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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF OREGON
EUGENE DIVISION

PAUL MANEY; GARY CLIFT; GEORGE NULPH; THERON HALL; DAVID HART; MICAH RHODES; and SHERYL LYNN SUBLET, individually, on behalf of a class of other similarly situated, Plaintiffs, v. KATE BROWN, COLETTE PETERS; HEIDI STEWARD; MIKE GOWER; MARK NOOTH; ROB PERSSON; KEN JESKE; and PATRICK ALLEN Defendants.	Case No. 6:20-cv-00570-SB DECLARATION OF COUNSEL

1. My name is Juan C. Chavez, and I am one of the Counsels of Record for the Plaintiff in the above-referenced case.

2. This declaration is prepared for the purpose of identifying exhibits for Plaintiffs' Motion and Memorandum for Entry of a Temporary Restraining Order.

3. I am attaching with this declaration true and correct copies of excerpts from the Depositions of Daniel Dewsnup, MD, conducted on November 9, 2020, and Snake River Superintendent Brad Cain, conducted on December 22, 2020. I note that portions of Dr. Dewsnup are currently confidential pursuant to the parties' Stipulated Protective order. No excerpts provided come from the confidential section of the deposition.

I HEREBY DECLARE THAT THE ABOVE STATEMENT IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF, AND THAT I UNDERSTAND IT IS MADE FOR USE AS EVIDENCE IN COURT AND IS SUBJECT TO PENALTY FOR PERJURY.

DATE: January 21, 2020.

/s/ *Juan C. Chavez*
Juan C. Chavez, OSB #136428
Attorney for Plaintiff

*** CONFIDENTIAL PORTIONS***

Deposition of :

Daniel Dewsnup, MD

November 9, 2020

Paul Maney; et al.

vs.

State of Oregon; et al.

Case No.: 6:20-CV-00570-SB

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF OREGON

EUGENE DIVISION

PAUL MANEY; GARY CLIFT;
GEORGE NULPH; THERON HALL;
DAVID HART; MICAH RHODES; AND
SHERYL LYNN SUBLET,
individually, on behalf of a
class of other similarly
situated,

Plaintiffs,

v. No. 6:20-CV-00570-SB

STATE OF OREGON; KATE BROWN;
COLETTE PETERS; HEIDI STEWARD;
MIKE GOWER; MARK NOOTH; ROB
PERSSON; and KEN JESKE,

Defendants.

ZOOM VIDEOCONFERENCE DEPOSITION OF

DANIEL DEWSNUP, M.D.

Taken on behalf of Plaintiffs

CONFIDENTIAL PORTION

1 BE IT REMEMBERED THAT, pursuant to the
2 Oregon Rules of Civil Procedure, the Zoom
3 videoconference deposition of DANIEL DEWSNUP, M.D.
4 was taken before Rosemary Tanzer, a Registered
5 Professional Reporter and a Certified Shorthand
6 Reporter for Oregon and Washington, on Monday,
7 November 9, 2020, commencing at the hour of 9:08
8 a.m., in Portland, Oregon.
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1 APPEARANCES
2
3 Appearing on behalf of the Plaintiffs:
4 OREGON JUSTICE RESOURCE CENTER
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6 MS. BRITTNEY PLESSER (Appearing Remotely)
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12 ALSO PRESENT REMOTELY: Jake Quain, videographer
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1 EXAMINATION INDEX

2 EXAMINATION BY: PAGE NO.

3 MR. CHAVEZ 7

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14 CONFIDENTIAL PORTION:

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1 THE VIDEOGRAPHER: Here begins the
2 videotaped deposition of Dr. Daniel Dewsnup in the
3 matter of Paul Maney et al. versus State of Oregon et
4 al.
5 Will counsel please introduce yourselves
6 for the record.
7 MR. CHAVEZ: Good morning. My name is Juan
8 Chavez. I represent the Plaintiffs.
9 MR. SUGERMAN: David Sugerman. I'm here on
10 behalf of Plaintiffs in the proposed class.
11 MS. PLESSER: Brittney Plesser on behalf of
12 the plaintiffs.
13 MR. BRUGGEMEIER: This is Franz Bruggemeier
14 on behalf of the plaintiffs.
15 MR. MEGGITT: Alex Meggitt also for the
16 plaintiffs.
17 MR. HALLMAN: Andrew Hallman on behalf of
18 the defendants. I'm in the room with Dr. Dewsnup.
19 THE VIDEOGRAPHER: Stenographer will now
20 swear in the witness.
21
22 DANIEL DEWSNUP, M.D.,
23 Having first been sworn by the Certified Shorthand
24 Reporter to tell the truth, testified under oath as
25 follows:

1 that a recommendation to the governor or was that
2 just information being provided to the governor?
3 A It was informational in order to establish the
4 extent of the issue. If you wanted to -- because
5 basically what we are trying to do -- as this
6 actually came from Mr. Gower's office. What they
7 were trying to do was to establish how many people
8 would we have to release in order to establish what
9 was then thought as the Holy Grail, which was three
10 to six feet of social distancing. And that's the
11 figure they came up with.
12 For me, right now, I think it would be
13 close down every dormitory and only have celled
14 units, given the problems that we have of COVID 19 in
15 dormitories. But that's what they came up with at
16 the beginning, and it still makes sense today.
17 Q Now, did you have a hand in developing that
18 informational package to the governor?
19 A No. That came from Mike Gower's office, the
20 assistant director for operations.
21 Q I see. He did mention that. Now, presently are
22 you aware of any lists that address your concern
23 about dormitory housing? Let me strike that and
24 rephrase.
25 How many people would you need to release

1 to empty out the dormitories of ODOC?
2 A Oh, boy. I would have to consult with an
3 operation's specialist to know the exact number. It
4 would be closer to 50 to 60 percent -- 60 percent.
5 Q Okay. Earlier I think you talked about -- I
6 think you described this primitive facilities with
7 CDCR. Do you recall that testimony?
8 A Yeah.
9 Q Does ODOC have similar, let's use primitive,
10 engineering structural?
11 A It does, especially in areas where the
12 prison -- to give an example, the prison at Eastern
13 Oregon Constructional Institution in Pendleton was
14 originally not built as a prison. It was built as a
15 mental health hospital for the state, and it's been
16 re-purposed to be a prison. So it's exclusively --
17 well, not exclusively. There might be 15 percent
18 individual cells, but the rest is dormitory housing.
19 And it makes it very, very difficult to control an
20 airborne illness within its walls once it gets in.
21 The only real chance you have to control it is make
22 sure it doesn't get in.
23 When you have a virus that is
24 asymptomatically passed in the majority of cases,
25 that makes it extremely difficult to get it stopped

1 and never have exposure to anyone until COVID went
2 away. That's just not an option. So we have to work
3 within what we can do.
4 And all those things will -- the
5 comprehensive program will include testing, and has
6 included testing up to this point, which we're
7 expanding, hand washing, social distancing when
8 possible, masking, masking, masking, masking, and
9 hopefully, in the near future, vaccine use.
10 So I think an acceptable risk would be
11 doing the things that are necessary to do within the
12 institution to maintain public health and public
13 safety and utilizing, to our best ability, all of the
14 tools that we have to mitigate COVID 19 transmission.
15 I think that's about as close as I'm going
16 to be able to come to that definition.
17 Q I understand. And that's helpful, because I
18 think, then, hopefully it will be easy to identify
19 unacceptable risk better. Would you be able to
20 define unacceptable risk in this circumstance or
21 point to any examples?
22 A Unacceptable. Well, unacceptable implies on a
23 certain level that you can say no. And that's the
24 problem with unacceptable risk in the correctional
25 system where there are things we would love to say no

1 ingress into prisons of all nonessential personnel.
2 The only way to get COVID into the institution is
3 have it come in through a staff member. And that has
4 been the way each of these except -- with the
5 exception of one, that's been the way that each of
6 these outbreaks have started since April.
7 Q So that's been determined by your investigators,
8 that all but one was through some sort of staff
9 ingress?
10 A Correct. (indiscernible audio) was right at the
11 beginning where -- remember, in mid-March we closed
12 down visiting and inter-institutional transfers until
13 they were screened. And on that same day that we
14 were doing it, there were institutional transfers
15 from Santiam Correctional Institution to Shutter
16 Creek Correctional Institution, and that included one
17 or more infected persons. And they went to a
18 specific dorm at Shutter Creek, and that's where the
19 infection was first -- was recognized at Shutter
20 Creek. After -- everything has been staff-to-staff
21 transmission and eventually staff-to-AIC
22 transmission.
23 Q Two questions, and we'll get back to our
24 previous thread.
25 First, are these investigations reported in

1 A That is something we're giving an incredible
2 amount of thought to and are talking with Devarshi to
3 do all kinds of statistical analysis on our hospital
4 patients.
5 We believe that the major drivers of the
6 mortality rate are the same thing that drive it in
7 the community, in other words, advanced age or
8 advanced physiologic age, and multiple co-morbid
9 medical conditions, the ones that increase
10 vulnerability to COVID 19.
11 Q You used the term physiological age. What do
12 you mean by that?
13 A Well, there is pretty well-documented -- so
14 let's explain it this way. A person who is 60 on the
15 outside and has certain number -- has a certain risk
16 for underlying medical conditions. That same risk of
17 underlying medical conditions would be comparable to
18 a person in corrections at age 45 or 50. So that's
19 meaning they're -- they've been exposed to a lot more
20 risk. They're harder smokers. They're harder
21 drinkers. They've been exposed to more homelessness.
22 They've been exposed to more sexually transmitted
23 diseases. These things have taken a toll on them.
24 And by the time they get up to age 50, they're as
25 beat up as somebody who is 60 or 70 in the general

1 for a longer period of time. Their recovery is
2 delayed. Even if they're not contagious, they still
3 have symptoms for a longer period of time.
4 Q What do the symptoms look like?
5 A They look like chronic obstructive disease.
6 They look like COPD. They look like asthma. They
7 look like exercise intolerance. They look like
8 chronic dyspnea, shortness of breath. They can
9 include chest pain, pleuritic chest pain, meaning --
10 pleuritic chest pain meaning pain with breathing
11 because of scaring. There is a whole range of
12 symptoms that can be manifested.
13 Q Do we know how long those symptoms manifest
14 currently?
15 A To date we have knowledge about what happens
16 acutely all the way up to multisystem failure and
17 death and how to manage that. And we also have -- we
18 also have long-term data on four different classes of
19 what is called, in the community, a long COVID,
20 L-O-N-G, long COVID, or persistent COVID, which
21 basically means all the sequela of a COVID 19
22 infection such as lung scaring, such as heart --
23 scaring in the heart from cardiomyopathy causing
24 problems in, again, all the same symptoms that I was
25 talking to you about.

1 Also there are symptoms that look a lot
2 like chronic fatigue syndrome and symptoms that are
3 vague and characterize and move from body system to
4 body system that look more like somatization. Much
5 more difficult to characterize.
6 There is just -- they're human beings, and
7 they have a variety of ways that their body responds
8 to this huge infectious challenge.
9 Q Thank you for that. That's really helpful.
10 But just for our record, some terms I might
11 need to look back on, but I think it might be easier
12 if you can define some things -- some words that you
13 used. The first one was cytokine. What's that?
14 A Cytokine, C-Y-T-O-K-I-N-E. A cytokine is a
15 cellular -- it is a protein usually that is released
16 from an inflammatory cell that augments, potentiates,
17 or enhances and helps to target the inflammatory
18 response at the individual cellular level.
19 Q What about cardiomyopathy?
20 A Cardiomyopathy. Myopathy is spelled
21 M-Y-O-P-A-T-H-Y. Cardiomyopathy is a result of
22 direct infection of heart tissue by COVID 19 causing
23 loss of efficiency of the heart muscle, which
24 increases the chance of congestive heart failure and
25 heart attack and other complications of heart

1 Q Now I've heard of other potential long-term
2 symptoms of COVID. One of the more -- well, I'm
3 going to use the word popular. But thinking of
4 popular, I think of COVID of the loss of sense of
5 smell and taste. Have you seen that as well in a
6 symptom?
7 A Not long-term loss of smell and taste.
8 Certainly in the acute phase there is loss of smell
9 and taste.
10 In the literature there are reports of
11 longer term loss of smell and taste. And these are
12 presumably related to specific nerve damage of the
13 olfactory nerve or of the (indiscernible audio) nerve
14 or of some organ in either system that is damaged to
15 the point where sensations can no longer be
16 interpreted correctly by the brain.
17 Q How does that damage to the nerve --
18 A Usually the cells that are infected by COVID 19
19 are killed and then replaced by scar tissue. And
20 scar tissue looks like -- it looks like regular
21 tissue but it doesn't work like regular tissue. It
22 doesn't have the same function. It's not able to
23 carry sensations to the brain that you interpret as
24 smell or hearing.
25 Q There is a laundry list of symptoms and health

1 level of care, so we send them out for a pulmonary
2 referral.
3 And to date we've not found anything that
4 we could intervene on, just a chronic -- chronic lung
5 disease, basically, is what's happened. It's made
6 their existing lung disease worse or their existing
7 heart disease more symptomatic.
8 Q And you would agree that affects their quality
9 of life going forward in their lives.
10 A Yes.
11 Q How so?
12 A Well, they feel terrible. They don't have --
13 they don't have any energy. When you don't have your
14 energy state, you feel rotten. You feel like you're
15 not able -- you don't feel safe in, say, a prison
16 environment, or you don't feel safe doing your
17 activities of daily living without an undue risk of
18 falling. You just don't feel like you have the
19 sensei apparatus to keep you feeling safe. So you
20 may feel anxious and concerned and feeling like there
21 is an impending sense of doom about what's going on.
22 This is a small minority of patients, but it's very
23 real to them.
24 Q This brings something to mind. On the Oregon
25 Department of Corrections website, have you seen the

1 Corrections, somebody who recaught the disease in
2 three to five months?
3 A We have not seen a documented re-infection case
4 yet, although we've wondered. But no, no we haven't
5 seen that yet.
6 Q My understanding from just a tacit review of the
7 medical literature is that there is at least one
8 documented case of re-infection; is that accurate?
9 A No, there is multiple now. Probably four that
10 I've seen in the literature. It's not common, but
11 actually it's probably more common than we realize.
12 But still, among the millions of cases of COVID, it's
13 not a common phenomenon.
14 And the reason is because it's not just
15 antibodies that protect us against re-infection.
16 There is the cell-based immunity arm of the immune
17 system, which is not talked about in the media
18 because it's complicated. And among those cells are
19 cells called T memory cells. And what they do is
20 that if they are later presented with the -- with
21 that same COVID challenge, they respond much more
22 quickly. They clone much more readily and
23 reconstitute immune response within hours as opposed
24 to the days and week that it might take upon an
25 initial exposure. So T memory cells are very, very

1 So just a couple of points that I wanted to
2 get back to, what you just testified to. I think you
3 mentioned that nursing staff was low in some of these
4 facilities. First of all, do you know which
5 facilities had?
6 A Yeah, we've had our greatest challenge at EOCI,
7 Pendleton, where the staffing -- nursing staffing
8 levels have gone down to as low as 35 percent.
9 Q Any other facilities?
10 A They usually -- let me explain it. Pendleton --
11 that means that in a perfect world, Pendleton, they
12 would have 20 full-time nurses. That means they were
13 working with seven or eight to cover 24/7 shifts.
14 That's led to extreme fatigue and some burnout among
15 nurses at EOCI.
16 The other institutions -- Snake River
17 hasn't been playing with low numbers as much as extra
18 work, and they've asked for a lot of people, a lot of
19 extra overtime, and that's just made people very
20 tired. And it's been difficult for them to keep
21 responding day after day after day after month after
22 month to these ongoing -- these ongoing case numbers.
23 TRCI has been doing okay. The smaller
24 institutions we've had, they tend to be shorter. The
25 acute symptomatic period tends to be shorter.

1 A Sure.
2 Q Was that in existence pre-pandemic?
3 A Yes.
4 Q And --
5 A Made it worse.
6 Q I can imagine. Now, had ODOC attempted to
7 address that shortage prior to the pandemic?
8 A Yes. We've been trying to hire and trying to --
9 not only nursing but a provider shortage. During the
10 pandemic, we've -- on a provider level, we've hired
11 extra nurse practitioners, locum tenens, and diverted
12 one of our physicians to go there regularly, and
13 Dr. Roberts is doing clinics there. But I've not
14 been able to get out of the office since this all
15 started, because I'm involved in the administrative
16 details here and also the case contact investigations
17 and deciding what to do with the institutions. But
18 I'm in telephone contact with them, so that's been
19 very, very helpful.
20 As far as the nursing is concerned, that's
21 been a chronic problem at EOCI, because the nurses
22 have FMLA leave, family leave. And so specifically
23 EOCI has worked with a nursing deficit for a while.
24 If you want specific details about that,
25 I'm not the right person to give you all that answer.

1 Joe Weir (phonetic) is well aware of these issues.
2 He could address them, both preCOVID and during
3 COVID.
4 Q Now, it's my understanding, from looking at the
5 rates of infection at the various facilities, EOCI
6 has a very high infection rate; is that accurate?
7 A Yeah, I think EOCI, Snake River, and OSP all
8 have very high rates. They're almost reaching herd
9 immunity.
10 Q Is it at all correlative that EOCI has this
11 nursing shortage and also has this high infection
12 rate?
13 A I think it's an association. I know that
14 they've been doing heroic work. I don't know -- all
15 I can do is make a statistical association with it.
16 I can't say that in this specific instance, that this
17 patient was ignored or this patient didn't get the
18 care because there wasn't a nurse to give it to them.
19 But you expect that in institutions where
20 there is difficulty covering every shift, that you're
21 going to have a -- there is a higher chance for
22 somebody to slip through the cracks. That's just
23 what you expect. Without pointing blame at anybody,
24 it's just -- when you see that phenomenon, that's why
25 you have to get extra staff there. But we've done a

1 ton of work trying to get extra staff there. We have
2 not been able to do it.
3 Q EOCI -- I think all three of the institutions
4 you just listed, EOCI, OSP and SRCI, all have laundry
5 facilities; is that correct?
6 A They do.
7 Q And those laundry facilities are staffed by
8 AICs.
9 A Correct.
10 Q I think earlier you talked about COVID seeming
11 to congregate in laundry facilities; do you recall
12 that?
13 A Kitchen, laundry facility, physical plant
14 workers, very common.
15 Q And all three of those facilities have plant
16 workers, food workers and laundry workers; is that
17 right?
18 A Correct.
19 Q Is that, in your mind, correlative with the high
20 infection rates of those facilities?
21 A Yeah. They're definitely associated, and they
22 seem to be a way that the AIC-to-AIC transmission
23 spreads out into the facility, into other dorms, and
24 to patients who have to come through the line to get
25 their food, for example in the kitchen. So yeah, I

1 from the entire institution from different units.
2 Did you have a recommendation about different units
3 coming together at OCE facilities?
4 A Actually in some cases they do and in some cases
5 they don't. We've dealt with OCE or we've dealt
6 with, like, laundry outbreaks. At OSP, for example,
7 all the laundry workers come from one unit. At
8 OSP -- excuse me. At OSCI, all the laundry workers
9 came from one unit. At OSP they came from all
10 different units. You are correct. At TRCI, they
11 were mainly from minimum. They're all from the TRCI
12 are minimum, so they weren't mixing with the medium
13 population. At Snake River I'm not aware of where
14 they were all coming from. I don't think they have
15 OCE laundry at Snake River.
16 Q Let me back up for a second. When did you make
17 those recommendations about OCE's operations?
18 A They were ongoing from the first -- from the
19 outbreak that we recognized at OSP. That would have
20 been May -- May and June era.
21 Q And do you know when those recommendations were
22 adopted?
23 A Yes, and then reinstituted at TRCI. It's been a
24 process of education for all of them.
25 Q Okay. And forgive me, did you say that you

1 ODOC.
2 Q I apologize. I know I said that was the last
3 question. But it feels like if I don't say it now,
4 I'll forget after lunch.
5 Earlier, when we were talking about OSP,
6 and I think this was after my question about your
7 frustrations and your recommendations, I think you
8 used the words none of your recommendations seemed
9 acceptable.
10 A To who?
11 Q Precisely. That's my question. Who did they
12 seem unacceptable to?
13 A None of my recommendations seemed like they were
14 enforceable, basically because of the operational
15 requirements of OSP. I have an incomplete
16 understanding of their operational requirements. And
17 it seemed like the recommendations that I made for
18 medical isolation, for increasing social distancing,
19 for hand washing, and specifically for masking,
20 masking, masking, were not readily accepted by
21 inmates or staff.
22 Q Do you feel like medical is often second fiddle
23 to operations?
24 A I think there has been an unprecedented level of
25 cooperation in this COVID 19 epidemic. I was an

1 integral part of the AOC from the beginning. I think
2 this is -- the whole tone of this epidemic, as
3 opposed to what I experienced with the TB epidemic
4 down in California 25 years ago, is just completely
5 different. There is really good people here who are
6 trying to make things work and who listen to what
7 medical people have to say, who listen as scientific
8 evidence is explained, and who really want to try to
9 practically apply that evidence. But still, we are
10 up against some insolvable problems of dormitories
11 and older ventilation systems and issues of crowding
12 and operations that make it very, very difficult to
13 control an airborne rapidly transmissible infection.
14 Plus the in-acceptance of our primary means
15 of reducing transmission, which is masking. That
16 that has been wildly controversial and it's been
17 politicized. I don't think I need to explain all the
18 issues that we have had with that. But that has
19 directly resulted in noncompliance with masking among
20 both staff and inmates. And do I think that's
21 associated with higher rates among people who don't
22 mask, higher rates of infection and higher rates of
23 transmission to others? Yes, it obviously has in my
24 mind.
25 Q I'll just ask this simply then: Do you think

1 the masking issue is an unacceptable risk?
2 A I think the masking issue is one that it's
3 completely manageable and there should be 100 percent
4 compliance with masking. And any person who's not
5 masking appropriately within the ODOC, that should be
6 considered an unacceptable risk and that person
7 should be removed from that environment. And that is
8 the policy that we have right now since the Heidi
9 Steward deputy director's policy statements. I think
10 those were -- the expectation was created in May, but
11 the actual progressive discipline policy was outlined
12 in July.
13 Q If I were to tell you that ODOC staff members
14 were still not wearing masks, is it your testimony
15 that's an unacceptable risk; is that right?
16 A Yes, and the AOC believes that, as the director
17 and the deputy director. And there are both AOC --
18 there are both AICs and staff that are noncompliant.
19 Q I promise, last question.
20 A That was three promises ago.
21 Q You know, it's lawyers. Our reputation.
22 So do you think that suspending laundry
23 operations would have led to a lower infection rate
24 at TRCI and OSP?
25 A At OSP is where I really came up against this.

1 A Well, we started educating the staff about it in
2 early May -- or actually the second week of May after
3 the press conference. I developed a poster that was
4 sent out to everybody, to all staff, about mask
5 wearing being associated with fewer transmissions and
6 also less symptoms and less hospitalization. And
7 then we had the memos from Heidi Steward that laid
8 out the evidence again and said what the expectation
9 was. And then there was a whole lot of union
10 fighting after that.
11 Q When did the union fighting start?
12 A Up to and after the initial memos.
13 Q Would you be able to summarize for me the thrust
14 of those union contentions?
15 A No, I cannot. I haven't been involved in that.
16 All I know is that it was masking to the extent that
17 we wanted was vigorously opposed.
18 Q And were you ever made aware then of individual
19 COs or ODOC staff was flouting the expectation that
20 they should be wearing a mask?
21 A Yes.
22 Q And when did you first become aware of that?
23 A When I saw it. When we did infectious --
24 infection control reviews. The initial one was done
25 at OSP, and quite a number of staff were found --

1 this would have been after the memos, so the end of
2 May. And lots of staff were found not to be wearing
3 masks. I saw it for myself at OSP before the memos,
4 because I went in to do some paperwork and to see a
5 patient at OSP, and I found that less than ten
6 percent of staff and inmates were wearing masks at
7 that point.
8 Q You said less than ten percent?
9 A Yeah.
10 Q Go ahead.
11 A That was my estimate at the time. When I went
12 in -- when I went in, it was less than ten percent.
13 When I came out, word having proceeded that
14 Dr. Dewsnup was in the facility, among staff anyway
15 it was almost 50 percent.
16 Q What did you think when you saw that?
17 A Why do I think I saw it?
18 Q What did you think when you saw --
19 A I was disappointed.
20 Q Why were you disappointed?
21 A I was disappointed because I thought everybody
22 should know that we need to be wearing masks.
23 The healthcare -- health services at OSP
24 had decided in mid May, before I got there that one
25 time, that they were going to go to 100 percent

1 mask-on policy, and they followed it very very well.
2 But that was not the case among correctional officers
3 or AICs.
4 Q And what happened after you saw this
5 noncompliance?
6 A Well, it was the basis -- one of the basis, not
7 the entire basis, but it was one of the inputs that
8 the AIC received, and subsequently made a
9 recommendation that we make sure to clarify our
10 mask-wearing expectations. And then in July they
11 were further clarified with progressive discipline
12 for staff and inmates.
13 Q So why was there a delay between the institution
14 of discipline from May to July?
15 A I don't know, COVID rebellion, confusion,
16 politicization, orneriness. I don't think it was
17 lack of education, but lack of acceptance of
18 education. There are still large parts of eastern
19 Oregon and -- well, everywhere, really. There are
20 people -- 50 percent of the population may believe
21 that masking is part of a conspiracy. I can't
22 explain that rationally, Mr. Chavez.
23 Q Nor can I, frankly. So I guess more to my
24 question, was there this COVID rebellion within AIC?
25 Because it seems like there was -- I'll characterize

1 this delay between the recognition and the general
2 policy.
3 A Yeah, I would agree.
4 Q Why do you agree with me?
5 A Because I think I saw a delay. That's why the
6 need for the memos regarding progressive discipline.
7 If everybody had complied, there wouldn't have been a
8 problem. Oh, you need to wear a mask. Oh, I'm going
9 to hurt less people. Oh, I won't be as hurt. So
10 wear a mask. Perfect. That's it. We're done.
11 That's not the way it went. It was I don't
12 want to wear a mask. I don't have to wear a mask.
13 You can't make me wear a mask. Go ahead and try.
14 Q So following the issuance of this progressive
15 discipline plan, how has mask wearing gone? Is it
16 increased or is it --
17 A It's much better than it was.
18 Q But not 100 percent; is that right?
19 A In certain institutions at certain times I think
20 it's as close to 100 percent as you can expect. I
21 believe it's better, generally, in the institutions
22 that have had more COVID. It's certainly better
23 among staff who face the biggest brunt of progressive
24 discipline, because they can be sent home without
25 pay. But, you know, it's not perfect, but it's

1 Q So it's possible that the infections began
2 before in July and then it trickled down to --
3 A That's what I believe.
4 Q So it sounds like that delay was very serious.
5 A The delay was serious?
6 Q Yeah, or resulted in serious consequences.
7 A I agree.
8 Q Now, did people voice their sense of COVID
9 rebellion to you particularly?
10 A Some did and asked me to prove to them that
11 masks are required. I attempted to explain the
12 evidence, and that evidence was rejected. And it
13 didn't take too many of those kinds of conversations
14 for me to start taking another approach. Because I
15 found, in my own mind, this is similar to talking to
16 someone who is opposed to taking vaccines. There is
17 nothing rational about the argument that says that a
18 vaccine for myself or my children, that the benefits
19 far, far outweigh any risks. But there are some
20 people who just don't believe that. And they believe
21 for -- they may say it's for religious reasons or
22 because of politics or because they have people that
23 say that that evidence is tainted or many different
24 kinds of reasons, none of which are supported by
25 scientific evidence. They may say that they don't

1 variable factors, how far that -- how much
2 aerosolization occurs and how far that aerosolization
3 actually spreads.
4 So the basis of six-foot social distancing,
5 as I said before, is the fact that the primary means
6 of transmission of COVID 19 is by droplet
7 transmission.
8 Q And I think in your declaration -- you quote the
9 OHA guidelines. I think it's paragraph 20 on page 5.
10 It refers to social distancing as the cornerstone of
11 producing transmission. You still agree with that
12 statement; is that right?
13 A It is one of them. I think masking and social
14 distancing now probably ought to be equal, given the
15 data that we have about a greater amount of
16 aerosolization than we initially expected to see with
17 COVID 19. And then, of course, in the future we have
18 to put vaccines as highly critical to eventual
19 control.
20 Q We'll get to vaccines as well. But just on
21 social distancing, what's the best option ODOC -- let
22 me back up. What would you recommend as the best
23 option for ODOC to allow for social distancing in
24 their facility -- facilities?
25 A I believe the best option that we have right now

1 CERTIFICATE
2
3 I, Rosemary Tanzer, a Registered
4 Professional Reporter, and a Certified Shorthand
5 Reporter for Oregon and Washington Certified Court
6 Reporter, hereby certify that said witness appeared
7 before me via Zoom at the time and place set forth in
8 the caption hereof; that at said time and place I
9 reported in stenotype all testimony adduced and other
10 oral proceedings had in the foregoing matter; that
11 thereafter my notes were transcribed through
12 computer-aided transcription, under my direction; and
13 that the foregoing pages constitute a full, true and
14 accurate transcript of said proceedings to be best of
15 my ability to discern comments made from masked
16 deponent, and of the whole thereof.
17 Witness my hand at Portland, Oregon, this
18 16th day of November, 2020.
19
20
21
22
23 Rosemary Tanzer
24 OREGON CSR NO. 94-0299
25 Expires September 30, 2023

Deposition of:

Brad Cain

December 22, 2020

Paul Maney; et al.

vs.

State of Oregon; et al.

Case No.: 6:20-CV-00570-SB

1 UNITED STATES DISTRICT COURT
2 FOR THE DISTRICT OF OREGON
3 EUGENE DIVISION
4
5 PAUL MANEY; GARY CLIFT;
6 GEORGE NULPH; THERON HALL;
7 DAVID HART; MICAH RHODES; AND
8 SHERYL LYNN SUBLET,
9 individually, on behalf of a
10 class of other similarly
11 situated,
12 Plaintiffs,
13 v. No. 6:20-CV-00570-SB
14 STATE OF OREGON; KATE BROWN;
15 COLETTE PETERS; HEIDI STEWARD;
16 MIKE GOWER; MARK NOOTH; ROB
17 PERSSON; and KEN JESKE,
18 Defendants.
19
20
21
22 ZOOM VIDEOCONFERENCE DEPOSITION OF BRAD CAIN
23 Taken on behalf of Plaintiffs
24 December 22, 2020
25

1 BE IT REMEMBERED THAT, pursuant to the
2 Oregon Rules of Civil Procedure, the Zoom
3 videoconference deposition of BRAD CAIN was taken
4 before Rosemary Tanzer, a Registered Professional
5 Reporter and a Certified Shorthand Reporter for
6 Oregon and Washington, on Tuesday, December 22, 2020,
7 commencing at the hour of 9:01 a.m., in Portland,
8 Oregon.
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1 APPEARANCES
2
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1 APPEARANCES (continued)
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11
12 ALSO PRESENT REMOTELY: Scott Gibson, videographer
13 Yufeng Luo
14
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EXAMINATION INDEX

EXAMINATION BY:	PAGE NO.
MR. CHAVEZ	6

EXHIBIT INDEX

EXHIBIT NO.	DESCRIPTION	PAGE NO.
1	Instructions to Deponent	7
2	Exhibit Bates-stamped Maney 9406	41
3	Exhibit Bates-stamped Maney 9767	86
4	Exhibit Bates-stamped Maney 9726	87

1 THE VIDEOGRAPHER: Here begins the
2 videotaped deposition of Brad Cain in the matter of
3 Maney et al. versus State of Oregon et al.
4 Will Counsel please state your appearances
5 for the record.
6 MR. CHAVEZ: Good morning. My name is Juan
7 Chavez. I represent the Plaintiffs.
8 MR. HALLMAN: Andrew Hallman on behalf of
9 the Defendants.
10 THE VIDEOGRAPHER: The stenographer will
11 now swear in the witness.
12
13 BRAD CAIN,
14 Having first been sworn by the Certified Shorthand
15 Reporter to tell the truth, testified under oath as
16 follows:
17 EXAMINATION
18 BY MR. CHAVEZ:
19 **Q Good morning, Mr. Cain. My name is Juan Chavez,**
20 **as you heard, during our read-in. I represent a**
21 **group of plaintiffs who filed an action in federal**
22 **court.**
23 **I forwarded a document that I've labeled**
24 **Exhibit 1 to Mr. Hallman. Was that forwarded to you?**
25 A I believe so.

1 **Q Were you told why some staff members didn't want**
2 **to wear a mask?**
3 A I've heard people's opinions on it. Some people
4 didn't believe in it. They just didn't believe in
5 it. They felt as if it was against their rights. I
6 had a staff member tell me it was against his
7 religious beliefs. I've had staff tell me that it's
8 all political and it's not real.
9 **Q I think you referred to these as opinions. Is**
10 **there -- is mask wearing a matter of opinion; do you**
11 **think?**
12 A No.
13 **Q And why is that?**
14 A Well, the CDC guidance and the OHA guidance
15 talks about the science behind it and the protective
16 factors that mask wearing gives and the social
17 distancing. So the only -- I don't think it's about
18 that at all. I think it's about trying to protect
19 people.
20 **Q What do you tell people, then, when they say,**
21 **"In my opinion I don't want to wear a mask. It's a**
22 **hoax"?**
23 A It's not an option. It doesn't matter, my
24 opinion.
25 **Q And what if they -- what if you get pushback**

1 me, it felt as if this was a statewide issue and it
2 was being dealt with at the AOC.
3 **Q So is your testimony today that this was a**
4 **problem through all of ODOC, the mask issue?**
5 A Yeah. It's a statewide issue, yes. The
6 pandemic in itself was a statewide issue and it was
7 being managed through the AOC as a statewide issue.
8 **Q Now, the mask memo comes in and you're now able**
9 **to discipline people. In that first month -- or I**
10 **guess it's about two months that it's reflected in**
11 **the mask document that I was provided, was there any**
12 **disciplining of staff members for not wearing masks?**
13 A So I'll try to answer this to the best of my
14 ability. So, yes, we took staff through the process
15 and it just has taken a while. There is one case
16 that had to go through DOJ and it was settled at a
17 certain level. But there's one in process right
18 now -- like I said, we're taking it through the
19 predismissal process, and that meeting happens
20 tomorrow. So we'll figure out the outcome of that
21 here pretty soon. But there is a couple of others
22 that have been investigated, and I believe we're
23 waiting on the outcome of those two.
24 **Q And why, then, I guess -- I understand that it**
25 **takes some time to go through disciplining process,**

1 A All I can tell you on that one, it's been
2 frustrating. And I think we probably got to that
3 point where it's like, we've got to do something.
4 **Q What was your source of frustration?**
5 A That people were continuing to violate the
6 process.
7 **Q Did the mask violations increase after the memo**
8 **or stay the same?**
9 A No, I think they decreased. I think they did.
10 But as you can see, it was still happening.
11 **Q So let me ask: Are you in contact with ODOC's**
12 **epidemiologist, Dr. Dewsnup?**
13 A Dr. Dewsnup, I have been. He's part of the AOC.
14 He's not anymore. They switched -- they switched
15 doctors, so I'm not in contact with him much anymore,
16 but we were with AOC. He was part of the contact
17 tracing and part of the planning with AOC.
18 **Q And did Dr. Dewsnup ever provide to you, or did**
19 **anybody from AOC provide to you, a theory on how SRCI**
20 **suffered an outbreak in the manner that it did?**
21 A Can you ask that question again, please? I'm
22 sorry.
23 **Q Sure. What's your understanding of why ODOC**
24 **suffered an outbreak?**
25 A Okay. Well, I think it was his opinion that

1 staff brought it in.
2 **Q Do you believe in that opinion?**
3 A I would say yes. I mean because we had a
4 community outbreak here -- it's just to -- makes
5 sense. I can see that happening.
6 **Q By "community outbreak" you mean Ontario or**
7 **Malheur County?**
8 A I would say from Washington County, Payette
9 County, Malheur County and Ontario, Canyon County,
10 Ada County, all the way. Because we're right on the
11 border, and most of our staff work in -- I mean live
12 in Idaho. They work here but they live in Idaho. So
13 yes, as the outbreak started, I could clearly see how
14 it could happen.
15 **Q Do you have any contact with the local health**
16 **authorities?**
17 A Yes.
18 **Q Are you in contact with health authorities in**
19 **Idaho as well?**
20 A Not as much. I actually work through our local
21 one here. She actually communicates with them. I
22 haven't really talked with the others, no.
23 **Q Once the disease is -- I guess we're working**
24 **from an hypothesis that it was brought in by staff.**
25 **But once it is brought in, are you aware of how it**

1 **spreads, then, within the facility?**
2 A Well, it's my understanding it's droplets. So
3 it's spread through people being in close contact and
4 talking and sneezing, coughing, being in close
5 proximity with each other.
6 **Q Now I'll represent to you that when we talked**
7 **with Dr. Dewsnup -- let me back up.**
8 **Have you reviewed any transcripts from**
9 **other depositions taken in this matter?**
10 A No.
11 **Q No? Okay. I'll represent to that you we spoke**
12 **to Dr. Dewsnup in a deposition, and he took issue**
13 **with dorm-style housing, I think for obvious reasons**
14 **that we were just discussing, the respiratory**
15 **transfer -- or respiratory-droplet transfer.**
16 **That seems to only account for about 330 or**
17 **so beds in Snake River. So I guess my question is:**
18 **Are you aware of how folks in nondormitory housing**
19 **might have contracted COVID 19?**
20 A Just through contact of potentially -- I guess
21 I'm guessing on this one. It's some type of contact.
22 So either AIC contact or employee contact. That's
23 what I would assume.
24 **Q Now, has anybody told you that SRCI's HVAC**
25 **system might have had a part in spreading respiratory**

1 **Q And so the -- is it accurate to say that the**
2 **food services department supervises and manages the**
3 **AIC cooks and orderlies?**
4 A Yes.
5 **Q Okay. Would the food services department be in**
6 **charge of maintaining social distancing and proper**
7 **mask wearing?**
8 A Yes, as much as possible. Like in the kitchen
9 it's -- we do our very best to social distance in
10 there.
11 **Q What are the prohibitions on -- well, let me**
12 **back up.**
13 **What makes social distancing difficult in**
14 **the kitchen?**
15 A Pretty tight quarters in there, especially when
16 it comes to, like, the serving line. It's a pretty
17 tight, narrow area. In the production kitchen it's a
18 little bit easier. It's a bigger area.
19 **Q And by serving line, that's food being handed to**
20 **AICs?**
21 A Yes.
22 **Q Are you aware of -- let me back up.**
23 **So AICs for satellite kitchens, are they**
24 **from different units?**
25 A Yes. They're different units but within the

1 complex.
2 **Q Okay, I see. And same for the production**
3 **kitchen, different units?**
4 A Yes. Different units for the production
5 kitchen. I know at one point in time during this
6 pandemic we actually scaled down, and we only had
7 workers for complex one for a while, just to reduce
8 the movement.
9 **Q And how long, do you know, was that practice in**
10 **place?**
11 A The length of time that it was in place?
12 **Q Yeah.**
13 A Probably a few weeks.
14 **Q Do you know about when that happened?**
15 A Probably June or July.
16 **Q And was that a restriction that was put in place**
17 **by SRCI or by AOC?**
18 A That was Snake River.
19 **Q And why did you make that decision?**
20 A At that point we were really trying to just do
21 our best to try to control the spread. You talked
22 about the spike in numbers, and we were just doing
23 our best to try to contain that.
24 And, you know, quite honestly, we have
25 COVID cases, especially in the kitchen, it's

1 extremely problematic for us. We have to feed the
2 AICs.
3 **Q Indeed. Why did you lift that restriction, that**
4 **complex-one worker restriction?**
5 A I'm trying to remember. I know we consulted
6 with our operations team here and we felt like at
7 that point we could manage the kitchens
8 appropriately. That's pretty much all I can say on
9 that. I don't have any details to give you.
10 **Q Okay. That decision, did it come from your**
11 **office or where did it come from?**
12 A Yes, it came from my office. We have our own
13 operations center here, so we discuss these things.
14 And collectively it's my decision. But we do have a
15 commander in this situation, Jason Bell. So a lot of
16 this stuff does get approved through him. But in
17 this emergency situation, I'm considered the
18 institution liaison with Central Office. But
19 collectively we make that decision.
20 **Q A moment ago you brought up a term commander.**
21 **I've seen, in some of the documents, there is**
22 **references to an incident commander. Is that what**
23 **you're talking about?**
24 A Yes.
25 **Q And what kind of decisions does the incident**

1 use the phones, but we had to make sure that
2 everything stayed clean and only a couple of people
3 out at a time. We really tried to manage this the
4 best we could.
5 **Q And you were referring earlier to the harms of**
6 **the prisoners being placed under lockdown conditions.**
7 **What kind of harms are we talking?**
8 A Well, there was talk about there being a hunger
9 strike. There was threats towards staff. Those type
10 of things were happening. And people were getting
11 frustrated, even though staff did a great job as far
12 as communicating with the AICs. I think we did a
13 really great job of communicating and letting them
14 know what was going on. But there is a certain point
15 in time where people get frustrated, and some of
16 these people are pretty dangerous and they do bad
17 things.
18 **Q I think you kind of touched on this a bit. But**
19 **I'm wondering if you can explain to me, since you've**
20 **come in closer contact with folks in this condition,**
21 **are you aware of any problems that affect people when**
22 **they're in isolation?**
23 A Oh, absolutely. Yeah, I've seen it over the
24 years.
25 **Q What have you seen?**

1 A So long-term isolation it really -- it wears on
2 people after a while. I worked disciplinary
3 segregation for quite a few years, and I would watch
4 people decompensate and get paranoid and frustrated
5 and act out from that isolation.
6 **Q Were you seeing that kind of decompensation in**
7 **the folks during this 19-day lockdown?**
8 A Yes. And it was really problematic because just
9 being isolated alone creates a lot of issues for
10 these guys. But on top of that -- yeah, like in
11 society. There is a lot of misinformation going on.
12 And it's hard enough for the staff let alone the guys
13 that are living in a cell that may not have contact
14 with their loved ones. So it just compounds things.
15 **Q What kind of misinformation are we talking**
16 **about?**
17 A Well, just to talk. People talk. And some
18 people say, hey, you know, this is nothing. Or this
19 is something. Just that talk.
20 **Q Uh-huh.**
21 A You hear things on the news. Right? Or, you
22 know, they get a letter from their loved one.
23 I think the department's done a really good
24 job as far as communicating with the AICs, probably
25 the best I've ever seen in my career. Colette,

1 **Q Do you know if anybody from SRCI who's passed**
2 **was under the age of 50?**
3 A I do not believe so.
4 **Q I need a moment. I don't need a full break.**
5 **So I want to go back to the period where it**
6 **was apparent the outbreak was starting.**
7 **Was there anything that could have made**
8 **your job easier at that time?**
9 A That's a tough question. It would have helped
10 if people would have wore the masks. That would have
11 been helpful. I'm not sure. It's just been -- I'm
12 not sure.
13 **Q Are you aware that the governor had requested**
14 **names of people who could be eligible for either**
15 **early release or a commutation to reduce the**
16 **population of ODOC? Are you aware of that?**
17 A Yes.
18 **Q Did you at all participate in providing names or**
19 **suggestions of people who could be released?**
20 A No. That was done at a central level.
21 **Q Okay. Would you have wanted fewer people in**
22 **your facility to facilitate social distancing?**
23 A I guess if you had less people, it would
24 probably be a little bit easier. But a prison is
25 pretty tight quarters anyway. Have to be a lot of

1 CERTIFICATE
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3 I, Rosemary Tanzer, a Registered
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15 oral proceedings had, and of the whole thereof.
16 Witness my hand at Portland, Oregon, this
17 6th day of January, 2021.
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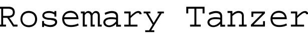

23 Rosemary Tanzer
24 OREGON CSR NO. 94-0299
25 Expires September 30, 2023