FACT-FINDING REPORT
for
The County of Napa

Regarding:	**Process for Administration of End of Day Excess COVID-19 Vaccine**
Fact Finders:	**Camille Hamilton Pating, Esq.** **Travis Hall, Esq.**
Report Submitted:	**May 5, 2021**

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I. INTRODUCTION

Meyers Nave was retained by the County of Napa ("County") pursuant to a motion[1] of the County Board of Supervisors ("Board") on March 4, 2021, to conduct an independent Fact-Finding review documenting the County's process for end of day ("EOD") excess dose COVID-19 vaccinations during the first three weeks of operation of the County's mass vaccination clinic, between January 11 and 29, 2021.

The Board directed the Fact-Finding review after receiving questions from the public about the County's process after Supervisor Belia Ramos ("Supervisor Ramos") received an EOD excess dose vaccination on January 20, 2021. Specifically, based on the discussion by the Board at the March 4, 2021 meeting[2] and questions the fact-finders deemed to be relevant to analyzing the County's process, this Fact-Finding report 1) identifies the County's process for administering EOD excess vaccines at the mass vaccination clinics[3] during the relevant time period; 2) analyzes whether the process was being followed as it evolved; 3) documents the events of January 20 leading to an EOD vaccine being offered to Supervisor Ramos, the reasons why it was offered and whether this was consistent with the County's process at the time; and 4) documents changes made to the process. In addition, pursuant to the request of County Executive Officer ("CEO") Minh Tran, this report 5) addresses whether the County's process permitted or involved throwing away EOD excess doses at any time.

During this fact finding, thirteen (13) witnesses were interviewed, including members of the County's Emergency Operations Center ("EOC"), public health staff at the clinic, human resources staff and other persons with personal knowledge of the County's process or the events at issue. Relevant documents and other relevant materials were reviewed. The fact-finders interviewed all persons necessary to make findings of fact. At the request of the County, individual names and job positions of witnesses have been redacted from this report. However, Supervisor Belia Ramos requested that her name appear unredacted in the report.

A summary of the Fact-Finding, followed by answers to the specific questions above, is set forth below.

II. SUMMARY OF FINDINGS

The County's first mass vaccination clinic opened at the Napa Valley Expo Fairgrounds ("Expo") starting on January 11, 2021. Effective January 21, the clinic moved to the Health and Human Services Agency ("HHSA") South Campus location ("South Campus"). The Expo clinic was under the operations supervision of the County's Emergency Operations Center ("EOC") and was designed to deliver 300 to 700 vaccines per day to eligible individuals in Phase 1a or 1b, Tier 1. When the Expo clinic started, these phases included healthcare workers, followed by workers in education, emergency services, food and agriculture and people aged 75 and older. Then the guidelines quickly expanded to include first responders, direct service public employees, and people over the age of 65. [redacted]) was a member of the task force responsible for

[1] Motion 11-A-2 dated March 4, 2021 (Exh. 1, Exh. 2)

[2] Exh. 1

[3] Pursuant to the direction of the Board, this report applies only to EOD processes used at the Expo and South Campus vaccination sites. (Exh. 2)

planning of the County's mass vaccination sites. Among many other responsibilities, [redacted] coordinated and implemented the standby process for EOD excess vaccine doses together with [redacted] who supervised public health staff at the vaccination clinic.

During this time, [redacted] and the vaccination task force worked six to seven days a week to prepare for the state's ambitious goal of getting 1 million vaccine doses into arms. Witnesses interviewed described this period as "chaotic," "exhausting" and "building and airplane while trying to fly it." (Exh. 18, Exh. 20, Exh. 22, Exh. 24, Exh. 25, Exh. 26)

A. Why The Clinic Had Excess Doses

The clinics used the Moderna vaccine during the relevant time period. A vial of vaccine contained ten or sometimes eleven doses. When a vial is opened, all doses must be used or they will expire. At the end of the day, excess doses resulted if the number of open vials exceeded the number of people showing up at appointments for the day. No-shows occurred frequently as a result of bad weather.

B. January 11 to 14 – No Formal Standby Process

The evidence showed that the issue of excess doses at the end of the day was initially not anticipated. This was because the emphasis of the effort was on giving hundreds of scheduled vaccinations a day. Therefore, when the clinic opened, there was no formal process for dealing with EOD dose management.

On the first clinic day, January 11, there were approximately 30 excess doses remaining at end of the clinic. This resulted in clinic staff scrambling to find people for the excess vaccine before the doses expired. On January 11, this was accomplished by bringing employees from law enforcement to the clinic and taking the remaining doses to HHSA offices and offering them to employees there. (Exh. 20, Exh. 25)

The evidence showed that the clinic staff's practice was to use all excess doses and not waste them, as the vaccine was regarded by clinic staff as "liquid gold." (Exh. 18, Exh. 19, Exh. 25)

According to the witnesses, in the first four days of the clinic, public health staff would "find arms" for excess doses by "cold calling" people they knew who were eligible to come in on short notice and bringing doses back to HHSA offices to offer to available people. [redacted] reported that some of the people obtained using these methods were eligible for the vaccine and some were not. During this early period, EOD excess doses were also given onsite to clinic staff and longtime volunteers - those who signed up to regularly to work at the Expo clinic or COVID 19 testing center. (Exh. 25)

To reduce excess doses, clinic staff began closely monitoring the inventory of vaccine against the day's scheduled appointments at multiple times throughout the day. The clinic day was divided into two shifts to facilitate this review. The clinic staff thawed only enough vials needed for that day's clinics. However, some excess doses still resulted when a new vial was opened or when vials contained extra doses. (Exh. 18, Exh. 19, Exh. 25)

C. January 15 – Creation of a Standby Process

Starting on January 15, in response to the need to have people available on short notice for excess doses, EOC leadership began formalizing an EOD standby process. At this point, [redacted] began gathering names for a standby list of municipal employees age 65 or older. [redacted] asked city managers from American Canyon, Calistoga, Napa, Saint Helena and Yountville to send her lists of their oldest employees who consented to be in a standby pool for excess vaccines. (Exh. 7a, Exh. 20, Exh. 25)

These names were added to the list of County employees age 65 or older, which was already being compiled and vetted by the County Human Resources ("HR") Department. The combined County and Municipal employee age 65+ standby list was then used to provide names when EOD excess doses were available[4]. (Exh. 8f, Exh. 8g, Exh. 8i, Exh. 20)

D. How the Standby Process Worked

The evidence showed that, starting on January 15, [redacted] administered the standby process from the clinic site. From this point forward, she personally called standbys at the end of the day. The process worked as follows: throughout the day, [redacted] and her staff closely monitored vaccine inventory against remaining appointments in PrepMod. At about 3:00 p.m. (45 minutes before the last appointment) nurses would count the cars in line and share remaining doses of vaccine between stations to avoid opening vials at the last minute. One of the nurses would collect the excess doses from the injection stations. At about 3:30 p.m., [redacted] would tell [redacted] how many excess doses there would be that day. [redacted] would then assess certain priority groups and call individuals from those groups who were willing to wait on standby for excess doses. (Exh. 18, Exh. 25)

Over the first three weeks of the clinic's operation, the County utilized five different priority groups as resources for EOD standbys. These priority groups were used during the time periods indicated below.

- **Staff and long-time volunteers.**[5] These individuals regularly worked onsite at the Expo clinic or COVID 19 testing center. In the first days of the Expo clinic, CERT volunteers, EOC staff working at the clinic and other public health staff working onsite were vaccinated with excess doses. Staff and long-time volunteers were vaccinated on their first day of clinic service to minimize exposure. Clinic volunteers were signed up for regular, weekly service. These individuals were identified onsite by clinic staff and [redacted]. This group was used as a resource for excess vaccines between January 11 and 29. (Exh. 7c, Exh. 7e, Exh. 25)

[4] County officials were cognizant of the safety and risk management issues associated with having non-municipal workers on the standby list wherein they would be asked to quickly rush to the vaccination site to receive an end of day dose. The emphasis at this time was to have eligible, non-municipal workers sign up for regular appointments.

[5] Long-time volunteers who were vaccinated onsite were required to be signed up for weekly volunteering at the clinic.

- **Individuals eligible for vaccine in Phase 1a or 1b, Tier 1 who were unable to obtain scheduled appointments through the online scheduling system**. Identifying and contacting these individuals for standby doses was challenging over the relevant period because state guidelines changed frequently during this time. The County's HR department and [redacted] collaborated to identify persons who could receive EOD excess doses based on Phase/Tier eligibility. This group was used as a resource for excess vaccines between January 11 and 29. (Exh. 7c, Exh. 20, Exh. 25)

- **County and Municipal employees age 65 and older standby list.** This list was maintained by the HR department. [redacted] provided names to be contacted for excess doses to [redacted] on a daily basis, or as requested. This list was started with County employees aged 65 or older on January 12 when the CDC guidelines changed to include individuals 65+ as being eligible for the vaccine. It expanded to include municipal employees age 65 or older on January 15 and remained in effect until it began to deplete on approximately January 26. The list was later replenished with individuals from the Phase 1a or 1b, Tier 1 category as eligibility expanded to include more job classifications, after January 28. The County's HR department and [redacted] continued to collaborate to identify eligible employees for the County and Municipal employees standby list based on Phase/Tier eligibility. This group was used as a resource for excess vaccines between January 15 and 26, and after January 29. (Exh. 7c, Exh. 7e, Exh. 20, Exh. 25)

- **Emergency Services Employees list.** These employees worked at the emergency operations center, i.e., were not working at the Expo clinic. This list came from the Office of Emergency Services through the HR department. This group was used as a resource for excess vaccines between approximately January 15 and 27 (Exh. 7c, Exh. 7e)

- **Individuals age 65 and older from the County's General Interest list who consented to come to the clinic on short notice**. This General Interest list consisted of people who signed up online and expressed interest in receiving the vaccine. It contained over 40,000 names during the relevant period. It was utilized for a brief period when the County and Municipal Employees Standby list was depleted, before being replenished by including employees eligible under the expanded state guidelines for Phase/Tier eligibility. [redacted] contacted these individuals for excess doses. This group was used as a resource for excess vaccines approximately between January 27 and 28. (Exh. 8c, Exh. 20)

The evidence showed that once informed how many excess doses were available that day, [redacted] would call people to come to the clinic and wait in the parking lot until the clinic closed. If there was vaccine available, standbys would be brought into the line for a vaccine. If there was no vaccine, they would come back the next day or until there was vaccine available. The evidence showed that standbys were told they may have to come back multiple days. Only existing excess doses were given to standbys. New vials were not opened for the standby list. (Exh. 25)

Prior to January 27, there were usually four people on standby on any given day for a potential excess dose. After an ABC7 report about [redacted] receiving a

vaccination, the County increased the number of standbys waiting to up to six people. In addition, [redacted] and the staff would stay after closing as late as required to ensure that they obtained eligible individuals from the standby groups to receive excess doses. (Exh. 18, Exh. 25)

The evidence showed that [redacted] utilized this general standby process consistently from January 15 through January 29, with the exception of one instance on January 20. The process was utilized to administer an average of two to four EOD excess vaccines per day during that period. It evolved continuously and adapted to changing circumstances and changing state guidelines. During the first three weeks of the vaccine clinic, the changes to the standby process reflected new classifications becoming eligible and lists or groups becoming depleted or replenished during that time. However, after January 15, the County's standby process consistently drew from priority groups and tracked eligibility factors under the Phase/Tier definitions then in effect. (Exh. 7c, Exh. 20, Exh. 25)

The evidence showed that throughout the period of January 11 to 29, 2021, public health staff did not waste any EOD excess doses. No excess doses were thrown away because of a lack of arms to receive them. The evidence in this review showed that the clinic staff was very careful to follow waste reduction practices and, after January 15, the priority group process was designed to find "eligible" arms for EOD excess doses based on age over 65, job functions, being a clinic worker or long-time volunteer or other prioritized status, particularly after the creation of the County and Municipal employees standby list for employees over age 65. (Exh. 18, Exh. 19, Exh. 22, Exh. 25)

E. Supervisor Ramos' Vaccination on January 20, 2021.

On January 20, 2021, at approximately 3:00 pm, Supervisor Ramos came to the clinic to film a Public Service Announcement ("PSA") for a private organization. That morning, Supervisor Ramos was asked to do a Spanish-language PSA to encourage farm workers from the Latinx community to be vaccinated. She arrived at the clinic and was met by [redacted] a [redacted] who was assisting with the PSA but did not work at the clinic.

Pursuant to the County's practice, at approximately 3:30 pm, [redacted] and [redacted] conferred and [redacted] was told that there were six (6) excess vaccine doses that day.

[redacted] met Supervisor Ramos and [redacted] in the parking lot and greeted them. [redacted] asked if Supervisor Ramos was there to get vaccinated and she responded, "I don't think so." (Exh. 23). [redacted] stated that Supervisor Ramos should wait on site because there "might be an excess dose" available for her. (Exh. 23). [redacted] responded, "No, I have names to call." [redacted] then went to her office and called in two individuals from the County and Municipal Employees 65+ standby list, three clinic volunteers and an individual who was in an eligible tier, for a total of six standbys. (Exh. 25)

Supervisor Ramos was filmed for the PSA by a representative from the private organization who was also a [redacted], and another [redacted] named [redacted] or [redacted] As part of the PSA, Supervisor Ramos was filmed receiving a simulated vaccination administered by [redacted]. The filming of Supervisor Ramos going through the drive-thru only took "a matter of minutes." (Exh. 16, Exh. 25)

After all six excess doses were accounted for at about 4:20 pm, [redacted] came out of her office and walked towards the tent. [redacted] then stated that there was an additional, seventh excess dose. [redacted] said, "I have Belia's dose." [redacted] was surprised and caught off guard. [redacted] and [redacted] conferred briefly. [redacted] asked if Supervisor Ramos was supposed to get a real vaccine as part of the PSA and [redacted] answered "No." [redacted] then spoke to Supervisor Ramos, who had completed filming the PSA but was still onsite talking to a [redacted], about an RFP.

Supervisor Ramos reported that she believed she "was there on standby for an excess dose." [redacted] reported that she felt "uncomfortable" and "pressured" because of the Supervisor's presence, to offer the vaccine. [redacted] then offered the seventh excess dose to Supervisor Ramos, who accepted it. [redacted], who had participated in the PSA simulation, was directed to give Supervisor Ramos the seventh excess dose. [redacted] reported that she also felt "uncomfortable" to be giving the vaccine. (Exh. 18)

At 4:24 pm, [redacted] received a text message from [redacted], asking if there was any "overage today" and if names from the County and Municipal Employees 65+ standby list were needed. [redacted] responded that two persons from the previous day's list had been vaccinated and asked for five additional names for the next day. (Exh. 8s, Exh. 20)

Supervisor Ramos received her shot at approximately 4:25 pm. (Exh. 23, Exh. 25). The evidence showed that Supervisor Ramos was not on the County or Municipal Employees age 65+ standby list, was not a clinic staff member or long-time volunteer, was not in an eligible tier being scheduled at that time, and did not fit into any of the then-utilized priority groups.

F. Conclusion. These fact-finders note that these events occurred during the first weeks of the rollout of the County's mass vaccination clinic, in the middle of the pandemic. At the time, emotions ran high as vaccine shortages made it difficult for eligible individuals to schedule appointments at the clinic. Accordingly, public trust in the County's process for EOD excess vaccines was under scrutiny.

After a careful review of the record and the supporting documentation provided by the County and others, and considering the credibility of the witnesses, these fact-finders do not find that any individual involved in these events acted to intentionally violate public trust in the County's EOD excess vaccine process. However, actions have consequences, whether intended or not. The evidence in this review showed that the County's EOC and public health staff worked under extremely challenging circumstances to successfully launch the mass vaccination clinics, create a standby process to administer EOD excess vaccines in an equitable manner that tracked Phase/Tier eligibility requirements, and prevented waste of any EOD excess doses during those first weeks. In the fact-finders' view, it is unfortunate that the County's EOC and public health staff faced criticism as a result of these events. The evidence showed that with the exception of one instance, the EOC and public health staff did the best they could to follow the County's standby process as it evolved during the relevant period.

III. ANSWERS TO QUESTIONS REGARDING THE COUNTY'S STANDBY PROCESS

1. Between January 11 to 29, 2021 what was the County's process for administering EOD excess vaccines at the mass vaccination clinics?

As described above, the evidence showed that until January 15, there was no formal process in place for administering extra vaccine doses at the end of the day. After January 15, the County used a standby process which drew from five priority lists or groups as a resource for excess vaccine recipients during this time period. These priority groups included: Staff and long-time volunteers; Individuals eligible for vaccine in Phase 1a or 1b, Tier 1; County and Municipal employees age 65 and older; Emergency Services Employees and Individuals age 65 and older from the County's General Interest list. In addition, public health staff reduced the number of EOD excess doses by closely monitoring vaccine inventory and only opening vials when needed. Prior to January 27, approximately four standbys would be called to at the clinic; this number was increased to six starting on approximately January 28. (Exh. 18, Exh. 21, Exh. 25)

2. Between January 11 and 29, 2021, was the County's process for EOD excess doses being followed as it was evolving?

Generally, yes. The evidence showed only one known exception, which occurred on January 20, regarding the EOD excess dose offered to Supervisor Ramos. While it was allowed under California Department of Public Health ("CDPH") Guidelines, which permits offering EOD vaccine to persons in lower priority groups to avoid waste, this instance was inconsistent with the County's standby process in that the recipient was not in any of the priority categories being used by the County during that time. [redacted] and public health staff credibly stated that the excess vaccine offered to Supervisor Ramos would have been offered to an eligible individual on the County and Municipal Employees age 65+ standby list if she had not accepted it. At that time, the standby list had over 50 names on it. The evidence showed that the HR department offered [redacted] additional names from the standby list at 4:24 pm, moments before Supervisor Ramos was vaccinated. Staff employees interviewed credibly stated that they would have found another eligible individual within the priority groups and no EOD excess dose would have been thrown away. [redacted] and [redacted] reported that this was the first time they knowingly gave an EOD excess vaccine to someone outside the County's priority categories. (Exh. 8s, Exh. 18, Ex. 19, Exh. 20, Exh. 25)

3. Why did Supervisor Ramos receive an excess dose?

[redacted] and [redacted] reported that the vaccine was offered to Supervisor Ramos because: 1) CDPH protocols allowed vaccinations to drop down tiers to avoid waste; 2) [redacted] felt there was "confusion" over whether Supervisor Ramos was supposed to receive a real vaccine as part of the PSA; however, [redacted] reported that she was not aware of this concern until several days later and 3) [redacted] reported that she felt "pressured" to offer the excess vaccine to Supervisor Ramos, who she perceived was "making her presence known on the site." [redacted] reported that Supervisor Ramos was "very visible at the clinic, circulating and talking to many people." [redacted] described the situation as "awkward and uncomfortable"

when Supervisor Ramos was still present at the clinic at the time the seventh dose became available. (Exh. 7e, Exh. 25)

[redacted] reported that "it would have been difficult for staff to say no in a situation like that." (Exh. 18). [redacted], who gave the vaccine, reported that she felt "uncomfortable" to be directed to give the dose to Supervisor Ramos because at that time, "it was for the elderly, healthcare workers, emergency responders." (Exh. 19)

4. Was Supervisor Ramos on the County and Municipal Employees age 65+ standby list?

No. Supervisor Ramos stated in a Facebook post that she was "on the list" and this is why she received the excess dose that day. The video remains posted and has not been taken down. In her interview, Supervisor Ramos reported that it was an unfortunate word choice to comment on her Facebook post that she was on the "standby list." She stated that she misspoke and meant to say she was on "standby" and not on the "standby list." Supervisor Ramos was not on the County and Municipal Employees age 65+ standby list, but she was on the General Interest list, which had over 40,000 names at that time. On January 20, the General Interest list was not then being used for EOD excess dose standbys. It was later used on January 27 and 28, but only for individuals over age 65. As of January 20, there was no public standby list.[6]

5. What changes were made to the process after January 20 to provide EOD excess doses to persons within Phase 1a and 1b, Tier 1?

The mechanics of the standby process largely remained unchanged. However, up to six names were provided from the eligible priority groups by the HR department to [redacted] on a daily basis. The evidence showed that the priority groups expanded and contracted during this period. For example, when the County and Municipal Employees age 65+ list became depleted, the General Interest list was used to call individuals age 65 and older. New job categories were added as groups eligible under Phase 1a and 1b, Tier 1 changed. In addition, clinic staff would remain at the clinic site as late as necessary to ensure all EOD excess doses were administered to individuals who were in priority groups or otherwise eligible based on the then-utilized criteria. (Exh. 18, Exh. 21. Exh. 25)

6. Between January 11 and 29, did the County's process permit or involve throwing away EOD excess doses at any time?

No. The evidence showed that from January 11 to 14, before a process for EOD excess vaccine was in place, no doses were thrown away because clinic staff found arms for such doses as described in this report. After January 15, the County's process was to find eligible arms for excess doses using the standby process. There was no evidence that any excess doses were thrown away due to a lack of eligible arms. The evidence showed that [redacted] and the EOC or clinic staff would keep calling people until someone from the priority groups was found, regardless of time. This meant that sometimes the staff would have to stay very late after the clinic closed. (Exh. 18)

[6] Exh. 20

IV. METHODOLOGY

A. Background

On March 4, 2021, County CEO Minh Tran contacted this fact-finder on behalf of the County and asked this fact-finder to conduct an independent Fact-Finding Review regarding the County's process for EOD COVID-19 vaccinations between January 11 and 29, 2021. This fact-finder was requested to address the questions raised by the Board of Supervisors in their discussion of the motion, as well as additional questions raised by Mr. Tran concerning whether the County's process permitted or involved throwing away EOD excess doses at any time. This fact-finder was requested to issue a report. This fact-finder conferred with Mr. Tran and [redacted] to obtain necessary background information and relevant documents and to formulate a list of witnesses to be interviewed.

B. Witness Statements

To the extent conflicts existed between witness statements as to whether a contested fact happened, credibility determinations were made based on the EEOC's five points of analysis for determining credibility of witnesses, including: (1) presence or absence of corroboration; (2) presence or absence of contradictions; (3) whether the facts are inherently improbable; (4) whether the witness has a motive to fabricate; and (5) presence or absence of declarations against interest. (Equal Employment Opportunity Commission, *Enforcement Guidance on Vicarious Employer Liability for Unlawful Harassment by Supervisors* (June 18, 1999).)

The following witnesses were interviewed by Zoom:

WITNESS	POSITION
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

Numerous documents and email communications were reviewed. Based upon the evidence in the Fact-Finding review, the following questions were identified for the review. The fact-finders interviewed all available witnesses we thought necessary to reach conclusions about the questions.

C. Relevant COVID-19 Standards.

On December 5, 2020 the California Department of Public Health ("CDPH") issued the following Allocation Guidelines for COVID-19 Vaccine During Phase 1A: Recommendations

> "To avoid wastage or disuse of scarce supplies and maximize their benefit to Californians: After intensive and appropriate efforts[7] to reach the groups prioritized at that moment, health departments and facilities may offer vaccine promptly to persons in lower priority groups when:... Doses are about to expire according to labeling instructions"

On December 14, 2020, the CDPH issued [Further] Allocation Guidelines for COVID-19 Vaccine During Phase 1A: Recommendations, which contained the same language as above in terms of dealing with unused doses.

D. Scope of Fact-Finding review.

Pursuant to the direction given by the Napa County Board of Supervisors at a Special Meeting dated March 4, 2021, the scope of this Fact-Finding review is to provide an independent, third-party report on Napa County's vaccination process for excess EOD doses between January 11 and 29, 2021, focusing on the specific facts and circumstances regarding the administration of excess EOD doses on January 20, 2021. The scope of this review is neutral fact-finding only and shall not include any discipline against any County staff. (Exh. 1, Exh. 2)

V. FACTUAL CHRONOLOGY

1. In December 2020, California officials proposed a four-phase system for who should be vaccinated first given the limited supply of the COVID-19 vaccine: Healthcare workers were designated for Phase 1A. Education, emergency services or food and agriculture workers would be in the next phase, Phase 1B Tier 1, along with those aged 75 and older. Manufacturing, transportation and logistics or facilities and services workers would be in Phase 1B Tier 2, along with people who are homeless, incarcerated or aged 65 to 74 with chronic conditions. Workers communications, defense, finance and energy would be in Phase 1C, along with those aged 65 to 74 without chronic conditions and those aged 16 to 64 with chronic conditions. The rest of Californians would be in the last phase.[8]

2. However, the following month, in response to vaccine scarcity and delays, California changed its vaccine prioritization framework multiple times. In early January, the state

[7] The Guidelines contains no guidance on what constitutes "intensive and appropriate efforts"
[8] https://www.sacbee.com/news/politics-government/capitol-alert/article249023830.html

moved those aged 65 to 74 without chronic conditions into Phase 1B. All of those aged 50 to 64 moved into Phase 1C.[9] A few days afterward, state officials moved everyone 65 and over to the front of the line right after healthcare workers, after delays in vaccine administration prompted federal health officials to change their guidelines and urged states to do the same.

3. On December 5, 2020, the CDPH issued Allocation Guidelines for COVID-19 Vaccine During Phase 1A. The Recommendations stated: "To avoid wastage or disuse of scarce supplies and maximize their benefit to Californians: After intensive and appropriate efforts to reach the groups prioritized at that moment, health departments and facilities may offer vaccine promptly to persons in lower priority groups when... Doses are about to expire according to labeling instructions." No guidance was provided on what constitutes "intensive and appropriate efforts." (Exh. 3)

4. In December, as vaccine was coming in slowly, the County was primarily vaccinating healthcare workers. On January 6, 2021, Governor Newsom publicly pledged that the state would administer 1 million doses of COVID-19 vaccine in 10 days ("Million Dose Challenge"). The Governor's office started to push vaccines out. (Exh. 4, Exh. 23)

5. In Napa County, the Emergency Operations Center ("EOC") supervised the distribution of COVID-19 vaccine, and the planning of the County's mass vaccination clinics. (Exh. 5, Exh. 22, Exh. 26). Between January 16 through January 30, the EOC command structure included the following individuals: CEO Minh Tran as EOC Director, [redacted] (Exh. 5)

6. On January 11, 2021, the County opened its first mass vaccination clinic at the Napa Valley Expo fairgrounds ("Expo"). The Expo clinic was supposed to open on January 18, but the County pushed it up by one week after the Governor's Million Dose Challenge. (Exh. 18)

7. The morning clinics ran from 9:00 a.m. – 12:00 p.m., and the afternoon clinics ran from 1:00 p.m. – 3:45 p.m. The clinics had between four and six injection stations staffed by public health nurses. The last scheduled appointments were set for 3:45 p.m., but the clinic would stay open until 4:00 p.m. in case people came late. (Exh. 18)

8. The Expo clinic was designed to deliver 300 to 700 vaccines per day to eligible individuals in Phase 1a or 1b. These phases included essential workers who had or may have had in-person or face to-face contacts with clients or the community. (Exh. 4, Exh. 18)

9. The state guidelines were changing constantly during this time. At the start of the Expo clinic, the emphasis was on healthcare workers and people over the age of 75. Then the guidelines quickly expanded to include first responders, direct service public employees, and people over the age of 65. (Exh. 4)

[9] https://www.sacbee.com/news/politics-government/capitol-alert/article249023830.html

10. Eligible individuals could schedule vaccine appointments online through the PrepMod system. However, because demand for appointments outpaced supply of vaccine, many eligible individuals were unable to obtain appointments.

11. The goal was to "get shots into arms" and the EOC and public health staff worked quickly 6-7 days a week, 9-10 hours a day to get the facility up and running. This period was described by EOC command staff members as "chaotic" and "exhausting" because they were learning the process running a mass vaccination clinic while doing it. This was often described as "building the airplane while flying it." (Exh. 18, Exh. 25)

12. On January 11, the first day of the clinic, 406 scheduled vaccine doses were administered at Expo clinic. (Exh. 6). The issue of management of EOD excess doses was initially not anticipated. (Exh. 22). However, excess dose management became an issue when, at the end of the first clinic day, there were 30+ excess doses that had been pulled and were expiring. (Exh. 20)

13. Excess doses resulted because the Moderna vaccine contained 10 doses, or sometimes 11 doses, per vial, and it was necessary to use all the doses once the vial is opened in order to avoid waste. In addition, excess doses resulted due to no-shows for scheduled appointments, which happened in the month of January due to bad weather[10].

14. On January 11, to utilize the EOD excess doses, clinic staff called the law enforcement agencies that day and told them to send people. Both sworn law enforcement officers and non-sworn staff came and were vaccinated that day with EOD excess doses[11]. Also on January 11, clinic staff took EOD excess doses to the HHSA Department and distributed them to staff in offices there.[12] In the end, all of the excess doses from the first clinic day were distributed and there was no waste of any doses at the end of the day.

15. The next day, during the EOC's staff meeting, EOC command staff was briefed about the excess dose problem. [redacted] stated that "something had to be done" about EOD excess dose concerns. (Exh. 20)

16. Over the next few days, [redacted] became involved in creating a process to administer EOD excess doses. Sometime during that week, "the question came up about waste, were we throwing away doses?" This question was raised in response to a news article about another jurisdiction that was wasting and tossing excess vaccine doses at the end of the day. "The question came up 'what do we do at the end of the day?'" The EOC staff determined that they would take necessary steps to ensure that no vaccine was wasted. (Exh. 25)

17. Starting on January 12, [redacted] began pulling county personnel reports, reaching out to those eligible county employees age 65 or older. [redacted] reviewed personnel records of all County employees in order to identify employees who were over age 65 or who were eligible

[10] According to [redacted], on January 11 there were 30 doses left at the end of the clinic. (Exh. 20)
[11] Exh. 8e.
[12] The HHSA managers and staff who received the EOD excess doses were considered to be an "eligible" sector by [redacted]. (Exh. 22) According to [redacted] the excess doses were carried to HHSA in order to find eligible arms for the doses. (Exh. 18)

for vaccine based on job function. [redacted] began reviewing eligibility of County employees, contacting them and determining if they were willing to standby for excess vaccines. (Exh. 20)

18. During the remainder of the Expo clinic's first week[13], there was no formal, written policy for managing EOD excess doses. However, clinic staff reported that their priority was to treat the vaccine as "liquid gold" and to distribute the leftover vaccine so that no doses would be wasted. In addition, clinic staff reported that onsite they followed practices to minimize waste and, after the unanticipated overage at the beginning of the clinic, to distribute EOD excess doses to individuals in eligible tiers, based on age over 65 and Phase eligibility. EOD excess doses were also used during this time to vaccinate clinic staff and long-time clinic volunteers onsite. (Exh. 18, 25)

19. These practices used by staff during the first week of clinic included carefully monitoring the County's online system for vaccination appointments signups throughout the day and managing vaccine allocation so staff would only thaw as many vaccinations as needed each day. (Exh. 19)

20. In addition, public health staff counted EOD excess doses by about 3:30 pm each day. Then, excess doses were distributed to individuals in priority groups, MRC volunteers, CERT volunteers and other clinic volunteers who were at risk of COVID 19 exposure because they were working or volunteering in the clinic. Sometimes individuals were called to come to the clinic or referred to the clinic based on age or job function (such as County employees over age 65 who were being vetted by [redacted]) to receive excess doses that day. In addition, some individuals who received excess doses were in the tiers being scheduled for appointments at that time. Staff reported that by following these practices they did their best to find "eligible" arms for excess vaccines. (Exh. 18)

21. According to [redacted], in the early days of the Expo clinic, the process was followed and public health staff "were very conscientious about how we did this. We would stay behind to ensure that all the doses got given. We tried hard to stick to the Phase group." (Exh. 18). [redacted] reported that giving excess doses to individuals in the Phase groups, i.e., avoiding favoritism or distribution to non-eligible individuals, was consistently practiced by staff. (Exh. 18)

22. By using these practices in the first week of the clinic, the EOD excess dose numbers dropped significantly from more than 30 on January 11 to averaging 2 to 4 EOD doses per day during the remainder of the first week. Excess doses were never officially tracked during the period for this fact-finding review, but the evidence indicates that EOD excess doses dropped to an average of 2-4 doses per day through January 29, with the exception of January 20, as discussed below. (Exh. 20, Exh. 25)

23. On January 13, 2021, the County created a General Interest list for any person who worked or lived in the County and wanted to express interest in getting vaccinated. There was no age or job function eligibility requirement for getting on the General Interest list.

[13] The volume of scheduled vaccination remained high. On January 12, 503 scheduled vaccinations were given; on January 13, 511 scheduled vaccinations were given; and on January 14, 470 scheduled vaccinations. (Exh. 6)

Citizens could register online. The County list quickly accumulated more than 40,000 names. The General Interest was not used at this point for excess vaccine standby.[14] (Exh. 20, Exh. 25). Supervisor Ramos was on the General Interest list. (Exh. 23)

24. Also on January 13, the Allocation Guidelines for COVID-19 Vaccine were revised to prioritize vaccinating health care personnel, including vaccinators, and all persons 65 years of age or older. Under CDPH guidelines, "Health departments and providers may offer doses promptly to people in lower priority groups when…doses that have been thawed and would otherwise go to waste." (Exh. 3, Exh. 4)

25. By January 15, direction came from Mr. Tran to develop a process. Based on discussions with the EOC team and clinic managers, [redacted] started to create a list of Municipal employees age 65+ to add to the County employees age 65+ list that was already being curated by [redacted]. "We didn't have 75 year old employees, so it was 65+." (Exh. 25). This became known as the County and Municipal Employees Standby List. In addition to being age 65 or older, those on the list had to be able to get to the clinic on short notice. Employees were able to come to the clinic grounds quickly and could also provide consent that would limit liability concerns. "You don't call in members of the public from the general public interest list – didn't want people to get in an accident" trying to rush to the clinic in 15 minutes. (Exh. 25)

26. On Friday, January 15, 2021, a managers meeting was convened where it was announced that the names of each city's oldest employees age 65+ would be collected to add to the standby list for EOD excess doses. [redacted] requested the cities of American Canyon, St Helena, Yountville, Napa and Calistoga to produce lists of their employees. At 3:22 p.m., [redacted] received the first such list from [redacted] for Yountville, listing its 10 oldest employees. (Exh. 7)

27. On January 18, 2021, [redacted] used some of the names received from Yountville as standbys to receive 5 excess doses that day. On the same day, [redacted] followed up with an email to multiple city managers, stating: "please send [redacted] and I a list of your employees (with their phone numbers and email addresses) that are over the age of 65 and other priority employees (up to 10 total), for us to have to use as a standby list. At the end of the day we sometimes have a couple extra doses and to avoid waste, we will call down the standby list to get those that fit in the current Phase and Tier vaccinated." (Exh. 8l)

28. On January 19, 2021, Mr. Tran emailed [redacted], and suggested increasing the standby list by prioritizing EOC staff for EOD, leftover doses as "most of those actively working as volunteers have gotten them already. Since we may run out of County employees (65+) for end-of-day vaccines, it may be good to show our appreciation to EOC staff (both Shift A and B), who have time and again gone beyond the call of duty work to do what's needed. These EOC staff are onsite and will be there for vaccines readily." [redacted] responded that [redacted] has a list. [redacted]

[14] This list was not used for creating standby names for excess end of day doses until after the names on the County list were exhausted (around the third week of January).

asked we also schedule these folks, so I will send [redacted] links for next week for when [redacted] sends the list and will call anyone earlier if we have availability after working with [redacted] through the employee lists. We have 3 staff that are 65+ on standby today." (Exh. 8h, Exh. 25)

29. At this point, a survey form was sent out to all Napa Municipal employees soliciting those employees to join the standby list. The response varied from day to day. In the beginning, there were less names than doses available. [redacted] was creating a growing list, and when she got a new survey response, those names were added to the list. A list of County employees who were over age 65 was also being compiled. (Exh. 20)

30. The Standby List consisted of both County and Municipal Employees, and [redacted] compiled it from various sources. The General Interest list was not used for the distribution of EOD doses between January 11 and 20. It became used for EOD excess doses later in the week of January 25, 2021 after exhausting the County and Municipal Employees age 65+ list. (Exh. 20, Exh. 25)

31. [redacted] is a [redacted] with Napa County. [redacted] is a [redacted], and she is part of the County's [redacted]. [redacted] is a bilingual specialist. [redacted] the County's Spanish language Facebook Live broadcasts. On January 19, [redacted] learned that a Spanish-language Public Service Announcement ("PSA") encouraging Latinx workers to get vaccinated was going to be filmed the following day, January 20, 2021, at the County's Expo clinic. [redacted] first learned of Supervisor Ramos' participation in the video on January 19 as well. The PSA was not sponsored by the County but by the [redacted]. The [redacted] plan was for the [redacted] to film the video themselves; no production crew was hired and no County staff was involved other than [redacted]. (Exh. 16)

32. On the morning of January 20, 2021, Supervisor Ramos was contacted by one of the Board's aides and asked to step in to do the PSA with the [redacted]. Supervisor Ramos was asked by her aide to arrive at the site around 3:00 p.m. since the clinic closed at 4:00 p.m. and the [redacted] wanted to film people being vaccinated. Supervisor Ramos was not told in advance what the content of the video would be. Supervisor Ramos was told there would be [redacted] staff on site along with [redacted] to handle the PSA, and that she could check in with [redacted] upon her arrival. (Exh. 23)

33. At approximately 3:00 p.m., Supervisor Ramos arrived and met two staffers from [redacted] who were in charge of filming the PSA. Supervisor Ramos and [redacted] do not recall the names of these [redacted]. According to [redacted], one was [redacted] and the other volunteer[15] had worked all day at the clinic before filming the PSA. Supervisor Ramos also met [redacted] at the site. (Exh. 16, Exh. 23, Exh. 25)

34. [redacted] was only on camera for the first part (Q&A) of the filming. For the second part, the filming captured Supervisor Ramos completing the drive-thru process of receiving a

[15] [redacted] described one [redacted] as a blonde woman who she named [redacted] and another as a dark-haired woman who she thinks was named [redacted] or [redacted]

vaccination. The filming of Supervisor Ramos going through the drive-thru only took "a matter of minutes." (Exh. 16)

35. As part of the video, Supervisor Ramos received a blank CDC vaccination card and some paperwork after receiving her simulated vaccination. Once the filming was finished, [redacted] asked Supervisor Ramos for the blank CDC card so she could return it to the workers at the Expo site. After returning the CDC card, [redacted] then left the site. (Exh. 16)

36. Other volunteers at the site greeted Supervisor Ramos, and she explained to them that she was at the site to film a PSA. They had to wait until the clinic closed for the day before they could start filming Supervisor Ramos receiving the simulated vaccine so as to avoid any HIPAA violations associated with showing members of the public being vaccinated. (Exh. 16, Exh. 23)

37. Also on the morning of January 20, at 8:50 a.m., [redacted] received an email from [redacted] for the City of St. Helena, containing the names of their employees over age 65 to add to the standby list. [redacted] noted that 4 of the names on the list were over age 65 and had consented to be on the standby list; she had provided seven names total. (Exh. 8l)

38. On January 20, at 9:33 a.m. [redacted] emailed [redacted] to answer a question about an employee who was on the standby list from St. Helena and asked if, should she be called for an EOD excess dose, would she be allowed to bring her 87 year old grandmother instead. [redacted] responded:

> "We are building a standby list for excess vaccine at the end of day to make sure we do not waste. The intent is to be able to call someone who can come down in 15 minutes or less and that is not feasible with the general public. We will always schedule 75+ for all available appointments. These are completely different purposes. But sure, if she would prefer to bring her grandmother if she gets called, as long as she can do it in 15 minutes, I have no issue with that." (Exh. 8l)

39. At some point between 3:00 p.m. and 3:30 p.m., as was their practice, [redacted] talked to [redacted] to get the number of excess does for the day. At about this time every clinic day, [redacted] would tell [redacted] how many people needed to be produced for excess doses. Based on the information received from [redacted], [redacted] would get standby list names from [redacted] and start calling. (Exh. 25)

40. On January 20, [redacted] told [redacted] there were six EOD excess doses that day. After conferring with [redacted], [redacted] understood that the excess doses would be distributed as follows: three to [redacted] one to [redacted] who was in an eligible tier, and two to individuals on the County and Municipal Employees age 65+ standby list. [redacted] reported that she already had the contact information for the two individuals from the standby list because they had come to the clinic and waited unsuccessfully the day before. (Exh. 25)

41. After speaking to [redacted], but before she called the six individuals for the excess doses, [redacted] talked to [redacted] and Supervisor Ramos in the parking lot. [redacted] asked Supervisor Ramos, "you're not here for a vaccination, right?" Supervisor Ramos responded,

"No, I don't think so." [redacted] made a comment, "sometimes there's excess doses" or "there might be an excess dose." [redacted] responded, "No, I have names to call in." (Exh. 23, Exh. 25)

42. The PSA started filming around 3:45 p.m. when the clinic was closed. At the same time, [redacted] was calling in the six individuals to receive excess doses. (Exh. 23, Exh. 25)

43. The first segment of filming the PSA captured Supervisor Ramos and [redacted] being interviewed in a Q&A format in the parking lot. (Exh. 16, Exh. 23)

44. At about 4:00 p.m., the next segment captured Supervisor Ramos completing the drive-thru process of receiving a simulated vaccination. Supervisor Ramos was requested to do the simulated vaccination by [redacted] and the other [redacted]. This was filmed on an iPhone by [redacted] and [redacted] was also present. (Exh. 19, Exh. 23)

45. [redacted] was asked to be [redacted] to administer the simulated vaccine to Supervisor Ramos on camera for the PSA. [redacted] indicated to [redacted] and [redacted] that she did not feel comfortable using an actual vaccine dose to "fake" the administration of the vaccine for the camera.[16] Accordingly, [redacted] handed [redacted] an empty syringe without the needle attached to it to use for the filming. (Exh. 19, Exh. 24)

46. Supervisor Ramos then drove up to [redacted] in the vaccination area. While being filmed, [redacted] started asking Supervisor Ramos the pre-screening questions that were asked to patients about to receive the vaccine. [redacted] was instructed by [redacted] to ask the questions in Spanish. Once the screening questions were complete, Supervisor Ramos handed [redacted] a completed consent form for the vaccination. (Exh. 19, Exh. 23)

47. [redacted] then cleaned Supervisor Ramos' arm and simulated the administration of the vaccine. There was no needle stick. In response, and while on camera, Supervisor Ramos made a comment to the effect of "of my gosh, wow, I did not feel a thing." Supervisor Ramos then repeated the comment. In response, [redacted] said, "that's exactly what we want to hear." These comments were spontaneous as the entire PSA was not scripted. As part of the video, Supervisor Ramos received a blank CDC vaccination card and some paperwork after receiving her simulated vaccination. (Exh. 19, Exh. 23)

48. As Supervisor Ramos then drove to the observation area,[17] [redacted] reported that she became concerned based on Supervisor Ramos' comment about "not feeling a thing." [redacted] reported that she was concerned Supervisor Ramos might have thought she received an actual dose of the vaccine when she did not. [redacted] then notified nursing [redacted][18]. [redacted] told [redacted] to notify [redacted] or [redacted]. [redacted] then went to [redacted] to report her concern about the possible "confusion." (Exh. 18, Exh. 19, Exh. 24)

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[16] [redacted] only had approximately 3-4 remaining doses at her station at that time and did not want to risk potentially contaminating one of them. (Exh. 19)

[17] Supervisor Ramos recalled filming the simulated vaccination twice, although other witnesses reported that this was done once.

[18] [redacted] was aware that at the end of the day, [redacted] had an extra dose at her station. [redacted] does not know how or from whom [redacted] received that dose. (Exh. 24)

49. [redacted] reported that [redacted] came up to [redacted] and said "I think Supervisor Ramos thinks she got the real shot." [redacted] reported that she understood [redacted] concern that Supervisor Ramos would falsely think she was protected or immune, and believed this to be a legitimate concern. [redacted] described this as not being [redacted] fault. After [redacted] told [redacted], both wondered if Supervisor Ramos was supposed to receive a real shot. (Exh. 18)

50. However, no one followed up with Supervisor Ramos to determine if she believed she had received a real vaccine. No one clarified that Supervisor Ramos did not receive a real vaccine during the filming. (Exh. 18)

51. Supervisor Ramos stated that she understood that the PSA-filmed vaccine was simulated, not real. Supervisor Ramos did not report to any public health staff or County staff that she was confused about whether she had been vaccinated. (Exh. 23)

52. [redacted] says that she then went to speak with [redacted] and sought clarification as to whether Supervisor Ramos was supposed to have received an actual vaccine dose as part of the PSA. According to [redacted], [redacted] said she was not. [redacted] reported that she then told [redacted] about [redacted] concern that Supervisor Ramos might think she received a real shot. However, [redacted] denied this and reported that [redacted] did not tell her about the alleged "confusion" until two days later. (Exh. 18, Exh. 25)

53. According to [redacted], [redacted] said, "If Belia wants a shot, let's give her a shot,"[19] before offering the dose to Supervisor Ramos. (Exh. 18)

54. According to Supervisor Ramos, she concluded filming the PSA and the [redacted] left. Although the PSA was filmed, it apparently was not shown.[20] Supervisor Ramos reported that she was advised there was a problem with the audio. (Exh. 23)

55. Supervisor Ramos reported that at about 4:20 p.m. she was standing outside her car talking to [redacted] about an RFP. The conversation with [redacted] was interrupted by [redacted] who said, "hold on there might be an extra dose." However, [redacted] denied making this comment and stated that she had already left the site before any excess doses were discussed. Right after [redacted] walked off, [redacted] appeared and said they were finishing up the people standing by in their cars. [redacted] did not offer Supervisor Ramos an extra dose at this time. Supervisor Ramos then asked, "is everyone here vaccinated already?" and [redacted] responded "yes." Supervisor Ramos then walked off and started speaking to [redacted] and [redacted]. (Exh. 16, Exh. 17, Exh. 23)

56. According to Supervisor Ramos, [redacted] came back and told Supervisor Ramos everyone was vaccinated including [redacted]. [redacted] instructed Supervisor Ramos to wait where she was until the clinic was finished with its current patients. A few minutes later, [redacted] appeared and exclaimed, from about 10 feet away from Supervisor Ramos, "Belia, it's yours, proceed through." (Exh. 23). [redacted] denies

[19] [redacted] recalled that [redacted] said "since she thinks she got it can you just give her a shot?" (Exh. 19)

[20] These fact-finders requested a copy of the film from [redacted] for this review but were advised by that it was not available.

making this comment as well and says she left the area before any dose was approved or given to Supervisor Ramos. (Exh. 16)

57. At 4:24 pm, [redacted] texted [redacted] asking if there was any "overage today" in vaccines and if names from the County and Municipal Employees 65+ standby list were needed. [redacted] responded that two persons from the previous day's list had been vaccinated and asked for five additional names for the next day. (Exh. 8s)

58. At approximately 4:25 p.m., Supervisor Ramos drove through the vaccination area and received a real vaccination. (Exh. 23)

59. The clinic's staff used the same paperwork that Supervisor Ramos had already filled out during the simulated process. The same [redacted] from the simulated process administered the real dose to Supervisor Ramos. She did not feel a thing again and had to ask the [redacted] if she did it for real that time. (Exh. 19, Exh. 23)

60. After receiving her vaccination, Supervisor Ramos greeted the clinic staff and thanked them for their important work. (Exh. 23)

61. At shortly before 5:00 p.m., Supervisor Ramos left the clinic. (Exh. 23)

62. [redacted] and [redacted] reported that the vaccine was offered to Supervisor Ramos because: 1) CDPH protocols allowed vaccinations to drop down tiers to avoid waste; and 2) [redacted] and [redacted] reported that they felt obligated to offer the dose to Supervisor Ramos. (Exh. 18, Exh. 19, Exh. 25)

63. Supervisor Ramos stated that she did not request or ask for the vaccine. (Exh. 23)

64. [redacted] reported that Supervisor Ramos was very visible at the clinic, circulating and talking to many people. [redacted] described the situation as "awkward and uncomfortable" when Supervisor Ramos was still present at the clinic at the time the seventh dose became available. (Exh. 25)

65. [redacted], who gave the vaccine to Supervisor Ramos, reported that she felt "uncomfortable" to be directed to give the dose because at that time, "it was for the elderly, healthcare workers, emergency responders." (Exh. 19)

66. [redacted] and [redacted] reported that this was the first time they knowingly gave an EOD excess dose to someone outside the five priority categories, and [redacted] reported that she believes "it would have been difficult for staff to say no" in a situation like that. (Exh. 18, Exh. 19)

67. [redacted] reported that she felt "pressure" to offer the dose based on Supervisor Ramos's presence at the clinic that day. [redacted] reported that if she had to make the same decision regarding another person who was outside all the criteria for an EOD excess dose, no vaccine would have been offered. (Exh. 25)

68. [redacted] is one of the last people to leave the vaccination clinics every day. He reported that the policy for the staff at the clinic is to stay as late as needed to avoid wasting any excess doses. (Exh. 17)

69. [redacted], [redacted], [redacted], and [redacted] provided different versions of events; however, they agreed that Supervisor Ramos would not have qualified in an eligible County priority group on January 20, even though providing the vaccine was within state policy at the time. They also agreed that the appearance of an extra seventh dose at the very end of the day created the opportunity for Supervisor Ramos to receive the vaccine. (Exh. 18, Exh. 19, Exh. 24, Exh. 25)

70. On January 21, [redacted] of American Canyon, submitted a roster of City employees for the standby list. (Exh. 8)

71. On or about January 21, The County started its clinics at South Campus and eventually moved all clinics there permanently. (Exh. 18)

72. On January 25, Governor Newsom announced the state's "age-based approach," meaning that after vaccinating those age 65 and over as well as some essential workers such as teachers and farmworkers, the state would distribute vaccines based on age rather than occupation, health status or crowded living conditions.[21] (Exh. 4)

73. On January 27, Supervisor Ramos posted a video on Facebook. In the video, Supervisor Ramos stated that she went through a simulated process to show how to get the vaccine, and that this was part of a Spanish-language PSA. She stated that at end of day there were extra doses that can be anywhere from 1-9 doses per day, so she received a dose of the real vaccine. Extra doses go to those on the standby list, then volunteers/clinic workers who haven't already been vaccinated. Supervisor Ramos stated that the standby list was for tiers 1a and 1b only (age 65+). She stated that she was "on the list" and this is why she received the excess dose that day. The video remains posted and has not been taken down. (Exh. 9)

74. On January 27, a reporter contacted Supervisor Ramos by email and text message asking to discuss the fact that she had received the vaccine. Supervisor Ramos forwarded the inquiry to [redacted]. Supervisor Ramos declined to speak with the reporter, and referred him to her Facebook page. (Exh. 23)

75. On January 27, [redacted] wrote a statement to the Board of Supervisors "to provide clarification" on how extra doses are administered at the end of each day. In it, she identified the County's process of reducing waste by carefully managing vaccine inventory and, when an average of 2 to 4 EOD excess doses are available each day, selecting individuals to receive doses from five priority groups. [redacted] noted that "No process will be perfect, however, what we have refined to date seems to be working."

[redacted] identified the five priority groups that were then being "assessed each day to create the standby process:

> 1. Phase 1a or County and City staff that are in Phase 1a or 1b, Tier 1 that were invited to clinic and unable to obtain an appointment. For example, yesterday, a Sheriff's Deputy that was on vacation the week deputies were vaccinated still needed a vaccine and was called in yesterday.

[21] https://www.sacbee.com/news/politics-government/capitol-alert/article249023830.html

2. Staff from County, City and other agencies that regularly work at the vaccine or testing site

3. 65+ County and municipal employees and officials. This list comes from Human Resources who received lists from each jurisdiction and contacted employees to determine interest.

4. Emergency Services employees that staff the emergency operations center in the event of another emergency. This list came from the Office of Emergency Services through Human Resources.

5. 65+ from the vaccine interest form that can quickly and safely make it to the site on short notice." (Exh. 25)

76. [redacted] further reported that each day, "we have 4 people from the lists described above come wait in the parking lot until the clinic is closed and if there is vaccine available, those people waiting are brought into the line for a vaccine. If there is no vaccine, they come back the next day and the next day until these is vaccine." However, [redacted] did not explain that there were not four people waiting on standby on January 20. (Exh. 7b)

77. [redacted] further stated, "The nurses work very hard to ensure nothing is wasted and there are very few 'extra doses' at the end of the day. We would all rather turn standby away than try to find people at the last minute—it extends an already long and labor intensive day." (Exh. 7b)

78. After the news story broke, the County increased the number of people that come in on standby from 4 to 6 each day. (Exh. 13, Exh. 14, Exh. 21)

79. On January 28, 2021, in a Facebook Live Discussion Between [redacted], [redacted], and [redacted], [redacted] read a statement on behalf of the County. [redacted]: "we need to do better... we need to have processes in place for extra vaccines." (Exh. 14)

80. On March 4, 2021, the Board of Supervisors passed Motion 11A2. The clerk of the Board documented the following points directed by the Board as to the Fact-Finding report: "The Board of Supervisors directed the CEO to prepare a report regarding COVID Vaccination processes in Napa County. The dates of January 11 to January 29 are to be included in the report. The locations to be reviewed are the County Expo and South Campus." The CEO was directed to engage a Third Party to prepare the report. (Exh. 1)

On March 4, 2021 this Firm was engaged to perform this Fact-Finding. (Exh. 2)