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13 IN THE UNITED STATES DISTRICT COURT
 14 FOR THE CENTRAL DISTRICT OF CALIFORNIA
 15 WESTERN DIVISION – FIRST STREET COURTHOUSE
 16

17
 18 **MATTHEW BRACH, et al.,**
 19 Plaintiffs,
 20 v.
 21 **GAVIN NEWSOM, in his official**
 22 **capacity as the Governor of**
 23 **California, et al.,**
 Defendants.

Case No. 2:20-cv-06472 SVW (AFMx)

**MEMORANDUM OF POINTS
 AND AUTHORITIES IN
 OPPOSITION TO APPLICATION
 FOR TEMPORARY
 RESTRAINING ORDER (Dkt. 28)**

Date: August 17, 2020
 Time: 1:30 p.m.
 Courtroom: 10A - Telephonic
 Judge: The Honorable Stephen
 V. Wilson
 Trial Date: Not set
 Action Filed: 7/21/2020

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INTRODUCTION

The State of California, like the rest of the world, is combatting a public health emergency of a magnitude unseen for at least a century. SARS-CoV-2, the novel coronavirus causing the novel coronavirus disease-2019 (COVID-19) that is spreading rapidly throughout the country, has infected more than 4.6 million Americans and killed over 150,000, and those numbers grow on a daily basis. COVID-19 has devastated the lives of its victims and their families. It has imposed significant costs and burdens on Californians who are all making sacrifices in the face of this unprecedented challenge.

Against this backdrop, and facing widespread surges of COVID-19 in many parts of the State, on March 4, 2020, Governor Gavin Newsom proclaimed a state of emergency and, on March 19, 2020, issued an executive order directing all Californians to heed State public health directives. Since that time the California Department of Public Health has issued multiple public health directives to combat this unprecedented pandemic, including, on July 17, 2020, an emergency order and related guidelines limiting in-person instruction at schools operating in a county on the State’s Monitoring List due to high rates of COVID-19.

Plaintiffs, who are parents of children who attend school in California and one student, allege that the Orders and Guidance violate their constitutional and statutory rights. In contending that the order and guidance are not based on scientific data, plaintiffs rely on their inaccurate and outdated beliefs that school-age children do not spread COVID-19, and that opening schools for in-person instruction in counties with high COVID-19 rates poses a negligible health risk. Yet COVID-19 knows no age boundaries. People of all ages, including children, are susceptible to the disease. There is currently no proven vaccine or widely effective treatment. More importantly, a large percentage of people infected with COVID-19 have no symptoms, but can still unknowingly spread it.

1 In the early stages of the pandemic, when scientific knowledge about COVID-
2 19 was limited, COVID-19 was incorrectly believed to have minimal effect on
3 children of any age. Although children with COVID-19 do not always exhibit the
4 same signs and symptoms as adults, it is now the scientific consensus that children
5 are not only susceptible to the disease, but may experience uniquely severe
6 complications as a result. In fact, California saw its first pediatric death, of a
7 teenager, late last month.¹ One of the most well-known of those complications is
8 multisystem inflammatory syndrome (“MIS-C”), which can cause serious
9 symptoms for children, including severe inflammation affection multiple organ
10 systems, and even death. See National Institutes of Health, Special Considerations
11 in Children (updated Jun. 11, 2020), accessed at
12 <https://www.covid19treatmentguidelines.nih.gov/special-populations/children/>. It
13 is now suspected that positive cases and deaths in children related to COVID-19
14 may have been mis-identified, and “[w]ithout widespread testing, including for
15 mild symptoms, the true incidence of severe disease in children is unclear.” *Id.*

16 Moreover, because children may spread the virus throughout the community
17 in the same manner as adults, they must be factored into the community-wide
18 efforts to control the spread of COVID-19. There are approximately 6.5 million
19 school-age children in California. Thus, widely reopening schools for in-person
20 instruction in counties with high rates of COVID-19 would result in a significant
21 amount of new movement throughout the community of students, parents, and
22 school employees as they travel to and from school, and a mixing of individuals
23 from various households, with students and teachers together in groups indoors for
24 extended periods of time. These results would create substantial new risks of
25 transmission of COVID-19 in the community.

26 California’s public health officials—trained doctors, scientists and other

27 _____
28 ¹ See <https://www.cdph.ca.gov/Programs/OPA/Pages/NR20-179.aspx> (last
accessed August 8, 2020).

1 medical professional—are expressly charged with protecting the health and safety
2 of *all* Californians. For that reason, courts have recognized that, as the experts who
3 are accountable for the public welfare, they are entitled to wide discretion in
4 enacting necessary public-health measures, and where those broad limits are not
5 exceeded, they should not be second-guessed by an “‘unelected federal judiciary,’
6 which lacks the background, competence, and expertise to assess public health and
7 is not accountable to the people.” *S. Bay United Pentecostal Church v Newsom*,
8 591 U.S. ___, 140 S. Ct. 1613, 1613-1614 (2020) (Roberts, CJ, concurring) (*South*
9 *Bay III*); see also *Calvary Chapel Dayton Valley v. Sisolak*, 591 U.S. ___, 2020 WL
10 4251360, at *11 (U.S. July 24, 2020) (Kavanaugh, J, dissenting) (“Under the
11 Constitution, state and local governments, not the federal courts, have the primary
12 responsibility for addressing COVID–19 matters such as quarantine requirements,
13 testing plans, mask mandates, phased reopenings, school closures, sports rules,
14 adjustment of voting and election procedures, state court and correctional institution
15 practices, and the like.”).

16 As every federal court to consider this question with respect to California’s
17 orders has concluded, the Governor’s current emergency order and the related
18 public-health orders and guidelines regarding school reopening are a legitimate
19 exercise of the State’s police powers and are entitled to deference by this Court.
20 *Jacobson v. Commonwealth of Mass.*, 197 U.S. 11, 25 (1905). Even without
21 *Jacobson* deference, Plaintiffs have failed to articulate, let alone substantiate, a
22 cognizable violation of their constitutional rights. Plaintiffs assert that State
23 officials have violated their alleged fundamental right to a basic education under the
24 Fourteenth Amendment’s substantive due process clause, but no such right has been
25 recognized. Even if such a right exists, plaintiffs have not established that there is a
26 fundamental right to an *in-person* education. The challenged state orders and
27 guidance do not stop education all together, but rather call for temporary
28 implementation of distance learning for schools in counties where high rates of

1 community spread of COVID-19 represent dangers to all citizens. Plaintiffs have
 2 also failed to show a likelihood of success on their equal protection claim, and have
 3 no likelihood of success on their claims for violation of Title VI of the Civil Rights
 4 Act and the federal disability-related statutes because binding precedent forecloses
 5 those claims. Nor have Plaintiffs shown that the remaining equitable factors favor a
 6 TRO. If anything, the State and its residents would be irreparably harmed by the
 7 relief Plaintiffs seek because schools open to in-person instruction will inevitably
 8 result in outbreaks in California, which will have a cumulative impact on the spread
 9 of the disease, hospitalization rates and increased death rates.

10 The Court should deny the application for a temporary restraining order.

11 BACKGROUND

12 I. COVID-19 AND CALIFORNIA’S RAPID RESPONSE TO CONTAIN IT

13 COVID-19 is a highly contagious and deadly infectious disease, which can be
 14 readily transmitted when people gather in groups outside the home. *See* Decl. of
 15 James Watt (“Watt Decl.”) ¶¶ 12-13, 18. COVID-19 has infected more than 18
 16 million people and caused the deaths of around 691,000 people worldwide.² In the
 17 United States alone, COVID-19 has infected over 4.8 million people and caused the
 18 deaths of over 150,000 people nationwide, with over 10,000 in California.³ As of
 19 August 7, 2020, there have been 538,416 confirmed COVID-19 cases in the State,
 20 Watt Decl. ¶17.)

21 The novel coronavirus that causes this highly infectious and frequently fatal
 22 disease spreads through respiratory droplets that remain in the air or on surfaces,
 23 and may be transmitted unwittingly by individuals who exhibit no symptoms.

24 _____
 25 ² *See* World Health Organization, Coronavirus Disease (COVID-19)
 Situation Report No. 197 (August 4, 2020),
 26 <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports/> (last accessed August 4, 2020).

27 ³ *See* Cases in U.S., <https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html> (last accessed August 6, 2020) and cases in California,
 28 <https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/ncov2019.aspx> (last accessed Aug. 8, 2020).

1 *South Bay III*, 140 S. Ct. at 1613 (Roberts, C.J., concurring). There is no known
2 cure, no widely effective treatment, and no vaccine. *Id.* Consequently, measures
3 such as physical distancing that limit physical contact are the only widely
4 recognized way to slow the spread. *Gish v. Newsom*, No. EDCV20-755-JGB
5 (KKx), 2020 WL 1979970, at *4 (C.D. Cal. Apr. 23, 2020); Watt Decl. ¶ 16.

6 California responded early and decisively to combat and contain the COVID-
7 19 threat. In early December 2019, the State began working closely with the
8 national Centers for Disease Control and Prevention, the United States Health and
9 Human Services Agency, and local health departments to monitor and plan for
10 spread of COVID-19 to the United States. Request for Judicial Notice (RJN), Ex.
11 A.1. The California Department of Public Health began providing COVID-19
12 related guidance to hospitals, clinics, and other health providers. *Id.*

13 On March 4, 2020, the Governor proclaimed a State of Emergency in
14 California, making additional resources available to combat the emergency and help
15 the State prepare for the broader spread of the disease. RJN, Ex. A.1. On March
16 19, the Governor issued Executive Order N-33-20, the Stay-at-Home Order, which
17 required “all individuals living in the State of California to stay home or at their
18 place of residence except as needed to maintain continuity of operations of the
19 federal critical infrastructure sectors,” *id.*, Ex. C, and the Public Health Officer
20 subsequently designated a list of “Essential Critical Infrastructure Workers” under
21 the Order, *id.*, Ex. C.

22 On April 28, 2020, the Governor announced a “Resilience Roadmap” to guide
23 the gradual and safe reopening of the State. RJN, Ex. D. The Roadmap had four
24 stages: (1) safety and preparation; (2) reopening of lower-risk workplaces and other
25 spaces; (3) reopening of higher-risk workplaces and other spaces; and (4) an end to
26 the Stay-at-Home Order. *Id.*, Ex. D.5. To implement the Roadmap, on May 4,
27 2020, the Governor issued Executive Order N-60-20, providing that all California
28 residents are to continue complying with the Stay-at-Home Order and that the State

1 Public Health Officer shall establish criteria and procedures for qualifying local
2 jurisdictions to move more quickly through Stage 2 of the Roadmap. *Id.*, Ex. E.2-3.

3 On May 7, 2020, based on her review of current data, the State Public Health
4 Officer issued an order moving the State into Stage Two, stating that she would
5 “progressively designate sectors, businesses, establishments, or activities that may
6 reopen with certain modifications, based on public health and safety needs” and at
7 “a pace designed to protect public health and safety.” RJN, Ex. F.2 (¶ 2).

8 Guidance governing the reopening of in-person instruction at schools as part of
9 Stage 2 was initially released on June 5, 2020, see *id.*, Ex. D.8, with other sectors
10 reopening in phases throughout June.

11 In response to the recent surge in COVID-19 positive rates in late June to early
12 July, the State Public Health Officer, on July 13, 2020, issued an order closing,
13 statewide, certain activities that had been permitted to reopen under the Roadmap,
14 and closing additional indoor activities in counties on the state’s County
15 Monitoring List. See RJN, Ex. H.1-2. The Public Health Officer noted that,
16 particularly in counties on the County Monitoring List, “the risks and impacts of
17 disease transmission are even greater.⁴ The science suggests that for indoor
18 operations the odds of an infected person transmitting the virus are dramatically
19 higher compared to an open-air environment. Thus, for those counties on the list, it
20 is necessary to close indoor operations for additional sectors which promote closed-
21 space mixing of populations beyond households and/or make adherence to physical
22 distancing with face coverings difficult.” *Id.*, Ex. H.2; *see also id.*, Ex. I.3-4
23 (“Guidance on Closure of Sectors in Response to COVID-19”).

24
25 ⁴ The California Department of Public Health uses six indicators to track the level
26 of COVID-19 infection in each California county as well as the preparedness of the
27 county health care system—data that includes the number of new infections per
28 100,000 residents, the test positivity rate, and the change in hospitalization rate,
among others. A county that does not meet the State’s benchmarks is put on the
County Monitoring List. See RJN, Exs. R and S.

1 On July 17, 2020, the Department of Public Health issued its COVID-19 and
2 Reopening In-Person Learning Framework for K-12 Schools in California, 2020-
3 2021 School Year. RJN, Exs. J, OO. It updated its previously issued School Sector
4 Specific Guidelines to specify that “[s]chools and school districts may reopen for
5 in-person instruction at any time if they are located in a local health
6 jurisdiction (LHJ) that has not been on the county monitoring list within the
7 prior 14 days.” RJN, Ex. J.1 (emphasis in original). The guidance noted that a
8 waiver of the criteria “may be granted by the local health officer for elementary
9 schools to open for in-person instruction.” *Id.* The waiver request must be made
10 by the superintendent or equivalent for charter and private schools. *Id.*

11 On August 3, 2020, the Department of Public Health again updated its
12 guidance to schools. RJN, Ex. K. It has also issued an FAQ and additional
13 documents to assist schools who may seek a waiver. See *id.*, Exs. L-P. The
14 materials additionally explain that, “[b]ased on the current best available scientific
15 evidence, COVID-related risks in schools serving elementary-age students (grades
16 TK-6) are lower than and different from the risks to staff and to students in schools
17 serving older students.” Specifically, “there appears to be lower risk of child-to-
18 child or child-to-adult transmission in children under age 12,” and a lower risk of
19 infection and serious illness in younger children. RJN, Exs. L.4, M.1.

20 II. THE PRESENT ACTION

21 On July 21, 2020, before the Department of Public Health had time to update
22 its school guidance documents and waiver process, the plaintiff parents and one
23 child filed their complaint against Governor Gavin Newsom, Attorney General
24 Xavier Becerra, Director of the California Department of Public Health, Sonia
25 Angell, and State Superintendent of Public Instruction Tony Thurmond. Pls.
26 Comp., ECF No. 1. On July 29, 2020, Plaintiffs filed the operative First Amended
27 Complaint (Pls. First Am. Compl. (FAC), ECF No. 9), adding additional parent
28 plaintiffs and modifying their claims. Plaintiffs challenge the Governor’s Executive

1 Order N-60-20 and the State’s COVID-19 Industry Guidance for Schools and
2 School Based Programs (collectively, “Order”), imposing restrictions on in-person
3 education in K-12 grade schools.

4 Plaintiffs assert four claims: (1) violation of substantive due process under the
5 Fourteenth Amendment; (2) violation of the equal protection clause to the
6 Fourteenth Amendment; (3) violation of Title VI of the Civil Rights Act of 1964
7 (disparate impact on minorities); and (4) violation of federal disability rights
8 statutes. FAC 31:1-37:23. Plaintiffs pray for a declaration that the Order is
9 unconstitutional, facially and as applied, and that an injunction issue against
10 enforcing it against Plaintiffs. FAC 37:24-38:11 and attached Exs. 1 and 2. They
11 filed Plaintiffs’ Application for a Temporary Restraining Order on August 3, 2020.
12 Pls. App. for Temporary Restraining Order (TRO App.), ECF No. 28.

13 ARGUMENT

14 I. LEGAL STANDARD

15 To obtain a TRO or preliminary injunction, Plaintiffs must show: (1) they are
16 likely to succeed on the merits; (2) they are likely to suffer irreparable harm without
17 preliminary relief; (3) that the balance of equities tips in their favor; and (4) that an
18 injunction is in the public interest. *Winter v. Nat. Res. Def. Couns., Inc.*, 555 U.S.
19 7, 20 (2008). Plaintiffs’ TRO application should be denied because they fail to
20 satisfy these equitable factors that the Court weighs to determine whether to grant
21 the extraordinary relief of a TRO.

22 II. PLAINTIFFS FAIL TO SATISFY THE EQUITABLE FACTORS FOR A 23 TEMPORARY RESTRAINING ORDER

24 A. Plaintiffs Have Failed to Demonstrate a Likelihood of Success on the Merits of Their Claims

25 1. The Challenged Order is a Constitutional Exercise of the 26 Governor’s Emergency Powers to Combat COVID-19

27 The Supreme Court has long recognized that states have broad authority to
28 respond to public-health emergencies. *Jacobson Mass.*, 197 U.S. at 27. Thus, it

1 has held that “a community has the right to protect itself against an epidemic of
2 disease which threatens the safety of its members.” *Id.* at 27 (internal quotation
3 marks omitted); see also *Kansas v. Hendricks*, 521 U.S. 346, 356-57 (1997)
4 (recognizing the continued vitality of *Jacobson*). Moreover, it is not a court’s role
5 “to determine which one of two modes [is] likely to be the most effective for the
6 protection of the public against disease.” *Id.* at 30. To the contrary, because States
7 often must take swift and decisive action during a health emergency, constitutional
8 rights may be reasonably restricted “as the safety of the general public may
9 demand.” *Id.* at 29. Thus, a measure taken to combat a public-health emergency
10 will be upheld against constitutional challenge unless it has no “real or substantial
11 relation” to the emergency or “is, beyond all question, a plain, palpable invasion of
12 rights” secured by the Constitution. *Jacobson*, 197 U.S. at 31.

13 Plaintiffs’ TRO application simply ignores *Jacobson*. See generally TRO. Yet
14 the Supreme Court recently relied upon *Jacobson* in a challenge to another
15 Executive Order by Governor Newsom that limited gatherings to address the spread
16 of COVID-19. Chief Justice Roberts reiterated that the judiciary should accord
17 wide deference to local officials “actively shaping their response to changing facts
18 on the ground.” In the Court’s decision denying a church’s application for an
19 injunction suspending California’s public-health orders for COVID-19, Chief
20 Justice Roberts wrote that, “The notion that it [was] ‘indisputably clear’ that the
21 Government’s limitations are unconstitutional seem[ed] quite improbable.” *South
22 Bay III*, 140 S. Ct. 1613-14 (mem) (Roberts, C.J., concurring in denial of
23 application for injunctive relief). As Chief Roberts further observed, the COVID-
24 19 pandemic “is a dynamic and fact-intensive matter subject to reasonable
25 disagreement,” as the situation within California and across the world rapidly
26 evolves. *Id.* at 1613 (Roberts, C.J., concurring).

27 Numerous federal courts, also applying *Jacobson*, have already concluded that
28 similar challenges to the State’s public health orders are unlikely to succeed on the

1 merits. *See, e.g., Best Supplement Guide, LLC v. Newsom, et al.*, No. 2:20-cv-
 2 00965-JAM-CKD, 2020 WL 2615022, at *3–7 (E.D. Cal. May 22, 2020)
 3 (concluding that the State’s orders are a “constitutional response to an
 4 unprecedented pandemic”); *Givens v. Newsom*, __ F. Supp. 3d __, 2020 WL
 5 2307224 (E.D. Ca.. May 8, 2020), at *3–5 (applying *Jacobson* to conclude that the
 6 plaintiffs were unlikely to succeed on their challenge to the stay-at-home orders);
 7 *Monica Six, et al. v. Newsom, et al.*, __ F. Supp. 3d __, No. 820-cv-00877-JLS-
 8 DFM, 2020 WL 2896543 at *1–7 (C.D. Cal. May 22, 2020) (same); *Cross Culture*
 9 *Christian Ctr. v. Newsom*, __ F. Supp. 3d __, No. 2:20-cv-00832-JAM-CKD, 2020
 10 WL 2121111, at *3–5 (E.D. Cal. May 5, 2020) (the State’s orders “bear a real and
 11 substantial relation to public health”); *Gish*, 2020 WL 1979970 at *4-5, (C.D. Cal.
 12 Apr. 23, 2020) (State’s order did not constitute a “plain and palpable invasion” of
 13 plaintiffs’ free exercise of religion because, while plaintiffs “are unable to gather
 14 together in-person, they are free to gather virtually or over the phone”).

15 Furthermore, the Supreme Court has repeatedly recognized state sovereignty
 16 in the areas of education and public-health policy. *See United States v. Lopez*, 514
 17 U.S. 549, 564 (1995); *Marshall v. United States*, 414 U.S. 417, 427 (1974);
 18 *Jacobson*, 197 U.S. at 23-29. The Court has cautioned that, where other branches
 19 of government undertake “to act in areas fraught with medical and scientific
 20 uncertainties,” the judiciary should proceed with caution, even where “judges with
 21 more direct exposure to the problem might make wiser choices.” *Marshall*, 414
 22 U.S. at 427.⁵

23 Here, although Plaintiffs argue that it is safe to immediately open schools for
 24 children to attend in-person in their counties, see, e.g., FAC ¶¶ 10, 18, 20, 99,

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 26 ⁵ Justice Kavanaugh recently underscored this point. *See Calvary Chapel*
 27 *Dayton Valley*, 591 U.S. ___, 2020 WL 4251360 (Kavanaugh, J, dissenting).
 28 Although Justice Kavanaugh argued in his dissent that *Jacobson* should not govern
 First Amendment challenges, he accepted that *Jacobson* provides the appropriate,
 deferential standard for reviewing numerous “COVID-19 matters,” including
 “school closures.” *Id.* at *11.

1 individual opinions and views do “not affect the validity” of a state policy, “nor
2 entitle [plaintiffs] to be excepted from its provisions,” *Jacobson*, 197 U.S. at 23.
3 Plaintiffs cite to research which they argue shows that there are low safety risks in
4 reopening schools for in-person instruction, irrespective of high COVID-19 levels.
5 See FAC ¶¶ 37-69. The federal Center for Disease Control and Prevention,
6 however, recently issued guidance, which analyzed many of the same studies to
7 which Plaintiffs cite and concluded that schools may be safely reopened in
8 communities *where community spread is low*. RJN, Ex. DD.4. Unfortunately, that
9 is not the case in California as a whole, and certainly not in counties on the
10 Monitoring List, which considers whether case rates are above 100 per 100,000
11 individuals. Watt Decl. ¶¶ 17, 29; RJN, Exs. R-T.

12 Moreover, there is growing consensus that: children are susceptible to
13 infection by COVID-19 and transmission; the current positive rate data may not
14 accurately reflect the actual rate of infection of children and the transmission
15 between children and adults because testing of children is sparse and children may
16 have less severe symptoms or be asymptomatic; and opening schools for in-person
17 instruction increases the risk of COVID-19 transmission within the school and the
18 broader community, especially since some evidence exists that older children are
19 able to spread the virus throughout the community in the same manner as adults.
20 Watt Decl. ¶¶ 18-19, 22-29, 36-38; RJN, No. 24, Exs. M, W, X, Y, AA, BB.
21 Reopening schools for in-person instruction in communities with high COVID-19
22 rates is risky, especially for middle and high schools. Watt Decl. ¶¶ 26, 29; RJN,
23 Exs. DD.2-3, This has been demonstrated in some other countries with high
24 COVID-19 rates, and in recent in-person school openings in other states.⁶

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26 ⁶ RJN, Exs. DD.3, W-BB. For example, in Israel, two weeks after schools
27 reopened for in-person instruction, COVID-19 outbreaks began sweeping through
28 schools, including at least 130 cases in one school, with both staff and students
testing positive for COVID-19. *Id.*, Exs. Y, Z. Similarly, when schools recently
reopened for in-person instruction in Georgia and Indiana, both states faced
COVID-19 outbreaks. *Id.*, Exs. BB, CC.

1 Such evidence supports California’s health officials’ constitutional prerogative and
2 discretion to enact public-health policy limiting in-person classes during a
3 widespread and ever-worsening health emergency. *Jacobson*, 197 U.S. at 27.

4 Plaintiffs also fail to show that the harms they allege their children suffered
5 through distance learning in the Spring—such as an excess of screen time, less
6 instruction, insufficient services for students with disabilities, and a disinterest in
7 continuing to participate in school —will befall their children who begin the year
8 with distance learning. All schools in the State must provide instruction to students
9 in the 2020-21 school year, whether by distance learning or in-person instruction.
10 The State has adopted new laws and guidance requiring schools to meet certain
11 thresholds for distance learning and the provision of services to students with
12 special needs. RJN, No., Exs. EE-JJ. The State has also appropriated more than \$5
13 billion in additional funding to public schools for the 2020-21 school year to
14 address learning loss that may have occurred last spring and to provide additional
15 supports and services to improve delivery of education this year, including if
16 distance learning continues. *Id.*, Exs. JJ, NN. Moreover, schools that start the
17 school year with distance learning are permitted to switch to in-person instruction
18 as soon as 14 days after the county has been removed from the Monitoring List, and
19 are not required to wait until the end of a quarter or semester. *Id.*, Ex. L.5. Thus,
20 the distance-learning mandate is not permanent, but is designed to be fluid and
21 directly responsive to a county’s ability to reduce its COVID risk.

22 Nor can plaintiffs show that their alleged harms would outweigh the already
23 proven risks of spread of COVID-19 not only between students and school staff,
24 but also to their families and the broader community, if the State were to
25 immediately allow in-person learning in all schools despite the recent surge in
26 COVID-19 in the State. Watt Decl. ¶¶ 17, 21, 29, 34. Moreover, the State
27 authorized a waiver process through which county public-health officials may
28 permit elementary schools to offer in-person instruction in counties on the

1 Monitoring List because younger children have been found to have a lower risk of
2 child-to-child or child-to-adult transmission and a lower risk of serious infection.
3 RJN, Exs. L.5, M.1-2.

4 Further, even if Plaintiffs were correct that the public-health situation is
5 allegedly better than the State originally anticipated, they “fail to account for the
6 possibility” that this may be true precisely “because of” the public-health orders
7 that are seeking to invalidate. *Monica Six*, __ F. Supp. 3d __, No. 820-cv-00877-
8 JLS-DFM, 2020 WL 2896543 at *8; see FAC ¶¶ 100-02. It is for this reason that
9 the courts have held that it is “the duty of the constituted authorities primarily to
10 keep in view the welfare, comfort, and safety of the many, and not permit the
11 interests of the many to be subordinated to the wishes or convenience of the few.”
12 *Jacobson*, 197 U.S. at 29.

13 The restrictions California has imposed on in-person instruction plainly have a
14 “real” and “substantial relation” to public health and safety. *Jacobson*, 197 U.S. at
15 31. As detailed in the declaration of Dr. James Watt, Chief of the Division of
16 Communicable Diseases at the California Department of Public Health, the
17 COVID-19 virus is highly infectious, and indoor, in-person gatherings create a
18 great danger of transmission of the virus because such gatherings bring large
19 numbers of people together at the same time, in the same place, for an extended
20 period of time. Watt Decl. ¶¶ 22-28. Accordingly, the restrictions on in-person
21 classes in counties on the Monitoring List to protect the health and safety of
22 students, staff, and the surrounding community are not “beyond all question” a
23 “plain, palpable” invasion of the any Fourteenth Amendment right or a violation of
24 any federal statute prohibiting discrimination.

25 Defendants do not discount the challenges and burdens that school closures
26 bring for students, families, and school employees. Indeed, the more than \$5
27 billion investment that the State has made to support schools this year is intended to
28 mitigate those impacts. Certainly, everyone would prefer that the country was not

1 in the midst of an unprecedented pandemic. But we are, and given current
 2 epidemiological trends, schools cannot operate as normal in certain communities
 3 without imperiling public health. Watt. Decl. ¶¶ 30, 42. Thus, the Order falls well
 4 within the scope of the Governor’s emergency authority to combat the current
 5 public health crisis, and is entitled to significant deference by the courts.

6 **2. Even Under Non-Emergency Conditions, Plaintiffs Fail to**
 7 **Demonstrate a Likelihood of Success on the Merits**

8 As discussed above, the COVID-19 pandemic presents an unprecedented
 9 health emergency, and the State’s current response by trained officials on the front
 10 lines is entitled to deference. But even if Plaintiffs’ claims are analyzed under
 11 traditional constitutional standards that apply in non-emergency circumstances, the
 12 claims are still unlikely to succeed because the alleged injuries do not represent
 13 cognizable constitutional harms.

14 **a. Plaintiffs’ Claims Are Deficient**

15 **(1) Plaintiffs fail to state a claim for violation of**
 16 **substantive due process**

17 Plaintiffs claim the Order deprives their children of their alleged “fundamental
 18 right” to a basic education under the Substantive Due Process Clause of the
 19 Fourteenth Amendment. TRO 14-15. Yet, as Plaintiffs concede, no court has
 20 recognized a fundamental right to a basic education under the Substantive Due
 21 Process Clause. *Id.* at 15:8-11, 16:8.⁷ Thus, they cannot show a likelihood of
 22 success on the merits on this claim warranting a TRO.

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 24 _____
 25 ⁷ Nor is education a fundamental right for purposes of the Fourteenth
 26 Amendment’s Equal Protection Clause. *See, e.g., San Antonio Indep. Sch. Dist. v.*
 27 *Rodriguez*, 411 U.S. 1 (1973); *Plyler v. Doe*, 457 U.S. 202, 223-24 (1982);
 28 *Papasan v. Allain*, 478 U.S. 265, 284-85 (1986); *Kadrmas v. Dickinson Pub. Sch.*,
 487 U.S. 450, 458 (1988); *see also Bd. of Nat. Res. of State of Wash. v. Brown*, 992
 F.2d 937, 944 (9th Cir. 1993) (finding the applicable standard of review for equal
 protection cases involving education is rational basis review, based on Supreme
 Court precedent).

1 The Fourteenth Amendment’s Due Process Clause “prohibits any state
2 deprivation of life, liberty, or property without the due process of law.” *Ingraham*
3 *v. Wright*, 430 U.S. 651, 672 (1977). A party alleging a substantive due process
4 claim must meet the “threshold requirement—that a challenged state action
5 implicates a fundamental right” before a court will require more than a “reasonable
6 relation to a legitimate state interest to justify the action.” *Washington v.*
7 *Glucksberg*, 521 U.S. 702, 722 (1997). The Due Process Clause is understood as a
8 “limitation on the State’s power,” and not a guarantee of certain obligations to
9 individuals by the state. *DeShaney v. Winnebago Cty. Dep’t of Soc. Serv.*, 489 U.S.
10 189, 195 (1989). Here, Plaintiffs’ allegations fail the threshold test for a
11 substantive due process violation because there is no “fundamental right” to a basic
12 minimum education that is protected by the Due Process Clause.⁸

13 Plaintiffs argue that even if there is no recognized fundamental interest in
14 education warranting strict scrutiny, education claims are “a ‘quasi’ fundamental
15 right subject to intermediate scrutiny,” pursuant to *Plyler v. Doe*. TRO 16:8-12
16 (citing *U.S. v. Harding*, 971 F.2d 410, 412 n.1 (9th Cir. 1992)). First, Plaintiffs
17 appear to be conflating substantive due process claims with equal protection claims.
18 *Plyler* involved a claim for violation of equal protection, not substantive due
19 process, as it turned on a classification created by the state law. *See Plyler*, 457
20 U.S. at 205 (stating the question presented was whether the state law was
21 “consistent with the Equal Protection Clause of the Fourteenth Amendment”); *id.* at
22 225 (holding “the discrimination contained in § 21.031 can hardly be considered
23 rational unless it furthers some substantial goal of the State”). *Harding* also
24 addressed an equal protection claim and did not involve any claim regarding an

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26 ⁸ Plaintiffs nonetheless argue that a fundamental right to a basic education
27 should be recognized, citing to provisions in state constitutions recognizing an
28 affirmative right to public school education. TRO at 15:8-22. To the extent
Plaintiffs are attempting to state a substantive due process claim based on the
California Constitution, such a claim is barred by the Eleventh Amendment. *See*
Pennhurst State Sch.l & Hosp. v. Halderman, 465 U.S. 89, 98-100 (1984).

1 equal right to a free education. It merely observed that some “quasi-fundamental”
2 rights mandate a heightened level of scrutiny under the Equal Protection Clause.
3 *Harding*, 971 F.2d at 411-412. Second, even if *Plyler* did authorize some
4 heightened level of scrutiny under substantive due process (it did not), it addressed
5 a law that *completely denied* access to education to undocumented children. *See*
6 457 U.S. at 224. Here, Plaintiffs cannot credibly argue their children are *completely*
7 denied access to education, so *Plyler* is inapposite.

8 This argument is fatally flawed for the further reason that this claim is based
9 on the false premise that, because some schools initially faced challenges adapting
10 to distance learning at the beginning of a sudden, global pandemic in March,
11 distance learning in the upcoming school year will preclude students from receiving
12 a basic education. FAC ¶¶ 110-11. To the contrary, between March 2020 and the
13 present, the California Department of Education (CDE) has developed substantial
14 resources and guidance to support school districts’ efforts to improve distance
15 learning. (RJN, Exs. EE-II, KK.) Pursuant to newly enacted State law, school
16 districts must submit a Learning Continuity and Attendance Plan for the 2020-2021
17 school year by September 30, 2020, setting forth plans for both in-person and
18 distance learning that meet certain thresholds set by the Legislature, including,
19 among other things, supporting students’ mental health, providing additional
20 supports for students with disabilities, re-engagement of students absent from
21 distance learning, and professional development for teachers. *Id.*, Exs. GG-II, NN;
22 Cal. Ed. Code §43500, et seq. (new requirements for distance learning, including
23 those pertaining to special education). CDE is also helping schools ensure that
24 students have access to devices and technology. RJN, Ex. LL, MM. Moreover, the
25 State budget includes a new, one-time investment of \$5.3 billion for school districts
26 to support student achievement, including through distance learning, to mitigate
27 learning loss related to COVID-19. *Id.*, Exs. JJ, NN. Such funds are available for
28 districts to provide student supports to address barriers to learning, including

1 programs to address student trauma and provide mental health and counseling
2 services, providing meals for students even during distance learning, and providing
3 professional development opportunities to help teachers support pupils in distance-
4 learning contexts. RJN, Exs. II, JJ, NN.

5 At its essence, Plaintiffs' novel position is that there is a fundamental right to
6 in-person school, and that school that is offered remotely is somehow tantamount to
7 no school at all. While in-person instruction is, of course, the generally preferred
8 means of instruction when the State is not in the midst of a public-health crisis
9 borne out of in-person transmission, the evidence simply fails to support the
10 proposition that the distance learning California schools will provide in the
11 upcoming school year amounts to the wholesale denial of an education. By
12 alleging their children's experiences with distance learning in the spring were
13 unsatisfactory or not the most optimal for their children's learning styles, Plaintiffs
14 are essentially asking this Court, rather than the schools, to dictate to how schools
15 must provide an education. See FAC ¶¶ 7-21. But, even when, unlike here,
16 fundamental rights are at issue, courts "have never presumed to possess either the
17 ability or the authority to guarantee to the citizenry the most effective" expression
18 of their fundamental rights. *Rodriguez*, 411 U.S. at 36. Thus, in a recent case
19 before this Court, *Six v. Newsom*, the Court rejected claims similar to those made
20 by Plaintiffs here. *Six*, ___ F. Supp. 3d ___, No. 820-cv-00877-JLS-DFM, 2020 WL
21 2896543 at *2, 6-7. It denied a plaintiff's allegation that the State stay-at-home
22 orders caused her to lose her school and study community, which she felt would
23 negatively impact her educational progress and college prospects, even where her
24 claim was based on the "fundamental right" to free association. *Id.*

25 In sum, Defendants' actions here do not infringe upon any alleged
26 fundamental right under the Due Process Clause, and are well within the powers of
27 the state to decide policy during an unprecedented public health crisis.
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(2) Plaintiffs fail to state a claim for violation of the Equal Protection Clause

Plaintiffs argue that the Order also violates the Equal Protection Clause of the Fourteenth Amendment both because it arbitrarily prohibits children in counties on the Monitoring List to hold in-person classes, while allowing schools in other counties to hold in-person classes, and because it does not require day camps and childcare facilities to close. FAC 121; TRO 19-20. But given that the Order is rationally related to the legitimate government interest of protecting public health during a global pandemic, it easily survives rational basis review.

For most governmental actions, courts use the rational basis test to determine whether a classification under the law “bear[s] some fair relationship to a legitimate public purpose” because states “must have substantial latitude to establish classifications that roughly approximate the nature of the problem perceived [and] accommodate competing concerns.” *Plyler*, 457 U.S. at 216. Plaintiffs concede that rational basis review applies to their equal protection claim. TRO 19:1-20:10. Under rational basis review, government action “carries with it a presumption of constitutionality that can only be overcome by a clear showing of arbitrariness and irrationality.” *Kadrmas*, 487 U.S. at 451.

As Defendants’ actions do not treat alike groups dissimilarly, Plaintiffs cannot make the threshold showing under rationality review that the State is treating similarly situated individuals differently, or that the Order is arbitrary or irrational. *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432 (1985). Plaintiffs argue that schools are not treated alike under the plan for reopening, improperly comparing schools within one county to schools in another, and schools to daycares and camps. See FAC ¶¶ 32, 121-22. This mischaracterizes the Order, which distinguishes between schools in counties on the County Monitoring List (which is based on epidemiological and other data related to each county’s capacity to manage the pandemic in its communities) and those in counties not on the list, and

1 permits schools to open for in-person instruction if they have not been on the list
2 for 14 days. The criteria for a county to be placed on and removed from the
3 Monitoring List is the same for *all* counties in the State. Thus, the Order
4 distinguishes between schools in counties on the Monitoring List and those not on
5 the list based on the level of COVID-19 cases in the county. Therefore, the
6 counties are not similarly situated due to their different levels of COVID-19
7 transmission, and all counties are being evaluated by the same objective criteria.

8 Moreover, schools are not equivalent to daycares and camps in many
9 significant respects, and thus are not similarly situated. *Cf. Lupert v. California*
10 *State Bar*, 761 F.2d 1325 (9th Cir. 1985) (rejecting Equal Protection claim based on
11 differing requirements for students at accredited and unaccredited law schools in
12 California). In early June, some day camps were allowed to open in a limited
13 capacity. The number of children participating in day camps during the summer
14 months is smaller than the volume of students in K-12 schools in California during
15 the school year. Additionally, day camps are generally structured with smaller
16 group sizes and in a manner that allows more distancing and outdoor activities than
17 traditional school. Finally, day camps were operating throughout the summer and
18 generally close when school resumes, while schools generally close for the summer.
19 Allowing *continued* operation of a sector that has been open versus permitting a
20 sector that has been closed to reopen has vastly different implications and risks,
21 especially given the relatively lower risk generally presented by day camps versus
22 schools. Watt Decl. ¶22.

23 Plaintiffs' comparison to childcare facilities is even more strained, given the
24 significant differences between the settings. First, childcare settings primarily serve
25 children who are younger than school age, and thus present a relatively lower risk
26 of spread for the same reason that elementary schools present a lower risk than
27 middle and high schools. Second, childcare settings are regulated in a way that
28 schools are not. Most notably, state regulations provide a hard cap for adult-to-

1 child ratios in childcare settings that are not applicable to schools, for example, with
2 childcare for infants and toddlers capped at a 4-to-1 and 6-to-1 ratio in family day
3 care settings, *see* 22 C.C.R. § 102416.5, and no more than a 15-to-1 ratio in
4 childcare center settings, *see* 22 C.C.R. § 101216.3. State preschool similarly
5 imposes maximum adult-to-child ratios that vary by age, with the largest being 15-
6 to-1. *See* 5 C.C.R. § 18290. There are no comparable requirements for schools,
7 and the *average* teacher-to-student ratio for public schools in California is 21-to-1,
8 *see* <https://www.ed-data.org/state/CA> (Staff, Demographics, Per Pupil Ratio:
9 Teachers), which is higher than the maximum ratio for childcare settings. As a
10 result, there is a greater likelihood of safely maintaining small group sizes and
11 stable cohorts to reduce the risk of transmission in childcare settings than schools.

12 Under rational basis review, courts have historically deferred to other branches
13 of government in deciding questions of education and public health policy. In
14 *Rodriguez*, the Supreme Court noted that education policy, because of the “very
15 complexity of the problems of financing and managing a statewide public school
16 system,” was an “area in which this Court’s lack of specialized knowledge and
17 experience counsels against premature interference with the informed judgments
18 made at the state and local levels.” 411 U.S. at 42. Defendants, here, are likewise
19 in the best position to weigh and balance competing health and policy imperatives
20 in the face of a rapidly changing public-health crisis, and the differences and
21 relative risks among the various settings in which children from different
22 households mix and interact with adults. Moreover, a state policy or program “may
23 not be condemned simply because it imperfectly effectuates the State’s goals,” and
24 even “the existence of ‘some inequality’ in the manner in which the State’s
25 rationale is achieved is not alone a sufficient basis for striking down the entire
26 system.” *Id.* at 51. To the extent, solely for the sake of argument, that Defendants’
27 reopening plan treats any alike groups differently, that alleged disparate treatment is
28 not “so irrational as to be invidiously discriminatory” in violation of Equal

1 Protection. This is because the reopening plan furthers the not just legitimate—but
 2 crucially important—governmental interest of protecting the public health from a
 3 deadly and highly contagious disease. *Cross-Culture Christian Ctr.*, E.D. Cal. May
 4 5, 2020, No. 2:20-cv-00832-JAM-CKD at *10.

5 **(3) Plaintiffs fail to state a disparate impact claim**
 6 **under Title VI of the Civil Rights Act**

7 Plaintiffs argue that the Order violates Title VI of the Civil Rights Act of 1964
 8 and its regulations because it causes a disparate impact on racial minorities. TRO
 9 20:16-21:4. Specifically, they argue that distance learning will be especially
 10 harmful to students from low-income families who are disproportionately
 11 minorities in California. *Id.* at 21:5-13. However, as Plaintiffs half-heartedly
 12 concede, binding Ninth Circuit precedent forecloses this claim. *See* TRO 20 fn.22
 13 (citing *Save Our Valley v. Sound Transit*, 335 F.3d 932 (9th Cir. 2003) (holding that
 14 Department of Transportation’s disparate impact regulation under Title VI “cannot
 15 create individual rights enforceable through § 1983”)). Because there is no private
 16 right of action under Section 1983 to enforce disparate-impact regulations
 17 promulgated under Title VI of the Civil Rights Act of 1964, this claim fails as a
 18 matter of law.⁹ *See Save Our Valley*, 335 F.3d at 938-39; *see also Guzman v.*
 19 *Shewry*, 552 F.3d 941, 952 (9th Cir. 2009).

20 By claiming a violation of Title VI through a disparate impact theory under
 21 section 1983, Plaintiffs are bound by the Supreme Court holdings that “[t]here is no
 22 private right of action to enforce disparate-impact regulations promulgated under
 23 Title VI”, *Alexander v. Sandoval*, 532 U.S. at 293, and a private litigant may bring
 24 suit under § 1983 only to enforce private rights that Congress has created in “clear
 25 and unambiguous terms.” *Gonzaga Univ. v. Doe*, 536 U.S. 273, 290 (2002). Based
 26 on those rulings, the Ninth Circuit has held that federal rights are created by

27 ⁹ Individuals may sue to enforce a prohibition on *intentional* discrimination
 28 under Title VI. *Alexander v. Sandoval*, 532 U.S. 275, 280-281 (2001). Here,
 plaintiffs brought their Title VI claim based on disparate impact allegations, and
 have not made any allegations to state a claim for intentional discrimination.

1 Congress, and not agencies. *See Save Our Valley v. Sound Transit*, 335 F.3d 932,
 2 938-39 (9th Cir. 2003); *Guzman v. Shewry*, 552 F.3d at 952. Thus, Plaintiffs' claim
 3 fails.

4 **(4) Plaintiffs fail to state a claim for violation of**
 5 **federal disability rights statutes**

6 Plaintiff Z.R. and his mother, and three other parents of students with
 7 disabilities, allege that Defendants discriminated against them in violation of the
 8 Individuals with Disabilities in Education Act (IDEA), the Americans with
 9 Disabilities Act (ADA), and Section 504 of the Rehabilitation Act. FAC 36:16-
 10 37:23. Their claim is defective because they improperly brought it pursuant to
 11 Section 1983 and because they failed to exhaust administrative remedies.

12 Ninth Circuit precedent clearly establishes that a Section 1983 action cannot
 13 be brought for violation of IDEA rights, or for violation of Section 504 or ADA
 14 rights. *Blanchard v. Morton Sch. Dist.*, 509 F.3d 934, 938 (9th Cir. 2007); *Vinson*
 15 *v. Thomas*, 288 F.3d 1145, 1155-1156 (9th Cir. 2002).

16 In addition, this claim is barred because Plaintiffs have failed to exhaust
 17 administrative remedies. The IDEA requires that students with disabilities be
 18 provided a free appropriate public education (FAPE) through an individualized
 19 education plan (IEP). 20 U.S.C. §§ 1412(a)(1), 1414(d) (2006). Before a plaintiff
 20 may challenge the provision of a FAPE in court, she must first exhaust the available
 21 administrative remedy through a special-education due-process hearing.¹⁰ 20
 22 U.S.C. § 1415(l); 20 U.S.C. § 1415(i)(2)(A). When a plaintiff has failed to exhaust
 23 the required administrative remedy, the complaint is subject to dismissal. *Albino v.*
 24 *Baca*, 747 F.3d 1162, 1169 (9th Cir. 2014) (en banc). Furthermore, exhaustion of

25 ¹⁰ There are three categories of exceptions to the requirement to exhaust the
 26 due process administrative remedy: (1) it would be futile to go to due process, (2)
 27 the educational agency has adopted a policy or pursued a practice of general
 28 applicability that is contrary to law, or (3) it is improbable that adequate relief can
 be obtained by pursuing administrative remedies. *Doe v. Arizona Dep't of Educ.*,
 111 F.3d 678, 681, 683-684 (9th Cir. 1997) (finding exhaustion not excused on its
 facts); *Hoefst v. Tucson Unified Sch. Dist.*, 967 F.2d 1298, 1303 (9th Cir. 1992)
 (same). Plaintiffs have not established that any of these exceptions apply here.

1 administrative remedies is required when the gravamen of a complaint seeks redress
2 for a school’s failure to provide a FAPE, “even if not phrased or framed in precisely
3 that way.” *Fry v. Napoleon Community Schools*, 137 S. Ct 743, 755 (2017).

4 Thus, in order to file a federal civil action pursuant to section 504 or the ADA
5 that seeks relief available under the IDEA, section 1415(l) of the IDEA requires
6 that a party must first exhaust the IDEA’s administrative remedy. *Payne v.*
7 *Peninsula Sch. Dist.*, 653 F.3d 863, 880 (9th Cir. 2011) (where claim arises as a
8 result of an alleged denial of a FAPE, whether pled under the IDEA or as disability
9 discrimination, “exhaustion is clearly required”); *Paul G. v. Monterey Peninsula*
10 *Unified Sch. Dist.*, 933 F.3d 1096, 1102-1102 (9th Cir. 2019) (gravamen of
11 plaintiff’s Section 504 claim was alleged denial of FAPE, thus plaintiff was barred
12 from seeking systemic relief against CDE because he failed to obtain a finding from
13 OAH as to whether he had been denied a FAPE).

14 Z.R. and the Plaintiff parents with children with disabilities seek relief for
15 alleged denials of FAPE. Specifically, Z.R. and the relevant parents allege in the
16 FAC and declarations that he/their students have IEPs, and that their schools failed
17 to provide the services required under their IEPs during distance learning in the
18 Spring of 2019. FAC ¶¶ 15, 16, 18, 21; Ruiz Decl. ¶¶ 4-6, 8, 11, 12, 15-18;
19 Hawkins Decl. ¶¶ 4-11; Bema Decl. ¶¶ 12; Ramirez Decl. ¶¶ 8-9. These allegations
20 assert that their students were denied a FAPE. *See, e.g.*, Ruiz Decl. ¶¶ 8-9 (“It is
21 mandated that my son receive a free, appropriate public education (FAPE) – this is
22 the law;” “As a result of this denial of FAPE . . .”). Accordingly, exhausting their
23 administrative remedies was a mandatory prerequisite to this action. Yet, Plaintiffs
24 failed to allege in their FAC or their declarations that they pursued the required
25 administrative remedy at OAH against their school districts, nor did they allege that
26 they are aggrieved by a final decision of OAH. Because Plaintiffs have failed to
27 exhaust their administrative remedies, their claim is barred.

28

1 **B. The Remaining Factors Weigh Heavily Against Issuing a**
2 **Temporary Restraining Order**

3 Besides failing to demonstrate a likelihood of success on the merits, Plaintiffs
4 also fail to show that they will suffer irreparable harm, that the balance of equities
5 weighs in their favor, or that a TRO is in the public interest. *Winter*, 555 U.S. at
6 20; *Drakes Bay Oyster Co. v. Jewell*, 747 F.3d 1073, 1092 (9th Cir. 2014) (“Where
7 the government is a party to a case in which a preliminary injunction is sought, the
8 balance of the equities and public interest factors merge.”).

9 Plaintiffs argue they will be irreparably harmed if the Court does not enjoin
10 the Order because many schools will be forced to offer distance learning, allegedly
11 depriving children of a constitutionally-protected “adequate education.” TRO
12 24:21-25:22. However, they have failed to show that they are likely to succeed on
13 the merits on their due process claim. Plaintiffs further argue that children will
14 suffer “intangible injuries” consisting of “abuse, depression, and hunger” if they
15 cannot start the school year with in-person learning. TRO at 24:23-24:26. Yet, the
16 State has taken important steps to mitigate any such harms, including requiring
17 districts to provide students access to meals, and providing funding to offer students
18 mental health services to address trauma. See, e.g., RJN, Exs. GG-JJ, NN.¹¹

19 As to the remaining factors, Plaintiffs argue that “forced school closures”
20 allegedly violate their “Fourteenth Amendment rights” and it is in the public
21 interest to prevent the violation of a party’s constitutional rights. TRO 25:12-15.
22 But, again, they fail to demonstrate that any fundamental constitutional rights are
23 being harmed from the State’s actions, and their statutory claims are legally barred.

24 Conversely, the State and the residents of California would be irreparably
25 harmed if the Court were to grant Plaintiffs’ requested injunction by suspending the
26 State’s measures to control the spread of the virus and limit infections in the school

27 ¹¹ Moreover, enjoining the Order would not prevent counties with high rates
28 of COVID-19 from issuing their own county-wide order mandating in-person
school closures until the county is removed from the Monitoring List, or prevent
schools from deciding not to start the school year with in-person learning.

1 setting. As this Court recognized in the first federal action in California
2 challenging COVID-19 restrictions, individuals exposed to potential transmission
3 of the disease without adequate safety measures “face the threat of immediate and
4 irreparable injury.” *City of Costa Mesa v. United States*, 2020 WL 882000, at *1
5 (C.D. Cal. Feb. 21, 2020).

6 The State has been working hard to minimize the spread of COVID-19, but
7 new scientific evidence and surges in many counties across the State in July proved
8 that California public-health officials’ work was not done. As previously
9 discussed, the State has set forth a reasonable process based on science and
10 evidence to permit schools in counties on the Monitoring List to open for in-person
11 instruction in a safe manner when the COVID-19 surges in their counties subside.
12 It has also provided for a waiver exception for elementary schools based on the
13 emerging scientific evidence that COVID-related risks in schools serving
14 elementary-age students are lower than and different from the risks to staff and to
15 students in schools serving older students, due to lower risks of transmission and
16 infection in children under age 12. RJN Exs. L-O. Permitting schools with older
17 children to open for in-person instruction in counties with high rates of COVID-19
18 would increase the risk of transmission in counties that already have high
19 transmission rates and would be overwhelmingly contrary to the public interest.

20 **CONCLUSION**

21 For the foregoing reasons, the Court should deny Plaintiffs’ TRO application.

22 Dated: August 9, 2020

Respectfully submitted,

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24 Attorney General of California
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26 /s Jennifer A. Bunshoft
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8 *Gavin Newsom, in his official capacity as the*
Governor of California, Xavier Becerra in his
9 *official capacity as the Attorney General of*
California, Sonia Y. Angell, M.D., in her official
10 *capacity as the State Public Health Officer and*
Director of the Department of Public Health and
11 *Tony Thurmond, in his official capacity as State*
Superintendent of Public Instruction and Director
12 *of Education*

13 IN THE UNITED STATES DISTRICT COURT
14 FOR THE CENTRAL DISTRICT OF CALIFORNIA
15 WESTERN DIVISION

17 **MATTHEW BRACH, et al.,**

18 Plaintiffs,

19 v.

20 **GAVIN NEWSOM, et al.,**

21 Defendants.

2:20cv06472 SVW (AFMx)

**DECLARATION OF JAMES
WATT, M.D., M.P.H., IN SUPPORT
OF DEFENDANTS' OPPOSITION
TO PLAINTIFFS' APPLICATION
FOR TEMPORARY
RESTRAINING ORDER AND FOR
ORDER TO SHOW CAUSE WHY
PRELIMINARY INJUNCTION
SHOULD NOT ISSUE**

22 Judge: The Honorable Stephen
23 V. Wilson

24 Action Filed: 7/21/2020

25
26
27
28

1 I, JAMES WATT, M.D., M.P.H., declare as follows:

2 1. I am over the age of 18 and a United States citizen. I know the following
3 facts of my own personal knowledge, and if called upon as a witness, I could and
4 would testify competently thereto.

5 **I. EDUCATION AND PROFESSIONAL BACKGROUND**

6 2. I am currently employed as the Chief of the Division of Communicable
7 Diseases at the California Department of Public Health (CDPH).

8 3. My background is in the epidemiology of communicable diseases. I
9 received my bachelor's degree at Stanford University and completed my medical
10 degree at UC San Diego in 1990 with medical specialty training in Pediatrics. I also
11 received a master's degree in Public Health at UC Berkeley in 1995. I hold a
12 California medical license and am Board Certified in Pediatrics.

13 4. During my career, I have published over 60 scientific papers focused on
14 infectious diseases. As a physician scientist, my research has focused on the diverse
15 challenges that we face in preventing infectious diseases, including emerging
16 infections, and vaccine safety and efficacy. I have provided international
17 consultation to address infectious diseases in many regions of the world and have
18 served on CDC and World Health Organization (WHO) advisory panels. I currently
19 hold an academic position at UCSF School of Medicine and at the Johns Hopkins
20 Bloomberg School of Public Health, mentoring students and teaching about
21 communicable disease control. My accomplishments have been recognized
22 through honors and awards including the United States Public Health Service
23 Achievement Medal in 2000, the National Center for Infectious Diseases Honor
24 Award in 2001 and Outstanding Achievement Award from the California
25 Department of Public Health in 2015 and 2016.

26 5. In 1996, I joined the California Department of Health Services (CDHS)
27 as a Public Health Medical Officer II. In 1999, I joined the federal Centers for
28 Disease Control and Prevention (CDC) as an Epidemic Intelligence Service Officer

1 in the Respiratory Diseases Branch. In 2001, I became an Assistant Scientist in the
2 School of Public Health at Johns Hopkins University.

3 6. I joined CDPH as a Public Health Medical Officer in 2006 and became
4 Chief of the Tuberculosis Control Branch in 2008. In 2010, I took on my current
5 position of Chief of the Division of Communicable Diseases. In this position, I am
6 responsible for disease control and prevention of the diverse infectious diseases that
7 affect Californians as well as for the State laboratories that support those efforts. As
8 Division Chief, I also serve as the Co-Director for the California Emerging
9 Infections Program.

10 7. From January 2020 through July 12, 2020, I served as the Acting Deputy
11 Director of the Center for Infectious Diseases and Interim State Epidemiologist at
12 CDPH. As the Acting Deputy Director of the Center for Infectious Diseases and
13 Interim State Epidemiologist at CDPH, I coordinated CDPH's epidemiologic
14 response to disease outbreaks and emerging health threats and have been very
15 involved in CDPH's response to the COVID-19 (SARS-CoV-2) pandemic.

16 8. CDPH is one of sixteen departments and offices within the California
17 Health and Human Services Agency, and its fundamental responsibilities include
18 infectious disease control and prevention, food safety, environmental health,
19 laboratory services, patient safety, emergency preparedness, chronic disease
20 prevention and health promotion, family health, health equity, and vital records and
21 statistics. Our mission is to advance the health and well-being of California's
22 diverse people and communities.

23 9. CDPH's Center for Infectious Diseases protects the people in California
24 from the threat of preventable infectious diseases and assists those living with an
25 infectious disease in securing prompt and appropriate access to healthcare,
26 medications and associated support services.

27 10. As noted, I have been intimately involved with the statewide COVID-19
28 response since January 2020. My role since that time was to oversee analysis of

1 statewide data on COVID-19 cases and trends in disease activity. Since January, I
2 have been working full time for approximately 60-70 hours per week to address the
3 pandemic. I am familiar with the guidance issued by CDPH and the State of
4 California Executive Orders N-33-20 and N-60-20, as well as the ongoing guidance
5 from CDPH regarding school and school-based programs.

6 11. Attached hereto as Exhibit A is a true and correct copy of my curriculum
7 vitae.

8 **II. THE TRANSMISSION OF THE NOVEL CORONAVIRUS AND THE SPREAD OF**
9 **THE COVID-19 PANDEMIC**

10 **A. General**

11 12. People with COVID-19 have reported a wide range of symptoms,
12 ranging from no or mild symptoms to severe illness. COVID-19 can cause severe
13 and long-term health complications, including death. Older adults and people of
14 any age who have serious underlying medical conditions are at higher risk for
15 severe illness from COVID-19. There is no vaccination for COVID-19.

16 13. A large percentage of people infected with SARS-CoV-2, the virus that
17 causes COVID-19, have no symptoms. People who have no symptoms can,
18 however, still spread COVID-19.

19 14. There is widespread consensus among epidemiologists that the virus that
20 causes COVID-19 spreads from person to person mainly through respiratory
21 droplets produced when an infected person—even an asymptomatic one—speaks,
22 coughs, or sneezes. These droplets can land in the mouths or noses of people who
23 are nearby or possibly be inhaled into the lungs.

24 15. Some scientists and studies have suggested that the COVID-19 virus also
25 may be spread through aerosol transmission, that is, through smaller particles
26 emitting from an infected person (such as through speaking, singing and other
27 vocalization) that can travel farther than respiratory droplets. Some studies have
28 also suggested that the virus can be spread through contaminated surfaces, although

1 that risk appears to be lower than person-to-person transmission. Research is
2 ongoing related to the role and importance of these additional transmission
3 pathways.

4 16. COVID-19 can spread quickly. A person with COVID-19, on average,
5 infects approximately two people. Unchecked, COVID-19 spreads exponentially
6 and over 10 transmission cycles, one person could be responsible for 1,024 other
7 people contracting the virus. Physical distancing interventions can be and indeed
8 have been successful in reducing the number of persons infected by each case and
9 changing the exponential pattern of case increases. That is why these interventions
10 are so important for controlling COVID-19 in California. Physical distancing
11 measures include staying home and staying at least six feet away from others when
12 outside the home.

13 17. COVID-19 is currently spreading in the community (community spread)
14 in many affected geographic areas. An area is experiencing community spread
15 when residents are becoming infected with the virus in community settings, and it is
16 not possible to identify the source of exposure in some cases. As of August 7,
17 2020, there have been: (1) 545,787 confirmed COVID-19 cases in the state, (2)
18 5746 hospitalized patients (currently admitted), and (3) 10,189 fatalities.

19 **B. Transmission and Infection of COVID-19 and Children in**
20 **California**

21 18. Research shows that children are susceptible to infection by COVID-19.
22 Although they generally present with less severe symptoms than adults, there have
23 been severe cases in persons under 18, with one recent confirmed COVID-19
24 related death recorded in California. A severe condition called multisystem
25 inflammatory syndrome in children (MIS-C) has been linked to COVID-19, and at
26 least 30 cases in California have been reported of this more severe manifestation of
27 COVID-19, with children often hospitalized and ill for extended periods.
28

1 19. Because children have less severe symptoms, or may more commonly be
2 asymptomatic, they are likely not tested at the same rate as adults. Limited testing
3 would reduce the number of infections identified in children.

4 20. In early June, some day camps and daycare facilities were allowed to
5 open in a limited capacity. The number of children participating in day camps
6 during the summer months is smaller than the volume of students in K-12 schools
7 in California during the school year. Additionally, day camps are generally
8 structured with smaller group sizes and in a manner that allows more distancing and
9 outdoor activities than traditional school.

10 21. When the Department of Public Health issued guidance in June for the
11 various sectors that reopened under the phased reopening plan, the data and trends
12 on positive cases, COVID-related deaths, and other key measures had stabilized.
13 Unfortunately, that was no longer the case in July, and, as explained below,
14 decisions about reopening sectors or activities that have been closed must take into
15 account how that additional activity and mixing will impact the pandemic's spread
16 in communities across the state.

17 **C. The Increased Risk of Transmission Among In-Person**
18 **Gatherings**

19 22. Whenever a group of people from different households gather, there is an
20 increased risk that the COVID-19 virus may be transmitted among the gathering
21 and into the community at large. The risk increases commensurately with the size
22 of the group (other factors being equal), as well as when members of the group are
23 in close proximity to one another. Thus, in-person gatherings pose a heightened
24 risk of transmission of COVID-19.

25 23. The spread of COVID-19 is more likely when people are in close contact
26 or proximity with one another (within about six feet). While keeping six feet of
27 separation between individuals and wearing face coverings can reduce the risk of
28

1 disease transmission, any gathering increases the risk of individual and community
2 transmission. This includes in-person classes in the school setting.

3 24. The risk of transmission also increases when groups of individuals gather
4 in close proximity for extended periods, and when they do so in enclosed (indoor)
5 spaces. Indoor gatherings pose increased risk compared to outdoor gatherings
6 because of reduced airflow and smaller contained spaces for the virus to be
7 concentrated and for people to come into contact with the virus. In the outdoors,
8 wind and air temperatures and ultraviolet light constitute additional factors that can
9 negatively affect the virus and can disperse the virus particles such that contact and
10 inhalation by persons are diminished and infection is less likely to occur.

11 25. The risk of COVID-19 transmission is increased by activities engaged in
12 by groups that increase the likelihood that respiratory droplets will be spread from
13 one person to another person or persons, including speaking, chanting, shouting,
14 and singing in close proximity to others and especially indoors. There have been
15 multiple reports of significant spread of COVID-19 resulting from gatherings
16 involving such activities, including among others, choir practices and services in
17 houses of worship.

18 26. While limited data suggest children, particularly older children, may
19 spread COVID-19, their overall role in spread has not been fully defined.
20 However, in schools, adults intermingle with children, and transmission may
21 happen between adults, between children, from adults to children or from children
22 to adults. It is possible that in the school setting, as in other settings, asymptomatic
23 transmission may occur. Thus, people who gather in groups or near others (other
24 than those with whom they live), will not know whether other individuals who are
25 in close proximity are carrying the virus. By gathering in large groups, and in close
26 proximity to others, individuals put themselves and others at increased risk of
27 transmission, which could be expected to increase the spread of COVID-19 in their
28 communities and in any other communities they visit. This spread could fan out

1 into different parts of the state, jeopardizing the hard work to contain COVID-19
2 that is going on in many communities and placing a further strain on hospitals and
3 other resources across the state.

4 27. While keeping six feet of separation between individuals and wearing
5 face coverings can reduce the risk of disease transmission, any gathering
6 nevertheless increases the risk of individual and community transmission for the
7 reasons explained above.

8 28. Contact that occurs with longer duration increases the opportunity for
9 spreading infection. Brief encounters in grocery stores and during shopping
10 excursions carry a lower risk of person-to-person spread by virtue of their less
11 extended, fleeting nature compared to encounters that occur with in-person school
12 instruction, or gatherings for events that are carried out over a much longer time
13 period.

14 29. In-person classroom instruction thus creates increased public risk of
15 COVID-19 transmission until localities have attained sufficient testing, tracking,
16 hospital capacity, and infection rates that indicate epidemiological stability and an
17 ability to treat outbreaks if they occur. At such a time, there may be modifications
18 that mitigate risk to an acceptable level. As the federal Centers for Disease Control
19 and Prevention recognized in updated guidance issued in July, evidence from
20 around the world suggests that reopening of schools may be safe in communities
21 with low COVID-19 rates. California, however, is currently not low, exceeding
22 100 cases per 100,000 residents in numerous counties across the state.

23 **III. THE STATE'S MEASURES TO CURB THE SPREAD OF COVID-19**

24 30. The purpose of the State's public health measures to combat the COVID-
25 19 pandemic is to protect vulnerable people from infection with the coronavirus
26 that causes COVID-19 and to reduce the spread of the virus in the community. By
27 reducing community spread, we can protect persons at increased risk of severe
28 disease and prevent critical infrastructure, particularly health care facilities, from

1 being overwhelmed. In geographic areas where community spread has been
2 reduced and/or in those areas that are less susceptible to being overwhelmed by a
3 potential community spread and that have demonstrated the ability to test and trace
4 in accordance with relevant guidelines, other health and safety rules may be
5 promulgated to allow more sectors of the economy to operate with appropriate
6 public health modifications. This includes public, private, and parochial schools.

7 31. Governor Gavin Newsom instituted a stay at home order on March 19,
8 2020 to prevent the rapid spread of COVID-19 that was occurring, and to allow the
9 state to build capacity to respond to the crisis. As the data revealed that the spread
10 of COVID-19 was stabilizing, California was able to begin reopening sectors of the
11 economy and activities based on relative risk of activities.

12 32. To reduce the incidence of community spread, the state adopted a staged
13 reopening plan, starting first with opening lower-risk businesses and activities,
14 based on what is known about the transmission of the virus. Such an approach
15 reduces the chance that the state and local capacity that has been developed to
16 respond to outbreaks will be overwhelmed as the state moves to reopening all
17 sectors and activities, with modifications. By contrast, a plan in which the state
18 reopens all businesses at once—as opposed to this progressive plan—would expose
19 the state to severe risk of an escalating outbreak and limit the state’s ability to
20 ensure that testing and medical capacity keeps pace with disease levels.

21 33. This staged reopening can vary between different regions and counties
22 depending on their rates of infection and medical capacity. Regions with low
23 infection rates may move through the various reopening stages more rapidly than
24 regions with higher infection rates. If a region reopens and its infection rate
25 increases, the reopening will be reassessed and possibly slowed, or stopped.

26 34. In July 2020, the case positivity rate and other indicators started
27 increasing again, prompting new orders and directives to pause reopening or, in
28 some cases, roll back the reopening of certain higher risk activities, particularly

1 indoor activities where the risk of transmission is greater. Activities in counties
2 with particularly high rates of transmission, or other data reflecting that the
3 disease's renewed spread could overwhelm the health system, were rolled back.

4 35. While managing a pandemic, public health officials' decisions to reopen
5 new sectors are informed by current conditions and evaluation of the risk of
6 activities in those sectors, in light of the particular activities and in the broader
7 context of how renewing those activities may impact community spread.

8 36. Based on estimates, there are nearly 6.5 million children enrolled in
9 public and private schools in California. Reopening schools for in-person
10 instruction would result in a significant amount of new movement throughout the
11 community of students, parents, and school employees as they travel to school, and
12 a mixing of individuals from various households, with students and teachers
13 together in groups indoors for extended periods of time.

14 37. This movement and mixing would introduce substantial new risks of
15 transmission of COVID-19.

16 38. Because data on the extent to which children spread COVID-19 are
17 evolving, and some evidence exists that older children can transmit the disease,
18 children must be factored into the community-wide efforts to control the spread of
19 COVID-19, protect vulnerable populations, and prevent the overburdening of
20 hospitals. Based on estimates that there are approximately 6.5 million school-age
21 children throughout the state of California. In addition, many adults are involved in
22 teaching children and managing schools. It is for this reason the opening of public,
23 private, and parochial school systems, consisting of transitional kindergarten
24 through 12th grade, must be carefully considered and planned.

25 39. The State's public health measures attempt to identify and impose the
26 least restrictive feasible restrictions available at a given point in time that can be
27 reasonably anticipated (based on the latest data and scientific consensus) to meet
28

1 the State's primary public health purpose, that is, reducing the spread of COVID-
2 19.

3 40. The State's pandemic response was designed to be, and has been, a work
4 in progress that must be adjusted in real time as the data and circumstances change.
5 The course of the pandemic has varied greatly over time, and in different parts of
6 the State, and likely will continue to do so. In accordance with these realities, as
7 the State has obtained more data and scientific understanding has increased, the
8 State has been increasingly able to tailor and target its public health measures,
9 including at a county-by-county level, and to focus more restrictive measures in
10 areas that are currently experiencing elevated rates of infection and hospitalization.

11 41. The State is monitoring the spread of COVID-19 closely in each local
12 county community and has set up a county monitoring list. If a county is on a
13 monitoring list for more than 3 days, it is required to roll back some activities that
14 present higher risk of transmission, as explained in the July 13, 2020 order by the
15 State Public Health Officer. A county will be allowed to re-open its schools if it
16 remains off the monitoring list for 14 days and can institute other safety criteria.

17 42. As the State has obtained additional experience with the course and
18 effects of the COVID-19 pandemic and obtained additional risk-related data, it has
19 engaged in ongoing assessment of relative risk, and has updated its guidance based
20 on its experience and data.

21 43. CDPH guidance also requires that people wear a cloth face covering over
22 their nose and mouth in the community setting, subject to certain exemptions. This
23 is a public health measure people must take to reduce the spread of COVID-19 in
24 addition to, not instead of, physical distancing, frequent hand cleaning, and other
25 everyday preventive actions. A cloth face covering is not necessarily intended to
26 protect the wearer but serves to prevent the spread of virus from the wearer to
27 others. This is especially important when someone is infected but is not aware of
28 their illness and is not self-isolating. CDPH guidance requires a cloth face covering

1 to be worn when people go into public settings. Although wearing a face covering
2 or frequently washing one's hands will not completely prevent the spread of the
3 virus, each of these measures contributes to reducing the risk of transmission.

4 I declare under the penalty of perjury under the laws of the United States that
5 the foregoing is true and correct to my personal knowledge.

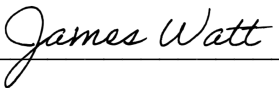
6 Executed on August 8th, 2020, in Albany, California.

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James Watt, M.D., M.P.H.

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EXHIBIT A

CURRICULUM VITAE

Name: James Watt, MD, MPH

Position: Chief, Division of Communicable Disease Control
Center for Infectious Diseases
California Department of Public Health

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850 Marina Bay Parkway
Richmond, CA 94804

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Email: james.watt@cdph.ca.gov

EDUCATION AND TRAINING

1980-84	Stanford University, Stanford, CA	B.S. (Biology) B.A. (German Studies)
1985	Deutches Primatenzentrum, Goettingen, Germany	Krupp Fellowship
1985-90	University of California, San Diego	M.D.
1990-93	Oakland Children's Hospital, Oakland, CA	Resident (Pediatrics)
1994-95	University of California, Berkeley	M.P.H. (Maternal and Child Health)
1995-96	California Department of Health Services, San Francisco, CA	Resident (Preventive Medicine)

LICENSES, CERTIFICATION

1991-present Medical Licensure, California
1995-present Board Certification, Pediatrics

PRINCIPAL POSITIONS HELD

1996-99	Public Health Medical Officer II Immunization Branch Division of Communicable Disease Control California Department of Health Services
1999-01	Epidemic Intelligence Service Officer Respiratory Diseases Branch Division of Bacterial and Mycotic Diseases National Center for Infectious Disease Centers for Disease Control and Prevention
2001-06	Assistant Scientist Department of International Health School of Public Health Johns Hopkins University

1/8/2019

Curriculum Vitae
James Watt, MD, MPH

2006-07 Public Health Medical Officer III (Epidemiology)
Tuberculosis Control Branch
Division of Communicable Disease Control
Center for Infectious Diseases
California Department of Public Health

2008-10 Chief
Tuberculosis Control Branch
Division of Communicable Disease Control
Center for Infectious Diseases
California Department of Public Health

OTHER POSITIONS HELD CONCURRENTLY

2006-present Associate
Johns Hopkins University
School of Public Health

2009-present Associate Clinical Professor
University of California, San Francisco
School of Medicine

2009-2010 Member representing high incidence jurisdictions
Board of Directors
National Tuberculosis Controllers Association

2008-2010 Executive Committee (ex officio)
California Tuberculosis Controllers Association

2012-present Deputy State Epidemiologist
California Department of Public Health

2015 Acting State Health Officer, California

HONORS AND AWARDS

1984 Phi Beta Kappa, Stanford University
2000 United States Public Health Service Achievement Medal
2001 Honor Award, National Center for Infectious Diseases
2002 Committee recognition award for two outstanding abstracts, International Symposium on Pneumococci and Pneumococcal Disease
2015 Outstanding Achievement Award, California Department of Public Health
2016 Outstanding Achievement Award, California Department of Public Health

INVITED PRESENTATIONS

INTERNATIONAL

International Symposium on the Global Reduction of Hib Disease; Scottsdale, Arizona, 2002 (invited talk)
Indian Academy of Pediatrics Meeting (Pedicon); Calcutta, 2005 (invited talk)

1/8/2019

Curriculum Vitae
James Watt, MD, MPH

International Symposium on Pneumococci and Pneumococcal Disease; Alice Springs, Australia, 2006
(invited talk)

NATIONAL

National Vaccine Advisory Committee Conference on Pneumococcal Disease Prevention in Adults:
Potential Vaccine Strategies; Baltimore, MD, 2003 (invited talk)
5th National Association of Public Health Laboratories Meeting on Essential Mycobacteriology Services;
San Diego, CA, 2008 (invited talk)
Francis J. Curry National Tuberculosis Center National Web Training--Practical Applications of
Genotyping in Tuberculosis Control; San Francisco, CA, 2008 (invited talk)

ADVISORY PANELS

Immunization Partnership, American Academy of Pediatrics/California Department of Health Services
Preventive Medicine Residency Advisory Committee, California Department of Health Services
Cost effectiveness of Hib conjugate vaccine in Egypt, Egyptian Ministry of Health and Population, WHO
Eastern Mediterranean Regional Office, and CDC
A tool for rapidly assessing Hib disease burden, WHO
Standardized interpretation of chest radiographs for the diagnosis of pneumonia, WHO
Research Advisors, Pneumococcal Accelerated Development and Implementation Program
Estimating the burden of *Haemophilus influenzae*, type b in India, Indian Council for Medical Research
Estimating the global burden of Hib and pneumococcal disease, WHO
Development of guidelines for the control of tuberculosis in foreign born persons, CDC
Expert Group to Evaluate Molecular Drug Susceptibility Testing, NTCA

INTERNATIONAL CONSULTATIONS

2001 Estimating Hib disease burden, WHO Africa Regional Office personnel. Harare, Zimbabwe.
2002 Options for Assessing Disease Burden due to Hib in Mongolia, WHO Western Pacific
Regional Office, Ulaan Baatar, Mongolia.
2004 Evaluation of Surveillance for Invasive Hib Disease in Mongolia, WHO Western Pacific
Regional Office, Ulaan Baatar, Mongolia.
2011-12 Review of evidence on the effectiveness of different Hib conjugate vaccine schedules, WHO
Secretariat, Geneva, Switzerland

TEACHING AND MENTORING

JOHNS HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH

COURSES TAUGHT

Introduction to Quantitative and Qualitative Research for American Indian Health (Summer Institute, 2006,
Principal Instructor. Enrollment of 20).

Collecting, Analyzing and Using Public Health Data in Native American Communities (Summer Institute,
2005, Principal Instructor. Enrollment of 30).

Collecting, Analyzing and Using Public Health Data in Native American Communities (Summer Institute,
2004, Principal Instructor. Enrollment of 36).

STUDENTS MENTORED (Johns Hopkins University)

Aparna Roy (MPH, 2005)

Capstone Project Title: *Incidence of community acquired pneumonia in adults.*

1/8/2019

Curriculum Vitae
James Watt, MD, MPH

Cecilia Young Kwak (MPH, 2004)

Capstone Project Title: *The incidence of community acquired pneumonia in adults: a literature review*

Laurel Murrow (medical student, summer internship 2003)

Project Title: *Evaluation of an Active, Laboratory-based Surveillance System for Invasive Bacterial Infections among the Navajo and White Mountain Apache*

Dahlia McGregor, MD (MPH, 2003)

Integrating Experience Title: *Population-based surveillance of invasive pneumococcal disease in Jamaican children: Providing data for cost-benefit analysis of conjugate pneumococcal vaccines*

FELLOWS MENTORED (CDPH)

Jessica Cunningham, MPH (CSTE fellow)

Major Project: Epidemiology of tuberculosis among homeless persons in California.

Darryl Kong, MPH (Cal-EIS fellow)

Major Project: Identification and management of tuberculosis patients co-infected with HIV in California.

Erin Murray, PhD (CDC EIS Officer)

Major Project: Identification of geographic areas with increased incidence of tuberculosis.

Jonathan Nunez, MD (CDC EIS Officer)

Major Project: Analysis of the impact of non-screening of immigrants prior to arrival on imported tuberculosis in the United States

Patrick Ayscue, DVM, PhD (CDC EIS Officer)

Major Project: Analysis of trends in hospitalization for Varicella and Zoster in California

Jacklyn Wong, PhD (CDC EIS Officer)

Increased tuberculosis risk among immigrants arriving to California with abnormal domestic chest radiographs.

Hope Biswas, PhD (CDC EIS Officer)

Major Project: Characteristics associated with delivery of an infant with congenital syphilis and missed opportunities for prevention—California 2012-2014.

Yasser Bakhsh, MD, MPH (CDC EIS Officer)

Current.

FRANCIS J. CURRY NATIONAL TUBERCULOSIS CENTER

COURSES TAUGHT

Tuberculosis Clinical Intensive (February, 2009, Course Faculty).

RESEARCH AND CREATIVE ACTIVITIES

RESEARCH AWARDS AND GRANTS

1. California Emerging Infections Program
(co-director)

1/1/12-present

1/8/2019

Curriculum Vitae
James Watt, MD, MPH

Centers for Disease Control and Prevention

2. Cooperative Agreement for Epidemiology and Laboratory Capacity (principal investigator) 1/1/11-present
Centers for Disease Control and Prevention
3. Determination of HIV status and prevalence of HIV co-infection among tuberculosis cases in California (co-principal investigator) 7/1/09-6/31/10
Centers for Disease Control and Prevention
4. Cooperative Agreement for Tuberculosis Prevention, Control and Elimination in the United States (principal investigator) 1/1/08-12/31/10
Centers for Disease Control and Prevention.
5. Hib Initiative (co-investigator) 9/1/04-7/31/06
Global Alliance for Vaccines and Immunization (GAVI)
Supporting evidence-based decision making about *Haemophilus influenzae*, type b (Hib) vaccine use in developing countries
6. India Hib Disease Burden Project (project lead) 9/1/04-7/31/06
GAVI, USAID, Government of India
Estimating the burden of Hib disease in India to support an evidence-based decision about vaccine use
7. Indirect effects of pneumococcal conjugate vaccine in the community (co-investigator) 1/1/00-12/31/03
Wyeth Lederle Vaccines
8. Epidemiology of pneumococcal pneumonia among Navajo and Apache adults (co-investigator) 1/1/01-12/31/04
Aventis
9. Safety and Efficacy of Pentavalent (G1, G2, G3, G4 and P1) Human-Bovine Reassortant Rotavirus Vaccine in Healthy Infants (co-investigator) 1/1/01-12/31/04
Merck & Co.
10. Pneumonia Epidemiology in White Mountain Apache Adults (principal investigator) 9/1/03-8/31/04
NIH/NIGM RO1 (under grant U26 94 00012-01)
11. A Phase 3 Study of MEDI-524 (Numax™), an Enhanced Potency Humanized Respiratory Syncytial Virus (RSV) Monoclonal Antibody, for the Prevention of RSV Disease Among Navajo and White Mountain Apache Infants (co-investigator) 1/1/04-7/31/06
MedImmune, Inc.

PUBLICATIONS

1. Kahane SM, **Watt JP**, Newell K, Kellam S, Wight S, Smith NJ, et al. Immunization Levels and Risk Factors for Low Immunization Coverage Among Private Practices. *Pediatrics* 2000;105(6):e73.
2. Hyde TB, Gilbert M, Zell ER, **Watt JP**, Schwartz SB, Thacker WL, et al. Azithromycin prophylaxis during a hospital outbreak of *Mycoplasma pneumoniae* pneumonia. *Journal of Infectious Disease* 2001;183:907-12.

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3. **Watt JP**, Schuchat A, Erickson K, Honig JE, Gibbs R, Schulkin J Group B Streptococcal Prevention Practices of Obstetrician-Gynecologists. *Obstetrics and Gynecology* 2001;98(1):7-13.
4. Benin AL, O'Brien KL, **Watt JP**, Reid R, Zell ER, Katz S, Donaldson C, Parkinson A, Schuchat A, Santosham M, Whitney CG. Effectiveness of the 23-valent polysaccharide vaccine against invasive pneumococcal disease in Navajo adults. *Journal of Infectious Diseases* 2003;188(1):81-9.
5. **Watt JP**, Levine OS, Santosham M. Global reduction of Hib disease: what are the next steps? Proceedings of the meeting. *Journal of Pediatrics* 2003;143(6 Suppl):S163-87.
6. **Watt JP**, O'Brien KL, Benin AL, Whitney CG, Robinson K, Parkinson AJ, Reid R, Santosham M. Invasive Pneumococcal Disease among Navajo Adults, 1989-1998. *Clinical Infectious Diseases* 2004;38(4):496-501.
7. Feikin DR, Nelson CB, **Watt JP**, Mohsni E, Wenger JD, Levine OS. Rapid Assessment Tool for *Haemophilus influenzae*, type b Disease in Developing Countries. *Emerging Infectious Diseases* 2004;10(7):1270-6.
8. **Watt JP**, O'Brien KL, Katz S, Bronsdon MA, Elliott J, Dallas J, Perilla MP, Reid R, Murrow L, Facklam R, Santosham M, Whitney CG. Nasopharyngeal versus Oropharyngeal Sampling for Detection of Pneumococcal Carriage in Adults. *Journal of Clinical Microbiology* 2004;42(11):4974-6.
9. O'Brien KL, Shaw J, Weatherholtz R, Reid R, **Watt J**, Croll J, Dagan R, Parkinson AJ, Santosham M. Epidemiology of invasive Streptococcus pneumoniae among Navajo children in the era before use of conjugate pneumococcal vaccines, 1989-1996. *American Journal of Epidemiology*. 2004;160(3):270-8.
10. Millar EV, O'Brien KL, **Watt JP**, Lingappa J, Pallipamu R, Rosenstein N, Hu D, Reid R, Santosham M. Epidemiology of Invasive Haemophilus influenzae Type a Disease among Navajo and White Mountain Apache Children, 1988-2003. *Clinical Infectious Disease*. 2005;40(6):823-30.
11. Benin AL, **Watt JP**, O'Brien KL, Zell E, Donaldson C, Schuchat A, Santosham M. Delivering Pneumococcal Vaccine to a High Risk Population: The Navajo Experience. *Human Vaccines*. 2005;1(2):e2-5.
12. Chandran A, **Watt JP**, Santosham M. Prevention of *Haemophilus influenzae* Type b (Hib) Disease: Past Success and Future Challenges. *Expert Review of Vaccines*. 2005;4(6):819-27.
13. Vesikari T, Matson DO, Dennehy P, Van Damme P, Santosham M, Rodriguez Z, Dallas MJ, Heyse JF, Goveia MG, Black SB, Shinefield HR, Christie CDC, Ylitalo S, Itzler RF, Coia ML, Onorato MT, Adeyi BA, Marshall GS, Gothefors L, Campens D, Karvonen A, **Watt JP**, O'Brien KL, DiNubile MJ, Clark HF, Boslego JW, Offit, PA, Heaton, PM. Safety and Efficacy of a Pentavalent Human-Bovine (WC3) Reassortant Rotavirus Vaccine. *New England Journal of Medicine*. 2006;354(1):23-33.
14. Millar EV, O'Brien KL, **Watt JP**, Bronsdon MA, Dallas J, Whitney CG, Reid R, Santosham M. Effect of community wide conjugate pneumococcal vaccine use in infancy on nasopharyngeal carriage through 3 years of age: a cross-sectional study in a high-risk population. *Clinical Infectious Disease*. 2006;43(1):8-15.
15. Moisi JC, Levine OS, **Watt JP**. Sensitivity of Surveillance for *Haemophilus influenzae*, type b Meningitis. *Pediatric Infectious Disease Journal*. 2006;25(10):960.
16. **Watt JP**, O'Brien KL, Benin AL, McCoy SI, Donaldson CM, Reid R, Schuchat A, Zell ER, Hochman M, Santosham M, Whitney CG. Risk Factors for Invasive Pneumococcal Disease Among Navajo Adults. *American Journal of Epidemiology*. 2007 Nov 1;166(9):1080-7.

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17. Hochman ME, **Watt JP**, Reid R, O'Brien KL. The Prevalence of End Stage Renal Disease in Native American Adults on the Navajo Reservation. *Kidney International*. 2007;71(9):931-7.
18. Rossi I, Zuber P, Dumolard L, Walker D, **Watt JP**. Introduction of Hib vaccine into national immunization programmes: a descriptive analysis of global trends. *Vaccine*. 2007;25:7075-80.
19. Santosham M, Reid R, Chandran A, Millar EV, **Watt JP**, Weatherholtz R, Donaldson C, Croll J, Moulton LH, Thompson CM, Siber GR, O'Brien KL. Contributions of Native Americans to the global control of infectious diseases. *Vaccine*. 2007;22:2366-74.
20. Menzies R, McIntyre P, Reid R, O'Brien K, Santosham M, **Watt JP**, et al. Vaccine preventable diseases in indigenous populations—International perspectives. *Vaccine*. 2007;25:7281-4.
21. Millar EV, **Watt JP**, Bronsdon MA, Dallas J, Reid R, Santosham M, O'Brien KL. Indirect effect of 7-valent pneumococcal conjugate vaccine (Pnc7-CRM) on pneumococcal colonization among unvaccinated household members. *Clinical Infectious Disease*. 2008;47(8):989-96.
22. Mendsaikhan J, **Watt JP**, Mansoor O, Suvdmaa N, Edmond K, Litt DJ, Nymadawa P, Baoping Y, Altantsetseg D, Slack M. Childhood Bacterial Meningitis in Ulaanbaatar, Mongolia, 2002-2004. *Clinical Infectious Disease*. 2009;48(S2):S141-146
23. Wolfson LJ, O'Brien KL, **Watt JP**, Henkle E, Deloria-Knoll M, McCall N, Lee E, Mulholland K, Levine OS, Cherian T. Methods to estimate the global burden of disease due to *Haemophilus influenzae* type b and *Streptococcus pneumoniae* in children less than 5 years of age. *Lancet*. 2009; published online.
24. O'Brien KL, Wolfson LJ, **Watt JP**, Henkle E, Deloria-Knoll M, McCall N, Lee E, Mulholland K, Levine OS, Cherian T. The global burden of disease due to *Streptococcus pneumoniae* in children less than 5 years of age. *Lancet*. 2009;374:893-902.
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26. **Watt JP**, Moïsi JC, Donaldson RLA, Reid R, Ferro S, Whitney CG, Santosham, M, O'Brien KL. Measuring the Incidence of Community Acquired Pneumonia in a Native American Community. *Epidemiology and Infection*. 2010; 138:1146-54.
27. **Watt JP**, Moïsi JC, Donaldson RLA, Reid R, Ferro S, Whitney CG, Santosham, M, O'Brien KL. Use of serology and urine antigen detection to estimate the proportion of adult community-acquired pneumonia attributable to *Streptococcus pneumoniae*. *Epidemiology and Infection*. 2010;138:1796-803.
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29. Banerjee R, Allen J, Lin SYG, Westenhouse J, Desmond E, Schechter GF, Scott C, Raftery A, Mase S, **Watt JP**, Flood J. Rapid Drug Susceptibility Testing with a Molecular Beacon Assay Is Associated with Earlier Diagnosis and Treatment of Multidrug-Resistant Tuberculosis in California. *J Clin Microbiol*. 2010;48(10):3779-81.
30. Metcalfe J, Facer M, Damesyn M, Xia Q, **Watt J**, Hill J, Hopewell P, Westenhouse J, Flood J. Evolution of tuberculosis/HIV co-infection in California during the HAART Era, 1996-2007. *Retrovirology*. 2010;7(Suppl1):01.

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31. Fitzwater S, **Watt JP**, Levine OS, Santosham M. *Haemophilus influenzae* type B conjugate vaccines: considerations for vaccination schedules and implications for developing countries. *Human Vaccines*. 2010;6:810-8.
32. Lowenthal P, Westenhouse J, Moore M, Posey DL, **Watt JP**, Flood J. Reduced importation of tuberculosis after the implementation of an enhanced pre-immigration screening protocol. *International J Tuberculosis Lung Dis*. 2011;15:761-6.
33. Grant LR, Gentsch JR, Esona MD, **Watt J**, Reid R, Weatherholtz RC, Santosham M, Parashar UD, O'Brien KL. Detection of G3P[3] and G3P[9] rotavirus strains in American Indian children with evidence of gene reassortment between human and animal rotaviruses. *J Med Virol*. 2011;83:1288-99.
34. Pascopella L, DeRiemer K, **Watt JP**, Flood JM. When tuberculosis comes back: Who develops recurrent tuberculosis in California? *PLOS One* 2011;6:e26541
35. Grant LR*, **Watt JP***, Weatherholtz RC, Moulton LH, Reid R, Santosham M, O'Brien, KL. Efficacy of a pentavalent human-bovine reassortant rotavirus vaccine against rotavirus gastroenteritis among American Indian children. *Pediatr Infect Dis J* 2012;31:184-8. *equal contribution
36. Grant L, Vinje J, Parashar U, **Watt J**, Reid R, Weatherholtz R, Santosham M, Gentsch J, O'Brien K. Epidemiologic and Clinical Features of Other Enteric Viruses Associated with Acute Gastroenteritis in American Indian Infants. *J Pediatr* 2012;161:110-5.e1.
37. Winter K, Harriman K, Zipprich J, Schechter R, Talarico J, **Watt JP**, Chavez G. California Pertussis Epidemic, 2010. *J Pediatr* 2012;161:1091-6.
38. Said MA, Johnson HL, Nonyane BA, Deloria-Knoll M, O'Brien KL, AGEDD Adult Pneumococcal Burden Study Team (**Watt JP** study team member). Estimating the burden of pneumococcal pneumonia among adults: a systematic review and meta-analysis of diagnostic techniques. *PLoS One* 2013;8(4):e60273.
39. Kong D, **Watt JP**, Marks S, Flood J. HIV Status Determination Among Tuberculosis Patients From California During 2008. *J Public Health Management Practice* 2013;19:169-77.
40. Grant J, **Watt J**, Moulton L, Weatherholtz R, Reid R, Santosham M, O'Brien K. Lack of non-specific protection against all-cause, non-rotavirus gastroenteritis by vaccination with orally administered rotavirus vaccine. *J Pediatr Gastroent Nutr* 2013; epub ahead of print.
41. Murray EL, Samuel MC, Brodsky J, Akiba CF, King C, Li M, Wollesen M, Gonzales PE, **Watt JP**, Bolan G. *Neisseria gonorrhoeae* Outbreak: Unintended Consequences of Electronic Medical Records and Using an Out-of-State Laboratory—California, July 2009-February 2010. *Sex Trans Dis* 2013;40:556-8.
42. Metcalfe JZ, Porco TC, Westenhouse J, Damesyn M, Facer M, Hill J, Xia Q, **Watt JP**, Hopewell PC, Flood J. Tuberculosis and HIV co-infection, California, USA, 1993–2008. *Emerg Infect Dis* 2013; 19:400-6.
43. Scott S, Altanseseg D, Sodbayer D, Nymadawa P, Bulgan D, Mendsaikhan J, **Watt JP**, Slack M, Carvalho MG, Hajjeh R, Edmond KM. Impact of *Haemophilus influenzae* Type b Conjugate Vaccine in Mongolia: Prospective Population-Based Surveillance, 2002-2010. *J Peds* 2013;163(1 Suppl):S8-11.
44. Núñez JJ, Fritz CL, Knust B, Buttke D, Enge B, Novak MG, Kramer V, Osadebe L, Messenger S,

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Curriculum Vitae
James Watt, MD, MPH

- Albariño CG, Ströher U, Niemela M, Amman BR, Wong D, Manning CR, Nichol ST, Rollin PE, Xia D, **Watt JP**, Vugia DJ. An Outbreak of Hantavirus Infections Among Overnight Visitors to Yosemite National Park, California, USA, 2012. *Emerg Infect Dis* 2014;20(3):386-93.
45. Kong D, **Watt JP**, Marks SM, Flood JM. Timely HIV Diagnosis and HIV/TB Comanagement among California Patients in 2008. *Publ Health Rep* 2014;129:170-7.
 46. Ayscue P, Murray E, Uyeki T, Zipprich J, Harriman K, Salibay C, Kang M, Luu A, Glenn-Finer R, **Watt J**, Glaser C, Louie J. Influenza-Associated Intensive-Care Unit Admissions and Deaths—California, September 29, 2013—January 18, 2014. *MMWR* 2014;63(7):143-7.
 47. Winter K, Glaser C, Watt J, Harriman K. Pertussis epidemic—California, 2014. *MMWR* 2014;63(48):1129-32.
 48. Ayscue P, Van Haren K, Sheriff H, Waubant E, Waldron P, Yagi S, Yen C, Clayton A, Padilla T, Pan C, Reichel J, Harriman K, Watt J, Sejvar J, Nix WA, Feikin D, Glaser C. Acute flaccid paralysis with anterior myelitis—California, June 2012-June 2014. *MMWR* 2014;63(40):903-6.
 49. Greninger AL, Naccache SN, Messacar K, Clayton A, Yu G, Somasekar S, Federman S, Stryke D, Anterson C, Yagi S, Messenger S, Wadford D, Xia D, **Watt JP**, Van Haren K, Dominguez SR, Glaser C, Aldrovandi G, Chiu CY. A novel outbreak enterovirus D68 strain associated with acute flaccid myelitis cases in the USA (2012-14): a retrospective cohort study. *Lancet Infect Dis* 2015; epub March 31.
 50. Shahkarami M, Yen C, Glaser C, Xia D, **Watt J**, Wadford DA. Laboratory Testing for Middle East Respiratory Syndrome Coronavirus, California, USA, 2013-2014. *Emerg Infect Dis* 2015;21(9):epub.
 51. Zipprich J, Winter K, Hacker J, Xia D, **Watt J**, Harriman K. Measles outbreak—California, December 2014-February 2015. *MMWR* 2015;64(6):153-4.
 52. Smith EM, Khan MA, Reingold A, **Watt JP**. Group B streptococcus infections of soft tissue and bone in California adults, 1995-2012. *Epidemiol Infect* 2015;143(15):3343-50.
 53. Van Haren K, Ayscue P, Waubant E, Clayton A, Sheriff H, Yagi S, Glenn-Finer R, Padilla T, Strober, JB, Aldrovandi G, Wadford DA, Chiu, CY, Xia D, Harriman K, **Watt JP**, Glaser Ca. Acute flaccid myelitis of unknown etiology in California, 2012-2015. *JAMA* 2015; 314(24):2663-71.
 54. Langley G, Hao Y, Pondo T, Miller L, Petit, S, Thomas A, Lindegren ML, Farley MM, Dumyati G, Como-Sabetti K, Harrison LH, Baumbach J, **Watt J**, Van Beneden C. The Impact of Obesity and Diabetes on the Risk of Disease and Death due to Invasive Group A *Streptococcus* Infections in Adults. *Clin Infect Dis* 2016;62(7):845-52.
 55. Nelson GE, Pondo T, Toews K, Farley MM, Lindegren ML, Lynfield R, Aragon D, Zansky SM, **Watt JP**, Cieslak PR, Angeles K, Harrison LH, Petit S, Beall B, Van Beneden CA. The Epidemiology of Invasive Group A Streptococcal Infection in the United States, Implications for Vaccine Prevention. *Clin Infect Dis* 2016; epub April 22.
 56. Barry PM, Kay AW, Flood JM, **Watt J**. Getting to Zero: Tuberculosis Elimination in California. *Curr Epidemiol Rep* 2016; epub March 29.
 57. Kozyreva VK, Jospin G, Greninger AL, **Watt JP**, Eisen JA, Chaturvedi V. Recent Outbreaks of Shigellosis in California Caused by Two Distinct Populations of *Shigella sonnei* with either Increased Virulence or Fluoroquinolone Resistance. *mSphere* 2016;1(6); e00344-16.

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James Watt, MD, MPH

58. Blain AE, Lewis M, Banerjee E, Kudish K, Liko J, McGuire S, Selvage D, **Watt J**, Martin SW, Skoff TH. An Assessment of the Cocooning Strategy for Preventing Infant Pertussis—United States, 2011. *Clin Infect Dis* 2016;63(suppl 4):S221-S226.
59. Skoff TH, Blain AE, **Watt J**, Scherzinger K, McMahon M, Zansky SM, Kudish K, Cieslak PR, Lewis M, Shang N, Martin SW. Impact of the US Maternal Tetanus, Diphtheria, and Acellular Pertussis Vaccination Program on Preventing Pertussis in Infants <2 Months of Age: A Case-Control Evaluation. *Clin Infect Dis* 2017: epub 2017.
60. Wong J, Lowenthal P, Flood J, **Watt J**, Barry PM. Increased tuberculosis risk among immigrants arriving to California with abnormal domestic chest radiographs. *Intl J Tuberculosis Lung Dis* 2018;22(1):73-79
61. Biswas HH, Ng RA, Murray EL, Chow JM, Stoltey JE, **Watt JP**, Bauer HM. Characteristics Associated with Delivery of an Infant with Congenital Syphilis and Missed Opportunities for Prevention—California, 2012-2014. *Sexually Trans Dis*. 2018;45(7):435-441.
62. Porse CC, Messenger S, Vugia DJ, Jilek W, Salas W, **Watt J**, Kramer V. Travel-Associated Zika Cases and the Threat of Local Zika Transmission in California during the Global Zika Outbreak. *Emerging Infect Dis*. 2018;24(2):1626-32.
63. Pitts SI, Maruthur NM, Langley GE, Pondo T, Shutt KA, Hollick R, Schrag SJ, Thomas A, Nichols M, Farley M, **Watt JP**, Miller L, Schaffner W, Holtzman C, Harrison LH. Obesity, Diabetes, and the Risk of Invasive Group B Streptococcal Disease in Nonpregnant Adults in the United States. *Open Forum Infect Dis*. 2018;5(6):ofy030.

BOOKS AND CHAPTERS

1. Chandran A, **Watt JP**, Santosham M. Chapter 11: *Haemophilus influenzae* Vaccines. Plotkin SA, Orenstein WA, Offit PA, Editors. *Vaccines*. Fifth edition. Philadelphia: W.B. Saunders Co. 2007.
2. Chandran A, **Watt JP**, Santosham M. Chapter 11: *Haemophilus influenzae* Vaccines. Plotkin SA, Orenstein WA, Offit PA, Editors. *Vaccines*. Sixth edition. Philadelphia: W.B. Saunders Co. 2012.

OTHER PUBLICATIONS

1. Estimating the local burden of *Haemophilus influenzae* type b (Hib) disease preventable by vaccination. WHO/V&B/01.27. World Health Organization, Geneva, 2001. (*contributor*)
2. Expert review of a tool for rapidly assessing *Haemophilus influenzae* type b (Hib) disease burden. WHO/V&B/01.25. World Health Organization, Geneva, 2001. (*rapporteur/primary author of meeting summary*)
3. Centers for Disease Control and Prevention. Adoption of Perinatal Group B Streptococcal Disease Prevention Recommendations by Prenatal-Care Providers--Connecticut and Minnesota, 1998. *MMWR* 2000;49(11):228-31. (*primary author*)
4. Global Literature Review of *Haemophilus influenzae* type b and *Streptococcus pneumoniae* invasive disease among children less than five years of age, 1980-2005. World Health Organization, Geneva, 2008. (*co-author*)

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5. Centers for Disease Control and Prevention. Notes from the Field: Hantavirus Pulmonary Syndrome in Visitors to a National Park—Yosemite Valley, California, 2012. *MMWR* 2012;61(46):952. *(co-author)*
6. Centers for Disease Control and Prevention. Mumps Outbreak on a University Campus, 2011. *MMWR* 2012;61:986-9. *(co-author)*

CERTIFICATE OF SERVICE

Case Name: Brach v. Newsom, et al. No. 2:20cv06472 SVW (AFMx)

I hereby certify that on August 9, 2020, I electronically filed the following documents with the Clerk of the Court by using the CM/ECF system:

- MEMORANDUM OF POINTS AND AUTHORITIES IN OPPOSITION TO APPLICATION FOR TEMPORARY RESTRAINING ORDER (Dkt. 28)
- DECLARATION OF JAMES WATT, M.D., M.P.H., IN SUPPORT OF DEFENDANTS' OPPOSITION TO PLAINTIFFS' APPLICATION FOR TEMPORARY RESTRAINING ORDER AND FOR ORDER TO SHOW CAUSE WHY PRELIMINARY INJUNCTION SHOULD NOT ISSUE
- REQUEST FOR JUDICIAL NOTICE IN OPPOSITION TO APPLICATION FOR TEMPORARY RESTRAINING ORDER (Dkt. 28); EXHIBITS
- DECLARATION OF DARIN WESSEL IN SUPPORT OF REQUEST FOR JUDICIAL NOTICE IN OPPOSITION TO APPLICATION FOR TEMPORARY RESTRAINING ORDER (Dkt. 28)

I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

I declare under penalty of perjury under the laws of the State of California and the United States of America the foregoing is true and correct and that this declaration was executed on August 9, 2020, at San Francisco, California.

G. Guardado
Declarant

/s/ G. Guardado
Signature

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