

[55] Alyson M. Cavanaugh et al., *Reduced Risk of Reinfection with SARS-CoV-2 After COVID-19 Vaccination — Kentucky, May–June 2021*, 70 Morbidity & Mortality Weekly Rep. 1081 (Aug. 13, 2021), https://bit.ly/306e4Bg.

[56] *Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Approved or Authorized in the United States*, CDC (last updated Jan. 7, 2022), https://bit.ly/3rwXkNf.

contact with people who are incarcerated. California argues that the order is "overbroad" because it includes "workers who are not CDCR employees and those who do not directly interact with incarcerated persons." App. Br. at 35. But the SARS-CoV-2 virus does not distinguish between the technicalities of whether an individual in prison is an employee or a contractor. And even if an individual worker is unlikely to come into contact with incarcerated people himself, he is still in a position to spread COVID-19 to his fellow workers, who may then infect incarcerated people in turn.

Other mitigation measures, such as mask wearing and social distancing, remain important. They do not, however, provide the same level of protection against COVID-19 as vaccination. Although masks can be highly effective at limiting the transmission of SARS-CoV-2 in non-carceral settings, mask mandates appear to be "associated with only a small decline in infections among incarcerated persons."[57] The other elements of a layered prevention strategy are often impossible in carceral settings, where "[a] lack of space in prison inhibits social distancing, cohorting prisoners (i.e., limiting movement in prison to smaller groups

[57] Wallace, *supra* note 18.

of prisoners at a time), creating areas for hand washing or sanitization, and medical isolation."[58] And although testing protects workers better than no requirement at all, it does not rise to the level of protection that widespread uptake of vaccinations would provide. "[I]n short, even with strong infection control policies in place, correctional staff are associated with infection spread within prisons."[59] As the district court found, "Defendants have pointed to no measure or combination of measures that offers the incarcerated population the same level of protection as the vaccine mandates recommended by the Receiver," 1-ER-16, and that factual finding merits deference, *see Brown* v. *Plata*, 563 U.S. 493, 513 (2011).

California is therefore incorrect in its position that these mitigation strategies—absent vaccination—are sufficient. *See* App. Br. at 23. Indeed, California has already demonstrated its belief that masking and testing measures provide an insufficient standard of care in congregate settings, evidenced by the fact that the State has instituted vaccination

[58] *Id.*

[59] *Id.*

mandates for both schoolchildren[60] and healthcare workers, even requiring booster shots for the latter.[61] And although California now argues that it is "overbroad" for the district court's order to encompass prison workers who are not CDCR employees, or who do not come into direct contact with people who are incarcerated, App. Br. at 35, the State vaccination requirement for healthcare workers encompasses both of those categories: non-employees, and workers who do not come into direct contact with patients.[62] California does not offer an explanation for its apparent view that patients in prisons merit a lower standard of care than those in the general population.

Although it is true that, as California argues, "millions of Californians risk contracting COVID-19 from unvaccinated individuals when they report to work, shop for food, or otherwise go about their daily lives," App. Br. at 23, the State fails to recognize a critical distinction: those Californians are choosing to take that risk. Many others—particularly

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[60] *California Becomes First State in Nation to Announce COVID-19 Vaccine Requirements for Schools*, Office of Gov. Gavin Newsom (Oct. 1, 2021), https://bit.ly/3qsQHwb.

[61] *State Public Health Officer Order of December 22, 2021*, Cal. Dep't of Public Health (Dec. 22, 2021), https://bit.ly/3HZAWCC.

[62] *Id.*

those who are immunocompromised or otherwise at high risk for severe complications from infection—have chosen to work remotely and curtail their social interactions. People who are incarcerated do not have the luxury of those choices and should not be forced to encounter unvaccinated individuals in cramped settings that have already been proven to lead to outsized infection rates. Immediate, widespread vaccination of prison workers against COVID-19 is the surest way to protect people who are incarcerated.

CONCLUSION

For the reasons stated above and in Plaintiffs-Appellees' and Receiver-Appellee's filings, the ACCP urges this Court to affirm the decision below.

Respectfully Submitted,

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UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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