

Charles S. LiMandri (SBN: 110841)
 Paul M. Jonna (SBN: 265389)
 Jeffrey M. Trissell (SBN: 292480)
 LIMANDRI & JONNA LLP
 P.O. Box 9120
 Rancho Santa Fe, CA 92067
 Telephone: (858) 759-9930
 Facsimile: (858) 759-9938
 cslimandri@limandri.com
 pjonna@limandri.com
 jtrissell@limandri.com

Harmeet K. Dhillon (SBN:207873)
 Mark P. Meuser (SBN: 231335)
 Gregory R. Michael (SBN: 306814)
 DHILLON LAW GROUP INC.
 177 Post Street, Suite 700
 San Francisco, CA 94108
 Telephone: 415-433-1700
 Facsimile: 415-520-6593
 harmeet@dhillonlaw.com
 mmeuser@dhillonlaw.com
 gmichael@dhillonlaw.com

Thomas Brejcha, *pro hac vice**
 Peter Breen, *pro hac vice**
 THOMAS MORE SOCIETY
 309 W. Washington St., Ste. 1250
 Chicago, IL 60606
 Telephone: (312) 782-1680
 tbrejcha@thomasmoresociety.org
 pbreen@thomasmoresociety.org
 *Application forthcoming

Attorneys for Plaintiffs

Attorneys for Plaintiffs

UNITED STATES DISTRICT COURT
 SOUTHERN DISTRICT OF CALIFORNIA

SOUTH BAY UNITED PENTECOSTAL
 CHURCH, a California non-profit
 corporation; and BISHOP ARTHUR
 HODGES III, an individual,

Plaintiffs,

v.

GAVIN NEWSOM, in his official capacity
 as the Governor of California, *et al.*,

Defendants.

Case No. 3:20-cv-865-BAS

**Declaration of Sean G.
 Kaufmann in Support of
 Plaintiffs' Renewed Motion for a
 Temporary Restraining Order /
 Preliminary Injunction**

Judge: Hon. Cynthia Bashant

1 I, Sean G. Kaufman, declare and state as follows:

2 1. I am a certified public health professional (CPH), behaviorist, health
3 education and infectious disease specialist, with particular expertise in both
4 behavioral-based training and infectious disease risk mitigation in clinical, laboratory
5 and other public health settings. I make this declaration of personal, firsthand
6 knowledge, and if called and sworn as a witness could and would testify competently
7 thereto.

8 2. I received my Bachelor of Arts and Sciences in Psychology in 1996 from
9 San Diego State University in San Diego, California. In 1999, I received my Master in
10 Public Health in Health and Human Behavior, also from San Diego State University
11 in San Diego California.

12 3. From 1997 to 1999, I was employed as a Project Manager and Health
13 Education Specialist at San Diego State University in San Diego, California, serving
14 in the Student Health Services Office of Health Promotion. In that role, I provided
15 training programs, counseling and patient services for a variety of health issues.

16 4. From 1999 through 2006, I worked for the Centers for Disease Control
17 and Prevention ("CDC") in Atlanta, Georgia, serving during my tenure in CDC's
18 National Center for HIV, AIDS and Tuberculosis, CDC's National Center for
19 Infectious Diseases, CDC's Office of Terrorism and Emergency Response and the
20 Office of the Director of the CDC. While with the CDC, I assisted with the CDC's
21 response to HIV, the 9/11 and 2001 anthrax attacks, the West Nile Virus, SARS and
22 monkeypox. I received a Distinguished Service Award from the United States
23 Department of Health and Human Services in 2002 for outstanding contributions
24 and public health activities in response to the 9/11 and subsequent anthrax attacks. I
25 also received a Distinguished Service Award from the United States Department of
26 Health and Human Services in 2003 for outstanding contributions and public health
27 activities in response to the 2003 SARS outbreak.

1 5. From 2004 through 2014, I served as Senior Associate and Director of
2 the Science and Safety Training Program in the Rollins School of Public Health at
3 Emory University in Atlanta, Georgia. During my association with Emory University,
4 I developed and directed the Biosafety Laboratory 3 (“BSL3”) and BSL4 Science and
5 Safety Training Program along with the ONSITE program, all of which programs
6 trained individuals both domestically and internationally to work safely in and
7 support high-containment laboratories equipped to handle the most infectious and
8 dangerous biological agents in the world. While associated with Emory University, I
9 trained and managed those who clinically treated the first two Ebola patients in the
10 United States working at the Emory University Isolation Unit during the 2014 Ebola
11 outbreak.

12 6. From 2011 through the present, I have served as the Founding Partner,
13 President and Chief Executive Officer of Safer Behaviors (USA), where I serve as an
14 expert consultant in behavioral-based training around infectious diseases in clinical
15 and laboratory settings. In that role, I develop, manage, implement, and deliver a
16 wide range of services for people working with and around infectious diseases,
17 including those in laboratories, healthcare settings, and high-containment work
18 environments, Applied Laboratory Emergency Response Training (ALERT)
19 Programs for first responders, Personal Protective Equipment (“PPE”) Training
20 Programs, Emergency Communication Leadership Programs, and Biological Risk
21 Mitigation Training for those serving on the frontline of emerging infectious diseases.

22 7. Since 2014, I have provided Advanced Biological Risk Mitigation
23 Training Programs with the American Society for Microbiology (ASM), National
24 Institutes of Health (NIH), Fogarty International Center, CRDF Global throughout
25 Pakistan, Egypt and Malaysia. I have consulted for the World Health Organization
26 (WHO) and developed its Shipping of Infectious Substances Training and its
27 Identification of Polio Samples for Eradication Efforts. In 2015, I received the John
28 H. Richardson Special Recognition Award from the American Biological Safety

1 Association, recognizing outstanding contributions that have enhanced ABSA and
2 the profession of biological safety.

3 8. My publications include the following: (a) *Anthrax in New Jersey: A*
4 *Health Education Experience in Bioterrorism Response and Preparedness*, HEALTH
5 PROMOT. PRACT. 6:430-36 (2005); (b) *Biosafety Behavioral Based Training for High*
6 *Biocontainment Laboratories: Bringing Theory into Practice for Biosafety Training*,
7 APPLIED BIOSAFETY J. 12:3 (2007); (c) *Review of the Emory University Applied*
8 *Laboratory Emergency Response Training (ALERT) Program*, APPLIED BIOSAFETY J.
9 14:1 (2009); (c) *Surviving Biosafety: Coping with Occupational Stressors of Serving the*
10 *Profession*, APPLIED BIOSAFETY J. 17:4 (2012); (d) *Chapter12: Strategies for*
11 *Communicating with the General Public About High-Containment Laboratories*, ANTH.
12 OF BIOSAFETY XIII, AM. BIOLOGICAL SAFETY ASSOCIATION (2012); (e) *Viral*
13 *Hemorrhagic Fevers: Chapter 9 – BSL4 Workforce Preparedness in Hemorrhagic Fever*
14 *Outbreaks*, TAYLOR & FRANCIS (2013); (f) *Bioerror and Safety Culture: The Leadership*
15 *Commitment to the Preparedness, Protection and Promotion of Scientists*, CULTURE: A
16 PUBLICATION OF THE AMERICAN SOCIETY FOR MICROBIOLOGY (2014); (g) *Biological*
17 *Safety Principles and Practices: Chapter 28 – A One-Safe Approach. Continuous Safety*
18 *Training Initiatives*, ASM PRESS (2017); and (h) *Prepare and Protect: Safer Behaviors in*
19 *Laboratories and Clinical Containment Settings*, ASM & WILEY PRESS (2020).

20 9. I am an International Federation of Biosafety Professionals Certified
21 Professional in Biorisk Management, am certified as an MBTI Certified Provider by
22 GS Consultants, hold a Certification in Public Health provided by the National Board
23 of Public Health Examiners and have been accredited as a Certified Health Education
24 Specialist by the National Commission for Health Education Credentialing.

25 10. In or about November 2019, while directing a Leadership Program in
26 Biological Risk Mitigation in Islamabad, Pakistan, I first became aware of an outbreak
27 of what was ultimately determined to be a novel coronavirus, SARS COV-2, in
28 Wuhan, China, that the world has since come to commonly refer to as COVID-19.

1 11. Over the ensuing months, as part of my biosafety work and regular
2 professional development, I have engaged in a thorough review of WHO and CDC
3 data and the reams of international and domestic scientific data that have been
4 published regarding COVID-19 in *The Lancet*, *Dispatch*, *The New England Journal of*
5 *Medicine*, *JAMA*, *Clinical Infectious Diseases* and other publications, as well as the
6 outcomes of prevailing international and domestic and international biosafety
7 protocols associated with COVID-19. I have also facilitated multiple trainings,
8 discussions, and assisted organizations with strategies minimizing risks to health and
9 safety specific to COVID-19.

10 12. Through that process, I have become readily familiar with COVID-19's
11 droplet (micro and macro) and surface transmission, the risks and likelihood of
12 symptomatic and pre-symptomatic transmission, reproduction rates, signs,
13 symptoms, mortality, risks and other infectious disease characteristics of COVID-19
14 across the population – including in both children and adults, as well as those with co-
15 morbidities. I have put that ongoing review, as well as my education and twenty-five
16 years of public health experience, to use in implementing and evaluating COVID-19
17 public health and safety protocols, including with respect to public health expertise I
18 am currently providing to, among others, large-scale venues and film and television
19 productions on safe operating procedures and protocols.

20 13. I understand that the State of California currently claims that there is no
21 way, consistent with science and public health, for houses of worship located within
22 any county that is either on or any less than 14 days removed from the State of
23 California's COVID-19 "monitoring list" – the precise criteria for which
24 "monitoring list" are opaque but appear to require some combination of what the
25 state deems to be a COVID-19 "surge" in infections or hospitalizations, what the
26 state deems to be "stretched" ICU bed or ventilator capacity, or what the state
27 deems to be "insufficient" COVID-19 testing – to open their doors to in-person
28 worship and to do so safely. As such, I understand that the default position of the

1 State of California is that the science of public health dictates that no church,
2 mosque, synagogue, or other house of worship located in California counties on the
3 “monitoring list” can open for in-person instruction at all.

4 14. Despite the state’s claim, there is no rational and legitimate scientific or
5 public health basis supporting the sweeping breadth and scope of the State of
6 California’s above-described closure mandate. Rather, given the real and significant
7 public health and other harms—including especially psychological harms—known to
8 be associated with restricting religious freedom, such unprecedented restriction
9 should only ever be properly wielded as a disease control mechanism when the risks
10 are far greater; when such closures are far more targeted – often at the individual
11 church level; and far more limited in time. None of these criteria are met by the State
12 of California’s closure mandate.

13 15. With respect to risks, everything that we know as public health and
14 infectious disease professionals about the likelihood of symptomatic and
15 presymptomatic transmission, reproduction rates, signs, symptoms, mortality, risks
16 and other infectious disease characteristics of COVID-19 both domestically and
17 internationally does not rationally comport with what I understand the state is
18 claiming to be true in attempting to justify its mandate. Indeed, commonly utilized
19 Susceptible, Infectious, and Recovered – or “SIR” – disease transmission modeling
20 associated with COVID-19, together with WHO and CDC public health metrics,
21 suggest that California’s mandate is likely to make the overall public health situation
22 worse and not better by, *inter alia*, enlarging the population of susceptible individuals.

23 16. With respect to targeting, the sweeping nature of the State of
24 California’s closure mandate shows that it is not rationally targeted as an infectious
25 disease control mechanism. There is no public health reason that a house of worship
26 in an unaffected portion of a California county must be prohibited from operating
27 because of an outbreak in an affected portion of a California county. Moreover, it is
28 simply not true for the State of California to claim that there is no way to safely

1 operate as a house of worship in a county that meets the state's criteria for placement
2 on its "monitoring list." While nothing is ever free from any risk, the data shows that
3 any house of worship in any California county that (1) removes from the in-person
4 church environment for between 5-7 days any individual that (i) reports having been
5 in contact with a person who is COVID-19 positive; or (ii) has exhibited COVID-19
6 symptoms; (2) engages in temperature screening of all attendees, staff and visitors at
7 points of entry, denying such entry to anyone who has a fever; (3) quickly and
8 aggressively tests, isolates and contact traces any child or staff member presenting
9 with COVID-19 symptoms; and (4) teaches, enforces and engages in frequent
10 handwashing, sanitization and decontamination of high travel points within the
11 church environment, may be said to meet commonly accepted public health
12 definitions of safe operating that minimize risks. From a public health and infectious
13 disease control perspective, all of these features are both feasible and sustainable at
14 minimum cost.

15 17. And with respect to being limited in time, the State of California's
16 church closure mandate is not properly time-limited as a matter of public health and
17 infectious disease control. To the extent the State of California may expect a vaccine
18 at some point in the future, it should be noted that a vaccine has never been
19 developed for a coronavirus like COVID-19. And even if developed and sufficiently
20 adopted, any COVID-19 vaccine is likely to be similar to influenza vaccines that have
21 been shown to quickly lose effectiveness. The latest COVID-19 data shows that the
22 disease is not likely to ever be eradicated.

23 ///

24 ///

25 ///

26 ///

27 ///

28 ///

