IN THE UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF OHIO – Cincinnati Division

HUNTER DOSTER, et. al.	:	Case No.: 1:22-cv-00084
Plaintiff	:	
v.	:	
Hon. FRANK KENDALL, et. al.	:	
Defendants	:	

RESPONSE TO GOVERNMENT'S BRIEF REGARDING MOTION FOR STAY PENDING APPEAL AND ADMINISTRATIVE STAY

The Government makes certain sweeping arguments that have already been fully briefed, and which this Court has emphatically rejected. Two such arguments are that the Government is likely to succeed on the merits and that class certification was improper. [See, e.g., Doc. 13, Doc. 21; Doc. 27 Doc. 30, Doc. 34; Doc. 46; Doc. 47, Doc. 72]. Consequently, we will not repeat Plaintiffs' rebuttal to all the Government's arguments. However, we note that other Courts have granted class certification on nearly identical claims. *See, e.g. U.S. Navy Seals, 1-26 v. Biden*, NDTX 4:21-cv-01236, at Doc. 140 (Navy Class); *Colonel Financial Management Officer, et. al. v. Lloyd Austin, et. al.*, MDFL 8:22-cv-1275, at Doc. 229 (entered earlier today, 8/18/2022) (Marine Corps).

We also note that, with the passage of time, the Government's case continues to fall apart. For instance, the CDC recently released several new recommendations and made several statements concerning COVID-19.[1] In particular:

[1] *See Summary of Guidance for Minimizing the Impact of COVID-19 on Individual Persons, Communities, and Health Care Systems — United States, August 2022*, https://www.cdc.gov/mmwr/volumes/71/wr/mm7133e1.htm, (last accessed Aug. 18, 2022).

1. The CDC now recognizes the immunity and protection provided to those who have previously recovered from a COVID-19 infection: "The risk for medically significant illness increases with age, disability status, and underlying medical conditions but *is considerably reduced by immunity derived from* vaccination, *previous infection*, or both, as well as timely access to effective biomedical prevention measures and treatments."[2]
2. The CDC also now confirms that "[h]igh levels of immunity and availability of effective COVID-19 prevention and management tools have reduced the risk for medically significant illness and death," thus annihilating the Government's argument regarding its allegedly compelling interest to reduce hospitalization and death among service members solely by means of forced vaccination.[3]
3. The "[C]DC's COVID-19 prevention recommendations now no longer differentiate based on a person's vaccination status because breakthrough infections occur, though they are generally mild, and persons who have had COVID-19 but are not vaccinated have some degree of protection against severe illness from their previous infection."[4]
4. Finally, "[R]eceipt of a primary series alone, in the absence of being up to date with vaccination through receipt of all recommended booster doses, provides minimal protection against infection and transmission."[5]

Thus, the CDC now refutes the Government's allegedly compelling interest in forcing vaccination regardless of prior infection, and its purported inability to accommodate class

[2] *Id.*

[3] *Id.*

[4] *Id.*

[5] *Id.*

members' religious beliefs. In fact, the Government's own declarant, the U.S. Air Force Chief of Immunization Healthcare Division, Defense Health Agency-Public Health directorate, relies entirely on the CDC's recommendations in justifying the Government's "vaccination is the only way" position.[6]

And it's not just the CDC that is factually undermining the Government's untenable position. Its own witnesses are piling on. In *U.S. Navy Seals, 1-26 v. Biden*, 4:21-cv-01236, the Plaintiffs took the deposition of the Vice Chief of Naval Operations, Admiral Lescher, who testified by way of declaration in the District Court, similar to the Declarations offered by the Government in this case. *See* Exhibit A.[7] The Declaration of Admiral Lescher was relied on by Justice Kavanaugh in his concurring opinion in *Austin v. United States Navy Seals*, 142 S. Ct. 1301 (2022), to grant a partial stay. Incredibly (or maybe not so incredibly), Admiral Lescher admitted numerous times that he did not have the personal knowledge to attest to the facts set forth in his prior Declaration, and admitted that significant portions of his Declaration amounted to unsubstantiated speculation. Including, for example, admitting that details regarding the effect COVID-19 had on naval ships was "not generally" within his purview and that he did not speak to individuals with such knowledge before drafting his declaration (Tr. at 22:11–22:20, 23:4–23:6, 23:16–24:1), admitting he was unaware of any combat operations negatively impacted by COVID-19 (Tr. at 33:18–34:8), or stating he was unaware of specific examples of COVID-19 made a medical evacuation more difficult (Tr. at 50:15–51:16). In other words, the passage of time has only demonstrated the wisdom of this Court's decision that the Government cannot meet its very high burden in this case.

[6] Exhibit 9, Doc. # 27-10, Declaration of Colonel Tonya Rans.

[7] All lettered Exhibits are attached hereto.

As for the other arguments raised by the Government, they are conditioned upon a strained reading of the plain language of the Court's Order or have otherwise been thoroughly analyzed and rejected by the Court. [Doc. 77]. We address these other arguments below.

1. What this Court ordered and the scope thereof

The injunction, by its terms, only applies to members of the class. Therefore, it only applies to "[a]ll active-duty, active reserve, reserve, national guard, inductees, and appointees of the United States Air Force and Space Force , including but not limited to Air Force Academy Cadets, Air Force Reserve Officer Training Corps (AFROTC) Cadets, Members of the Air Force Reserve Command, and any Airman who has sworn or affirmed the United States Uniformed Services Oath of Office or Enlistment and is currently under command and could be deployed." All of the past tense language within that definition makes clear that individuals must have met the criteria for that definition as of the date of the class modification, July 27, 2022 [Doc. 77]. Moreover, individuals must meet that criteria and must also have further: "(i) submitted a religious accommodation request to the Air Force from the Air Force's COVID-19 vaccination requirement, where the request was submitted or was pending, from September 1, 2021 to the present" (i.e., July 27, 2022, the date of the Order); "(ii) were confirmed as having had a sincerely held religious belief substantially burdened by the Air Force's COVID-19 vaccination requirement by or through Air Force Chaplains; and (iii) either had their requested accommodation denied or have not had action on that request."

Because all class membership requirements are stated in the past tense, including all of the requirements under (i), (ii), and (iii), which had to have been met by the date of the modified class order (i.e. July 27, 2022), there is no open-ended class. The Government is wrong to argue

otherwise. Simply put, the class is necessarily confined to those who met the class definition as of July 27, 2022. This is a plain reading of the Court's class definition.

Finally, insofar as the restrictions on National Guard are concerned, the application of the injunction is limited to the enforcement of the Secretary of the Air Force's vaccine mandate against those meeting the class definition. It would therefore not apply to any vaccine requirement that was separately imposed by any Governor, State Adjutant General, state legislature, or separate state authority.

After reading the Government's brief, to avoid any ambiguity and to conserve judicial resources, Plaintiffs offered to enter into an Agreed Order with the Government in order to clarify these points related to the class definition and to the National Guard issue. Predictably, the Government declined. *See* Exhibit B. To avoid the Government's strained reading, which is what supports the majority of its argument, the Court should consider entering a further order clarifying the scope of its previous order, so as to avoid the Government making this same, strained argument on appeal. We have tendered such an order. *See* Exhibit D.

2. The Government's argument about the "expansion" of the class without briefing, allegations that class-wide relief was legal error, and standing of class members

The Government argues that it was unfair to "expand" the class to "reserves," "inductees," "appointees," and "members of the 54 Air National Guards of the States. . . ." For several reasons, Plaintiffs respectfully disagree. The Government further argues that it did not have the opportunity to brief the expansion issue. It has now had that opportunity. [Doc. 83].

Turning again to this Court's order, this Court certified a class with regard to any active or active reserve member of the Air or Space Force to include Air Force Academy Cadets, Air Force Reserve Officer Training Corps (AFROTC) Cadets, Members of the Air Force Reserve Command,

and "any Airman who has sworn or affirmed the United States Uniformed Services Oath of Office and is currently under command and could be deployed." (Doc. 72).

However, this language was also limited to personnel "who: (i) submitted a religious accommodation request to the Air Force from the Air Force's COVID-19 vaccination requirement, where the request was submitted or was pending, from September 1, 2021 to the present; (ii) were confirmed as having had a sincerely held religious belief by or through Air Force Chaplains; and (iii) either had their requested accommodation denied or have not had action on that request."

By definition, Air Force ROTC Cadets are not on active duty or active reserves. But they do go through the entire process of religious accommodation processing. So what the Government calls an expansion was actually merely a clarification. Further, it is only by meeting all of this Court's requirements, all of which are stated in the past tense, that places someone within the class. Once again, this includes the requirements at (i), (ii), and (iii).

The Government next argues that Plaintiffs did not have standing to assert this relief [Doc. 83 at pp.5-6] because the Government observes that no Plaintiff is a member of the National Guard, and none were inductees or appointees. But typicality and commonality do not require such a showing. Rather, it is sufficient that all Plaintiffs, like all others in the class, were subject to the same mandate imposed by Secretary Kendall, all going to the same appeal authority, Lt. General Miller, and all were subject to the same systemic discrimination. *Coleman v. GM Acceptance Corp.*, 220 F.R.D. 64, 86-90 (M.D. Tenn. 2004) (explaining that standing is determined with respect to the question of whether the individual Plaintiffs have standing and have been harmed, observing that "where the potential class members cannot be enumerated, attempting to conduct a standing analysis with respect to these unenumerated class members would be impossible," and

class certification and definitions are appropriate "as long as the challenged policy or practice was generally applicable to the class as a whole").

The Government repeats its argument that RFRA requires individualized consideration. RFRA does require individual consideration. But the fact that the Government implemented a blanket policy of denials for every Air Force and Space Force member, other than those at the end of their term of service, while granting medical and administrative exemptions, rather than actually conducting that case-by-case assessment, as the Court has found [Doc. 47; Doc. 72], and as the Government has admitted in Court, is evidence of a systemic violation warranting systemic relief. [Doc.30-2, Transcript with Government admission about religious accommodations].

3. The Government's argument about inconsistent judicial orders

The Government again argues that class certification here conflicts with other cases and rulings that found that Defendants could substantially burden the religious freedom of service members, and they make the claim that having conflicting rulings is a good thing. [Doc. 83 at pp. 8-9]. Nothing could be further from the truth. First, avoiding conflicting rulings on identical facts and law is generally the point of class actions and certifications. *City of North Royalton v. McKesson Corp. (In re Nat'l Prescription Opiate Litig.)*, 976 F.3d 664, 674 (6th Cir. 2020) ("Rule 23 permits litigation classes primarily for the purposes of aggregating and adjudicating common claims for trial, which can avoid conflicting judgments in individualized proceedings and can more efficiently resolve the claims of the class through a single lawsuit.")

Second, to avoid the risk of inconsistent rulings in other class actions, some courts have excluded from the class persons who bring individual claims. Here, if the Court desired, it could

exclude from the class those who are pursuing individual actions.[8] *Vidal v. Wolf*, 501 F. Supp. 3d 117, 136-137 (NYED 2020). Courts have wide discretion to modify the definition of a class. *Powers v. Hamilton County Pub. Defender Comm'n*, 501 F.3d 592, 619 (6th Cir. 2007) ("district courts have broad discretion to modify class definitions").

But equally, there is no inconsistency. The Government cannot point to a single Court order that requires them to discriminate against the Plaintiffs or the class. The denial of relief, is just that – it imposes no burden or requirement on the Government. The same is true with court orders that direct more limited relief – the Government is not, by such orders, precluded from giving such persons more fulsome relief.

4. The Government's argument about the commissioning of officers or enlisting of new service members

Plaintiffs have undertaken significant research on this issue in response to the Government's arguments. While there is no question that the Government and its officials have violated RFRA, not every harm can be remedied. The Government is, unfortunately, correct that *Orloff v. Willoughby*, 345 U.S. 83, 90 (1953), states that "the commissioning of officers in the Army is a matter of discretion within the province of the President as Commander in Chief." We have found other cases beyond those cited by the Government, that state, as a matter of separation of powers, "[w]hatever control courts have exerted over tenure or compensation under an appointment, they have never assumed by any process to control the appointing power either in civilian or military positions." *Dysart v. United States*, 369 F.3d 1303, 1317 (Fed. Cir. 2004).

[8] The Court could exclude such individuals from the Class with the following additional language, which would have the effect of giving persons a reasonable opportunity to cease or stay in progress actions: "Excluded from the class is … or (ii) is deemed to have opted out, by asserting and maintaining a claim as a named or identified plaintiff (and not as a member of a class or a putative class) under RFRA or the First Amendment against the Government in relation to the vaccination mandate, in an action that is still pending on or after September 30, 2022, not inclusive of this action, or actions that are stayed pending final adjudication of this action."

Thus, "the President's decision here whether or not to exercise his appointment power is discretionary, and we hold that the President cannot be compelled to appoint military officers." *Id.*

Unfortunately, and consistent with our duty of candor to the Court, Plaintiffs believe that this aspect of the injunction must be withdrawn. We have proposed an order that does that.

5. The Government's argument about non-party state officials

We have already addressed much of this with clarifying language. Again, we have proposed an order that makes that clarification. At bottom, the Government should not be able to avoid the requirements of RFRA because of the actions of others. If the states want to impose a vaccination requirement and deny religious accommodations to it, so be it. Litigation can be brought in those states over that issue. But in the same vein, the violation here was by these Defendants, who systemically denied Air National Guard members' requests for religious accommodations to the Secretary of the Air Force's requirement. And that should not be permitted.

6. The Government's argument about court martial stays is moot

The Government complains the Court has stayed court-martial proceedings, but the Government's own filing admits "they are **not aware** of any ongoing court-martial." [Doc. 79]. Instead, the Government suggests that the Court's order should not apply to approximately 23 administrative proceedings under 10 U.S.C. § 815 (Article 15) underway. [Doc. 79]. They cite *Schlesinger v. Councilman*, 420 U.S. 738, 758 (1975) for the proposition that these administrative disciplinary measures should be permitted to continue, but by its language, (i) *Schlesinger*, 420 U.S. 738 does not apply to non-court martials; and (ii) *Schlesinger*, 420 U.S. 738 merely indicates that proceeding through a court-martial process is not irreparable harm. It does not speak to the

irreparable harm already found by this Court. To deal with this argument by the Government, Plaintiffs withdrew it in the attached order, because, again, it applies to no one.

7. The Government's argument about lack of analysis in the class-wide preliminary injunction

The Government claims the Court's order lacked "analysis." (Doc. 83 at 11). Of course, that views the Order in a vacuum. This Court previously, and quite extensively, considered the issues in this case [Doc. 47; Doc. 72]. Any order must, therefore, be viewed in conjunction with all prior orders touching on the same matter.

8. The Government's argument about Novavax

The Government next makes arguments about Novavax. This Court already found that Plaintiffs met their evidentiary burden under RFRA. However, we address the Governments' most recent attempt to argue that they have not substantially burdened Plaintiffs' sincerely held religious beliefs in light of the newest COVID-19 vaccine to receive emergency use authorization, Novavax. Specifically, the Government continues to falsely claim that Novavax is not morally problematic for those who object to vaccines which have a connection to aborted fetal tissue, and they again cite to Novavax's self-serving and false public statements that its product has no connection to aborted fetal tissue. The evidence is clear and admitted by Novavax itself: aborted fetal tissue was used to test its vaccine.[9]

The Government then argues that Novavax will not be religiously objectionable to everyone who has an aborted fetal cell objection. We acknowledge that service members who do not have an objection to vaccines tested on the cell line from an aborted child, and have no other

[9] https://wng.org/roundups/pro-lifers-question-novavaxs-fetal-tissue-claim-1655411473 (last visited 7/22/2022); https://personhood.org/2022/02/22/yes-novavax-used-hek293-an-aborted-fetal-cell-line/ (last visited 7/22/2022); https://www.lifesitenews.com/opinion/novavax-covid-jab-linked-to-aborted-fetal-cells-through-laboratory-testing/ (last visited 7/22/2022); see, also, Declarations of Plaintiffs, DE#30-4 through DE#30-20.

religious objection to Novavax, can receive this vaccine without violating their religious beliefs when it is soon available and FDA approved.[10] The Government also fails to recognize that any Plaintiffs and class members who have since gotten a vaccine (like Lts. Ramsperger and McCormick), or will do so as this case progresses, still require ongoing relief to prevent Defendants from punishing them for their past non-compliance due to their religious beliefs. *Ramsek v. Beshear*, 989 F.3d 494, 500 (6th Cir. 2021) (declining to find claims moot because of possibility of prosecution for past non-compliance).

Finally, the Government falsely claims that Plaintiffs must provide further evidence that every member of the class had his or her religious beliefs substantially burdened. But this ignores its own dispositive evidence that a Chaplain has already confirmed the sincerity *and* substantial burdening of beliefs of each service member the Court defined as a class member.

9. The Government's argument about Exemption Statistics

The Government next (and falsely) claims that exemption statistics support its argument that it is not systemically denying all religious exemptions. However, the Government has admitted in Court that any and all religious exemptions are solely to be given to service members who are at the end of their terms of service. [Doc.30-2, Transcript with Government admission about religious accommodations]. And the Government has come forward with no evidence to refute its prior in-court admission.

10. The Government's argument about lack of analysis in the class-wide preliminary injunction

[10] As an aside, for those Plaintiffs and class members whose only objection is the connection to aborted fetal cells (which is, admittedly, the vast majority), it is appearing more likely every day that a vaccine may come to market in the next 6 months that will alleviate those concerns. https://ir.ocugen.com/news-releases/news-release-details/ocugen-announces-fda-removes-clinical-hold-phase-23-clinical (last visited 7/22/2022). Thus, and contrary to the misrepresentation contained throughout Defendants' pleadings, Plaintiffs with those specific religious objections truly seek only a temporary exemption.

The Government also falsely claims that the Court's Order lacked analysis on equities and public interest. (Doc. 83 at 15). Once again, that erroneously views the order in a vacuum. This Court previously, and quite extensively, considered the issues in this case [Doc. 47; Doc. 72]. Any order must, therefore, be viewed in conjunction with all prior orders touching on the same matter. In any event, we have, again, proposed an order that does that.

11. A stay is not warranted because the Government has failed to meet the stay factors

In order to obtain a stay, Defendants must demonstrate: (1) the likelihood that the party seeking a stay will prevail on the merits of the appeal; (2) the likelihood that the movant will be irreparably harmed absent a stay; (3) the prospect that others will be harmed if the court grants the stay; and (4) the public interest in granting the stay. *See Grutter v. Bollinger*, 247 F.3d 631, 632 (6th Cir. 2001). As it turns out, those are the same factors that warrant the issuance of an injunction in the first place: "(1) the likelihood that the party seeking the stay will prevail on the merits; (2) the likelihood that the moving party will be irreparably harmed; (3) the prospect that others will be harmed by the stay; and (4) the public interest in the stay." *Crookston v. Johnson*, 841 F.3d 396, 398 (6th Cir. 2016); *Dahl v. Bd. of Trs. of Western Mich. Univ.*, 15 F.4th 728 at 736 (6th Cir. 2021).

A. Likelihood of Success on the Merits

Plaintiffs are likely to prevail on the merits, for substantially the same reasons that the Court previously stated in its decision for the original 18 Plaintiffs [Doc. 47]. The class definition, above, demonstrates that every member of the class will necessarily demonstrate both a sincerely held belief, as well as a substantial burdening of that belief. That, then, shifts the burden to the Government to demonstrate that its requirement or order is in furtherance of a compelling governmental interest and is the least restrictive means of furthering that compelling governmental interest. 42 U.S.C. 2000bb.

The Government argues that statistics have changed and it has granted more religious exemptions since the initial preliminary injunction [Doc. 83], but, again, the Government has admitted in Court that it is only granting these exemptions to those who are at their end-of-service, while granting medical exemptions and administrative exemptions much more widely. [Doc.30-2, Transcript with Government admission about religious accommodations]. And the Government *has not come forward* with any evidence that this admission is no longer the case, even though the Government has the burden. The Government makes much about the Novavax vaccine and a self-serving, hearsay (and Plaintiffs object to this letter under FRE 803), untested letter from the manufacturer [Doc. 83 at pp. 12-13], but Plaintiffs have submitted declarations and evidence that suggests that the ties to aborted fetal tissue in confirmatory testing would likewise raise religious concerns. [Declarations of Plaintiffs, Doc. 30-4 through Doc. 30-20].[11] That said, if the Chaplain who made a determination of sincerity and substantial burden re-evaluates a particular class member in light of a new vaccine, and determines that the belief is no longer substantially burdened, then they would no longer meet the class definition.

Most concerning as evidence of the patent discriminatory treatment at issue, is the Declaration of Major Andrea Corvi [Doc. 53-1], who was granted a medical exemption for pregnancy, but then denied a religious accommodation – no one suggests that her job duties, assignments, or interactions are in any way different – yet the Government accommodated her medical condition, and refused to accommodate her religious belief, both exemptions being temporary in nature. The Plaintiff class has demonstrated a likelihood of success on the merits of their RFRA and First Amendment claims.

[11] *See, also*, https://wng.org/roundups/pro-lifers-question-novavaxs-fetal-tissue-claim-1655411473 (last visited 7/22/2022); https://personhood.org/2022/02/22/yes-novavax-used-hek293-an-aborted-fetal-cell-line/ (last visited 7/22/2022); https://www.lifesitenews.com/opinion/novavax-covid-jab-linked-to-aborted-fetal-cells-through-laboratory-testing/ (last visited 7/22/2022); see, also, Declarations of Plaintiffs, Doc. 30-4 through Doc. 30-20.

B. Irreparable Harm

While the Government has argued irreparable harm, so have the members of the class, from the loss of their constitutional and statutory rights. *Dahl*, 15 F.4th 728, 735-736, holds that the loss these constitutional rights for the class are irreparable. We have attached, hereto, the Declaration of Major Pottinger, and we remind the Court of the testimony of Lt. Colonel Stapanon at the Preliminary Injunction hearing: the Air Force is not meeting its pilot or other accession and enlistment goals. [Doc. 45].[12] The suggestion by Lt. General Schneider of irreparable harm because other Air Force members will have to deploy for the less than 2% of the Air and Space Force within the class, is incredible in light of the small percentage at issue, and relies upon the proposition that there are persons who would readily replace members of the class. The testimony at the Preliminary Injunction Hearing by Lt. Colonel Stapanon, which recounted the training pipeline and a lack of fungibility, which only consisted of the Plaintiffs offering testimony, which was subject to adversarial testing by the Government, and in which the Government offered no live testimony to support its case, suggests that this is not the case and not the zero-sum game Defendants make it out to be. The Court should find Lt. Colonel Stapanon's testimony more credible than Lt. General Schneider because his testimony was subjected to and tested on cross-examination. Irreparable harm thus favors the Plaintiff class.[13]

C. Harm to Others

[12] https://www.airforcetimes.com/news/your-air-force/2022/01/21/air-forces-enlisted-recruitment-pipeline-is-drying-up-general-warns/ (last visited 8/18/2022).

https://www.nbcnews.com/news/military/every-branch-us-military-struggling-meet-2022-recruiting-goals-officia-rcna35078 (last visited 8/18/2022).

[13] If the Government would like to offer Lt. General Schneider's testimony at a live hearing, or subject his testimony to cross-examination, similar to that conducted by VCNO Admiral Lescher, who offered a similar declaration that did not withstand cross-examination, the Court should be willing to reconsider his testimony.

As this Court has already concluded, ". . . the limited scope of this preliminary injunction will not cause substantial harm to the Air Force because '[Plaintiffs'] religious-based refusal to take a COVID-19 vaccine simply isn't going to halt a nearly fully vaccinated Air Force's mission to provide a ready national defense.'" *Doster*, --- F. Supp.3d ---, 2022 U.S. Dist. LEXIS 59381 at 48 (SDOH 2022) (*citing Air Force Officer*, --- F. Supp.3d ---, 2022 WL 468799, at *12 (NDGA 2022)). As in *Dahl*, 15 F.4th 728, 735-736, the harm to others suggested by Defendants appears to be "speculative." Similarly, in *Dahl*, the Sixth Circuit suggested this was the exact case in light of the low percentage of affected Air and Space Force members "does not limit [someone's] exposure to unvaccinated [persons] at large." Notably, too, is the Air and Space Force's ability to conduct its mission prior to the advent of these vaccines, [Declarations of Plaintiffs, Doc. 30-4 through Doc. 30-20], or for months while exemption requests were pending.

D. Public Interest

Finally, "[p]roper application of the Constitution, moreover, serves the public interest." *Dahl*, 15 F.4th 728 at 736.

A stay is thus not warranted; however, as explained, some clarifications and modifications might be.

II. Defendants do not face an irreparable harm from the preliminary injunction

The Government argues that granting a preliminary injunction to the class would cause harm to Defendants. [Doc. 83, PageID#4583]. Nevertheless, they fail to cite one instance of how the Air and Space Force has been harmed by these same unvaccinated Airmen (now class members) for the past *two years*. Notwithstanding this, for 10, now going on 11, months, these same class members have been unable to travel, attend required schooling, and deploy. Not because they were physically unable to travel or deploy, but because Defendants made the decision

to treat their unvaccinated service members this way once vaccines became available. It is not surprising then that Lt. Gen. Schneider could not cite a single example of this alleged irreparable harm in his declaration.[14] The class he references that would cause this serious endangerment to the Air Force mission accounts for less than 2% of the entire Air and Space Force based on Lt. Gen. Schneider's numbers, spread out over and between hundreds of thousands of other service members.[15] Given that the Air and Space Force has systemically been driving out or coercing religious believers to accede to its vaccination requirement in the face of sincerely held religious beliefs, the actual numbers at this point are likely far less than that.

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[14] Plaintiffs note that although not needed here, there is a large and growing body of evidence that unvaccinated individuals who have had COVID-19 are far more protected than those who are vaccinated with 1 dose of J&J or 2 doses of an mRNA vaccine. So, it is unsurprising that Lt. Gen. Schneider cannot cite a single example of harm. *See, also, Effects of Previous Infection and Vaccination on Symptomatic Omicron Infections*, New England Journal of Medicine, Altarawneh, et. al., June 15, 2022, https://www.nejm.org/doi/full/10.1056/NEJMoa2203965 (last visited 7/25/2022).

Protection of prior natural infection compared to mRNA vaccination against SARS-CoV-2 infection and severe COVID-19 in Qatar – "Natural infection was associated with stronger and more durable protection against infection, regardless of the variant, than mRNA primary-series vaccination." https://www.medrxiv.org/content/10.1101/2022.03.17.22272529v1 (last visited 7/25/ 2022).

SARS-CoV-2 Naturally Acquired Immunity vs Vaccine-induce Immunity, Reinfections versus Breakthrough Infections: a Retrospective Cohort Study – "Naturally acquired immunity confers stronger protection against infection and symptomatic disease caused by the Delta variant of SARS-CoV-2, compared to the BNT162b2 two-dose vaccine-induced immunity." https://pubmed.ncbi.nlm.nih.gov/35380632/ (last visited 7/25/ 2022).

Effects of Previous Infection and Vaccination on Symptomatic Omicron Infections – "The effectiveness of previous infection alone against symptomatic BA.2 infection was 46.1% (95% confidence interval [CI], 39.5 to 51.9). The effectiveness of vaccination with two doses of BNT162b2 and no previous infection was negligible (−1.1%; 95% CI, −7.1 to 4.6), but nearly all persons had received their second dose more than 6 months earlier… Previous infection alone, BNT162b2 vaccination alone, and hybrid immunity all showed strong effectiveness (>70%) against severe, critical, or fatal Covid-19 due to BA.2 infection. Similar results were observed in analyses of effectiveness against BA.1 infection and of vaccination with mRNA-1273." https://www.nejm.org/doi/pdf/10.1056/NEJMoa2203965?articleTools=true (last visited 7/25/ 2022)

Duration of immune protection of SARS-Cov-2 natural infection against reinfection in Qatar – "Effectiveness of primary infection against severe, critical, or fatal COVID-19 reinfection was 97.3% (95% CI: 94.9- 98.6%), irrespective of the variant of primary infection or reinfection, and with no evidence for waning." https://www.medrxiv.org/content/10.1101/2022.07.06.22277306v1.full.pdf (last visited 7/25/ 2022).

[15] "Similarly, an injunction expanded to apply to 10,000 or more service members. . ." and "As of March 14, 2022, the Department of the Air Force had approximately 501,00 uniformed Service members - . . ." Doc # 73-1, PAGEID # 4490, 4493.

The Government makes the claim that the members of the class (again, less than 2% of the total force), take up space for others who would get vaccinated. Well, we know that is not true: the military, including the Air and Space Force, is in dire straits from a current recruiting crisis, and has not met its recruiting goals this year.[16] (Declaration Pottinger).

The Government's solution? Separate *more people* in the face of this recruiting crisis. Of course, if one stops to analyze the situation, the Government might find that the systemic religious discrimination it engages in has something to do with its current recruiting crisis.

The Government argues that keeping these members on hand and unvaccinated puts more of a burden on other airmen and guardians. No – the Government's decision not to deploy them does (a decision we do not dispute they have the authority to do). And, again, the Government's suggestion rests upon the faulty premise that these airmen and guardians will be readily replaced. The Court has already seen and taken evidence of pilot shortages and the pipeline to train them that takes years. We have submitted, in connection with this Response, a Declaration from Major Pottinger (one of the Class Representative Plaintiffs). A few days before this Court's preliminary injunction, he was pulled from aeronautical orders and "grounded." (Declaration Pottinger, attached as Exhibit C). That, of course, was well within the operational/deployment exception.[17] But in light of a known severe shortage of pilots, out of necessity his Commander reinstated his flying orders. *Id.* The same is true with everyone in the class – particularly in the face of a recruiting shortage.

[16] https://www.nbcnews.com/news/military/every-branch-us-military-struggling-meet-2022-recruiting-goals-officia-rcna35078 (last visited 8/18/2022).

[17] The Government also argues that the prohibition on them continuing reservists on "no pay, no points," is somehow an operational, assignment, or deployment decision. That is absurd. They can, if they wanted, let those reservists sit at home and collect pay and points, could instead assign them to fold towels at the base gym, could ground them, as they did to Major Pottinger, until they realized they needed him to fly to fill shortages, the decision is strictly theirs.

As this Court has already concluded, ". . . the limited scope of this preliminary injunction will not cause substantial harm to the Air Force because '[Plaintiffs'] religious-based refusal to take a COVID-19 vaccine simply isn't going to halt a nearly fully vaccinated Air Force's mission to provide a ready national defense.'" *Doster v. Kendall*, --- F. Supp.3d ---, 2022 U.S. Dist. LEXIS 59381 at 48 (SDOH 2022) (*citing Air Force Officer v. Austin*, --- F. Supp.3d ---, 2022 WL 468799, at *12 (NDGA 2022)). The continued preservation of Constitutional rights is always in the public interest and here it is no different. *Dahl v. Bd. of Trs. of Western Mich. Univ.*, 15 F.4th 728 at 736 (6th Cir. 2021) ("it is always in the public interest to prevent the violation of a party's constitutional rights.").

III. The balance of harms and public interest support the preliminary injunction

The Government argues that the class-wide preliminary injunction is not supportable under the balance of harms and public interest prongs.

As this Court has already concluded, ". . . the limited scope of this preliminary injunction will not cause substantial harm to the Air Force because '[Plaintiffs'] religious-based refusal to take a COVID-19 vaccine simply isn't going to halt a nearly fully vaccinated Air Force's mission to provide a ready national defense.'" *Doster*, --- F. Supp.3d ---, 2022 U.S. Dist. LEXIS 59381 at 48 (*citing Austin*, --- F. Supp.3d ---, 2022 WL 468799, at *12).

IV. Conclusion

The Government's Motion should be denied, except to the extent we concede certain issues. A proposed order is attached.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that I have served a copy of the foregoing by CM/ECF, this 18 day of August, 2022.

/s/ Christopher Wiest

No. 22-10077

In the United States Court of Appeals for the Fifth Circuit

U.S. NAVY SEALS 1-26; U.S. NAVY SPECIAL WARFARE COMBATANT CRAFT CREWMEN 1-5; U.S. NAVY EXPLOSIVE ORDNANCE DISPOSAL TECHNICIAN 1; U.S. NAVY DIVERS 1-3,
Plaintiffs-Appellees,

v.

JOSEPH R. BIDEN, JR., in his official capacity as President of the United States of America; LLOYD AUSTIN, Secretary, U.S. Department of Defense, individually and in his official capacity as United States Secretary of Defense; UNITED STATES DEPARTMENT OF DEFENSE; CARLOS DEL TORO, individually and in his official capacity as United States Secretary of the Navy,
Defendants-Appellants.

On Appeal from the United States District Court
for the Northern District of Texas, Fort Worth Division
No. 4:21-cv-01236

MOTION TO SUPPLEMENT THE RECORD

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Counsel for Plaintiffs-Appellees

Plaintiffs-Appellees hereby move to supplement the record before this Court with the deposition transcript of Admiral William K. Lescher. In support, Plaintiffs-Appellees state as follows:

1. On January 24, 2022, Defendants filed the Declaration of Admiral William Lescher, Vice Chief of Naval Operations (the "Declaration") in support of their Motion for a Partial Stay Pending Appeal. ROA.22-10534.2578-96. In the Declaration, Admiral Lescher makes factual assertions regarding various topics, including the harm the district court's injunction would cause to the Navy, the necessity of the Navy's COVID-19 vaccine mandate, and COVID-19's threat to the Navy. *See generally id.*

2. The Declaration is a key piece of evidence in this case. In fact, when the Supreme Court granted Defendants' Motion for Partial Stay, Justice Kavanaugh cited the Declaration as a reason for granting the partial stay. *Austin v. U. S. Navy Seals 1–26*, 142 S. Ct. 1301, 1302 (2022) (Kavanaugh J., concurring). Defendants also cite the Declaration extensively in their Opening Brief and in their Supplemental Brief and argue the statements made in the Declaration and Admiral Lescher's resulting judgment are entitled to deference. *See* Opening Br. at 35-38; Supp. Br. at 16.

3. Recently uncovered facts illustrate that the Declaration is entitled to no such deference. On June 30, 2022, Plaintiffs deposed Admiral Lescher. During the deposition, Admiral Lescher demonstrated numerous times that he did not have the personal knowledge to attest to the facts set forth in the Declaration and that significant portions of his declaration amount to unsubstantiated speculation. *See,*

e.g., Mot. Appx. Ex. A (Tr. at 22:11–22:20, 23:4–23:6, 23:16–24:1 (stating details regarding the effect COVID-19 had on naval ships was "not generally" within his purview and that he did not speak to individuals with such knowledge before drafting his declaration));[1] *id.* at 33:18–34:8 (stating he was unaware of any combat operations negatively impacted by COVID-19);[2] *id.* at 50:15–51:16 (stating he was unaware of specific examples of COVID-19 made a medical evacuation more difficult, was contracted through a rebreathing device, or was contracted on a submarine);[3] *id.* at

---

[1] Q Do you know how many other ships, other than the 22 you mentioned that currently have COVID cases, were unable to accomplish their mission prior to the vaccine mandate as a result of COVID-19 infections other than ROOSEVELT?
A Again, that type of detail is not generally in the purview of the vice chief.
. . .

Q Did you speak with any of those individuals [with knowledge about the ships] prior to or while preparing your -- your declaration concerning this statement or – or any other statements contained herein?
A . . . nothing specific in the context of this declaration.

[2] Q Okay. Can you identify any combat operations or combat missions that could not be completed successfully as a result of COVID-19?
A . . . I believe the most accurate response to that is I'm unaware of any combat failure, as well I'm -- because those type of details and missions would not be under the purview of the vice chief . . . .

[3] Q Okay. Do you -- can you identify any Naval Special Warfare missions in which COVID-19 infection prevented a medical evacuation of a Service member?
. . .
A No.

73:16–73:20 (stating he had not had any discussions with individuals with relevant knowledge regarding missions impacted by COVID-19 prior to signing his declaration);[4] *id.* at 81:19–82:1 (stating he did not review any documents or reports while reviewing and editing his declaration).[5]

4. The district court correctly rejected Defendants' arguments that courts owe blind deference to military commanders on matters implicating the Religious Freedom Restoration Act (RFRA). Admiral Lescher's deposition testimony bolsters

---

Q Could you -- can you identify or are you aware of any instances in which COVID-19 made a medical evacuation of a Service member more difficult?
A No.

Q Can you identify any instances in which a Naval Special Warfare Service member contracted COVID-19 as a result of using a re-breathing device?
A Again, I would -- that would not be something that I would become aware of, but the answer is no.

Q Okay. And can you identify any instances in which Service members deployed on a submarine -- Naval Special Warfare Service members deployed on a submarine contracted COVID-19?
A I'm unaware.

[4] Q Okay. And so prior to -- prior to executing your declaration, you had not had those conversations about any specific Naval Special Warfare missions that had been impacted by – [COVID?]
A Correct.

[5] Q Okay. So you don't recall looking at any -- any documents, reports or other types of information when you were reviewing, editing the draft of your declaration. Is that right?
A That's correct.

this conclusion and demonstrates that this Court should not rely upon the Declaration while considering Defendants' appeal, or at minimum, should give it the weight appropriately given to hearsay statements made without personal knowledge. So that the Court may decide the proper weight that it should give to the Declaration in deciding this appeal, this Court should allow Plaintiffs to supplement the record with of the transcript of Admiral Lescher's deposition.

5. Admiral Lescher's deposition testimony will also be helpful to the Court in deciding the legal issues in this appeal: namely, whether the Navy has a compelling interest that justifies the vaccine mandate as applied to religious objectors, and whether the mandate is the least restrictive means available to accomplish that interest. For instance, Admiral Lescher testified at length about his understanding that Religious Accommodation requests should be considered based on detailed individual circumstances and also take into account the recommendation of the commanding officer of the individual requesting accommodation. *See, e.g.*, Mot. Appx. Ex. A (Tr. at 17:13–18:5, 61:19–62:4, 62:17–63:1, 138:11–139:19). This is relevant because as Defendants emphasize in arguing for deference to Lescher's assertions, Admiral Lescher is the "second-highest uniformed officer in the Navy." Opening Br. 35. Admiral Lescher also testified about the Navy's permissive attitude toward individuals at recognized high risk for complications or severe cases of COVID-19, in contrast to its treatment of religious objectors. *See, e.g.*, Mot. Appx. Ex. A (Tr. at 155:14–157:16, 159:1–159:6, 165:7–167:7, 170:18–173:3).

6. Courts have long recognized that they have the authority to permit the appellate record to be supplemented when doing so would be in the interest of

justice. *Gibson v. Blackburn*, 744 F.2d 403, 405 n.3 (5th Cir. 1984); *see also Ross v. Kemp*, 785 F.2d 1467, 1474 (11th Cir. 1986) (recognizing the court's "inherent equitable authority to enlarge the record and consider material that has not been considered by the court below"); *Turk v. United States*, 429 F.2d 1327, 1329 (8th Cir. 1970) (authorizing enlargement of record on appeal with preliminary hearing evidence not presented to trial court if it is "in the interest of justice" to do so); *Gatewood v. United States*, 209 F.2d 789, 792 n. 5 (D.C. Cir. 1953) (considering a transcript of preliminary proceedings which had not been before trial court because it was in interest of both parties and due administration of justice).

7. Courts address requests to supplement an appellate record on a case-by-case basis. *Ross*, 785 F.2d at 1474; *see also Singleton v. Wulff*, 428 U.S. 106, 121 (1976) (stating the "matter of what questions may be taken up and resolved for the first time on appeal is one left primarily to the discretion of the courts of appeals, to be exercised on the facts of individual cases.").

8. Factors courts consider when examining a request for supplementation include whether the supplemental materials contain information that will illuminate an issue before the court and whether remanding the case to the district court for consideration of the additional material would be contrary to both the interests of justice and the efficient use of judicial resources. *See Vital Pharms., Inc. v. Alfieri*, 23 F.4th 1282, 1288 (11th Cir. 2022) (allowing supplementation because the supplemental material illuminated an important issue in the appeal); *Teamsters Loc. Union No. 117 v. Washington Dep't of Corr.*, 789 F.3d 979, 986 (9th Cir. 2015) (allowing supplementation for the limited purpose of confirming harms

acknowledged by a party in general terms during discovery and because a remand would merely prolong the proceedings); *Ross*, 785 F.2d at 1475 (discussing the factors); *see also Gibson*, 744 F.2d at 405 n.3 (permitting supplementation because remanding the case would unnecessarily prolong proceedings and because the evidence confirmed the proper resolution of the case).

9. Here, the interests of justice weigh in favor of allowing supplementation. The preliminary injunction at issue in this interlocutory appeal was partially stayed by the Supreme Court. The important issues in this case show that supplementing the record with this pertinent information will be helpful to the Court. Further, the deposition transcript that Plaintiffs seek to submit to this Court undermines a key piece of evidence that was cited by Justice Kavanaugh as a reason for partially staying the injunction and deferring to high-ranking military officials. *Austin*, 142 S. Ct. at 1302 (Kavanaugh J., concurring). As demonstrated by Admiral Lescher's deposition testimony, the Declaration was largely speculation and factual allegations that were beyond Admiral Lescher's personal knowledge. Illumination of these facts is essential as this Court considers whether the district court's preliminary injunction was an abuse of discretion.

10. Further, remanding the case for the district court to consider this evidence would not be a good use of judicial resources. The district court already rejected the assertions in the Declaration when it denied Defendants' Motion to Stay the Preliminary Injunction. *See* ROA.22-1077.2964-73. Asking the district court to reach this conclusion again with evidence that bolsters the conclusion the court already reached would unnecessarily prolong the resolution of this case. Thus, to aid the

Court in deciding the issues pending in this interlocutory appeal and to preserve judicial resources, Plaintiffs request that the record on appeal be supplemented with the transcript from Admiral Lescher's deposition.[6] In the alternative, Plaintiffs request that the Court take judicial notice of the transcript. *See Hall v. City of Houston*, No. 21-20451, 2022 WL 3031306, at *2 (5th Cir. Aug. 1, 2022) (judicial notice appropriate where facts "can be accurately and readily determined from sources whose accuracy cannot reasonably be questioned." (quoting Fed. R. Civ. P. 201)).

11. Counsel for Plaintiffs-Appellees conferred with counsel for Defendants-Appellants regarding this Motion and the relief requested. Defendants-Appellants oppose the relief sought by this Motion.

[6] Defendants are not prejudiced by this request as they rely on Admiral Lescher's Declaration on appeal, they can respond to any arguments regarding the testimony in their reply brief, and they had an opportunity to make objections and ask questions during Admiral Lescher's deposition. They have also submitted an errata sheet, which is included in the appendix to this motion. *See* Mot. Appx. Ex. C.

Conclusion

For the foregoing reasons, the Court should grant the motion to supplement the record.

Respectfully submitted.

/s/Heather Gebelin Hacker

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Certificate of Conference

On August 15 and 16, 2022, the undersigned conferred by e-mail with Sarah Clark, counsel for Defendants-Appellants, regarding this Motion. Defendants-Appellants oppose the relief sought on the grounds that the deposition transcript is not a part of the record under Federal Rule of Appellate Procedure 10 but will not file a further response.

/s/ Heather Gebelin Hacker
Heather Gebelin Hacker

Certificate of Service

On August 16, 2022, this motion was served via CM/ECF on all registered counsel and transmitted to the Clerk of the Court. Counsel further certifies that: (1) any required privacy redactions have been made in compliance with Fifth Circuit Rule 25.2.13; (2) the electronic submission is an exact copy of the paper document in compliance with Fifth Circuit Rule 25.2.1.

/s/ Heather Gebelin Hacker
Heather Gebelin Hacker

Certificate of Compliance

This brief complies with: (1) the type-volume limitation of Federal Rule of Appellate Procedure 27(d)(2)(A) because it contains 1824 words, excluding the parts exempted by Rule 27(a)(2)(B); and (2) the typeface and type style requirements of Rule 27(d)(1)(E) because it has been prepared in a proportionally spaced typeface (14-point Equity) using Microsoft Word (the program used for the word count).

/s/ Heather Gebelin Hacker
Heather Gebelin Hacker

APPENDIX

Exhibit A: Condensed Transcript of Admiral William K. Lescher

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

U.S. NAVY SEALS 1-3: on behalf of themselves and all others similarly situated; U.S. NAVY EXPLOSIVE ORDNANCE DISPOSAL TECHNICIAN 1, on behalf of himself and all others similarly situated; U.S. NAVY SEALS 4-26; U.S. NAVY SPECIAL WARFARE COMBATANT CRAFT CREWMEN 1-5; and U.S. NAVY DIVERS 1-3,		
Plaintiffs,		Case Number: 4:21-cv-01236
vs.		
LLOYD J. AUSTIN, III, in his official capacity as Untied States Secretary of Defense; UNITED STATES DEPARTMENT OF DEFENSE; CARLOS DEL TORO, in his official capacity as United States Secretary of the Navy,		
Defendants.		

VIDEOTAPED DEPOSITION OF ADMIRAL WILLIAM LESCHER

DATE: June 30, 2022
TIME: 8:02 a.m. to 2:44 p.m.
LOCATION: Naval Air Systems Command
Naval Support Facility
701 South Courthouse Road, Suite 2000
Arlington, Virginia

REPORTED BY: Felicia A. Newland, CSR

A P P E A R A N C E S

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Also Present:

Captain Elizabeth Josephson
Commander Eric Osterhues
Karen Hecker, Esquire
Commander Patrice Hentz
LCDR Will Burroughs
Ryan J. Heathcock, Videographer

C O N T E N T S

LESCHER DEPOSITION EXHIBITS

(*Exhibits attached to transcript.)

P R O C E E D I N G S

* * * * * * *

VIDEOGRAPHER: Good morning. We are on the record. The time is 8:02 a.m. And today's date is Thursday, June the 30th 2022. Please note that the microphones are sensitive and may pick up whispering and private conversations. Please mute your phones at this time.

Audio and video recording will continue to take place until all parties agree to go off the record.

This begins Media Unit Number 1 in the video-recorded deposition of William Lescher, taken by counsel for the Plaintiff in the matter of U.S. Navy SEALs, et al. versus Lloyd Austin.

This case is being filed in the U.S. -- United States District Court, Northern District of Texas, Fort Worth Division. The case Number is 4:21-CV-012360.

The location for today's deposition is the Naval Air Systems Command Washington Liaison Office, located at 701 South Courthouse

Road in Arlington, Virginia.

My name is Ryan Heathcock from the firm Veritext Legal Solutions, and I am the videographer. The court reporter today is Ms. Felicia Newland, also representing Veritext Legal Solutions.

I am not authorized to administer an oath. I am not related to any party in this action, nor am I financially interested in the outcome.

Counsel and all present in the room and everyone -- well, there's no one attending remotely -- will now state their appearances and affiliations for the record.

MR. STEPHENS: Andrew Stephens, Hacker Stephens, LLP for the Plaintiffs.

MS. HACKER: Heather Hacker, Hacker Stephens, LLP for the Plaintiffs.

MR. BERRY: Michael Berry, First Liberty Institute for the Plaintiffs.

MS. RANDALL: Holly Randall, First Liberty Institute for the Plaintiffs.

MR. CARMICHAEL: Andrew Carmichael, DoJ, for the Defendants.

MS. YANG: Catherine Yang, DoJ for the Defendants.

CAPTAIN JOSEPHSON: Captain Elizabeth Josephson, JAG Corps, United States Navy.

COMMANDER ERIC OSTERHUES: Commander Eric Osterhues, JAG Corps, United States Navy.

MS. HECKER: Karen Hecker, DoD, Office of General Counsel.

COMMANDER PATRICE HENTZ: Commander Patrice Hentz, United States Navy.

LCDR WILL BURROUGHS: Lieutenant Commander Will Burroughs, JAG Corps, United States Navy.

VIDEOGRAPHER: Thank you very much.

At this time, will the court reporter please swear in the witness?

(Witness duly sworn.)

VIDEOGRAPHER: Counsel, you may proceed.

* * * * * *

Whereupon,

ADMIRAL WILLIAM LESCHER

was called as a witness and, having been first duly sworn, was examined and testified as follows:

EXAMINATION BY COUNSEL FOR PLAINTIFFS

BY MR. STEPHENS:

Q Good morning, Admiral Lescher.

A Good morning.

Q My name is Andrew Stephens. I'm a lawyer in Austin, Texas. I am one of the lawyers representing the Plaintiffs in the lawsuit United States Navy SEALs 1 through 26, et al. versus Austin, pending in the Northern District of Texas Federal Court.

Are you familiar with that lawsuit?

A I am.

Q Could you just tell me generally what you know about that lawsuit.

A The Plaintiffs assert that the department's mandatory vaccination policy violates their right to religious freedom.

Q Have you offered any sworn testimony

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in that lawsuit?
A I have not.
Q Have you offered a sworn declaration in the lawsuit?
A I have.
Q Okay. And you understand that you're here today to give a deposition in the lawsuit. Is that right?
A Yes.
Q Have you been deposed before?
A I have not.
Q The -- I'd like to hand you what we will mark as Lescher Deposition Exhibit 1, which is a copy of your declaration.
(Lescher Deposition Exhibit Number 1 marked for identification.)
BY MR. STEPHENS:
Q And while we do that, the court reporter will put the exhibit number on it and hand you the exhibit.
Admiral Lescher, in a deposition, you understand that you're under oath and that you've

Page 11

sworn to tell the truth. Is that correct?
A That is correct.
Q And there's no reason sitting here today that you wouldn't be able to testify truthfully and honestly in this --
A That's correct.
Q -- lawsuit?
It's difficult sometimes during a deposition, I have a tendency to do it as well, to be conversational and interrupt each other. I'll do my best not to interrupt you. And I would ask that you do the same so that the court reporter can transcribe the full question without making a transcript that's difficult to follow.
I have no doubt the court reporter will remind us to slow down and not interrupt if we have that issue, but the deposition -- the Deposition Exhibit 1 that I just handed you, are you familiar that document?
A Yes.
Q And what is it?
A It's my declaration to the court.

Page 12

Q Okay. And this is the declaration that I asked about and that you testified you submitted in this lawsuit. Is that right?
A That's correct.
Q You signed that declaration under oath. Is that correct?
A That's correct.
Q I'm going to mark this as Deposition Exhibit 2.
(Lescher Deposition Exhibit Number 2 marked for identification.)
BY MR. STEPHENS:
Q Okay. Have you seen the document that's been marked as Deposition Exhibit 2 before?
A No, I have not.
Q Okay. I'll represent to you that this is a notice of -- amended notice of deposition provided to your counsel, giving notice of the deposition that's being taken today in the lawsuit U.S. Navy SEALs 1 through 3 versus Austin. And you can set that to the side.
Turning back to Lescher Deposition

Page 13

Exhibit 1, a copy of your declaration, how did you come to submit that testimony?
Were you ordered to do so or did you decide on your own to do that?
A I was not ordered to do so.
Q Okay.
MR. CARMICHAEL: Objection. That's a compound question.
You can answer, sir.
THE WITNESS: Okay. My JAG came to me and represented that this would be helpful to the department's case to continue our vaccine policy.
BY MR. STEPHENS:
Q Okay. And who specifically from JAG made that request -- or made that representation to you?
A My JAG.
Q Okay.
A Captain Josephson.
Q I'm sorry, who was that?
A Captain Josephson.

Q Had you had any involvement or knowledge of this lawsuit prior to that time?
A No involvement. Knowledge of it.
Q Okay. Approximately when were you asked to provide the declaration testimony in the lawsuit, if you recall?
A So the declaration, I see, was submitted in January of this year. It would have been in that general time frame.
Q Okay. And when did you start working on the declaration, do you recall?
A Again, not a specific date.
Q Okay. Did you draft the declaration?
A I did not.
Q Okay. Did you draft any part of the declaration?
A Well, to be clear, a draft was provided to me and then I reworked that significantly. So I went through it sentence by sentence and made significant edits to it.
Q Okay. Was there one draft or more than one draft that you exchanged with -- I assume

the draft came to you from JAG. Is that correct?
A Correct.
MR. CARMICHAEL: Objection as to -- or that it calls for attorney-client privilege as to what was in the drafts.
BY MR. STEPHENS:
Q I don't want -- I'm not -- I don't want to ask you any questions or have you answer or tell me any specific -- the substance of any specific communications you had with your counsel. My question is: If you recall, how many drafts you exchanged back and forth with JAG or with DoJ?
A So there were multiple iterations. The draft came to me. I reworked it. I had questions, made some changes. And as I said, that occurred at least twice.
Q Okay. In paragraph 1 of your declaration, that's been marked as Deposition Exhibit 1, the bottom of the first page, the last sentence begins, "The statements made in this declaration are based on my personal knowledge, my military judgment and experience, and on

information that has been provided to me in the course of my official duties."
The second part of that sentence continues on the top of page 2.
Do you see that sentence?
A I do see that.
Q Is that -- that statement true and accurate?
A Yes.
Q Okay. As we go through your declaration, I'll have a number of questions as to the information that you relied on in preparing and as support or evidence for some of the statements contained in the declaration.
In -- in the first -- the second sentence of paragraph 2 on page 2 of Deposition Exhibit 1, you -- you testified -- and I say testified because a declaration is sworn testimony -- that you believe the Court's injunction will cause immediate harm to the Navy.
Do you see that language?
A I do see that language.

Q How would the Court's injunction cause immediate harm to the Navy?
A Waivers to our medical readiness standards introduce risk because they lower the medical readiness standard. The Navy's approach is to manage that risk on a case-by-case basis and make specific risk decisions. The preliminary injunction takes that away from the Navy, so it removes our ability to manage the risk we're exposed to with this virus.
Q Prior to the preliminary injunction being entered by the District Court in this lawsuit, did the Navy conduct a case-by-case analysis of the risk associated with each individual religious accommodation request pertaining to the vaccine?
A Each religious accommodation request, yes, is an individual case.
Q Okay. And did the Navy conduct -- or you mentioned a case by case --
A So each case is evaluated on its merits.

Q Okay. So, to your knowledge, were each of the religious accommodation requests that were submitted by the class members in this lawsuit evaluated on a case-by-case basis?

A That's my understanding.

Q Did you have any role in that analysis?

A I did not.

Q And do you know who did?

Do you know who did?

A Again, so the vice chief does not have a role in the religious accommodation process. So I have a general understanding of that process, which is the requests go to the immediate commander of the 06 level, from there to the bureau to the Chief of Naval Personnel to adjudicate it, with the appeal authority being the Chief of Naval Operations.

Q In the middle of paragraph 2 of your declaration, there's a sentence that states, "The Court's injunction directly impacts the Navy's ability to carry out its responsibilities to

protect and maintain the health and safety of our Force, in particular our ability to halt the spread of COVID-19 through a mandatory vaccination requirement."

Do you see that language?

A I do.

Q What -- what did you rely on as evidence or data or information to support or reach that conclusion or that assertion?

A In terms of directly impacting the Navy's ability to carry out its responsibilities, this is the issue of not -- the injunction precluding the ability of the Navy to examine these waivers on a case-by-case basis.

If the issue is what information do I deduce that was required to maintain the health and safety of our Force, so the Navy has, since the onset of COVID, significant experience in the impact of that virus on our Force.

Q So in the second clause of the sentence it says, "In particular, our ability to halt the spread of COVID-19 through a mandatory

vaccination requirement."

How did the injunction affect the Navy's ability to halt the spread of COVID-19?

A By precluding the Navy from making those judgments on a case-by-case basis, it would provide a blanket ability for unvaccinated individuals to move into our operational forces. Again, exposing us to unmanaged risks.

Q Did you make a determination or review any data or information for purposes of evaluating for -- of evaluating the degree of that risk?

A The degree of risk presented to the Navy from COVID, what I use in my experience here, spans our experience starting with the THEODORE ROOSEVELT carrier and subsequent. So the degree of risk in terms of in the Navy experience, what we saw the impact of COVID on mission and on the health of our people.

Q Other than -- sorry. Go ahead.

A I was going to say to include the -- the deaths of sailors, the hospitalizations of

sailors were certainly part of that experience and part of the statement there.

Q Other than the ROOSEVELT example that you mentioned -- and you mentioned that in the context of impacting the Navy's ability to accomplish its mission. Is that right?

A Yes.

Q Did you -- do you have other examples or did you consider other examples in which COVID-19 impacted the Navy's ability to accomplish its mission?

A Yes.

Q Okay. And which -- which missions -- or what were those examples other than the ROOSEVELT?

A So at a high level, the Navy tracks COVID cases per ships. So some of them very public, MILWAUKEE, PHILIPPINE SEA, many not in the public domain. The mission impact as well is not simply as stark as THEODORE ROOSEVELT coming off mission for 51 days in the WESTPAC. So even today we have 22 ships with COVID cases onboard them and

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that -- that figure fluctuates.

The mitigations through the most-effective tool of vaccination in concert with other -- other measures, such as isolation, all of -- even those elements have an impact on the mission that the commander has to work around, as those members of the crew are not available. So understanding that context over the course of this virus is really the experience I brought to that statement.

Q Do you know how many other ships, other than the 22 you mentioned that currently have COVID cases, were unable to accomplish their mission prior to the vaccine mandate as a result of COVID-19 infections other than ROOSEVELT?

A Again, that type of detail is not generally in the purview of the vice chief. So the vice chief in terms of operational impact would be in the force of employment the combatant commanders and the naval component commanders. Those mission impacts take place at multiple levels, so the most public I would be aware of, of course.

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At other various levels, as a commander changes the scheme of maneuver, changes timelines, makes other mission-impacting decisions based on the health of their crew, I would not have individual awareness across the scope of the Navy of those impacts.

Q Okay. And you mentioned several positions within the Navy, individuals who might have knowledge of those impacts. And who would those individuals be?

A So most centrally they would be the Naval component commanders. We have NAVEUR, NAVAF, NAVCENT. These are the leaders in the Navy that employ the forces, that employ the operational forces.

Q Did you speak with any of those individuals prior to or while preparing your -- your declaration concerning this statement or -- or any other statements contained herein?

A So I interact with the Naval component commanders periodically. It's an ongoing relationship with them, nothing specific in the

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context of this declaration.

Q Okay. And -- and you don't recall any specific examples in which the Navy's missions were impacted as a result of COVID-19 that were discussed between you and those individuals other than the ROOSEVELT?

A There were discussions on mission impact over the course of the past two years.

Q Okay. And do you recall any specifics about what impact COVID had on those missions, and which missions they were?

Or I'll follow that up with another question.

A I can tell you about the types of impacts. So COVID impacts to turnover requiring forces forward to stay deployed longer. There were COVID impacts that required missions to not be executed.

Q Okay. And do you know which missions those were?

A In a general nature. So this is based on, you know, conversations. So what I

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recall is the types of missions and the types of impacts without the specifics.

Q Okay. Do you recall the name -- and you've referred to the ROOSEVELT. That's the name of a ship that was impacted. Is that correct?

A Right.

Q Do you recall the names of any of the other ships that were negatively impacted or couldn't complete missions as a result of COVID-19?

A Yeah. So again, yes, MILWAUKEE, PHIL SEA, PHILIPPINE SEA would be two others.

Q Okay. And do you recall how COVID-19 negatively impacted the missions of those two ships?

A In a very general way. PHILIPPINE SEA, I believe it was in March of '21, in the CENTCOM AOR, area of responsibility, had a COVID outbreak of about, as I recall, 20 sailors out of a crew of about 330, that pulled them off mission into Bahrain while they worked through that.

The USS MILWAUKEE, I believe it was in December of '21, had a COVID outbreak in the

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crew and delayed executing the mission getting underway for a week.

Q And you -- I think you just testified as to the date. Is it PHILIPPINE SEA? Is that the name --

A It is.

Q -- of the ship?

A Yes.

Q And what was the date of that mission that was impacted?

A So as I recall, it would have been in early '21. I believe it was around the March '21 time frame.

Q You testified earlier that there are currently 22 ships with COVID-19 infections or with Service members, I assume onboard, with COVID-19 infections. Is that right?

A Yes.

Q And is it your testimony that the missions of those 22 ships are being negatively impacted?

A So, again, with those ships not

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directly in the chain of command under me, I don't have specific insight. My experience is there's no excess manpower on our ships. So when there's COVID cases on our ships and our -- our experience, our learned approach and our standard operating guidance is to go to isolation for five days. That pulls people off mission.

And so my experience is that there is an impact. It's a manageable impact by virtue of the vaccinations, the isolation, the health preventive measure, that in aggregate have enabled us to work through these type of COVID cases onboard ships.

Q Do you know whether there are any unvaccinated Service members on those -- on any of those 22 ships?

A I do not.

Q Okay. Do you know the date of the vaccine mandate that's at issue in this lawsuit?

A I know the secretary -- so in August of '21, the Secretary of Defense issued a guidance. I believe it was on the 24th or 25th, and the

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SECNAV issued the Navy guidance that same month.

Q Okay. So if the Navy -- by the Navy's policies pertaining to the mandatory vaccine requirement for COVID-19, there shouldn't be unvaccinated Service members on any of the 22 ships that you had mentioned with COVID infections currently. Is that right?

MR. CARMICHAEL: Objection as to the form.

You can go ahead and answer.

THE WITNESS: So it's speculation, but if the policy is fully in effect right now, then yes, our policy is not to have unvaccinated sailors on operational ships.

BY MR. STEPHENS:

Q Okay. Looking back to paragraph 2 of your declaration, there's a sentence that begins in the middle of the paragraph, "Unvaccinated or partially vaccinated Service members are at higher risk to contract COVID-19." Do you see --

A Yes.

Q -- that clause?

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What is the basis, your personal knowledge or the information you relied on, for that -- as support for that statement?

A So certainly being exposed to or aware of the conversations as we worked through COVID with the Surgeon General and others, certainly the Navy experience, you know, the 17 sailors that have died of COVID, 16 of them were unvaccinated, one was partially vaccinated or the hospitalizations of Navy sailors, they skew heavily to the unvaccinated.

I saw in Admiral Merz's declaration, he cited on the order of 600 hospitalizations and 578 or so unvaccinated. That reflects the Navy experience.

Q Okay. I want to focus on the specific language of that clause where it says, "At high risk to contract COVID-19," and distinguish between contracting COVID-19 versus -- and whether the vaccine has an impact or is effective at preventing individuals from contracting COVID-19 versus --

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A Right.
Q -- producing severity.
Do you understand?
A I do.
Q Okay. And so this, as I read it, is addressing whether the COVID-19 vaccine will have an impact on risk or likelihood that -- that sailors would contract COVID-19. Is that right?
A Yes.
Q Okay. And so the evidence you mentioned, I believe, it sounded to me pertained to reducing the impact or severity of infection. Is that right?
A Yes.
MR. CARMICHAEL: Admiral --
Objection. The -- it mischaracterizes the statement because the clause has an "and" in there.
But you can answer the question.
THE WITNESS: So the Navy experience is also that Service members are at a higher risk to contract COVID-19. You know, a visual depiction

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of that would be in the declaration of the fleet forces, Force medical officer, as I recall. But it showed the case prevalence between unvaccinated and vaccinated in the Navy substantially different. And toward the end of '21, as vaccinations came online, you see a strong divergence in case prevalence between unvaccinated and vaccinated personnel.
BY MR. STEPHENS:
Q And do you recall what you reviewed that showed that divergence between vaccinated and unvaccinated, what type of information?
A Yeah. So throughout this time, the Navy has -- provides regular leadership updates weekly, really an accounting of cases, vaccinated, unvaccinated, hospitalizations. And so it's that body of weekly updates that informed my statement.
Q Okay. And do you consider those weekly updates reliable sources of information?
A Yes.
Q And have you -- have you continued to review those updates since signing your

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declaration?
A Yeah. For example, the 22 ships was in yesterday's update. I do not review them every week because I -- the action often is not under the direct purview of the vice chief, but they come to me every week and I review them periodically.
Q Do you -- based on the information you've seen since the date of your declaration in January of 2022, or since the date you signed your declaration, have you seen any change in the data regarding the effectiveness of the COVID vaccine at reducing the risk of contracting the disease?
A Your question is have I seen data that shows?
Q Any change in the effectiveness of the vaccine at reducing the likelihood of contracting COVID or the risk.
A I think with the Omicron variant, that we did see increasing COVID rates in both populations, vaccinated and unvaccinated. And again, differentially unvaccinated contracting -- contracting it at a higher rate is my recollection.

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Q Do you know at -- at what higher rate or how much of an additional --
A I cannot --
Q -- risk?
A -- quantify it for you, but it was a differential.
Q Do you review CDC data?
A I personally do not have a flag officer, Surgeon General of the Navy that we -- that I rely on as the expert to bring that perspective into the department.
Q Do you have any knowledge of information made public by the CDC yesterday pertaining to the effectiveness of the COVID-19 vaccine of reducing risk of contracting the disease?
A I do not.
Q Okay. Can you identify any combat operations or combat missions that could not be completed successfully as a result of COVID-19?
A So I'm thinking through some of the classified elements here. I believe the most

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accurate response to that is I'm unaware of any combat failure, as well I'm -- because those type of details and missions would not be under the purview of the vice chief, I'm also unaware of how accurate that perception is and what other mitigations and risks were accrued to manage for a lower medical readiness standard and/or if there was COVID impacts.

Q When you say other methods for mitigating risk of COVID, what -- what do you mean by that?

A So conceptually, if a commander knew that their people were at a higher risk of illness and developing symptoms that impact their ability, a responsible commander would seek to mitigate that risk, perhaps by adding people, perhaps by tethering the mission to a shorter range of maneuver closer to medical facilities, by adding a footprint to provide medical evacuation capability.

So the hard choices of a commander is why we make these choices on a local case-by-case basis, because the commander is responsible and

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accountable to use all the tools at her or his disposal to manage that risk.

Q The mitigation measures that -- that could be taken pertaining to COVID-19, is it your testimony that there are measures that can be taken to mitigate risk other than vaccination?

A Yes. We do that today. We do them in concert.

Q And back to my question about combat operations that could not be successfully completed. You testified you're not familiar with any specific combat operations because that's within the knowledge or -- or experience of those below you in the chain of command. Is that right?

A Of the Naval component commanders. It's not necessarily below in the chain of command.

Q Sure. Okay.

Who specifically would have that information or would know whether any such instances of combat operations failing as a result of COVID, whether that has happened?

A Again, the leaders that employ the

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forces would know that, and that would be the Naval component commanders.

Q Okay. And who are their -- what are their names if you -- or how many are there? Let's start there.

A So the NAVEUR, Europe is Admiral Burke, getting ready to turn it over to Admiral Munsch. NAVCENT is the Three Star Fleet Commander of the Fifth Fleet at NAVCENT. PACFLT, commander of PACFLT, Admiral Paparo. NAVSOUTH is a Two Star for the Naval commander forces in Southern Command would be examples of that.

Q Okay. And so those individuals may have knowledge of combat operations that -- that failed as a result of COVID-19 infection, but you're not aware of any specific examples?

A Correct.

MR. CARMICHAEL: Objection, just to vagueness for combat operations. It's never been defined.

BY MR. STEPHENS:

Q How would you define combat

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operations, as you use it, in the sentence at the middle of paragraph 2 of your declaration, the last two words of the sentence that begins, "Vaccination begins" -- or "Fully vaccinated"?

A So combat operations, I would, in this sense, characterize as operations in the context of actively hostile forces, hostile opposition.

Q Okay. And -- and using your definition, can you identify a single combat operation that could not be successfully completed as a result of COVID-19 infection?

A Again, I would be unware. I'm unaware of that.

Q Okay. Sitting here today, you're not aware of any specific examples.

A Correct.

Q Is that correct?

Are you aware that this lawsuit as originally filed involved Naval Special Warfare primarily?

A Yes.

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Q Okay. With respect to Naval Special Warfare, are you aware of any Naval Special Warfare missions, combat or otherwise, that could not be successfully completed as a result of COVID-19?
A I am generally aware of -- I've had conversations where I've been made aware of that.
Q Okay. What -- who did you have those conversations with?
A Chief of Staff of Naval Spec Warfare, Captain Brown, Admiral Merz, who is now OPNAV on the staff of the Chief of Naval Operations. At the time he was commander of 7th Fleet. There's two examples where conversations had made me aware of that type of mission impact.
Q Okay. And in those conversations -- neither Brown, nor Merz are lawyers in the case, correct?
A Are what?
Q They're not lawyers involved in the case, right?
A They are not lawyers.
Q Okay. They -- in those

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conversations, did they inform you or provide you information about specific missions, Naval Special Warfare missions, that could not be successfully completed?
A Yes.
Q Okay. And which missions were those?
Or what types -- let's start with what types of missions --
A Yeah.
Q -- were involved.
A I don't believe we can talk about specific missions, but the types of missions were impacts to SWCC, Special Warfare Combatant-Craft Crew, the team that brings excellent intel that had an outbreak that precluded them from doing that. And impact to a mission with SEALs on a ship where the SEALs were impacted by COVID and could not execute the mission from the ship.
Q Do you know when the -- those -- when the impact on those missions occurred?
A I don't recall the -- the exact time frame of those two instances.

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Q Do you recall those instances generally or do you know the specifics of those missions, we just can't talk about the specifics because they're classified?
Does that make sense?
A No, I understand your question.
But I -- yes, again, I'm not in the chain of command of those missions, and so I don't -- I did not delve into the specifics -- the specific details; the time, place, launch point, target. I don't have those details.
Q And you don't recall the time frame?
A I don't recall.
Q Do you recall whether it was pre- -- was it before -- if you recall, before or after August 30th, 2021?
A I don't know.
Q Okay. Are those questions that -- for Admiral Brown?
A I'm sorry?
Q That Admiral Brown said --
A Captain Brown.

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Q Captain Brown --
A Yes.
Q -- would know the answer to?
A For one of those he would.
Q And is it Admiral Merz?
A It is Admiral Merz.
Q And would he know the answer to the specifics -- the specific -- the questions about specific mission impact and the --
A Yes.
Q -- specifics of the mission?
A Yes, he would know what you would expect a 7th Fleet commander to know of that mission. So I can't speculate in what detail, but he would know certainly more detail about it.
Q Do you recall -- in the second example where there were Navy SEALs deployed on a ship who were negatively impacted by COVID-19, do you recall what geographic area they were -- the ship was deployed?
A I -- I -- I'm uncertain. I believe I could offer to hazard a guess, but it's uncertain.

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It would be better to ask Captain Brown.
Q And the SWCC -- it's SWCC. Is that correct?
A Correct.
Q The SWCC mission that you mentioned, do you recall where that mission was being conducted at the time there was an impact negatively for COVID-19?
A That was in the INDOPACOM AOR. That's why Admiral Merz, as the 7th Fleet commander, was aware of it.
Q Other than those two examples or conversations you had with Captain Brown and Admiral Merz about specific missions that were negatively impacted by COVID-19, Naval Special Warfare Missions, do you recall any others?
A Any others?
Q Any other examples?
A I do not.
Q Okay. Were those combat operations or combat missions if you recall?
A I don't know. It's -- it's a fair

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assumption to say the INDOPACOM one was not, but the other one, it's possible it was. I don't know.
Q Okay. Do you know whether it -- from your conversations with Captain Brown and Admiral Merz, the missions were negatively impacted by COVID-19, but still successfully completed or whether the missions could not be successfully completed because of COVID-19?
A I don't have detail on how they worked around that impact.
Q Okay. So you're not familiar with any other mitigation measures or other steps that were taken --
A No.
Q -- by those commanders?
A No.
Q Okay. In paragraph 2 of your declaration, the following sentence that begins, "Restriction of the Navy's ability to reassign unvaccinated personnel in order to mitigate COVID-19 related risks to units preparing to deploy or that are deployed will cause direct and

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immediate impact to mission execution."
Do you see that sentence?
A I do.
Q Okay. Other than what we've discussed at your deposition so far, what other direct and immediate impacts on mission execution are supported by evidence or information that you reviewed in preparing this declaration?
A So restricting our ability to sustain high medical readiness standards creates a direct and immediate impact in the workarounds that commanders have to do to control that lower medical readiness standard.
Part of the learning of the Navy has been because the vaccinations are the most effective tool. It's enabled the Navy to create a more sustainable approach to controlling the virus. In 2021, before the vaccine mandate, the Navy used very heavy and hard measures to control the risk to mission and the health of our people.
So we had pre-deployment sequester of people. We, in terms of preparing units to deploy,

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combined the certification underway period, known as COMPTUEX, which is typically a four- or six-week event, with the deployment.
So previous baseline, the baseline we would be able to go to which is more sustainable, is sailors who are departing their family, departing their homeport, workup, they do the certification event, they come back, they interact with their families, then they deploy. During deployment, they have port visits to sustain their energy, their morale, and then they return.
So direct and immediate impact, if the Navy were forced to go back to those types of measures to control the risk, pre-sequester, pre-deployment sequester, COMPTUEX and go, extend the deployments, no port visits, those types of measures, in my experience, are not sustainable. And we saw that with the declining retention rates, in terms of the quality of the Service over '20 -- the calendar year '20, '21, and into '22. And we see that, the stress on our people with increased demand for mental health.

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So we talked about many of the measures a commander can do to address essentially the higher risk of COVID in the Force. And I'll highlight what the Navy did before the vaccine mandate as impacts to the Force for sure.

Q So you -- you called these heavy and hard measures. And you had mentioned, by my account, two -- two examples, pre-deployment, sequester, and then I think you called it COMPTUEX.

Is that right?

A Yeah, COMPTUEX and go.

Q And --

A The third would be with an unvaccinated crew, who are more likely to contract COVID, and when contracting it, more likely then to spread it to the crew. The measure in 2021, pre-vaccine, was very few, if any, port visits.

MR. CARMICHAEL: I'll object just as -- in addition to that third one, there was also a measure of longer deployment times.

BY MR. STEPHENS:

Q Are those measures that could be

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employed now for individual Service members who are unvaccinated?

A Can you explain more of your question?

Q Sure.

If a Service member were to be granted a religious accommodation, providing an exemption from the COVID-19 vaccine, and -- could the Navy apply these measures to that individual, say, pre-deployment without negatively impacting the mission as a whole?

A I think those -- those measures, A, clearly would impact the mission and the individual; and, B, those measures are not all executable on an individual basis.

Q Okay. Let's start with the first, pre-deployment to sequester. If an individual Service member were given a religious accommodation exemption from the COVID-19 vaccination requirement, could the Navy require pre-deployment sequester of that individual without impacting the overall mission?

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A No. The Navy could require that individual to pre-deployment sequester. During pre-deployment sequester, typically, in my experience, they're not doing their work. So they're not interacting with the rest of the crew who's not sequestered.

Q And what would the time period be for the pre-deployment sequester?

A So the Navy experience over that, as I recall, evolved. My best recollection is that the pre-deployment sequesters were on the order of 14 days.

Q Were the -- were these measures, the four that you mentioned, effective at mitigating COVID-19 risks pre-vaccine, pre-August 30, 2021?

A So our experience was that those heavy, hard measures enabled the Navy to continue to execute the mission. We reallocated the risk elsewhere in a way that's not sustainable. So we -- essentially those measures fell heavily on the backs of our people to pre-deploy sequester, COMPTUEX and go, up to ten-month deployments, up to

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200 days without a port visit. The port visits you would get during this time frame were frequently tied up to a pier and stay on the pier.

Q Is the Navy still employing any of those measures or has the Navy continued to employ any of those measures after October 30th, 2021?

A With the use of the most effective tool, the vaccines, the measures that the Navy continues to apply are local health protective measures to include, based on the status of the crew in terms of boosters, whether to mask when first getting underway, cleanliness, cleaning the surfaces periodically, isolating when becoming -- when testing positive.

The ability to do port visits has returned and improved, that also requires host country approval where they check the vaccination status of the crew. That's my understanding.

Q Did you consult with the Secretary of Defense regarding the Secretary's determination that COVID-19 vaccination -- mandatory COVID-19 vaccination was necessary to protect the health and

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readiness -- military readiness of the Force?
A I did not talk to Secretary Austin.
Q Do you know or have any personal knowledge of whether Secretary Austin spoke with any other -- anyone else at the Navy prior to making that determination?
A I -- I'm unaware of that.
Q Okay. And you didn't have any communications with the Secretary of Defense pertaining to that determination?
A I did not.
Q Okay. Written or e-mails or phone conversations?
A No.
Q Okay. Do you -- can you identify any Naval Special Warfare missions in which COVID-19 infection prevented a medical evacuation of a Service member?
A Prevented a medical evacuation?
Q Yes.
A No.
Q Could you -- can you identify or are

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you aware of any instances in which COVID-19 made a medical evacuation of a Service member more difficult?
A No.
Q Can you identify any instances in which a Naval Special Warfare Service member contracted COVID-19 as a result of using a re-breathing device?
A Again, I would -- that would not be something that I would become aware of, but the answer is no.
Q Okay. And can you identify any instances in which Service members deployed on a submarine -- Naval Special Warfare Service members deployed on a submarine contracted COVID-19?
A I'm unaware.
Q Okay. Are those -- if -- if that had occurred, is that something that Captain Brown or Admiral Merz would know? It would be within their area of oversight?
A It's something that I believe the operational commander would know. So, again, the

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Naval component commanders at the three-star level typically, or if there was elements where the down-echelon commander at the 06 or 05 level mitigated, but I expect -- my speculation would be NAVSPEC Warfare would know. And Captain Brown, as the chief of staff, would likely be to know.
Q Approximately -- I had asked you questions about could you identify specific missions that were impacted or negatively impacted as a result of COVID-19. And I had asked questions in particular about pre-August 30th, 2021.
Do you recall that?
Pre-August -- August 30th, 2021, I had asked you a series of questions --
A Right.
Q -- about any -- can you identify any missions that were negatively impacted as a result of COVID-19 infections.
Do you know approximately how many missions, using your definition -- you referred to missions in your declaration -- are conducted each year by the Navy?

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A It'd be thousands.
Q Approximately how many thousands? Hundreds of thousands or --
MR. CARMICHAEL: Objection. Calls for speculation.
You can answer the question.
THE WITNESS: In the context, so a mission could be executing a flight, it could be a mission. You're talking -- I mean, again, it's speculation. You're talking tens of thousands of missions.
BY MR. STEPHENS:
Q Okay. And I'm asking you as you use it in your declaration.
A Right.
Q There's a discussion about missions and accomplishing certain missions, and I'm trying to understand what the scope is of the Navy's missions. I mean, how many are we talking about here each year.
A Right.
Q And it sounds like it's tens of

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thousands?
A The other point that I would cite that's relevant to that -- so our conversation thread is -- is strongly in the rear-view mirror in terms of what type of missions. It's worth noting that the types of missions that the Department of Defense and the Navy are executing are changing strongly as we shift to -- from two decades of primarily fighting the shore against violent extremists, which is a fight that will still continue, but at a lesser pace.
And our competition context right now is shifting strongly to a strategic competition, to a higher level of war against the peer economy, a peer threat. So that's certainly part of the lens that I brought here as well.
It's not simply in the context of SPEC Warfare of both the emergent missions that they have to be prepared to do in the violent extremist context and the rotational missions they've largely done in the Central Command AOR.
There's a much heavier expectation if

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conflict breaks out in the Western Pacific on a different context in a higher capacity flow that's relevant to this conversation as well.
Q And how would -- how would it change -- how is it relevant to the opinions or the assertions you've made here as to the vaccine requirement?
A It's a different mission set.
Q And how so?
A So with -- over the course of the last two decades, the mission focus was heavily on fighting violent extremists in Iraq and Afghanistan, and more broadly in that AOR. Admiral Howard, the commander of NAVSPEC Warfare, is shifting the structure of NAVSPEC Warfare from what it has historically been to address the key capacity to do that, but to address a different mission set, which is high-end warfare in a different theater.
Q And so how does changing the mission set of Naval Special Warfare affect the decisions that are being made by you and others within the

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Navy as to whether exemptions from the vaccine mandate should or should not be granted?
A Because the lens we're looking at is a broader conflict, a higher-scale conflict. So again, it puts a strong premium on having the full Force medically ready.
Q Do you know whether, or have you considered, any evidence or information as to whether the vaccine requirement may be negatively impacting the Navy's retention of sailors?
A What was the first part of the question again?
Q Do you have any knowledge or have you considered any information concerning whether the vaccine requirement -- the COVID-19 vaccine requirement is having a negative impact on the Navy's retention of sailors?
A I have not seen any data on that.
Q And do you know or have you considered any information or data concerning whether the COVID-19 vaccine mandate is negatively affecting the Navy's ability to recruit new

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sailors?
A No information on that.
Q Okay. Have you had any discussions with anyone concerning the affect of the COVID-19 vaccine mandate on recruiting?
A I have not had conversations about it.
Q Okay. And have you had any conversations about whether the COVID-19 vaccine mandate is negatively affecting the Navy's ability to retain sailors?
A No specific conversations on that.
Q Okay. Do you recall any general conversations?
A I -- I believe there are -- yes, I vaguely recall general conversations about that.
Q Do you know whether any unvaccinated Navy SEALs have been deployed on missions since August 30th, 2021?
A I don't know.
Q If a -- if an -- if unvaccinated Navy SEALs or an unvaccinated Navy SEAL were to be

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deployed or had deployed on a mission after August 30th, 2021, would you expect to see an increase in the incidence rate of COVID-19 within Naval Special Warfare?

MR. CARMICHAEL: Objection. Improper hypothetical that makes several unstated assumptions.

You can answer the question.

THE WITNESS: Could you restate the question?

BY MR. STEPHENS:

Q If an -- if an -- if unvaccinated Navy SEALs had been deployed or have been deployed on missions since August 30th, 2021, after the vaccine mandate, would you expect to see a higher incidence rate of COVID-19 infections in individuals deployed on those missions?

A I would expect that they -- if that were the case hypothetically, I would expect that they were deploying and accepting a lower medical readiness standard. And I would then expect them to -- the commander to design mitigations to

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counter that risk.

So it might either manifest, if that were done poorly, as increased COVID or it might manifest as increased mission risks they took or it might manifest as risks they pushed elsewhere for people to compensate for the reduced medical standard.

Q Does the Navy use other mitigation measures with respect to Service members who receive a medical or administrative exemption from the COVID-19 vaccine requirement?

A I don't understand the question. Do they use different standards for?

Q Different mitigation measures to address the risk that would arise from granting a medical or administrative exemption to a -- to a Service member from the COVID-19 vaccine requirement.

A So I believe your question is regardless of the basis for a waiver for the vaccine, when it comes to determining medical readiness to the standard, is there a different

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approach? And my understanding is there's not.

And then your question was, are there different mitigation approaches based on the basis of your vaccination waiver? And, again, that's not directly in my purview as vice chief, but my understanding, again, is that there is not.

Q Why -- why do you -- why, if you know, does the Navy allow medical and administrative exemptions from the COVID-19 vaccine requirement?

A The -- the overarching principle is to make those cases -- weigh those decisions on an individual basis and -- and grant that waiver when the -- from a risk perspective, that benefit outweighs the cost. So I believe some of the administrative examples would be if somebody is separating or retiring soon, then that cost benefit risk calculus might suggest a waiver.

Certainly if there's been a reaction to a vaccine dose, if there's medical underlying conditions, if there's pregnancy, all of those elements are basically -- and in this specific

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case, what's the risk to the Operational Force? What's the risk and the benefit to the individual?

I would say another general principle is the Navy, in my experience, supports the individual in religious accommodations, whether it's beards, headwear, et cetera, and supports the individual in general. And where the hard choices get made is when the individual benefit and right now starts to impact the unit, other people's health in this case, or unit mission execution.

Q In the examples that you gave, you mentioned that the analysis, at least as you understand it, is -- is to consider on an individual basis or an individualized assessment of whether the risk outweighs the cost. Is that right?

A That's the general risk management principle.

Q Okay. And those are in -- those are all, as you understand it, individualized assessments?

A It's a case-by-case assessment.

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Q Case by case.
And so you look at the specific individual's job duties, their unit, their -- the missions they are involved in. Is that correct?
A Again, so I'm not in -- I can talk in general approaches.
Q Sure.
A I'm not involved in that process, either in the initial or the appeal, so I can't speak with more specificity about what other factors they might be using.
Q Okay. But as you understand it, an individualized assessment for medical or other administrative exemptions from COVID-19, it is -- it's conducted on an individualized basis?
A Correct.
Q Okay. And do you know or do you have any understanding of whether the Service members who submitted religious accommodation requests for the COVID-19 vaccine were given the same type of individualized review or individualized assessment?
A It's my understanding, they are

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individual assessments.
Q Okay. Are you aware of any directive or communication to individuals involved in that process informing them that all religious accommodation requests should be denied?
A No.
Q Okay. Are you familiar with any protocol or procedure that the Navy has promulgated for purposes of conducting a review of religious accommodation requests?
A So I'm aware of a discussion about a checklist that N1 uses. I am not familiar with the details.
Q And who is N1 or --
A Chief of Naval Personnel.
Q Okay. And is that Admiral Nowell?
A It was Admiral Nowell until a few weeks ago and he retired. And it's now Admiral Cheeseman.
Q Okay. And so at the time when religious accommodation requests or -- let's start with that. At the time of the vaccine mandate,

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August 30th of 2021, and the submission of religious accommodation requests by Service members, Admiral Nowell -- I may be mispronouncing it -- but Admiral Nowell was --
A Yes.
Q -- in charge of the process for evaluating those, ultimately responsible?
A Admiral Nowell was the adjudication authority.
Q Okay. And you -- you said that Admiral Nowell has retired?
A He has.
Q Do you know where he's working now or if he has taken another job?
A I don't. He literally retired two weeks ago, I believe.
MR. CARMICHAEL: Andrew, I generally like to not -- to take breaks at 90 minutes, if that's okay.
MR. STEPHENS: That's fine.
MR. CARMICHAEL: We're like 15 minutes away, so I just wanted to --

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MR. STEPHENS: However you want to do it, that's fine.
BY MR. STEPHENS:
Q On page 8 of your declaration, and it's paragraph 11, we're looking at declaration exhibit -- or Deposition Exhibit 1, there are a number of statistics cited in this paragraph.
Do you see that?
A I do.
Q Did you calculate these numbers or where did you -- where did these numbers come from?
A These numbers came from the Joint Staff Surgeon for the Military Force.
Q Okay. Before I ask some more questions about this data, I want to go back to the religious accommodation questions I had. And ask you if you learned that religious accommodation requests were not being given individualized consideration or an individualized assessment or case-by-case assessment, I think was the term that you used, would you agree with that?
A No.

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Q Okay. Why not?
A The fundamental principle that I've used throughout my 42 years, I make these type of risk decisions, particularly when -- and these -- it's not constrained to just religious accommodation. Whenever we make decisions where we're weighing the rights and the interests of the individual against the broader imperative of a unit mission, those always have to be done on a case-by-case basis in my experience.
Q All right. Back on -- turning back to page 8 of your declaration, paragraph 11, the statistics that I had referenced, did you -- you testified that these came from who?
A The joint staff surgeon.
Q Okay. And who is the joint staff surgeon?
A I don't know their name.
Q Okay. And did you request these statistics from the joint staff surgeon?
A These statistics, I recall, were part of the initial draft that I reviewed.

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Q Okay. Did you do anything to verify the accuracy of the statistics?
A I asked the source.
Q Okay. And what was the source?
A The joint staff surgeon.
Q Okay. And do you know what -- who's -- that's an individual, correct?
A That's right.
Q And do you know what the source was for the joint staff surgeon, the underlying data or information?
A I don't.
Q Okay. So that's not something that you reviewed?
That's not something that you reviewed --
A Correct.
Q -- the underlying data or information?
A Correct.
Q Okay. And so you can't testify or -- or can you testify that these calculations are true and accurate based on your personal knowledge?
A I cannot.
Q Okay. And as you understand it, these are statements by the joint staff surgeon. Is that right?
A As I understand it, correct.
Q Okay.
MR. STEPHENS: Okay. Drew, do you want to just go ahead and take a break? I can probably streamline some questioning.
MR. CARMICHAEL: Sure.
VIDEOGRAPHER: We are going off the record. The time is 9:21 a.m. This concludes Media Unit Number 1. Thank you.
(Recess from 9:21 a.m. to 9:40 a.m.)
VIDEOGRAPHER: We are back on the record. The time is 9:40 a.m. And this begins Media Unit Number 2.
Counsel, you may proceed.
BY MR. STEPHENS:
Q Admiral Lescher, you understand that you're still under oath, correct?

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A I do.
Q Before the break, I had asked you questions about individualized assessments, do you recall that, of religious and other types of exemption requests for COVID-19 vaccine?
A Right.
Q Do you recall that?
A Case by case, sure.
Q In your testimony, I believe that -- that you said, and correct me if I'm wrong, that -- that the commanders would be in the best position to make those types of risk assessments. Is that -- is that right?
A It depends on what type of risk assessment we're talking about. So specifically in the context of religious accommodations?
Q Yes. Or -- or in the context of a medical exemption from a vaccine requirement.
A Right.
So the concept of a central adjudication, as the Navy has put in place for religious accommodations, is to bring consistency

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to those determinations. So the commander starts the process with the individual, and then the ultimate decision is done with a consolidated decision authority.

Q Do you know of any religious accommodation requests that have been recommended for approval by commanders?

A Again, not being in that process, I do not.

Q Okay. Do you know on what basis -- if you were to review a religious accommodation request and a commander were to recommend approval of that request, what -- what types of factors would you look to to determine whether you would also approve it or reach a different conclusion that it should be denied?

A So, hypothetically speaking, I always would go to the standard first; what are the standards? What are the guidance? In this case, I believe the legal standard is compelling interest, and is the most effective tool. In terms of weighing a request that was favorably endorsed by

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the commander, I believe I would then look at that broader standard.

The commander may have a local perspective in terms of a specific unit. Say, for example, the commander was on a ship who was undergoing depo maintenance, not deploying any time soon, a commander might be inclined to say -- as the commander makes that local risk benefit judgment we talked about, that the benefit to the individual outweighs the mission risk that the commander sees. At the consolidated level, it's possible that that individual -- in my case, I would look more broadly.

And the question would be in that -- that type of context maybe a limited duration religious accommodation that recognizes the fact that the risk calculus changes as that local context changes, as that ship comes out of depo maintenance back into a more operational posture for deploying with other countries, with other members. That might be a different calculus.

On the other hand, it's possible the

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local commander also sees the risk of introducing COVID into a crew in the maintenance phase as unacceptable. But contextually, that's how I think those conversations and those decisions would be made.

Q Okay. And -- and you haven't been involved -- I think you've testified to this, but you weren't and have not been involved in any of that -- those conversations pertaining to approval or denial of any religious accommodation requests for COVID-19 vaccine mandate?

A Correct.

Q Okay. You had testified earlier that Captain Brown and Admiral Merz were the individuals that you had spoken with and received information about Naval Special Warfare missions that could not be completed as a result of COVID-19 infections.

Do you recall that?

A That were impacted.

Q Okay. Impacted, but -- well, do you know whether those missions were still successfully completed?

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A So I think, as I recall, that's the question you asked --

Q Right.

A -- and so no, I don't have that awareness of the detail of was there a workaround; was it delayed, but executed. I don't know that either.

Q Do you recall when you talked to Captain Brown -- approximately when you talked to Captain Brown about that mission?

A I do. Really in part of the preparation for this deposition, I talked to Admiral Merz as the Navy headquarters staff lead on COVID. And I talked to Captain Brown. And Captain Brown, I had a conversation with yesterday.

Q Okay. And so prior to -- prior to executing your declaration, you had not had those conversations about any specific Naval Special Warfare missions that had been impacted by --

A Correct.

Q -- COVID?

Okay. How long did you speak with

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Captain Brown?
It was this week?
A Yes.
Q And how long did you speak with him?
A I would estimate ten minutes.
Q Was it a phone call or a meeting?
A Phone call.
Q Okay. And -- and how long did you speak with Admiral Merz?
A So I speak to Admiral Merz pretty regularly. In this context, I estimate it was 25 minutes.
Q And did you -- you didn't speak with Admiral Merz before executing your declaration about this specific issue or question of Naval Special Warfare missions that had been negatively impacted or adversely impacted by COVID-19?
A Right, correct.
Q Okay. In your testimony concerning mitigation measures that were taken pre-vaccine for purposes of mitigating the effects of -- of COVID-19 on the Navy's ability to accomplish its

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missions, you mentioned that certain measures were hard on sailors. Is that correct?
A Correct.
Q And so that's something that it seems, at least to me, that -- that you care about, the impact on your individual sailors on their lives, on their families, and how it -- the Navy's policies or practices will affect them. Is that fair to say?
A Yes.
Q Okay. And with respect to Service members who submitted religious accommodation requests, do you have any reason to doubt the sincerity of their religious beliefs underlying those requests?
A I do not.
Q Okay. And have you considered or had any discussions with other Naval leadership, anyone -- anyone else in Naval leadership, about the impact a denial of a religious accommodation request would have on a -- on a sailor who has sincere religious beliefs?

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A Yes.
Q Okay. And what was the nature of those conversations?
A So I recall having conversations with the Navy chief of chaplains about spiritual health and the role of spiritual health in sailor resiliency.
Q When -- when was that conversation?
A More than one. When I talk to the chief of chaplains, that's always an element that we talk about. The chief of chaplains turned over fairly recently, so the new chief of chaplains and I talked about this, I don't know, maybe two months ago, a month and a half, two months, ago. And with his predecessor, you know, periodically, episodically before that.
Q Okay. And you -- what was -- who is the current chief of chaplains?
A Admiral Todd.
Q Emmett Todd?
A Admiral Todd.
Q Admiral?

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A Yeah.
Q And who was the predecessor?
A Scott.
Q In those conversations, did the chief of chaplains or either of the chiefs of chaplains express their concern about the impact a denial of religious accommodations would have on -- on sailors?
A Those conversations were very much in the context of what we've talked about here, which is we recognize spiritual health is something we strive to develop, mature, to support. It's many of the programs that the chief of chaplains works.
When it comes to COVID, then essentially that rough judgment calculus we talked about is at what point does the benefit to the individual of a religious accommodation become outweighed by the risk of personal health to others who don't get a choice about whether they deploy and the risk to the mission. So it was -- it was in that context.
Q And in your experience or in your

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judgment, at what level does that risk become unacceptable or does the risk outweigh --

A So, again, I would expect those typically case by case. But as an exemplar, in the operational force in the context -- a strategic context that we're in today of being prepared to deter not a small adversary in the 5th fleet, but a large adversary and being prepared, if deterrence fails, to deploy rapidly into a fight, that medical readiness standard is what prevails.

Q Would the medical readiness standard prevail if by denying religious accommodation requests, the Navy was experiencing retention issues or sailors were leaving the Navy as a result of that decision?

A Yes. And the principle there would be the Navy has high medical readinesses standards to come into the Navy for specifically that purpose. And there's no doubt that the high medical readiness standards to come into the Navy cause less people to come into the Navy than would otherwise.

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But the concept is because we operate in high-risk, harsh, unforgiving environments, bringing people into the Navy who can't meet those medical readiness standards, it's not purposeful to the -- to the mission.

Q Are there certain other requirements for entering the Navy that the Navy has waived recently for purposes of addressing recruitment and retention concerns?

A I'm not familiar with any.

Q Do you know whether there -- the Navy still requires a high school diploma?

A I -- I don't know. You know, the -- based on the type of rating that one is going to, there's different levels of education and score on the entry exam. And I don't have the detail to know if there are any that -- where a GED would be sufficient.

MR. STEPHENS: Mark this as Lescher Deposition Exhibit 3.

(Lescher Deposition Exhibit Number 3 marked for identification.)

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MR. STEPHENS: Thank you.

BY MR. STEPHENS:

Q Admiral Lescher, is this a document that you've seen before?

A It is not.

Q It's not.

I'll represent to you that this was a -- is a request for production served by the Plaintiffs counsel on the Defendants requesting certain documents.

And if you would turn to page 6 of Deposition Exhibit 3, there are four specific requests on -- or four requests on page 6 and then there's a fifth on page 7. And then on page 8 is the date that this was served on Defendants' counsel.

I believe I understood your testimony to be that this document was not provided to you or you don't recall it being provided to you?

A It was not provided to me.

Q Okay. Were you requested by your counsel to provide documents in response to any

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discovery requests?

A I don't recall being asked to do that.

Q Okay. Did you collect or compile any documents, e-mails, notes, other types of documents for purposes of responding to any discovery in this case?

A So it looks like this is discovery specifically in drafting or preparing the declaration.

Q Correct.

A So I believe Captain Josephson and I talked about this perhaps. I mean, that would be my supposition. And -- and then in doing the declaration, my best recollection is I was just working off the draft. I don't recall studying, reaching out to other coordination to do the declaration.

Q Okay. So you don't recall looking at any -- any documents, reports or other types of information when you were reviewing, editing the draft of your declaration. Is that right?

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A That's correct.
Q Okay. And do you recall having any -- any communications other than with counsel about the substance of the declaration, e-mails or phone calls?
A I don't. My best recollection is, you know, it came to me. I thought it needed work, but the perspective I brought was my experience and just, you know, from being aware of these issues. I'm largely talking to as what's written in the declaration. I don't recall reaching outside my office at the time of the declaration.
So that's my best recollection, that the draft came, iterated on it a couple of times, and that was that.
Q Okay. So is it fair to say that -- that any documents that your counsel produced to us in response to these requests were not documents that you provided to your counsel?
A Correct.
Q Okay.
A Well, again, this is going back some

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time. Yeah, there was nothing that I would have pulled that I used. It's not inconceivable that -- I just don't recall, that if she gave me some references as well as the draft itself.
Q Okay. Do you recall having any -- any meetings with anyone about the substance of your declaration prior to executing the declaration?
A I don't recall those.
Q Okay. How do you -- you typically keep your schedule?
Do you use an Outlook calendar or --
A Yes.
Q And -- and did you produce to counsel any calendar records that you recall pertaining to the declaration about meetings or phone calls?
A Well, she has access to them. My recollection is -- and typically in these type of things you would not schedule a block to it. You know, the schedule is kind of hectic, and it's kind of merged. I would pull it out and mark it up and send it back.

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Q Okay. And who is she?
Is that your assistant or --
A It's Captain Josephson.
Q Okay. Okay.
Okay. And do you know an individual, Darse Crandall?
A I know Admiral Crandall, the Navy JAG.
Q Okay. And was Admiral Crandall involved in your declaration or in communications or discussions about the substance of your declaration with you?
A I don't ever recall talking to him about it. I -- I would imagine that he participated in the draft that I received, but that's speculation.
Q Okay. You don't recall a meeting on January 12th with Admiral Crandall about your declaration?
A I don't.
Q Okay. I'll show you a document.

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(Lescher Deposition Exhibit Number 4 marked for identification.)
BY MR. STEPHENS:
Q I've handed you a document marked as Lescher Declaration Exhibit 4, which was produced in response to the Plaintiffs' First Request for Production. And it is Bates stamped NSW00007803.
Do you have that document?
A I do.
Q Okay. Do you know what this document is?
A It looks like an Outlook calendar invite --
Q Okay.
A -- or calendar entry is the format.
Q Okay. And is this -- the subject of this document, it appears to me to say, "MTG with/OJAG." Do you see that?
A Correct.
Q Okay. Do you know what that means?
A JAG would be a meeting with Admiral Crandall.

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Q And the location is 4E642?
A Yes.
Q Do you know what that is?
A That's my office.
Q Okay. And that's at the Pentagon. Is that right?
A Correct.
Q Okay. Do you know -- you don't know if this meeting ever happened. Is that right?
A I don't -- yeah, I don't recall.
Q Okay.
(Lescher Deposition Exhibit Number 5 marked for identification.)
BY MR. STEPHENS:
Q I have handed you a document marked as Lescher Deposition Exhibit 5, Bates stamped NSW00007804. Do you have that document?
A I do.
Q And in this document -- and if you could look at Deposition Exhibit 4, this is -- you're looking at 5 now, with -- with the prior Exhibit 4. Do you recall this document or seeing

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this document before?
A I don't.
Q And in the second part at the top of the page, "Sent 6/16/2022." Do you see that in Exhibit 5?
A I do.
Q Okay. Do you know what that means or what the significance of when this invite was sent?
A Yeah, I -- I haven't seen this format before, but it appears to indicate that on June 16th of '22 that a meeting with OJAG was scheduled or tentatively scheduled.
Q And when was it scheduled for?
A It shows here as 1600 on January 12th of 2022.
Q Do you recall sending this calendar invite?
A No. I did -- I would -- I don't send calendar invites. My office, my scheduler, you know, runs the schedule, sends the invites, runs the Outlook.
Q Okay.

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A I must note this is kind of quirky in that it was sent apparently six months after the meeting. I don't know what to make of that.
Q Right. I didn't either, that's why I wanted to raise the question --
A Yeah.
Q -- because if -- and you didn't recall the meeting on the 12th, so it seemed odd to me as well.
A Yeah.
(Lescher Deposition Exhibit Number 6 marked for identification.)
BY MR. STEPHENS:
Q Admiral Lescher, I've handed you a document that's been marked as Lescher Deposition Exhibit 6, Bates stamped NSW00007805.
Do you have that document?
A I do.
Q And do you recognize or recall this document?
A I recognize this type of document. I don't recall this specific one.

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Q Okay. On the fourth line of the -- there are a number of e-mail addresses listed in the "To" field on the first page. On the fourth line, it -- it has your last name, comma, first name, and then your -- your title.
Do you see that?
A Yes.
Q Okay. And so does that indicate to you that this is an e-mail that you received?
A Yeah, that would indicate that that was an e-mail that would have come to my in-box.
Q Right.
And who is Bruce Gillingham, the sender of this e-mail?
A He's the surgeon general of the Navy.
Q Okay. In your testimony before the break this morning, you had mentioned that you periodically will receive certain reports with medical-related information pertinent to the Navy.
Do you recall that?
A Yes.
Q Is -- is this the type of e-mail that

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you're referring to?
A It's not. The e-mail I was referring to in that case is the weekly battle watch update that, as I recall, come from the N3, N5, the operations and plans deputy chief of naval operations. And that is really -- provides all the leaders a snapshot of trends in terms of active cases, resolved cases, hospitalizations, to include prevalence on ships, the figure I cited for you.
Q You called that document, "The Weekly Battle Force Update." Is that right?
A The document I believe is titled just "Weekly COVID Update."
Q And -- and that's something that you considered and relied on as data or evidence to support some of the assertions in your declaration?
A That's -- so again, those come out weekly. Episodically, I am able to review them, but over -- that accumulative awareness over time influenced my experience, my -- my declaration.
Q Okay. And you said they're weekly. Do they come out consistently every week and you

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review those every week?
A They come out every week. I do not review them every week.
Q Right.
The e-mail that I handed you that's been marked as Deposition Exhibit 6, is this something that -- it has a number of attachments it looks like on the -- on the first page of the e-mail. Do you review what's sent to you in the body of these types of e-mails and attached or do you focus primarily on the weekly COVID report or the battle force update?
A The latter.
Q Okay. Do you know who compiles or prepares or drafts the -- do you call it the "Weekly Battle Force Update"?
A The "Weekly COVID Update."
Q The "Weekly COVID Update."
The "Weekly COVID Update," do you know who prepares or drafts that?
A I believe it is resident within OPNAV N35, the Deputy Chief of Naval Operations for

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Operations and Plans. That's Admiral Merz, who's the Navy of NAV staff COVID lead.
Q And does it contain information that's classified or confidential?
A It does.
Q Okay.
A That's -- that's an e-mail that's resident on the secret network.
Q Okay. Does -- does an e-mail -- is it called SIPR?
A SIPR.
Q Are all communications that are sent on SIPR classified?
A No.
Q Okay. And who receives the --
A Just to amplify that, I mean the vast majority are. It's unusual for unclassified traffic to be on the SIPR.
Q Okay. And the "Weekly COVID Update," do you know who receives that --
A It's a --
Q -- besides yourself?

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A It's a pretty large shop group. It's -- you know, conceptually it wouldn't be -- it's not this address group, but it's probably about that size.
Q And -- and the e-mail is sent to you from -- do you know who sends it to you?
Is it Admiral Merz?
A I believe it's the BattleWatch Center.
Q Okay.
A The Navy has a BattleWatch. So it's either -- so, again, it's residence in the headquarter staff. Likely N3, N5, of which the Battlewatch Center worked for.
Q Okay.
(Lescher Deposition Exhibit Number 7 marked for identification.)
BY MR. STEPHENS:
Q Admiral Lescher, I've handed you a document that's been marked as Lescher Deposition Exhibit 7, and it's Bates Stamped NSW00007813 through 7830.

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Do you have that document in front of you?
A I do.
Q And is this a document that you are familiar with?
A I believe this is a document that was part of the -- I've seen a document like this that was part of my preparation binder, one of multiple tabs for the declaration.
Q For the deposition or for the declaration?
A Oh, I'm sorry, for the deposition.
Q Okay. So -- so this was something that you reviewed in preparation for the deposition, but not something that you recall seeing or relying on -- well, seeing before you executed your declaration?
A That's correct. I misspoke. So basically I saw this in the past few days.
Q Okay. And it's not something that you relied on for purposes of the statements and the opinions offered in your declaration?

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A That's correct.
Q Okay. Are you familiar generally with, you know, what this type of document is? The Naval Medical -- it's titled the "Naval Medical Intelligence Report."
A I'm not. So I have not been a consumer of this type of document. The way this type of longer-term medical trends would come to my attention is we have either weekly or biweekly, we call them OPNAV syncs, or synchronization events. We go around the people in that meeting. And the surgeon general -- or his rep is one of them, and typically in a fairly succinct fashion, he or his rep would, when newsworthy, update, I think, the type of trends that appears are being talked about in this document.
Q How often are the OPNAV meetings where the surgeon general would provide an update of the issues that are reflected in this type of document?
A Yeah. So that cadence is designed to be weekly. It doesn't always execute that way.

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When executed, the surgeon general is not necessarily always there. Although, typically he or his rep would be. So that's that cadence.
Q Okay. Do you recall an OPNAV meeting occurring on or around January 14th, 2022?
A I don't have a specific recollection of that.
Q Okay. Do you recall an OPNAV meeting in which -- on or around January 14th, 2022, in which the surgeon general advised at the meeting that vaccine effectiveness was 64 percent?
A No, I don't recall a specific figure. I do recall the surgeon general speaking at those meetings about the -- and I don't recall if this is specifically in the context of Omicron or if this predates it, but conveying information about what we're seeing in terms of effectiveness against evolving variants as part of those conversations.
Q And was the nature of what the surgeon general was discussing or advising on the new variants that the vaccine was more or less effective at preventing incidents of -- of COVID-19

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vaccination?
A I recall the general entered that conversation being --
MR. CARMICHAEL: Objection. Vague. I just think you might have misspoke on your question because you said vaccination preventing vaccination or something like that. And so --
MR. STEPHENS: That's what I get for reading ahead.
BY MR. STEPHENS:
Q Do you recall the nature of the surgeon general's discussion, whether it involved information concerning vaccines becoming more or less effective as a result of the newer strains of COVID-19?
A So, as I recall, the -- the thread of those type of conversations were -- had two dimensions. One was paying close attention to the efficacy of the vaccination against new variants in terms of number of cases per capita, balanced by still seeing differential results between

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vaccinated and unvaccinated people in terms of the case rate and the severity of the cases.

So with -- so basically with both populations increasing, increasing differentially in terms of prevalence and consequence is my best recollection of how those conversations transpired.

Q On page -- on the first page of Deposition Exhibit 7, in the paragraph -- the first paragraph under executive -- well, first, the date is January 14th, 2022, that was before your -- the date you executed your declaration. Is that right?

A Correct.

Q In that first paragraph, the second to the last sentence says, "Vaccines have an overall effectiveness of 64 percent."

Do you see that?

A Yes.

Q And that's not something you recall being informed of at that time?

A I was not.

Q Okay. If you had been informed of that prior to executing your declaration, would you

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have changed any of the statements in your declaration pertaining to the vaccine mandate and its effectiveness at preventing COVID-19, the spread of COVID-19, within the Navy population?

A No. Based on the medical updates that we talked about, our experience shows it's still clearly the most effective available medication. And while the overall effectiveness data shows here -- and I don't know how that number has changed over time from January of 2022 -- the relative effectiveness in terms of prevalence, and in particular of controlling the severity of the cases, is -- makes it compelling and makes it the most effective tool we have.

Q Turning back to Deposition Exhibit 1, on page 2, which is -- that's a copy of your declaration. On page 2, in paragraph 2, halfway -- well, a third of the way down in that paragraph, there's a sentence that said -- and we talked about this earlier -- "The injunction directly impacts the Navy's ability to carry out its responsibilities to protect and maintain the health

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and safety of our Force, in particular our ability to halt the spread of COVID-19 through a mandatory vaccination requirement."

At what level of effectiveness would you determine that the vaccine is not halting the spread of COVID --

MR. CARMICHAEL: Objection. Calls for --

BY MR. STEPHENS:

Q -- within the Navy?

MR. CARMICHAEL: Objection. Calls for speculation.

You can answer the question.

THE WITNESS: So you'd like me to provide an estimate of what level of COVID effectiveness would halt the spread?

I mean, my short answer is, I'm not a medical expert --

BY MR. STEPHENS:

Q Right.

A -- and would very much have that type of conversation with the surgeon general and -- and

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our medical experts.

Q And you testified that the vaccine mandate or the vaccination is the most effective tool.

A Yes.

Q Is that right?

A Yes.

Q Is that -- do you -- is that -- is that another way of saying it's the least restrictive means?

Have you heard the term "least restrictive means"?

A I have.

So I think it's an element of least restrictive. Because it's so effective, it's for sure an element, in my view, of the least restrictive.

Q Okay. If the effectiveness of the vaccine at preventing COVID-19 infections were 16 percent, would you still believe that it is -- the vaccine is effective at stopping the spread of COVID?

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MR. CARMICHAEL: Objection. Calls for speculation. Improper hypothetical with unstated assumptions.

You can answer the question.

THE WITNESS: I believe the COVID vaccine that decreased the prevalence of COVID at that type of rate, but still provided substantial Force health benefits, in terms of mitigating the severity, yes, would -- would still be an effective -- the most effective tool.

What we see on the ships, so the 22 ships today, they're able to manage these cases that do emerge because the -- because of the -- they're not having to hospitalize people, they're not having to evacuate people.

BY MR. STEPHENS:

Q Is it also fair to say that on those ships vaccination is not preventing COVID-19 infections?

A Yes, that's fair to say.

Q Okay.

A It's -- it's not preventing all

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infections, which really highlights the risk of introducing unvaccinated people into that crew.

Q I'm sorry. Say that again.

A I said it just highlights the risk that the commander is evaluating when unvaccinated individuals come into a crew, where the -- even the vaccinated crew is still susceptible to infection.

Q Do you know of any instances on ships in which there have been COVID-19 infections among only vaccinated members -- Service members on that ship, but -- but not among the unvaccinated members of that ship?

A I'm not familiar with a case like that. The MILWAUKEE is an example we talked about where the crew was 100 percent vaccinated and had a mission impact with an outbreak.

Q Okay.

(Lescher Deposition Exhibit Number 8 marked for identification.)

BY MR. STEPHENS:

Q Admiral Lescher, I've handed you a document that's marked as Lescher Exhibit Number 8.

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It does not have a Bates number. It was not produced in discovery.

Do you have that document?

A I have Exhibit 8.

Q Okay. And the title of that document on the first page is, "Statement of Admiral William K. Lescher, Vice Chief of Naval Operations Before the House Armed Services Committee, Subcommittee on Readiness on Learning from and Preventing Future Training Mishaps, March 23rd, 2021."

Do you see that?

A I do.

Q Okay. I'd like you to look at the first page -- well, is this a statement that you gave to Congress to the House Armed Services Committee?

A It appears to be the written statement for this March 23rd hearing.

Q Okay. So you -- you submitted this statement in writing to the committee?

A Yes.

Q Okay. And --

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MR. CARMICHAEL: I -- I do want to do an objection. Maybe this will get it cleared up. There's no page numbers or any indication that this is the entire document, but maybe it'll get cleared up.

BY MR. STEPHENS:

Q Admiral Lescher, on page -- well, on the first page following the title page -- let me -- let me start over.

The first page, it says March 23rd, 2021. Do you see that, the very -- the cover page --

A Yes.

Q -- of the document?

And as of -- in March -- as of March 23rd, 2021, the Navy had been dealing with COVID-19 for over a year. Is that -- or approximately a year?

A About a year.

Q About a year.

Okay. So at the time of this -- of giving this statement to Congress or to the House

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Armed Services Committee, you had -- you and others in the Navy had experienced a year of how to accomplish the missions, deal with COVID-19.

Fair to say?

A Yes.

Q Okay. On -- on the following page, in the second paragraph it says, "Our nation requires a Navy that is ready to deploy globally in defense of U.S. interests. 2020 provided a strong example of how the U.S. Navy is executing that imperative.

"While large portions of world activity were curtailed with the pandemic, the Navy's operational tempo continued at a high pace, highlighted by eight major Carrier Strike Group and Expeditionary Strike Group deployments.

"In 2020, Naval Aviation flew over 700,000 flight hours and Navy Afloat forces amassed over 23,000 total steaming days. In a number of instances, U.S. Naval Forces deployments were extended to support high priority Secretary of Defense tasking.

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"One such unit, the USS NIMITZ (CVN 68) Carrier Strike Group returned last month from the longest aircraft carrier deployment in modern history."

Is that -- did I read that correctly?

A You did.

Q And that was part of your statement that you gave to the subcommittee House Armed Services Committee on March 21st, 2021?

A Yes.

Q And that was a true statement at time, correct?

A Yes.

Q Okay. In that statement, you made no mention of COVID-19. Is that correct?

A There's no mention of COVID-19 in here right now, yes.

Q Okay. So is it fair to say that your characterization of 2020 and the Navy's performance during 2020, at least, suggests that the Navy was able to accomplish its missions despite the impact of COVID-19?

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A Right. It's exactly the context we touched on briefly before. The Navy was mission focused and executed the mission, and you can tell even from the statements in here in ways that were very hard on our people.

Q Okay. The Navy was able to accomplish its missions successfully, as you told Congress, despite COVID -- despite COVID-19 and before a COVID-19 vaccine mandate -- or vaccine even existed. Is that right?

A The Navy executed these missions at this pace in 2020.

Q Okay. Did you --

A So highlighted here, you know what missions were impacted, what missions didn't get executed.

Q Did you inform Congress or the House Armed Services Committee, or any other committee of Congress, at any time of the Navy's missions that you said were negatively impacted by COVID-19?

A I don't recall in the context either of this hearing or in the interactions with the

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professional staff if we talked about it.

Clearly at the time frame that's stated here, they would have been well aware of the very high profile events on THEODORE ROOSEVELT, and -- and, of course, there were interactions with the Congress and the oversight committees about that.

And in terms of the broader issues, I do know -- I recall talking about the impact on our people. This is something that congressional committees rightfully strongly focus on in terms of the deployment lengths, again, that are talked about in this -- the uncertainty they're dealing with in terms of the phrase here, "A number of instances of extended deployments due to the dynamic nature of Secretary of Defense tasking."

So I mean it clearly was in the context of the conversations with the committees.

Q You mentioned the ROOSEVELT, and I had asked you earlier about another example of a -- a ship with a COVID outbreak.

Do you -- do you recall a Navy ship

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in July 2021 that -- where the Service members deployed on that ship, 98 percent were vaccinated and only the vaccinated Service members were allowed onshore, and there was a COVID outbreak. The Navy determined however that patient zero was a fully-vaccinated Service member and that of the 22 infected Service members, all were fully vaccinated?

MR. CARMICHAEL: Objection. Facts not in evidence and -- yeah, facts not in evidence.

But you can answer the question.

THE WITNESS: I don't recall those details.

BY MR. STEPHENS:

Q Okay. Did you review any information or reports from the U.S. Department of Health and Human Services or CDC?

A No.

Q Okay. Are you aware of the Navy providing any information regarding COVID-19 infections within the Navy to CDC or the Department of Health and Human Services?

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A I'm not aware of -- of that process.

Q Okay. Would you consider the Health and Human Services and CDC a reliable source of information pertaining to COVID-19 infection?

A I have no reason to question it. The source I use is our medical experts and the surgeon general and the Department of Defense.

Q Okay. And that's the -- that's what you mentioned before, it's the Battlewatch Group, Weekly COVID Update, and then your meetings with the surgeon general --

A Right.

Q -- primarily?

A Primarily.

Q And -- and are there any other sources that you would consider?

Not with respect to your declaration, just generally for your knowledge of the COVID-19 situation within the Navy.

A Those are the two primary sources.

Q Okay. Are you familiar with -- you mentioned the ROOSEVELT. Are you familiar with any

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other deployments of ships that successfully mitigated or any instances where a ship was -- carried out its mission with zero cases of COVID-19?

A So there's a couple of ways to think through that question. Do you mean am I aware of any cases of where a ship's mission was a full deployment that executed with zero cases of COVID? It's -- that's not a figure I -- I track.

Q Okay.

A And so typically the way we monitor this is across the Force, which ships have active COVID cases and -- and how that -- how those are trending. So yeah, I don't have a -- I'm not aware of what you just asked.

(Lescher Deposition Exhibit Number 9 marked for identification.)

BY MR. STEPHENS:

Q I've handled you a document that's been marked as Lescher Deposition Exhibit 9. It does not have a Bates number. It's not something that was produced in discovery.

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At -- at the bottom of the page, do you see where it says U.S. Department of Health and Human Services --

A Uh-huh.

Q -- Center for Disease Control and Prevention?

A Uh-huh.

Q Okay. And the title of this is -- of this document -- at the top it says, "Morbidity" -- at the very top, "Morbidity and Mortality Weekly Report."

Do you see that?

A Uh-huh.

Q And below that the title of the -- of the journal article is, "Outbreak of COVID-19 Among a Highly Vaccinated Population Aboard a U.S. Navy Ship After a Port Visit, Iceland, July 2021."

A Uh-huh.

Q And is this something that you've seen before?

A No.

Q Okay. Are you familiar with this

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ship's deployment and the COVID outbreak involving this ship?
A So I'm going to take --
Q Sure, you can take time to --
A -- a few moments to read it.
Q Yeah, that's fine.
A Yeah.
Okay.
Q Okay. So you've had a chance to review the document --
A Yes.
Q -- marked as Deposition Exhibit 9?
Would -- would this example and the deployment of the ship and the facts discussed in this Health and Human Services CDC article change your opinion that the COVID-19 vaccine is effective to prevent the spread of COVID on ships deployed -- Navy ships that have been deployed?
A No, it would not.
Q Okay. And that's despite the fact that it had a 98 percent vaccination rate, according to this article?

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A Well, I would highlight the article says, "Vaccination, in combination with other prevention strategies, resulted in a much lower attack rate of COVID."
Q Okay. And all of the infections, at least according to this article, on that ship were among vaccinated individuals. Is that right?
A Yes.
Q Okay. And there were other measures taken on that ship to prevent further spread. Is that right?
A Correct.
Q And there was no spread among -- spread of COVID-19 or no reported COVID-19 infections among any unvaccinated sailors deployed on that ship, right?
A I don't recall if it says in here whether any of the unvaccinated were close contacts.
Q Okay. So perhaps then on this deployment they were able to maintain social distancing among Service members on that ship?

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A Yeah. So again, the report says the outbreak in this environment suggests that high vaccination rates, in combination with the other prevention measures, can substantially reduce the spread despite the high transmissibility.
Q Does this article change your opinion that unvaccinated Service members or crew members on this -- sailors on this deployment were detrimental or could be detrimental to the mission?
A It does not.
Q Okay. Why?
A Well, I'll highlight the sentence that says, "Among the 22 infected personnel, all were fully vaccinated. No patients required hospitalization or supplemental oxygen and no deaths occurred."
So I don't know if the -- in the tiny fraction of the crew that was unvaccinated, 2 percent, serendipitously didn't happen to have close contact. But our experience shows if they had, that we could not with the some confidence make the assumption that they would not have

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required hospitalization, supplementation oxygen or death.
Q Were -- were the unvaccinated Service members who were on this ship at the time of the COVID-19 infections detrimental to this mission, the mission of this ship?
MR. CARMICHAEL: Objection. Speculation. Lack of foundation.
THE WITNESS: The unvaccinated members on this ship decreased the medical readiness of the ship. They presented a risk if they had been a close contact and in this case had become infected with the Delta variant.
The data is clear, they would have been at a higher risk of more severe symptoms and at a higher risk of hospitalization. They're also at a higher risk of death based on the Navy experience.
MR. STEPHENS: Okay. Objection. Nonresponsive.
BY MR. STEPHENS:
Q My question is: Did that happen?

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Not what could have happened, but what actually happened on this ship.
MR. CARMICHAEL: Objection.
BY MR. STEPHENS:
Q Were the unvaccinated Service members detrimental to this ship accomplishing its mission?
MR. CARMICHAEL: Objection. Lack of foundation. He just said he doesn't recall this -- this incident, so his knowledge is coming from this article.
But you can answer the question.
THE WITNESS: The unvaccinated -- the small 2 percent of this crew that was unvaccinated presented a higher risk of becoming severely symptomatic. And if you're saying in this specific vignette in Reykjavik, Iceland in -- in July 2021, looking in the review view mirror, did that happen? The answer is no.
(Lescher Deposition Exhibit Number 10 marked for identification.)
BY MR. STEPHENS:
Q Okay. Admiral Lescher, I have handed

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you a document marked as Deposition Exhibit 10. And it's from a journal, Military Medicine. Are you familiar with that journal?
A I'm not.
Q Okay. This was not produced in --
MR. CARMICHAEL: Just a --
MR. STEPHENS: Go ahead.
MR. CARMICHAEL: Yeah, I would just make a note for the record that what is produced -- what was handed appears to be pages 178 through 180, and not the prior pages or any latter pages. But you can go ahead and ask your question.
THE WITNESS: I'm sorry, what was the question?
BY MR. STEPHENS:
Q The question was whether you were familiar with the journal, Military Medicine. And I think your answer was no?
A No.
Q And this is not a document that was produced to us in discovery. And I -- have you seen this before?

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A I have not.
Q Okay. If you'd like to take the time to read it, I do have a couple of questions about this, about the facts discussed in this article as well.
A Yeah, please.
Okay.
Q Okay. Admiral Lescher, you've had a chance to review the document that's marked as Lescher Deposition Exhibit 10. Is that right?
A I have.
Q And it is from a journal, Military Medicine, or at least that's what it indicates at the top of the page, the first page, 178.
Do you see that?
A I do.
Q And it's -- the title of this is "U.S. Navy Aircraft Carrier Prevents Outbreak at Sea in Midst of COVID-19." Do you see that?
A I do.
Q And the author is CDR Veronica E. Bigornia. Do you see that?

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A I do.
Q What is -- what does CDR stand for?
A Commander is her rank.
Q Commander.
Do you know Commander Bigornia?
A I do not.
Q Okay. And according to this article, she was the senior medical officer on the USS HARRY S. TRUMAN, which was deployed from Norfolk, Virginia in November of 2019 with a crew of 5,461 personnel. Is that --
A Yes.
Q -- right?
Okay.
A She's referring to the Strike Group, which is TRUMAN, and as shown below, it includes a destroyer squadron and an embarked carrier wing.
Q Okay. Multiple ships?
A Yes.
Q Okay. And the crew between the multiple ships was 5,461 personnel. Is that right?
A Correct.

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Q Okay. And the deployment, at least according to her account, it led -- the striker left November 2019, left Norfolk, Virgina. Is that right?
A Correct.
Q And it returned home June of 2020?
A Yes.
Q And at the time it returned home in June of 2020, it -- there had been reported zero cases of Coronavirus on any of the ships that were part of that strike group?
A Correct.
Q All right. And this was -- you mentioned the ROOSEVELT as an example of a ship being deployed and having a -- being negatively impacted by COVID-19. Is that correct?
A Uh-huh.
Q And the ROOSEVELT was around what time, do you recall?
A So she first saw her COVID cases, as I recall, in the March '20 time frame.
Q The ROOSEVELT?

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A The ROOSEVELT, correct.
Q Okay. So this was on or around the same time. This was a separate strike group that was deployed at least for a period of the time when the ROOSEVELT was --
A Yeah, no, I mean -- no, this is a strike group that deployed pre-pandemic.
Q Right.
And it remained deployed, at least for a period of time in which the ROOSEVELT was also deployed. Is that right?
A Correct.
Again, the -- the document clearly states that once COVID received pandemic status in that time frame in March, they did no more port visits.
Q And --
A This is an example of a strike group that deployed pre-pandemic, and then in the pandemic, cut off all port visits and controlled exposure that way.
Q Is it also -- so is it an example of

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a strike group that employed mitigation measures, and as a result of those mitigation measures, reported zero cases of COVID-19 infection?
A In the context of their -- the situation, Commander Bigornia implemented strong -- strong countermeasures. It's noteworthy that she refers to them as "heroic efforts" on page 180. "Heroic efforts were given to the prevention of an outbreak at sea."
Q Is that -- sorry, go ahead.
A It's admirable. But it gets to my point on the type of measures that were taken in the 2020 time frame were heavy and hard and affected strongly the quality of Service that a -- in my experience is not an enduring approach. So we would not expect, as a matter of routine, deployments from here in perpetuity to have heroic measures needed to be taken.
Q And on the -- for the USS TRUMAN Carrier Striker that's discussed here, are you -- are you assuming or suggesting that you have some knowledge of these mitigation measures that were

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taken having a negative impact on the sailors who were part of this deployment?
A Yes. Well, I'm saying what I read here, stopping all port visits from March on, even things as local as the essential personnel flying aboard to keep the -- the ship ready, the -- the aircrew will basically be given box lunches in their aircraft, the pre-embark quarantine, other elements, they're the right kind of measures for sure. But yes, those type of kind of measures impact quality of Service.
Q Okay. And what do you mean by "quality of Service"?
A I mean the quality of life onboard ship.
Q Okay.
A The stress of serving in operational units forward.
Q Do you think that the quality of life or stress of serving for a Navy Service member would be negatively affected if that Service member has a very strong religious belief and is denied a

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religious accommodation for the COVID-19 vaccine?
A I believe that affects their spiritual health.
Q Okay. And would spiritual health also be something that would affect quality of Service on a -- on a ship or within the Navy more broadly?
A That would be a factor, yes.
Q Okay.
MR. CARMICHAEL: We've been going about 85 minutes.
MR. STEPHENS: Okay. Do you want to do a break?
MR. CARMICHAEL: Yeah. I mean I'm usually at 90 minutes, but that's --
MR. STEPHENS: Yeah, that's fine, we can do one.
MR. CARMICHAEL: Do you want to do one now?
MR. STEPHENS: Yeah, we'll take a break.
VIDEOGRAPHER: We are going off the

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record. The time is 11:04 a.m. This concludes Media Unit Number 2. Thank you.
(Recess from 11:04 a.m. to 11:22 a.m.)
VIDEOGRAPHER: We are back on the record. The time is 11:22 a.m. And this is the beginning of Media Unit Number 3.
Counsel, you may proceed.
BY MR. STEPHENS:
Q Admiral Lescher, you understand that you're still under oath, correct?
A I do.
Q Did you -- you mentioned the ROOSEVELT and the COVID-19 infections that occurred on the ROOSEVELT deployment several times in your testimony today.
A I'm sorry, the what?
Q The ROOSEVELT.
A Yeah, the -- March '20?
Q Correct?
A Yeah.
Q Correct.
And did you, as VCNO, conduct or

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initiate, oversee an investigation of the chain of command's actions that were involved with that outbreak?
A I did not. I was not yet VCNO.
Q Okay. And you -- so you became VCNO in --
A End of May of '20.
Q Okay. So after that investigation was completed or after it had been initiated?
A After it was completed.
Q Okay. Are -- are you familiar with that investigation?
A I'm generally familiar with it, not --
Q Okay.
A -- not the details.
Q And what do you know about that -- the -- the findings from that investigation?
A Can you be more specific?
Q Sure. Sure.
You said you were generally familiar with the investigation. Do you know -- are you

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familiar with any of the findings that came out of that investigation or anything more specific than just that --
A Yes.
Q -- an investigation occurred?
A So I'm most familiar with the judgments that the CNO made regarding the Navy's response to it, both at the strike group commander and the ship's CO level.
Q Oh, okay. So you're -- so you're familiar with decisions that were made as a result of that or based on that investigation --
A Right.
Q -- but not the specific findings or underlying analysis or investigation that --
A Not --
Q -- was conducted?
A Not in detail.
Q Okay. Have you read any reports discussing that investigation that you recall?
A No.
Q Okay. Do you -- do you ever review

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any reports by RAND Corporation?
A I'm sure I have, but very infrequently.
Q Okay. Is -- is RAND Corporation -- does RAND Corporation, is it a contractor with -- with the Navy in certain circumstances?
A I believe they're a Federally Funded Research and Development Agency at the RDC. The primary -- the primary Navy FFRDC is Center for Navy Analysis, so that's who we more commonly work with. Infrequently, I -- I can remember seeing RAND products. I'm sure it's -- I'm sure the Navy entities contract with them, but not -- you know, not frequently.
Q Okay. You've mentioned a few times in your testimony that there is a differential between vaccinated Service members and unvaccinated Service members in terms of the number of cases and the -- and also the severity of those cases.
A Yes.
Q And is there -- if there were -- were -- were very small -- or if there were little

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differential between unvaccinated and vaccinated, would that change your opinions as to requiring the vaccine -- or the vaccine mandate?
MR. CARMICHAEL: Objection. Calls for speculation. Hypothetical, has unstated assumptions.
You can answer the question.
THE WITNESS: If there was a small differential rate in prevalence of death, then the answer's no. It's still a high consequence, so the fact that there's incremental difference is still significant.
BY MR. STEPHENS:
Q Okay. And how would you measure severity of cases -- I think you had mentioned severity or -- in discussing, you know, that being one of the measures of effectiveness of vaccine.
A Right.
Q Is severity in your -- by you -- by your estimation, do you consider that in terms of of number of deaths or is there some other measure that you look to?

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A I believe you characterized severity by number of deaths, number of hospitalizations, number of medevacs, number of significant symptoms. Although, those would degrade the readiness of an operational unit as those individuals work to recover.
Q If there were no differential in the number of deaths between unvaccinated and vaccinated Service members, would that change your opinion?
A So the next level of severity I would look at is number of hospitalizations. And I think the same principle applies. That significant adverse event to any individual to be hospitalized for a disease like this, and even if those -- even if there's incremental advantage to prevent the hospitalization or death, then I think that's a compelling use of -- of the vaccination.
Q Okay. And if there were no -- so then if there were no differential between unvaccinated and vaccinated Service members with respect to hospitalizations as a result of

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COVID-19, would that change your opinion?
MR. CARMICHAEL: Objection. Calls for speculation and hypothetical. It includes unstated assumptions.
You can -- you can answer the question.
THE WITNESS: The commander's perspective, I would bring to that. So then I would go to the next level of consequence, which is, what's the degree of the severity of symptoms as they're able to remain in the unit. And so now we're talking -- we're not talking about the risk of spreading, we're simply talking about the risk of how severe a manifestation an individual has.
And so we -- this -- you know, there's no hard-and-fast numbers there, but this would be the judgment of the commander. If there's an ability to differentially decrease the severity of symptoms so that a crewmember who is pulled off to isolate was able to do that for a shorter period or could, with other countermeasures, still be effective in the crew,

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then I think that would be considered.
BY MR. STEPHENS:
Q Have you reviewed or are you familiar with any data or analysis of the differential between vaccinated and unvaccinated Service members and those types of symptoms that require someone to, for example, be removed from that job, the third category you said you'd look at?
A Yeah. I'm familiar with the differential -- that does sound familiar with the differential hospitalizations. On your question, I have not seen the data. And that's, again, where I rely on the medical professionals who have conveyed. But there are differences in severity of symptoms between vaccinated and unvaccinated people.
Q Okay. And if there were no differential with respect to the symptoms for vaccinated and unvaccinated individuals for COVID-19, then would your opinions change on the vaccine mandate?
MR. CARMICHAEL: Objection. Calls

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for speculation. And the assumption -- contains unstated assumptions.
You can answer the question, Admiral.
THE WITNESS: I believe the judgment of operational impact at that point -- so you're saying there's no -- between vaccinated and unvaccinated, assuming hypothetically that there was no difference in magnitude of illness, then the value proposition in the vaccine to the commander becomes, "Is there a differential in spread and the likelihood to get it?" And if obviously one gets it, they're more likely to spread it to the crew.
BY MR. STEPHENS:
Q And if there were no differential, then your opinion would or would not change as to the necessity of a mandate?
MR. CARMICHAEL: Same objection. Calls for speculation, hypothetical, and contains unstated assumptions.
You can answer the question.
THE WITNESS: If there were no

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difference in -- between the vaccinated and the unvaccinated population in terms of protection against severity or protection in terms of prevalence, then I believe that would conceptually change the conversation.
BY MR. STEPHENS:
Q And so is there some degree of differential or some level of differential between the two that would -- that would -- at which point your opinions as to the necessity of the mandate would change or is it that any differential between vaccinated and unvaccinated is enough?
MR. CARMICHAEL: Objection. Calls for speculation.
You can answer the question.
THE WITNESS: Any differential in death, any differential in hospitalization, I believe would be compelling. The consequence of that differential -- if those are the same and now we're talking about mission impact due to members isolating and not being available, weighing that again -- so we're weighing again impact to other

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people's health from having an unvaccinated person, impact to the unit, impact to the mission versus the spiritual health of the individual, then, as Delta -- as Delta death, Delta hospitalization go away and we're now just talking about Delta mission impact for symptoms, then you -- then you have -- then I think you have to have a conversation on the merits of each case. What's the context by which I would be taking and accepting an increased likelihood of members being more impacted and coming off mission?
And, again, to your point, if that difference went away, then what's the consequence of a greater spread if that exist, in terms of people who test positive now having to isolate and come off task in the unit?
BY MR. STEPHENS:
Q Would -- would you consider in that analysis the impact of -- a negative impact on Force retention from the vaccine mandate?
A I think the -- the way I would think through that, members that are retained that cannot

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serve in operational units is not a strong -- it's not a strong proposition. That's why these medical readiness standards exist, so that the people that we have are able to contribute.

And that's essentially why we are retaining the Force, for them to -- we retain -- we retain people in our Force who meet many different types of standards so that they can effectively contribute in high-risk, harsh environments that the -- the Naval Force operates in.

Q And so is it -- is it your position that there is no accommodation that could be provided to individuals seeking a religious exemption from the COVID-19 vaccine mandate?

A No.

Q Why not?

A Why not?

Q That -- that is your opinion or that is not your opinion?

A I think religious accommodations, again with that not being directly under my purview, but we talked about there's a -- a

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judgment to be made, spiritual health of the individual versus the health risk to that individual's shipmates and the performance of the unit. And that's the -- that's the judgment that has to be made on a case-by-case basis.

Q Okay. And if you were making that judgment, would you expect that there would be zero religious accommodations or religious exemption requests approved --

MR. CARMICHAEL: Objection. Calls for --

BY MR. STEPHENS:

Q -- that were truly an individualized assessment?

MR. CARMICHAEL: Objection. Calls for speculation.

THE WITNESS: I believe your question is hypothetically would I expect all the cases to resolve the same way? No.

(Lescher Deposition Exhibit Number 11 marked for identification.)

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BY MR. STEPHENS:

Q Admiral Lescher, I've handed you a document marked as Deposition Exhibit 11. It was produced in discovery by the Defendants -- by Defense Counsel, and is Bates stamped NSW00007831 through 7835.

Do you have that document in front of you?

A 7831, yes, I have in front of me. Oh, and 32, 33, 34, and 35.

Q Okay. Is this a document that you're familiar with or that you've seen before?

A It is not.

Q Okay. Do you know what this document is?

A If you'd give me a moment and let me take a look at it.

Q Sure.

A Okay.

Q This is not something that you've seen before. Is that right?

A That's correct.

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Q Okay. It's not something you've then considered in preparing your declaration?

A Correct.

Q Is this a document that would be useful to you in making a determination -- an individualized determination of the risk associated with allowing an -- a religious exemption for an individual Service member?

A So before answering that, I just want to highlight again, that's not my role. I'm starting to get a little uncomfortable with answering those hypotheticals because were that my role, I would study that pretty hard. I would inform myself in a more detailed way than -- than this situation here.

Q Okay. So you would consider, for example, things like incidents rate -- incident rate in certain areas where an individual might be deployed. You'd familiarize yourself with this kind of information?

A I think that's fair.

Q Okay.

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(Lescher Deposition Exhibit Number 12 marked for identification.)

BY MR. STEPHENS:

Q Admiral Lescher, I've handed you a document marked as Lescher Deposition Exhibit 12, Bates stamped NSW000007808 through 7812.

Do you have that document in front of you?

A I do.

Q And you've had a chance to review that today?

A I just looked at it, yes.

Q And you had not seen that or had you seen that before reviewing it at your deposition just now?

A I have not seen it before.

Q Okay. So it was produced in response to our request for documents from the Defendants and produced to us by Defendants' counsel.

Is this -- this is similar to the prior document that was marked as Deposition Exhibit 11. It -- and I have similar questions.

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Is this a document that you would consider or would want to consider if you were in the position of making individualized assessments as to whether a religious accommodation should be granted or denied?

MR. CARMICHAEL: Objection. Calls for speculation. I think Admiral Lescher has already made clear that he's not involved in that particular process and does not do these religious accommodations.

But you can answer the question, Admiral.

THE WITNESS: I think the -- this is going to be the context that would be an element that would be considered.

BY MR. STEPHENS:

Q And is that because, at least based on your review of this document today, it indicates that there are different risks -- as with the prior document, Exhibit 11, there are different risks associated with different geographic areas?

A Right. So, again, not having done

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these, and seen these, but it seems to me a judgment that would be made is: What's the impact to the unit? What's the risk? Is the unit fixed geographically in a very dynamic COVID environment? How -- you know, how dynamic are these trends? How long, given those elements, would that religious accommodation make sense?

Those seem, to me, to be part of the contours, I think heavily caveated, I haven't really prepared to do that work so . . .

Q Right.

A I think the other thing that I would like to highlight on that is that type of local context becomes increasingly less relevant if the unit or the individual is expected to be worldwide deployable. So that local context obviously is very ephemeral and subject to change and subject to world events. And so if we're talking about operational units that are maneuver units that deploy, then that local context becomes not very significant in my perspective.

Q Does the Navy require certain

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vaccinations only for Service members who are deployed to different geographic regions of the world?

A It's my understanding the answer is yes.

Q Okay. And so at least in the context of some vaccines that the Navy requires, the Navy does take into account the risk associated with deployment to certain geographic regions. Is that right?

A Yes.

Q Okay. And so the -- hypothetically, the Navy could make the same analysis or analyze the same risk with respect to COVID-19 vaccine and deployment?

MR. CARMICHAEL: Objection. Calls for -- same -- same -- same objection, that it calls for speculation. And Admiral Lescher is not involved in the -- these particular religious exemptions.

THE WITNESS: The judgment there, it seems to be, again the risk judgment, is how

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certain are we that this member will be deployed to, and confined to, that region versus being worldwide deployable.

The examples you cite are typically additive vaccines on top of the worldwide medical readiness standard. So when there's a local condition with a local endemic, that's typically, I believe, where you would see additional vaccinations that are required to control for that risk, but it doesn't eliminate the foundational vaccinations which are required to be worldwide deployable since both the Navy and Marine Corps are expeditiously Forces and -- Forces and readiness.

MR. STEPHENS: All right. Why don't we take a lunch break. How long do you all want?

Let's go off the record.

VIDEOGRAPHER: We are going off the record. The time is 11:53 a.m. This also concludes Media Unit Number 3. Thank you.

(Recess from 11:53 a.m. to 12:33 p.m.)

VIDEOGRAPHER: We are back on the

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record. This is the beginning of Media Unit Number 4. The time is 12:33 p.m.

Counsel, you may proceed.

BY MR. STEPHENS:

Q Good afternoon, Admiral Lescher. You understand that you're still under oath, correct?

A Yes.

Q I'm going to hand you a document that we will mark as Deposition Exhibit 13.

(Lescher Deposition Exhibit Number 13 marked for identification.)

BY MR. STEPHENS:

Q I'll represent to you that this a -- Deposition Exhibit 13 is a copy of the Supreme Court opinion on the Defendants' motion for partial stay in this case.

Have you seen this document before?

A I've seen excerpts of this document, not the whole document.

Q Okay. The excerpt that I would like to direct your attention to is on page 2, bottom of the page or the last paragraph, the second sentence

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of -- the third sentence of the last paragraph, it says, "As Admiral William Lescher, Vice Chief of Naval Operations, explained, quote, Sending ships into combat without maximizing the crew's odds of success, such as would be the case with ship deficiencies in ordnance, radar, working weapons or the means to reliably accomplish the mission is dereliction of duty. The same applies to ordering unvaccinated personnel into an environment in which they endanger their lives, the lives of others and compromise accomplishment of essential missions."

Do you see that language?

A Yes.

Q And that language comes from your declaration, the declaration that is marked as Exhibit 1. Is that correct?

A It does.

Q Okay. The second sentence that I read, that says, "The same applies to ordering unvaccinated personnel into an environment in which they endanger their lives, the lives of others, and compromise accomplishment of essential missions."

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Would the same apply to ordering Service members with increased risk of severe illness from COVID-19 into an -- into a deployment?

A I'm not sure I understand the question.

Q Sure.

So -- so you -- so the language from your declaration that's quoted here is suggesting that ordering individuals who are unvaccinated into an environment, such as on a deployment for example, would be a dereliction of duty because it presents some additional degree of risk.

Is that fair to say?

A Yes.

Q Okay. Would the same be true if -- with respect to ordering individuals on to -- into a deployment who are at high risk of severe illness from COVID-19?

MR. CARMICHAEL: Objection. Calls for speculation. And calls for a hypothetical, unstated assumptions.

You can answer the question.

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THE WITNESS: Okay.
So let me work to that answer just as I would think through it. So what I am clearly saying here is when confronted with a level of risk that is manifested in dead sailors, hospitalized sailors, for leaders not to use the most effective available tool to a known avoidable risk is the issue I'm highlighting here.
Your question is, does it apply to deployments? And I think conceptually it's similar, but it's obviously the judgment to be made on the specifics. But where we left off before lunch, for example, where combatant commanders require additional vaccines if a member is being deployed to an area with an endemic or a local increased threat to health is the same concept.
BY MR. STEPHENS:
Q Okay. And are there certain individual Navy Service members who are at a higher risk of severe COVID-19 symptoms than other Navy

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Service members if they contract the disease?
A I'm not a medical expert, but I believe that's a true statement. I believe there's other factors.
Q Okay. So if there are such individuals who are at higher risk of severe symptoms in the event that they contract COVID-19, would you support deploying those higher-risk individuals despite the risk that exists from COVID-19 and the higher risk those individuals face?
MR. CARMICHAEL: Objection. Speculation. Calls for hypothetical, unstated assumptions and lack of foundation.
THE WITNESS: Yeah, there's quite -- there's quite a lack of detail there. But I support deploying individuals that meet our medical readiness standards. And I believe our medical readiness standards are designed to specifically address that issue.
To the extent an individual has -- is at high risk for a certain deployment

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location, then it's my expectation those conversations would take place with a medical professional to make a case based on -- a judgment based on the specifics as opposed to generalities.
BY MR. STEPHENS:
Q Okay. And so it would be within, for example, the discretion of the commander in consultation with a medical expert?
A Meeting specified medical readiness standards would not be at the discretion. If we're talking about a -- a level of conversation above and beyond medical standards, then I think that's correct.
Q Okay. I'll hand you a document that we'll mark as Exhibit 14.
(Lescher Deposition Exhibit Number 14 marked for identification.)
BY MR. STEPHENS:
Q Admiral Lescher, I've handed you a document that we've marked as Lescher Deposition Exhibit 14, which was produced in response to

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Plaintiffs' discovery request, and is Bates stamped NSW00000043 through 48.
Do you have that document in front of you?
A I do.
Okay.
Q You've had a chance to review the document that's marked as Deposition Exhibit 14. Is that correct?
A Yes.
Q And this is -- what is this document?
A This is the Navy's Standard Operating Guidance Version 5 of January of this year.
Q Okay. And what is a NAVADMIN?
A It's a type of message that essentially goes Navy wide, broadly distributed.
Q Okay. And who issues NAVADMINs?
A They can be issued from generally senior flag officers. This one by Admiral Merz, Deputy Chief of Naval Operations.
Q And where do you see on here that it was issued by Admiral Merz?

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A The very last line, paragraph ten on page 48.
Q And what date was this issued?
A The date time group is 15 January of '22.
Q And your declaration you signed on January 19th, 2022. Is that correct?
A Correct.
Q So this document was -- this NAVADMIN was issued and distributed to the Navy prior to you executing your declaration?
A Yes.
Q Had you reviewed this document prior to signing your declaration?
A So I don't recall specifically whether I did or not.
Q Okay. Did you have any input or role in the -- in the substance of this NAVADMIN?
A No.
Q Do you typically review NAVADMINs before they are, I'll say, issued or distributed Navy-wide?

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A I typically do not.
Q Okay. Who has -- who would be responsible for reviewing this NAVADMIN before it was sent out by Admiral Merz?
A I think that varies, but I recall seeing e-mails where Navy, typically a Three-Star, who's getting ready to release a NAVADMIN, will send an e-mail saying, "Hey, in the upcoming period, I expect to release this NAVADMIN."
And as I recall, those are generally directed to CNO, is my recollection. It may be a -- a broader shop group. They certainly -- I see them, or they come into my -- my in-box.
Q This NAVADMIN allows for operations and deployment of high-risk personnel.
A It --
Q Is that correct?
A It stipulates a process by which those type of decisions can be made.
Q And so it -- it provides that under certain circumstances for high-risk personnel can be deployed or can be operational, is that right,

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at the discretion of the commander?
A Right. So on a case-by-case basis, the commander is advised by medical providers and is reported up echelon, can make those type of decisions.
Q Okay.
MR. CARMICHAEL: Just objection to misstating -- misstating the document. It says "vaccinated high-risk personnel."
BY MR. STEPHENS:
Q In paragraph 7.d on the third page of -- what page is it -- it's Bates stamped NSW00000046, paragraph 7.d. Do you see that paragraph?
A I'm sorry, 7 "B" or "D"?
Q "D" as in dog.
A I do see that.
Q "Vaccinated high-risk personnel: The decision to operate and deploy with vaccinated high-risk personnel rests with the commander, as advised by medical providers, who must report intentions to their immediate superior in command

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(ISIC). High-risk personnel shall be PCR viral tested within three days of embarking."
Is that -- did I read that correctly?
A Yes.
Q And so the provision of this NAVADMIN that I was asking about, I was referring to this -- this paragraph.
And is it correct that this paragraph allows high-risk personnel to be operational and deployed as long as they're vaccinated, if approved by the commander?
A On a case-by-case basis, inconsistent with what you read, the commander is advised by their medical provider, and as reported up echelon, can make those decisions as per this standard operating guidance.
Q Okay. And the Navy does not allow unvaccinated personnel to be operational or deployed even if the commander -- even if that person's low risk and the commander believes that it -- with advice from a medical adviser, recommends such?

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A I believe there's a stipulation where Naval component commanders can make that decision. I'm not 100 percent sure.
Q And what component or what circumstances are you referring to?
Do you know the specifics of that?
A So --
Q Or any more details of that?
A Standard operation guidance talks about operational Forces and the requirement that 100 percent of the operational Forces be vaccinated.
I believe, if I recall correctly, that there's a stipulation where a Naval component commander essentially can make a determination where it found compelling on a case-by-case basis.
Q Is that in -- in -- do you know the guidance or the NAVADMIN or -- or where that would be?
A I believe that's in Standard Operating Guidance 6.0, the one that follows this one.

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Q Okay. And so looking at 7.d, is it fair to say that -- that commanders have discretion with the advice of medical providers to deploy and/or deem operational a high -- a vaccinated high-risk individual --
A Yes.
Q -- Service member?
A Yes.
Q Okay. And what percentage, approximately, if you know, of Navy Service members are high-risk personnel?
A I don't know.
Q Do you know what qualifies as high -- as a -- who qualifies or would -- would indicate that someone is within that definition of a high-risk personnel?
A At a very general level, I believe there's certain medical conditions or history of medical conditions that conceptually would place one in a high-risk status. But, again, that's -- that's not in the vice chief's purview to review or make those decisions, so I'm not strongly familiar.

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Q Okay. If you look at the page -- at Deposition Exhibit 14, the page that is NSW000000044, paragraph 4.c.
A I'm sorry, what document are we looking at?
Q Exhibit 14 --
A Yeah.
Q -- the one that's the NAVADMIN.
A Okay.
Q And the last two digits of the Bates Number are 44. And it's paragraph 4.c.
A Uh-huh.
Q It provides a definition of high-risk personnel. Do you see that?
A Yes.
Q And that paragraph says, "High-risk personnel: Those individuals designated by a medical provider who meet the CDC criteria for increased risk of severe illness. Qualifying conditions are included on the CDC website."
Do you see that?
A Yes.

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Q Okay. So for purposes of -- of this NAVADMIN, high-risk personnel are those personnel who are at severe risk of COVID-19 illness as defined by the CDC. Is that right?
A It doesn't say COVID, it says --
Q Or -- or of -- of severe illness?
A "Who meets CDC criteria for increased risk of severe illness," correct.
Q Okay. And so you said it doesn't say COVID. Are you saying that it somehow excludes individuals who are at severe risk of illness from COVID?
A No. I'm just saying --
Q Okay.
A -- it says increased risk of severe illness.
Q Sure. Okay.
All right. And so that definition of high-risk personnel is -- is -- is incorporated and -- and used in paragraph 7.d --
A Right.
Q -- the paragraph that allows

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commander's discretion to deploy his-risk personnel --
A Vaccinated.
Q -- or vaccinated -- or vaccinated with advice of --
MR. CARMICHAEL: Objection.
BY MR. STEPHENS:
Q -- medical providers?
MR. CARMICHAEL: Objection. Lack of foundation.
You can answer the question.
THE WITNESS: Yes, that's -- that's what --
BY MR. STEPHENS:
Q Okay.
A -- is in paragraph 7.d.
Q Okay. And -- and you don't know approximately what percentage of Navy personnel are high risk, I believe you already said that you didn't know that, correct?
A Correct.

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(Lescher Deposition Exhibit Number 15 marked for identification.)
BY MR. STEPHENS:
Q Turning to now a document that we'll now mark as Lescher Deposition Exhibit 15.
A Okay.
Q Okay. Have you had a chance to review the document that's marked as Lescher Deposition Exhibit 15?
A I have.
Q Okay. I'll represent to you it is a document from Center for Disease Control and Prevention, or the CDC.
Do you see that at the top of the page?
A Yes.
Q Okay. And the CDC is -- looking back at Lescher Deposition 14, and in paragraph 4.c, that defined high-risk personnel, it references, "CDC Criteria for Increased Risk of Severe Illness."
A Yes.

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Q Do you recall that?
Okay. And here at Exhibit 15 is a document from the CDC, that the middle of the first page states, bullet -- first bullet point, "Having obesity increases the risk of severe illness from COVID-19. People who are overweight may also be at increased risk."
And then the next bullet point says, "Having obesity may triple the risk of hospitalization due to a COVID-19 infection."
Do you see that?
A I do.
Q And so does that indicate to you that within the definition of high-risk personnel would be individuals who are -- who are obese?
A Yes.
MR. CARMICHAEL: Objection. Lack of foundation that this -- that this is specifically that 4 -- paragraph 4.c of -- of Deposition Exhibit 14 is referring to this document.
You can answer the question.

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BY MR. STEPHENS:
Q Do you -- do you dispute that individuals who have obesity are at higher risk severe illness from COVID-19?
A I'm not medically qualified to make the determination. I don't dispute Exhibit 15.
Q Okay. And so the -- the paragraph we looked at, 7.d, vaccinated high-risk personnel in Exhibit 14, it would allow the deployment of obese Service members who were vaccinated despite the risk of -- a higher risk of severe illness from COVID-19 for such individuals if the commanders exercise their discretion to deploy such individual in consult -- consultation with a medical adviser?
A Yes. So -- yeah, precisely that, on a case-by-case basis, as I read the guidance, in consultation with the individual and the medical provider, to -- to make that determination.
Q Okay. Are you aware that approximately 25 percent of the Navy is obese?
MR. CARMICHAEL: Objection. Lack of foundation.

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You can answer the question.
THE WITNESS: I was not -- I was not aware of that specific statistic, but I was aware that it's generally on that order.
BY MR. STEPHENS:
Q Approximately a quarter of the Navy is -- is identified as obese?
A (Moving head up and down.)
Q And so approximately a quarter, or 25 percent, of the Navy would fall within the --
A Can I ask you the -- I'm sorry. Can I ask you the source of that?
Q Sure.
(Lescher Deposition Exhibit Number 16 marked for identification.)
BY MR. STEPHENS:
Q I can point you to --
A Yeah.
Q -- save us time to page 33 of the document that's been marked as Deposition Exhibit 16, which is a Service profile of the Navy.
And in particular under the -- the

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first chart middle of the page there's a measure of obesity percent and then Navy value.
Do you see that?
A I do.
Q And that value, it says 25 percent --
A It seems odd that it's outside the DoD range, but I -- I do see that figure.
Q Okay. And this -- this document -- are you familiar with this document, "Health of the Force"?
A No.
So this is a 2020 document? Do you have -- what was the date of the data?
Q Well, it says at the bottom of the page that -- on page 33 in the footnote the -- the Footnote A, it says, "Number as of June 2020." So presumably it's, you know, at some point after June of 2020, but I don't know the specific date of this document.
Would you -- would you -- do you -- do you ask because you believe there's been some change in the percentage?

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A I do think that it's dynamic. You know, one of the impacts of COVID was, in terms of access to gyms and facilities, that we saw at our shore installations. But yeah, I'm -- I'm always interested in the source and -- and the timing, so . . .
Q Well, it's a 2020 report, and so, you know, it --
A Yeah, I --
Q The obesity percentage presented in this document, DoD, Health of Force for 2020, it states 25 percent of the Navy falls within that high-risk --
A Yeah, point taken.
Q -- category. And it may be slightly higher or lower than that now. Is that -- is that fair to say?
A It's central, yeah.
Q That's higher, at least according to this report, than any of the other branches in the military. Is that right?
A That's what I saw. Well, I saw it at

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the high end of the DoD range, so I didn't look at the other services, but it makes sense.
Q Okay. And then under -- on page 33 where it says, "Additional Information," it explains that obesity can contribute to certain health conditions. Is that right?
A Yes.
Q Okay. So at least according to this DoD report, that's marked as Deposition Exhibit 16, and then looking to Deposition Exhibit 14 and 15 as well, is it -- is it fair to say that approximately 25 percent of the Navy is at high risk of severe illness from COVID-19 infection?
MR. CARMICHAEL: Objection. Lack of foundation. Calls for speculation.
You can answer the question.
THE WITNESS: So based on the thread of the CDC, highlighting that obesity increases the risk of severe illness from COVID and the data on the demographics of the Navy Force, and the paragraph 4 supposition that the CDC criteria for increased risk of severe illness -- is that what

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Exhibit 15 says?
Yeah, it does, "Having obesity increases the risk of severe illness from COVID-19." Yeah, I follow that thread.
BY MR. STEPHENS:
Q Okay. And so then it would follow from that by looking at paragraph 7 -- 7.d of the NAVADMIN, that 25 percent of the Navy is at high risk of severe illness from COVID-19, despite being vaccinated or unvaccinated, they're at high risk of severe illness and that --
MR. CARMICHAEL: Objection. Lack of foundation.
You can answer the question.
MR. STEPHENS: I haven't asked the question, yet.
BY MR. STEPHENS:
Q Is it fair to say that based on Exhibits 14, 15, and 16, looking at paragraph 17 of -- of Exhibit 14, that 25 percent of the Navy is at high risk of severe illness from COVID-19; yet, paragraph 7.d of the NAVADMIN, in Exhibit 14,

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allows commander's discretion to make operational and deploy such individuals as long as they're vaccinated based on the commander's judgment with advice from medical providers?
A That's correct.
Q Okay. And the Navy has no such policy that you're aware of allowing commander's discretion with respect to unvaccinated personnel or Service members who are not at high risk?
A So referring to my earlier statement, I believe that there's a provision for Naval component commanders to make that judgment. As 7.d is written, this applies to vaccinated high-risk personnel only.
Q And do you agree with the Navy's decision to allow operations and deployment of vaccinated high-risk personnel knowing that approximately 25 percent of the Navy fall into the category of being at risk of severe illness from COVID-19?
A What was your question?
Q Do you -- do you -- do you agree with

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this position of allowing for this decision --
A I do.
Q -- to allow?
Why do you agree with that?
A Because it permits the commander to make risk decisions in the specific context of a case-by-case person, which I think -- I think we've talked earlier today, that's the -- that's the approach that the Navy -- that the Navy brings, accept risk when the benefit outweighs the cost, don't accept unnecessary risk, make risk decisions at the proper level. So it's very consistent with that approach.
As a hypothetical or as a vignette to illuminate this, I would imagine a commander talking to a medical provider and characterizing the risk: How obese is this individual? Are there other factors? What are mitigations if the choice is made to operate and deploy with a vaccinated high-risk person? What are the other mitigations that come into play, in terms of physical activity, diet, exposure, all of those elements?

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Those were all elements on how a specific case, it seems to me, would be determined in this context.
Q And in the context of a religious accommodation or request for a religious accommodation or exemption from the COVID-19 vaccine, should those same factors apply and/or same approach be applied?
A Again, not the purview of the vice chief, so we're starting to get into a hypothetical again. I haven't grounded myself in the guidance and the standards for that. The -- the same approach should be applied as it should be done on a case-by-case basis.
Q Okay. Would you support a policy or a decision to deploy an HIV-positive Navy SEAL on a mission, for example, to kill or capture a -- a high-value individual?
MR. CARMICHAEL: Objection. Lack of foundation. And hypothetical as unstated assumptions.
You can answer.

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THE WITNESS: The very direct answer is I'm not medically qualified to -- to make that decision. I'm trying to imagine by what parameters I would evaluate that. And it's -- I don't have the medical background to offer an informed opinion on that.

BY MR. STEPHENS:

Q What would you look to to make that determination, of -- of whether an HIV-positive, for example, Navy SEAL should be deployed on a mission -- on such a mission?

A Yeah, I think they're quite similar to the factors here in some respect: What's the risk of illness? What's the risk of trans medical readiness? What's the risk -- what's the increased risk of requiring a medical evacuation?

So without understanding all of the parameters of where that illness is now, it's fundamentally from a commander's perspective, are there elements -- first of all, is that -- is that a deviation from our medical readiness standards that essentially is driving us to accept a lower

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readiness standard? And then the commander has to go through the -- the -- this evaluation.

Does -- you know, I think you said in the context of a SEAL Team. So you're talking teams of four or fewer people. If that condition represents increased susceptibility to becoming ill, to -- to require medical evacuation, that forces a commander to accept a completely different risk calculus, when of one of four members has a higher risk of pitching out of a fight. And that can change mission design, that can shift risk to support elements. I think -- that's how I would think through that.

Q So -- so fundamentally it sounds similar to your -- to your discussion of the individualized assessment that would be involved in determining a deployment of -- of a high-risk individual, as we talked about, with respect to COVID-19, that individual has obesity, the commanders would evaluate the specific circumstances at issue in the mission or deployment?

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A Unless the medical advice is such that -- that the record -- the understanding of the illness is such that it doesn't require a case by case. You know, we -- you know, let's use an extreme, the common cold doesn't require a -- a case-by-case judgment.

So I just don't know the medical impact determination on HIV to say where it falls in that spectrum of increasing risk of death, hospitalization, and mission impact.

Q Okay. I'll hand you a document that we'll mark as Deposition Exhibit 17.

(Lescher Deposition Exhibit Number 17 marked for identification.)

BY MR. STEPHENS:

Q And while she's marking that, I'll ask you a follow-up question.

Do you know whether Navy SEALs or other members of Naval Special Warfare have to do blood transfusions in the field?

A I would expect that that is something that would be required.

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Q Okay. Is it something that could happen or that you're aware of occurring?

A By the nature of their mission, I believe that's -- it could happen.

Q Okay.

A Okay.

Q Okay. You've been provided a document that's marked as Lescher Deposition Exhibit 17. Do you have that in front of you and have you had a chance to review it?

A Yes and yes.

Q And have you seen it before today?

A I have not.

Q Okay. Do you know what this document is or what it indicates to be to you after having reviewed it?

A Yes. It looks to a policy change on this topic.

Q Okay. The subject is, "Policy Regarding Human Immunodeficiency Virus-Positive Personnel Within the Armed Forces." Is that right?

A Yes.

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Q And it's from -- well, it's dated June 6, 2022. Is that right?
A Yes.
Q And then who issued this policy?
A Secretary of Defense.
Q And who did it -- who was it sent to or who does it at least indicate on its face it was sent to?
A So it says, "Memo for Senior Pentagon Leadership, Commanders of the Combatant Commands and Defense Agency and DoD Field Activity Directors."
Q Okay. But you don't recall this being distributed to you?
A No.
Q Okay. The second sentence of the first paragraph -- the second and third sentence say, "Individuals who have been identified as HIV-positive are asymptomatic, and who have clinically confirmed undetectable viral load hereinafter, quote, covered personnel, end quote, will have no restrictions applied to their

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deployability or to their ability to commission while a Service member solely on the basis of their HIV-positive status. Nor will such individuals be discharged or separated solely on the basis of their HIV-positive status."
Do you see that?
A I do.
Q And so in light of this being a -- a memorandum from Lloyd Austin, the Secretary of Defense, is it fair to say that that's a new policy of the Department of Defense, which would include the Navy?
A Yes, I would think so.
Q Okay. And so as part of this policy, it -- its individual -- such individuals -- HIV-positive individuals states that it cannot be discharged or separately solely on the basis of their HIV-positive status. Is that right?
A Uh-huh.
Q And that they'll have no restrictions applied to their deployability, correct?
A Yes.

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MR. CARMICHAEL: Objection. Misstates the document. And that it also says, "Solely on the basis of the HIV-positive status."
You can answer.
THE WITNESS: I'm sorry. Highlight that again. Where is that?
MR. CARMICHAEL: I'm just stating --
THE WITNESS: I see what you're saying.
MR. CARMICHAEL: I'm just doing the whole sentence.
THE WITNESS: I got it.
MR. CARMICHAEL: Reading the whole sentence.
THE WITNESS: "No restrictions apply to deployability solely on the bases of HIV status," correct.
BY MR. STEPHENS:
Q It's true, at least -- to your knowledge, is it true that unvaccinated soldiers are being discharged solely because of their vaccination status?

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A Yes.
Q Okay. And the part of the first sentence that your counsel highlighted for you, does that have any impact on -- limitation on the statement in the first part of the paragraph that says, "There will be no restrictions applied to their deployability"?
MR. CARMICHAEL: Objection. Lack of foundation.
You can answer the question.
BY MR. STEPHENS:
Q The first part of the sentence says, "Individuals who have been identified as HIV-positive, are asymptomatic and who have clinically confirmed undetectable viral load will have no restrictions applied to their deployability."
A On that basis, on the basis of that condition.
Q On the basis of their HIV-positive status. Is that --
A Yes.

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Q -- how you read it?
A Yes.
Q Okay. And so does that -- does that mean to you that there can be some other basis for restricting them that has to do with their HIV status?
MR. CARMICHAEL: Objection. Lack of foundation.
BY MR. STEPHENS:
Q Or that their HIV status cannot be considered at all?
MR. CARMICHAEL: Just hold on, Admiral.
Objection to lack of foundation. The Admiral said this is the first time that he had seen the policy and has not been briefed on the meaning of the policy.
But you answer the question.
THE WITNESS: Yeah. So I'll take a stab at the question. Typically, I would get -- look to get educated further on other elements. But I believe your question was, would a reader

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interpret this to mean -- I'm sorry, say the question --
BY MR. STEPHENS:
Q Or would you -- would you interpret it to mean?
A To mean what?
Q That -- that HIV positive -- HIV status can be considered as one factor in determining deployability?
A Well, this -- based on this, you know, the emergent reading appears to say to me is that within the Department of Defense, Services will not make deployability go/no-go decisions for covered individuals based solely on the fact that while they have an undetectable viral load, they test -- they pop positive on HIV test.
Q Okay. And -- and because I -- you had no involvement or role in developing this policy. Is that correct?
A That's correct.
Q Okay. And -- and you weren't aware of it today -- before today?

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A Correct.
Q Did anyone consult with you about this policy before it was issued in any way?
A No.
Q Do you agree with the policy?
A As I'm still scanning this here, how I would interpret this policy is these are individuals that essentially have no virus in them, but they test positive based on undetectable residual virus. I think it's noteworthy that for both accessions and retentions, it says these covered personnel will be evaluated on a case-by-case basis. So that feature, we've talked about in the context of high risk, medical waivers, elsewhere. I think it's important in that it lets local understanding specific conditions be applied on a case-by-case basis. So it seems a reasonable approach to me.
(Lescher Deposition Exhibit Number 18 marked for identification.)
THE WITNESS: Okay.

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BY MR. STEPHENS:
Q Admiral Lescher, I've handed you a document that's been marked Lescher Deposition Exhibit 18.
And have you seen this document before today?
A I have not.
Q What does it appear to be to you?
A It is a NAVADMIN released by the Chief of Naval personnel on 28 June, so Tuesday of this week. And its subject is, "Active Component Active Duty Enlisted Force Management Actions." And yeah, that's its topic.
Q Okay. What does Force management policy or personnel policy generally involve? What is that?
A So how we size and shape the personnel, our sailors and officers, so Force management. You can see the -- the dynamics here in terms of keeping the size of the Navy where we need to fully resource our -- our ships is a thread here. And there's -- there's a strong shape as

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well. You know, I'm looking at -- at page 2, where it talks about filling sea duty, critical operational billets, sea duty billets, sea duty incentive pay. So a combination of the proper size and the proper shape of billets is what it appears to be targeted for upon first read.

Q And so there were -- in this -- on the first page of Deposition Exhibit 18, there's a sentence that says, "Due to the uncertainty regarding COVID-19 Pandemic vaccination losses in the recruiting environment, where competition for talent is especially tough, the Navy is opening the aperture for additional FM personnel policy levers to retain Sailors."

Do you see that language?

A Yes.

Q And -- and does that -- what does that mean, or what -- what does "opening the aperture" mean?

A So it lists a series of actions, or at least separation, so sailors who had requested to separate prior to essentially their Service

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obligation. So it's saying, hey, we're no longer going to permit that. For voluntary extension opportunity, for offering, again, in a very focused way sailors who desire to delay separation or retirement either due to higher tenure or other elements.

So the sentence "opening to aperture" means to get the proper size and shape of, in this case, our active enlisted force are changing certain policies to permit that.

Q Okay. And -- and in part that was -- that is, in part, addressing losses -- well, it says "COVID-19 Pandemic vaccination losses," that means losses of -- of sailors?

A Yeah. It says, "Due to the uncertainty," regarding, you know, the pace, the magnitude of sailors leaving the Navy early. The combination of that and the recruiting environment, which is a context you see broadly in the country, that that combination is leading the Navy to implement these force management policy actions.

Q The -- the prior sentence before,

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"Due to the uncertainty," it says, "As the Navy shifts into a new environment of sustainment, retention of every capable Sailor will be critical to the operational readiness of the -- of the Navy."

Do you see that?

A Yes.

Q What -- what does that mean, it shifts an environment of sustainment?

A Yeah. So it refers to the trajectory and the size of the Navy. Right. So it's simply saying the Navy is shifting really from a recent trend of shedding some capacity to now sustaining level-loading.

And that's going to require us to have a strong focus on sizing and shaping the enlisted Force to be able to -- to man those ships and -- and other units in the Navy.

Q And the last sentence in -- in paragraph 1, "This requires retention of the right talent at a time of uncertainty to ensure sustainment of the Force."

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Do you see that?

A Yes.

Q Okay. What is the time of uncertainty?

A So I would interpret that to talk about the world context. Obviously you look at Central Command AOR, with the actions of Iran, the issues going on there, look at the European Command theater with Ukraine, and you look at Indo-Pacific, and the significant tensions over Taiwan, put it in the context of one of uncertainty.

Q The prior sentence that we -- we started with that talks about -- that begins -- the prior sentence says, "Due to the uncertainty regarding COVID-19 Pandemic vaccination," do you think that the reference to uncertainty in the following sentence is -- is not -- is different, it's not referring to uncertainty associated with the pandemic or vaccination losses from COVID-19?

MR. CARMICHAEL: Objection. Calls for speculation.

You can answer the question,

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Admiral.
THE WITNESS: To me, it's a different nuance. The second sentence talks about a time of uncertainty, the first one talks to a specific uncertainty. I mean --
BY MR. STEPHENS:
Q I understand.
A Yeah.
Q I'm going to hand you a document marked as -- we'll mark as Number 19.
(Lescher Deposition Exhibit Number 19 marked for identification.)
THE WITNESS: Thank you.
MR. CARMICHAEL: Thank you.
THE WITNESS: Okay.
MR. CARMICHAEL: Just real quick, Admiral, before you get asked a question, I just want to put on the record that the Prosecution Exhibit 18, the NAVADMIN, we just -- we just pulled it up and it looks like it's a slightly different version than this. So maybe it was changed since you last printed it.

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BY MR. STEPHENS:
Q I've handed you a document marked as Lescher Deposition Exhibit 19. Do you have that in front of you?
A I do.
Q And that's the document that you just read -- reviewed?
A (Moving head up and down.)
Q At the top of the document marked as Exhibit 19 -- well, let's look at the -- where -- do you see about halfway down the first page it says, "NAVADMIN 142-22"?
A Yes.
Q Okay. And then turning back to the prior exhibit, Exhibit 18, that's the same NAVADMIN number.
A Right.
Q Is that right?
A Correct.
Q And then Exhibit 19, the title it says in the parenthetical, "Corrected Copy."
A Yes.

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Q Do you see that?
Had you -- had you seen this document before today?
A No.
Q Okay. Does that indicate to you -- or will the Navy sometimes issue a corrected copy of a NAVADMIN changing -- changing certain language?
A I've seen -- obviously, I've seen corrected-copy messages before. I can't specifically recall a corrected copy of a NAVADMIN, but it -- it wouldn't be wildly unusual, I suppose.
Q Okay. And so this NAVADMIN, at least as it indicates, it has the same number, 142-22, as the prior document, Exhibit 18, 142-22?
A Right.
And having not seen these, so my understanding is Exhibit 18 was transmitted to the fleet NAVADMIN, and then Exhibit 19, was -- even though they have the same date and time group at the top, was subsequently submitted as a corrected copy?

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Q Okay.
A No, that's my question.
Q I -- I don't know -- I don't know if it was -- if it was sent. I know that this says "corrected copy."
A Okay.
Q And so I have questions for you about that. And the NAVADMIN number is the same. And most of the substance is -- is the same, it appears to me.
A Yeah, I notice there's different references, and to your point, some different wording.
Q Right.
And so looking to Exhibit 18 -- the language we were discussing in Exhibit 18 was in paragraph 1 about, "Due to the uncertainty regarding COVID-19 Pandemic vaccination losses" --
A Uh-huh.
Q -- "and the recruiting environment where competition for talent is especially tough. The Navy is opening the aperture for additional FM

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personnel policy levers to retain sailors."
Do you recall that?
A Yes.
Q And that's reflected in --
A Right.
Q -- Exhibit 18, NAVADMIN 142-22.
And then looking at Exhibit 19, NAVADMIN 142-22, which has the heading, "Corrected Copy," that language is not in this document.
A Correct.
Q Is that correct?
A (Moving head up and down.)
Q Do you know approximately how far the Navy is falling short in filling billets that the Navy has determined need to be filled?
A Yeah, we discussed frequently a measure called gaps at sea, gaps of operational billets at sea. And my last understanding of that figure was that it was in the order of 7,000 gaps at sea. That's out of a billet based on the order of 148 or 149,000 billets.
MR. STEPHENS: Okay. Drew, why don't

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we take a quick break. I think I'm almost done.
MR. CARMICHAEL: Okay.
VIDEOGRAPHER: We are going off the record. This concludes Media Unit Number 4. The time is 1:58 p.m.
(Recess from 1:58 p.m. to 2:14 p.m.)
VIDEOGRAPHER: We are back on the record. This is the beginning of Media Unit Number 5. The time is 2:14 p.m.
Counsel, you may proceed.
BY MR. STEPHENS:
Q Good afternoon, Admiral Lescher. You understand that you're still under oath, correct?
A Yes.
Q Are you aware that some class members -- Plaintiff class members in this case are choosing to be involuntarily separated rather than waiting for this lawsuit to conclude?
A I am familiar with the NAVADMIN that Admiral Cheeseman said that basically facilitates that, yes. I'm unaware of any specific members who have elected that.

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Q Okay. And the NAVADMIN you're referring to is what is -- is facilitating their separation how?
A If I recall correctly, and I believe I saw a NAVADMIN that outlined the path to withdraw from the class to -- this is what you were referring to -- to then be able to voluntarily exit the Navy, which they're precluded to as a member of the class.
Q And -- and why do you believe they're precluded to as a member of the class?
MR. CARMICHAEL: Objection. Lack of foundation.
Go ahead and answer the question.
THE WITNESS: So not -- again, not having been involved in that discussion, it's my inference based on the publication of that NAVADMIN. It seems to me -- and, again, I -- I've glanced at that NAVADMIN fairly quickly. There would be no purpose for it if a member could simply opt out of the Navy while in the class.

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BY MR. STEPHENS:
Q And based on what we've discussed today, or has anything we've discussed today or the information in the documents that you've seen today made you change your mind as to any of the statements in your declaration?
A No.
Q And so if you were to submit that declaration today, you wouldn't change anything?
A No.
MR. STEPHENS: I'll pass the witness.
MR. CARMICHAEL: Okay.
EXAMINATION BY COUNSEL FOR DEFENDANTS
BY MR. CARMICHAEL:
Q Thank you, Admiral Lescher. I'm going to ask a few questions.
Could you give a brief summary of your -- the billets that you have had in your 42-year career, at least starting from graduation from the Naval Academy on.
A Okay. Briefly. So after graduating from the academy, went to flight school. First

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operational tour was a helicopter squadron that deploys on small ships worldwide. Deployed to South America, deployed to the Middle East. Deployed to submarine finding, I guess the Soviet Union. From there, I went to a program that's a cooperative degree program, where I spent one year at Naval Postgraduate School, one year at Test Pilot School, designated as test pilot. And did three years of developmental test at the Naval Yard Test Center. Those are both performance and mission system testing.

From there I returned to the Operational Force and assigned to another helicopter squadron that deploys on small ships worldwide. Deployed for Desert Storm, to the CENTCOM AOR. And returned and was squadron maintenance officer. I ran the largest department in the squad.

Following that department tour, I went to a Civilian Business School. From there, I went to the Pentagon to do resource allocation, decisions in space and electronic warfare. From

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there I screened for a command. Was executive officer and then commanding officer of a helicopter squadron that deploys detachments on small ships.

From there I went to become the executive officer of the USS Inchon, Mine Countermeasures Command and Control Ship Aviation Capable. From that assignment, I became commanding officer for the second time of the Fleet Replacement Squadron, the squadron that trains all Seahawk pilots and aircrewmen on how to fly that weapon system.

From there I became the commodore of the Helicopter Maritime Strike Wing, which oversees five squadrons that do that mission. Deploying aircraft worldwide on the -- on small ships, destroyers and frigates in the Navy.

From commodore to D.C., Office of Secretary of Defense doing liaison work. I led the shop that did appropriations liaison with the Congressional Appropriation Committees. From there, Joint Staff, Joint Staff Acquisition and Resource Allocation. From there to commander of

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the Expeditionary Strike Group 5, Expeditionary Strike Group 4 deployed in Bahrain. Commander Task Force 5-1, Commander Task Force 5-9. This is a strike group and task force that oversee all the expeditionary forces in 5th fleets. So the Amphibious Ready Group, a large deck amphib with -- employes harriers, ospreys, skid aircraft. Marine component of about 4,000 and special warfare elements that we served with and operated from the ESG ships in that time frame.

From there, I -- I think I left out -- from there I also served as the director of the Navy Operations Division in the Office of Budget. And also served as the deputy director for resources and allocation in the Joint Staff. Came back, was the Navy budget officer, making decisions about supporting the fleets realtime.

From Navy budget officer to a Three-Star position as the deputy chief of Naval Operations for Integration and Capability Resources, basically assigned to size and shape the future of the Navy. And from that position to the

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Vice Chief of Naval Operations.

Q Admiral, you were -- you mentioned you were a helicopter pilot. In that position, did you ever perform medical evacuation?

A I did.

Q What goes into a medical evacuation?

A Generally, in my experience, they're emergent based on a developing medical condition or a specific incident of -- of trauma. In the case of operating, as I did, I did the vast majority of my operational flying on very small ships. It's -- typically we would have one independent duty corpsman, not a doctor aboard. So it's fairly easy to exceed the capability of the onboard medical capacity, so we task others to step up and -- and address that.

So one specific example that comes to mind a sailor aboard USS ELROD, where I was the lieutenant commander in charge of the helicopter detachment, required an emergent medical evacuation. And this is an examplar of some of the risks that's involved in that. We were in high sea

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state poor weather, but obviously the medical urgency required us to accept some risks.

We took off. Transported the patient over a hundred-plus miles to a big deck aircraft carrier, which had the facilities to do it. For operational reasons, required to return back to home base ship. And when we went got there, the weather was such that the ship could not operate within side the recovery envelope. And once we were ashore, we recovered outside the recovery envelope. So it was an element of high-risk profile one might expect to execute those type of missions.

Q What are the risks involved in landing outside of the -- outside of the window, I guess the winds and seas?

Is that what that is?

A Yeah. The recovery envelopes are defined by test pilots to control the pitch and roll of the ship and the wind velocity so that you don't exceed the limits of the helicopter. And so when one is forced to operate outside the envelope,

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that -- every one of those envelopes is developed by a test pilot, and it means that in the test pilot's judgment, you're at very low margin for damaging or crashing the aircraft.

Q And you mentioned that you were -- commanded an expeditionary strike group. Did that expeditionary strike group have a Naval Special Warfare component?

A During the expeditionary strike group tour, I had three ARG MEUs rotationally come through that worked for me. They reported to me as their operational commander. And in the number of cases Navy SPEC Warfare personnel came aboard and operated from my ships to conduct missions, an assortment of missions.

Q And how long -- how long were you an expeditionary strike group commander?

A From 2012 to 2013. Just -- just about a little over a year.

Q And did you deploy during that period?

A I was -- I was full deployed the

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whole time in Bahrain. So headquartered in Bahrain, but my ships were across the AOR. And I -- I would, you know, balance my time between operating on the ships and operating do -- doing key leader engagement with leaders in the -- in the region.

This was just post-Benghazi, so we were doing both direct action missions in support of the fight with the SEAL Teams, and we were also quite active in preparing, and in some cases staging, for an embassy reinforcement and evacuation missions. So there was travel to talk to the ambassadors. It was those types of -- those types of conditions.

Q Can you explain your current role as the vice -- vice chief of Naval Operations?

A Yeah. The Service vice chiefs, oftentimes the civilian kind of decoding of that position is associated with being a chief operating officer. So the vice chief is very much focused on ensuring the Service can organize, train, and equip Forces, which then flow forward and are employed

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operationally by Naval component commanders and the combatant commanders.

So the vice chief role is not directly associated with employing the Forces, the vice chief role is more focused on how we generate that readiness through this cycle as well as there's a strong focus on a longer-term look at the Navy of how we size and shape the force for the competitive environment we see, what type of ships we buy, aircraft, and the acquisition element as well.

Q In that role do you rely on individual commanders below you?

A Yes.

Q Do you trust the individual commanders below you?

A Yes.

Q Do you have any reason to doubt any information that those commanders provided you was not accurate?

A I do not.

Q Is trusting the individual commanders

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below you important to you?
A It's essential. Those commanders are selected based on their proven ability to speak truth and to deliver trustworthy representations of what they see.
Q I want to talk a little bit about some of the measures that you discussed earlier, the -- the pre-vaccine measures that you had called hard measures.
Can you describe a little bit what COMPTUEX and go means?
A So that -- again, the COMPTUEX is a certifying event for a strike group typically. And it's high end because it's a certification events, as our Forces and strike groups progress from what we call the maintenance phase, so after a long deployment, they'll go into heavy maintenance, designed to be on the order of six months or so.
And then once they come out of maintenance, they start progressing through basic and intermediate training. So increasing levels of sophistication, coordination, working together, all

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being tested on their abilities to deliver lethal effects while staying in a high state of readiness.
From the basic and integrated phase, then it goes to the advanced phase, which culminates with this COMPTUEX exercise, which is essentially a practice fight against a high-end adversary. So it's all about shooting ordnance, high uptempo. And proving again that that strike group can be certified as a lethal and ready Force.
So a change that we talked about was over the course of this progression, coming out of the maintenance phase, which is long hours, fixing the ship, maintaining the ship, into a basic phase, underway, out and back, developing proficiency to an intermediate phase to an integrated phase and certification.
You're increasing the tempo of being away from home. So for sailors with family, even single sailors, it's stressful as you spend more and more time away. But you get those times back to reconnect with the family. There's typically a pre-overseas movement phase, is what we've had in

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the past, where you spend a specific amount of time with the family and then you deploy, which is seen as a milestone event.
Our system is typically deployed on the order of seven months and then you would return. Again, the baseline is during those seven months, our practice had been no more than every 60 days or so to have a port visit. Again, to have the crew, you know, recover mentally, physically, in a port, you know, see the world and then come back out and start sprinting again.
What changed in 2020 was those episodic touches back to family, whatever, were taken away. So COMPTUEX and go was preceded with a pre-deployment sequester, then into this multi-week certification high-end exercise, and then just keep going, just go deploy from there. So not pre-overseas movement, not back with the family.
Longer deployments, as we talked about in the example earlier today, I believe it was the HARRY S. TRUMAN that once they -- they deployed pre-pandemic, but once they hit pandemic,

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their port visits stopped. And so we saw that that was not uncommon where port visits -- I think it was Admiral Merz said in his declaration, 160 up to 200 days underway without port visits. And then not infrequently those ports visits were pure carrier, anchor out, take a boat to the pier and your -- and your liberty is in a sandbox out on the pier.
So those are measures that enabled the Navy to meet mission at a critical time in 2020. There was a lot going on in the world. But that was harsh on our people. And as you might imagine, all of those elements are stressing. And so to include the protective measures we were taking onboard ship, in terms of being masked up, social distancing the best we can.
So that is where we saw that wear and tear on our people manifest, with the declining retention over '20, '21, and '22. And a real growth in the request for access to mental health assistance, counseling, and support.
Q Does -- does combining COMPTUEX and

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deployment, does that -- does that result in additional operational risk to the Navy or to the unit, or can it?

A The incremental -- so, again, we talked about, as you do these heavy, hard-to-do, measures, we -- we were allocating risk in a different way. So to control the risk of COVID, which was seen as clearly a pressing risk, a known risk, a risk that we mitigated with these elements, we reallocated the risk with increased stress on our Force.

So you're saying does that manifest as an operational risk? It -- it can be seen that way in the sense that our people would -- you know, who are operating, you know, flying tactical jets on and off carriers and they haven't been in port for 200 days, I mean, we manage that closely, we're paying attention to their -- you know, their condition, are they getting proper rest, et cetera.

But it's safe to say that that overall hard-extended deployments, the reason that's not the norm is because we recognize it's

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not sustainable and it can create specific elements of risk.

Q Can it lead to additional fatigue for the crew?

A If not properly managed, it can fatigue the crew. And even -- and then, of course, there's limits within the ability of the commander to manage that. And so that's why we -- we work that very close.

Q Can extending deployments or combining deployments with COMPTUEX, can that -- can that put additional strain on the ships itself and the equipment?

A Yes. We typically do voyage repairs during deployment. We pull in, we would have technicians come aboard. We would have host country maintenance folks do work in certain cases. And during that time frame, much of that was constrained.

Again, we talked about the exhibit that we looked at, talked about how the medical officer really cracked down on who had access to

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the ships, critical mission essential crew.

The carrier onboard delivery aircraft flying out to the aircraft carrier, touching down, get a box lunch, eat in the cockpit or on the flight deck and then, you know, get out of here. So all of those elements are just, you know, small vignettes of how the Navy adapted and learned to control COVID, but in ways that were hard on the people.

Q For any of these -- for these measures, I guess the extended port visits, the extended deployment, pre-deployment COMPTUEX and go, do they decrease the chance that somebody who gets COVID will get severely ill?

A Those countermeasures will not control the severity of the illness.

MR. CARMICHAEL: I don't have any further questions.

EXAMINATION BY COUNSEL FOR PLAINTIFFS

BY MR. STEPHENS:

Q Admiral Lescher, Mr. Carmichael asked you a question -- or a series of questions about

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your experience as a helicopter pilot in conducting a medevac.

Do you recall that?

A I do.

Q When was the last time that you were personally involved with a medevac?

A It would be that instance.

Q And -- and when was that?

A So that was during Desert Storm. That was early '90s.

Q Okay. And when was the last time that you worked with a SEAL Team or a Naval Special Warfare Team on a deployment?

A Operationally it would have been in 2013.

Q Okay. If -- if the Navy wins this lawsuit, the result could be -- would be that around 4,000 otherwise qualified members of the class would be terminated from the Navy. And based on your experience, many years of experience, in the Navy, and your current role and -- and your -- your position and responsibilities for organizing,

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training, and equipping the Forces, would you consider that an acceptable loss to the Navy?

MR. CARMICHAEL: Just objection real quick that it's not certain that every member of the class would -- would get separated.

You can answer the question.

THE WITNESS: That would be a hard loss for the Navy. The -- you know, as I was looking again at the -- the last two NAVADMINs that we talked about, it highlights a point that we had discussed earlier, which is clearly inferred in both the original message and the corrected copy, is that all of these actions are creating opportunities for people through these other -- these other levers to stay in the Navy, inferred, we're talking about, and specified people who meet the standards.

And so this is the hard element of whether they all of that class left the Navy or some subset didn't, clearly in the context of these messages, that would be not the best outcome for the Navy to lose that size of a

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Force. But I also talked about the shape of the Force and how the message specifically talking about sea duty operational, sea duty incentive pay.

And so the foundational elements here that we're talking about is that it's not purposeful. No matter how talented these individuals are, if they can't meet standard -- and there's standards beyond medical readiness standards, but sailors who can't meet standard, which are designed to create ready and lethal operational Forces to operate forward in a harsh environment, it's not purposeful to retain them in the Navy.

BY MR. STEPHENS:

Q If 80 percent of DEVGRU were unvaccinated, would you allow the commanders the discretion to decide whether those members of DEVGRU can remain in the Navy and be deployed or would you separate all of them from the Navy?

MR. CARMICHAEL: Objection. Calls for speculation. Hypothetical with unstated

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assumptions.

You can answer the question, Admiral.

THE WITNESS: So it seems like quite an outlier scenario, but I get conceptually the point you're making. If 80 percent of that population did not meet standard, then I believe an action we would look at for 80 percent not meeting standard is: What's the underlying reason for that? What are the root causes that lead to a standard we've had for decades? And now I have 80 percent of this subset of the Force that can't meet it? And I think that's where I would start in terms of trying to think through that question.

BY MR. STEPHENS:

Q And -- and what if -- I understand your reference to the -- the standard, the vaccination requirements that have been around for decades, but what if my question were specific to the COVID-19 vaccine, if 80 percent of DEVGRU had not received the COVID-19 vaccine, would you then -- would you then evaluate that issue in the

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same way?

MR. CARMICHAEL: Same objection. Speculation and improper hypothetical.

You can answer.

THE WITNESS: So let me think through that. The concept of standard for vaccines, as you just highlighted, has been present for decades. That medical readiness standards applies to all vaccines, not just COVID. And you're saying, hey, what, if nonetheless, the disqualifying event in every case was one vaccine for 80 percent of the Force, then I think a thoughtful commander would think through -- would -- again, would have to dive into that, what's taking place there?

BY MR. STEPHENS:

Q And the purpose of that would potentially be to determine whether the standard -- whether maintaining that standard and separating those Service members would have -- have a greater impact or negative impact on the Navy's ability to accomplish its mission as -- as opposed to allowing them to stay in?

A It is that approach we talked about. The way we manage risk is to look at benefit versus cost and risk. And, you know, again, we -- it's interesting we talked today best practice are clearly to do that on a case-by-case basis. I mean, just in the cases that we talked today, the high-risk sailors is case by case, medical waiver to standard is case by case, HIV policy we talked about, case by case, Force management message, pursuing transfer to other branches, pursuing commissions, case by case.

And so I note the preliminary injunction, which precludes the Navy from doing case by case is foundational to my declaration.

MR. STEPHENS: Okay. I have no further questions.

I don't know if you have redirect.

MR. CARMICHAEL: No, I don't.

VIDEOGRAPHER: If there are no further questions, we are now going off of the record. The time is 2:44 p.m. And this concludes today's testimony given my William Lescher.

The total number of media units used today was five. And these will be retained by Veritext Legal Solutions. Thank you all very much. Have a nice day.

(Whereupon, at 2:44 p.m., the videotaped deposition of ADMIRAL WILLIAM LESCHER was concluded; signature reserved.)

CERTIFICATE OF NOTARY PUBLIC

I, FELICIA A. NEWLAND, CSR, the officer before whom the foregoing videotaped deposition was taken, do hereby certify that the witness whose testimony appears in the foregoing deposition was duly sworn by me; that the testimony of said witness was taken by me in stenotype and thereafter reduced to typewriting under my direction; that said deposition is a true record of the testimony given by said witness; that I am neither counsel for, related to, nor employed by any of the parties to the action in which this deposition was taken; and, further, that I am not a relative or employee of any counsel or attorney employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

FELICIA A. NEWLAND, CSR
Notary Public

My commission expires:
September 15, 2024

Andrew E. Carmichael, Esquire
andrew.e.carmichael@usdoj.gov

RE: U.S. Navy Seals 1-3 Et Al v. Austin, Lloyd J. III Et Al
6/30/2022, William K. Lescher (#5289637)

The above-referenced transcript is available for review.

Within the applicable timeframe, the witness should read the testimony to verify its accuracy. If there are any changes, the witness should note those with the reason, on the attached Errata Sheet.

The witness should sign the Acknowledgment of Deponent and Errata and return to the deposing attorney. Copies should be sent to all counsel, and to Veritext at cs-midatlantic@veritext.com

Return completed errata within 30 days from receipt of testimony.

If the witness fails to do so within the time allotted, the transcript may be used as if signed.

Yours,
Veritext Legal Solutions

U.S. Navy Seals 1-3 Et Al v. Austin, Lloyd J. III Et Al
William K. Lescher (#5289637)

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_____ _____
William K. Lescher Date

U.S. Navy Seals 1-3 Et Al v. Austin, Lloyd J. III Et Al
William K. Lescher (#5289637)

ACKNOWLEDGEMENT OF DEPONENT

I, William K. Lescher, do hereby declare that I have read the foregoing transcript, I have made any corrections, additions, or changes I deemed necessary as noted above to be appended hereto, and that the same is a true, correct and complete transcript of the testimony given by me.

_____ _____
William K. Lescher Date
*If notary is required
SUBSCRIBED AND SWORN TO BEFORE ME THIS
_____ DAY OF _____, 20___.

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NOTARY PUBLIC

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

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Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

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Exhibit B: Deposition Exhibits for Admiral William K. Lescher

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS

U.S. NAVY SEALs 1-26;
U.S. NAVY SPECIAL WARFARE COMBATANT CRAFT CREWMEN 1-5;
U.S. NAVY EXPLOSIVE ORDNANCE DISPOSAL TECHNICIAN 1; and
U.S. NAVY DIVERS 1-3,
Plaintiffs,

v.

LLOYD J. AUSTIN, III, individually and in his official capacity as United States Secretary of Defense; **UNITED STATES DEPARTMENT OF DEFENSE; CARLOS DEL TORO,** individually and in his official capacity as United States Secretary of the Navy,
Defendants.

Case No. 4:21-CV-01236-O

DECLARATION OF WILLIAM K. LESCHER

I, William K. Lescher, hereby state and declare as follows:

1. I am an admiral[1] in the United States Navy, currently serving as the Vice Chief of Naval Operations (VCNO), located in Arlington, Virginia at the Pentagon. The position of VCNO is appointed by the President, with the advice and consent of the Senate, and is the second highest uniformed Officer in the Navy. I have served in this position since May 29, 2020. I make this declaration in support of the Government's motion for a stay of this Court's preliminary injunction pending appeal. The statements made in this declaration are based on my

[1] The rank of "admiral" is the highest military rank in the Navy. The term "admirals" is also frequently referred to as "flag officers." Flag officers include the ranks of rear admiral (lower half), rear admiral (upper half), vice admiral and admiral. Flag officers comprise the most senior levels of uniformed leadership in the Navy.

EXHIBIT
1

personal knowledge, my military judgment and experience, and on information that has been provided to me in the course of my official duties.

Preliminary Statement

2. I have reviewed the preliminary injunction order issued by this Court on January 3, 2022. I believe the Court's injunction will cause immediate harm to the Navy, and in particular to the operations of Naval Special Warfare (NSW) and Special Operations Forces (SOF), and to the national security of the United States. Operationally, in 2021, the Navy executed more than 30,000 steaming days and one million flying hours to protect America, deter conflict and keep the sea lanes open and free. The Court's injunction directly impacts the Navy's ability to carry out its responsibilities to protect and maintain the health and safety of our Force, in particular our ability to halt the spread of COVID-19 through a mandatory vaccination requirement. Unvaccinated or partially vaccinated service members are at higher risk to contract COVID-19, and to develop severe symptoms requiring hospitalizations that remove them from their units and impact mission execution. Vaccination against COVID-19 has proven to be essential in keeping Navy units on mission by mitigating the impact of COVID-19. Fully vaccinated naval forces are required to ensure readiness to carry out Navy missions throughout the world and, if required, to engage in combat operations. Restriction of the Navy's ability to reassign unvaccinated personnel in order to mitigate COVID-19 related risks to units preparing to deploy, or that are deployed, will cause direct and immediate impact to mission execution. Further, the harm caused by this injunction is not limited to 35 unvaccinated Plaintiffs. The heath, readiness, and mission execution of broader conventional Navy units and personnel who support these personnel are threatened as well.

Naval Background and Experience

3. As the Vice Chief of Naval Operations,[2] I work in coordination with the Chief of Naval Operations (CNO), the senior admiral in the U.S. Navy,[3] in the execution of his statutory duties and responsibilities as they pertain to the employment of the Navy. Those duties include recruiting, organizing, supplying, equipping, training, servicing, mobilizing, demobilizing, administering, and maintaining the Navy, as will assist in the execution of any power, duty, or function of the Secretary of the Navy or the Chief of Naval Operations. Additionally, the CNO delegated several specific responsibilities to me. I oversee programs and policies that impact Sailors and their families, including health affairs, and monitor and enact polices that promote good order and discipline in the Navy.

4. I have served in the United States Navy for nearly 42 years. A 1980 graduate of the United States Naval Academy, my experience includes command of the Vipers of Helicopter Anti-Submarine Light (HSL) Squadron-48, the Airwolves of HSL-40 and the Maritime Strike Wing Atlantic. As Commanding Officer, HSL-48, my responsibilities included training, preparing, and executing Seahawk helicopter detachment deployments on Navy ships deploying worldwide. As Commanding Officer, HSL-40, I was responsible for the training, evaluation, and maintenance of the Seahawk helicopter squadron that trains all East Coast Seahawk pilots in employment of this weapon system. As Commander, Maritime Strike Wing Atlantic, I was responsible for the material readiness and training of eight Helicopter Maritime Strike (HSM)

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[2] "The [VCNO] has such authority and duties with respect to the Department of the Navy as the Chief of Naval Operations, with the approval of the Secretary of the Navy, may delegate to or prescribe for him. Orders issued by the [VCNO] in performing such duties have the same effect as those issued by the Chief of Naval Operations." 10 U.S.C. § 8035(c).

[3] The CNO is the senior uniformed officer in the United States Navy. *See* 10 U.S.C. § 8033(b) ("The Chief of Naval Operations, while so serving, has the grade of admiral without vacating his permanent grade. In the performance of his duties within the Department of the Navy, the Chief of Naval Operations takes precedence above all other officers of the naval service.").

squadrons, the Weapons School, Fleet Replacement Squadron, and a total of 42 detachments deploying on Atlantic Fleet aircraft carriers and air capable ships, encompassing 68 aircraft and 1,900 personnel. Between command of the Vipers and Airwolves, I was the executive officer of Mine Countermeasures Command and Control Ship USS Inchon (MCS 12), a 20,000 ton vessel with a crew of 700. As the second in command, I was responsible for the supervision, training and development of the crew and the daily execution of the command mission, which included training and preparing the crew for deployment, maintaining and improving operational readiness and material condition of the ship. As a flag officer, I commanded Expeditionary Strike Group 5 (ESG-5) and Task Forces 51/59 (CTF 51/59) in Bahrain, leading multiple Amphibious Ready Groups, Marine Expeditionary Units and the afloat forward staging base USS Ponce (AFSB(I)-15) in execution of theater security events, combat operations, and emergent national taskings spanning the Middle East/Central Command region. My responsibilities as ESG-5 and CTF 51/59 included multiple events working with NSW forces embarked on my ships and interoperability exercises with partner countries. I also served as Joint Staff deputy director for resources and acquisition, deputy assistant Secretary of the Navy for budget, and Deputy Chief of Naval Operations for integration of capabilities and resources.

Specific Functions of the United States Navy

5. The United States Navy and Marine Corps comprise the Nation's principal maritime forces. Their missions are to provide globally deployable forces in order to "secure the Nation from direct attack; secure strategic access and retain global freedom of action; strengthen existing and emerging alliances and partnerships; establish favorable security conditions; deter aggression and violence by state, non-state, and individual actors and, should deterrence fail, prosecute the full range of military operations in support of U.S. national interests." *See*

Department of Defense Directive (DoDD) 5100.01, Change 1, 09/17/2020, Encl. 6, ¶ 5.a. –b (attached hereto). Effective execution of all of these discrete functions is vital to the national security of the United States, and is accomplished by providing fully trained and qualified naval forces to joint commanders[4] to deter aggression and, if required, engage in combat operations and win decisively.

Naval Special Warfare (NSW) and Special Operations Forces (SOF)

6. Naval Special Warfare (NSW) and Special Operations Forces (SOF) are composed of Navy SEALs[5] and Special Warfare Combatant-Craft Crewmen (SWCC). The NSW team is a multipurpose combat force organized and trained to conduct a variety of special operations missions in all environments. Navy SEALs conduct clandestine missions infiltrating their objective areas by fixed and rotary-wing aircraft, Navy surface ships, combatant craft, submarines and ground mobility vehicles. Service members designated as Navy SEALs consist of officers and enlisted members who have been designated pursuant to Navy and NSW policies. SWCC focus on infiltration and exfiltration of SEALs and other SOF to include from other Services, and they provide dedicated rapid mobility in maritime environments, as well as the ability to deliver combat craft via parachute drop. SWCC operate and maintain state-of-the-art surface craft to conduct special operations.

7. In addition to SEALs and SWCC, combat support (CS) and combat service support (CSS) personnel are assigned to NSW units to support the mission. CS/CSS personnel

[4] Joint commanders are the combatant vested with authority and responsibility for military operations within their area of responsibility. The Navy and other branches of the Armed Forces provide forces to the combatant commanders to execute those responsibilities and functions. The combatant commanders exercise authority, direction and control over the commands and forces assigned to them and employ those forces to accomplish missions assigned to the combatant commander. Department of Defense Directive (DoDD) 5100.01, Change 1, 09/17/2020, Encl. 1, ¶1.a through d.

[5] The term "SEAL" refers to "Sea, Air, Land."

include officers and enlisted service members identified in Plaintiffs' complaint (i.e., Explosive Ordinance Disposal (EOD) personnel and Navy Divers), in addition to other officers and enlisted service members performing a variety of military functions (e.g., chaplains, medical personnel, mobile communications teams, tactical cryptologic support, etc.). Navy EOD personnel perform missions neutralizing explosive weapons, including various weapons of mass destruction. Their duties include detonating or demolishing hazardous munitions, neutralizing various ordnance, including sea mines, torpedoes or depth charges, performing parachute or helicopter insertion operations, and clearing waterways of mines in support of our military operations. Navy Divers perform a variety of military functions, including wreckage salvage operations and underwater repairs, harbor and waterway clearance operations, assisting in construction and demolition projects, executing search and rescue missions, performing deep submergence operations, and serving as technical experts for diving operations for numerous military special operations units.

8. Service members in the NSW force are responsible for performing special operations. Special operations require unique tactics, techniques, procedures and equipment. They are often conducted in hostile, austere or diplomatically sensitive environments, and are characterized by one or more of the following: time-sensitivity, clandestine nature, low visibility, working with or through host-nation forces, greater requirements for regional orientation and cultural expertise, and a higher degree of risk. These missions often require members of the NSW force to work in close quarters where social distancing is not possible. Small NSW teams may travel for an extended duration on boats, submersibles, helicopters, aircraft, or other vehicles that are less than six feet across, and/or which have limited ventilation. Service members may be in such close quarters while traveling that they must sit shoulder-to-shoulder.

Additionally, members may be required to operate in subsea environments and may have to share diving rebreather devices and inhale one another's exhalation.

Mandatory Vaccination Requirements in Response to COVID-19 Pandemic

9. On August 24, 2021, the Secretary of Defense directed the Secretaries of the Military Departments to immediately begin full vaccination of all members of the Armed Forces on active duty or in the Ready Reserve. The Secretary of Defense determined that mandatory COVID-19 vaccinations are necessary to protect the health and military readiness of the force. The Secretary of the Navy directed implementation of Secretary of Defense's COVID-19 vaccination mandate[6] via a Department-wide administrative message (ALNAV) on August 30, 2021. The ALNAV applies to both Services within the Department of the Navy (DON), the United States Navy and the United States Marine Corps. The ALNAV required all active duty DON Service members, who were not already vaccinated, exempted, or currently seeking an exemption, to be fully vaccinated with an FDA-approved COVID-19 vaccine within 90 days of the ALNAV, and all Reserve Component personnel to be fully vaccinated within 120 days. ALNAV 062/21 ¶ 4. Active duty Sailors and Marines were required to become fully vaccinated[7] by November 28, 2021, and Reserve Component Sailors and Marines by December 28, 2021. The requirement to obtain full vaccination constitutes a lawful order under Article 92 of the Uniform Code of Military Justice (UCMJ), and failure to comply may result in punitive or adverse administrative action, or both. ALNAV 062/21 ¶ 5.

[6] Secretary of Defense Memorandum, "Memorandum for Senior Pentagon Leadership, Commanders of the Combatant Commands, Defense Agency, and DoD Field Activity Directors," (August 24, 2021).
[7] Although refusal to receive the vaccine may subject a member to adverse administrative or disciplinary action, the vaccine will not be forcibly administered to any member who refuses.

10. The United States Navy issued service-specific guidance via a separate administrative message ("NAVADMIN") on September 1, 2021. NAVADMIN 190/21 outlines Navy policy concerning the mandatory vaccination of Navy service members, vaccination administration and reporting requirements, and general guidance related to logistics and distribution of vaccines. The policy reiterates that COVID-19 vaccination "is mandatory for all DoD service members who are not medically or administratively exempt" under existing Navy policy. NAVADMIN 190/21 ¶ 2, 3.a. Refusal to become fully vaccinated against COVID-19 without an approved or pending exemption constitutes a failure to obey a lawful order and is punishable under Article 92, UCMJ.

The COVID-19 Pandemic Threat to Naval Forces

11. The judgment of each of the Military Services is that vaccines are the most effective tool the Armed Forces have to keep our personnel safe, fully mission capable and prepared to execute the Commander-in-Chief's orders to protect vital United States' national interests. As of January 5, 2022, 261,504 members of the Armed Forces have contracted the COVID-19 virus, resulting in 2,320 hospitalizations and 82 deaths. Eighty of 82 members who have died were unvaccinated. Of all active duty personnel who were required to be hospitalized because of COVID-19, 0.8% received a booster shot prior to hospitalization. Separately, there have only been six active duty personnel who have received a booster and had a breakthrough COVID-19 infection that required hospitalization. Among the active duty force, 12% of those required to be hospitalized have received a primary COVID-19 vaccine without the booster. Among Reserve and National Guard service members, 97% of those hospitalized with COVID were unvaccinated or partially vaccinated; 3% of hospitalized members received primary vaccination but no booster shot; 0.2% hospitalized members had received a booster shot.

Sending ships into combat without maximizing the crew's odds of success, such as would be the case with ship deficiencies in ordnance, radar, working weapons or the means to reliably accomplish the mission, is dereliction of duty. The same applies to ordering unvaccinated personnel into an environment in which they endanger their lives, the lives of others and compromise accomplishment of essential missions.

12. The environment in which Navy personnel operate -- in close quarters for extended periods of time -- make them particularly susceptible to contagious respiratory diseases such as COVID-19 and renders mitigation measures such as social distancing unrealistic. In mid-March 2020, the aircraft carrier USS THEODORE ROOSEVELT (CVN 71) was deployed to the Western Pacific Ocean, a vital geo-political center of gravity encompassing several of the world's largest militaries and five nations allied with the U.S. through mutual defense treaties. The leadership of USS THEODORE ROOSEVELT began to see several COVID-19 cases among the crew. By April 1, 2020, USS THEODORE ROOSEVELT had been pulled off mission and into Guam with approximately 1,000 crew removed from the ship, with a reduced crew remaining to maintain the nuclear reactor and other essential systems. By April 20, 2020, 4,069 Sailors had been removed from the ship out of a crew of approximately 4,800. The ship was unavailable for 51 days to maintain presence in a strategically important area which includes the world's busiest sea lanes, creating a national security vulnerability in an area vital to our national interests. When USS THEODORE ROOSEVELT finally got underway on May 21, 2020, approximately 1,800 Sailors remained in Guam. Tragically, one Sailor succumbed to the COVID-19 virus and died.

13. Even with approximately 97% of the Navy vaccinated, the COVID-19 virus can degrade units and impact mission. Last month, USS MILWAUKEE (LCS 5), with a 100%

vaccinated 100-person crew, remained in port one week beyond its schedule because several members tested positive for COVID-19. Because the full crew was vaccinated, infected personnel were asymptomatic or had mild symptoms and the impact to mission accomplishment was substantially mitigated compared to the USS THEODORE ROOSEVELT's experience of more than 4,000 crew removed from the ship and a 51-day loss of mission. Given the hospitalizations and death statistics cited above, the MILWAUKEE's minor deployment delay would likely have been far worse with unvaccinated personnel. The MILWAUKEE is one example of a Navy manning model where each individual crew member has a high level of responsibility with little redundancy. The medical staff of the MILWAUKEE consists of only two Navy Hospital Corpsman, comparable to an Emergency Medical Technician in the civilian setting. There is little ability on ship to care for a service member with severe COVID symptoms. If a service member were to develop severe symptoms on this type of ship, it would require a return to port or an emergency medical evacuation by helicopter. Helicopter medical evacuation is not always viable due to the location of the ship and the limited range of helicopters. At the deployable unit level, NSW, EOD, and diver personnel operate in units that can be as small as a squad of four personnel. Medical evacuations in these small units can be even less practical and significantly more damaging than the loss of an equal number of crew on a ship the size of the MILWAUKEE.

14. The types of missions conducted by SEALs, SWCC, EOD and divers cannot be conducted remotely. A SEAL assigned to perform a counterterrorism mission in a foreign country cannot perform that task from home; a SWCC cannot drive a combatant craft and transport SEALs in a telework status; an explosive ordnance disposal technician—whose job it is to disarm and dispose of explosives—cannot perform that task remotely. Similarly, the arduous

training necessary to prepare NSW personnel for these missions cannot be performed remotely. It is not possible for a Navy Diver to remotely prepare compressed air and oxygen tanks for personnel to complete their training dives. A safety diver must be physically present during a high-risk training evolution that may require rescue divers or oxygen technicians. In particular, Navy Divers assigned to NSW must be able to operate a diving recompression chamber – a small confined space where the Navy Diver must be in the chamber to assist with the personnel casualty – which cannot be done remotely. SEAL trainers cannot oversee dangerous swim or survival training from a physically distanced location. NSW personnel also routinely interact with the greater Navy population, on ships and aircraft, and in dining facilities and office environments across the globe. They are required to deploy with no-notice. NSW, EOD and diver training and operations necessitate our service members interact in close-quarters, confined spaces, and under conditions where telework, social distancing, and mask-wearing are not reliable mitigation options.

Immediate Harm to Readiness and Mission Accomplishment

15. The preliminary injunction forbids the Navy from applying MANMED § 15-105(3)(n)(9), NAVADMIN 225/21, NAVADMIN 256/21 and Trident Order #12. Order 26, ECF No. 66. MANMED § 15-105(3)(n)(9) states that personnel who choose not to receive required vaccinations will be disqualified from special operations duty. NAVADMIN 225/21 provides guidance for disposition of offenses involving Navy service members who are not fully vaccinated by the required deadlines. Navy Service members who refuse the COVID-19 vaccine, absent a pending or approved exemption, are required to be processed for administrative separation.[8] NAVADMIN 225/21 ¶ 2. A Navy Service member is considered to be "refusing the

[8] Although processing for separation is required, this does not automatically result in a member actually being separated. Members processed for separation may ultimately be retained in the service.

vaccine, if: (1) the individual has received a lawful order to be fully vaccinated, (2) is not or will not be fully vaccinated by the date required, and (3) does not have a pending or approved exemption request." *Id.* ¶ 3.c. The policy designates the Chief of Navy Personnel, a 3-star admiral, as the COVID-19 Consolidated Disposition Authority to ensure fair and consistent administrative processing across the service. *Id.* at ¶ 5.b. For disciplinary matters, authority to initiate disciplinary proceedings, either non-judicial punishment or court-martial, is withheld to the Vice Chief of Naval Operations. *Id.* NAVADMIN 256/21 provides additional guidance on administrative separation processing for those refusing the vaccine, as well as guidance on other applicable administrative actions. These other applicable administrative actions include: cancellation of government travel for training or other official purposes; temporary reassignment within the local area for unvaccinated personnel (with or without a medical exemption or religious accommodation); adverse fitness reports and evaluations; prohibition on executing permanent change of station orders; potential termination of special duty and incentive pays; potential recoupment of unearned bonuses; termination of and potential reimbursement for Navy-funded education and training; promotion and advancement delays; and removal of additional qualification designations or Navy Enlisted Classifications.[9] *See* NAVADMIN 256/21 ¶¶ 4.b.through 13. Trident Order # 12, which is directed to the NSW force, does not create any new requirements or adverse administrative actions. It consolidates and restates previously promulgated Navy implementing guidance.

16. The preliminary injunction forbids the Navy from "[t]aking any adverse

[9] Navy Enlisted Classifications define the work performed by Navy enlisted members and the requirements to perform specific "ratings" (i.e., occupations). *See generally*, MANUAL OF NAVY ENLISTED MANPOWER AND PERSONNEL CLASSIFICATIONS AND OCCUPATIONAL STANDARDS, VOL II NAVY ENLISTED CLASSIFICATIONS (NAVPERS 18068F), April 21, 2021 (supplementing the enlisted rating structure in identifying personnel and billets [i.e., jobs] and skills, knowledge, aptitude, or qualifications that must be documented to identify both people and billets for management purposes).

action against Plaintiffs on the basis of Plaintiffs' requests for religious accommodation." Order 26, ECF No. 66. The order specifically references actions that Plaintiffs allege are being taken against them while they await a decision on their religious accommodation requests, actions such as restrictions on travel, access to non-work activities, unpleasant assignments, and being relieved of leadership duties. Order 26, ECF No. 66. This aspect of the order is intrusive and harmful to Navy operations, including deployment decisions. In the Navy, "adverse action" refers to an action that is punitive or the action itself has a direct adverse impact on one's career such as a court martial or discharge. The Court's order, however, indicates that routine personnel actions, such as assignment, official travel and specific duties, are adverse decisions. Contrary to the Court's apparent understanding, temporarily reassigning personnel to other units because they are unvaccinated, regardless of the reason they are unvaccinated (e.g., medical exemption, religious accommodation, or pending exemption request) is not an adverse action but a step to protect the health of the whole unit and maintain mission readiness. The Court's injunction appears to require the Navy to leave unvaccinated NSW, EOD, and diver personnel in their units, performing their same duties and deploying on missions regardless of the known risk to personnel and mission. Such an injunction will degrade NSW, EOD, and diver mission readiness, breakdown good order and discipline within the NSW force, unnecessarily limit the Navy's ability to conduct daily operations and operational missions, and could clearly result in mission failure in contingencies and crises that cause harm to national security.

17. NSW personnel must be fully medically ready and at peak fitness given that their training and missions are physically demanding and arduous. It is vital that all members of the NSW force be medically fit to perform daily operations and to train or deploy on short notice. Regardless of their current assignment, all naval forces, NSW in particular, must be ready to

respond to contingencies and crises around the world. All NSW personnel are expected to meet this requirement, whether in a training status, on instructional duty, or at a headquarters, as the mission of NSW is to be ready to provide maritime SOF to conduct full spectrum operations to support national objectives. The Navy could easily require Navy Special Warfare Command to mobilize personnel outside from any unit, regardless of the planned deployment cycles of a unit or the currently assigned duties of NSW personnel to respond to the full range of contingencies and crises. Medical conditions or illness create risk, both medical and operational, not only for the service member afflicted, but for other members of the unit. As a result, unvaccinated personnel in a unit degrade the force health protection conditions in the unit, placing personnel in the unit at risk and degrading the unit's ability to safely conduct operations, regardless of the scope of the operation. The following publicly available mission event illustrates how rapidly a NSW unit can go from steady state in the United States to deploying forward on a mission of the highest difficulty, requiring peak medical, physical and mental readiness. This example illustrates the rapid manner in which a contingency or crisis could unfold, and although more than a decade old, is used due to the unclassified classification of my declaration.

18. On April 8, 2009, armed Somali pirates boarded the U.S.-flagged container ship, *Maersk Alabama* in the Indian Ocean, taking the crew, composed of U.S. citizens, hostage and making ransom demands. USS BAINBRIDGE (DDG-96) was the first ship of the international counter-piracy task force to respond. BAINBRIDGE's commanding officer realized he needed additional capabilities beyond what he had available on the ship. In response, on short notice, a SEAL team flew 8,000 miles from the United States to USS BAINBRIDGE and were recovered onboard. By the evening of April 12, 2009, the situation escalated and SEALs on BAINBRIDGE eliminated the threat to the remaining hostage, *Maersk Alabama* Captain

Phillips, who was subsequently rescued. This is but one example, using a well-publicized mission, that illustrates how an unvaccinated member would put himself, his teammates, the conventional forces and the mission at great risk. While NSW personnel may be assigned to various units with various mission-sets, all naval forces must be ready to respond to global contingencies and crises on short notice.

19. If this type of crisis or contingency occurred today, with the Court's preliminary injunction in place, the Navy could be required to deploy a SEAL team with one or more unvaccinated members, risking a COVID-19 outbreak within that unit or on the host Navy destroyer. Destroyer crews, and others embarked aboard, sleep in confined shared berthing spaces, are in close proximity in passageways, and eat meals in a communal galley. An unvaccinated service member is not only more likely to contract COVID-19, but to experience significant disease symptoms, impact the mission and spread the disease to others.

20. Navy ships have limited health care facilities. A Sailor experiencing severe COVID symptoms would require the ship to pull into port instead of executing its mission. NSW forces often deploy in countries with little or no healthcare support structure and in remote areas where healthcare is scarce. This is why there has been a long-standing requirement for all members of the NSW force to be fully medically ready to deploy. A small number of SOF medical personnel provide limited medical support and patient movement; therefore, any encumbrance placed on that limited capability unnecessarily puts the mission and the force at-risk. While some SEALs are trained to perform emergency, life-saving procedures in remote and hostile environments, those personnel are not physicians or nurses. Unlike doctors and nurses, formal civilian medical licenses are not required for them. They do not generally have the capability, capacity or training to use a ventilator. Additionally, they do not have access to this

equipment in the types of austere environments in which the NSW units operate. If a deployed team member contracts COVID-19, there is a strong possibility that the necessary equipment or treatment would not be readily available. Further, if medical evacuation is necessary for a member of the unit, this creates additional risk not only to the mission, but places those service members executing medical evacuation at a risk of harm to themselves such as when the member requires transport from a hostile, remote or diplomatically sensitive areas.

21. Redirecting these assets and their crew to perform preventable evacuations results in a degradation of the Navy's ability to accomplish its primary missions and incurs collateral impacts. Medical evacuations often require one or more member from the service member's unit to accompany the evacuated service member. The loss of even one member can degrade the effectiveness of small NSW units and may compromise the mission. This is similarly the case for SWCC personnel, who routinely operate with a crew of as little as four personnel on a combatant craft. Every member of a SEAL team is vital.

22. Unvaccinated NSW personnel put conventional Navy forces at risk as well. Navy SEALs are one of the most versatile elements of the SOF across all branches of the military services, in part, because the Navy can deliver them to their mission locations through a variety of conventional means (*e.g.*, fixed-wing aircraft, helicopters, surface ships and submarines). All of these means of delivery are confined spaces in which social distancing is impractical. Because NSW personnel rely on conventional Navy forces to support their missions, any unvaccinated NSW personnel will put the crew of those conventional forces at unnecessary risk as well. The Navy must balance the risk to unvaccinated individuals and vaccinated personnel alike. That risk calculation led to the mandatory vaccination mandate and associated personnel policies pertaining to the COVID-19 pandemic. It is imperative for the entire force, including

every member of NSW, to be vaccinated and ready to deploy and execute assigned missions on short notice.

23. The capabilities NSW personnel provide include crisis response, support to forward presence operations, support to conventional Naval forces at sea and in training, support to Law Enforcement agencies and clandestine insertion operations. EOD personnel provide critical safety and response to units using live ordnance; Navy divers, EOD and SEALs support underwater surveys and route clearances. SEALs conduct insertions and extractions by sea, air or land; they capture high-value enemy personnel and terrorists around the world, carry out small-unit direct-action missions against military targets and perform underwater reconnaissance and strategic sabotage. SEALs, SWCC, EOD and divers frequently deploy to foreign countries to train partners and allies and participate in exercises. Reducing the Navy's ability to apply long-standing, proven medical readiness principles to this small, elite community will clearly negatively impact the NSW force's ability to conduct their operations and could have significant negative effects to the NSW force's ability to respond to large-scale contingencies or crises. This would damage the national security interests of the United States and our foreign allies and partners.

24. These concerns apply if the injunction requires the Navy to maintain these 35 Plaintiffs in their current status while an appeal is pending. Of the 35 Plaintiffs, 18 are assigned to nine different parent commands and may deploy anywhere in the world in the immediate future to perform the type of missions described. 15 Plaintiffs are assigned to the NSW Center or a NSW Center subordinate command, with 14 of them assigned to NSW Advanced Training

Command (ATC);[10] some as instructors who necessarily have close contact with ATC students in courses to prepare them for NSW operations and some as students attending an advanced training course before returning to their current or prospective assignment. Two Plaintiffs are currently assigned to non-NSW training commands. Because the court's order prohibits them from being temporarily reassigned, the 14 unvaccinated personnel at NSW ATC have close contact with fellow instructors and students. These students then circulate among the larger NSW community as soon as their courses at ATC end. Simply put, close quarters contact during training creates the opportunity to contract COVID-19 from the unvaccinated instructors at ATC detachments. The unvaccinated instructors can spread COVID-19 to dozens of candidates in training, and qualified SEALs, SWCCs, and other personnel, including fellow instructors, at NSW ATC training courses who will promptly return to their primary units or interact with additional training classes.

25. In summary, the Navy's judgment is that COVID-19 vaccines are a critical defense against COVID-19 and mitigate risk both to our force and to our mission. This judgment takes into account the environments our service members operate in, the operations the Navy conducts, and the absence of other effective COVID-19 mitigation measures in the environments in which we operate. The COVID-19 virus has had a proven substantial impact on Navy unit readiness. The Court's order, which bars implementation of the vaccine requirement and requires the Navy to keep service members it has determined are not medically fit for deployment in a ready to deploy status, will undermine military readiness through the spread of disease and cause

[10] ATC's mission is to provide standardized and accredited individual training and education for qualified NSW and support personnel, U.S. SOF (i.e., from other Services), partner nation SOF and other personnel, as required for NSW Operations. There are several ATC detachments. The largest detachment in Coronado, California provides a course of instruction to candidates (i.e., those seeking to obtain their SEAL or SWCC designation). It also provides training to those already designated as SEALs, SWCC or combat support personnel. Other ATC detachments provide training in specialized areas to NSW personnel, other SOF and partner nation SOF.

significant harm to military operations by allowing unvaccinated service members to remain in an unvaccinated status.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed this 19th day of January, 2022.

W. K. LESCHER

ENCLOSURE 6

FUNCTIONS OF THE MILITARY DEPARTMENTS

1. COMMON MILITARY DEPARTMENT FUNCTIONS. For purposes other than the operational direction of the Combatant Commands, the chain of command runs from the President to the Secretary of Defense to the Secretaries of the Military Departments and, as prescribed by the Secretaries, to the commanders of Military Service forces.

a. Subject to the authority, direction, and control of the Secretary of Defense, the Secretaries of the Military Departments are responsible for, and have the authority necessary to conduct, all affairs of their respective Departments, including:

(1) Recruiting.

(2) Organizing.

(3) Supplying.

(4) Equipping (including research and development).

(5) Training.

(6) Servicing.

(7) Mobilizing.

(8) Demobilizing.

(9) Administering (including the morale and welfare of personnel).

(10) Maintaining.

(11) Construction, outfitting, and repairs of military equipment.

(12) Construction, maintenance, and repair of buildings, structures, and utilities as well as the acquisition, management, and disposal of real property and natural resources.

b. Subject to the authority, direction, and control of the Secretary of Defense, the Secretaries of the Military Departments are also responsible to the Secretary of Defense for ensuring that their respective Departments:

(1) Operate effectively, efficiently, and responsively.

(2) Formulate policies and programs that are fully consistent with national security objectives and policies established by the President and the Secretary of Defense.

(3) Implement, in a timely and effective manner, policy, program, and budget decisions and instructions of the President or Secretary of Defense.

(4) Present and justify positions on the plans, programs, and policies of the Department of Defense.

(5) Prepare, submit, and justify budgets before Congress, in coordination with other USG departments and agencies, as applicable; and administer the funds made available for maintaining, equipping, and training the forces of their respective departments, including those assigned to the Combatant Commands. Among other things, budget submissions shall be informed by the recommendations of the Military Service Chiefs, Commanders of the Combatant Commands, and of Military Service component commanders of forces assigned to the Combatant Commands.

(6) Establish and maintain reserves of manpower, equipment, and supplies for the effective prosecution of the range of military operations and submit, in coordination with the other Military Departments, mobilization information to the Joint Chiefs of Staff.

(7) Develop integrated mobilization plans for the expansion of peacetime components to meet the needs of war.

(8) Perform Military Department functions necessary to fulfill the current and future operational requirements of the Combatant Commands, including the recruitment, organization, training, and equipping of interoperable forces.

(9) Provide forces to enhance military engagement, conduct security cooperation, build the security capacity of partner states, and deter adversaries to prevent conflict. These actions shall be coordinated with the other Military Departments, Combatant Commands, USG departments and agencies, and international partners, as required.

(10) Provide forces, military missions, and detachments for service in foreign countries as may be required to support the national interests of the United States, and provide, as directed, assistance in training, equipping, and advising the military forces of foreign nations.

(11) Coordinate with the other Military Departments and all of the other DoD Components to provide for more effective, efficient, and economical administration; eliminate duplication; and assist other DoD Components in the accomplishment of their respective functions by providing personnel, intelligence, training, facilities, equipment, supplies, and services, as may be required.

(12) Develop, garrison, supply, equip, and maintain bases and other installations, including lines of communication, and provide administrative and logistical support for all assigned forces and bases, unless otherwise directed by the Secretary of Defense.

(13) Provide, as directed, administrative and logistical support to the headquarters of the Combatant Commands, to include direct support of the development and acquisition of the command and control systems of such headquarters.

(14) Supervise and control Military Department intelligence activities, including the collection, production, and dissemination of military and military-related foreign intelligence and counterintelligence as required for execution of Military Department responsibilities.

(15) Afford the Assistant Secretary of Defense for Special Operations and Low-Intensity Conflict; the Commander, USSOCOM; the PCA; and the Commander, USCYBERCOM, an opportunity to coordinate on Military Department and Military Service personnel management policy and plans as they relate to accessions, assignments, compensation, promotions, professional development, readiness, retention, sustainment, and training of all SOF (for USSOCOM) and all cyber operations forces (for USCYBERCOM) personnel. This coordination shall not interfere with the title 10 authorities of the Military Departments or Military Services.

(16) Engage in such other activities as are prescribed by law, the President, or the Secretary of Defense.

2. COMMON MILITARY SERVICE FUNCTIONS. The Army, the Navy, the Air Force, the Marine Corps, and the Space Force, and the Coast Guard, when transferred to the Department of the Navy in accordance with sections 2, 3, and 145 of Reference (h), to include the Active and Reserve Components of each, under their respective Secretaries, shall provide conventional, strategic, and SOF to conduct the range of operations as defined by the President and the Secretary of Defense. Further, they shall perform the following common functions:

a. Develop concepts, doctrine, tactics, techniques, and procedures, and organize, train, equip, and provide land, naval, air, space, and cyberspace forces, in coordination with the other Military Services, Combatant Commands, USG departments and agencies, and international partners, as required, that enable joint force commanders to conduct decisive operations across the spectrum of conflict in order to achieve the desired end state.

b. Determine Military Service force requirements and make recommendations concerning force requirements to support national security objectives and strategy and to meet the operational requirements of the Combatant Commands.

c. Recommend to the Joint Chiefs of Staff the assignment and deployment of forces to the Combatant Commands established by the President through the Secretary of Defense.

d. Monitor and assess Military Service operational readiness and capabilities of forces for assignment to the Combatant Commands and plan for the use of the intrinsic capabilities of the other Military Services, USSOCOM, and USCYBERCOM that may be made available.

e. Develop doctrine, tactics, techniques, and procedures for employment by Military Service forces and:

(1) Assist the Chairman of the Joint Chiefs of Staff in the development of joint doctrine.

(2) Coordinate with the Chairman of the Joint Chiefs of Staff, the Combatant Commands, the other Military Services, USG departments and agencies, partner security forces, and non-governmental organizations, in the development of the doctrine, tactics, techniques, and procedures necessary for participation in and/or command of joint, interagency, and multinational operations.

(3) Coordinate with the Commanders, USSOCOM and USCYBERCOM, in the development of the doctrine, tactics, techniques, and procedures employed by Military Service forces when related to special operations and cyber operations, respectively.

f. Provide for training for joint operations and joint exercises in support of Combatant Command operational requirements, including the development of Military Service joint training requirements, policies, procedures, and publications.

g. Provide logistical support for Military Service and all forces assigned to joint commands, including procurement, distribution, supply, equipment, and maintenance, unless otherwise directed by the Secretary of Defense.

h. Organize, train, and equip forces to contribute unique service capabilities to the joint force commander to conduct the following functions across all domains, including land, maritime, air, space, and cyberspace:

(1) Intelligence, surveillance, reconnaissance, and information operations, to include electronic warfare and MISO in order to provide situational awareness and enable decision superiority across the range of military operations.

(2) Offensive and defensive cyberspace operations to achieve cyberspace superiority in coordination with the other Military Services, Combatant Commands, and USG departments and agencies.

(3) Special and cyber operations in coordination with USSOCOM, USCYBERCOM, and other Combatant Commands, the Military Services, and other DoD Components.

(4) Personnel recovery operations in coordination with USSOCOM and other Combatant Commands, the Military Services, and other DoD Components.

(5) Counter weapons of mass destruction.

(6) Building partnership capacity/security force assistance operations.

(7) Forcible entry operations.

(8) Missile Defense.

(9) Other functions as assigned, such as Presidential support and antiterrorism.

i. Organize, train, and equip forces to conduct support to civil authorities in the United States and abroad, to include support for disaster relief, consequence management, mass migration, disease eradication, law enforcement, counter-narcotics, critical infrastructure protection, and response to terrorist attack, in coordination with the other Military Services, Combatant Commands, National Guard, and USG departments and agencies.

j. Operate organic land vehicles, aircraft, cyber assets, spacecraft or space systems, and ships or craft.

k. Conduct operational testing and evaluation.

l. Provide command and control.

m. Provide force protection.

n. Consult and coordinate with the other Military Services on all matters of joint concern.

3. INDIVIDUAL MILITARY DEPARTMENT FUNCTIONS. The forces developed and trained to perform the primary functions set forth in sections 4 through 6 of this enclosure shall be employed to support and supplement the other Military Service, USSOCOM, and USCYBERCOM forces in carrying out their primary functions, wherever and whenever such participation shall result in increased effectiveness and shall contribute to the accomplishment of overall military objectives.

4. FUNCTIONS OF THE DEPARTMENT OF THE ARMY

a. The Department of the Army includes land combat, and service forces, and such aviation, water transport, and space and cyberspace forces as may be organic therein, and shall be organized, trained, and equipped primarily for prompt and sustained combat incident to operations on land, and to support the other Military Services and joint forces. The Army is responsible for the preparation of land forces necessary for the effective prosecution of war and military operations short of war, except as otherwise assigned. The Army is the Nation's principal land force and promotes national values and interests by conducting military engagement and security cooperation; deterring aggression and violence; and should deterrence fail, compelling enemy behavioral change or compliance. The Army shall contribute forces through a rotational, cyclical readiness model that provides a predictable and sustainable supply of modular forces to the Combatant Commands, and a surge capacity for unexpected contingencies.

b. The Functions of the Army. In addition to the common military service functions listed in paragraphs 2.a. through 2.n. of this enclosure, the Army, within the Department of the Army, shall develop concepts, doctrine, tactics, techniques, and procedures, and organize, train, equip,

and provide forces with expeditionary and campaign qualities to perform the following specific functions:

(1) Conduct prompt and sustained combined arms combat operations on land in all environments and types of terrain, including complex urban environments, in order to defeat enemy ground forces, and seize, occupy, and defend land areas.

(2) Conduct air and missile defense to support joint campaigns and assist in achieving air superiority.

(3) Conduct airborne and air assault, and amphibious operations. The Army has primary responsibility for the development of airborne doctrine, tactics, techniques, and equipment.

(4) Conduct CAO.

(5) Conduct riverine operations.

(6) Occupy territories abroad and provide for the initial establishment of a military government pending transfer of this responsibility to other authority.

(7) Interdict enemy sea, space, air power, and communications through operations on or from the land.

(8) Provide logistics to joint operations and campaigns, including joint over-the-shore and intra-theater transport of time-sensitive, mission-critical personnel and materiel.

(9) Provide support for space operations to enhance joint campaigns, in coordination with the other Military Services, Combatant Commands, and USG departments and agencies.

(l0) Conduct authorized civil works programs, to include projects for improvement of navigation, flood control, beach erosion control, and other water resource developments in the United States, its territories, and its possessions, and conduct other civil activities prescribed by law.

(11) Provide intra-theater aeromedical evacuation.

(12) Conduct reconnaissance, surveillance, and target acquisition.

(13) Operate land lines of communication.

5. FUNCTIONS OF THE DEPARTMENT OF THE NAVY

a. The Department of the Navy is composed of naval, land, air, space, and cyberspace forces, both combat and support, not otherwise assigned, to include those organic forces and capabilities necessary to operate, and support the Navy and Marine Corps, the other Military Services, and joint forces. The Navy and Marine Corps comprise the Nation's principal maritime force. They

employ the global reach, persistent presence through forward-stationed and rotationally-based forces, and operational flexibility to secure the Nation from direct attack; secure strategic access and retain global freedom of action; strengthen existing and emerging alliances and partnerships; establish favorable security conditions; deter aggression and violence by state, non-state, and individual actors and, should deterrence fail, prosecute the full range of military operations in support of U.S. national interests.

b. The Functions of the Navy. In addition to the common military service functions listed in paragraphs 2.a. through 2.n. of this enclosure, the Navy, within the Department of the Navy, shall develop concepts, doctrine, tactics, techniques, and procedures and organize, train, equip, and provide forces to perform the following specific functions:

(1) Conduct offensive and defensive operations associated with the maritime domain including achieving and maintaining sea control, to include subsurface, surface, land, air, space, and cyberspace.

(2) Provide power projection through sea-based global strike, to include nuclear and conventional capabilities; interdiction and interception capabilities; maritime and/or littoral fires, to include naval surface fires; and close air support for ground forces.

(3) Conduct ballistic missile defense.

(4) Conduct ocean, hydro, and river survey and reconstruction.

(5) Conduct riverine operations.

(6) Establish, maintain, and defend sea bases in support of naval, amphibious, land, air, or other joint operations as directed.

(7) Provide naval expeditionary logistics to enhance the deployment, sustainment, and redeployment of naval forces and other forces operating within the maritime domain, to include joint sea bases, and provide sea transport for the Armed Forces other than that which is organic to the individual Military Services, USSOCOM, and USCYBERCOM.

(8) Provide support for joint space operations to enhance naval operations, in coordination with the other Military Services, Combatant Commands, and USG departments and agencies.

(9) Conduct nuclear operations in support of strategic deterrence, to include providing and maintaining nuclear surety and capabilities.

c. The Functions of the Marine Corps. In addition to the common military service functions listed in paragraphs 2.a. through 2.n. of this enclosure, and pursuant to section 8063 of Reference (e), the Marine Corps, within the Department of the Navy, shall develop concepts, doctrine, tactics, techniques, and procedures and organize, train, equip, and provide forces, normally

employed as combined arms air ground task forces, to serve as an expeditionary force-in-readiness, and perform the following specific functions:

(1) Seize and defend advanced naval bases or lodgments to facilitate subsequent joint operations.

(2) Provide close air support for ground forces.

(3) Conduct land and air operations essential to the prosecution of a naval campaign or as directed.

(4) Conduct complex expeditionary operations in the urban littorals and other challenging environments.

(5) Conduct amphibious operations, including engagement, crisis response, and power projection operations to assure access. The Marine Corps has primary responsibility for the development of amphibious doctrine, tactics, techniques, and equipment.

(6) Conduct security and stability operations and assist with the initial establishment of a military government pending transfer of this responsibility to other authority.

(7) Provide security detachments and units for service on armed vessels of the Navy, provide protection of naval property at naval stations and bases, provide security at designated U.S. embassies and consulates, and perform other such duties as the President or the Secretary of Defense may direct. These additional duties may not detract from or interfere with the operations for which the Marine Corps is primarily organized.

d. The Functions of the Coast Guard. The Coast Guard is a unique Military Service residing within the Department of Homeland Security while simultaneously providing direct support to the Department of Defense under its inherent authorities under References (e) and (h). In addressing the Coast Guard when it is not operating in the [Department of the] Navy, this issuance is descriptive in nature and does not purport to be either directive or regulatory. As directed by the President, and in accordance with Memorandum of Agreement between the Department of Defense and Department of Homeland Security on the use of Coast Guard Capabilities and Resources in Support of the National Military Strategy (Reference (ab)), the Department of the Navy shall coordinate with the Department of Homeland Security regarding Coast Guard military functions in time of limited war or defense contingency, without transfer of Coast Guard authority to the Secretary of the Navy. As directed, the Department of the Navy will provide intelligence, logistical support, and specialized units to the Coast Guard, including designated ships and aircraft, for overseas deployment required by naval component commanders, maritime search and rescue, integrated port security, and coastal defense of the United States. The Coast Guard shall maintain a state of readiness to function as a specialized Military Service in the Department of the Navy in time of war or national emergency. If specified in a declaration of war by Congress or if directed by the President, the Coast Guard shall operate as a Military Service in the Department of the Navy, and shall continue to do so

until the President transfers the Coast Guard back to the Department of Homeland Security by Executive order pursuant to section 3 of Reference (h).

(1) The Coast Guard shall develop concepts, doctrine, tactics, techniques, and procedures and organize, train, equip, and provide forces to perform the following specific functions when providing direct or cooperative support to the Department of Defense:

(a) Conduct coastal sea control and maritime and air interception and interdiction operations.

(b) Conduct maritime homeland security and counterterrorism operations.

(c) Provide for port operations, security, and defense.

(d) Provide maritime operational threat response.

(e) Conduct counter-illicit trafficking operations.

(f) Conduct military environmental response operations.

(g) Conduct theater security cooperation operations.

(h) Conduct search and rescue operations.

(i) Conduct ice operations.

(j) Provide for marine safety, including aids to navigation.

(2) The Coast Guard will coordinate with the Department of Defense, including the Department, of the Navy to provide specialized Coast Guard units, or obtain Navy units, including designated ships and aircraft, for deployment as requested by Military Service component or joint commanders.

6. FUNCTIONS OF THE DEPARTMENT OF THE AIR FORCE

a. The Department of the Air Force is composed of air, space, and cyberspace forces, both combat and support, not otherwise assigned. The Air Force and Space Force are the Nation's principal air and space forces, and are responsible for the preparation of forces necessary for the effective prosecution of war. The Department of the Air Force shall organize, train, equip, and provide air, space, and cyberspace forces for the conduct of prompt and sustained combat operations, military engagement, and security cooperation in defense of the Nation, and to support the other Military Services and joint forces. The Air Force and Space Force will provide the Nation with global vigilance, global reach, and global power in the form of in-place, forward-based, and expeditionary forces possessing the capacity to deter aggression and violence by state, non-state, and individual actors to prevent conflict, and, should deterrence fail, prosecute the full range of military operations in support of U.S. national interests.

b. The Functions of the Air Force. In addition to the common military service functions listed in paragraphs 2.a. through 2.n. of this enclosure, the Air Force, within the Department of the Air Force, shall develop concepts, doctrine, tactics, techniques, and procedures and organize, train, equip, and provide forces to perform the following specific functions:

(1) Conduct nuclear operations in support of strategic deterrence, to include providing and maintaining nuclear surety and capabilities.

(2) Conduct offensive and defensive operations, to include appropriate air and missile defense, to gain and maintain air superiority, and air supremacy as required, to enable, the conduct of operations by U.S. and allied land, sea, air, space, and special operations forces.

(3) Conduct global precision attack, to include strategic attack, interdiction, close air support, and prompt global strike.

(4) Provide timely, global integrated intelligence, surveillance, and reconnaissance capability and capacity from forward deployed locations and globally distributed centers to support world-wide operations.

(5) Provide rapid global mobility to employ and sustain organic air and space forces and other Military Service and USSOCOM forces, as directed, to include airlift forces for airborne operations, air logistical support, tanker forces for in-flight refueling, and assets for aeromedical evacuation.

(6) Provide agile combat support to enhance the air and space campaign and the deployment, employment, sustainment, and redeployment of air and space forces and other forces operating within the air and space domains, to include joint air and space bases, and for the Armed Forces other than which is organic to the individual Military Services and USSOCOM in coordination with the other Military Services, Combatant Commands, and USG departments and agencies.

(7) Conduct global personnel recovery operations including theater-wide combat and civil search and rescue, in coordination with the other Military Services, USJFCOM, USSOCOM, and DoD Components.

(8) Conduct global integrated command and control for air and space operations.

c. The Functions of the Space Force. In addition to the common military service functions listed in Paragraphs 2.a. through 2.n. of this enclosure, the Space Force, within the Department of the Air Force, shall develop concepts, doctrine, tactics, techniques, and procedures and organize, train, equip, and provide forces to perform the following specific functions:

(1) Provide freedom of operation for the United States in, from, and to space.

(2) Provide prompt and sustained space operations.

(3) Protect the interests of the United States in space.

(4) Deter aggression in, from, and to space.

(5) Conduct space operations.

7. DEPARTMENT OF THE ARMY AND DEPARTMENT OF THE AIR FORCE: THE NGB. The NGB is a joint activity of the Department of Defense. The NGB performs certain Military Service-specific functions and unique functions on matters involving non-federalized National Guard forces as set forth in Reference (i).

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

U.S. NAVY SEALs 1-3; on behalf of themselves and all others similarly situated; **U.S. NAVY EXPLOSIVE ORDNANCE DISPOSAL TECHNICIAN 1**, on behalf of himself and all others similarly situated; U.S. **NAVY SEALS 4-26**; **U.S. NAVY SPECIAL WARFARE COMBATANT CRAFT CREWMEN 1-5**; and **U.S. NAVY DIVERS 1-3**,

Plaintiffs,

v.

LLOYD J. AUSTIN, III, in his official capacity as United States Secretary of Defense; **UNITED STATES DEPARTMENT OF DEFENSE**; **CARLOS DEL TORO**, in his official capacity as United States Secretary of the Navy,

Defendants.

Case No. 4:21-cv-01236-O

AMENDED NOTICE OF DEPOSITION

To: William K. Lescher
c/o Andrew Carmichael
United States Department of Justice
Civil Division, Federal Programs Branch
1100 L Street, N.W.
Washington, DC 20005

Please take notice that pursuant to Rule 30 of the Federal Rules of Civil Procedure, Plaintiffs, by their attorneys, will take the deposition of William K. Lescher, in his official capacity as Vice Chief of Naval Operations for the United States Department of Defense, before a Certified Court Reporter. The deposition will take place on June 30, 2022, beginning at 8:00 a.m., at Naval Air Systems Command Washington Liaison Office, Naval Support Facility (NSF) Arlington, 701 South Courthouse Road, Suite 2000, Building 15, Arlington, Virginia 22204.

The deposition will be stenographically and electronically recorded and will be videotaped. The deposition will be used for discovery and/or evidentiary purposes to the full extent allowed by the Federal Rules of Civil Procedure and the Federal Rules of Evidence.

Dated: June 3, 2022

Respectfully submitted.

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Hiram S. Sasser, III
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Attorneys for Plaintiffs

** Not yet admitted to the D.C. Bar, but admitted to practice law in Florida. Practicing law in D.C. pursuant to D.C. Court of Appeals Rule 49(c)(8) under the supervision of an attorney admitted to the D.C. Bar.

CERTIFICATE OF SERVICE

I hereby certify that on June 3, 2022, I served the foregoing document on counsel of record for each party.

/s/Andrew B. Stephens
ANDREW B. STEPHENS

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

U.S. NAVY SEALs 1–3, on behalf of themselves and all others similarly situated; **U.S. NAVY EXPLOSIVE ORDNANCE DISPOSAL TECHNICIAN 1,** on behalf of himself and all others similarly situated; **U.S. NAVY SEALS 4–26; U.S. NAVY SPECIAL WARFARE COMBATANT CRAFT CREWMEN 1–5; and U.S. NAVY DIVERS 1–3,**

Plaintiffs,

v.

LLOYD J. AUSTIN, III, in his official capacity as United States Secretary of Defense; **UNITED STATES DEPARTMENT OF DEFENSE; CARLOS DEL TORO,** in his official capacity as United States Secretary of the Navy,

Defendants.

Case No. 4:21-cv-01236-O

PLAINTIFFS' FIRST REQUESTS FOR PRODUCTION OF DOCUMENTS

Pursuant to Federal Rules of Civil Procedure 26 and 34, Plaintiffs hereby request that Defendants produce the following documents in accordance with the definitions and instructions set forth below at the office of Plaintiffs' counsel, First Liberty Institute, c/o Justin Butterfield, 2001 W. Plano Parkway, Suite 1600, Plano, Texas 75075, within 30 days after service of these requests.

Please be advised that Plaintiffs will be taking the deposition of Admiral William K. Lescher on June 30, 2022. Plaintiffs may seek to compel a second deposition of Admiral Lescher if Defendants do not fully comply with these requests and produce all responsive documents on or before the deadline set forth above.

DEFINITIONS

1. "Concerning" means having any relationship or connection to, regarding, relating, being connected to, commenting on, responding to, addressed to, sent to, containing, evidencing, showing, memorializing, describing, analyzing, reflecting, pertaining to, comprising, constituting, or otherwise establishing any reasonable, logical, or causal connection.

2. "Document" and "documents" are synonymous in meaning and equal in scope to the usage of the terms as defined in Federal Rule of Civil Procedure 34(a)(1)(A) and shall include all items subject to inspection and copying under those Rules, including any original, reproduction, copy, or draft of any kind of written or documented material, stored in any medium, including but not limited to audio and video tapes, correspondence, memoranda, interoffice communications, electronic mail, text messages, notes, diaries, calendars, personal digital assistant device entries, contract documents, estimates, vouches, minutes of meetings, invoices, checks, reports, notes of telephone conversations, notes of oral communications, computer-stored information that is retrievable in any form, writings, drawings, graphs, charts, photographs, and other data compilations, from which information can be obtained, and electronically stored information that is retrievable in any form, or translated if necessary, by Defendants through detection devices into a reasonably usable form, except that neither electronically stored voicemails nor the information stored in the memories of copiers, printers, and fax machines are "documents" under this definition.

3. The singular shall be construed to include the plural, and the plural shall be construed to include the singular, as necessary to bring within the scope of each request all documents that might otherwise be construed as nonresponsive to the request.

4. The connectives "and" and "or" and the phrase "and/or" shall be construed either disjunctively or conjunctively to bring within the scope of each request all documents that might otherwise be construed as nonresponsive to the request. The word "and" shall be construed to mean both "and" and "or," and vice versa, as necessary to bring within the scope of each request all documents that might otherwise be construed as nonresponsive to the request.

5. "Lescher Declaration" means the declaration of Admiral William K. Lescher signed on January 19, 2022 and submitted in support of Defendants' Application for a Partial Stay of the Injunction Issued by the United States District Court for the Northern District of Texas. A copy of the Lescher Declaration is attached hereto as Exhibit A.

6. "COVID-19" refers to severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), coronavirus disease 2019 and/or the illness caused by the SARS-CoV-2 virus.

INSTRUCTIONS

1. In responding to these document requests, Defendants are required to furnish all responsive documents in their possession, custody, or control, or in the possession, custody, or control of their attorneys, agents, employees, independent contractors, and all other persons acting on behalf of each of them or any of them.

2. Each document request shall be responded to separately and fully, unless it is in good faith objected to, in which event the reasons for the objection shall be stated with specificity. If an objection pertains to only a portion of the request, or to a word, phrase, or clause contained therein, Defendants shall state the objection to that portion only and respond to the remainder of the request.

3. If, in responding to these document requests, Defendants claim any ambiguity in a document request, or in a definition or instruction applicable thereto, Defendants shall not rely

upon the ambiguity as a basis for refusing to respond, but shall set forth as part of their response the language deemed to be ambiguous and the interpretation used in responding to the request.

4. An original or one copy of each responsive document shall be produced. Any copy of a document that varies in any way from the original or from any other copy of the document, whether by reason of handwritten or other notation, highlighting, underlining, or other marks, or a draft or successive iteration thereof and all modifications thereto, shall constitute a separate document and must be produced, whether or not the original of such document is within Defendants' possession, custody, or control. If the same document exists in both electronic and non-electronic format, the electronically maintained document must be produced; provided, if the non-electronically maintained document varies in any way from the electronically maintained document as described above, both the electronically maintained and non-electronically maintained documents shall be produced.

5. Documents shall be produced as they are kept in the ordinary course of business. Each document requested is to be produced in its original file folder, file jacket, or cover (or Defendants may, in the alternative, designate in writing the titles of such folder, jacket, or cover with respect to each document). The individual or department from whose files the document is being produced is to be indicated.

6. If there are no documents responsive to any particular request, Defendants shall state so in writing.

7. A request for documents shall be deemed to include a request for all transmittal sheets, cover letters, exhibits, enclosures, and attachments to the documents, in addition to the document itself, without abbreviation or expurgations. Documents attached to other documents or

materials shall not be separated unless information is provided sufficient to permit reconstruction of the grouping or context in which the document is maintained in the ordinary course of business.

8. If the documents requested differ from one office, division, or location to another, the requests require production of documents for each office, division, or location.

9. Each document requested shall be produced in its entirety and without redactions, deletions, or excisions, regardless of whether Defendants consider the entire document to be relevant or responsive to these requests.

10. For any document withheld under a claim of privilege, submit a privilege log that complies with FRCP 26(b)(5)(A) with your response to these requests.

11. These document requests are continuing in nature. Any document obtained, created, identified, or located after service of any response to these requests that would have been included in the responses had the document been available or had its existence been known at that time should be produced immediately.

12. For any document responsive to these requests that has been destroyed, lost, is otherwise unavailable, or is no longer in Defendants' present possession, custody, or control, identify with respect to each document: the author, addressee, date, number of pages, and subject matter; and explain in detail the events leading to the destruction or loss, or the reason for the unavailability of such document, including the location of such document when last in your possession, custody, or control, and the date and manner of its disposition.

13. The relevant time period for these document requests is October 1, 2019, through the time of trial, unless otherwise stated.

REQUESTS FOR PRODUCTION

Document Request No. 1:

Produce all documents relied on, reviewed, considered, cited, discussed, analyzed, consulted or referenced by Admiral William K. Lescher in drafting or preparing the Lescher Declaration.

Document Request No. 2:

Produce all documents reflecting communications by and between Admiral William K. Lescher and any other person concerning the Lescher Declaration, including all communications concerning each document produced in response to Document Request No. 1, all communications concerning the facts contained in the Lescher Declaration, and all communications concerning any and all opinions or conclusions contained in the Lescher Declaration.

Document Request No. 3:

Produce all documents concerning any meetings or telephone calls by and between Admiral William K. Lescher and any other person concerning the Lescher Declaration, including but not limited to, calendar appointments, notes, memos, visitor logs, and phone records.

Document Request No. 4:

Produce all documents in the possession, custody, or control of Admiral William K. Lescher between October 1, 2019 and the present concerning COVID-19, or the claims alleged in this lawsuit, the facts alleged in this lawsuit, the defenses asserted by Defendants in this lawsuit, or the facts, opinions, or conclusions contained in any declarations or other sworn statements submitted by Defendants in this lawsuit.

Document Request No. 5:

Produce all documents reflecting communications by and between Admiral William K. Lescher between October 1, 2019 and the present and any other person concerning COVID-19, or the claims alleged in this lawsuit, the facts alleged in this lawsuit, the defenses asserted by Defendants in this lawsuit, or the facts, opinions, or conclusions contained in any declarations or other sworn statements submitted by Defendants in this lawsuit.

Dated: May 17, 2022

Respectfully submitted.

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CERTIFICATE OF SERVICE

I hereby certify that I caused to be served copies of the foregoing Plaintiffs' First Set of Requests for Production of Documents by electronic mail this 17th day of May 2022, upon counsel for Defendants.

/s/Andrew B. Stephens
ANDREW B. STEPHENS

EXHIBIT A

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS

U.S. NAVY SEALs 1-26;
U.S. NAVY SPECIAL WARFARE COMBATANT CRAFT CREWMEN 1-5;
U.S. NAVY EXPLOSIVE ORDNANCE DISPOSAL TECHNICIAN 1; and
U.S. NAVY DIVERS 1-3,
Plaintiffs,

v.

LLOYD J. AUSTIN, III, individually and in his official capacity as United States Secretary of Defense; **UNITED STATES DEPARTMENT OF DEFENSE; CARLOS DEL TORO,** individually and in his official capacity as United States Secretary of the Navy,
Defendants.

Case No. 4:21-CV-01236-O

DECLARATION OF WILLIAM K. LESCHER

I, William K. Lescher, hereby state and declare as follows:

1. I am an admiral[1] in the United States Navy, currently serving as the Vice Chief of Naval Operations (VCNO), located in Arlington, Virginia at the Pentagon. The position of VCNO is appointed by the President, with the advice and consent of the Senate, and is the second highest uniformed Officer in the Navy. I have served in this position since May 29, 2020. I make this declaration in support of the Government's motion for a stay of this Court's preliminary injunction pending appeal. The statements made in this declaration are based on my

[1] The rank of "admiral" is the highest military rank in the Navy. The term "admirals" is also frequently referred to as "flag officers." Flag officers include the ranks of rear admiral (lower half), rear admiral (upper half), vice admiral and admiral. Flag officers comprise the most senior levels of uniformed leadership in the Navy.

personal knowledge, my military judgment and experience, and on information that has been provided to me in the course of my official duties.

Preliminary Statement

2. I have reviewed the preliminary injunction order issued by this Court on January 3, 2022. I believe the Court's injunction will cause immediate harm to the Navy, and in particular to the operations of Naval Special Warfare (NSW) and Special Operations Forces (SOF), and to the national security of the United States. Operationally, in 2021, the Navy executed more than 30,000 steaming days and one million flying hours to protect America, deter conflict and keep the sea lanes open and free. The Court's injunction directly impacts the Navy's ability to carry out its responsibilities to protect and maintain the health and safety of our Force, in particular our ability to halt the spread of COVID-19 through a mandatory vaccination requirement. Unvaccinated or partially vaccinated service members are at higher risk to contract COVID-19, and to develop severe symptoms requiring hospitalizations that remove them from their units and impact mission execution. Vaccination against COVID-19 has proven to be essential in keeping Navy units on mission by mitigating the impact of COVID-19. Fully vaccinated naval forces are required to ensure readiness to carry out Navy missions throughout the world and, if required, to engage in combat operations. Restriction of the Navy's ability to reassign unvaccinated personnel in order to mitigate COVID-19 related risks to units preparing to deploy, or that are deployed, will cause direct and immediate impact to mission execution. Further, the harm caused by this injunction is not limited to 35 unvaccinated Plaintiffs. The heath, readiness, and mission execution of broader conventional Navy units and personnel who support these personnel are threatened as well.

Naval Background and Experience

3. As the Vice Chief of Naval Operations,[2] I work in coordination with the Chief of Naval Operations (CNO), the senior admiral in the U.S. Navy,[3] in the execution of his statutory duties and responsibilities as they pertain to the employment of the Navy. Those duties include recruiting, organizing, supplying, equipping, training, servicing, mobilizing, demobilizing, administering, and maintaining the Navy, as will assist in the execution of any power, duty, or function of the Secretary of the Navy or the Chief of Naval Operations. Additionally, the CNO delegated several specific responsibilities to me. I oversee programs and policies that impact Sailors and their families, including health affairs, and monitor and enact polices that promote good order and discipline in the Navy.

4. I have served in the United States Navy for nearly 42 years. A 1980 graduate of the United States Naval Academy, my experience includes command of the Vipers of Helicopter Anti-Submarine Light (HSL) Squadron-48, the Airwolves of HSL-40 and the Maritime Strike Wing Atlantic. As Commanding Officer, HSL-48, my responsibilities included training, preparing, and executing Seahawk helicopter detachment deployments on Navy ships deploying worldwide. As Commanding Officer, HSL-40, I was responsible for the training, evaluation, and maintenance of the Seahawk helicopter squadron that trains all East Coast Seahawk pilots in employment of this weapon system. As Commander, Maritime Strike Wing Atlantic, I was responsible for the material readiness and training of eight Helicopter Maritime Strike (HSM)

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[2] "The [VCNO] has such authority and duties with respect to the Department of the Navy as the Chief of Naval Operations, with the approval of the Secretary of the Navy, may delegate to or prescribe for him. Orders issued by the [VCNO] in performing such duties have the same effect as those issued by the Chief of Naval Operations." 10 U.S.C. § 8035(c).

[3] The CNO is the senior uniformed officer in the United States Navy. *See* 10 U.S.C. § 8033(b) ("The Chief of Naval Operations, while so serving, has the grade of admiral without vacating his permanent grade. In the performance of his duties within the Department of the Navy, the Chief of Naval Operations takes precedence above all other officers of the naval service.").

squadrons, the Weapons School, Fleet Replacement Squadron, and a total of 42 detachments deploying on Atlantic Fleet aircraft carriers and air capable ships, encompassing 68 aircraft and 1,900 personnel. Between command of the Vipers and Airwolves, I was the executive officer of Mine Countermeasures Command and Control Ship USS Inchon (MCS 12), a 20,000 ton vessel with a crew of 700. As the second in command, I was responsible for the supervision, training and development of the crew and the daily execution of the command mission, which included training and preparing the crew for deployment, maintaining and improving operational readiness and material condition of the ship. As a flag officer, I commanded Expeditionary Strike Group 5 (ESG-5) and Task Forces 51/59 (CTF 51/59) in Bahrain, leading multiple Amphibious Ready Groups, Marine Expeditionary Units and the afloat forward staging base USS Ponce (AFSB(I)-15) in execution of theater security events, combat operations, and emergent national taskings spanning the Middle East/Central Command region. My responsibilities as ESG-5 and CTF 51/59 included multiple events working with NSW forces embarked on my ships and interoperability exercises with partner countries. I also served as Joint Staff deputy director for resources and acquisition, deputy assistant Secretary of the Navy for budget, and Deputy Chief of Naval Operations for integration of capabilities and resources.

Specific Functions of the United States Navy

5. The United States Navy and Marine Corps comprise the Nation's principal maritime forces. Their missions are to provide globally deployable forces in order to "secure the Nation from direct attack; secure strategic access and retain global freedom of action; strengthen existing and emerging alliances and partnerships; establish favorable security conditions; deter aggression and violence by state, non-state, and individual actors and, should deterrence fail, prosecute the full range of military operations in support of U.S. national interests." *See*

Department of Defense Directive (DoDD) 5100.01, Change 1, 09/17/2020, Encl. 6, ¶ 5.a. –b (attached hereto). Effective execution of all of these discrete functions is vital to the national security of the United States, and is accomplished by providing fully trained and qualified naval forces to joint commanders[4] to deter aggression and, if required, engage in combat operations and win decisively.

Naval Special Warfare (NSW) and Special Operations Forces (SOF)

6. Naval Special Warfare (NSW) and Special Operations Forces (SOF) are composed of Navy SEALs[5] and Special Warfare Combatant-Craft Crewmen (SWCC). The NSW team is a multipurpose combat force organized and trained to conduct a variety of special operations missions in all environments. Navy SEALs conduct clandestine missions infiltrating their objective areas by fixed and rotary-wing aircraft, Navy surface ships, combatant craft, submarines and ground mobility vehicles. Service members designated as Navy SEALs consist of officers and enlisted members who have been designated pursuant to Navy and NSW policies. SWCC focus on infiltration and exfiltration of SEALs and other SOF to include from other Services, and they provide dedicated rapid mobility in maritime environments, as well as the ability to deliver combat craft via parachute drop. SWCC operate and maintain state-of-the-art surface craft to conduct special operations.

7. In addition to SEALs and SWCC, combat support (CS) and combat service support (CSS) personnel are assigned to NSW units to support the mission. CS/CSS personnel

[4] Joint commanders are the combatant vested with authority and responsibility for military operations within their area of responsibility. The Navy and other branches of the Armed Forces provide forces to the combatant commanders to execute those responsibilities and functions. The combatant commanders exercise authority, direction and control over the commands and forces assigned to them and employ those forces to accomplish missions assigned to the combatant commander. Department of Defense Directive (DoDD) 5100.01, Change 1, 09/17/2020, Encl. 1, ¶1.a through d.

[5] The term "SEAL" refers to "Sea, Air, Land."

include officers and enlisted service members identified in Plaintiffs' complaint (i.e., Explosive Ordinance Disposal (EOD) personnel and Navy Divers), in addition to other officers and enlisted service members performing a variety of military functions (e.g., chaplains, medical personnel, mobile communications teams, tactical cryptologic support, etc.). Navy EOD personnel perform missions neutralizing explosive weapons, including various weapons of mass destruction. Their duties include detonating or demolishing hazardous munitions, neutralizing various ordnance, including sea mines, torpedoes or depth charges, performing parachute or helicopter insertion operations, and clearing waterways of mines in support of our military operations. Navy Divers perform a variety of military functions, including wreckage salvage operations and underwater repairs, harbor and waterway clearance operations, assisting in construction and demolition projects, executing search and rescue missions, performing deep submergence operations, and serving as technical experts for diving operations for numerous military special operations units.

8. Service members in the NSW force are responsible for performing special operations. Special operations require unique tactics, techniques, procedures and equipment. They are often conducted in hostile, austere or diplomatically sensitive environments, and are characterized by one or more of the following: time-sensitivity, clandestine nature, low visibility, working with or through host-nation forces, greater requirements for regional orientation and cultural expertise, and a higher degree of risk. These missions often require members of the NSW force to work in close quarters where social distancing is not possible. Small NSW teams may travel for an extended duration on boats, submersibles, helicopters, aircraft, or other vehicles that are less than six feet across, and/or which have limited ventilation. Service members may be in such close quarters while traveling that they must sit shoulder-to-shoulder.

Additionally, members may be required to operate in subsea environments and may have to share diving rebreather devices and inhale one another's exhalation.

Mandatory Vaccination Requirements in Response to COVID-19 Pandemic

9. On August 24, 2021, the Secretary of Defense directed the Secretaries of the Military Departments to immediately begin full vaccination of all members of the Armed Forces on active duty or in the Ready Reserve. The Secretary of Defense determined that mandatory COVID-19 vaccinations are necessary to protect the health and military readiness of the force. The Secretary of the Navy directed implementation of Secretary of Defense's COVID-19 vaccination mandate[6] via a Department-wide administrative message (ALNAV) on August 30, 2021. The ALNAV applies to both Services within the Department of the Navy (DON), the United States Navy and the United States Marine Corps. The ALNAV required all active duty DON Service members, who were not already vaccinated, exempted, or currently seeking an exemption, to be fully vaccinated with an FDA-approved COVID-19 vaccine within 90 days of the ALNAV, and all Reserve Component personnel to be fully vaccinated within 120 days. ALNAV 062/21 ¶ 4. Active duty Sailors and Marines were required to become fully vaccinated[7] by November 28, 2021, and Reserve Component Sailors and Marines by December 28, 2021. The requirement to obtain full vaccination constitutes a lawful order under Article 92 of the Uniform Code of Military Justice (UCMJ), and failure to comply may result in punitive or adverse administrative action, or both. ALNAV 062/21 ¶ 5.

[6] Secretary of Defense Memorandum, "Memorandum for Senior Pentagon Leadership, Commanders of the Combatant Commands, Defense Agency, and DoD Field Activity Directors," (August 24, 2021).
[7] Although refusal to receive the vaccine may subject a member to adverse administrative or disciplinary action, the vaccine will not be forcibly administered to any member who refuses.

10. The United States Navy issued service-specific guidance via a separate administrative message ("NAVADMIN") on September 1, 2021. NAVADMIN 190/21 outlines Navy policy concerning the mandatory vaccination of Navy service members, vaccination administration and reporting requirements, and general guidance related to logistics and distribution of vaccines. The policy reiterates that COVID-19 vaccination "is mandatory for all DoD service members who are not medically or administratively exempt" under existing Navy policy. NAVADMIN 190/21 ¶ 2, 3.a. Refusal to become fully vaccinated against COVID-19 without an approved or pending exemption constitutes a failure to obey a lawful order and is punishable under Article 92, UCMJ.

The COVID-19 Pandemic Threat to Naval Forces

11. The judgment of each of the Military Services is that vaccines are the most effective tool the Armed Forces have to keep our personnel safe, fully mission capable and prepared to execute the Commander-in-Chief's orders to protect vital United States' national interests. As of January 5, 2022, 261,504 members of the Armed Forces have contracted the COVID-19 virus, resulting in 2,320 hospitalizations and 82 deaths. Eighty of 82 members who have died were unvaccinated. Of all active duty personnel who were required to be hospitalized because of COVID-19, 0.8% received a booster shot prior to hospitalization. Separately, there have only been six active duty personnel who have received a booster and had a breakthrough COVID-19 infection that required hospitalization. Among the active duty force, 12% of those required to be hospitalized have received a primary COVID-19 vaccine without the booster. Among Reserve and National Guard service members, 97% of those hospitalized with COVID were unvaccinated or partially vaccinated; 3% of hospitalized members received primary vaccination but no booster shot; 0.2% hospitalized members had received a booster shot.

Sending ships into combat without maximizing the crew's odds of success, such as would be the case with ship deficiencies in ordnance, radar, working weapons or the means to reliably accomplish the mission, is dereliction of duty. The same applies to ordering unvaccinated personnel into an environment in which they endanger their lives, the lives of others and compromise accomplishment of essential missions.

12. The environment in which Navy personnel operate -- in close quarters for extended periods of time -- make them particularly susceptible to contagious respiratory diseases such as COVID-19 and renders mitigation measures such as social distancing unrealistic. In mid-March 2020, the aircraft carrier USS THEODORE ROOSEVELT (CVN 71) was deployed to the Western Pacific Ocean, a vital geo-political center of gravity encompassing several of the world's largest militaries and five nations allied with the U.S. through mutual defense treaties. The leadership of USS THEODORE ROOSEVELT began to see several COVID-19 cases among the crew. By April 1, 2020, USS THEODORE ROOSEVELT had been pulled off mission and into Guam with approximately 1,000 crew removed from the ship, with a reduced crew remaining to maintain the nuclear reactor and other essential systems. By April 20, 2020, 4,069 Sailors had been removed from the ship out of a crew of approximately 4,800. The ship was unavailable for 51 days to maintain presence in a strategically important area which includes the world's busiest sea lanes, creating a national security vulnerability in an area vital to our national interests. When USS THEODORE ROOSEVELT finally got underway on May 21, 2020, approximately 1,800 Sailors remained in Guam. Tragically, one Sailor succumbed to the COVID-19 virus and died.

13. Even with approximately 97% of the Navy vaccinated, the COVID-19 virus can degrade units and impact mission. Last month, USS MILWAUKEE (LCS 5), with a 100%

vaccinated 100-person crew, remained in port one week beyond its schedule because several members tested positive for COVID-19. Because the full crew was vaccinated, infected personnel were asymptomatic or had mild symptoms and the impact to mission accomplishment was substantially mitigated compared to the USS THEODORE ROOSEVELT's experience of more than 4,000 crew removed from the ship and a 51-day loss of mission. Given the hospitalizations and death statistics cited above, the MILWAUKEE's minor deployment delay would likely have been far worse with unvaccinated personnel. The MILWAUKEE is one example of a Navy manning model where each individual crew member has a high level of responsibility with little redundancy. The medical staff of the MILWAUKEE consists of only two Navy Hospital Corpsman, comparable to an Emergency Medical Technician in the civilian setting. There is little ability on ship to care for a service member with severe COVID symptoms. If a service member were to develop severe symptoms on this type of ship, it would require a return to port or an emergency medical evacuation by helicopter. Helicopter medical evacuation is not always viable due to the location of the ship and the limited range of helicopters. At the deployable unit level, NSW, EOD, and diver personnel operate in units that can be as small as a squad of four personnel. Medical evacuations in these small units can be even less practical and significantly more damaging than the loss of an equal number of crew on a ship the size of the MILWAUKEE.

14. The types of missions conducted by SEALs, SWCC, EOD and divers cannot be conducted remotely. A SEAL assigned to perform a counterterrorism mission in a foreign country cannot perform that task from home; a SWCC cannot drive a combatant craft and transport SEALs in a telework status; an explosive ordnance disposal technician—whose job it is to disarm and dispose of explosives—cannot perform that task remotely. Similarly, the arduous

training necessary to prepare NSW personnel for these missions cannot be performed remotely. It is not possible for a Navy Diver to remotely prepare compressed air and oxygen tanks for personnel to complete their training dives. A safety diver must be physically present during a high-risk training evolution that may require rescue divers or oxygen technicians. In particular, Navy Divers assigned to NSW must be able to operate a diving recompression chamber – a small confined space where the Navy Diver must be in the chamber to assist with the personnel casualty – which cannot be done remotely. SEAL trainers cannot oversee dangerous swim or survival training from a physically distanced location. NSW personnel also routinely interact with the greater Navy population, on ships and aircraft, and in dining facilities and office environments across the globe. They are required to deploy with no-notice. NSW, EOD and diver training and operations necessitate our service members interact in close-quarters, confined spaces, and under conditions where telework, social distancing, and mask-wearing are not reliable mitigation options.

Immediate Harm to Readiness and Mission Accomplishment

15. The preliminary injunction forbids the Navy from applying MANMED § 15-105(3)(n)(9), NAVADMIN 225/21, NAVADMIN 256/21 and Trident Order #12. Order 26, ECF No. 66. MANMED § 15-105(3)(n)(9) states that personnel who choose not to receive required vaccinations will be disqualified from special operations duty. NAVADMIN 225/21 provides guidance for disposition of offenses involving Navy service members who are not fully vaccinated by the required deadlines. Navy Service members who refuse the COVID-19 vaccine, absent a pending or approved exemption, are required to be processed for administrative separation.[8] NAVADMIN 225/21 ¶ 2. A Navy Service member is considered to be "refusing the

[8] Although processing for separation is required, this does not automatically result in a member actually being separated. Members processed for separation may ultimately be retained in the service.

vaccine, if: (1) the individual has received a lawful order to be fully vaccinated, (2) is not or will not be fully vaccinated by the date required, and (3) does not have a pending or approved exemption request." *Id.* ¶ 3.c. The policy designates the Chief of Navy Personnel, a 3-star admiral, as the COVID-19 Consolidated Disposition Authority to ensure fair and consistent administrative processing across the service. *Id.* at ¶ 5.b. For disciplinary matters, authority to initiate disciplinary proceedings, either non-judicial punishment or court-martial, is withheld to the Vice Chief of Naval Operations. *Id.* NAVADMIN 256/21 provides additional guidance on administrative separation processing for those refusing the vaccine, as well as guidance on other applicable administrative actions. These other applicable administrative actions include: cancellation of government travel for training or other official purposes; temporary reassignment within the local area for unvaccinated personnel (with or without a medical exemption or religious accommodation); adverse fitness reports and evaluations; prohibition on executing permanent change of station orders; potential termination of special duty and incentive pays; potential recoupment of unearned bonuses; termination of and potential reimbursement for Navy-funded education and training; promotion and advancement delays; and removal of additional qualification designations or Navy Enlisted Classifications.[9] *See* NAVADMIN 256/21 ¶¶ 4.b.through 13. Trident Order # 12, which is directed to the NSW force, does not create any new requirements or adverse administrative actions. It consolidates and restates previously promulgated Navy implementing guidance.

16. The preliminary injunction forbids the Navy from "[t]aking any adverse

[9] Navy Enlisted Classifications define the work performed by Navy enlisted members and the requirements to perform specific "ratings" (i.e., occupations). *See generally*, MANUAL OF NAVY ENLISTED MANPOWER AND PERSONNEL CLASSIFICATIONS AND OCCUPATIONAL STANDARDS, VOL II NAVY ENLISTED CLASSIFICATIONS (NAVPERS 18068F), April 21, 2021 (supplementing the enlisted rating structure in identifying personnel and billets [i.e., jobs] and skills, knowledge, aptitude, or qualifications that must be documented to identify both people and billets for management purposes).

action against Plaintiffs on the basis of Plaintiffs' requests for religious accommodation." Order 26, ECF No. 66. The order specifically references actions that Plaintiffs allege are being taken against them while they await a decision on their religious accommodation requests, actions such as restrictions on travel, access to non-work activities, unpleasant assignments, and being relieved of leadership duties. Order 26, ECF No. 66. This aspect of the order is intrusive and harmful to Navy operations, including deployment decisions. In the Navy, "adverse action" refers to an action that is punitive or the action itself has a direct adverse impact on one's career such as a court martial or discharge. The Court's order, however, indicates that routine personnel actions, such as assignment, official travel and specific duties, are adverse decisions. Contrary to the Court's apparent understanding, temporarily reassigning personnel to other units because they are unvaccinated, regardless of the reason they are unvaccinated (e.g., medical exemption, religious accommodation, or pending exemption request) is not an adverse action but a step to protect the health of the whole unit and maintain mission readiness. The Court's injunction appears to require the Navy to leave unvaccinated NSW, EOD, and diver personnel in their units, performing their same duties and deploying on missions regardless of the known risk to personnel and mission. Such an injunction will degrade NSW, EOD, and diver mission readiness, breakdown good order and discipline within the NSW force, unnecessarily limit the Navy's ability to conduct daily operations and operational missions, and could clearly result in mission failure in contingencies and crises that cause harm to national security.

17. NSW personnel must be fully medically ready and at peak fitness given that their training and missions are physically demanding and arduous. It is vital that all members of the NSW force be medically fit to perform daily operations and to train or deploy on short notice. Regardless of their current assignment, all naval forces, NSW in particular, must be ready to

respond to contingencies and crises around the world. All NSW personnel are expected to meet this requirement, whether in a training status, on instructional duty, or at a headquarters, as the mission of NSW is to be ready to provide maritime SOF to conduct full spectrum operations to support national objectives. The Navy could easily require Navy Special Warfare Command to mobilize personnel outside from any unit, regardless of the planned deployment cycles of a unit or the currently assigned duties of NSW personnel to respond to the full range of contingencies and crises. Medical conditions or illness create risk, both medical and operational, not only for the service member afflicted, but for other members of the unit. As a result, unvaccinated personnel in a unit degrade the force health protection conditions in the unit, placing personnel in the unit at risk and degrading the unit's ability to safely conduct operations, regardless of the scope of the operation. The following publicly available mission event illustrates how rapidly a NSW unit can go from steady state in the United States to deploying forward on a mission of the highest difficulty, requiring peak medical, physical and mental readiness. This example illustrates the rapid manner in which a contingency or crisis could unfold, and although more than a decade old, is used due to the unclassified classification of my declaration.

18. On April 8, 2009, armed Somali pirates boarded the U.S.-flagged container ship, *Maersk Alabama* in the Indian Ocean, taking the crew, composed of U.S. citizens, hostage and making ransom demands. USS BAINBRIDGE (DDG-96) was the first ship of the international counter-piracy task force to respond. BAINBRIDGE's commanding officer realized he needed additional capabilities beyond what he had available on the ship. In response, on short notice, a SEAL team flew 8,000 miles from the United States to USS BAINBRIDGE and were recovered onboard. By the evening of April 12, 2009, the situation escalated and SEALs on BAINBRIDGE eliminated the threat to the remaining hostage, *Maersk Alabama* Captain

Phillips, who was subsequently rescued. This is but one example, using a well-publicized mission, that illustrates how an unvaccinated member would put himself, his teammates, the conventional forces and the mission at great risk. While NSW personnel may be assigned to various units with various mission-sets, all naval forces must be ready to respond to global contingencies and crises on short notice.

19. If this type of crisis or contingency occurred today, with the Court's preliminary injunction in place, the Navy could be required to deploy a SEAL team with one or more unvaccinated members, risking a COVID-19 outbreak within that unit or on the host Navy destroyer. Destroyer crews, and others embarked aboard, sleep in confined shared berthing spaces, are in close proximity in passageways, and eat meals in a communal galley. An unvaccinated service member is not only more likely to contract COVID-19, but to experience significant disease symptoms, impact the mission and spread the disease to others.

20. Navy ships have limited health care facilities. A Sailor experiencing severe COVID symptoms would require the ship to pull into port instead of executing its mission. NSW forces often deploy in countries with little or no healthcare support structure and in remote areas where healthcare is scarce. This is why there has been a long-standing requirement for all members of the NSW force to be fully medically ready to deploy. A small number of SOF medical personnel provide limited medical support and patient movement; therefore, any encumbrance placed on that limited capability unnecessarily puts the mission and the force at-risk. While some SEALs are trained to perform emergency, life-saving procedures in remote and hostile environments, those personnel are not physicians or nurses. Unlike doctors and nurses, formal civilian medical licenses are not required for them. They do not generally have the capability, capacity or training to use a ventilator. Additionally, they do not have access to this

equipment in the types of austere environments in which the NSW units operate. If a deployed team member contracts COVID-19, there is a strong possibility that the necessary equipment or treatment would not be readily available. Further, if medical evacuation is necessary for a member of the unit, this creates additional risk not only to the mission, but places those service members executing medical evacuation at a risk of harm to themselves such as when the member requires transport from a hostile, remote or diplomatically sensitive areas.

21. Redirecting these assets and their crew to perform preventable evacuations results in a degradation of the Navy's ability to accomplish its primary missions and incurs collateral impacts. Medical evacuations often require one or more member from the service member's unit to accompany the evacuated service member. The loss of even one member can degrade the effectiveness of small NSW units and may compromise the mission. This is similarly the case for SWCC personnel, who routinely operate with a crew of as little as four personnel on a combatant craft. Every member of a SEAL team is vital.

22. Unvaccinated NSW personnel put conventional Navy forces at risk as well. Navy SEALs are one of the most versatile elements of the SOF across all branches of the military services, in part, because the Navy can deliver them to their mission locations through a variety of conventional means (*e.g.*, fixed-wing aircraft, helicopters, surface ships and submarines). All of these means of delivery are confined spaces in which social distancing is impractical. Because NSW personnel rely on conventional Navy forces to support their missions, any unvaccinated NSW personnel will put the crew of those conventional forces at unnecessary risk as well. The Navy must balance the risk to unvaccinated individuals and vaccinated personnel alike. That risk calculation led to the mandatory vaccination mandate and associated personnel policies pertaining to the COVID-19 pandemic. It is imperative for the entire force, including

every member of NSW, to be vaccinated and ready to deploy and execute assigned missions on short notice.

23. The capabilities NSW personnel provide include crisis response, support to forward presence operations, support to conventional Naval forces at sea and in training, support to Law Enforcement agencies and clandestine insertion operations. EOD personnel provide critical safety and response to units using live ordnance; Navy divers, EOD and SEALs support underwater surveys and route clearances. SEALs conduct insertions and extractions by sea, air or land; they capture high-value enemy personnel and terrorists around the world, carry out small-unit direct-action missions against military targets and perform underwater reconnaissance and strategic sabotage. SEALs, SWCC, EOD and divers frequently deploy to foreign countries to train partners and allies and participate in exercises. Reducing the Navy's ability to apply long-standing, proven medical readiness principles to this small, elite community will clearly negatively impact the NSW force's ability to conduct their operations and could have significant negative effects to the NSW force's ability to respond to large-scale contingencies or crises. This would damage the national security interests of the United States and our foreign allies and partners.

24. These concerns apply if the injunction requires the Navy to maintain these 35 Plaintiffs in their current status while an appeal is pending. Of the 35 Plaintiffs, 18 are assigned to nine different parent commands and may deploy anywhere in the world in the immediate future to perform the type of missions described. 15 Plaintiffs are assigned to the NSW Center or a NSW Center subordinate command, with 14 of them assigned to NSW Advanced Training

Command (ATC);[10] some as instructors who necessarily have close contact with ATC students in courses to prepare them for NSW operations and some as students attending an advanced training course before returning to their current or prospective assignment. Two Plaintiffs are currently assigned to non-NSW training commands. Because the court's order prohibits them from being temporarily reassigned, the 14 unvaccinated personnel at NSW ATC have close contact with fellow instructors and students. These students then circulate among the larger NSW community as soon as their courses at ATC end. Simply put, close quarters contact during training creates the opportunity to contract COVID-19 from the unvaccinated instructors at ATC detachments. The unvaccinated instructors can spread COVID-19 to dozens of candidates in training, and qualified SEALs, SWCCs, and other personnel, including fellow instructors, at NSW ATC training courses who will promptly return to their primary units or interact with additional training classes.

25. In summary, the Navy's judgment is that COVID-19 vaccines are a critical defense against COVID-19 and mitigate risk both to our force and to our mission. This judgment takes into account the environments our service members operate in, the operations the Navy conducts, and the absence of other effective COVID-19 mitigation measures in the environments in which we operate. The COVID-19 virus has had a proven substantial impact on Navy unit readiness. The Court's order, which bars implementation of the vaccine requirement and requires the Navy to keep service members it has determined are not medically fit for deployment in a ready to deploy status, will undermine military readiness through the spread of disease and cause

[10] ATC's mission is to provide standardized and accredited individual training and education for qualified NSW and support personnel, U.S. SOF (i.e., from other Services), partner nation SOF and other personnel, as required for NSW Operations. There are several ATC detachments. The largest detachment in Coronado, California provides a course of instruction to candidates (i.e., those seeking to obtain their SEAL or SWCC designation). It also provides training to those already designated as SEALs, SWCC or combat support personnel. Other ATC detachments provide training in specialized areas to NSW personnel, other SOF and partner nation SOF.

significant harm to military operations by allowing unvaccinated service members to remain in an unvaccinated status.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed this 19th day of January, 2022.

W. K. LESCHER

ENCLOSURE 6

FUNCTIONS OF THE MILITARY DEPARTMENTS

1. COMMON MILITARY DEPARTMENT FUNCTIONS. For purposes other than the operational direction of the Combatant Commands, the chain of command runs from the President to the Secretary of Defense to the Secretaries of the Military Departments and, as prescribed by the Secretaries, to the commanders of Military Service forces.

a. Subject to the authority, direction, and control of the Secretary of Defense, the Secretaries of the Military Departments are responsible for, and have the authority necessary to conduct, all affairs of their respective Departments, including:

(1) Recruiting.

(2) Organizing.

(3) Supplying.

(4) Equipping (including research and development).

(5) Training.

(6) Servicing.

(7) Mobilizing.

(8) Demobilizing.

(9) Administering (including the morale and welfare of personnel).

(10) Maintaining.

(11) Construction, outfitting, and repairs of military equipment.

(12) Construction, maintenance, and repair of buildings, structures, and utilities as well as the acquisition, management, and disposal of real property and natural resources.

b. Subject to the authority, direction, and control of the Secretary of Defense, the Secretaries of the Military Departments are also responsible to the Secretary of Defense for ensuring that their respective Departments:

(1) Operate effectively, efficiently, and responsively.

(2) Formulate policies and programs that are fully consistent with national security objectives and policies established by the President and the Secretary of Defense.

(3) Implement, in a timely and effective manner, policy, program, and budget decisions and instructions of the President or Secretary of Defense.

(4) Present and justify positions on the plans, programs, and policies of the Department of Defense.

(5) Prepare, submit, and justify budgets before Congress, in coordination with other USG departments and agencies, as applicable; and administer the funds made available for maintaining, equipping, and training the forces of their respective departments, including those assigned to the Combatant Commands. Among other things, budget submissions shall be informed by the recommendations of the Military Service Chiefs, Commanders of the Combatant Commands, and of Military Service component commanders of forces assigned to the Combatant Commands.

(6) Establish and maintain reserves of manpower, equipment, and supplies for the effective prosecution of the range of military operations and submit, in coordination with the other Military Departments, mobilization information to the Joint Chiefs of Staff.

(7) Develop integrated mobilization plans for the expansion of peacetime components to meet the needs of war.

(8) Perform Military Department functions necessary to fulfill the current and future operational requirements of the Combatant Commands, including the recruitment, organization, training, and equipping of interoperable forces.

(9) Provide forces to enhance military engagement, conduct security cooperation, build the security capacity of partner states, and deter adversaries to prevent conflict. These actions shall be coordinated with the other Military Departments, Combatant Commands, USG departments and agencies, and international partners, as required.

(10) Provide forces, military missions, and detachments for service in foreign countries as may be required to support the national interests of the United States, and provide, as directed, assistance in training, equipping, and advising the military forces of foreign nations.

(11) Coordinate with the other Military Departments and all of the other DoD Components to provide for more effective, efficient, and economical administration; eliminate duplication; and assist other DoD Components in the accomplishment of their respective functions by providing personnel, intelligence, training, facilities, equipment, supplies, and services, as may be required.

(12) Develop, garrison, supply, equip, and maintain bases and other installations, including lines of communication, and provide administrative and logistical support for all assigned forces and bases, unless otherwise directed by the Secretary of Defense.

(13) Provide, as directed, administrative and logistical support to the headquarters of the Combatant Commands, to include direct support of the development and acquisition of the command and control systems of such headquarters.

(14) Supervise and control Military Department intelligence activities, including the collection, production, and dissemination of military and military-related foreign intelligence and counterintelligence as required for execution of Military Department responsibilities.

(15) Afford the Assistant Secretary of Defense for Special Operations and Low-Intensity Conflict; the Commander, USSOCOM; the PCA; and the Commander, USCYBERCOM, an opportunity to coordinate on Military Department and Military Service personnel management policy and plans as they relate to accessions, assignments, compensation, promotions, professional development, readiness, retention, sustainment, and training of all SOF (for USSOCOM) and all cyber operations forces (for USCYBERCOM) personnel. This coordination shall not interfere with the title 10 authorities of the Military Departments or Military Services.

(16) Engage in such other activities as are prescribed by law, the President, or the Secretary of Defense.

2. COMMON MILITARY SERVICE FUNCTIONS. The Army, the Navy, the Air Force, the Marine Corps, and the Space Force, and the Coast Guard, when transferred to the Department of the Navy in accordance with sections 2, 3, and 145 of Reference (h), to include the Active and Reserve Components of each, under their respective Secretaries, shall provide conventional, strategic, and SOF to conduct the range of operations as defined by the President and the Secretary of Defense. Further, they shall perform the following common functions:

a. Develop concepts, doctrine, tactics, techniques, and procedures, and organize, train, equip, and provide land, naval, air, space, and cyberspace forces, in coordination with the other Military Services, Combatant Commands, USG departments and agencies, and international partners, as required, that enable joint force commanders to conduct decisive operations across the spectrum of conflict in order to achieve the desired end state.

b. Determine Military Service force requirements and make recommendations concerning force requirements to support national security objectives and strategy and to meet the operational requirements of the Combatant Commands.

c. Recommend to the Joint Chiefs of Staff the assignment and deployment of forces to the Combatant Commands established by the President through the Secretary of Defense.

d. Monitor and assess Military Service operational readiness and capabilities of forces for assignment to the Combatant Commands and plan for the use of the intrinsic capabilities of the other Military Services, USSOCOM, and USCYBERCOM that may be made available.

e. Develop doctrine, tactics, techniques, and procedures for employment by Military Service forces and:

(1) Assist the Chairman of the Joint Chiefs of Staff in the development of joint doctrine.

(2) Coordinate with the Chairman of the Joint Chiefs of Staff, the Combatant Commands, the other Military Services, USG departments and agencies, partner security forces, and non-governmental organizations, in the development of the doctrine, tactics, techniques, and procedures necessary for participation in and/or command of joint, interagency, and multinational operations.

(3) Coordinate with the Commanders, USSOCOM and USCYBERCOM, in the development of the doctrine, tactics, techniques, and procedures employed by Military Service forces when related to special operations and cyber operations, respectively.

f. Provide for training for joint operations and joint exercises in support of Combatant Command operational requirements, including the development of Military Service joint training requirements, policies, procedures, and publications.

g. Provide logistical support for Military Service and all forces assigned to joint commands, including procurement, distribution, supply, equipment, and maintenance, unless otherwise directed by the Secretary of Defense.

h. Organize, train, and equip forces to contribute unique service capabilities to the joint force commander to conduct the following functions across all domains, including land, maritime, air, space, and cyberspace:

(1) Intelligence, surveillance, reconnaissance, and information operations, to include electronic warfare and MISO in order to provide situational awareness and enable decision superiority across the range of military operations.

(2) Offensive and defensive cyberspace operations to achieve cyberspace superiority in coordination with the other Military Services, Combatant Commands, and USG departments and agencies.

(3) Special and cyber operations in coordination with USSOCOM, USCYBERCOM, and other Combatant Commands, the Military Services, and other DoD Components.

(4) Personnel recovery operations in coordination with USSOCOM and other Combatant Commands, the Military Services, and other DoD Components.

(5) Counter weapons of mass destruction.

(6) Building partnership capacity/security force assistance operations.

(7) Forcible entry operations.

(8) Missile Defense.

(9) Other functions as assigned, such as Presidential support and antiterrorism.

i. Organize, train, and equip forces to conduct support to civil authorities in the United States and abroad, to include support for disaster relief, consequence management, mass migration, disease eradication, law enforcement, counter-narcotics, critical infrastructure protection, and response to terrorist attack, in coordination with the other Military Services, Combatant Commands, National Guard, and USG departments and agencies.

j. Operate organic land vehicles, aircraft, cyber assets, spacecraft or space systems, and ships or craft.

k. Conduct operational testing and evaluation.

l. Provide command and control.

m. Provide force protection.

n. Consult and coordinate with the other Military Services on all matters of joint concern.

3. INDIVIDUAL MILITARY DEPARTMENT FUNCTIONS. The forces developed and trained to perform the primary functions set forth in sections 4 through 6 of this enclosure shall be employed to support and supplement the other Military Service, USSOCOM, and USCYBERCOM forces in carrying out their primary functions, wherever and whenever such participation shall result in increased effectiveness and shall contribute to the accomplishment of overall military objectives.

4. FUNCTIONS OF THE DEPARTMENT OF THE ARMY

a. The Department of the Army includes land combat, and service forces, and such aviation, water transport, and space and cyberspace forces as may be organic therein, and shall be organized, trained, and equipped primarily for prompt and sustained combat incident to operations on land, and to support the other Military Services and joint forces. The Army is responsible for the preparation of land forces necessary for the effective prosecution of war and military operations short of war, except as otherwise assigned. The Army is the Nation's principal land force and promotes national values and interests by conducting military engagement and security cooperation; deterring aggression and violence; and should deterrence fail, compelling enemy behavioral change or compliance. The Army shall contribute forces through a rotational, cyclical readiness model that provides a predictable and sustainable supply of modular forces to the Combatant Commands, and a surge capacity for unexpected contingencies.

b. The Functions of the Army. In addition to the common military service functions listed in paragraphs 2.a. through 2.n. of this enclosure, the Army, within the Department of the Army, shall develop concepts, doctrine, tactics, techniques, and procedures, and organize, train, equip,

and provide forces with expeditionary and campaign qualities to perform the following specific functions:

(1) Conduct prompt and sustained combined arms combat operations on land in all environments and types of terrain, including complex urban environments, in order to defeat enemy ground forces, and seize, occupy, and defend land areas.

(2) Conduct air and missile defense to support joint campaigns and assist in achieving air superiority.

(3) Conduct airborne and air assault, and amphibious operations. The Army has primary responsibility for the development of airborne doctrine, tactics, techniques, and equipment.

(4) Conduct CAO.

(5) Conduct riverine operations.

(6) Occupy territories abroad and provide for the initial establishment of a military government pending transfer of this responsibility to other authority.

(7) Interdict enemy sea, space, air power, and communications through operations on or from the land.

(8) Provide logistics to joint operations and campaigns, including joint over-the-shore and intra-theater transport of time-sensitive, mission-critical personnel and materiel.

(9) Provide support for space operations to enhance joint campaigns, in coordination with the other Military Services, Combatant Commands, and USG departments and agencies.

(10) Conduct authorized civil works programs, to include projects for improvement of navigation, flood control, beach erosion control, and other water resource developments in the United States, its territories, and its possessions, and conduct other civil activities prescribed by law.

(11) Provide intra-theater aeromedical evacuation.

(12) Conduct reconnaissance, surveillance, and target acquisition.

(13) Operate land lines of communication.

5. FUNCTIONS OF THE DEPARTMENT OF THE NAVY

a. The Department of the Navy is composed of naval, land, air, space, and cyberspace forces, both combat and support, not otherwise assigned, to include those organic forces and capabilities necessary to operate, and support the Navy and Marine Corps, the other Military Services, and joint forces. The Navy and Marine Corps comprise the Nation's principal maritime force. They

employ the global reach, persistent presence through forward-stationed and rotationally-based forces, and operational flexibility to secure the Nation from direct attack; secure strategic access and retain global freedom of action; strengthen existing and emerging alliances and partnerships; establish favorable security conditions; deter aggression and violence by state, non-state, and individual actors and, should deterrence fail, prosecute the full range of military operations in support of U.S. national interests.

b. The Functions of the Navy. In addition to the common military service functions listed in paragraphs 2.a. through 2.n. of this enclosure, the Navy, within the Department of the Navy, shall develop concepts, doctrine, tactics, techniques, and procedures and organize, train, equip, and provide forces to perform the following specific functions:

(1) Conduct offensive and defensive operations associated with the maritime domain including achieving and maintaining sea control, to include subsurface, surface, land, air, space, and cyberspace.

(2) Provide power projection through sea-based global strike, to include nuclear and conventional capabilities; interdiction and interception capabilities; maritime and/or littoral fires, to include naval surface fires; and close air support for ground forces.

(3) Conduct ballistic missile defense.

(4) Conduct ocean, hydro, and river survey and reconstruction.

(5) Conduct riverine operations.

(6) Establish, maintain, and defend sea bases in support of naval, amphibious, land, air, or other joint operations as directed.

(7) Provide naval expeditionary logistics to enhance the deployment, sustainment, and redeployment of naval forces and other forces operating within the maritime domain, to include joint sea bases, and provide sea transport for the Armed Forces other than that which is organic to the individual Military Services, USSOCOM, and USCYBERCOM.

(8) Provide support for joint space operations to enhance naval operations, in coordination with the other Military Services, Combatant Commands, and USG departments and agencies.

(9) Conduct nuclear operations in support of strategic deterrence, to include providing and maintaining nuclear surety and capabilities.

c. The Functions of the Marine Corps. In addition to the common military service functions listed in paragraphs 2.a. through 2.n. of this enclosure, and pursuant to section 8063 of Reference (e), the Marine Corps, within the Department of the Navy, shall develop concepts, doctrine, tactics, techniques, and procedures and organize, train, equip, and provide forces, normally

employed as combined arms air ground task forces, to serve as an expeditionary force-in-readiness, and perform the following specific functions:

(1) Seize and defend advanced naval bases or lodgments to facilitate subsequent joint operations.

(2) Provide close air support for ground forces.

(3) Conduct land and air operations essential to the prosecution of a naval campaign or as directed.

(4) Conduct complex expeditionary operations in the urban littorals and other challenging environments.

(5) Conduct amphibious operations, including engagement, crisis response, and power projection operations to assure access. The Marine Corps has primary responsibility for the development of amphibious doctrine, tactics, techniques, and equipment.

(6) Conduct security and stability operations and assist with the initial establishment of a military government pending transfer of this responsibility to other authority.

(7) Provide security detachments and units for service on armed vessels of the Navy, provide protection of naval property at naval stations and bases, provide security at designated U.S. embassies and consulates, and perform other such duties as the President or the Secretary of Defense may direct. These additional duties may not detract from or interfere with the operations for which the Marine Corps is primarily organized.

d. The Functions of the Coast Guard. The Coast Guard is a unique Military Service residing within the Department of Homeland Security while simultaneously providing direct support to the Department of Defense under its inherent authorities under References (e) and (h). In addressing the Coast Guard when it is not operating in the [Department of the] Navy, this issuance is descriptive in nature and does not purport to be either directive or regulatory. As directed by the President, and in accordance with Memorandum of Agreement between the Department of Defense and Department of Homeland Security on the use of Coast Guard Capabilities and Resources in Support of the National Military Strategy (Reference (ab)), the Department of the Navy shall coordinate with the Department of Homeland Security regarding Coast Guard military functions in time of limited war or defense contingency, without transfer of Coast Guard authority to the Secretary of the Navy. As directed, the Department of the Navy will provide intelligence, logistical support, and specialized units to the Coast Guard, including designated ships and aircraft, for overseas deployment required by naval component commanders, maritime search and rescue, integrated port security, and coastal defense of the United States. The Coast Guard shall maintain a state of readiness to function as a specialized Military Service in the Department of the Navy in time of war or national emergency. If specified in a declaration of war by Congress or if directed by the President, the Coast Guard shall operate as a Military Service in the Department of the Navy, and shall continue to do so

until the President transfers the Coast Guard back to the Department of Homeland Security by Executive order pursuant to section 3 of Reference (h).

(1) The Coast Guard shall develop concepts, doctrine, tactics, techniques, and procedures and organize, train, equip, and provide forces to perform the following specific functions when providing direct or cooperative support to the Department of Defense:

(a) Conduct coastal sea control and maritime and air interception and interdiction operations.

(b) Conduct maritime homeland security and counterterrorism operations.

(c) Provide for port operations, security, and defense.

(d) Provide maritime operational threat response.

(e) Conduct counter-illicit trafficking operations.

(f) Conduct military environmental response operations.

(g) Conduct theater security cooperation operations.

(h) Conduct search and rescue operations.

(i) Conduct ice operations.

(j) Provide for marine safety, including aids to navigation.

(2) The Coast Guard will coordinate with the Department of Defense, including the Department, of the Navy to provide specialized Coast Guard units, or obtain Navy units, including designated ships and aircraft, for deployment as requested by Military Service component or joint commanders.

6. FUNCTIONS OF THE DEPARTMENT OF THE AIR FORCE

a. The Department of the Air Force is composed of air, space, and cyberspace forces, both combat and support, not otherwise assigned. The Air Force and Space Force are the Nation's principal air and space forces, and are responsible for the preparation of forces necessary for the effective prosecution of war. The Department of the Air Force shall organize, train, equip, and provide air, space, and cyberspace forces for the conduct of prompt and sustained combat operations, military engagement, and security cooperation in defense of the Nation, and to support the other Military Services and joint forces. The Air Force and Space Force will provide the Nation with global vigilance, global reach, and global power in the form of in-place, forward-based, and expeditionary forces possessing the capacity to deter aggression and violence by state, non-state, and individual actors to prevent conflict, and, should deterrence fail, prosecute the full range of military operations in support of U.S. national interests.

b. The Functions of the Air Force. In addition to the common military service functions listed in paragraphs 2.a. through 2.n. of this enclosure, the Air Force, within the Department of the Air Force, shall develop concepts, doctrine, tactics, techniques, and procedures and organize, train, equip, and provide forces to perform the following specific functions:

(1) Conduct nuclear operations in support of strategic deterrence, to include providing and maintaining nuclear surety and capabilities.

(2) Conduct offensive and defensive operations, to include appropriate air and missile defense, to gain and maintain air superiority, and air supremacy as required, to enable, the conduct of operations by U.S. and allied land, sea, air, space, and special operations forces.

(3) Conduct global precision attack, to include strategic attack, interdiction, close air support, and prompt global strike.

(4) Provide timely, global integrated intelligence, surveillance, and reconnaissance capability and capacity from forward deployed locations and globally distributed centers to support world-wide operations.

(5) Provide rapid global mobility to employ and sustain organic air and space forces and other Military Service and USSOCOM forces, as directed, to include airlift forces for airborne operations, air logistical support, tanker forces for in-flight refueling, and assets for aeromedical evacuation.

(6) Provide agile combat support to enhance the air and space campaign and the deployment, employment, sustainment, and redeployment of air and space forces and other forces operating within the air and space domains, to include joint air and space bases, and for the Armed Forces other than which is organic to the individual Military Services and USSOCOM in coordination with the other Military Services, Combatant Commands, and USG departments and agencies.

(7) Conduct global personnel recovery operations including theater-wide combat and civil search and rescue, in coordination with the other Military Services, USJFCOM, USSOCOM, and DoD Components.

(8) Conduct global integrated command and control for air and space operations.

c. The Functions of the Space Force. In addition to the common military service functions listed in Paragraphs 2.a. through 2.n. of this enclosure, the Space Force, within the Department of the Air Force, shall develop concepts, doctrine, tactics, techniques, and procedures and organize, train, equip, and provide forces to perform the following specific functions:

(1) Provide freedom of operation for the United States in, from, and to space.

(2) Provide prompt and sustained space operations.

(3) Protect the interests of the United States in space.

(4) Deter aggression in, from, and to space.

(5) Conduct space operations.

7. DEPARTMENT OF THE ARMY AND DEPARTMENT OF THE AIR FORCE: THE NGB. The NGB is a joint activity of the Department of Defense. The NGB performs certain Military Service-specific functions and unique functions on matters involving non-federalized National Guard forces as set forth in Reference (i).

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Subject: Mtg w/OJAG
Location: 4E642

Start: 1/12/2022 4:00:00 PM
End: 1/12/2022 4:30:00 PM
Show Time As: Busy

Recurrence: (none)

SUBJECT: Document review

POC:
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614-7420

From: Lescher, William K ADM USN VCNO (USA) [/o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=26bd1b980b6f44abba84009925f929e2-william.k.l]
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Subject: Mtg w/OJAG
Location: 4E642

Start: 1/12/2022 4:00:00 PM
End: 1/12/2022 4:30:00 PM
Show Time As: Tentative

SUBJECT: Document review

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From: Gillingham, Bruce L RADM USN SURGEON GENERAL (USA) [bruce.l.gillingham.mil@mail.mil]
Sent: 1/14/2022 8:50:41 AM
To: Del Toro, Carlos HON (USA) [carlos.deltoro.civ@us.navy.mil]; Gilday, Michael M ADM USN CNO (USA) [michael.m.gilday.mil@us.navy.mil]; Berger, David H Gen USMC CMC (USA) [david.h.berger@usmc.mil]; Berger, Meredith A HON (USA) [meredith.a.berger.civ@us.navy.mil]; Smith, Eric M Gen USMC ACMC (USA) [eric.m.smith@usmc.mil]; Lescher, William K ADM USN VCNO (USA) [william.k.lescher.mil@us.navy.mil]; Simon, Martin S (Marty) SES USN UNSECNAV DC (USA) [martin.s.simon.civ@us.navy.mil]; Hogue, Robert D SES USN SECNAV WASHINGTON DC (USA) [robert.d.hogue.civ@us.navy.mil]; Schwarz, Christopher J CAPT USN NAVLEADETHCTR NPT RI (USA) [christopher.j.schwarz2.mil@mail.mil]; Sardiello, Carlos A RDML USN USFFC (USA) [carlos.a.sardiello.mil@us.navy.mil]; meredith.berger@navy.mil; christopher.w.grady.mil@us.navy.mil; Aquilino, John C ADM USN INDOPACOM (USA) [john.c.aquilino.mil@us.navy.mil]; Paparo, Samuel J Jr ADM USN COMPACFLT N0 (USA) [samuel.j.paparo.mil@us.navy.mil]; Ortiz, Melinda Elisa (Ortiz Melinda E HMC) CPO USN BUMED FCH VA (USA) [melinda.e.ortiz.mil@mail.mil]; liams, Kevin M LtGen USMC TECOM (USA) [kevin.iiams@usmc.mil]; robert.hedelund@usmc.mil; Nowell, John B Jr VADM USN DCNO N1 (USA) [john.b.nowell.mil@us.navy.mil]; Haeuptle, Andrew S SES USN DNS (USA) [andrew.s.haeuptle.civ@us.navy.mil]; Malloy, James Joseph VADM USN CENTCOM CCCG (USA) [james.j.malloy8.mil@mail.mil]; Merz, William Rhode (Bill) VADM USN CNO (USA) [william.r.merz.mil@mail.mil]; Aiken, James A (Jim) RADM USN USNAVSO-FOURTHFLT (USA) [james.a.aiken2.mil@us.navy.mil]; timothy.j.white@navy.mil; Williamson, Ricky Lee VADM USN DCNO N4 (USA) [ricky.l.williamson4.mil@us.navy.mil]; Tela, Stephen D CIV USN BUMED FCH VA (USA) [stephen.d.tela.civ@mail.mil]; michael.b.mcginnis; Brown, Kevin J CAPT USN USFFC (USA) [Kevin.J.Brown@mail.mil]; Weiner, Matthew A CAPT USN BUMED FCH VA (USA) [matthew.a.weiner.mil@mail.mil]; Hall, Matthew T LCDR USN NAVHOSP JAX FL (USA) [matthew.t.hall24.mil@mail.mil]; Holcomb, Matthew J (Matt) CAPT USN ASSTSECNAV MRA DC (USA) [matthew.j.holcomb2.mil@us.navy.mil]; Case, Matthew CAPT USN BUMED FCH VA (USA) [matthew.case.mil@mail.mil]; Lindsey, Yancy B VADM USN CNIC WASHINGTON DC (USA) [yancy.b.lindsey.mil@us.navy.mil]; Place, Ronald J LTG USARMY DHA DIR OFC (USA); Barnes, Christopher E CDR USN OSD OUSD P-R (USA) [christopher.e.barnes3.mil@mail.mil]; Smith, David J SES OSD OUSD P-R (USA) [david.j.smith152.civ@mail.mil]; robert.p.burke@eu.navy.mil; Mueller, Troy J SES USN NNPP (USA) [troy.j.mueller.civ@us.navy.mil]; Rudder, Steven R LtGen USMC MARFORPAC (USA) [steven.r.rudder.mil@us.navy.mil]; Biehn, Jeremy O CDR USN BUMED FCH VA (USA) [jeremy.o.biehn.mil@mail.mil]; Thomas, Karl O VADM USN CNO (USA) [karl.o.thomas.mil@us.navy.mil]; Truesdale, Lisa M SES USN ASSTSECNAV MRA DC (USA) [lisa.m.truesdale.civ@us.navy.mil]; Roberts, Michael J MCPO USN BUMED FCH VA (USA) [michael.j.roberts5.mil@mail.mil]; Freedman, Rick RDML USN DCNO N4 (USA) [rick.freedman.mil@us.navy.mil]; james.hancock@usmc.mil; Via, Darin K RDML USN NAVMED EAST PORS VA (USA) [darin.k.via.mil@mail.mil]; Kuehner, Cynthia Ann RDML USN NAVMEDEDTRNCMDSATTX (USA); Kurtz, Christopher A CAPT USN BUMED FCH VA (USA) [christopher.a.kurtz.mil@mail.mil]; Malanoski, Michael P SES USN (USA) [michael.p.malanoski.civ@mail.mil]; Miller, Pamela C RDML USN INDOPACOM PCJ0 (USA) [pamela.c.miller4.mil@us.navy.mil]; Riggs, Mary C RADM USN DHA J-9 (USA); Sze, Donald Y RDML USN BUMED FCH VA (USA) [donald.y.sze.mil@mail.mil]; Roberts, Michael J MCPO USN BUMED FCH VA (USA) [michael.j.roberts5.mil@mail.mil]; ROSS, THOMAS W (Tommy) JR SES USN SECNAV WASHINGTON DC (USA) [thomas.w.ross41.civ@us.navy.mil]; Felder, Adrain D LCDR USN BUMED FCH VA (USA) [adrain.d.felder.mil@mail.mil]; Bealer, Joel R CDR USN BUMED FCH VA (USA) [joel.r.bealer.mil@mail.mil]; DellaVedova, Joseph P CIV USN BUMED FCH VA (USA) [joseph.p.dellavedova.civ@mail.mil]; Manning, Debra A CAPT USN BUMED FCH VA (USA) [debra.a.manning.mil@mail.mil]; karl.thomas@fe.navy.mil; frederick.kacher2@navy.mil; Shaffer, Gayle D RADM USN BUMED FCH VA (USA) [gayle.d.shaffer2.mil@mail.mil]; Morlock, Marcy M CAPT USN BUMED FCH VA (USA) [marcy.m.morlock.mil@mail.mil]; secnav78 [secnav78.fct@us.navy.mil]; Gillingham, Bruce L RADM USN SURGEON GENERAL (USA) [bruce.l.gillingham.mil@mail.mil]
Subject: Naval Medical Intelligence Report - 14 January 2022
Attachments: COVID19 State Surveillance Medical Intel_06JAN2022.pdf; Naval_Med_Intel_Report_14 JAN 2022.pdf; COVID19 Country Surveillance Medical Intel_06JAN2022.pdf; smime.p7s

Mr. Secretary, CNO, CMC, ACMC, VCNO,

Attached is this week's edition of BUMED's Naval Medical Intelligence Report produced by our Scientific Panel. Below is a quick look at some of the key topics for the week:

UPDATE: Post-Immunization COVID-19 Infections

BLUF & IMPACT: For the weeks of 21 DEC – 11 JAN, the occurrence of COVID-19 among immunized active-duty Sailors and Marines remains very low. There have been 152 severe cases in unvaccinated Sailors and Marines, while only 22 severe cases in partially vaccinated Sailors and Marines, and 6 severe (hospitalized) cases in fully vaccinated Sailors and Marines for the time period 17 December 2020 – 28 December 2021 (One fully vaccinated case previously classified as hospitalized has been reclassified as not hospitalized after further review). Vaccines have an overall effectiveness of 64%. Of note, last week 96% of Navy cases and 91% of USMC cases occurred in fully immunized individuals.

Active Component Influenza Vaccinations

For week 1: Navy Active Component (**87.9%**) and Marine Corps Active Component (**86.4%**).
Unvaccinated individuals may obtain their influenza vaccination at the same time they receive a COVID-19 primary or booster dose.

UPDATE: CDC COVID-19 Isolation and Quarantine Recommendations in Consideration of Omicron

People with COVID-19 should isolate for 5 days and if they are asymptomatic or their symptoms are resolving (without fever for 24 hours), and follow that by 5 days of wearing a mask when around others to minimize the risk of infecting people they encounter. The change is motivated by science demonstrating that the majority of SARS-CoV-2 transmission occurs early in the course of illness, generally in the 1-2 days prior to onset of symptoms and the 2-3 days after. For people who are unvaccinated or are more than six months out from their second mRNA dose (or more than 2 months after the J&J vaccine) and not yet boosted, CDC now recommends quarantine for 5 days followed by strict mask use for an additional 5 days. Alternatively, if a 5-day quarantine is not feasible, it is imperative that an exposed person wear a well-fitting mask at all times when around others for 10 days after exposure. Individuals who have received their booster shot do not need to quarantine following an exposure, but should wear a mask for 10 days after the exposure.
Quarantined individuals MAY become SARS-CoV-2 positive, creating a use case for testing, while isolated individuals ARE SARS-CoV-2 positive and are able to exit isolation without testing based on our understanding of the risk of transmissibility.

Scientific Highlights of Operational Importance

- New research suggests the Omicron variant is five times likelier to cause reinfections. Larger amounts of data are emerging as the Omicron variant cases continue to spike in the U.S. Early data appears to demonstrate that Omicron is less severe in illness progression, but the reasons for this are not yet known.
- A third dose of the Pfizer vaccine greatly decreased the likelihood of testing positive for SARS-CoV-2, and the CDC recommends booster shots for all adults.
- One of the main circulating influenza viruses has changed, and the current flu vaccines do not match it well, however the vaccine is required of all active duty service members and is still expected to mitigate severe illness.

Also attached is this week's U.S. State Medical Surveillance Report (06 Jan 22), produced by our Preventive Medicine and Health Analysis Teams. COVID-19 incidence is increasing significantly in the majority of the country, and the Omicron variant is now present in every state. Due to local transmission rates, every state and county of interest is now classified as high-risk. The sudden increase in COVID-19 incidence is consistent with reports of the high transmissibility of the Omicron variant. However, despite the increasing COVID-19 incidence, the daily death count has decreased, further evidence that the Omicron variant causes less severe illness. Continued adherence to existing public health measures and maximizing vaccinations rates is imperative to initiate a downward trajectory in the incidence of disease and transition to lower risk classifications throughout the country.

SUMMARY: COVID-19 incidence is rising (278%) nationwide, and the risk level remains high throughout the country. In contrast to the rising case incidence, the death rate in the United States fell from 0.40 to 0.37 per hundred thousand people. 46 states and the District of Columbia, 22 new (AK, AZ, CA, CO, ID, IN, KS, KY, MD, MI, MN, MT, NE, NH, NM, OK, OR, PA, UT, VT, WI, and WY), rose in case incidence this week while 2 states, 1 new (ME), experienced a decline in case incidence. All states and counties are now classified as high-risk of transmission, and the Omicron variant is present in every state. This week, nearly all states and counties of interest experienced substantial surges in case incidence. The Omicron variant is now present nationwide. This report does not include North Dakota and Rhode Island due to data reporting irregularities.

Health Protection Conditions (HPCONs): ALPHA: 0; BRAVO: 47 (-3); BRAVO+: 22 (-5); CHARLIE: 12 (+8).

V/r, Bruce

Bruce L. Gillingham, MD, CPE, FAOA
RADM, MC, USN
Surgeon General, U.S. Navy
Chief, Bureau of Medicine and Surgery

NAVAL MEDICAL INTELLIGENCE REPORT

MEDICAL KNOWLEDGE FOR OPERATIONAL ADVANTAGE

14 January 2022

Previous weekly reports available here: Navy Medicine Science & Technology Panel Archive
Currently recommended clinical practice guidelines (CPG) and COVID-19 readiness guidance (CRG) can be found here: Navy Medicine Updated Guidance

Executive Summary

UPDATE: Post-Immunization COVID-19 Infections

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EXHIBIT 1

Prepared by the Navy Medicine Scientific Panel
Editor-in-Chief: LCDR Joshua Swift, joshua.m.swift.mil@mail.mil
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(Click topic titles to navigate to the full summary and article links)

Diagnostics

No updated situation to report

Therapies

FDA Authorizes Additional Oral Medication To Treat Mild/Moderate COVID-19

NIH Updates Outpatient Treatment Guidelines for Mild/Moderate COVID-19 + Patients at Risk for Progression to Severe Disease

Innovations

No updated situation to report

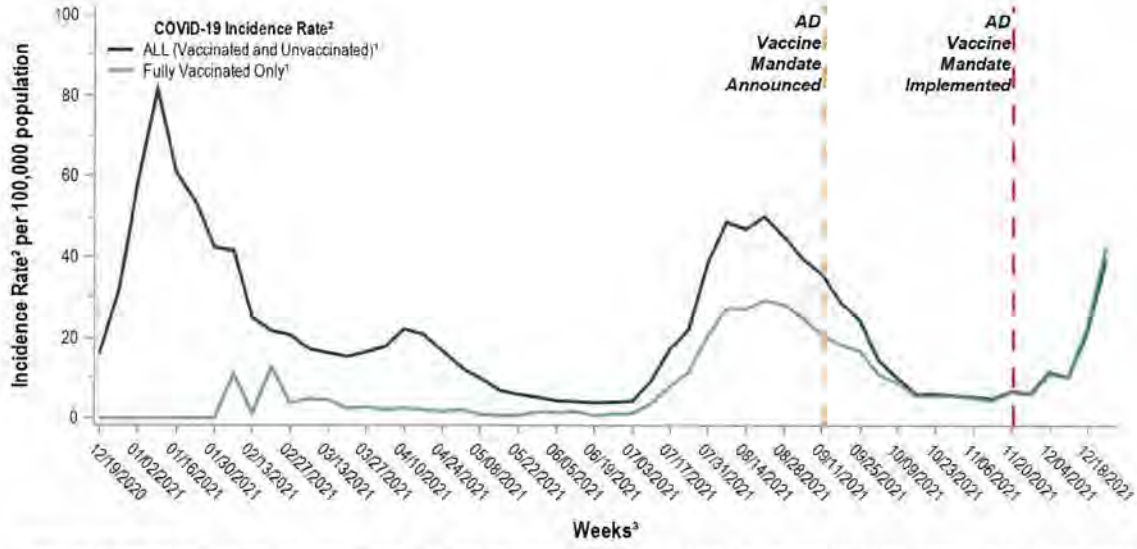
Full Summary

1. Actionable Operational Topics

Short Term:
UPDATE: Post-Immunization COVID-19 Infections

BLUF & IMPACT: For the week of 21 – 28 December, the occurrence of COVID-19 among immunized active-duty Sailors and Marines remains very low. There have been 152 severe cases in unvaccinated Sailors and Marines, while only 22 severe cases in partially vaccinated Sailors and Marines, and 6 severe (hospitalized) cases in fully vaccinated Sailors and Marines for the time period 17 December 2020 – 28 December 2021 (One fully vaccinated case previously classified as hospitalized has been reclassified as not hospitalized after further review). Vaccines have an overall effectiveness of 64%. Of note, last week 96% of Navy cases and 91% of USMC cases occurred in fully immunized individuals.
*Note: Data is from 28 DEC 2021 as the analysis is undergoing updates to account for Omicron and the booster vaccines.

Department of the Navy Active Duty: Total COVID-19 Cases After Vaccination[1]
17DEC2020-28DEC2021



[1] Two vaccine doses were considered complete for the Pfizer-BioNTech and Moderna COVID-19 vaccines, and one vaccine dose was considered complete for the J&J/Janssen COVID-19 vaccine. Individuals were considered fully vaccinated 14 days after receipt of the final dose. COVID-19 vaccines with an error in the Medical Readiness Reporting System were removed from this analysis.
[2] Incidence rate was calculated by dividing the case counts in the total group and the vaccinated groups by the person days of all active duty service members in the vaccination category by week multiplied by 100,000. For example, weekly incidence rate in the vaccinated =(weekly vaccinated cases) / (weekly person days in vaccinated) x 100,000.
[3] Numbered weeks aligns with the Center for Disease Control and Prevention (CDC) reporting intervals in the Morbidity and Mortality Weekly Report (MMWR).
Data Source: Medical Readiness Reporting System, Armed Forces Health Surveillance Division COVID-19 Master Positive List.
Prepared by the EpiData Center Department, Navy and Marine Corps Public Health Center, 29DEC2021.

Incidence Rate Trend: It is expected that as a greater percentage of the population is immunized, a higher percentage of cases will include breakthrough cases in immunized individuals. This is due mainly to a decreasing pool of susceptible non-immunized individuals and evolving variants.

Department of the Navy Active Duty: COVID-19 Vaccine Effectiveness[1] by Time Period and Vaccine Manufacturer 17DEC2020-28DEC2021 and 15JUN2021-28DEC2021

Time Period	Vaccination Status[2]	COVID-19 Vaccine Effectiveness[1]: Pfizer-BioNTech	COVID-19 Vaccine Effectiveness[1]: Moderna	COVID-19 Vaccine Effectiveness[1]: J&J Janssen	Overall COVID-19 Vaccine Effectiveness[1]
Overall (17DEC2020 -28DEC2021)	Fully immunized: >=14 days after final dose	71%	88%	58%	64%
Delta (15JUN2021 -28DEC2021)	Fully immunized: >=14 days after final dose	61%	80%	60%	59%

[1] COVID-19 vaccine effectiveness calculations by manufacturer were adjusted to reflect when the vaccinations were available. For Pfizer-BioNTech and Moderna the analysis date was 17DEC2021, and for J&J/Janssen the analysis date was 01MAR2021. Vaccine effectiveness was calculated using the following formula: (Unvaccinated Incidence Rate - Vaccinated Incidence Rate)/(Unvaccinated Incidence Rate) x 100.

[2] Two vaccine doses were considered complete for the Pfizer-BioNTech and Moderna COVID-19 vaccines, and one vaccine dose was considered complete for the J&J/Janssen COVID-19 vaccine. Individuals were considered fully vaccinated 14 days after receipt of the final dose. COVID-19 vaccines with an error in the Medical Readiness Reporting System were removed from this analysis.

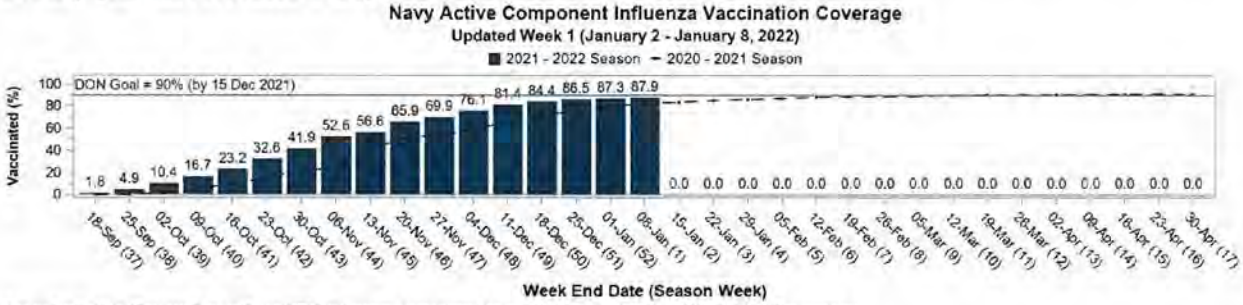
Data Source: Medical Readiness Reporting System, Armed Forces Health Surveillance Division COVID-19 Master Positive List.

Prepared by the EpiData Center Department, Navy and Marine Corps Public Health Center, 29DEC2021.

UPDATE: Influenza Vaccination

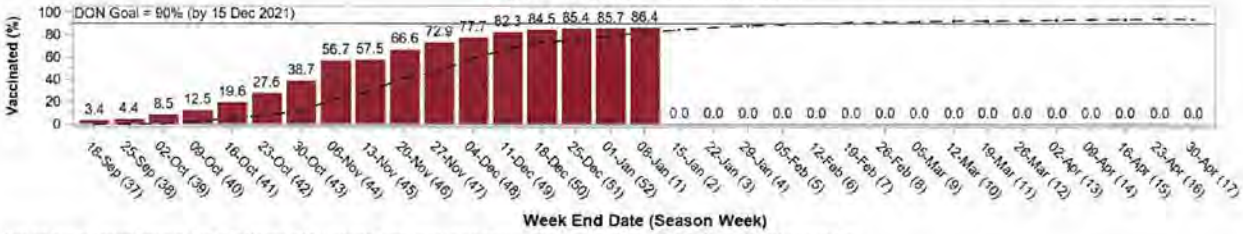
BLUF: As of 8 January, 87.9% of Sailors and 86.4% of Marines have been vaccinated against influenza. The Department of the Navy goal was 90% vaccinated by 15 December 2021.

Navy Active Component Influenza Vaccination Coverage
Updated Week 1 (January 2 - January 8, 2022)



Data are from the Medical Readiness Reporting System (MRRS) and represent the most current data available. Weeks are aligned to the 2021 - 2022 MMWR epi week dates.
Prepared by the EpiData Center, Navy and Marine Corps Public Health Center on 10 Jan 2022

Marine Corps Active Component Influenza Vaccination Coverage
Updated Week 1 (January 2 - January 8, 2022)



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Prepared by the EpiData Center, Navy and Marine Corps Public Health Center on 10 Jan 2022

UPDATE: CDC COVID-19 Isolation and Quarantine Recommendations (Link)

BLUF: Given what we currently know about COVID-19 and the Omicron variant, CDC is shortening the recommended time for isolation for the public. People with COVID-19 should isolate for 5 days and if they are asymptomatic or their symptoms are resolving (without fever for 24 hours), follow that by 5 days of wearing a mask when around others to minimize the risk of infecting people they encounter. The change is motivated by science demonstrating that the majority of SARS-CoV-2 transmission occurs early in the course of illness, generally in the 1-2 days prior to onset of symptoms and the

2-3 days after. For people who are unvaccinated or are more than six months out from their second mRNA dose (or more than 2 months after the J&J vaccine) and not yet boosted, CDC now recommends quarantine for 5 days followed by strict mask use for an additional 5 days. Alternatively, if a 5-day quarantine is not feasible, it is imperative that an exposed person wear a well-fitting mask at all times when around others for 10 days after exposure. Individuals who have received their booster shot do not need to quarantine following an exposure, but should wear a mask for 10 days after the exposure.

Quarantined individuals MAY become SARS-CoV-2 positive, creating a use case for testing, while isolated individuals ARE SARS-CoV-2 positive and are able to exit isolation without testing based on our understanding of the risk of transmissibility.

2. Public Health

Short Term:

UPDATE: How Severe Are Omicron Infections? (Link)

BLUF: Larger amounts of data are emerging as the Omicron variant cases continue to spike in the U.S. Early data appears to demonstrate that Omicron is less severe in illness progression, but the reasons for this are not yet known. It is difficult to determine whether lower severity is a function of the virus, or whether vaccination and recovery from natural infection may play a role. Significantly more information on Omicron, immunity, and breakthrough infections will be forthcoming as increased data is compiled.

Summary:

- Limited data on hospitalizations of Omicron variant cases exist world-wide, sometimes giving opposing data as to the severity of the variant. Overall, the numbers are too small to draw any firm conclusions about the severity of disease caused by Omicron. However, the rapidly spreading variant could dangerously strain health-care systems, even if the risk of sever disease or death is relatively low for any individual.
- Initial laboratory studies suggest that Omicron may evade some COVID vaccine-induced immunity. Early data from the UK Health Security Agency suggest that the vaccines are not as protective against Omicron infections as they have been against other variants, although the number of cases studied was too small be sure about how much protection has decreased.
- However, vaccines could continue to protect many recipients from severe disease and death from COVID-19, and additional boosters may offer enhanced immunity in the wake of variant outbreaks.

Impact: High.

UPDATE: Pfizer Booster Vaccination Effectiveness (Link; Link; Link)

BLUF: A third dose of the Pfizer vaccine greatly decreased the likelihood of testing positive for SARS-CoV-2, and the CDC recommends booster shots for all adults. Booster doses are recommended for persons in the age range of DoD personnel.

Summary:

- A November 30, 2021 Israeli study included 227,380 RT-PCR tests performed on those who had received 2 doses and 272,852 tests on those who had received 3 doses of Pfizer vaccine, with 14,989 (6.6%) and 4,941 (1.8%) positive test results in each group, respectively. Comparing those who received a booster and those who received 2 doses, there was an estimated 86% reduction in the odds of testing positive for SARS-CoV-2 28-65 days following receipt of the booster. Authors concluded further data from this population is needed to determine the duration of immunity following the booster (first link).
- On November 29, 2021, the CDC expanded its booster recommendations to include everyone ages 18 and older when they are 6 months after initial Pfizer or Moderna series or 2 months after initial J&J vaccine (second link).
- On Jan 5, 2022, the CDC further expanded its booster recommendations of the Pfizer-BioNTech COVID-19 vaccine to include those 12 years of age and older and reduced the time from series completion to booster to 5 months (third link).

Impact: Moderate.

Safety and Immunogenicity of COVID-19 and Influenza Vaccines Given Simultaneously (Link)

BLUF: COVID-19 and influenza vaccines given at the same time appear to be safe and effective. Immunization against SARS-CoV-2 and seasonal influenza may be done simultaneously.

Summary:

- A November 11, 2021 phase 4 U.K. trial included 679 participants in six cohorts that received either Astra-Zeneca or Pfizer SARS-CoV-2 vaccine plus one of 3 influenza vaccines. Of the 679, 340 participants received influenza vaccine and a second dose of COVID-19 vaccine at day 0 followed by placebo at day 21, and 339 participants received placebo and a second dose of COVID-19 vaccine at day 0 followed by influenza vaccine at day 21. Most systemic reactions to vaccination were mild or moderate. Rates of local and unsolicited systemic reactions were similar between the randomly assigned groups. One serious adverse event, hospitalization with severe headache, was considered related to the trial intervention. Authors concluded administration of COVID-19 vaccine plus an age-appropriate influenza vaccine raises no safety concerns and preserves antibody responses to both vaccines.

Impact: Moderate.

COVID-19 Vaccines and Omicron (Link; Link)

BLUF: Omicron is the predominant variant source of COVID-19 infections. Preliminary data demonstrates reduced effectiveness of the Pfizer-BioNTech and Moderna vaccine against infection. However, booster doses appear to enhance protection against infection and progression to severe disease and are strongly recommended.

Summary:

- A January 7, 2022 publication reported that a two-shot course of mRNA vaccines or the one-shot J&J vaccine seem to be less effective against the Omicron variant, especially for infection. Data so far indicates that mRNA vaccines (Pfizer-BioNTech or Moderna) offer the most promising protection against both infection and hospitalization, in line with the CDC's recommendations. Current figures suggest that vaccines offer 30 to 40 percent protection against infection and around 70 percent protection against hospitalization without boosters. Newer data is confirming that a third dose increases antibody production and boosts effectiveness against infection to around 75 percent, and 88 percent for severe disease (first link).
- A December 31, 2021 UK Health Security Health Agency study on vaccine effectiveness against Omicron found the risk of hospitalization is lower for Omicron cases after 2 and 3 doses of vaccine, with an 81% reduction in the risk of hospitalization after 3 doses compared to unvaccinated Omicron cases. After 3 doses of vaccine, the risk of hospitalization for a symptomatic case identified with Omicron through community testing was estimated to be reduced by 68% when compared to similar individuals with Omicron who were not vaccinated. Combined with the protection against becoming a symptomatic case, this gives a vaccine effectiveness against hospitalization of 88% for Omicron after 3 doses of vaccine. Although waning is seen in the effectiveness against symptomatic disease, there is insufficient data to assess the duration of protection against hospitalization, which is expected to last longer (second link).

Impact: High.

3. Emerging Threats

No updated situation to report.

4. Virology, Genomics, & Immunology

Short Term:

Novavax COVID-19 Vaccine Found To Be Safe and Effective (Link; Link)

BLUF: An investigational COVID-19 vaccine made by Novavax was found to be 90 percent effective at preventing COVID-19 illness, according to results from a Phase 3 clinical trial. During the first few months of 2021 when the study

was conducted, the predominant circulating strain was Alpha. The assessment did not include Delta or Omicron. Novavax submission for FDA Emergency Use Authorization is expected in early CY22 with no projected timeline for FDA decision.

Summary:

- The results indicate this vaccine is highly efficacious and very safe with many attractive features. It is made from a small piece of protein, like many currently licensed vaccines in the U.S. and has convenient refrigerator storage requirements, so it will be an important addition to the COVID-19 vaccine portfolio in the U.S. and countries where supply is lacking.
- Most side effects were mild to moderate and transient. Fever was very rare. The most common side effects included pain and tenderness at the injection site, headache, muscle aches and fatigue that lasted a day on average. None of the recipients developed serious reactions such as heart inflammation (myocarditis) or blood clots.
- A phase 3, randomized, observer-blinded, placebo-controlled trial in the United States and Mexico during the first half of 2021 published December 15, 2021 included 29,582 participants who received at least 1 dose of NVX-CoV2373, an adjuvanted, recombinant spike protein nanoparticle vaccine (19,714 received vaccine and 9,868 received placebo; second link). Vaccine efficacy against any variant of concern or interest was 92.6% (95% CI, 83.6 to 96.7)."

Impact: High.

Flu Vaccines Do Not Match the Main Circulating Flu Virus Strain (Link; Link)

BLUF: One of the main circulating influenza viruses has changed and the current flu vaccines do not match it well, an indication they may not prevent infection but are still likely to prevent severe illness. According to the CDC, influenza kills anywhere between 12,000 and 52,000 people a year and puts as many as 700,000 people into the hospital. Flu vaccines are required of all active duty service members and are expected to mitigate severe illness.

Summary:

- The vaccine mismatch may help explain an outbreak of flu at the University of Michigan last month affecting more than 700 people. More than 26% of those who tested positive were vaccinated against flu, the same percentage as those who tested negative, indicating the vaccine was not effective in preventing infection. The changes in the H3N2 virus this year are reminiscent of the mutations that rendered the vaccine so weak in 2014-2015.
- While cases of 2a2 H3N2 infections are quickly rising in the U.S. and other parts of the world, it is possible other clades of H3N2 will become predominant in the future, or that H1N1 or influenza B viruses might dominate later in the 2021-2022 season. It's not yet clear how well the vaccines might match those strains.
- In light of the major mismatch, experts still recommend the flu vaccine. Although early indicators allude that the flu vaccines may not prevent infection this year, it still helps protect against severe illness and death.

Impact: High.

Neutralization of Omicron Variant by Sera From Vaccinated Persons (Link; Link)

BLUF: Less than 25% of vaccine recipients had detectable neutralizing antibodies against the omicron variant. If antibody neutralization reflects vaccine effectiveness, mitigation strategies may require significant modification. The impact of T Cell-mediated immunity, thought to play a critical role in SARS-CoV-2 immunity, is not considered in this report.

Summary:

- A December 16, 2021 sequencing study found only 20% and 24% of BNT162b2 [Pfizer vaccine] recipients had detectable neutralizing antibody against the Omicron variant, while none of the Coronavac [Sinovac, a Chinese COVID-19 vaccine] recipients had detectable neutralizing antibody titer against either Omicron isolate. For Pfizer recipients, the geometric mean neutralization antibody titers (GMT) of the Omicron variant isolates (5.43 and 6.42) were 35.7-39.9-fold lower than that of the ancestral virus (229.4), and the GMT of both Omicron variant isolates were significantly lower than those of the Beta and Delta variants. Authors concluded the Omicron variant may be associated with lower COVID-19 vaccine effectiveness (first link).
- Another publication from December 23, 2021 found that administration of a booster Pfizer dose as well as vaccination of previously infected individuals generated an anti-Omicron neutralizing response, with titers 6 to 23 fold lower against Omicron than against Delta. Thus, Omicron escapes most therapeutic monoclonal antibodies and

to a large extent vaccine-elicited antibodies. Omicron remains however neutralized by antibodies generated by a booster vaccine dose (second link).
- Taken together, these preliminary findings demonstrate the ability of the Omicron variant to escape antibody neutralization from vaccines after a prolonged period and the efficacy of boosters to re-establish enhanced immunity with new variant outbreaks.

Impact: Moderate.

Severity of SARS-CoV-2 Reinfections As Compared With Primary Infections (Link)

BLUF: COVID-19 reinfections tend to be less severe than primary infections, and the odds of severe, critical, or fatal disease at reinfection is one-tenth that of primary infections. While the effectiveness of natural immunity compared to vaccine-induced immunity is still being determined, clinicians should be aware that cases of COVID-19 in recovered individuals are seldom severe.

Summary:
- A November 24, 2021 letter described an investigation of the risk of severe disease (leading to acute care hospitalization), critical disease (leading to hospitalization in an ICU), and fatal disease caused by reinfections as compared with primary infections in 353,326 persons with positive PCR test. The odds of severe disease at reinfection were 0.12 times that at primary infection.
- The odds of the composite outcome of severe, critical, or fatal disease at reinfection were 0.10 times that at primary infection. Reinfections had 90% lower odds of resulting in hospitalization or death than primary infections. Four reinfections were severe enough to lead to acute care hospitalization. None led to hospitalization in an ICU, and none ended in death. Reinfections were rare and were generally mild.

Impact: Moderate.

On-the-Horizon:
A Vaccine Against RSV, a Childhood Killer (Link)

BLUF: Millions of people per year are hospitalized by respiratory syncytial virus (RSV) and tens of thousands die. After decades of failure, four vaccines are now in late-stage trials (Figure 4).

Summary:
- Researchers have been trying for decades to develop a vaccine for RSV. Four candidates and one monoclonal antibody treatment are in late-stage clinical trials. RSV infects most children by age three and most adults many times over, but natural immunity is not long lasting. Infections are usually most severe in infants under two months old who are encountering the virus for the first time. A vaccine or treatment would drastically reduce hospital and intensive-care admissions for this most vulnerable group
- Monoclonal antibodies: One way to protect newborns is by injecting them with antibodies targeting the virus. AstraZeneca and Sanofi have partnered to test a monoclonal antibody called Nirsevimab directed against stabilized prefusion F protein, which proved effective at reducing RSV infections in a phase III trial in healthy premature and full-term term infants.
- mRNA: The success and speed of the COVID-19 vaccines' development created awareness at every level, renewed interest to participate in clinical trials, and brought new platforms like mRNA vaccines that might be more efficient ways to stimulate the immune system.
- Moderna's mRNA-based RSV vaccine was in development before SARS-CoV-2 appeared, giving the technology a head start. The COVID-19 vaccine benefited from the RSV program, and then it flipped, with the RSV program benefiting from efficiencies gained from the COVID-19 program.

Impact: High.

COVID-19 Can Trigger Self-Attacking Antibodies, Even in Mild or Asymptomatic Cases (Link)

BLUF: SARS-CoV-2 infection can trigger a damaging immune response that lasts well beyond the initial infection and recovery—even among people who had mild symptoms or no symptoms at all.

Summary:

- When people are infected with a virus or other pathogen, their bodies unleash proteins called antibodies that detect foreign substances and keep them from invading cells. In some cases, however, people produce autoantibodies that can attack the body's own organs and tissues over time.
- Investigators found that people with prior infection with SARS-CoV-2, the virus that causes COVID-19, have a wide variety of autoantibodies up to six months after they have fully recovered. Prior to this study, researchers knew severe cases of COVID-19 can stress the immune system so much that autoantibodies are produced. This study is the first to report not only the presence of elevated autoantibodies after mild or asymptomatic infection, but their persistence over time.
- Interestingly, some of the autoantibodies have been linked to autoimmune diseases that typically affect women more often than men. However, men had a higher number of elevated autoantibodies than women in this study.

Impact: Moderate.

Over-the-Horizon:
Real-World Data Confirms Pfizer Vaccine Is Safe for Kids Ages 5–11 (Link)

BLUF: New U.S. data based on nearly 9 million doses of the Pfizer COVID-19 vaccine delivered to kids ages 5 to 11 shows no major safety issues, according to researchers at the CDC. Although pediatric deaths from COVID-19 remain rare, hundreds of American children have died from the illness since the pandemic began. Pfizer is currently the only approved vaccine for kids in this age range.

Summary:

- The report was based on data collected by the agency's Vaccine Adverse Reporting System (VAERS). It relies on smartphone messages from parents and other guardians of children to alert the CDC of any health events occurring after a child's vaccination.
- During a six-week period after vaccine approval (Nov. 3 through Dec. 19), VAERS received 4,249 reports of adverse events after Pfizer vaccination in kids ages 5-11. More severe effects were exceedingly rare. Out of about 8.7 million vaccinations delivered during the study period, only 100 such reports were received by VAERS.
- There were only 15 preliminary reports of the rare heart condition known as myocarditis, an inflammation of the heart that has also been noted, in rare cases, among teens and young people who've received the COVID-19 vaccine.

Impact: High.

5. Clinical Practices

Short Term:
Concerning Antimicrobial Resistance Trends in E Coli Urinary Tract Infections in Females (Link)

BLUF: Urinary tract infections (UTIs) are among the most common community-onset bacterial infections and affect 10-12% of adult women each year. The increasing prevalence of infections caused by *E. coli* with extended-spectrum beta-lactamases (ESBL+) is of significant global concern given the implications for the empiric treatment of UTIs. This study highlights the need to educate physicians on best prescribing practice.

Summary:

- A study was conducted of over 1.5 million females ≥12 years old across the U.S who had *E coli* isolated from their urine cultures and antibiotic susceptibilities available in the outpatient setting between 2011-2019. Details about the type of antibiotic susceptibility (minimum inhibitory concentration (MIC) interpretive breakpoints) was analyzed over time.

- Twenty percent of the *E. coli* isolates were non-susceptible to the most commonly prescribed antibiotics, and 14% were non-susceptible to 2 or more antibiotics typically used for UTIs with 6.4% of the isolates ESBL-producing *E. coli*. ESBL+ isolates are not effectively treated with commonly prescribed antibiotics. There was regional variation; the highest number of isolates with antimicrobial resistance were from the East South Central region and Pacific Coast. There were areas of high non-susceptibility at the county level, notably in states bordering Mexico.
- National guidelines from the Infectious Diseases Society of America recommend when the antimicrobial resistance rate is >20% in a given region, the antibiotic should cease to be used for empiric treatment.

Impact: Low

6. Mental Health

Short Term:

One-Year Mental Health Outcomes in a Cohort of COVID-19 Survivors (Link) **and Secondary traumatic stress, anxiety, and depression among emergency healthcare workers in the middle of the COVID-19 outbreak: A cross-sectional study** (Link)

BLUF: At 6 and 12 months post-hospital discharge from severe COVID-19 infection, 44% and 45% of patients self-rated in the clinical range in one or more: depression, fatigue, trauma-invoking distress, and anxiety with 28% needing psychotropic medication (roughly similar rates of antidepressant, anxiolytic, and hypnotics). Similarly, in a prospective study of 363 emergency nurses and ancillary staff performed in Turkey in April 2021, 72% showed secondary traumatic stress (STS), 41% anxiety, and 56% depression.

Summary:

- All hospitalized patients (18 years and older) with confirmed COVID-19 admitted to IRCCS San Raffaele Hospital Emergency Department in Milan, Italy were consecutively enrolled in the study starting February 25, 2020 with follow-up at 1, 6, and 2 months (April-June 2020, August-November 2020 and April-May 2021). Of the 486 eligible, 402 were evaluated at 1 month, 216 at 6 months and 192 at 12 months, with 95 evaluated at all three time points.
- Females and those with a positive psychiatric history displayed increased scores in all the psychopathological domains. In all models, only psychopathology at 1 month dictated the entire 12 month psychopathology (sex and time did not). Males showed increasing depressive and anxiety symptoms over time, while these decreased in females. There was significant reduction of post-traumatic symptoms over time (regardless of sex).
- Clinical severity or care setting of COVID-19 did not affect psychopathology at 6 and 12 months.
- This is the first study to extend our understanding of the Mental Health impact of COVID-19 hospitalization to 1 year follow-up. Psychological sequelae of COVID-19 is notable, predicted at 1 month, worsens in males which make up a majority of Service members and often requires medication treatment.
- For emergency personnel, STS, anxiety and depression scores were high. Having financial difficulties and low job satisfaction were the most important factors in development of STS, anxiety and depression. Years of experience, comorbidities, living with an elderly relative, working with COVID-19 patients, nights or type of institution were not related. Women and younger participants reported increased anxiety, but it was lower in parents and those vaccinated against COVID-19.
- Participants with coping strategies to include hobbies, healthy nutrition, and reading books had lower levels of STS, anxiety, and depression. Exercise and sports were associated with lower STS and depression while breathing exercises were associated with lower anxiety and depression
- The mental health and wellness of emergency healthcare workers should be evaluated regularly and psychological, social and financial supports considered.

Impact: Moderate.

On-the-Horizon:

A New Suicide Hotline, 988, Will Launch in July 2022 and Offer Expanded Services (Link)

BLUF: By July, the United States will switch to an expanded suicide hotline for which people can call a three-digit number (988) to get help. 988 is meant to emulate 911 in simplicity and seriousness. 988 will eventually become the number called when a person is experiencing a behavioral-health crisis, obviating the need for police to show up at the scene of an emergency for which they may not be trained. This will be a gradual rollout.

Summary:

- 988 is not a nationwide calling code right now. Congress left it up to states to design 988, so roll out will vary. However, a new federal law mandates that, as of July 16, 2022, every U.S. state must have in place a call system to make it easier for people to seek immediate and appropriate for mental health or substance use crises.
- There are limited info concerning OCONUS. At the moments, Veterans and Service members may reach the Veterans Crisis Line - 1-800-273-8255 by pressing 1 after dialing, chatting online at www.veteranscrisisline.net, or texting 838255.

Impact: Moderate.

Perceptions of Firearm-Related Harm Among U.S. Adults Living in Firearm-Owning Households: A Nationally Representative Study (Link)

BLUF: In a nationally representative survey of 4030 U.S. adults living in firearm-owning households completed in summer 2019 (National Firearms Survey, excluded AD military personnel), respondents were more likely to report that unintentional injuries are more common than self-inflicted (especially suicide) or assault-related injuries although the opposite is true for all members of the household.

- When asked about risk in specific populations, 77% of respondents perceived unintentional harm to be most likely for all populations except those with drug or alcohol addiction or mental health issues: 77% for children under 10, 57% for adolescents 10-17, and 72% persons with Alzheimer's or another form of dementia.
- When asked about those with MH issues, 41% perceived intentional self-inflicted injury as most likely, 34% ranked unintentional injury and 26% ranked firearm-related assault as the most likely for this group.
- When queried about those with drug alcohol or drug addiction, 44% of respondents perceived unintentional firearm-related harm was most likely.
- **Impact: firearms are found in 1/3 of U.S. households.** Having a firearm in the home has been shown to increase risk of death from unintentional, intentional self-inflicted (especially suicide) and assault-related injury for all members of the household. The current messaging from Suicide Prevention focuses on securing firearms (storing them locked, unloaded, and separate from ammunition) as a safety issue. Addressing the disparity between relative risks of firearm injury and perception provides the opportunity for adjusting prevention messaging for maximum effectiveness.

Impact: Moderate.

Understanding the Clinical Characteristics of Lesbian, Gay, and Bisexual Military Service Members and Adult Beneficiaries within an Inpatient Psychiatric Sample (Link)

BLUF: To identify demographic characteristics associated with suicide risk in sexual minority patients, 186 U.S. service members and 23 adult beneficiaries with a suicide-related crisis leading to psychiatric inpatient hospitalization were recruited from two MTFs and one VA hospital. After controlling for age and gender, LGB participants reported higher uncontrollable suicidal ideation, significantly lower family support, higher perceived burdensomeness, but lower acquired capacity for suicide than their heterosexual peers with similar rates of depression, hopelessness, non-family support, family and non-family stress, dissatisfied belongingness and fearlessness about death.

- Overall 17.8% identified as lesbian/gay/bisexual (LGB); they were younger (25 vs 31), female (59% vs 31%), never married (59% vs 34%) and more likely to be enlisted (90% vs 80%) than their heterosexual peers.
- After controlling for age and gender, LGB participants reported significantly lower family support, higher perceived burdensomeness, but lower acquired capacity for suicide than their heterosexual peers. There was no significant difference reported with regard to depression, hopelessness, non-family support, family or non-family stress, dissatisfied belongingness or fearlessness about death. LGB participants were also twice as likely to report uncontrollable suicidal ideation and a lifetime history of multiple interrupted suicide attempts (18% vs 4%), but the latter was mitigated when adjusted for age and gender.
- Recent data from DoD shows about 6.3% of active duty U.S. service members identify as LGB compared to about 2.3% of the U.S. general population. Military peers, supervisors, chaplains and other programs in the military community may play a special role in providing increased individualized support.

Impact: Moderate.

7. Diagnostics

No updated situation to report.

8. Therapies

Short Term:

FDA Authorizes Additional Oral Medication to Treat Mild/Moderate COVID-19 (Link)

BLUF: On 23 December, the FDA issued a issued an emergency use authorization (EUA) for Merck's molnupiravir for the treatment of mild to moderate COVID-19 in adults with positive SARS-CoV-2 viral testing, or those who are at high risk for progression to severe COVID-19. This adds to the arsenal of treatment options for outpatients and the medication does not require intravenous administration, making it easier for outpatient providers to get to their patients.

Summary:

- Primary data supporting the EUA for molnupiravir are from MOVe-OUT, a randomized, double-blind, placebo-controlled clinical trial studying the drug for the treatment of non-hospitalized patients with mild to moderate COVID-19 at high risk for progression to severe COVID-19 and/or hospitalization. A 5-day course is the prescribed dose for COVID-19. Side effects observed in the trial included diarrhea, nausea and dizziness.
- This drug is not authorized for use in patients younger than 18 years of age because molnupiravir may affect bone and cartilage growth and it not authorized for the pre-exposure or post-exposure prevention of COVID-19.
- Animal studies indicated molnupiravir may cause fetal harm, therefore, molnupiravir is not recommended for use during pregnancy.

Impact: High

NIH Updates Outpatient Treatment Guidelines for Mild/Moderate COVID-19 Positive Patients at Risk for Progression to Severe Disease (Link)

BLUF: The majority of circulating COVID-19 virus in the U.S. as of January is the Omicron variant. This variant has numerous mutations in the spike protein and recent data predict the monoclonal antibodies previously recommended for outpatient treatment of mild/moderate infection may have markedly reduced susceptibility to cocktails. The NIH COVID-19 Treatment Panel has revised their guidelines based on the new data and recent approvals of two new oral anti-virals.

Summary:

- On December 22 and 23, 2021, the FDA issued EUAs that allow 2 new oral antiviral agents to be used in this patient population: ritonavir-boosted nirmatrelvir (Paxlovid) and molnupiravir. Both of these drugs are now included in the latest NIH outpatient treatment guidelines.
- Nirmatrelvir is packaged with ritonavir (as Paxlovid). Ritonavir has significant and complex drug-drug interactions, primarily due to the ritonavir component of the combination so prescribing physicians need to carefully review concomitant medications for potential interactions.
- The monoclonal antibody cocktails consistent of 1) bamlanivimab plus etesevimab and 2) casirivimab plus imdevimab are no longer recommended for outpatient use.
- Sotrovimab is now the only available anti-SARS-CoV-2 mAb that is anticipated to have activity against the Omicron VOC. Some Navy MTFs have some supply of this as of the week of 3 Jan. Infectious Disease Service and Pharmacy leadership have distributed guidance regarding eligibility criteria given the limited supplies.

Impact: High

9. Innovations

No updated situation to report.

Appendix

Supporting Figures

Figure 1

*Note: Data is from 28 DEC 2021 as the analysis is undergoing updates to account for Omicron and the booster vaccines.

Department of the Navy Active Duty: New COVID-19 Case Occurrence by Vaccination Status[1]
Cases Identified Since 21DEC2021 Report

Vaccination Status[1] and Severity[2]		Service				Total	
		Marine Corps		Navy			
Vaccination Status[1]	Severe Case[2]	Number of New COVID-19 Cases	%	Number of New COVID-19 Cases	%	Number of New COVID-19 Cases	%
Unvaccinated prior to the COVID-19 incident date	No	21	5.43%	26	2.35%	47	3.14%
	Yes-Hospitalized	0	0.00%	0	0.00%	0	0.00%
	Yes-Death	0	0.00%	0	0.00%	0	0.00%
Partially immunized[1]: COVID-19 incident date <14 days after first dose	No	6	1.55%	1	0.09%	7	0.47%
	Yes-Hospitalized	0	0.00%	0	0.00%	0	0.00%
	Yes-Death	0	0.00%	0	0.00%	0	0.00%
Partially immunized[1]: COVID-19 incident date >=14 days after first dose	No	4	1.03%	12	1.08%	16	1.07%
	Yes-Hospitalized	0	0.00%	0	0.00%	0	0.00%
	Yes-Death	0	0.00%	0	0.00%	0	0.00%
Partially immunized[1]: COVID-19 incident date <14 days after final dose	No	2	0.52%	1	0.09%	3	0.20%
	Yes-Hospitalized	0	0.00%	0	0.00%	0	0.00%
	Yes-Death	0	0.00%	0	0.00%	0	0.00%
Fully immunized[1]: COVID-19 incident date >=14 days after final dose	No	354	91.47%	1,068	96.39%	1,422	95.12%
	Yes-Hospitalized	0	0.00%	0	0.00%	0	0.00%
	Yes-Death	0	0.00%	0	0.00%	0	0.00%
Total		387	100.00%	1,108	100.00%	1,495	100.00%

[1] Two vaccine doses were considered complete for the Pfizer-BioNTech and Moderna COVID-19 vaccines, and one vaccine dose was considered complete for the J&J/Janssen COVID-19 vaccine. Individuals were considered fully vaccinated 14 days after receipt of the final dose. COVID-19 vaccines with an error in the Medical Readiness Reporting System were removed from this analysis.

[2] Severe COVID-19 case defined as hospitalization or death reported in the Armed Forces Health Surveillance Division COVID-19 Master Positive List.
Data Source: Medical Readiness Reporting System, Armed Forces Health Surveillance Division COVID-19 Master Positive List.
Prepared by the EpiData Center Department, Navy and Marine Corps Public Health Center, 29DEC2021.

Figure 2

Department of the Navy Active Duty: Total COVID-19 Case Occurrence by Vaccination Status[1]
17DEC2020-28DEC2021

Vaccination Status[1] and Severity[2]		Service: Marine Corps Number of COVID-19 Cases	Marine Corps %	Service: Navy Number of COVID-19 Cases	Navy %	Total Number of COVID-19 Cases	Total %
Vaccination Status[1]	Severe Case[2]						
Unvaccinated prior to the COVID-19 incident date	No	10,230	70.91%	13,661	62.48%	23,891	65.83%
	Yes-Hospitalized	64	0.44%	88	0.40%	152	0.42%
	Yes-Death	2	0.01%	7	0.03%	9	0.02%
Partially immunized[1]: COVID-19 incident date <14 days after first dose	No	626	4.34%	811	3.71%	1,437	3.96%
	Yes-Hospitalized	12	0.08%	8	0.04%	20	0.06%
	Yes-Death	0	0.00%	0	0.00%	0	0.00%
Partially immunized[1]: COVID-19 incident date >=14 days after first dose	No	266	1.84%	351	1.61%	617	1.70%
	Yes-Hospitalized	0	0.00%	0	0.00%	0	0.00%
	Yes-Death	0	0.00%	1	0.00%	1	0.00%
Partially immunized[1]: COVID-19 incident date <14 days after final dose	No	155	1.07%	182	0.83%	337	0.93%
	Yes-Hospitalized	2	0.01%	0	0.00%	2	0.01%
	Yes-Death	0	0.00%	0	0.00%	0	0.00%
Fully immunized[1]: COVID-19 incident date >=14 days after final dose	No	3,068	21.27%	6,751	30.88%	9,819	27.06%
	Yes-Hospitalized	2	0.01%	4	0.02%	6	0.02%
	Yes-Death	0	0.00%	0	0.00%	0	0.00%
Total		14,427	100.00%	21,864	100.00%	36,291	100.00%

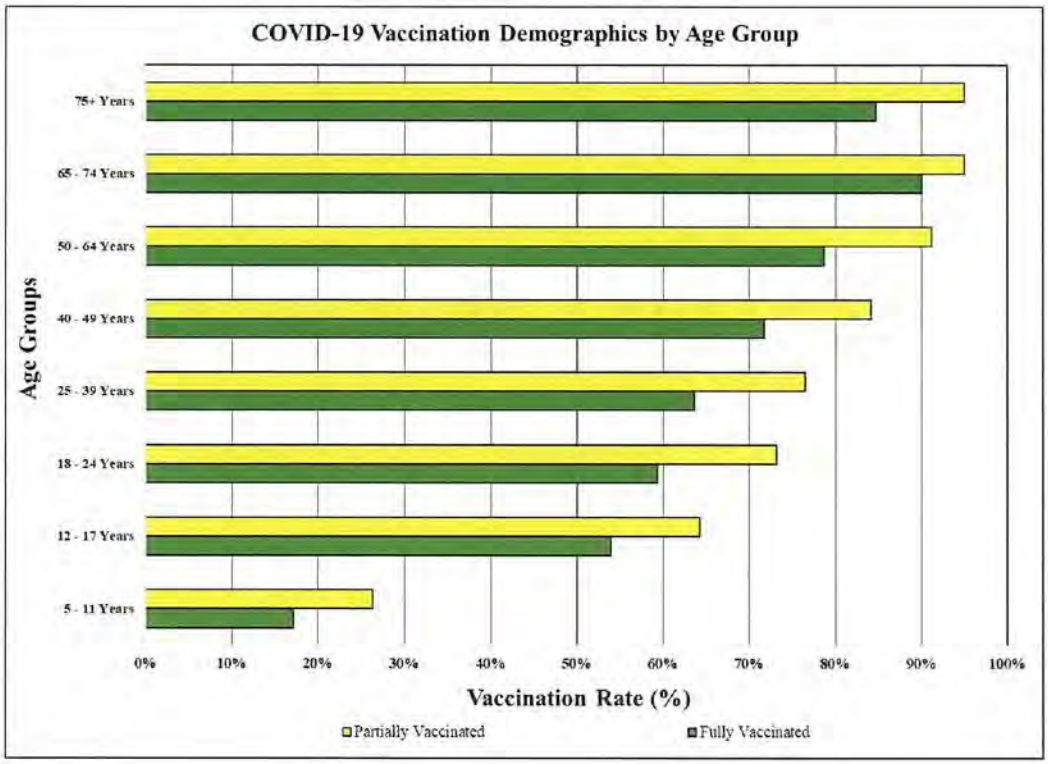
Number of AD Sailors Vaccinated or Unvaccinated as of 28DEC2021: Fully Immunized: 324833, Partially Immunized: 3288, Unvaccinated: 7426
Number of AD Marines Vaccinated or Unvaccinated as of 28DEC2021: Fully Immunized: 176659, Partially Immunized: 4117, Unvaccinated: 8397

[1]Two vaccine doses were considered complete for the Pfizer-BioNTech and Moderna COVID-19 vaccines, and one vaccine dose was considered complete for the J&J/Janssen COVID-19 vaccine. Individuals were considered fully vaccinated 14 days after receipt of the final dose. COVID-19 vaccines with an error in the Medical Readiness Reporting System were removed from this analysis.

[2]Severe COVID-19 case defined as hospitalization or death reported in the Armed Forces Health Surveillance Division COVID-19 Master Positive List.
Data Source: Medical Readiness Reporting System, Armed Forces Health Surveillance Division COVID-19 Master Positive List.
Prepared by the EpiData Center Department, Navy and Marine Corps Public Health Center, 29DEC2021.

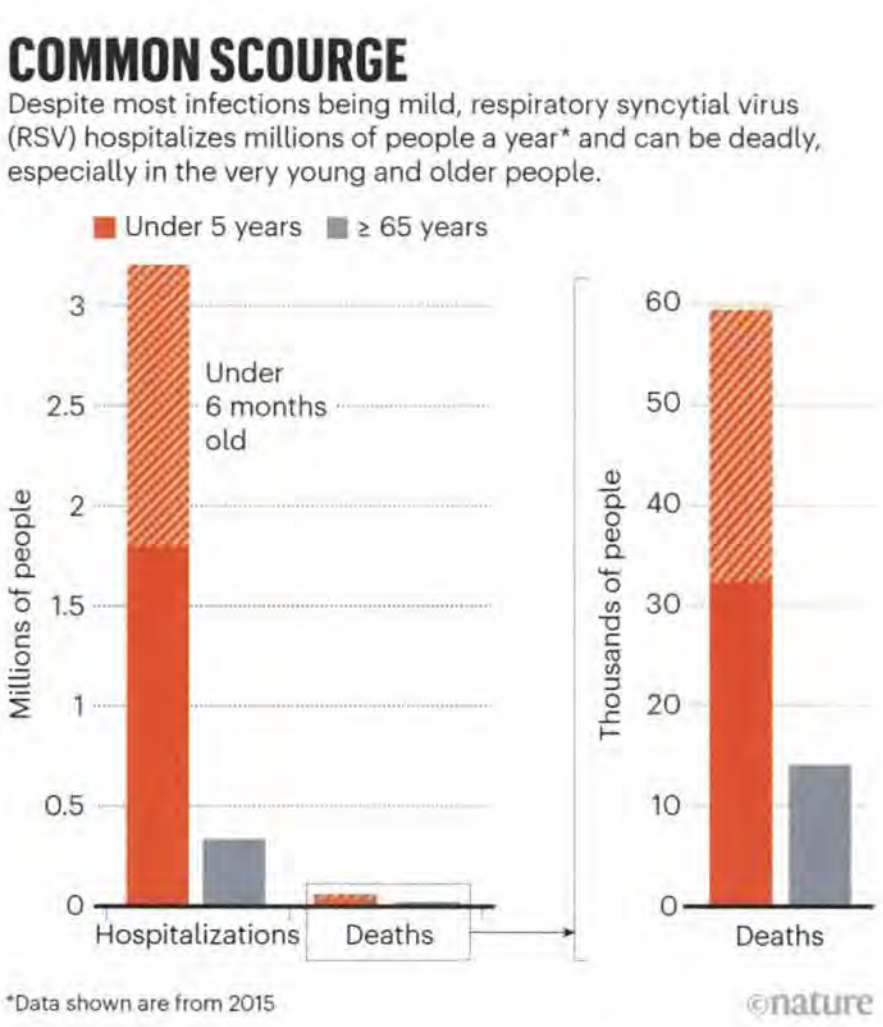
Figure 3

United States COVID-19 vaccination status stratified by age groups.
Data current as of 12 JAN 2022, per the CDC*.



*Data taken from: COVID-19 Vaccination and Case Trends by Age Group, United States | Data | Centers for Disease Control and Prevention (cdc.gov)

Figure 4



Sources: Under 5, Shi, T. *et al. Lancet* **390**, 946–958 (2017); over 65, Shi, T. *et al. J. Infect. Dis.* **222**, S577–583 (2020)

BUMED Scientific Panel

Chair:
CAPT Matthew Weiner, MSC, USN

Members and Contributors:
CAPT Janine Danko, MC, USN
CAPT Bryan Schumacher, MC, USN
CDR Theron Hamilton, MSC, USN
CDR Tracy Krauss, NC, USN
CDR Nick Martin, MC, USN
CDR Peter Seguin, MC, USN
CDR Robyn Treadwell, MC, USN
CDR Tim Whiting, NC, USN
LCDR Joshua Swift, MSC, USN
Dr. Chris Myers
Dr. Francis Obuseh
Dr. Jill Phan

NOT FOR PUBLICATION
UNTIL RELEASED BY THE
HOUSE ARMED SERVICES COMMITTEE
SUBCOMMITTEE ON READINESS

STATEMENT OF

ADMIRAL WILLIAM K. LESCHER

VICE CHIEF OF NAVAL OPERATIONS

BEFORE THE

HOUSE ARMED SERVICES COMMITTEE SUBCOMMITTEE ON READINESS

ON LEARNING FROM AND PREVENTING FUTURE TRAINING MISHAPS

MARCH 23, 2021

NOT FOR PUBLICATION
UNTIL RELEASED BY THE
HOUSE ARMED SERVICES COMMITTEE
SUBCOMMITTEE ON READINESS

Chairman Garamendi, Ranking Member Lamborn, and distinguished members of the House Armed Services Subcommittee on Readiness, thank you for the opportunity to appear before you today to discuss Navy mishap trends, our lessons learned, and the proactive steps we are taking to better understand and control risk, improve safety outcomes, and increase the combat effectiveness of our force.

Our nation requires a Navy that is ready to deploy globally in defense of U.S. interests. 2020 provided a strong example of how the U.S. Navy is executing that imperative. While large portions of world activity were curtailed with the pandemic, the Navy's operational tempo continued at a high pace, highlighted by eight major Carrier Strike Group and Expeditionary Strike Group deployments. In 2020, Naval Aviation flew over 700,000 flight hours and Navy Afloat forces amassed over 23,000 total steaming days. In a number of instances, U.S. Naval Forces' deployments were extended to support high priority Secretary of Defense tasking. One such unit, the USS Nimitz (CVN 68) Carrier Strike Group, returned last month from the longest aircraft carrier deployment in modern history.

This performance strongly aligns with CNO Gilday's message to the force: "*Failing to maintain our advantage at sea will leave America vulnerable. Mission One for every Sailor—active or reserve, uniformed and civilian—is the operational readiness of today's Navy.*" In alignment with this direction, the Navy is bringing a strong sense of urgency in addressing the critical topics of this hearing, working comprehensively to improve readiness generation outcomes and our safety culture.

Get Real – Get Better: Enabling a Culture of Excellence

The Navy has learned hard lessons over the past few years from major mishaps. Our improvement path is aligned to the "Get Real, Get Better" approach—proven in the Navy's work to transform Strike Fighter readiness, improve private shipyard depot maintenance performance, and drive better outcomes in other key mission areas. The "Get Real" element demands rigorous self-assessment, strong characterization of current performance, and detailed root cause analysis to identify the conditions or behaviors that led to a mishap. This "Get Real" element illuminates performance and capabilities as they are, as actually measured, rather than what leaders aspire performance to be. The "Get Better" element applies these root cause insights to develop, implement, and track action plans that drive improvement in the organization's operational and safety performance, using a strong cadence of measurement and accountability.

A recent example is the Navy's response to the 2017 USS Fitzgerald and USS John S. McCain mishaps. Two major reviews – the Comprehensive Review (CR) and Strategic Readiness Review (SRR) – identified root causes of the mishaps and made 111 recommendations aimed at driving Navy readiness improvement and preventing such consequential mishaps in the future.

The Navy's Readiness Reform & Oversight Council (RROC) executed action plans to address all 111 CR/SRR recommendations with a governance structure to monitor and measure progress. With the support of this committee, the Navy invested in and employed meaningful reforms in how we man our surface fleet, train our crews, schedule and execute workups and deployment, and how we equip and maintain our surface force.

Improvements have been made in (1) Surface Warfare Officer training; (2) Use of ship simulators to train shipboard teams in Navigation, Seamanship, and Ship Handling; and in

Combined Integrated Air and Missile Defense and Anti-Submarine Warfare training; (3) Readiness for Sea Assessments; (4) Force Generation Models; (5) Shipboard manpower requirements; and (6) Comprehensive Fatigue and Endurance Management Program.

This structured "Get Better" approach requires ongoing measurement of improvement self-talk against actual performance. Specific examples of measured outcomes include: (1) Establishment of Commander 7th Fleet (C7F) weekly Fleet Management Coordination Board, which more closely manages OPTEMPO; (2) Type Commander (TYCOM) semi-annual assessments of Basic & Advanced Phase performance versus entitlement, where for 2020 both Commander, Naval Air Force Pacific (CNAP) and Commander, Naval Surface Force Pacific (CNSP) completed 100% of Basic Phase training within entitlement (CNSP up from 38% in fiscal year 2019); (3) Readiness generation improvements where 100% of forces deployed with full readiness certifications; and (4) Forward Deployed forces achieving a 0% certification expiration rate, compared to 2015-2017 rates of 6-40% expiration.

USS Bonhomme Richard

In July 2020, USS Bonhomme Richard (BHR) suffered a catastrophic shipboard fire during a maintenance period in San Diego, CA. The BHR fire marked the 15th significant fire onboard a U.S. Navy vessel in the past 12 years, demonstrating that previous leadership interventions of the type the Fleet Commanders aggressively employed following the BHR fire have not in the past resolved root causes sufficiently to drive enduring change in the frequency of shipboard fire mishaps. Early this year, I directed the Fleet Commanders, working with the Naval Safety Center, Naval Reactors, Naval Sea Systems Command and Naval Installations Command, to conduct a detailed review of these shipboard fires. The goal is to illuminate

systemic issues regarding the standards, culture and environment driving daily discipline in shipboard stowage, cleanliness and readiness, and to recommend actions that establish the necessary culture and practices required to change Navy fire safety outcomes in an enduring way. This probe into systemic root causes of long-term shipboard fire safety performance completes in July and is designed to provide a foundation to broadly improve all Navy safety performance outcomes.

Figure 1: Naval Aviation Class A Mishaps (flight)

Naval Aviation Safety Update

Naval Aviation and the Naval Safety Center have fully reviewed the analysis and recommendations of the National Commission on Military Aviation Safety (NCMAS) that examined mishaps between fiscal year 2013-2018. The U.S. Navy is working closely with the Department of Defense to provide a department wide response to NCMAS. In the interim, Naval

Aviation continues the work to continually improve our safety culture. In 2019, Naval Aviation had its best year in the last decade for total mishaps (287 Class A-D mishaps/ 33.8 mishaps per 100,000 flight hours) and was the first time in 10 years where total mishaps did not increase. The 2020 A-D mishap totals dropped to 280 and there were zero Class A fatalities, while the overall mishap rate (36.4 per 1000,000 flight hours) was slightly higher than 2019. Class C Aviation Ground Mishaps (AGM) were the driver of the increased mishap rate in 2020.

Aviation Ground Mishaps: As part of Naval Aviation's Culture of Excellence Campaign, Naval Aviation began a campaign in 2020 to deep dive root causes of AGM, such as procedural compliance and human factors. Naval Aviation is leveraging data analytics, training and leadership intervention to bend the curve on AGMs. Specific initiatives include:

(1) Fleet Readiness Analytics Group (FRAG): The FRAG is applying internal and external data analytics to identify trends, readiness impacts and drivers associated with mishaps. The FRAG is aligned with our maintenance, safety, and operations processes to identify catalysts that can enable positive change.

(2) Safety Support Group (SSG) Pilot: Naval Aviation is executing this new program where TYCOM, Wing and Naval Safety Center subject matter experts conduct no-notice quality assurance visits to flight lines and commands.

(3) Maintenance ASAP: Implemented as a daily feedback tool to provide squadron leadership with insight into maintenance practices, risks and improvement opportunities in their commands.

Physiological Event (PE): In 2017, the U.S Navy temporarily grounded our fleet of T-45 trainer aircraft after a series of unexplained Physiological Events (PE) where instructors and students reported hypoxia-like symptoms during flight. In response, the Navy stood up the

Physiological Episodes Action Team (PEAT) to study PE and implement improved safety equipment and training to avoid hypoxia events. This comprehensive work led to mechanical fixes, increased aircrew education, and PE specific policy changes. As of March 2021, T-45 PE rates are down 94% since July 2017, and F/A-18 and E/A-18G PE rates are down 77% since November 2017.

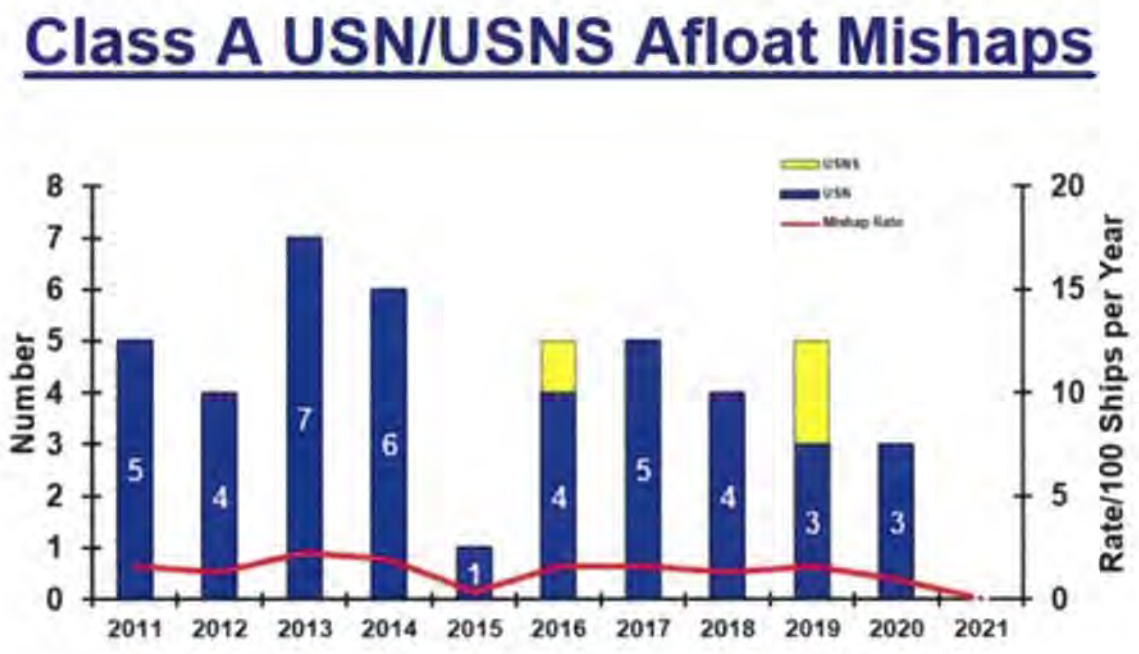


Figure 2. Navy Surface Force Class A Mishaps (Afloat)

Surface Force Safety Update

The Surface Force overall mishap rate is also trending down, benefitting from increased reporting of lower-level events and near misses to raise risk awareness. Between 2011 and today, surface force hazard reports (HAZREP) and lessons learned annual submissions have increased from 108 annually in 2011 to six times that number in 2020. This increase in risk

awareness is having a positive impact on the surface community's safety culture. Additionally, the surface fleet has developed and implemented key safety initiatives to address better crew coordination, improve decision-making and better manage crew fatigue to include:

Afloat Bridge Resource Management Workshop (ABRMW): ABRMWs are underway events where senior community leaders train ship leadership from theory to practice on operational safety fundamentals, and observe how Commanding Officers make day-to-day risk decisions. Since 2018, ships that completed ABRMW have had zero Class A or B mishaps.

Fire Safety Assessment (FSA): After the USS Bonhomme Richard fire, the Surface Fleet TYCOM developed and executed a no-notice/after-hours Fire Safety Assessment (FSA) program with Senior Department of the Navy civilians and post major command officers (O-6). The FSA program puts TYCOM experts on ships and provides a real-time picture of current shipboard fire-readiness across the waterfront. In an FSA, TYCOM Force Safety and Force Damage Control Assessment (DCA) leadership assesses ships in no-notice visits. Since program inception in September 2020, the Navy has identified and corrected deficiencies during 56 assessments.

Operational Safety Risk Indicator (OSRI): The mission of OSRI is to assess comprehensive safety and readiness (Man, Train, & Equip) indicators of surface ships to meet operational tasking. OSRI serves within existing command structures to facilitate effective use of resources, collaboration to achieve mission effectiveness, and streamline decision-making. The goal of OSRI is to provide: (1) Consistent cross-stakeholder information flow by working from the bottom-up and horizontally to avoid stope-piped information; (2) Improved process discipline; (3) Integrated, consistent, and hierarchical metrics; (4) Full transparency of data, information, and activities; (5) Data-informed recommendations for risk mitigation,

including re-apportionment of resources, recommended intervention points, and key actions; and (6) Integrated and effective governance of data collection/maintenance, data analysis, and data sharing to work across different commands, sustain operations, and develop new predictive models as new information and methods are introduced.

Submarine Force Safety Update

Mishap Rates - Improving: From 1980 to 2010 our submarine force averaged approximately three collisions, allisions (striking a stationary or non-moving object), and/or groundings per year. From 2011 to 2020, they averaged less than one per year, and in 2020, there were zero collisions and/or groundings.

Learning from "Near Miss" Events: The Submarine Force uses an innovative, near miss analysis approach to improve safety across the fleet that includes: (1) Leveraging a Windows-based "singular reporting" structure; (2) Analysis of near misses and near miss trends; (3) Providing near miss briefs to Flag leadership, staffs, and operational units; (4) Tracking briefing outcomes through a rigorous Force Improvement process. The trends are analyzed, briefed to leadership, and shared with all submarines and support staffs.

Conclusion

The intensified nature of the military competitive environment drives the Navy to aggressively improve status quo practices and behaviors in order to remain the most ready and lethal Navy in the world. We are working hard to identify and attack mishap drivers and root causes, to instill a strong culture of near miss reporting and learning, and to implement disciplined approaches to measure performance, identify precursor events, and correct off-track performance. I look forward to the continued partnership with this committee to continuously

improve readiness and keep our Sailors safe, and to ensure our Navy is properly and predictably resourced, manned, trained and equipped to answer the nation's call.

Morbidity and Mortality Weekly Report

EXHIBIT 9

Notes from the Field

Outbreak of COVID-19 Among a Highly Vaccinated Population Aboard a U.S. Navy Ship After a Port Visit — Reykjavik, Iceland, July 2021

Tammy E. Servies, MD[1]; Eric C. Larsen, MD[1]; Rodney C. Lindsay, MPH[1]; Jonathan S. Jones, MS[1]; Regina Z. Cer, MS[2]; Logan J. Voegtly, MS[2,3]; Matthew R. Lueder, MS[2,3]; Francisco Malagon, PhD[2,3]; Kimberly A. Bishop-Lilly, PhD[2]; Asha J. Riegodedios, MSPH[4]

On July 27, 2021, a fully vaccinated* crew member on a U.S. Navy ship who had been symptomatic with cough and congestion for 4 days was evaluated in the ship's onboard medical department and received a positive test result† for SARS-CoV-2, the virus that causes COVID-19. The ship had approximately 350 personnel on board§; COVID-19 vaccination rate was >98%.¶ The ship had been on an 8-week deployment with port visits in Norway (July 13–14) and in Reykjavik, Iceland (July 18–21). Masking and physical distancing mandates on the ship were relaxed while at sea but were immediately reimplemented upon identification of the crew member's positive test result. During the deployment, personnel had permission to go ashore only during the Iceland port visit and only if they were fully vaccinated. Before July 27, no one had been evaluated at the onboard medical department for respiratory symptoms. Although reported COVID-19 incidence was low in Iceland just before the port visit (17.5 per 100,000 population on July 18), incidence increased approximately elevenfold, to 219.5 per 100,000 on July 27 with emergence of the B.1.617.2 (Delta) variant.** At the onset of the COVID-19 pandemic, outbreaks on some U.S. Navy ships led to attack rates greater than 25% (*1*) of the crew in the confined environment. In this outbreak during Delta variant predominance, the combination of a high vaccination rate with prevention strategies resulted in a lower (6.3%) attack rate of COVID-19 than seen at the onset of the pandemic.

After identification of the initial case on July 27, all ship personnel were notified to report to the onboard medical department if they had any COVID-19–like signs or symptoms,†† resulting in diagnoses of an additional 11 COVID-19 cases that day. The ship immediately instituted prevention measures, including mask use, physical distancing, increased cleaning, isolation of the 12 initial patients, testing of 69 close contacts,§§ and testing and quarantine of six unvaccinated persons (two of whom were also close contacts). On July 28 and 29, six additional cases were identified through testing. Nasal swabs from these 18 persons with positive antigen test results were sent off the ship for reverse transcription–polymerase chain reaction (RT-PCR) testing and all were positive for SARS-CoV-2.¶¶ Further analysis determined 17 of the 18 specimens were Delta variant AY.9 lineage; 16 of the 17 were identical.*** During this same time frame at the end of July, Delta AY.9 was identified in 8% of specimens in Iceland and fewer than 1% of specimens in Norway and the United States.††† The 18 infected persons were removed from the ship on July 31 to reduce the ship's health care requirements and to prevent further transmission. Four additional cases of COVID-19 were identified during August 1–7 (including three diagnosed aboard the ship and one postdeployment) with onset July 28–August 5. The overall attack rate was 6.3%. The ship returned to its home port on August 3, concluding its deployment as scheduled.

Among the 22 infected personnel identified, all were fully vaccinated, and all were symptomatic. Most (91%) were aged <40 years (average age = 30.2 years). No patient required hospitalization or supplemental oxygen and no deaths occurred. Before the outbreak was identified on July 27, 13 (59%) of the 22 infected personnel had been symptomatic for a median of 3 days (range = 1–5 days) aboard the ship with no masking or physical distancing protocols in place (Figure). During the 15-day outbreak period (July 22–August 5), 91 personnel received rapid antigen testing.

* Fully vaccinated was defined as 2 weeks after receipt of a single dose of Ad.26.COV2.S (Janssen [Johnson & Johnson]) vaccine or the second dose of either BNT162b2 (Pfizer-BioNTech) or mRNA-1273 (Moderna) vaccines.

† The Abbott BinaxNOW COVID-19 Ag Card rapid antigen test was used to test personnel aboard the ship. During the deployment, personnel evaluated at the clinic for COVID-19–like symptoms were tested when seen by the ship's medical department.

§ During July 18–August 3, the total number of crew members fluctuated between 346 and 355.

¶ This outbreak occurred 1 month before the August 24, 2021, memo by the U.S. Secretary of Defense mandating vaccines in service members. However, personnel were not authorized to depart the ship for liberty without being fully vaccinated.

** https://www.covid.is/data/ (Accessed December 16, 2021)

†† Fever, chills, rigors, myalgia, headache, sore throat, loss of taste or smell, cough, shortness of breath, or difficulty breathing.

§§ A close contact was defined as anyone within 6 feet of an infected person for a cumulative total of ≥15 minutes within a 24-hour period.

¶¶ Samples were sent to the U.S. Naval Hospital in Rota, Spain, for RT-PCR testing and then sent to Naval Medical Research Center – Frederick on Fort Detrick, Maryland, for genome sequencing and phylogenetic analysis.

*** One of the 17 Delta variant samples had an additional mutation in ORF10 (G29645T, ORF10) resulting in a lysine versus a valine at amino acid V30L. The final sample was not assigned a lineage because of insufficient consensus genome length.

††† Reported data from Outbreak.info's AY.9 Lineage Report. https://outbreak.info/situation-reports?pango%C2%A0=%C2%A0AY.9&loc%C2%A0=%C2%A0ISL&loc%C2%A0=%C2%A0NOR&loc%C2%A0=%C2%A0USA&selected%C2%A0=%C2%A0ISL&overlay%C2%A0=%C2%A0false (Accessed December 31, 2021).

Only one case was identified >14 days after the Iceland port visit, demonstrating very limited spread of infection despite exposure to symptomatic personnel for a median of 3 days in the confined shipboard spaces. In previous U.S. Navy shipboard outbreaks, before COVID-19 vaccines were available, SARS-CoV-2 spread was rapid and extensive, with attack rates of 26.6% (1,271 of 4,779 personnel) on one ship (*1*) and 36.3% (121 of 333) on another (Navy and Marine Corps Public Health Center, unpublished data, 2020). These attack rates were approximately four and six times higher, respectively, than that described in this report.

Summary

What is already known about this topic?

At the onset of the COVID-19 pandemic, outbreaks on some U.S. Navy ships led to attack rates >25% in the confined environment.

What is added by this report?

During July 2021, an outbreak of Delta variant aboard a U.S. Navy ship after a port visit in Iceland resulted in a 6% attack rate. The ship's population was >98% immunized, and although prevention measures (e.g., mask use, extra cleaning, and distancing procedures) were relaxed during the underway period, they were reimplemented upon identification of the first case.

What are the implications for public health practice?

Vaccination, in combination with other prevention strategies, resulted in a much lower attack rate of COVID-19 than seen in the early months of the pandemic.

The findings in this report are subject to at least four limitations. First, shipboard testing was limited to rapid antigen testing, which has a lower sensitivity than RT-PCR testing in asymptomatic persons (*2*). Second, testing relied on persons to report symptoms and close contacts, which is subject to recall bias. Third, this was an outbreak of Delta variant and findings might not be applicable to B.1.1.529 (Omicron) or other variant outbreaks. Finally, this outbreak occurred in a highly vaccinated, young, healthy population, thus limiting generalizability to the overall U.S. population.

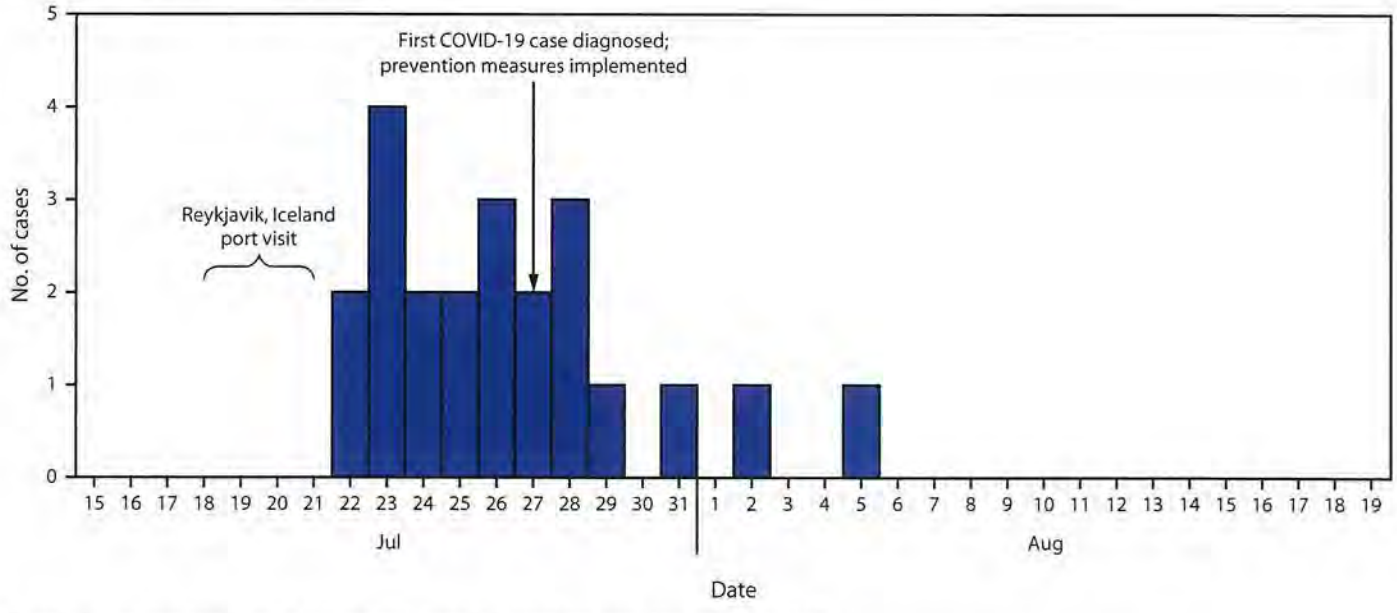
This outbreak in the enclosed environment of a ship suggests that high vaccination rates, in combination with COVID-19 prevention measures, can substantially reduce the spread of SARS-CoV-2, despite the high transmissibility of the Delta variant and introduction of SARS-CoV-2 into a congregate setting. Infections among vaccinated persons did occur, which is expected (*3*), but symptoms were mild. Vaccination, in coordination with multicomponent prevention strategies, are critical to limiting SARS-CoV-2 transmission and COVID-19–related illness.

Acknowledgments

Medical department and ship personnel; Bridget Ruiz, Ana Solis, U.S. Naval Hospital Rota, Spain team; Wendi Bowman, Digna Forbes, Navy and Marine Corps Public Health Center.

Corresponding author: Tammy Servies, tammy.e.servies.mil@mail.mil.

FIGURE. Date of symptom onset or specimen collection* for COVID-19 cases identified during an outbreak on a U.S. Navy ship (N = 22) — Reykjavik, Iceland, July–August 2021†



* Whichever occurred earlier; for all but one case, symptom onset preceded specimen collection.
† Prevention measures included mask use, physical distancing, increased cleaning, canvassing for mild symptoms, and increased testing.

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All authors have completed and submitted the International Committee of Medical Journal Editors form for disclosure of potential conflicts of interest. Kimberly A. Bishop-Lilly reports support from the Armed Forces Health Surveillance Division, Global Emerging Infections Surveillance Branch. No other potential conflicts of interest were disclosed.

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MILITARY MEDICINE, 186, 7/8:178, 2021

U.S. Navy Aircraft Carrier Prevents Outbreak at Sea in Midst of COVID-19

EXHIBIT 10

CDR Veronica E. Bigornia, MD, MPH, MC, USN

ABSTRACT

Background:
The USS Harry S Truman Strike Group deployed from Norfolk, VA in November 2019 with a crew of 5,461 personnel and successfully returned to home port in June 2020 with zero cases of COVID-19.

Methods:
Senior Medical Officer's observations and description of the evolution of the pandemic, impact to the crew of the USS Harry S Truman, a nuclear-powered aircraft carrier, and the public health principles and outbreak prevention protocols used to prevent an outbreak at sea.

Results:
The USS Harry S Truman Carrier Strike Group was composed of 4,810 personnel from Carrier Strike Group 8, Harry S Truman, Destroyer Squadron 28, and Carrier Air Wing One. The medical department of 52 personnel was made up of doctors, physician assistants, nurses, independent duty corpsman, and hospital corpsman. Our escorts were one destroyer, crew size 308 and one cruiser, crew size 343, each with one independent duty corpsman and one hospital corpsman for medical staff. The total number of personnel was 5,461, all of whom returned to home port with no cases of COVID-19.

Conclusions:
Outbreak with a respiratory pathogen in the shipboard environment could debilitate a crew and decrease mission effectiveness of a US Navy warship with implications to national security. Prevention of an outbreak at sea requires identification and mitigation of vulnerabilities, testing capability for identification of the pathogen, preparation for quarantine and isolation for immediate containment, and commitment from the entire crew for success.

The USS Harry S. Truman Strike Group deployed from Norfolk, VA, in November 2019 with a crew of 5,461 personnel and successfully returned to home port in June 2020 with zero cases of corona virus infection (COVID-19). As Senior Medical Officer, I saw a dedicated crew exercise an unyielding, admirable commitment to the prevention of an outbreak at sea from a rapidly evolving infectious agent.

We were operating in the northern Arabian Sea when reports began of an outbreak of severe respiratory illnesses in China in December 2019.[1] In early January, the agent was identified as a coronavirus and named novel coronavirus; by January 30, 2020, the WHO declared a global emergency with cases throughout Asia, Europe, and the United States.[1] In mid-January, we were preparing for a port call in Duqm, Oman. With no official guidance and unreliable Internet access, I had limited information on the extent of this threat but did know Oman had no known cases of this novel virus and a well-established public health infrastructure.[2] I recommended we proceed with our first liberty of the deployment after 60 days at sea. Our port call was uneventful due to controls placed over our population. Two hotels were authorized with rooms and day passes limited to a percentage of each department; a controlled system of shuttle transportation provided accountability for all sailors. The authorized location for the rest of the crew was pier side for a "sandbox port call." We returned to Duqm in February for a second port call with the same arrangements; only this time, the threat had evolved into COVID-19, a new disease caused by severe acute respiratory syndrome coronavirus 2.[1] There were two reported cases in the Omani capital city of Muscat, several hundred miles away, associated with travelers from Iran.[2] I deemed the risk low based on the absence of local cases, and our port call was again uneventful.

On March 11, 2020, the WHO upgraded COVID-19 to pandemic status,[1] merely a week since we left what would be our last visit to a foreign port. There was no guidance out for this unprecedented situation, and I was the sole advisor afloat as the public health authority for the strike group. Using what resources I could access, a plan tailored for the shipboard environment was developed, focusing on our points

USS Harry S. Truman, Naval Air Forces Atlantic, FPO, AE 09524, USA

The views expressed in this article are those of the author and do not necessarily reflect the official policy or position of the U.S. Navy, the Department of Defense, or the U.S. Government.

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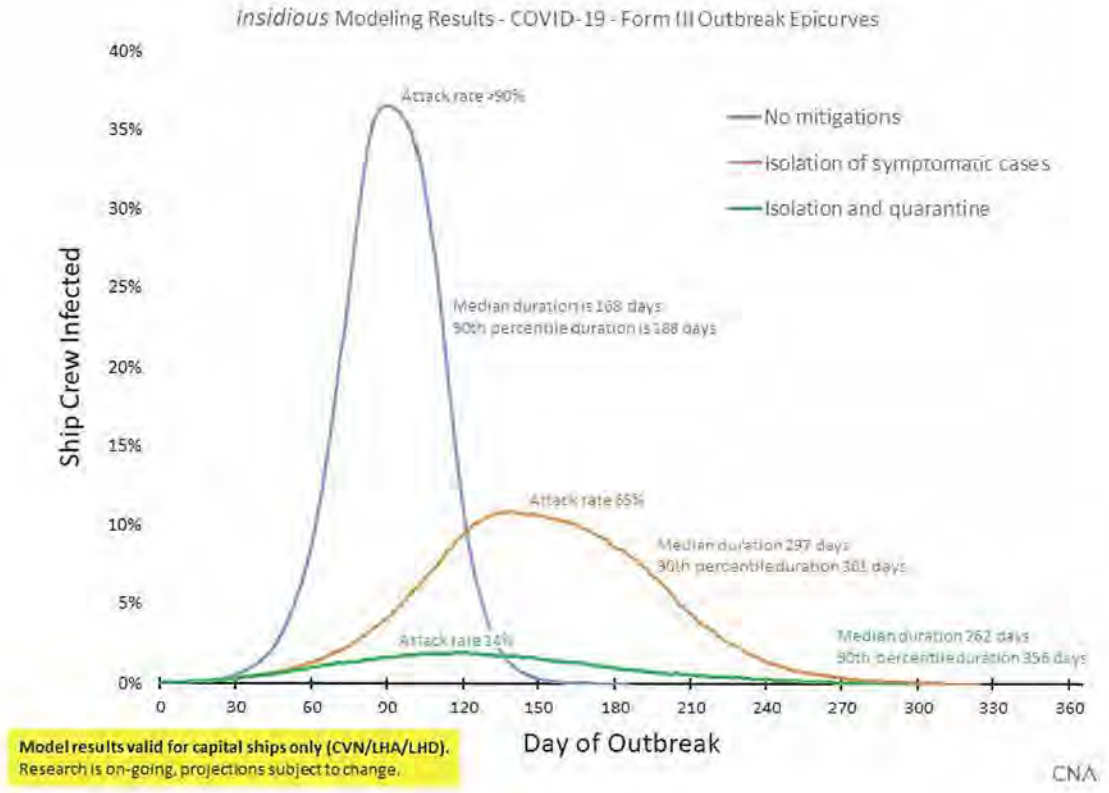

FIGURE 1. Early model results provided to the author demonstrating outbreak progression onboard capital ships (CVN/LHA/LHD) using crew size and configuration of USS Harry S. Truman. This early model was discovered to have an error that extends the outbreak in time as the CDC tables were misinterpreted and the latent period (non-infectious—mode ~3 days) conflated with the incubation period (pre-symptoms—mode ~5 days), adding 2 days to each disease generation. Corrected results indicated that the disease will ramp up quicker than the chart indicates and will take less time to "burn through" the ship, returning to operations more rapidly than indicated by the curves. Model results at the time indicated that quarantine was effective at slowing the disease but unsustainable in large outbreaks as nearly the entire ship quickly ends up in quarantine. This early effort hints at this outcome, and the quarantine burden became more apparent in later modeling efforts.

of vulnerability to COVID-19. Humans were the known primary vector, and all arrivals were screened in our flight deck battle dressing station with travel history questions and temperature checks. The C2 carrier-onboard-delivery bringing supplies and incoming personnel was another vector, and as the pandemic progressed, we stopped receiving nonessential personnel. Those deemed critical or essential to mission were allowed on board with strict precautions, including pre-embarkation quarantine for up to 21 days and testing when it became available. Carrier-onboard-delivery aircrew was not allowed into the skin of the ship except for a dedicated facility followed by disinfection. We provided box meals for consumption in the aircraft or on the flight deck while awaiting departure. The aircrews' final onboard landing ended in 14 days of quarantine as we crossed the Atlantic. Our transit through the Suez Canal required three different sets of Egyptian pilots to board, navigate for a distance of the canal, then change out with the next set of pilots. Each change increased our risk of exposure, but running aground was unacceptable. All parties took the preventive measures of wearing masks for the first time, social distancing as allowable, and sailors literally following the visitors and sanitizing passage ways and handrails as they transited to and from the bridge. We made it through safely and at the same time realized the usual social courtesies and customs must give way to the new normal of a pandemic age.

Evidence of virus surviving for up to 3 days on surfaces resulted in spraying of packages with disinfectant and transfer to the aircraft elevator to air dry before moving down into the hangar bay.[3] Personnel handling supplies were protected with surgical masks, gloves, and hand sanitizer to use when complete with handling of material. Medical evacuations leaving to shore posed another vector for aircrew transporting the patients then returning to ship. Infection control protocols for patient transfer and disinfection of the aircraft cabin and equipment upon return were instituted, and a novel use of our radiation decontamination showers was tested on aircrew returning from a medical evacuation, who reported the water was extremely cold, but the best shower they had on board.

Heroic efforts were given to the prevention of an outbreak at sea should defenses be breached. COVID-19 was known to be a highly infectious respiratory pathogen, transmitted person to person by droplet with prolonged, close exposure (<6 feet for >15 minutes).[1] Modeling data projecting spread of an infectious disease on a U.S. Navy ship indicated immediate isolation of symptomatic sailors, and quarantine of high-risk close contacts would increase the probability of outbreak control to 70% and decrease the total number of infections by 75% (Figure 1).[4] A contained outbreak on a carrier was projected to last 100 days with a peak at day 42 and result in 60 infected, 30 symptomatic, 6 debilitated, and 3 critical based on a population of 5,657.[4] Medical staff prepared the three-bed ICU and an isolation room to accommodate four patients. Quarantine berthing was set up to accommodate 30 patients, with additional quarantine spaces identified to expand for the projected maximum of 133 patients in quarantine and 16 patients in isolation based on the same model of a contained outbreak on a CVN.[4] Protocols for care of patients in isolation and quarantine were developed with attention to habitability, morale, food, and sanitation needs as well as medical monitoring while maintaining infection control practices.

Rapidly augmented with equipment for RT-PCR detection of severe acute respiratory syndrome coronavirus 2 as well as 21 other respiratory pathogens, we could identify the enemy with precision. Supplied with critical care equipment, surgical and N95 masks, gloves, gowns, thermometers, and disinfectant, we were armed for a different battle, but a battle nonetheless. The rules of outbreak prevention apply at sea and on land; with consistent, unyielding application of those rules, modified for the ship, we protected our population. It was difficult to social distance in tight quarters of a ship. It was uncomfortable to ask high-level visitors to submit to screening and temperature checks and possibly be denied boarding. It was awkward to wear masks when we were a clean ship. By April 2020, we were the sole "clean" carrier available and remained at sea, ready to respond to the call to defend our nation from outside threats, while our loved ones fought the pandemic at home.[5] Preparing to join the fight on land, we practiced social distancing, wearing masks, and routine disinfection of high touch surfaces with diluted bleach solution twice a day by all hands.

The USS Harry S. Truman Carrier Strike Group returned to the east coast of the United States in June 2020 untouched by the pandemic. This was accomplished by the dedication of all hands, strong leadership exercising decisive action, and the benefit of lessons learned by our shipmates across the Navy and around the world. We continue the fight in our home port of Norfolk, VA, committed to keeping COVID-19 off our ship.

FUNDING

I received no funding for this work.

CONFLICTS OF INTEREST STATEMENT

I have no financial conflicts of interest to disclose.

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NAVY AND MARINE CORPS PUBLIC HEALTH CENTER

PREVENTION AND PROTECTION START HERE

EXHIBIT 11

COVID-19 Country Surveillance Report:

Country Confirmed COVID-19 Cases and Navy Installation(s)

6 JAN 2022

The purpose of this document is to provide surveillance information on the number of international COVID-19 cases by country. To align with the US National Guidelines Three-Phased Approach the report has been modified to focus on the downward trajectory of documented COVID-19 cases within a 7-day period. Estimated incidence of new cases per 100,000 over 7 days will be used as the primary indicator to determine risk for each country. Numbers are reported as incidents occurring per 100,000 people. Only countries with over one case per 100,000 people are shown. Countries that are new to the report due to this qualification will not have a Previous Report Risk Level.

To align with the updated Center for Disease Control and Prevention (CDC) masking guidance, indicators have been included in the report to determine when indoor masking is required for all personnel based on level of community transmission. The metric: new COVID-19 cases per 100,000 persons in the last 7 days will be calculated to assess level of community transmission.
Transmission values have been classified as: ●Low (0-9.99), ●Medium (10-49.99), ●Substantial (50-99.99), or ●High (≥ 100) to support decision-making when enforcing indoor masking for all personnel.

Reporting Circumstances Potentially Impacting Reports:

- The 7 day window makes the report more susceptible to capturing exaggerated highs and lows resulting from a multi -day data lag followed by single-day reporting.
- Our data sources update their previous week's data as new information is available. To provide the most accurate information while also contextualizing the previous week's report, we include updated average daily case values in the previous week report section. These revised numbers appear within parentheses in the previous report section and are used to in the calculations for trend and percent change. However, we retain the previous week's risk level regardless of revised numbers.

Risk / Transmission / HPCON (A | B | B+ | C : 0 | 12 | 9 | 1)

see legends after table for more information on scales

Access our ArcGIS Online COVID-19 Mapping Tool through Internet Explorer by clicking here.

Region				Cases Per 100K[1]				Transmission	Vaccination	Deaths Per 100K[1]		Previous Report: 22 DEC			
Country[2]	Installations	HPCON Level[3]	Risk Level	Total Cases	Avg Daily Cases[4]	Percent Change from Previous Report[5]	8 Week Trend of New Cases	Masking[6]	Population Fully Vaccinated	Total Deaths	Avg Daily Deaths[4]	Risk Level[7]	Avg Daily Cases (Revised)[8]	Masking[6]	Population Fully Vaccinated
INDOPACOM															
Australia*				2,715	183.03	1007% ↑		Required	79.5%	9	0.04		16.53	Required	79.0%
Bangladesh*				974	0.38	171% ↑			52.6%	17	0.00		0.14		52.6%
Bhutan				350	0.17	0% →			75.9%	0	0.00		0.17		75.6%
Brunei Darussalam				3,587	2.21	22% ↑			91.8%	23	0.00		1.81		91.8%
Cambodia*				731	0.05	25% ↑			84.2%	18	0.00		0.04		84.0%
China*				7	0.01	0% →			87.2%	0	0.00		0.01		84.8%
Fiji				6,253	37.19	3899% ↑		Required	73.4%	79	0.10		0.93		73.3%
French Polynesia				16,657	4.71	474% ↑			61.5%	228	0.00		0.82		60.2%
Guam (US territory)				12,029	44.65	690% ↑		Required	75.6%	163	0.26		3.59 (5.65)		74.9%
	MCAG/Camp BLAZ	B													
	NAVBASE Guam	B+													
	USNH Guam	B													
India*				2,569	3.00	500% ↑			62.0%	35	0.02		0.5		59.7%
Indonesia*				1,576	0.09	12% ↑			60.8%	53	0.00		0.08		55.2%
Japan*				1,370	0.69	431% ↑			80.3%	14	0.00		0.13		79.5%
	CFA Okinawa	B													
	CFA Sasebo	B													
	CFA Yokosuka	B													
	JSA New Sanno	B													
	NAF Atsugi	B													
	NAF Misawa	B													
	NSF Diego Garcia	B													
	Singapore Area Coordinator	B													
Laos				1,601	11.97	-31% ↓		Required	50.8%	6	0.11		17.35	Required	50.8%
Malaysia*				8,680	10.12	-11% ↓		Required	79.4%	99	0.08		11.38	Required	79.2%
Maldives*				18,220	35.67	64% ↑		Required	73.0%	50	0.03		21.74	Required	72.9%
Mongolia				12,144	11.38	26% ↑		Required	68.1%	64	0.04		9.06	Required	68.0%
Myanmar				983	0.31	-14% ↓			38.0%	36	0.01		0.36		30.7%
Nepal*				2,901	1.01	40% ↑			49.1%	41	0.01		0.72		35.2%
New Caledonia				4,605	10.45	59% ↑		Required	63.7%	99	0.00		6.56		63.3%
New Zealand*				302	1.22	-8% ↓			77.6%	1	0.00		1.33		77.5%
Papua New Guinea				412	0.10	43% ↑			3.2%	7	0.00		0.07		3.1%
Philippines*				2,656	4.22	3736% ↑			50.5%	48	0.06		0.11		50.5%
Singapore*				4,866	8.99	63% ↑		Required	88.0%	14	0.02		5.52		87.0%
South Korea*				1,276	7.76	-40% ↓		Required	86.3%	11	0.12		12.99	Required	85.2%
	CFA Chinhae	B													
Sri Lanka*				2,764	2.21	-30% ↓			74.4%	71	0.08		3.17		74.3%
Taiwan				72	0.11	175% ↑			78.5%	4	0.00		0.04		78.1%

Country[2]	Installations	HPCON Level[3]	Risk Level	Total Cases	Avg Daily Cases[4]	Percent Change from Previous Report[5]	8 Week Trend of New Cases	Masking[6]	Population Fully Vaccinated	Total Deaths	Avg Daily Deaths[4]	Risk Level[7]	Avg Daily Cases (Revised)[8]	Masking[6]	Population Fully Vaccinated
Thailand*				3,211	3.75	-16%			73.0%	31	0.02		4.44		72.1%
Timor-Leste				1,535	0.10	233%			49.5%	9	0.00		0.03		48.5%
Vietnam				1,884	18.19	-4%		Required	79.3%	35	0.24		18.98	Required	77.1%
EUCOM															
Albania				7,359	15.48	58%		Required	40.2%	112	0.06		9.78	Required	39.0%
Andorra				32,843	457.51	166%		Required	73.8%	183	0.19		171.8	Required	73.2%
Armenia				11,672	2.50	-52%			32.3%	270	0.09		5.22		30.5%
Austria*				14,563	51.55	71%		Required	73.3%	154	0.18		30.15	Required	72.5%
Azerbaijan				6,160	4.37	-45%			50.6%	84	0.11		8.01	Required	50.3%
Belarus				7,443	11.01	-26%		Required	52.0%	60	0.17		14.78	Required	43.0%
Belgium*				18,890	128.67	111%		Required	76.6%	246	0.20		60.88	Required	76.4%
Bosnia and Herzegovina				8,944	24.08	77%		Required	27.1%	410	0.65		13.58	Required	27.1%
Bulgaria				10,921	48.56	137%		Required	27.6%	447	0.99		20.46	Required	27.6%
Croatia*				17,833	113.34	57%		Required	55.4%	308	0.92		71.97	Required	55.0%
Cyprus				15,711	362.83	566%		Required	74.2%	54	0.18		54.5	Required	71.5%
Denmark*				15,478	324.46	69%		Required	82.8%	58	0.19		173.03 (191.64	Required	82.0%
Estonia				18,569	78.26	75%		Required	63.7%	146	0.22		44.74	Required	63.2%
Faroe Islands				13,990	381.05	315%		Required	84.5%	31	0.58		91.84	Required	82.0%
Finland*				5,235	129.85	253%		Required	78.5%	29	0.20		36.82	Required	77.9%
France*				16,839	304.39	266%		Required	78.6%	192	0.32		83.27	Required	77.8%
Georgia*				23,658	53.84	-20%		Required	34.6%	351	1.19		67.68	Required	33.1%
Germany*				8,846	44.25	-3%		Required	73.8%	136	0.30		45.46	Required	72.8%
Gibraltar*				27,138	338.66	158%		Required	122.2%	294	0.00		131.51	Required	122.1%
Greece*				13,256	345.92	701%		Required	72.4%	202	0.65		43.16	Required	71.1%
NSA Souda Bay		B+													
Greenland				5,972	242.36	940%		Required	71.2%	2	0.00		23.31	Required	71.1%
Hungary				13,113	29.92	-27%		Required	65.1%	409	0.87		41.11	Required	64.8%
Iceland				10,000	361.86	470%		Required	78.2%	12	0.08		63.51	Required	83.8%
Ireland*				18,125	400.77	297%		Required	78.2%	122	0.12		100.9	Required	77.9%
Israel*				16,775	91.53	782%		Required	71.1%	97	0.02		10.38	Required	69.7%
Italy*				11,158	212.72	409%		Required	80.5%	228	0.28		41.82	Required	79.5%
NAS Signonella		B+													
NSA Naples		B+													
Latvia				14,743	51.57	30%		Required	70.4%	242	0.45		39.79	Required	69.8%
Liechtenstein*				16,858	103.38	-12%		Required	68.5%	187	0.75		117.29	Required	68.2%
Lithuania*				19,186	70.64	25%		Required	71.5%	271	0.65		56.68	Required	70.8%
Luxembourg*				17,592	164.89	159%		Required	73.2%	149	0.21		63.71	Required	72.3%
Malta				12,984	240.71	320%		Required	86.5%	110	0.19		57.37	Required	85.0%
Moldova				9,354	10.05	13%		Required	24.6%	255	2.34		8.92	Required	24.6%
Monaco				14,082	185.71	37%		Required	67.5%	105	1.10		135.9	Required	67.5%
Montenegro*				28,704	311.17	992%		Required	45.3%	387	0.61		28.5	Required	44.9%
Netherlands*				18,888	102.83	30%		Required	77.6%	123	0.15		79	Required	72.9%
Norway*				7,824	89.40	10%		Required	78.4%	25	0.12		81.05	Required	78.2%
Palestinian Territory				9,464	4.78	-28%			39.6%	99	0.10		6.62		38.7%
Poland*				10,987	31.08	-34%		Required	57.5%	260	1.12		47.2	Required	56.7%
NSF Redzikowo		C													
Portugal*				14,668	237.24	408%		Required	90.6%	186	0.15		46.68	Required	89.1%
Romania*				9,408	11.89	231%		Required	41.7%	304	0.16		3.59		41.2%
NSF Deveselu		B+													
Russian Federation*				7,133	12.41	-34%		Required	50.7%	210	0.57		18.69	Required	49.5%
San Marino				26,021	436.55	136%		Required	71.7%	303	1.68		185.29	Required	71.4%
Serbia				15,029	37.68	189%		Required	48.2%	146	0.27		13.02	Required	47.9%
Slovakia*				25,394	58.33	-39%		Required	49.9%	308	0.71		95	Required	49.6%
Slovenia*				22,849	100.27	75%		Required	60.2%	271	0.36		57.42	Required	59.8%
Spain*				14,812	241.29	261%		Required	85.4%	192	0.15		66.92	Required	83.7%
NAVSTA Rota		B+													
Sweden*				13,703	101.92	188%		Required	76.4%	153	0.10		35.41	Required	76.0%
Switzerland*				16,563	213.41	111%		Required	68.6%	143	0.22		101.18	Required	68.2%
Turkey*				11,651	60.52	173%		Required	67.0%	100	0.20		22.14	Required	66.7%
Ukraine				8,781	9.42	-40%		Required	34.0%	234	0.48		15.71	Required	33.3%
United Kingdom*				20,533	270.83	109%		Required	76.0%	221	0.25		129.29	Required	75.6%
CENTCOM															
Afghanistan				416	0.08	33%			10.4%	19	0.00		0.06		11.0%
Bahrain				17,461	49.21	900%		Required	68.9%	85	0.01		4.92		68.5%
Isa Air Base		B+													
NSA Bahrain		B+													
Egypt				388	0.80	-10%			33.9%	22	0.02		0.89		30.3%
Iran				7,479	1.84	-31%			70.3%	159	0.04		2.67		69.5%
Iraq				5,330	0.74	-13%			20.9%	62	0.01		0.85		20.1%
Jordan*				10,374	0.00	-100%			42.2%	122	0.00		33.34	Required	41.8%
Kazakhstan				5,791	2.13	-20%			47.4%	98	0.04		2.65		46.9%
Kuwait				10,056	23.65	1351%		Required	77.2%	59	0.00		1.63		76.8%
Kyrgyzstan				2,884	0.98	81%			18.7%	44	0.02		0.54		18.1%
Lebanon*				10,890	57.36	145%		Required	33.9%	134	0.26		23.42	Required	32.0%

Country[2] Installations	HPCON Level[3]	Risk Level	Total Cases	Avg Daily Cases[4]	Percent Change from Previous Report[5]	8 Week Trend of New Cases	Masking[6]	Population Fully Vaccinated	Total Deaths	Avg Daily Deaths[4]	Risk Level[7]	Avg Daily Cases (Revised)[8]	Masking[6]	Population Fully Vaccinated
Oman			6,161	3.26	624% ↑			59.8%	83	0.00		0.45		59.8%
Pakistan*			600	0.33	136% ↑			43.9%	13	0.00		0.14		39.9%
Saudi Arabia			1,650	4.51	1189% ↑			71.0%	26	0.01		0.35		70.5%
Syria			295	0.18	-51% ↓			12.5%	17	0.02		0.37		6.5%
Tajikistan			188	0.00	0% →			38.0%	1	0.00		0		44.9%
United Arab Emirates			7,931	25.95	840% ↑		Required	99.0%	22	0.01		2.76		99.0%
Uzbekistan			604	0.32	-43% ↓			55.4%	5	0.00		0.56		54.7%
Yemen			35	0.01	0% →			1.8%	7	0.00		0.01		1.8%
NORTHCOM[1]														
Bahamas			6,768	77.93	831% ↑		Required	39.8%	184	0.15		8.37	Required	39.6%
Bermuda			11,010	197.73	556% ↑		Required	74.7%	175	0.91		30.16	Required	74.4%
British Virgin Islands			12,533	328.10	1466% ↑		Required	60.6%	133	0.48		20.95	Required	60.3%
Canada*			6,401	105.73	320% ↑		Required	83.6%	82	0.10		24.4 (25.17)	Required	82.9%
Mexico*			3,158	8.16	383% ↑		Required	62.9%	235	0.10		1.69		62.9%
Puerto Rico (US territory) & "*"			10,663	269.03	343% ↑		Required	77.3%	10,663	269.03		29.38 (60.79)	Required	76.5%
Turks and Caicos Islands			9,374	104.89	800% ↑		Required	74.5%	68	0.00		11.65	Required	74.5%
United States*			17,535	174.65	278% ↑		Required	73.9%	253	0.37		44.99 (46.15)	Required	72.6%
See COVID19 State Surveillance Medical Intel Report for installation HPCON details														
SOUTHCOM[1]														
Anguilla			11,847	98.10	178% ↑		Required	66.6%	40	0.95		35.24	Required	66.6%
Antigua and Barbuda			4,625	33.43	847% ↑		Required	63.1%	123	0.15		3.53		63.0%
Argentina*			13,210	114.67	849% ↑		Required	84.1%	262	0.07		12.08	Required	82.6%
Aruba			22,840	699.33	1794% ↑		Required	79.2%	171	0.00		36.93	Required	78.7%
Barbados			10,515	105.23	686% ↑		Required	54.2%	92	0.15		13.39	Required	54.0%
Belize			8,879	93.81	1406% ↑		Required	56.8%	155	0.29		6.23		56.7%
Bolivia			5,486	56.99	229% ↑		Required	50.2%	172	0.23		17.33	Required	45.5%
Brazil*			10,580	4.01	154% ↑			77.8%	294	0.04		1.6 (1.58)		77.4%
Cayman Islands			14,629	246.81	294% ↑		Required	88.1%	18	0.22		62.64	Required	88.1%
Chile*			9,573	8.52	30% ↑		Required	90.2%	207	0.09		6.53		89.4%
Colombia*			10,369	23.00	518% ↑		Required	74.9%	259	0.08		3.72		73.9%
Costa Rica*			11,458	22.24	1317% ↑		Required	76.9%	146	0.05		1.57		76.6%
Cuba			8,551	4.91	705% ↑			92.3%	73	0.00		0.61		91.2%
NAVBASE Guantanamo Bay	B													
Dominica			9,824	101.98	197% ↑		Required	42.6%	65	0.40		34.33	Required	40.5%
Dominican Republic			4,039	23.20	1241% ↑		Required	63.4%	40	0.01		1.73		63.2%
Ecuador*			3,184	8.42	115% ↑		Required	79.2%	194	0.03		3.91		78.5%
El Salvador			1,891	0.71	-10% ↓			68.8%	59	0.01		0.79		68.6%
Falkland Islands			2,800	4.76	NA			74.6%	0	0.00		0		74.6%
Grenada			6,340	139.29	17990% ↑		Required	36.5%	179	0.00		0.77		36.3%
Guatemala			3,593	4.11	207% ↑			36.0%	92	0.01		1.34		35.2%
Guyana			5,290	39.77	608% ↑		Required	52.0%	135	0.16		5.62		51.4%
Haiti			233	0.35	400% ↑			1.1%	7	0.01		0.07		1.0%
Honduras			3,893	0.00	-100% ↓			48.9%	107	0.00		0.1		49.0%
Jamaica			3,293	19.95	1346% ↑		Required	24.1%	84	0.09		1.38		23.8%
Montserrat			1,520	88.57	2997% ↑		Required	31.1%	20	0.00		2.86		30.7%
Nicaragua			268	0.09	-18% ↓			72.8%	3	0.00		0.11		69.1%
Panama*			11,856	41.60	462% ↑		Required	69.2%	175	0.07		7.4	Required	69.0%
Paraguay			6,692	11.38	547% ↑		Required	48.1%	236	0.08		1.76		47.7%
Peru*			7,105	13.43	146% ↑		Required	73.5%	624	0.15		5.45		71.5%
Saint Kitts and Nevis			6,583	153.91	4297% ↑		Required	51.7%	53	0.00		3.5		51.3%
Saint Lucia			7,636	44.03	683% ↑		Required	30.3%	167	0.78		5.62		30.1%
Saint Vincent and the Grenadines			5,441	24.32	210% ↑		Required	30.1%	75	0.26		7.85	Required	29.8%
Suriname			9,531	82.25	1500% ↑		Required	44.3%	205	0.10		5.14		44.1%
Trinidad and Tobago*			6,754	34.65	-29% ↓		Required	51.0%	213	1.52		48.53	Required	50.2%
Uruguay			12,289	62.41	570% ↑		Required	79.5%	179	0.05		9.32	Required	79.3%
Venezuela			1,563	0.85	-41% ↓			64.1%	19	0.01		1.43		64.1%
AFRICOM														
Algeria*			512	0.92	48% ↑			15.8%	15	0.02		0.62		15.7%
Angola			272	3.66	618% ↑			22.6%	6	0.01		0.51		21.4%
Benin			216	0.71	7000% ↑			14.6%	1	0.00		0.01		10.9%
Botswana*			9,638	59.34	36% ↑		Required	48.6%	106	0.08		43.76	Required	47.0%
Burkina Faso			92	0.71	173% ↑			5.2%	2	0.01		0.26		2.1%
Burundi			278	5.84	122% ↑			0.0%	0	0.00		2.63		0.0%
Cabo Verde			8,362	156.94	5387% ↑		Required	53.9%	65	0.10		2.86		53.9%
Cameroon			423	0.00	-100% ↓			3.1%	7	0.00		0.2		3.0%
Central African Republic			262	0.88	NA			9.1%	2	0.00		0		9.1%
Chad			39	0.43	NA			1.7%	1	0.00		0		1.7%
Comoros			856	20.82	1083% ↑		Required	37.8%	19	0.08		1.76		31.8%
Congo			395	3.15	179% ↑			13.0%	7	0.01		1.13		13.0%
Congo DRC			92	0.85	-31% ↓			0.3%	1	0.00		1.23		0.2%

Country[2] Installations	HPCON Level[3]	Risk Level	Total Cases	Avg Daily Cases[4]	Percent Change from Previous Report[5]	8 Week Trend of New Cases	Masking[6]	Population Fully Vaccinated	Total Deaths	Avg Daily Deaths[4]	Risk Level[7]	Avg Daily Cases (Revised)[8]	Masking[6]	Population Fully Vaccinated
Côte d'Ivoire			292	4.72	1867% ↑			18.3%	3	0.01		0.24		12.2%
Djibouti			1,421	3.23	587% ↑			10.9%	19	0.00		0.47		10.9%
NSA Djibouti	B+													
Equatorial Guinea			1,023	2.52	4100% ↑			17.2%	13	0.00		0.06		17.2%
Eritrea			233	0.87	61% ↑			0.0%	2	0.02		0.54		0.0%
Ethiopia			390	3.33	350% ↑			7.9%	6	0.01		0.74		7.8%
Gabon			1,962	17.95	1240% ↑		Required	17.2%	13	0.01		1.34		17.2%
Gambia			442	1.46	630% ↑			10.0%	15	0.01		0.2		9.8%
Ghana*			487	3.19	538% ↑			18.2%	4	0.01		0.5		8.4%
Guinea			262	2.26	NA			17.7%	3	0.00		0		12.5%
Guinea-Bissau			340	0.41	583% ↑			19.4%	8	0.00		0.06		19.3%
Kenya*			579	4.18	43% ↑			12.7%	10	0.01		2.92		10.8%
Lesotho			1,412	12.13	-35% ↓		Required	30.1%	32	0.05		18.7	Required	30.1%
Liberia			139	1.66	564% ↑			19.6%	6	0.00		0.25		15.2%
Libya			5,779	8.62	15% ↑		Required	26.6%	85	0.14		7.5	Required	26.2%
Madagascar			194	1.14	42% ↑			2.9%	4	0.02		0.8		2.1%
Malawi*			417	3.37	24% ↑			7.6%	13	0.03		2.72		7.0%
Mali			116	1.72	213% ↑			4.3%	3	0.01		0.55		4.1%
Mauritania			986	11.80	1129% ↑		Required	29.0%	19	0.04		0.96		23.3%
Mauritius*			1,858	3.48	15% ↑			74.4%	19	0.00		3.03		72.0%
Morocco			2,680	7.24	1107% ↑		Required	66.0%	41	0.01		0.6		65.9%
Mozambique*			658	9.72	158% ↑		Required	26.8%	7	0.03		3.77		24.4%
Namibia*			6,034	21.87	-41% ↓		Required	15.6%	147	0.32		36.81	Required	15.0%
Niger			33	0.17	467% ↑			2.0%	1	0.00		0.03		2.0%
Nigeria*			122	0.36	-23% ↓			4.9%	2	0.00		0.47		4.2%
Rwanda			928	9.11	449% ↑		Required	57.3%	11	0.01		1.66		51.6%
Sao Tome and Principe			1,876	14.29	7045% ↑		Required	38.7%	28	0.27		0.2		38.7%
Senegal*			471	1.82	1922% ↑			7.9%	12	0.00		0.09		7.7%
Seychelles			26,791	249.13	637% ↑		Required	83.3%	137	0.00		33.82	Required	83.2%
Sierra Leone*			94	0.76	300% ↑			9.2%	2	0.00		0.19		9.2%
Somalia			157	0.67	644% ↑			7.4%	9	0.00		0.09		6.7%
South Africa*			5,968	14.92	-52% ↓		Required	31.8%	156	0.15		31.07	Required	31.1%
South Sudan			143	0.90	-25% ↓			2.0%	1	0.00		1.2		2.0%
Sudan			110	0.25	-4% ↓			8.9%	8	0.00		0.26		8.9%
Tanzania			53	0.31	675% ↑			3.4%	1	0.00		0.04		2.6%
Togo			402	6.35	630% ↑			16.4%	3	0.01		0.87		16.1%
Tunisia			6,271	11.34	500% ↑		Required	58.3%	219	0.08		1.89		53.9%
Uganda*			336	3.64	658% ↑			17.7%	7	0.01		0.48		17.7%
Zambia			1,512	21.08	260% ↑		Required	4.3%	21	0.04		5.85		4.3%
Zimbabwe			1,496	11.23	-55% ↓		Required	27.4%	35	0.15		25.12	Required	27.0%

[1] All case and death numbers are reported as per 100K people.
[2] Only Countries with over 1 per 100K total cases are shown.
[3] Current Health Protection Condition (HPCON) Status indicated per Public Health Emergency Management (PHEM) DoD Instruction 6200.03.
[4] Daily Count calculated with 1 week total averaged over 7 days.
[5] Arrows show increase, decrease, and no change of the percent change value:
↓ less average daily cases compared to the previous report ↑ more average daily cases compared to the previous report → no change in average daily cases compared to the previous report
NA (no arrow) means the previous report had 0 average daily cases.
[6] CDC has provided a scale for community transmission and reccomends all people wear masks when transmission reaches the substa ntial level. Mask Guidance for all DoD Installations and Other Facilities details that all DoD personnel should comply with CDC's masking guidance. See sources of information for more information.
[7] Blank Risk Levels from previous report indicate that the country is new to this report due to meeting minimum inclusion criteria of 100 total cases.
[8] Due to the complexity of collecting accurate realtime data on the impacts of Covid-19, case and death numbers continue to be refined into following weeks. Due to this, in situations where a revised number for the previous week is different than the number that was reported in the previous report, the revised number is included within the parentheses(). This revised number is used in the calculations for trend and percent change.
Asterisk (*) next to country name indicates that the omicron variant has been detected in country.
Carrot (^) indicates situations where reporting of data to source has been delayed.

Masking Indicators - Transmission Classification
(New cases per 100,000 persons in the past 7 days)

HIGH	≥100	Indoor Masking Required
SUBSTANTIAL	50 to 99.99	Indoor Masking Required
MEDIUM	10 to 49.99	
LOW	0 to 9.99	

Risk Levels
(Average of new daily cases per 100,000 population)

HIGH	≥7.5	Average known cases reported per day in last week per 100,000 individuals are greater than or equal to 7.5
SIGNIFICANT	5 to 7.49	Average known cases reported per day in last week per 100,000 individuals are greater than 5 and less than 7.5
MODERATE	1 to 4.99	Average known cases reported per day in last week per 100,000 individuals are greater than 1 and less than 5
LOW	0 to 0.99	Average known cases reported per day in last week per 100,000 individuals are less than 1

Risk level definitions may change for alignment with CDC, OSD, JS (e.g., Memo from JS on COVID-19 Medical Risk Algorithm dated 21FEB2020), and COCOM (e.g., NORTHCOM Global Campaign Plan 3551.13) guidance.
HPCONs reference DoD Instruction 6200.03, Public Health Emergency Management (PHEM) within the DoD.
Risk levels for naval operational forces from respective combatant commands supersedes this assessment from the Navy and Marine Corps Public Health Center.

HPCON levels
(Average of new daily cases per 100,000 population)

HPCON levels are determined by delegated authorities who use local public health conditions, public health surveillance data, CDC guidance, information from national, state, and local public health authorities, advice from the Public Health Emergency Officer and local MTF director or commander to assess appropriate HPCON status. Case counts play a large role in informing HPCON level decisions, but are not the sole metric from which HPCON levels are determined. More information about how HPCON levels are determined and appropriate actions to take for each HPCON designation can be found in GUIDANCE-FOR-COMMANDERS-RISK-BASED-RESPONSES-AND-IMPLEMENTATION-OF-THE-HEALTH-PROTECTION-CONDITION-FRAMEWORK-DURING-THE-COVID-19-PANDEMIC.

Delta (D)	≥ 61	Widespread Community Transmission: Onsite capacity limited to less than 15%. Cancel all non-mission-essential activities. Strongly consider declaring a local public health emergency.
Charlie (C)	31 to 60.99	Sustained Community Transmission: Onsite capacity limited to less than 25%. Re-scope, modify, or potentially cancel exercises. Consider declaring a local public health emergency.
Bravo+ (B+)	16 to 30.99	Elevated Community Transmission: Onsite capacity limited to less than 40%. Be prepared to limit access to installations by visitors or cancel events/exercises. Indoor common areas and large venues may be closed.
Bravo (B)	2 to 15.99	Increased Community Transmission: Onsite capacity limited to less than 50%. Medically vulnerable individuals and any personnel with whom they reside should shelter in place and be permitted to telework if possible.
Alpha (A)	0 to 1.99	Minimal Community Transmission: Onsite capacity limited to less than 100%. Emphasize personal hygiene and require physical distancing. Utilize telework and flexible scheduling to meet occupancy standards where possible.

Sources of information

1. Masking Requirement: https://www.cdc.gov/mmwr/volumes/70/wr/pdfs/mm7030e2-H.pdf
2. SECDEF Criteria: COVID19 - 20210728 DSD Updated Mask Guidelines For All DOD Installations and Other Facilities https://www.defense.gov/Explore/Spotlight/Coronavirus-DOD-Response/
3. HPCON Guidance: GUIDANCE-FOR-COMMANDERS-RISK-BASED-RESPONSES-AND-IMPLEMENTATION-OF-THE-HEALTH-PROTECTION-CONDITION-FRAMEWORK-DURING-THE-COVID-19-PANDEMIC https://www.defense.gov/Explore/Spotlight/Coronavirus-DOD-Response/
4. DOS: https://travel.state.gov/content/travel/en/traveladvisories/traveladvisories.html/
5. CDC: https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html
6. WHO: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports/
7. NCMI Country Risk Assessment Database: https://www.ncmi.detrick.army.mil/
8. Our World in Data (cases/deaths): https://ourworldindata.org/coronavirus
9. CDC (US Territory cases/deaths): https://data.cdc.gov/Case-Surveillance/United-States-COVID-19-Cases-and-Deaths-by-State-o/9mfq-cb36
10. Country Ministries of Health and Disease Surveillance agencies.
11. NMCPHC COVID-19 Page: https://www.med.navy.mil/sites/nmcphc/program-and-policy-support/Pages/Novel-Coronavirus.aspx
12. Other sources of information to include open source media for important supplemental information.

NAVY AND MARINE CORPS PUBLIC HEALTH CENTER

PREVENTION AND PROTECTION START HERE

EXHIBIT 12

COVID-19 State Surveillance Report:

U.S. State Confirmed COVID-19 Cases and Navy Installation HPCONs

6 JAN 2022

The purpose of this document is to serve as guidance in the Health Protection Condition (HPCON) level decision-making process and provide surveillance information on the number of COVID-19 cases in the U.S. in relation to U.S. Navy Installations. To align with the National Guidelines Three-Phased Approach the report has been modified to focus on the downward trajectory of documented COVID-19 cases within a 7-day period. Estimated incidence of new cases per 100,000 over 7 days will be used as the primary indicator to determine risk for each county/state. We switched from a 14 day period to a 7 day period in order to more accurately reflect changing trends in COVID-19 activity.

Numbers are reported as incidents occuring per 100,000 people. They are generated utilizing United States Census Bureau data for each state or county in conjunction with the source data. Source data is provided by USAFacts.

To align with the updated Center for Disease Control and Prevention (CDC) masking guidance, indicators have been included in the report to determine when indoor masking is required for all personnel based on level of community transmission. The metric: new COVID-19 cases per 100,000 persons in the last 7 days will be calculated to assess level of community transmission.
Transmission values have been classified as: ◦Low (0-9.99), ◦Medium (10-49.99), ◦Substantial (50-99.99), or ◦High (≥ 100) to support decision-making when enforcing indoor masking for all personnel.

Reporting Circumstances Potentially Impacting Reports:

- **The 7 day window makes the report more susceptible to capturing exaggerated highs and lows resulting from a multi-day data lag followed by single-day reporting.**
- **Our data sources update their previous week's data as new information is available. To provide the most accurate information while also contextualizing the previous week's report, we include updated average daily case values in the previous week report section. These revised numbers appear within parentheses in the previous report section and are used to in the caluclations for trend and percent change. However, we retain the previous week's risk level regardless of revised numbers.**

Risk

Transmission

HPCON

A	B	B+	C
0	47	22	12

see legends after table for more information on scales

Access our ArcGIS Online COVID-19 Mapping Tool through Internet Explorer by clicking here.

Region				Cases Per 100K[1]				Transmission	Vaccination	Deaths Per 100K[1]		Previous Report: 22 DEC			
State County[2]	Navy and Marine Corps Installations	HPCON Level[3]	Risk Level	Total Cases	Avg Daily Cases[4]	Percent Change from Previous Report[5]	8 Week Trend of New Cases	Masking[6]	Population Fully Vaccinated	Total Deaths	Avg Daily Deaths[4]	Risk Level	Avg Daily Cases (Revised)[7]	Masking[6]	Population Fully Vaccinated
Alabama*				18,787	136.48	705%		Required	47.9%	336	0.17		16.96	Required	47.2%
Alaska*				20,621	53.08	152%		Required	56.5%	128	0.00		18.57 (21.09)	Required	56.0%
Arizona*				19,396	92.53	131%		Required	57.3%	337	0.72		40.04	Required	56.5%
Yuma County				21,156	73.64	308%		Required	64.2%	462	0.53		18.04	Required	63.3%
	MCAS Yuma	B+													
Arkansas*				19,088	123.16	309%		Required	51.5%	306	0.71		30.13	Required	50.8%
California*				13,738	114.44	400%		Required	66.5%	191	0.08		13.7 (22.88)	Required	65.5%
Imperial County				21,195	93.50	96%		Required	79.0%	441	0.00		35.95 (47.77)	Required	76.3%
	NAF El Centro	B													
Kings County				22,764	60.90	172%		Required	43.1%	253	0.09		17.28 (22.42)	Required	42.3%
	NAS Lemoore	C													
	NAVHOSP Lemoore	B													
Los Angeles County				16,795	177.03	452%		Required	67.6%	273	0.10		19.24 (32.05)	Required	66.6%
Mono County				15,037	124.62	530%		Required		28	0.00		13.85 (19.78)	Required	
	MCMWTC Bridgeport	B													
Monterey County				11,760	32.65	191%		Required	65.5%	148	0.10		8.36 (11.22)	Required	64.5%
	NAVSUPPDET Monterey	B													
Orange County				11,275	108.69	595%		Required	67.8%	186	0.03		9.2 (15.65)	Required	66.9%
	NWS Seal Beach	B													
Riverside County				16,600	100.24	282%		Required	54.8%	221	0.10		16.61 (26.24)	Required	54.1%
San Bernardino County				18,435	135.13	414%		Required	53.3%	275	0.06		19.04 (26.26)	Required	52.6%
	MCLB Barstow	B+													
	NAWS China Lake	B													
	Twentynine Palms Main Base	B													
San Diego County				13,514	129.77	315%		Required	57.6%	134	0.06		9.31 (31.29)	Required	56.3%
	NAVHOSP 29 Palms	B													
	MCAS Miramar	B+													
	MCB Camp Pendleton	B+													
	MCRD San Diego	B+													
	NAVHOSP Camp Pendleton	B													
	Naval Medical Center San Diego	B													
	NB Coronado	B													
	NB Point Loma	B+													
	NB San Diego	B													
Ventura County				13,329	99.86	308%		Required	67.5%	142	0.07		13.81 (24.45)	Required	66.7%

State County[2] Navy and Marine Corps Installations	HPCON Level[3]	Risk Level	Total Cases	Avg Daily Cases[4]	Percent Change from Previous Report[5]	8 Week Trend of New Cases	Masking[6]	Population Fully Vaccinated	Total Deaths	Avg Daily Deaths[4]	Risk Level	Avg Daily Cases (Revised)[7]	Masking[6]	Population Fully Vaccinated
Naval Base Ventura County	B													
Colorado*			**16,718**	**133.60**	**262%** ↑		Required	**66.5%**	**179**	**0.34**		22 (36.93)	Required	**65.7%**
Connecticut*			**15,271**	**198.36**	**242%** ↑		Required	**75.0%**	**260**	**0.47**		57.94	Required	**74.2%**
New London County			14,327	143.72	131% ↑		Required	75.5%	201	0.54		62.22	Required	74.7%
NAVSUBASE New London	C													
Delaware*			**19,681**	**261.50**	**261%** ↑		Required	**64.5%**	**235**	**0.15**		72.37	Required	**63.5%**
District of Columbia*			**14,948**	**300.79**	**490%** ↑		Required	**67.9%**	**173**	**0.22**		50.95	Required	**66.9%**
JB Anacostia	B													
NDept Potomac Annex	B													
NSA Washington	B													
Florida*			**20,301**	**218.29**	**398%** ↑		Required	**63.6%**	**291**	**0.04**		31.18 (43.81)	Required	**62.9%**
Bay County			18,880	57.40	1091% ↑		Required	49.3%	226	0.00		4.82		48.8%
NSA Panama City	B													
Brevard County			14,727	118.59	1577% ↑		Required	61.5%	152	0.00		7.07		60.9%
NOTU Cape Canaveral	B+													
Duval County			18,465	124.26	1337% ↑		Required	58.3%	155	0.00		8.65	Required	57.6%
MCSF Blount Island	B													
NAS Jacksonville	B													
NS Mayport	B													
Escambia County			17,947	96.89	1043% ↑		Required	52.2%	222	0.00		6.48	Required	51.6%
NAS Pensacola	C													
Monroe County			16,650	183.80	809% ↑		Required	74.8%	70	0.00		20.21	Required	74.2%
NAS Key West	B													
Orange County			18,738	216.24	1393% ↑		Required	65.8%	94	0.00		14.48	Required	65.0%
NSA Orlando	B													
Santa Rosa County			18,464	69.91	1287% ↑		Required	48.3%	158	0.00		5.04		47.8%
NAS Whiting Field Milton	B													
Georgia*			**13,901**	**141.36**	**599%** ↑		Required	**51.3%**	**297**	**0.27**		20.21	Required	**50.6%**
Camden County			11,707	54.09	527% ↑		Required	46.6%	181	0.00		8.62	Required	46.0%
NAVSUBASE Kings Bay	B													
Dougherty County			11,262	100.37	3337% ↑		Required	28.6%	491	0.32		2.92		27.9%
MCLB Albany	B+													
Hawaii*			**8,719**	**190.28**	**348%** ↑		Required	**64.0%**	**77**	**0.12**		42.45	Required	**62.9%**
Honolulu County			9,036	212.45	297% ↑		Required		83	0.12		53.46	Required	
Joint Base Pearl Harbor-Hickam	B													
MCB Hawaii	B													
Kauai County			6,005	139.12	626% ↑		Required		25	0.00		19.17	Required	
PMRF Kauai	B													
Idaho*			**18,048**	**38.28**	**108%** ↑		Required	**46.4%**	**234**	**0.28**		18.44	Required	**46.0%**
Kootenai County			19,665	43.37	75% ↑		Required	41.1%	296	0.17		24.83	Required	40.8%
ARD Bayview	B													
Illinois*			**17,860**	**186.08**	**132%** ↑		Required	**64.5%**	**247**	**0.52**		80.31	Required	**63.9%**
Lake County			15,249	144.68	135% ↑		Required	73.8%	179	0.23		61.55	Required	73.0%
NS Great Lakes	C													
Indiana*			**19,170**	**126.46**	**97%** ↑		Required	**52.1%**	**286**	**0.69**		64.07	Required	**51.7%**
Martin County			16,080	48.76	21% ↑		Required	47.4%	205	0.00		40.4	Required	47.2%
NSA Crane	C													
Iowa*			**18,617**	**64.99**	**-1%** ↓		Required	**59.2%**	**249**	**0.00**		32.12 (65.87)	Required	**58.5%**
Kansas*			**18,343**	**107.58**	**98%** ↑		Required	**57.3%**	**242**	**1.82**		54.4	Required	**56.5%**
Kentucky*			**19,824**	**112.05**	**123%** ↑		Required	**54.4%**	**274**	**0.51**		50.27	Required	**53.8%**
Louisiana*			**18,696**	**191.44**	**859%** ↑		Required	**50.5%**	**323**	**0.12**		19.97	Required	**49.9%**
Plaquemines Parish			19,947	223.55	612% ↑		Required	58.9%	177	0.00		31.41	Required	58.2%
NAS JRB New Orleans	B													
Maine*			**11,026**	**53.18**	**-22%** ↓		Required	**76.1%**	**116**	**0.68**		68.06	Required	**75.3%**
Washington County			8,955	31.87	-41% ↓		Required	69.2%	127	0.91		53.72	Required	68.5%
NCTAMS Det Cutler	B													
York County			11,629	55.04	-21% ↓		Required	77.9%	92	0.28		69.9	Required	77.0%
NSY Portsmouth	B													
Maryland*			**12,669**	**188.34**	**129%** ↑		Required	**70.6%**	**198**	**0.57**				
Anne Arundel County			12,039	176.69	NA		Required	73.3%	146	0.59				
NSA Annapolis	B													
Charles County			12,740	254.73	NA		Required	63.1%	166	0.09		Maryland Data Lag		
Montgomery County			11,087	257.19	NA		Required	83.5%	168	0.18				
NSA Bethesda	B													
St. Marys County			11,890	226.41	NA		Required	64.6%	159	0.13				
NAS Patuxent River	B													

State County[2] Navy and Marine Corps Installations	HPCON Level[3]	Risk Level	Total Cases	Avg Daily Cases[4]	Percent Change from Previous Report[5]	8 Week Trend of New Cases	Masking[6]	Population Fully Vaccinated	Total Deaths	Avg Daily Deaths[4]	Risk Level	Avg Daily Cases (Revised)[7]	Masking[6]	Population Fully Vaccinated
Massachusetts*			15,381	119.20	64% ↑		Required	74.9%	294	0.28		72.89	Required	74.0%
Middlesex County			13,246	107.73	78% ↑		Required	76.3%	256	0.18		60.45	Required	75.5%
Michigan*			17,782	135.71	115% ↑		Required	57.0%	294	1.00		63.03	Required	56.4%
Minnesota*			18,533	88.52	57% ↑		Required	65.7%	188	0.51		56.33	Required	65.0%
Mississippi*			19,021	148.05	664% ↑		Required	48.7%	353	0.35		19.38	Required	48.0%
Harrison County			17,795	92.41	876% ↑		Required	52.0%	273	0.14		9.47	Required	51.3%
CBC Gulfport	B													
Jackson County			18,380	105.54	1315% ↑		Required	44.1%	276	0.30		7.46	Required	43.6%
Lauderdale County			17,713	94.05	1034% ↑		Required	48.4%	437	0.19		6.29	Required	47.7%
NAS Meridian	B													
Missouri*			16,857	99.96	105% ↑		Required	53.1%	262	0.07		48.71	Required	52.7%
Montana*			18,662	40.13	193% ↑		Required	54.1%	272	0.09		13.69	Required	53.7%
Nebraska*			17,802	58.62	52% ↑		Required	60.1%	173	0.06		26.58 (38.48)	Required	59.4%
Nevada*			16,793	102.33	291% ↑		Required	56.7%	275	0.35		26.15	Required	56.0%
Churchill County			18,130	44.16	83% ↑		Required	46.5%	369	0.57		24.09	Required	45.9%
NAS Fallon	C													
New Hampshire*			15,069	103.94	15% ↑		Required	67.4%	145	0.40		90.13	Required	66.4%
New Jersey*			18,852	330.63	346% ↑		Required	70.8%	328	0.38		74.13	Required	70.0%
Monmouth County			20,635	302.82	237% ↑		Required	64.4%	295	0.37		89.99	Required	63.7%
NWS Earle NJ	C													
Ocean County			20,808	249.77	225% ↑		Required	51.6%	409	0.35		76.75	Required	51.1%
New Mexico*			17,127	86.22	65% ↑		Required	66.5%	281	0.69		52.16	Required	65.7%
New York*			19,136	345.75	267% ↑		Required	72.1%	307	0.51		94.21	Required	71.1%
Saratoga County			14,102	182.22	168% ↑		Required	76.4%	117	0.19		67.87	Required	75.5%
Naval Support Unit Saratoga Springs	C													
North Carolina*			16,617	127.93	285% ↑		Required	57.0%	186	0.21		33.2	Required	56.2%
Craven County			15,416	65.74	176% ↑		Required	58.0%	161	0.00		23.78	Required	57.4%
MCAS Cherry Point	B+													
Onslow County			16,395	50.95	128% ↑		Required	56.5%	141	0.07		22.3	Required	55.9%
MCB Camp Lejeune	B+													
MCAS New River	B+													
North Dakota*		North Dakota Data Lag										44.95	Required	52.1%
Ohio*			17,906	168.25	102% ↑		Required	55.5%	254	1.09		83.34	Required	54.9%
Oklahoma*			18,220	72.79	120% ↑		Required	53.7%	299	0.00		19.09 (33.15)	Required	53.1%
Oregon*			10,324	65.81	248% ↑		Required	66.6%	135	0.27		18.93	Required	66.1%
Pennsylvania*			16,556	159.87	179% ↑		Required	64.2%	289	0.86		57.33	Required	63.3%
Cumberland County			15,052	116.09	97% ↑		Required	65.1%	288	0.96		58.81	Required	63.9%
NSA Mechanicsburg	C													
Philadelphia County			14,921	201.92	433% ↑		Required	63.0%	270	0.42		37.91	Required	62.1%
NSA Philadelphia	C													
Rhode Island*		Rhode Island Data Lag										68.03 (121.46)	Required	75.8%
Newport County												74.14	Required	74.8%
NS Newport	C													
South Carolina*			19,641	185.06	741% ↑		Required	53.4%	285	0.34		22	Required	52.7%
Beaufort County			15,453	111.76	699% ↑		Required	65.0%	169	0.30		13.98	Required	64.2%
MCRD Parris Island	B													
MCAS Beaufort	B													
Berkeley County			15,177	141.85	798% ↑		Required	45.4%	160	0.25		15.8	Required	44.9%
NWS Charleston	B													
South Dakota*			20,165	50.80	35% ↑		Required	57.4%	280	0.39		37.59	Required	56.5%
Tennessee*			21,423	155.62	413% ↑		Required	51.6%	307	0.45		30.32	Required	51.0%
Shelby County			19,007	268.70	737% ↑		Required	52.1%	290	0.26		32.12	Required	51.4%
NSA Midsouth Memphis	B													
Texas*			16,512	127.98	455% ↑		Required	57.2%	258	0.15		23.07	Required	56.5%
Bexar County			17,879	139.40	793% ↑		Required	65.1%	267	0.05		15.61	Required	64.2%
Jim Wells County			18,895	84.69	433% ↑		Required	51.3%	452	0.00		15.88		50.8%
NAS Kingsville	B													
Nueces County			18,065	78.98	1136% ↑		Required	54.9%	314	0.08		6.39		54.2%
NAS Corpus Christi	B													
Tarrant County			19,120	137.33	819% ↑		Required	53.7%	214	0.15		14.95	Required	53.1%
NAS JRB Fort Worth	B													
Utah*			20,475	117.11	284% ↑		Required	59.0%	119	0.16		30.51	Required	58.0%

State	County[2] / Navy and Marine Corps Installations	HPCON Level[3]	Risk Level	Total Cases	Avg Daily Cases[4]	Percent Change from Previous Report[5]	8 Week Trend of New Cases	Masking[6]	Population Fully Vaccinated	Total Deaths	Avg Daily Deaths[4]	Risk Level	Avg Daily Cases (Revised)[7]	Masking[6]	Population Fully Vaccinated
Vermont*				10,328	120.70	85% ↑		Required	77.8%	75	0.37		65.27	Required	76.7%
Virginia*				13,780	168.83	339% ↑		Required	68.3%	183	0.20		38.5	Required	67.5%
	Arlington County			11,736	200.98	177% ↑		Required	71.2%	119	0.00		72.5	Required	70.9%
	King George County			13,299	189.51	416% ↑		Required	44.1%	101	0.53		36.73	Required	44.0%
	NSA South Potomac	B													
	Norfolk City			12,133	150.95	614% ↑		Required		152	0.06		21.13	Required	
	NSA Norfolk	B+													
	Portsmouth City			16,249	218.83	771% ↑		Required		271	0.00		25.12	Required	
	Naval Medical Center Portsmouth	B+													
	NSA Norfolk NSY	C													
	Stafford County			14,423	253.88	451% ↑		Required	52.8%	76	0.09		46.07	Required	52.2%
	MCB Quantico	B													
	Virginia Beach City			13,806	188.55	530% ↑		Required		134	0.22		29.94	Required	
	NAS Oceana	B+													
	NAVPHIBASE Little Creek	B+													
	York County			9,915	111.72	434% ↑		Required	56.1%	127	0.21		20.92	Required	55.5%
	NWS Yorktown	B+													
Washington*				11,666	95.21	229% ↑		Required	68.1%	130	0.16		28.93	Required	67.4%
	Island County			6,071	56.88	197% ↑		Required	63.2%	67	0.34		19.13	Required	62.7%
	NAS Whidbey Island	B+													
	NAS Whidbey Island Sea Plane Base	B+													
	Jefferson County			4,792	58.08	245% ↑		Required	74.5%	65	0.00		16.85	Required	73.7%
	NAVMAG Indian Island	B													
	King County			9,511	117.79	260% ↑		Required	77.3%	95	0.08		32.75	Required	76.5%
	Kitsap County			7,809	76.72	263% ↑		Required	63.1%	97	-0.05		21.15	Required	62.5%
	Bremerton	B+													
	Keyport NUWC	B+													
	Naval Hospital NBK	B+													
	NBK Bangor	B+													
	Snohomish County			10,391	113.08	304% ↑		Required	66.7%	103	0.10		26.01	Required	66.0%
	NS Everett	B													
West Virginia*				18,954	128.66	119% ↑		Required	55.3%	299	0.58		58.72	Required	71.6%
Wisconsin*				19,619	113.83	66% ↑		Required	62.2%	193	0.40		50.45 (68.67)	Required	61.5%
Wyoming*				20,283	61.02	261% ↑		Required	47.7%	272	1.14		16.91	Required	47.1%

[1] All case and death numbers are reported as per 100K people.
[2] Only counties within 25 miles of a listed installation or specifically requested are shown.
[3] Current Health Protection Condition (HPCON) Status indicated per Public Health Emergency Management (PHEM) DoD Instruction 6200.03. Red indicates that status changed since the last report.
[4] Daily Count calculated with 1 week total averaged over 7 days.
[5] Arrows show increase, decrease, and no change of the percent change value:
↓: less average daily cases compared to the previous report ↑: more average daily cases compared to the previous report =: same average daily cases compared to the previous report
NA (no arrow) means the previous report had 0 average daily cases.
[6] CDC has provided a scale for community transmission and reccomends all people wear masks when transmission reaches the substantial level. Mask Guidance for all DoD Installations and Other Facilities details that all DoD personnel should comply with CDC's masking guidance. See sources of information for more information.
[7] Due to the complexity of collecting accurate realtime data on the impacts of Covid-19, case and death numbers continue to be refined into following weeks. Due to this, in situations where a revised number for the previous week is different than the number that was reported in the previous report, the revised number is included within the parentheses (). This revised number is used in the calculations for trend and percent change.
Asterisk (*) next to state name indicates that the omicron variant has been detected in that state..
Carrot (^) indicates situations where reporting of data to source has been delayed.

Masking Indicators - Transmission Classification
(New cases per 100,000 persons in the past 7 days)

HIGH	≥100	Indoor Masking Required
SUBSTANTIAL	50 to 99.99	Indoor Masking Required
MEDIUM	10 to 49.99	
LOW	0 to 9.99	

Risk Levels
(Average of new daily cases per 100,000 population)

HIGH	≥7.5	Average known cases reported per day in last week per 100,000 individuals are greater than or equal to 7.5
SIGNIFICANT	5 to 7.49	Average known cases reported per day in last week per 100,000 individuals are greater than 5 and less than 7.5
MODERATE	1 to 4.99	Average known cases reported per day in last week per 100,000 individuals are greater than 1 and less than 5
LOW	0 to 0.99	Average known cases reported per day in last week per 100,000 individuals are less than 1

AVG # new cases

Risk level definitions may change for alignment with CDC, OSD, JS (e.g., Memo from JS on COVID-19 Medical Risk Algorithm dated 21FEB2020), and COCOM (e.g., NORTHCOM Global Campaign Plan 3551.13) guidance.
HPCONs reference DoD Instruction 6200.03, Public Health Emergency Management (PHEM) within the DoD.
Risk levels for naval forces from respective USNORTHCOM commands/installations supersedes this assessment from the Navy and Marine Corps Public Health Center.

HPCON Levels
(Average of new daily cases per 100,000 population)

HPCON levels are determined by delegated authorities who use local public health conditions, public health surveillance data, CDC guidance, information from national, state, and local public health authorities, advice from the Public Health Emergency Officer and local MTF director or commander to assess appropriate HPCON status. Case counts play a large role in informing HPCON level decisions, but are not the sole metric from which HPCON levels are determined. More information about how HPCON levels are determined and appropriate actions to take for each HPCON designation can be found in GUIDANCE-FOR-COMMANDERS-RISK-BASED-RESPONSES-AND-IMPLEMENTATION-OF-THE-HEALTH-PROTECTION-CONDITION-FRAMEWORK-DURING-THE-COVID-19-PANDEMIC .

Delta (D)	≥ 61	Widespread Community Transmission: Onsite capacity limited to less than 15%. Cancel all non-mission-essential activities. Strongly consider declaring a local public health emergency.
Charlie (C)	31 to 60.99	Sustained Community Transmission: Onsite capacity limited to less than 25%. Re-scope, modify, or potentially cancel exercises. Consider declaring a local public health emergency.
Bravo + (B+)	16 to 30.99	Elevated Community Transmission: Onsite capacity limited to less than 40%. Be prepared to limit access to installations by visitors or cancel events/exercises. Indoor common areas and large venues may be closed.
Bravo (B)	2 to 15.99	Increased Community Transmission: Onsite capacity limited to less than 50%. Medically vulnerable individuals and any personnel with whom they reside should shelter in place and be permitted to telework, if possible.
Alpha (A)	0 to 1.99	Minimal Community Transmission: Onsite capacity limited to less than 100%. Emphasize personal hygiene and require physical distancing. Utilize telework and flexible scheduling to meet occupancy standards where possible

Sources of information

1. Masking Requirement: https://www.cdc.gov/mmwr/volumes/70/wr/pdfs/mm7030e2-H.pdf
2. SECDEF Criteria: COVID19 - 20210728 DSD Updated Mask Guidelines For All DOD Installations and Other Facilities https://www.defense.gov/Explore/Spotlight/Coronavirus-DOD-Response/
3. Masking Guidance: GUIDANCE-FOR-COMMANDERS-RISK-BASED-RESPONSES-AND-IMPLEMENTATION-OF-THE-HEALTH-PROTECTION-CONDITION-FRAMEWORK-DURING-THE-COVID-19-PANDEMIC https://www.defense.gov/Explore/Spotlight/Coronavirus-DOD-Response/
4. USAFacts (cases/population): https://usafacts.org/visualizations/coronavirus-covid-19-spread-map/
5. c4i (HPCON): https://c4isuite.alfp.cnic.navy.mil/my policy
6. CDC: https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html
7. Vaccinations: https://covid.cdc.gov/covid-data-tracker/#county-view|Vaccinations|Administered_Dose1_Pop_Pct|all https://data.cdc.gov/Vaccinations/COVID-19-Vaccinations-in-the-United-States-County/8xkx-amqh/data
8. Other sources of information to include open source media for important supplemental information.

SUPREME COURT OF THE UNITED STATES

No. 21A477

LLOYD J. AUSTIN, III, SECRETARY OF DEFENSE, ET AL. *v.* U. S. NAVY SEALS 1–26, ET AL.

ON APPLICATION FOR A PARTIAL STAY

[March 25, 2022]

The application for a partial stay presented to JUSTICE ALITO and by him referred to the Court is granted. The district court's January 3, 2022 order, insofar as it precludes the Navy from considering respondents' vaccination status in making deployment, assignment, and other operational decisions, is stayed pending disposition of the appeal in the United States Court of Appeals for the Fifth Circuit and disposition of the petition for a writ of certiorari, if such writ is timely sought. Should the petition for a writ of certiorari be denied, this order shall terminate automatically. In the event the petition for a writ of certiorari is granted, the order shall terminate upon the sending down of the judgment of this Court.

JUSTICE THOMAS would deny the application for a partial stay.

JUSTICE KAVANAUGH, concurring.

I concur in the Court's decision to grant the Government's application for a partial stay of the District Court's preliminary injunction for a simple overarching reason: Under Article II of the Constitution, the President of the United States, not any federal judge, is the Commander in Chief of the Armed Forces. In light of that bedrock constitutional principle, "courts traditionally have been reluctant to intrude upon the authority of the Executive in military and national security affairs." *Department of Navy* v. *Egan*, 484

U. S. 518, 530 (1988). As the Court has long emphasized, moreover, the "complex, subtle, and professional decisions as to the composition, training, equipping, and control of a military force are essentially professional military judgments." *Gilligan* v. *Morgan*, 413 U. S. 1, 10 (1973). Therefore, it is "difficult to conceive of an area of governmental activity in which the courts have less competence." *Ibid.*

In this case, the District Court, while no doubt well-intentioned, in effect inserted itself into the Navy's chain of command, overriding military commanders' professional military judgments. The Court relied on the Religious Freedom Restoration Act. See 42 U. S. C. §2000bb–1(b). But even accepting that RFRA applies in this particular military context, RFRA does not justify judicial intrusion into military affairs in this case. That is because the Navy has an extraordinarily compelling interest in maintaining strategic and operational control over the assignment and deployment of all Special Warfare personnel—including control over decisions about military readiness. And no less restrictive means would satisfy that interest in this context.

The Court "should indulge the widest latitude" to sustain the President's "function to command the instruments of national force, at least when turned against the outside world for the security of our society." *Youngstown Sheet & Tube Co.* v. *Sawyer*, 343 U. S. 579, 645 (1952) (Jackson, J., concurring). That fundamental principle applies here. As Admiral William Lescher, Vice Chief of Naval Operations, explained: "Sending ships into combat without maximizing the crew's odds of success, such as would be the case with ship deficiencies in ordnance, radar, working weapons or the means to reliably accomplish the mission, is dereliction of duty. The same applies to ordering unvaccinated personnel into an environment in which they endanger their lives, the lives of others and compromise accomplishment of essential missions." App. to Application for Partial Stay 110a.

In sum, I see no basis in this case for employing the judicial power in a manner that military commanders believe would impair the military of the United States as it defends the American people.

SUPREME COURT OF THE UNITED STATES

No. 21A477

LLOYD J. AUSTIN, III, SECRETARY OF DEFENSE, ET AL. *v.* U. S. NAVY SEALS 1–26, ET AL.

ON APPLICATION FOR A PARTIAL STAY

[March 25, 2022]

JUSTICE ALITO, with whom JUSTICE GORSUCH joins, dissenting.

By rubberstamping the Government's request for what it calls a "partial stay," the Court does a great injustice to the 35 respondents—Navy Seals and others in the Naval Special Warfare community—who have volunteered to undertake demanding and hazardous duties to defend our country. These individuals appear to have been treated shabbily by the Navy, and the Court brushes all that aside. I would not do so, and I therefore dissent.

I

In August 2021, the Secretary of the Navy made COVID–19 vaccination mandatory and threatened severe consequences, including dishonorable discharge and confinement, for anyone who refused.[1] Later Navy directives told service members that they could apply for religious exemptions, see Electronic Case Filing in *U. S. Navy Seals 1–26* v. *Biden*, No. 4:21–cv–01236 (ND Tex., Jan. 3, 2022) (ECF), Doc. 44–1, p. 40 (Trident Order #12), but this program, as

[1] See Decl. of W. Lescher in No. 4:21–cv–01236 (ND Tex.), ECF Doc. 87, p. 10 (explaining that the Navy's vaccination policy was that refusing to be vaccinated would constitute the refusal to obey "a lawful order under Article 92 of the Uniform Code of Military Justice," which is punishable by dishonorable discharge and confinement for two years).

described by the District Court, was largely "theater" designed to result in the denial of almost all requests. *U. S. Navy Seals 1–26* v. *Biden*, ___ F. Supp. 3d___ (ND Tex. 2022), App. to Application for Partial Stay 31a (App.).

The exemption procedure that the Navy set up included no fewer than *50 steps,* and during the first 35 steps, none of the various officials who processed requests gave any consideration to their merit. Decl. of A. Stephens, Exh. 1, ECF Doc. 62, at 10–26. Instead, a form letter rejecting each request was prepared and sent to seven offices for review. App. 40a.[2] A package of rejection letters was then assembled, together with a memo asking the vice admiral who served as a deputy chief of naval operations to sign the rejection letters. *Ibid.* Only at step 35 was someone in this chain told to read the exemption requests, but it appears that this individual was not given an opportunity to recommend that a request be granted. See ECF Doc. 62, at 7. Instead, this person's sole task was to record pertinent information on a spreadsheet and send the package on to the vice admiral. *Id.*, at 7–8.

Given the nature of this procedure, the results it produced are not surprising. Although more than 4,000 exemption requests had been submitted by February 15, 2022, not a single one had been approved when the complaint in this case was filed. See Application for Partial Stay 9, and n. 3 (Application) (citing ECF Doc. 129, at 16, n. 2 (Feb. 23, 2022)).

Respondents are among the many recipients of form rejection letters, and according to their declarations and testimony, some of them were told outright that pressing for a

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[2] Both the District Court and the Court of Appeals concluded based on the record that the Navy did not have a template for approving an exemption. See *U. S. Navy Seals* v. *Biden*, 27 F. 4th 336, ___ (CA5 2022) (*per curiam*), App. 6a; *id.*, at 40a. In the Reply filed in this Court, the Solicitor General claims that there was an approval template, Reply Brief 12, n. 6, but no such document been supplied to this Court.

religious exemption would end their naval careers. A respondent identified as Navy Seal 2 stated that a superior officer advised him that "'all religious accommodation requests will be denied'" because "'senior leadership . . . has no patience or tolerance for service members who refuse COVID–19 vaccination for religious reasons and want them out of the SEAL community.'" *U. S. Navy Seals* v. *Biden*, 27 F. 4th 336, ___ (CA5 2022) (*per curiam*), App. 9a. This officer allegedly added that "'even if a legal challenge is somehow successful, the senior leadership of Naval Special Warfare will remove [his] special warfare designation.'" *Ibid.* According to Navy Seal 5, he was told that "'there [would] be a blanket denial of all religious accommodation requests regarding COVID–19 vaccination.'" *Ibid.* Navy Seal 8 declared that his "'chain of command . . . made it clear that [his] request [would] not be approved and . . . provided [him] with information on how to prepare for separation from the U. S. Navy.'" *Ibid.* Navy Seal 11 stated that a command master chief told him that "'anyone not receiving the COVID–19 vaccine is an "acceptable loss" to the Naval Special Warfare (NSW) community.'" *Ibid.*

Forced to choose between violating their religious beliefs and the punishment that the Navy threatened, respondents brought this suit, claiming that the Navy's denial of their exemption requests violated the Free Exercise Clause of the First Amendment and the Religious Freedom Restoration Act of 1993 (RFRA), 107 Stat. 1488, 42 U. S. C. §2000bb *et seq*. See Complaint in ECF Doc. 1. The District Court found that these claims were likely to succeed, and it issued a preliminary injunction prohibiting the Navy from taking adverse actions against respondents due to their unvaccinated status. App. 56a. But the court made clear that its order did not require the Navy "to make any particular personnel assignments" and left "[a]ll strategic decisions . . . in the hands of the Navy." *Id.*, at 60a.

The Government appealed and asked the U. S. Court of

Appeals for the Fifth Circuit to stay the preliminary injunction, but the Fifth Circuit refused and issued a detailed opinion. 27 F. 4th 336.

The Government then applied to this Court for what it characterizes as a "partial stay," and the Court now issues a stay that uses precisely the language that the Government proposed. As I will explain, the Court's order essentially gives the Navy *carte blanche* to warehouse respondents for the duration of the appellate process, which may take years. There is no justification for this unexplained and potentially career-ending disposition.

II

In order to obtain a stay, the Government must show, among other things, that it is likely to succeed in defeating respondents' RFRA and free exercise claims, *Hilton* v. *Braunskill*, 481 U. S. 770, 776 (1987), and it cannot make that showing.

A

Under the clear terms of RFRA, all components of the Federal Government are forbidden to burden a person's exercise of religion unless the Government can demonstrate that the burden represents the least restrictive means of furthering a compelling interest. 42 U. S. C. §2000bb–1(b); *Holt* v. *Hobbs*, 574 U. S. 352, 357 (2015). The Government does not claim that Article II imperatives absolve the Navy's chain of command from complying with RFRA, and it concedes that the statute applies to the military. Application 28 (citing *Burwell* v. *Hobby Lobby Stores, Inc.*, 573 U. S. 682, 726–727 (2014)). Indeed, even the form disapproval letter for religious accommodation requests in the District Court record explains that RFRA applies to the Navy, and it is the Navy's position that "only those interests of the highest order can overbalance legitimate claims to the free exercise of religion." ECF Doc. 62, at 27–28.

Here, it is not disputed that compliance with the vaccination requirement would impose a substantial burden on respondents' free exercise of religion. Therefore, the two remaining questions are (1) whether the Navy's mandatory vaccination program furthers compelling interests and (2) whether the denial of respondents' exemptions represents the least restrictive means of furthering such interests.

As to the first question, I agree that the Navy has a compelling interest in preventing COVID–19 infection from impairing its ability to carry out its vital responsibilities, as well as a compelling interest in minimizing any serious health risk to Navy personnel. But the Navy's summary rejection of respondents' requests for religious exemptions was by no means the least restrictive means of furthering those interests. This is so for at least two reasons.

First, all the evidence available at this stage suggests that the Navy gave no real consideration to respondents' requests, and the Navy had no compelling need to proceed in that fashion. I cannot believe that this Court would tolerate such treatment in other contexts. Suppose, for example, that a federal agency processed employee complaints about discrimination on the basis of race, sex, or disability using a 50-step process in which rejection was presumed until the very last step, and suppose that the record showed that this procedure nearly always resulted in the denial of a claim. We would be outraged—and rightfully so. Why, then, is the Court willing to brush aside what appears to have occurred here?

Second, even if we ignore what the Navy did and accept the justification for the denials that Justice Department lawyers later provided in court, the relief that the Court now awards goes well beyond anything that can possibly be regarded as the least restrictive means of further compelling Navy interests. Focusing primarily on the Seals, the Government stresses certain characteristics of Seal missions, including small unit size, the frequent need to work

at very close quarters, and the remote and often inaccessible locations in which such missions are carried out. Due to those characteristics, the Government argues, there is a heightened danger that the COVID–19 virus will spread, as well as a special need to minimize the risk that a mission will be compromised by a sick team member who is unable to perform assigned tasks with maximum effectiveness.

In order to win at trial, it would not be enough for the Government to posit that sending an unvaccinated Seal on such a mission *might* produce such consequences. A court could not simply defer to the Navy's opinion, and mere "conjecture" or "speculation" would not be enough. See *Ramirez* v. *Collier*, 595 U. S. ___, ___–___ (2022) (slip op., at 13–15); *Fulton* v. *Philadelphia*, 593 U. S. ___, ___ (2021) (slip op., at 14). The Government would bear the burden of showing that mandatory vaccination is the least restrictive means of furthering the interest it asserts in light of the present nature of the pandemic, what is known about the spread of the virus and the effectiveness of the vaccines, prevalent practices, and the physical characteristics of Navy Seals and others in the Special Warfare community.

Whether the Government will be able to make the requisite showing remains to be seen, but for the purposes of considering interim relief that is sought in an emergency application, I am willing to accept the Navy's need to refrain from sending unvaccinated Seals on the types of missions the Government has described. But participating in such missions is not the only thing that respondents do, and the relief that the Government sought and that the Court now awards goes much further. Using the terminology selected by the Government, the Court stays the preliminary injunction with respect to decisions about "deployment," "assignment," and "other operational decisions."

The Government has not told us what these terms mean, but without any contrary guidance, we must assume that they will be interpreted in accordance with the definitions

in the Department of Defense Dictionary of Military and Associated Terms (DOD Dictionary).[3] And as defined in that dictionary, the terms seemingly allow the Navy to do just about anything it wants short of punishing respondents and drumming them out of the service.

"Deployment" is defined as "[t]he movement of forces into and out of an operational area,"[4] and an "operational area" seems to mean any "geographic are[a]" where the Navy might carry out "a strategic, operational, tactical, service, training, or administrative military mission."[5] Thus, sending a respondent somewhere for training or administrative purposes may constitute a deployment.

The term "assignment" appears to include detailing an individual to perform any duties on something more than a temporary basis.[6] And an "operational decision" apparently can include the carrying out of any "strategic, operational, tactical, service, training, or administrative military mission."[7]

Putting all this together, it appears that the Court's order allows the Navy to use respondents' unvaccinated status as a reason for directing them to perform whatever duties or functions the Navy wants, including sitting alone in a room

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[3] See DOD Dictionary (Nov. 2021), https://www.jcs.mil/Portals/36/Documents/Doctrine/pubs/dictionary.pdf.

[4] *Id.*, at 62.

[5] *Id.*, at 159.

[6] The DOD Dictionary does not define "assignment," but the term "assign" is given this complex definition:

"1. To place units or personnel in an organization where such placement is relatively permanent, and/or where such organization controls and administers the units or personnel for the primary function, or greater portion of the functions, of the unit or personnel. 2. To detail individuals to specific duties or functions where such duties or functions are primary and/or relatively permanent." *Id.*, at 20.

[7] The specific term "operational decision" is not defined, but the definition of "operation" includes "the carrying out of a strategic, operational, tactical, service, training, or administrative military mission." *Id.*, at 159.

pushing paper or reading manuals for the duration of the appellate process. It is squarely within the judicial power of Article III to assess whether the Government has shown that it has a compelling interest in obtaining this breadth of equitable relief pending appeal. The Government has not done so.

I would not rubberstamp the Government's proposed language. While I am not sure that the Navy is entitled to any relief at this stage, I am also wary, as was the District Court, about judicial interference with sensitive military decision making. Granting a substantial measure of deference to the Navy, I would limit the order to the selection of the Special Warfare service members who are sent on missions where there is a special need to minimize the risk that the illness of a member due to COVID–19 might jeopardize the success of the mission or the safety of the team members. This, I believe, was the aim of the District Court, and respondents themselves understand the preliminary injunction that way. See Response in Opposition 1 (stating that the injunction "does not require the Navy to deploy any of the thirty-five plaintiffs" (footnote omitted)).

B

Respondents are also likely to prevail on their claims under the Free Exercise Clause. Under our case law, if the Federal Government or a State treats conduct engaged in for religious reasons less favorably than similar conduct engaged in for secular reasons, that treatment is unconstitutional unless the relevant jurisdiction can satisfy "strict scrutiny," which is essentially the same as the standard imposed by RFRA. See *Employment Div., Dept. of Human Resources of Ore.* v. *Smith*, 494 U. S. 872, 878–879 (1990); *Church of Lukumi Babalu Aye, Inc.* v. *Hialeah*, 508 U. S. 520, 533 (1993).

That "[o]ur review of military regulations challenged on First Amendment grounds" is deferential does not "render

entirely nugatory in the military context the guarantees of the First Amendment." *Goldman* v. *Weinberger*, 475 U. S. 503, 507 (1986). "This Court has never held . . . that military personnel are barred from all redress in civilian courts for constitutional wrongs suffered in the course of military service." *Chappell* v. *Wallace*, 462 U. S. 296, 304 (1983).

Here, the Navy treated service members who applied for medical exemptions more favorably than those who sought religious exemptions. For one thing, requests for medical exemptions were seriously considered, and quite a few were granted, at least on a temporary basis. Application 7–8; 27 F. 4th, at ___, App. 20a ("[T]he Navy acknowledges that it has granted hundreds of medical exemptions from the COVID–19 vaccine, at least 17 of which were temporary medical exemptions for those in Naval Special Warfare"). In addition, service personnel with medical exemptions are not restricted as severely as respondents will be under the Court's order. App. 42a. Indeed, the District Court found that under Navy policy those participating in clinical trials and those with medical contraindications and allergies to vaccines remained deployable, unlike those seeking religious accommodations. *Id.*, at 50a (citing ECF Doc. 17–2, at 66). The Navy has no interest in different treatment for accommodation requests that produce otherwise identical outcomes. I would therefore specify in the Court's order that the Navy must provide equal treatment for all unvaccinated service members.

III

Today, the Court brushes aside respondents' First Amendment and RFRA rights. But yesterday, the Court handed down another decision that illustrates the strong protection for religious liberty that is provided by the framework that applies under RFRA and strict scrutiny. The decision in question, *Ramirez* v. *Collier*, involved a convicted murderer awaiting execution and his rights under

the Religious Land Use and Institutionalized Persons Act of 2000, 14 Stat. 803, 42 U. S. C. §2000cc *et seq.*, which, among other things, essentially requires prisons to comply with the RFRA standard. Ramirez argued that his exercise of religion will be burdened unless Texas allows his pastor to lay hands on him and pray aloud while he is being executed. Ramirez was less than punctilious and consistent in requesting a religious accommodation, see *Ramirez*, 595 U. S., at ___–___ (slip op., at 4–5); *id.*, at ___ (THOMAS, J., dissenting) (slip op., at 8), but the Court's decision forgave all that. Texas objected to Ramirez's request on the ground that the pastor's conduct might interfere with the execution, but the Court held that the State failed to discharge its burden to substantiate the likelihood of such harm. *Id.*, at ___ (slip op., at 12).

The contrast between our decision in *Ramirez* yesterday and the Court's treatment of respondents today is striking. We properly went to some lengths to protect Ramirez's rights because that is what the law demands. We should do no less for respondents.

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NARR/REF A IS NAVADMIN 110/21, U.S. NAVY COVID-19 STANDING GUIDANCE UPDATE 1.
REF B IS NAVADMIN 088/21, SARS-COV-2 VACCINATION AND REPORTING POLICY.
REF C IS NAVADMIN 289/21, GUIDANCE ENCOURAGING COVID-19 VACCINE BOOSTER.
REF D IS USD P&R FORCE HEALTH PROTECTION (FHP) SUPPLEMENT 15 REVISION 3 DOD GUIDANCE FOR CORONAVIRUS DISEASE 2019 LABORATORY TESTING SERVICES AVAILABLE AT https://www.defense.gov/Spotlights/Coronavirus-DOD-Response//Latest-DOD-Guidance/.
REF E IS THE SECRETARY OF DEFENSE MEMO MANDATING CORONAVIRUS DISEASE 2019 VACCINATION FOR DEPARTMENT OF DEFENSE SERVICE MEMBERS.
REF F IS ALNAV 062/21, 2021-2022 DEPARTMENT OF THE NAVY MANDATORY COVID-19 VACCINATION POLICY.
REF G IS NAVADMIN 190/21, 2021-2022 NAVY MANDATORY COVID-19 VACCINATION AND REPORTING POLICY.
REF H IS NAVADMIN 268/21, REQUIRED COVID-19 TESTING FOR UNVACCINATED SERVICE MEMBERS.
REF I IS NAVY AND MARINE CORPS PUBLIC HEALTH CENTER COVID-19 OMICRON VARIANT AND BOOSTER EFFECTIVENESS.
REF J IS NAVY AND MARINE CORPS PUBLIC HEALTH CENTER U.S. NAVY FORCE HEALTH PROTECTION WITH CONSIDERATIONS FOR VACCINE EFFICACY.
REF K IS NAVY AND MARINE CORPS PUBLIC HEALTH CENTER DOCUMENT ASSESSING REAL COVID-19 RISK.
REF L IS USD P&R FORCE HEALTH PROTECTION (FHP) SUPPLEMENT 23 REVISION 3 DOD GUIDANCE FOR CORONAVIRUS DISEASE 2019 VACCINATION ATTESTATION, SCREENING, TESTING, AND VACCINATION VERIFICATION AVAILABLE AThttps://www.defense.gov/Spotlights/Coronavirus-DOD-Response//Latest-DOD-Guidance/.
REF M IS NAVADMIN 086/21, UPDATED GUIDANCE TO COMMANDERS ON ADJUSTING HEALTH PROTECTION CONDITIONS AND BASE SERVICES DURING COVID-19 PANDEMIC (CORRECTED COPY).
REF N IS USD P&R FORCE HEALTH PROTECTION (FHP) SUPPLEMENT 20 REVISION 1 DOD GUIDANCE FOR PERSONNEL TRAVELING DURING THE CORONAVIRUS DISEASE 2019 PANDEMIC

AVAILABLE AT https://www.defense.gov/Spotlights/Coronavirus-DOD-Response//Latest-DOD-Guidance/.
REF O IS NAVADMIN 165/21, SOVEREIGN IMMUNITY POLICY.
REF P IS NAVADMIN 180/21, UPDATE TO COVID-19 REPORTING REQUIREMENTS.

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RMKS/ 1. Purpose. This NAVADMIN provides updated COVID-19 standardized operational guidance and cancels and replaces references (A) and (B). As a result of our unblinking focus on personnel safety, our sailors and civilians have proven resilient to the COVID-19 global pandemic. Vaccinations, vaccine boosters, command engagement, and personal accountability continue to form the foundation of our success. Although Commanding Officers hold ultimate responsibility for the health and welfare of their crews, in the case of a persistent pandemic every member of every command must take personal ownership and responsibility of the promulgated measures required to keep COVID-19 in check.

2. Applicability. This guidance applies to all service members (active duty and ready reserve) who are members of, or support, operational units as defined by the applicable Navy Component Commander (NCC) per paragraph 4.e below. Non-operational forces, civilian employees and contractor personnel should follow the latest Department of Defense (DOD) Force Health Protection, Center for Disease Control (CDC) and state/local area guidance. Additionally, host nation and/or higher-echelon Commanders guidance may apply.

3. Evolving Guidance. The fight against COVID-19 has been dynamic. Both the data and the response to the data continue to evolve and the CDC is the authority for COVID-19 measures for the general population. The CDC does not provide Navy-specific guidance. The Navy Surgeon General is the authority for Navy COVID-19 measures and advises the CNO on how best to apply CDC guidance across the spectrum of Navy operating environments. To date, the Navy has met or exceeded CDC guidance and continues to experience a much lower incidence of adverse effects than the general population. Accordingly, and except as noted below in this NAVADMIN, evolving CDC guidance related to virus behavior should first be evaluated by the Navy Surgeon General prior to Fleet implementation. Questions regarding applicable COVID-19 measures may be directed to the point of contact (POC) listed above.

4. Definitions. All CDC definitions regarding COVID-19 apply and are kept current on the CDC website: https://www.cdc.gov/.
The following additional Navy definitions are provided:
4.a. Immunized / Vaccinated: Interchangeable terms for an individual who has completed a primary vaccine series as defined in reference (C). Term applies two weeks after the final dose is received. During the time period from initial dose until two weeks after the final dose, an individual is considered partially immunized/vaccinated.
4.b. Vaccine Booster: The vaccine booster is a time-based reinforcement of the initial vaccine in order to prevent decreasing immunity. A vaccine booster is authorized greater than 5 months after a Pfizer/BioNTech or a Moderna mRNA two-dose vaccine series, and greater than 2 months after a Johnson and Johnson single-dose vaccine. Booster guidance is subject to change and the most up to date information is available on the CDC website.
4.c. High-risk personnel: Those individuals designated by a medical provider who meet CDC criteria for increased risk of severe illness. Qualifying conditions are included on the CDC website.
4.d. Commander: For the purposes of this NAVADMIN, the term Commander includes Commanding Officers, Officers-in-Charge, Masters, and Aircraft Commanders.
4.e. Operational and non-operational forces: For the purposes of this NAVADMIN, operational forces and non-operational forces are defined by the applicable NCC. For operational forces, this might include deployed forces,

forces in sustainment, or other operational elements that the NCC determines to fall within the intent and context of this NAVADMIN.
4.f. Restriction of movement (ROM): DOD term for limiting personal interaction to reduce risk to a broader population. Personnel executing directed ROM remain in a duty status and will not be charged leave. ROM-sequester is the Navy term for preemptive ROM in order to reduce risk of infection in advance of movement.
4.g. Health protection measures (HPM): Comprehensive term for mitigation measures that reduce the spread of COVID-19. This includes physical distancing, wearing of masks, and enhanced environmental cleaning. Recommended HPMs are included on the CDC website.
4.h. Viral test: For the purposes of this NAVADMIN, and unless specifically stated otherwise, a COVID test is defined as receiving a test that measures antigen produced by the body's immune response (antigen test) or a test that detects the actual presence of the virus (Polymerase Chain Reaction (PCR) test).
4.i. Close contact: A person who was less than 6 feet away from another, infected person (laboratory-confirmed or a clinical diagnosis) for a cumulative total of 15 minutes or more over a 24-hour period (for example, three individual 5-minute exposures for a total of 15 minutes).

5. COVID-19 infected personnel and close contacts.
5.a. Actions for personnel suspected of being infected.
5.a.1. Symptomatic. Test immediately those individuals exhibiting COVID-19 symptoms. If symptomatic and positive, isolate the individual per paragraph 5.a.3. and identify close contacts per reference (D); if symptomatic and negative, consult a medical provider prior to returning to work.
5.a.2. Close contacts. Asymptomatic close contacts should be tested 2-5 days after exposure, if testing is available (see paragraph 6). Close contacts may remain on duty but must wear a mask for 10 days. If symptoms develop, test per paragraph 5.a.1.
5.a.3. Isolation. Isolate individuals who test positive for 5 days or until symptoms are clearing, whichever is longer, including 24 hours with no fever and without fever-reducing medication (day 0 is date of positive test or symptom onset, whichever occurred first). Isolation may be conducted either ashore or afloat. Once released, individuals will wear a mask for an additional 5 days (minimum 10 days total). No exit testing is required and, absent symptoms, prior positives should not be PCR tested for 90 days (per paragraph 6.c).,
5.b. Actions for unvaccinated personnel.
5.b.1. Per references (E), (F) and (G), all operational Navy units are assumed to be 100 percent vaccinated. Unvaccinated uniformed personnel should only include those with an approved waiver, those awaiting waiver disposition, or those processing for separation. With the exception of separation orders, unvaccinated personnel will not execute orders until the COVID-19 Consolidated Disposition Authority (CCDA) has completed disposition of their case.

6. COVID-19 Testing.
6.a. Testing Priority. Personnel exhibiting COVID like symptoms are the highest priority for testing. If testing asymptomatic close contacts per paragraph 5.a.2. stresses testing supplies, or if operations preclude testing (e.g., small, remote teams or depleted supplies), Commanders are authorized to forego testing of asymptomatic close contacts.
6.b. Testing of unvaccinated personnel. Unvaccinated personnel shall follow the testing requirements of reference (H) and paragraph 6.c. below.
6.c. Testing of individuals previously infected with COVID-19. Individuals previously infected with COVID-19 may be asymptomatic and continue to test positive by PCR for up to 90 days from date of initial diagnosis due to the presence of persistent non-infectious viral fragments. Therefore, prior COVID positives are exempt from testing protocols for 90 days from the earlier of symptom onset or first positive test (90-day rule). Individuals exhibiting new or persistent symptoms during the 90-days following infection should be evaluated by a medical provider.
6.d. Surveillance / ship-wide testing. Surveillance or ship-wide testing is

neither required nor recommended and has previously generated large numbers of unmanageable persistent positives.

6.e. Test procurement. To ensure uninterrupted operations, and as feasible, Commands will coordinate with their supporting supply activities to obtain testing supplies 60 days in advance of need.

7. Requirements for Operational units.

7.a. Vaccine booster. To promote maximum protection, NCCs should continue the campaign for COVID-19 vaccine boosters. Because all studies are converging on the need for a vaccine booster to ensure enduring protection, it has essentially become the next-shot in a series and will likely become mandatory in the near future. There is no shortage of vaccine booster doses for those eligible.

7.b. Medical screening. Medical screening will include newly reporting personnel and a command-wide monthly data review and assessment, as directed by the applicable NCC. An additional pre-deployment screening will be completed within 7 days of deployment. Medical screening shall be conducted by medical providers and reported to the unit Commander to assist in assessing risk and mitigations. Screening will include, at a minimum, a review of vaccination and vaccine booster status, an assessment of COVID-19 exposure history (those under the 90-day rule), and a review and assessment of those with underlying risk factors (high-risk determination). Unvaccinated Navy personnel shall not be assigned to operational units.

7.c. Military Sealift Command (MSC). MSC shall medically screen Civil Service Mariners and contract personnel for deployment on MSC vessels in accordance with existing MSC Quality Management System processes and procedures. Unvaccinated personnel should not be assigned to operational units, with exceptions approved and mitigated by Commander, MSC.

7.d. Vaccinated High-risk personnel. The decision to operate and deploy with vaccinated high-risk personnel rests with the Commander, as advised by medical providers, who must report intentions to their immediate superior in command (ISIC). High-risk personnel shall be PCR viral tested within 3 days of embarking.

7.e. Pre-deployment ROM-sequester. Vaccinated individuals should not normally be required to ROM- sequester ahead of planned operations. In rare circumstances, the applicable NCC may direct a ROM-sequester in response, for example, to unanticipated virus behavior or in response to Geographic Combatant Commander (GCC) and/or host nation requirements. Foreign clearance guidance is available at https://www.fcg.pentagon.mil/.

7.f. Underway HPM. As a result of demonstrated vaccine effectiveness, a 100% vaccinated operational force and a healthy demographic, serious illness or death resulting from COVID-19 for vaccinated individuals is statistically very unlikely, and modeling contained in references (I), (J), and (K) indicates this will continue in the context of current variants. However, the increasing contagious nature of evolving variants can result in unmanageable numbers of even mild symptomatic positives that may pose general health and operational unit risk, i.e. risk to force (RTF) or risk to mission (RTM), regardless of symptom severity. The following HPM, at a minimum, is required:

7.f.1. Medical screening as outlined above in paragraph 7.b.

7.f.2. Wearing masks for the first 10 days (analogous with paragraph 5 requirements) after leaving port if more than 25% of the total crew meets the requirements for, but has not yet received, the vaccine booster. At Commanders discretion, masks may be removed if there is no evidence of COVID infection for 10 days (no positive symptomatic and no isolations). At the onset of COVID on board, and if still greater than 25% have not received the vaccine booster, return to wearing masks until there is no longer evidence of COVID. Although all vaccinated personnel have demonstrated protection against serious illness or death, this percentage indicates decreasing immunity and the potential for increasing numbers of symptomatic individuals requiring isolation.

7.f.3. Educate and reinforce self-monitoring for symptoms and prompt reporting.

7.f.4. Educate and reinforce frequent handwashing and social distancing, when applicable.

7.f.5. Aggressively isolate COVID-19 positive individuals per paragraph 5 above.
7.f.6. Ensure adequate ventilation in spaces routinely manned.
7.f.7. Educate and reinforce focused cleaning efforts on high-touch surfaces, at least daily or more frequently, depending upon usage (e.g., tables, hatch latches, ladderwells, phones, watch console keyboards and buttons, toilets, faucets, sinks, etc.). Although remote, there is evidence of surface spread of COVID-19 and other viruses with similar symptoms.
7.g. Considerations for adding or relaxing HPM. NCCs and Commanders should consider for any unit the operational impact resulting from the number of sailors in isolation, either ashore or afloat, regardless of percentage of immunized personnel, boosted personnel, or severity of symptoms. Commanders may elevate HPM at any time and retain the latitude to temporarily apply alternate HPM in lieu of isolation to support safe operations. An example might be a rapid spread that compels a Commander to utilize asymptomatic or mildly symptomatic positives to manage watch-bill impact while recovering others in isolation, applying additional alternate measures as needed to minimize spread. The following should be considered before adjusting HPM:
7.g.1. Overall number of individuals in isolation and trend. The general rule of thumb for a COVID outbreak trending in a favorable direction is that the number of those exiting isolation matches (flattening curve) or exceeds (lowering curve) those entering isolation, combined with the assessment that the total number of symptomatic individuals is manageable and improving, and watch-bill (operational) impact is manageable and improving.
7.g.2. Proximity of a units access to shore and afloat Medical Treatment Facilities (MTF) within a medically relevant timeline, balanced with paragraph
7.f HPM and onboard trend. Rule of thumb is within 1-week of an MTF for 100 percent vaccinated crew with a manageable COVID-positive case load; moving to a more restrictive, 72 hours or less, if a growing or concerning case load; or, moving to a less restrictive, beyond 1-week, if a small or no case load.
7.h. Port visits. Liberty is an important mission and should be pursued within the context of this NAVADMIN. Geographic NCCs (GNCC) will set conditions for foreign port off-base liberty in coordination with country teams and local authorities, taking into account host country requirements, vaccination and booster status, sovereign immunity per paragraph 8 below, COVID-19 prevalence and mission requirements.
7.i. Aircraft operations. On a case-by-case basis, aircrews and aircraft maintainers may be exempt from this guidance in order to meet emergent operational or NATOPS currency requirements. Exemptions and mitigation plans must be approved by the Squadron Commander. For aviation units embarked on surface ships, mitigation plans will be coordinated with the ships health protection plan and approved by the ships Commanding Officer.
7.j. Post-deployment. Personnel returning to homeports from deployment shall follow CDC and U.S. Department of State travel and testing requirements. If return travel includes foreign countries, personnel shall adhere to the requirements of those countries as well. Updated travel information is on the following website: https://travel.state.gov/content/travel.html.
7.k. Visitors embarking underway vessels and Navy aircraft. All visitors are required to be vaccinated in accordance with reference (L), and, if eligible, have received a vaccine booster. Masks will be worn during transit; and for ships, 10 days once onboard.

8. Sovereign immunity.
8.a. It is U.S. Government policy to protect the sovereign immunity of warships, naval auxiliaries, and aircraft, including protecting crew information to the maximum extent possible. Within the context of COVID-19, host nations may request or require crew or ship information exceeding that authorized by U.S. policy or international law. NCCs will ensure appropriate training and guidance on protecting U.S. sovereign immunity and the protection of health information as part of OPSEC/personal security.
8.b. GNCCs should determine in advance those host nations that may challenge our sovereign immunity and, as able, avoid them. See reference (O) for

additional guidance. In all cases, GNCCs shall authorize the minimum information necessary in order to meet operational requirements. The Navy Declaration of Health (NAVMED 6210/3) is the only authorized form for providing health information to foreign officials. If required by the host nation, and with GNCCs concurrence, Commanders at their discretion may include on the NAVMED 6210/3 that their unit is 100% vaccinated, those disembarking will have tested negative within the required timeframe, and those disembarking have received a vaccine booster.

8.c. Exception to Policy (ETP). On a case-by-case basis, and to support operations, OPNAV may grant an exception to policy (ETP) in deference to the varying impacts of COVID-19. Any action that may constitute or require a waiver of sovereign immunity must be coordinated by the applicable GNCC with OPNAV N3N5 for ETP approval no later than 5 days ahead of need.

To avoid precedence beyond COVID-19, any ETP will be messaged to the host nation as explicitly linked to the pandemic. Requests shall include justification for port selection; host nation mitigation and testing requirements; alternate port options; impact to mission if the request is denied; medical, legal, collection and privacy risk; and feedback from country team coordination.

Notifications and requests may be sent via record message traffic, email to the POC provided above, or both.

8.d. Guidance for Commanders. Per the direction of their GNCCs, Commanders shall comply with domestic and foreign quarantine regulations for port entry and document compliance on NAVMED 6210/3. Absent GNCC approval in advance, Commanders will not submit to host nation COVID-19 testing nor provide individual or collective medical data, copies of health records, nor any supplementary or locally demanded health forms, and shall not grant access to ship or crew health records or allow the same to be searched or inspected by host nations. If circumstances compel a Commander to acquiesce to additional host nation requirements without obtaining an ETP or GNCC concurrence (e.g., personnel emergency, weather avoidance), report the event and circumstances to OPNAV N3N5 via the chain of command as soon as practicable.

9. Reporting procedures. Reporting procedures are amended as follows and will be incorporated in the next revision of reference (P). OPREP-3 Navy Blue messages for COVID cases that do not result in death, request for assistance, or operational impact may instead be reported via SharePoint. If unable to report via SharePoint, a single daily OPREP-3 Navy Unit SITREP summarizing all COVID cases onboard is required. SharePoint information is used to produce daily reports to Senior Navy and DoD Leadership.

10. Released by VADM W. R. Merz, Deputy Chief of Naval Operations for Operations, Plans and Strategy, OPNAV N3/N5.//

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Centers for Disease Control and Prevention

EXHIBIT 15

Obesity, Race/Ethnicity, and COVID-19

Obesity is a common, serious, and costly chronic disease. Having obesity puts people at risk for many other serious chronic diseases and increases the risk of severe illness from COVID-19. Everyone has a role to play in turning the tide against obesity and its disproportionate impact on racial and ethnic minority groups.

Adult Obesity is Increasing

The 2020 CDC Adult Obesity Prevalence Maps[1] show that obesity remains high - sixteen states now have an adult obesity prevalence at or above 35 percent: Alabama, Arkansas, Delaware, Indiana, Iowa, Kansas, Kentucky, Louisiana, Michigan, Mississippi, Ohio, Oklahoma, South Carolina, Tennessee, Texas, and West Virginia. This is up from twelve states in 2019.

2020 Adult Obesity Prevalence Maps

Obesity Worsens Outcomes from COVID-19

Adults with excess weight are at even greater risk during the COVID-19 pandemic:

- Having obesity increases the risk of severe illness from COVID-19. People who are overweight may also be at increased risk.
- Having obesity may triple the risk of hospitalization due to a COVID-19 infection.
- Obesity is linked to impaired immune function.[2,3]
- Obesity decreases lung capacity and reserve and can make ventilation more difficult.[4]
- A study of COVID-19 cases suggests that risks of hospitalization, intensive care unit admission, invasive mechanical ventilation, and death are higher with increasing BMI.[5]
  - The increased risk for hospitalization or death was particularly pronounced in those under age 65.[5]
- More than 900,000 adult COVID-19 hospitalizations occurred in the United States between the beginning of the pandemic and November 18, 2020. Models estimate that 271,800 (30.2%) of these hospitalizations were attributed to obesity.[6]

Children diagnosed with obesity may suffer worse outcomes from COVID-19. In a study of COVID-19 cases in patients aged 18 years and younger, having obesity was associated with a 3.07 times higher risk of hospitalization and a 1.42 times higher risk of severe illness (intensive care unit admission, invasive mechanical ventilation, or death) when hospitalized.[7]

Obesity Disproportionately Impacts Some Racial and Ethnic Minority Groups

Combined data from 2018-2020 show notable racial and ethnic disparities:

- Non-Hispanic Black adults had the highest prevalence of self-reported obesity (40.7%), followed by Hispanic adults (35.2%), non-Hispanic White adults (30.3%), and non-Hispanic Asian adults (11.6%).
- 0 states among 35 states and territories with sufficient data had an obesity prevalence of 35 percent or higher among non-Hispanic Asian adults.

TOOLS TO HELP ACHIEVE HEALTH EQUITY

- 7 states among 49 states and territories with sufficient data had an obesity prevalence of 35 percent or higher among non-Hispanic White adults.
- 22 states among 49 states and territories with sufficient data had an obesity prevalence of 35 percent or higher among Hispanic adults.
- 35 states and the District of Columbia among 48 states and territories with sufficient data had an obesity prevalence of 35 percent or higher among non-Hispanic Black adults.

Hispanic and non-Hispanic Black adults have a higher prevalence of obesity and are more likely to suffer worse outcomes from COVID-19. Racial and ethnic minority groups have historically not had broad opportunities for economic, physical, and emotional health, and these inequities have increased the risk of getting sick and dying from COVID-19 for some groups. Many of these same factors are contributing to the higher level of obesity in some racial and ethnic minority groups.

What Can be Done

Obesity is a complex disease with many contributing factors. Neighborhood design, access to healthy, affordable foods and beverages, and access to safe and convenient places for physical activity can all impact obesity. The racial and ethnic disparities in obesity underscore the need to address social determinants of health such as poverty, education, and housing to remove barriers to health. This will take action at the policy and systems level to ensure that obesity prevention and management starts early, and that everyone has access to good nutrition and safe places to be physically active. Policy makers and community leaders must work to ensure that their communities, environments, and systems support a healthy, active lifestyle for all.

What CDC, Partners, States, and Communities are Doing

Our work with partners, states, and communities makes it easier for everyone to move more and eat a healthy diet where they live, learn, work, and play. Together, we work to remove barriers and promote health and wellness for all by:

- Bringing communities together to plan and carry-out local, culturally tailored interventions to address poor nutrition, and physical inactivity and tobacco use
- Promoting healthier food and beverage choices in childcare, schools, workplaces, hospitals, and public venues
- Making healthy foods more available by connecting local producers with retailers and organizations such as childcare, schools, hospitals, and food hubs
- Promoting nutrition standards in early care and education settings, food pantries, and faith-based organizations
- Designing communities that connect sidewalks, bicycle routes, and public transportation with homes, early care and education settings, schools, parks, and workplaces
- Ensuring screening for obesity and access to healthy lifestyle programs for children and their families

The epidemic of obesity is impacting the severity of the COVID-19 pandemic. Given the added risks associated with COVID-19, we need to support all individuals, especially members of racial and ethnic minority groups, to live active healthy lives.

Steps to Take Now

Systemic change takes time, as does long-term weight loss. In addition to the steps everyone should take to slow the spread of COVID-19, individuals can help protect themselves and their families during this pandemic by:

Eating a healthy diet

Eating a healthy diet with plenty of fruits and vegetables, lean protein, and whole grains as well as the appropriate amount of calories is important for your health, and can help with weight loss and preventing weight gain.[8] Good nutrition can help support optimal immune function.[9,10] A healthy diet can help prevent or support self-management of diseases such as heart disease and type 2 diabetes[8], which also increase the risk of severe illness from COVID-19.

Being active

People who do little or no physical activity are more likely to get very sick from COVID-19 than those who are physically active. Regular physical activity helps you feel better, sleep better, and reduce anxiety. It can also help with preventing weight gain and when combined with calorie reduction, helps with weight loss.[11] Physical activity can also help prevent diseases that increase a person's chances of having severe illness from COVID-19 such as heart disease and type 2 diabetes.[11] Emerging research suggests it may also help boost immune function.[12,13]

Getting enough sleep

Insufficient sleep has been linked to depression, as well as chronic diseases[14] that may increase the risk of severe illness from COVID-19 such as heart disease, type 2 diabetes, and obesity.

Coping with stress

Stress during an infectious disease outbreak can sometimes cause changes in sleep or eating patterns, increased use of alcohol and tobacco, or worsening of chronic health problems.

Over time, these actions can help individuals with obesity improve their overall health. And if they result in even modest weight loss, there are health benefits, such as improvements in blood pressure, blood cholesterol, and blood sugars.[15] And with a healthy BMI, the risk of severe illness from COVID-19 is reduced.[5]

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Resources

- Food assistance programs and food system guidance during COVID-19
- Policy resources to support social determinants of health
- Health Equity Resource Toolkit for State Practitioners Addressing Obesity Disparities
- COVID-19: Health Equity Considerations and Racial and Ethnic Minority Groups – What We Can Do
- Strategies to support healthy food systems, create activity-friendly environments, and prevent obesity.
- Healthy Eating for a Healthy Weight
- Physical Activity for a Healthy Weight
- Adult BMI Calculator
- CDC's Division of Nutrition, Physical Activity, and Obesity (DNPAO)
- DNPAO's State and Local Programs

Page last reviewed: May 20, 2022

DoD HEALTH OF THE FORCE

2020

INTRODUCTION

The *Department of Defense (DoD) Health of the Force* report represents a coordinated effort by the Defense Health Agency and the Army, Navy, and Air Force public health centers to provide a snapshot of active component (AC) Service member health and well-being. It is meant to be a resource for military leaders and decision makers to help identify changes in the health status of AC Service members, emerging health problems, and gaps in prevention and treatment efforts. It may also be of interest to program planners, health practitioners, researchers, and others interested in the well-being of Service members.

The current report focuses on ten subject areas: acute and cumulative traumatic injury, traumatic brain injury, noise-induced hearing injury, heat illness, behavioral health (BH), sexually transmitted infections (STIs), sleep disorders, obesity, acute respiratory illnesses, and coronavirus disease 2019 (COVID-19). It is based on data from calendar year 2020. The intent of the annual *DoD Health of the Force* report is to provide timely, concise, and useful information to generate ideas and drive progress toward enhancing the vitality and lethality of our fighting force.

ORGANIZATION OF THIS REPORT

This report is divided into two sections, Health Metrics and Service Profiles. The Health Metrics section provides health index measures for each of the ten subject areas; the Service Profiles section compares measures across Services.

Methodology is critical to understanding and using health care metrics, especially because of the growing number of sources of health care data. The appendices of this report present detailed information about the methods used to analyze data in each of the ten subject areas as well as specific limitations associated with the data analysis.

LIMITATIONS

There are many challenges associated with processing and interpreting health care data.[1,2] Variability in the collec-tion, collation, and processing of data; differences in study design and analytic methods; and the inherent intrica-cies of defining and measuring health itself contribute to complexity that cannot be fully resolved or explained in a summary report. Accordingly, this report is meant to be an adjunct to, rather than a substitute for, other reports related to Service member health, deployability, readiness, and total force fitness. Specific limitations include those associated with using electronic medical records for surveillance data (e.g., missing data, underrepresentation of conditions that do not come to the attention of the health care delivery system, miscoding) and failure to account for potentially important covariates such as age and sex when comparing Service populations. In 2020, the COVID-19 pandemic impacted the military health system as well as the entire world. Restrictions on appointments, in-per-son staffing, and social distancing, as well as changes to health care-seeking behavior as a result of these restric-tions, would be expected to cause a decrease in the ascertainment of many medical conditions in 2020.

This report is meant to evolve over time. It is anticipated that specific measures will change over time to account for data-related limitations and changing paradigms related to public health surveillance. Input related to improv-ing this report is critical and welcomed.

HIGHLIGHTS

- There were 211 acute and 948 cumulative traumatic injuries per 1,000 AC Service members in 2020. Sprains and strains were the most common acute injuries, and the lower extremities were the most commonly affected body region. The rate of acute injuries decreased by 30% between 2016 and 2020. The rate of cumulative traumatic injuries was similar between 2016 and 2019, but decreased 18.9% between 2019 and 2020.

- In 2020, a total of 16,914 (1.3%) of AC Service members had an encounter for traumatic brain injury. The majority (74.5%) of these were mild in severity, followed by 24.7% moderate, 0.5% severe, and 0.28% penetrating.

- The prevalence of noise-induced hearing injury was 4.1% in 2020. Prevalence was higher in male (4.4%) compared to female Service members (2.7%) and increased with increasing age group among both sexes.

- A total of 1,667 AC Service members (0.13%) suffered from heat exhaustion in 2020, and 476 (0.04%) suffered from heat stroke. The percentage of AC Service members affected by heat exhaustion increased from 2017 to 2018 and decreased from 2019 to 2020, whereas the percentage affected by heat stroke remained stable between 2016 and 2020. Overall, heat illnesses were more common among younger Service members and those in the Marine Corps.

- In 2020, 8.7% of AC Service members had a behavioral health (BH) disorder. The prevalence of BH disorders remained stable between 2016 and 2020. Adjustment disorder was the most common BH disorder among both male and female AC Service members.

- Approximately 25 per 1,000 AC Service members were diagnosed with or tested positive for a sexually transmitted infection (STI) (chlamydia, gonorrhea, or trichomoniasis) in 2020. Chlamydia was the most common STI (21 per 1,000), followed by gonorrhea (4 per 1,000), and trichomoniasis (1 per 1,000). The incidence of chlamydia and gonorrhea increased between 2016 and 2019, but decreased between 2019 and 2020. Younger and female Service members had higher rates compared to their respective counterparts.

- In 2020, 12% of AC Service members had a sleep disorder. The prevalence of sleep disorders remained stable between 2016 and 2020. The most common sleep disorder among male Service members was sleep apnea; the most common sleep disorder among female Service members was insomnia.

- The overall prevalence of obesity was 19% among AC Service members in 2020. The overall prevalence of obesity increased slightly between 2016 and 2020. Overall obesity prevalence was higher among male (20%) compared to female (15%) and older compared to younger Service members.

- On average, 20 per 1,000 AC Service members were diagnosed with acute respiratory infections each month during 2020, with rates highest in March and lowest in May (39 and 6.5 per 1,000, respectively). On average, female Service members had higher monthly rates of acute respiratory infections and respiratory symptoms compared to male Service members. Those in the youngest age group had the highest rates of acute respiratory infections, but those in the oldest age group had the highest rates of respiratory symptoms.

- The overall incidence of reported or laboratory-confirmed COVID-19 infection was 5.9% in 2020. Service members in the younger age groups had a higher incidence of COVID-19 than those in the older age groups.

Acute and Cumulative Traumatic Injury

Injuries consistently rank among the top health care bur-dens in the DoD. In this report, non-battle injury was eval-uated using two broad categories: acute injury (which includes musculoskeletal and other types of injury) and cumulative traumatic injury (musculoskeletal injury result-ing from repeated microtrauma).

Acute injuries and cumulative traumatic musculoskeletal injuries were identified in inpatient and outpatient med-ical records using the International Classification of Dis-eases, Tenth Revision, Clinical Modification (ICD-10-CM) injury codes described in the Army Public Health Cen-ter's taxonomy of injuries for public health monitoring and reporting.[3] The taxonomy defines body regions and nature-of-injury groups (i.e., the type of anatomic or physi-ologic disruption that occurred to the body region, such as a fracture, dislocation, open wound, burn, internal organ injury, or poisoning). Both acute and cumulative traumatic injuries were described by body region and nature-of-in-jury groups (e.g., fracture, open wound, sprain, musculo-skeletal tissue damage).

In 2020, there were 278,580 acute and 1,251,989 cumu-lative traumatic injuries among AC Service members, with rates of 211 per 1,000 and 948 per 1,000 AC ser-vice members, respectively. Injury rates were higher in females as compared to males in all Services and in both injury categories. Acute and cumulative traumatic injury rates were highest in the oldest age group among both sexes. Cumulative traumatic injury rates were markedly higher among older Service members, especially males, where the rate among males aged 45 years or older was more than triple that of males less than 25 years.

Among AC Service members who suffered **acute injuries,** the top five body regions and the top five nature-of-injury categories were similar for all Services and accounted for 99% and 81% of injuries, respectively. **The rate of acute injuries decreased by 30% between 2016 and 2020.**

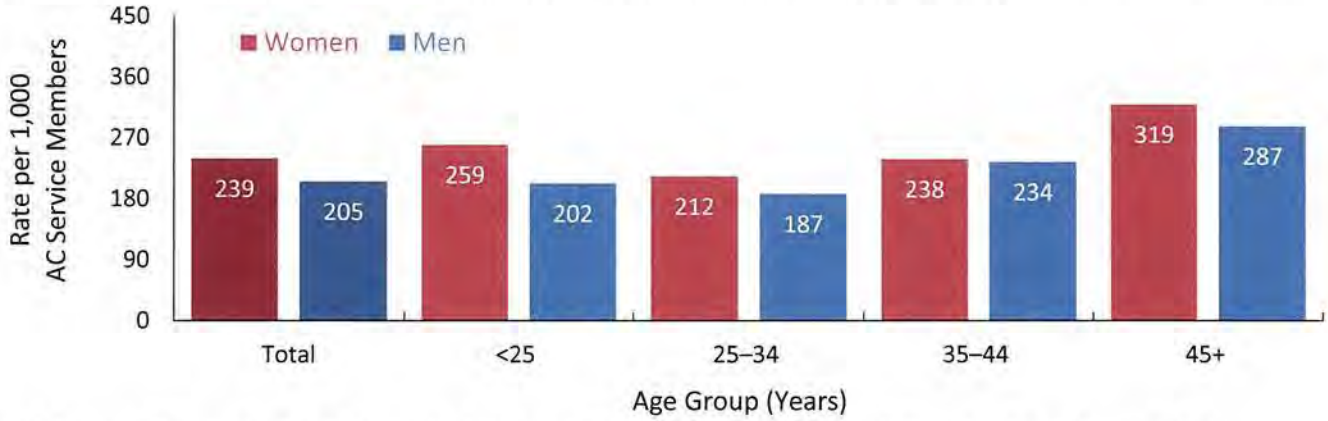
During 2020, 3,012 (1.4%) of the acute injury cases were hospitalized, and 1,700 (0.31%) of the cumulative traumatic cases were hospitalized. These hospitalizations resulted in 13,741 total bed days for acute injury and 5,571 total bed days for cumulative traumatic injury.

Among AC Service members who suffered **cumulative traumatic injuries**, the most commonly injured body regions were the trunk (43%) and lower extremities (34%). Musculoskeletal tissue damage (e.g., cervical disc disorders, pain in joints, tendonitis, bursitis, chondroma-lacia) was the most common nature-of-injury category, accounting for 88% of all cumulative traumatic injuries. **The rate of cumulative traumatic injuries decreased by 19% from 2019 to 2020.**

Non-combat musculoskeletal injuries have been found to be associated with increased limited duty days, decreased readiness, and increased medical costs to the U.S. govern-ment.[4,5] Of particular concern are injuries sustained during physical training, which is one of the leading cause of inju-ries in Service members. Many of these types of injuries are preventable and can be mitigated by proper training techniques, use of protective equipment, and program and policy implementation to address risk factors.[6–8]

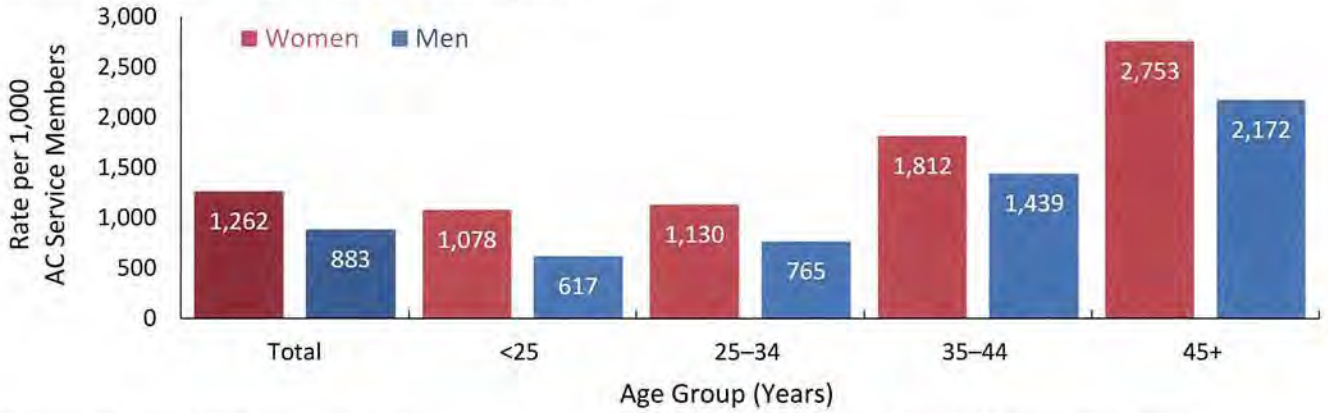
Incidence of Acute Injury by Sex and Age Group, AC Service Members, 2020

Overall, acute injury rates were higher for female compared to male Service members (239 and 205 per 1,000, respectively). Among both male and female Service members, acute injury rates were highest in the oldest age group (45+ years).



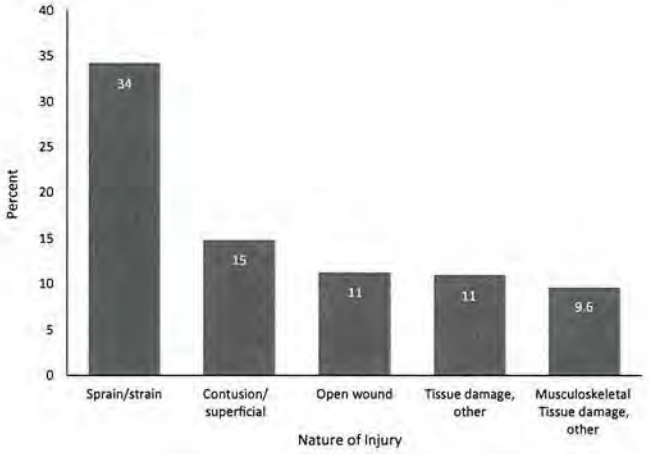
Incidence of Cumulative Traumatic Injury by Sex and Age Group, AC Service Members, 2020

Cumulative traumatic injury rates were higher for older compared to younger Service members and higher for female compared to male Service members (1,262 and 883 per 1,000, respectively).



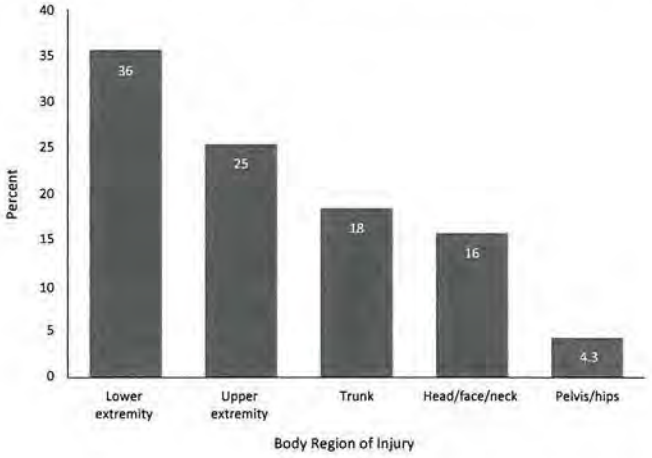
Nature of Acute Injury, Top Five Categories, AC Service Members, 2020

Sprains and strains was the most common nature-of-injury category, accounting for 34% of all incident acute injuries.



Body Region of Acute Injury, Top Five Categories, AC Service Members, 2020

Lower extremity was the most common region affected by acute injury, accounting for 36% of all incident acute injuries.

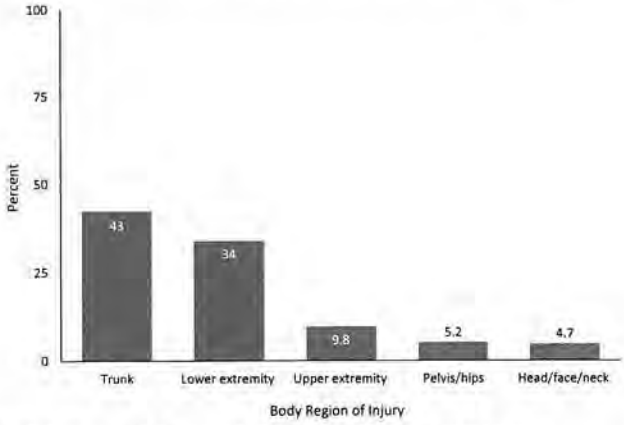


Nature of Cumulative Traumatic Injury, AC Service Members, 2020

Musculoskeletal tissue damage, other was the most common nature-of-injury category, accounting for 88% of all incident cumulative traumatic injuries.

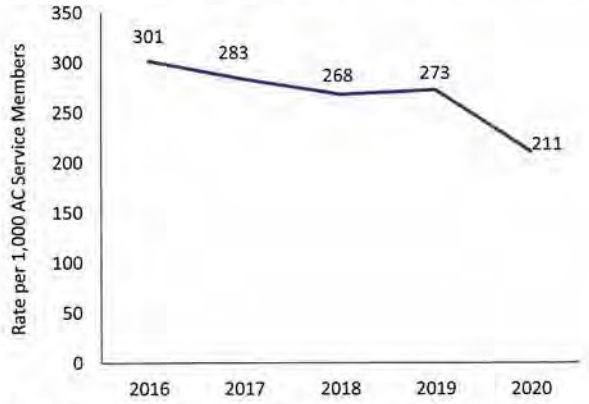
Body Region of Cumulative Traumatic Injury, Top Five Categories, AC Service Members, 2020

The trunk (43%) and lower extremity (34%) were the most common regions affected by cumulative traumatic injury.



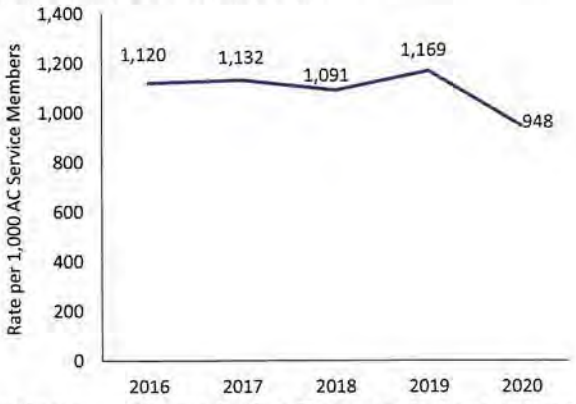
Incidence of Acute Injury, AC Service Members, 2016–2020

The rate of acute injuries decreased from 301 per 1,000 to 211 per 1,000 (30%) between 2016 and 2020.



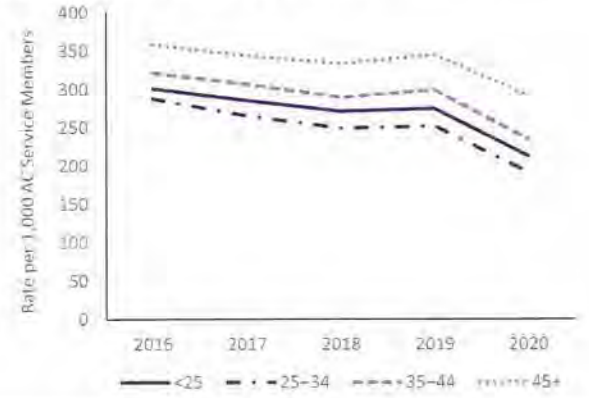
Incidence of Cumulative Traumatic Injury, AC Service Members, 2016–2020

The rate of cumulative traumatic injuries was similar between 2016 and 2019, but decreased from 1,169 per 1,000 to 948 per 1,000 (19%) between 2019 and 2020.



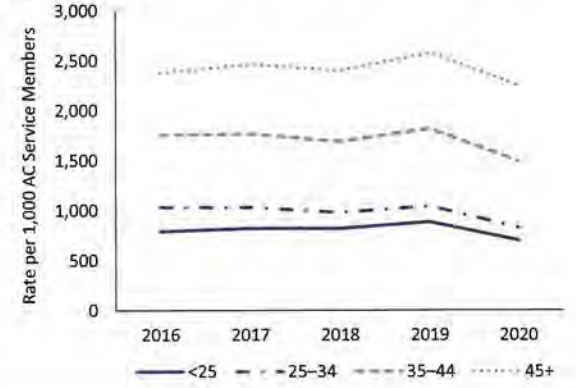
Incidence of Acute Injury by Age Group, AC Service Members, 2016–2020

The rate of acute injuries decreased among Service members in all age groups between 2016 and 2020.



Incidence of Cumulative Traumatic Injury by Age Group, AC Service Members, 2016–2020

The rate of cumulative traumatic injuries increased among Service members in all age groups between 2016 and 2019 before decreasing in 2020.



Traumatic Brain Injury

Traumatic brain injury (TBI) is structural alteration of the brain or physiological disruption of brain function caused by an external force.[9] TBI is the most common traumatic injury in the U.S. military and can be attributed to both deployment and non-deployment causes, including blast-related injuries, motor vehicle accidents, falls, contact sports, training activities, and combative actions.[10] The effects of TBI vary depending upon the severity of the injury and may include physical (headaches, sleep disturbances), cognitive (concentration and attention problems), and emotional (anxiety, depression) dysfunction. TBI can contribute to prolonged and permanent disability and may lead to military duty limitations or separation from service.

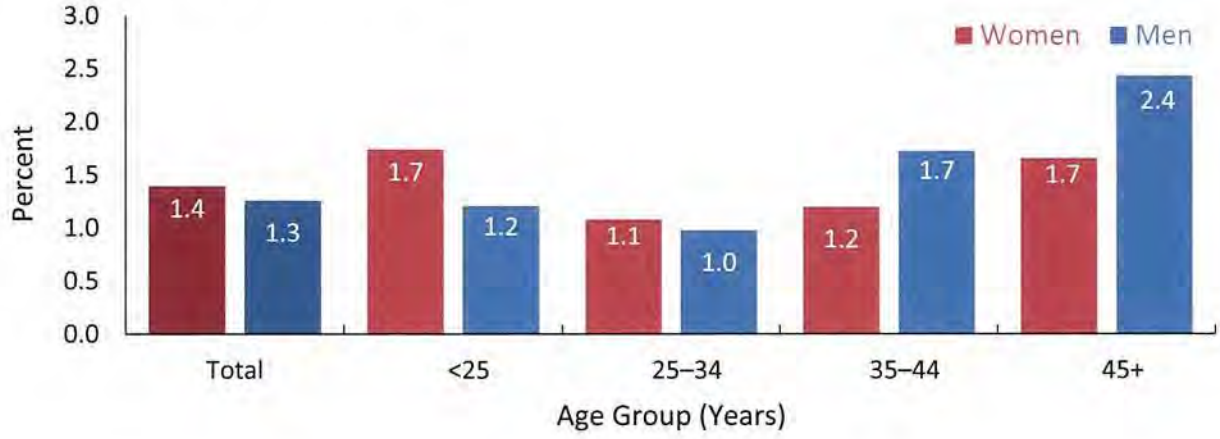
In 2020, a total of 16,914 AC Service members (1.3%) had medical encounters for TBI. Overall, similar percentages of male and female AC Service members had an encounter for TBI (1.3% and 1.4%, respectively). Male Service members aged 45 years or older (2.4%) were more than twice as likely to have an encounter for TBI as their counterparts aged 34 years or younger (1.1%). However, the percentage of female Service members with encounters for TBI did not increase with increasing age group. The association between increasing age and prevalence of TBI among male Service members may be related to these members seeking medical care at the end of their service in order to document their eligibility for Veterans disability compensation or follow-up medical care after separation, which could contribute to the identification of TBIs that were sustained earlier in service. Among those with TBI encounters, the most common severity was mild (74.5%) followed by moderate (24.7%), severe (0.5%), and penetrating (0.28%). **The annual prevalence of TBI remained stable from 2017 to 2019 and decreased slightly in 2020.**

A previous *MSMR* report evaluating TBI diagnoses from 2001 to 2016 found that incidence rates were highest among those aged 24 years or younger and among Service members in the Army or Marine Corps.[11] Prevention, awareness, and education about mild TBI is important since many TBIs are sustained as a result of non-combat related activities such as motor vehicle crashes or sports injuries.[10] Early detection, diagnosis, and treatment of mild TBIs will result in the best clinical outcome and help to prevent long-term neurological injury.

Overall, 1.3% of AC Service members had an encounter for TBI in 2020.
Rates ranged from 0.7% to 2.4% across Services.

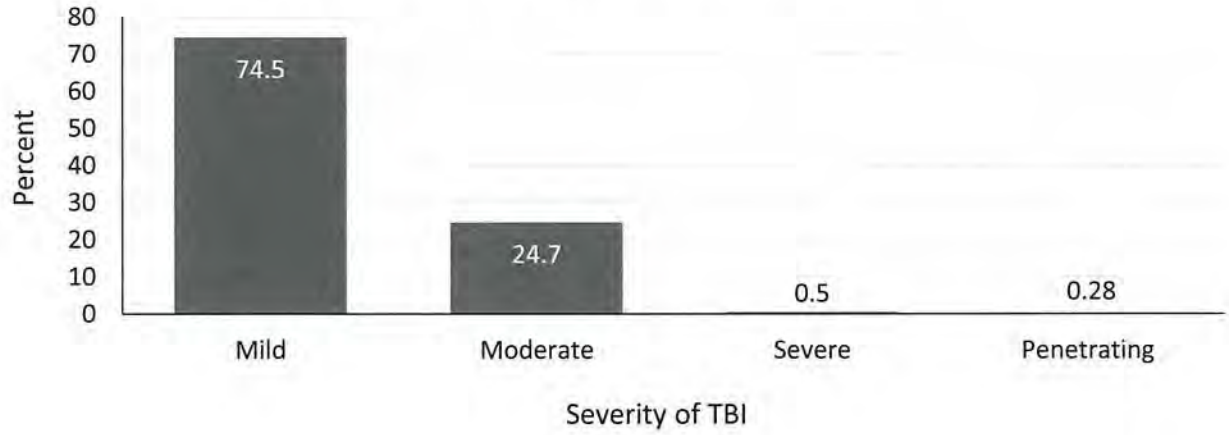
Prevalence of TBI by Sex and Age Group, AC Service Members, 2020

Among male Service members, those aged 45 years or older were more likely to have an encounter for TBI than those in younger age groups. Among female Service members, those in the youngest and the oldest age groups were more likely to have an encounter for TBI compared to those in intermediate age groups.



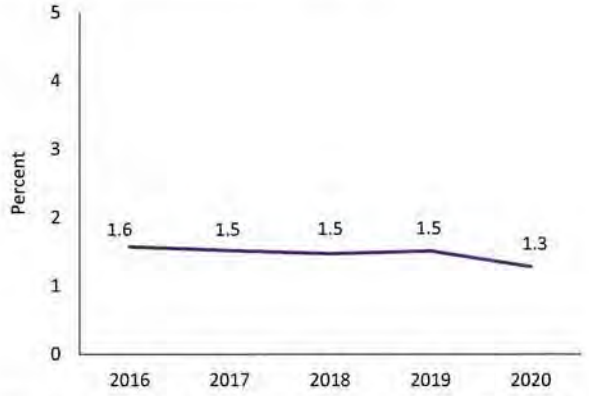
Severity of TBI, AC Service Members, 2020

Mild TBI was the most commonly diagnosed severity, accounting for 75% of all TBI diagnoses.



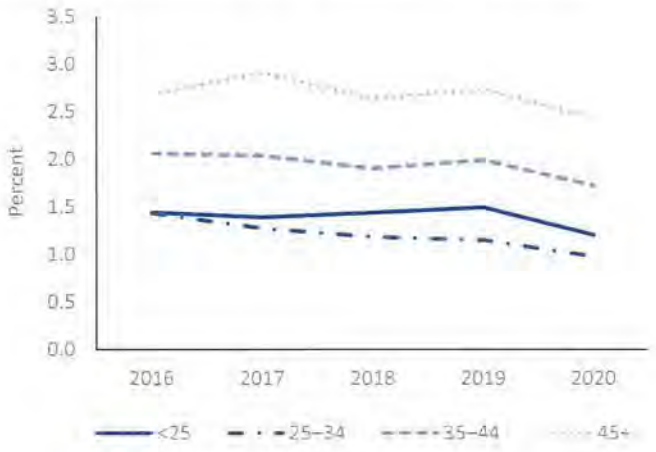
Prevalence of TBI, AC Service Members, 2016–2020

The prevalence of TBI remained relatively stable between 2016 and 2019 but decreased slightly in 2020.



Prevalence of TBI by Age Group, Male AC Service Members, 2016–2020

Between 2016 and 2020, the percentages of male Service members who had encounters for TBI decreased in all age groups.



Prevalence of TBI by Age Group, Female AC Service Members, 2016–2020

Between 2016 and 2020, the percentages of female Service members who had encounters for TBI remained stable for those less than 45 years old and decreased slightly for those aged 45 years or older.

Noise-induced Hearing Injury

Noise-induced hearing injury refers to acoustic trauma that can be caused by single exposure to an intense "impulse" sound such as an explosion or weapons fire, or by continuous or intermittent noise exposure over an extended period of time. Steady state exposures include military vehicles and aircraft, military equipment, and tools found in both military and civilian industrial environments.[12] Service members may also experience harmful noise exposure from recreational sources including motorcycles, target shooting and hunting, snowmobiles, and power tools.[13] Noise-induced hearing injury can significantly affect the health and operational effectiveness of Service members. Epidemiological estimates suggest that noise-induced hearing injuries are a growing problem among military personnel as well as the general population.[14] The Veteran's Benefits Administration reported that auditory disabilities were the second-most common service-related disability type among veterans in 2020, accounting for 13% of all disabilities.[15] Common types of noise-induced hearing injuries include tinnitus, a ringing or buzzing noise in one or both ears, and sensorineural hearing loss, which is hearing loss caused by damage to the inner ear. It should be noted that sensorineural hearing loss is typically considered a form of noise-induced hearing loss; however, for the purposes of this report, the two conditions are defined separately.

In 2020, a total of 53,958 AC service members (4.1%) had medical encounters for noise-induced hearing injuries. The prevalence of noise-induced hearing injuries was higher among male compared to female Service members (4.4% and 2.7%, respectively). Service members in the oldest age group had the highest prevalence of noise-induced hearing injuries in both sexes. Tinnitus (2.4%) was the most common specific noise-induced hearing injury sustained by service members in 2020, followed by sensorineural hearing loss (1.6%). **The annual prevalence of noise-induced hearing injuries decreased slightly between 2016 and 2020.**

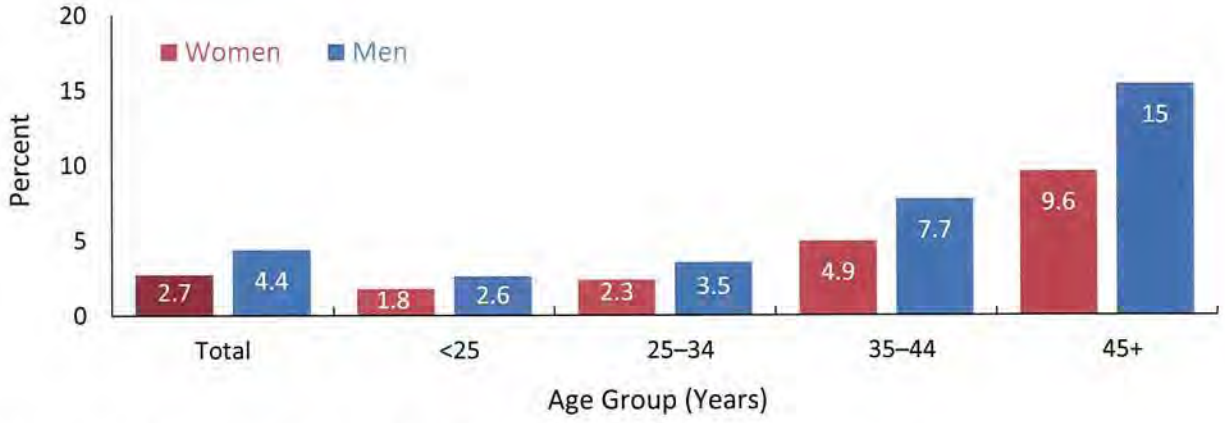
Previous studies have shown that rates of noise-induced hearing injuries are higher among male Service members, those 40 years or older, and those in combat-related occupations.[16] Hearing injuries can be reduced or prevented by the use of and compliance with hearing protection devices, distance and physical barriers to noise exposure, and follow-up audiological tests.[17,18]

Overall, 4.1% of AC Service members had medical encounters for noise-induced hearing injuries in 2020. Rates ranged from 2.7% to 5.2% across Services.

Army Navy Marine Corps Air Force

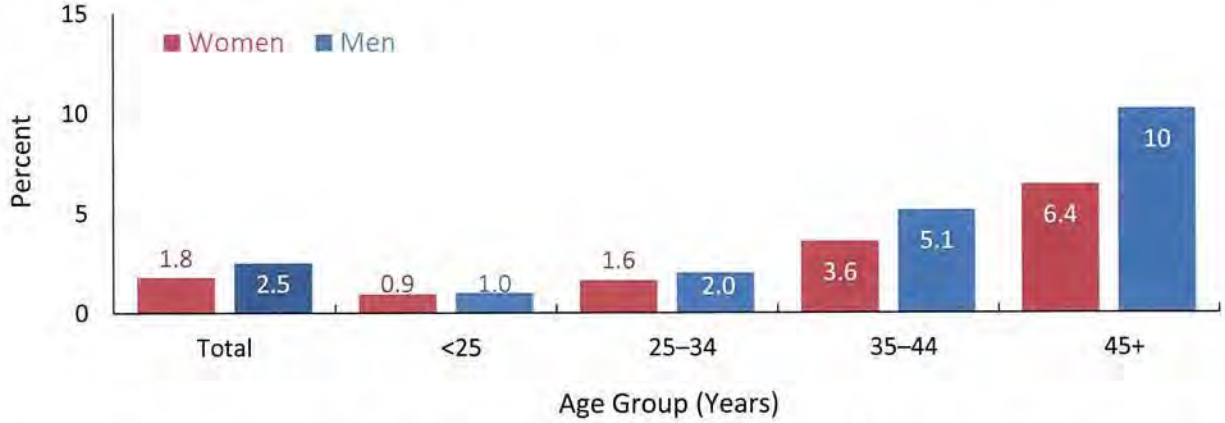
Prevalence of Noise-induced Hearing Injury by Sex and Age Group, AC Service Members, 2020

The prevalence of noise-induced hearing injuries was higher among male (4.4%) compared to female Service members (2.7%) and increased with increasing age in both sexes.



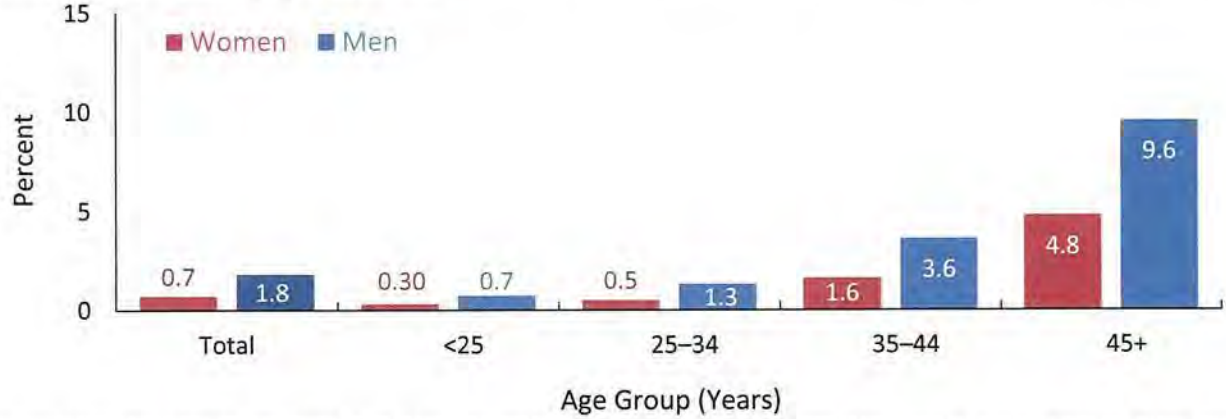
Prevalence of Tinnitus by Sex and Age Group, AC Service Members, 2020

The prevalence of tinnitus was higher among males (2.5%) compared to female Service members (1.8%), and the prevalence increased with increasing age in both sexes.



Prevalence of Sensorineural Hearing Loss[a] by Sex and Age Group, AC Service Members, 2020

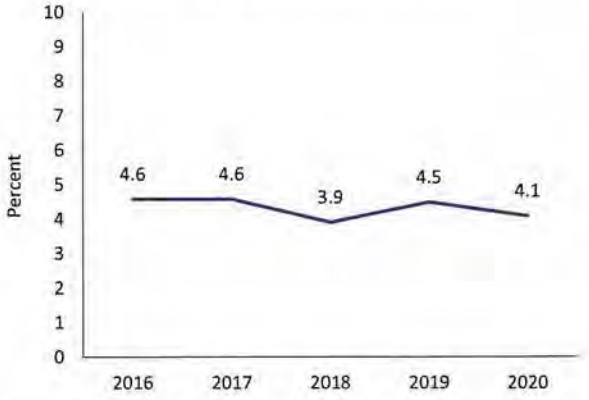
The prevalence of sensorineural hearing loss was higher among males (1.8%) compared to female Service members (0.7%), and prevalence increased with increasing age in both sexes.



[a]Sensorineural hearing loss is typically considered a form of noise-induced hearing loss; however, for the purposes of this report, the two conditions are defined separately.

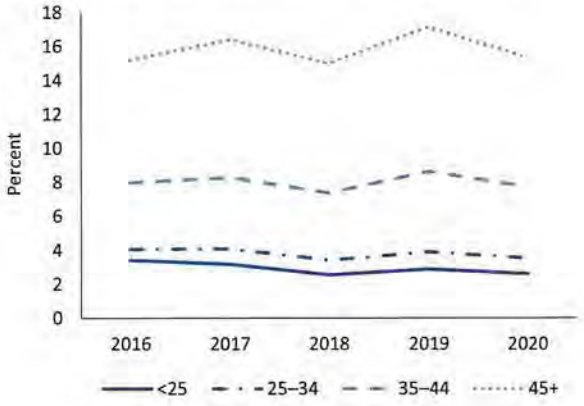
Prevalence of Noise-induced Hearing Injury, AC Service Members, 2016–2020

The prevalence of noise-induced hearing injuries among Service members decreased slightly between 2016 and 2020.



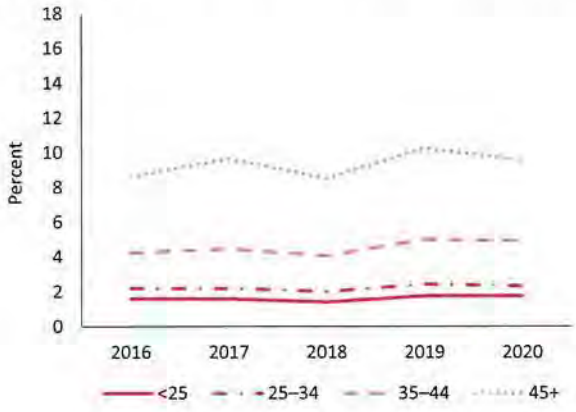
Prevalence of Noise-induced Hearing Injury by Age Group, Male AC Service Members, 2016–2020

Between 2016 and 2020, the prevalence of noise-induced hearing injuries decreased slightly among male Service members less than 45 years old.



Prevalence of Noise-induced Hearing Injury by Age Group, Female AC Service Members, 2016–2020

Between 2016 and 2020, the prevalence of noise-induced hearing injuries increased slightly among female Service members 35 years or older.



Heat Illness

Heat illness refers to a group of disorders that occur when the elevation of core body temperature surpasses the compensatory limits of thermoregulation. The Armed Forces routinely perform surveillance for the most common of these disorders, namely heat exhaustion and heat stroke. Heat exhaustion is caused by the inability to maintain adequate cardiac output because of strenuous physical exertion and environmental heat stress and is often accompanied by acute dehydration. Heat stroke is a debilitating illness characterized clinically by severe hyperthermia (i.e., a core body temperature of 104°F/40°C or greater), profound central nervous system dysfunction (e.g., delirium, seizures, or coma), and additional organ and tissue damage. The onset of heat stroke requires aggressive clinical treatments including rapid cooling and supportive therapies such as fluid resuscitation to stabilize organ function and prevent multiorgan system failure, which is the ultimate case of mortality due to heat stroke.

In 2020, a total of 1,667 AC Service members (0.13%) were diagnosed with heat exhaustion, and 476 (0.04%) were diagnosed with heat stroke. Overall, heat illnesses were more common among Service members under 25 years old, who accounted for 71% of all cases. Male Service members (0.17%) were slightly more affected by heat illnesses compared to female members (0.12%). **The percentages of AC Service members affected by heat exhaustion increased slightly between 2017 and 2018, leveled off in 2019, and then decreased between 2019 and 2020, while the percentages affected by heat stroke remained stable throughout the period.**

During 2020, 121 (25%) heat stroke cases were hospitalized and 22 (1.3%) heat exhaustion cases were hospitalized. These hospitalizations resulted in 349 total bed days for heat stroke and 44 total bed days for heat exhaustion.

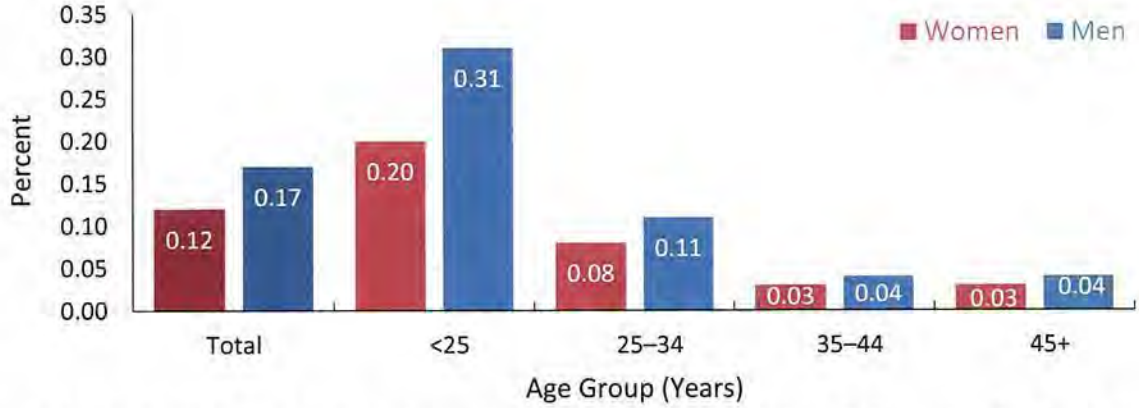
Rates of heat illness have previously been found to be highest among recruit trainees and those serving in combat specific occupational fields.[19] Efforts at preventing heat illnesses need to focus especially on these groups of Service members, who may engage in higher levels of demanding physical exertion during warm weather. In particular, trainees at basic training installations may not be acclimated to the heat or may not be physically fit.

Overall, 0.16% of AC Service members had a heat illness in 2020.

Rates ranged from 0.04% to 0.35% across Services.

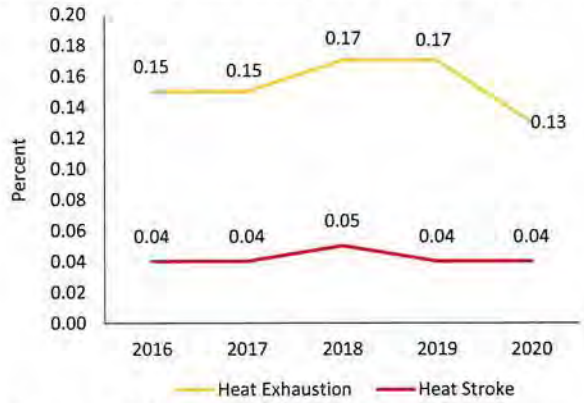
Incidence of Heat Illness by Sex and Age Group, AC Service Members, 2020

Younger Service members had higher incidence of heat illness compared to older members, and males had higher incidence compared to females.



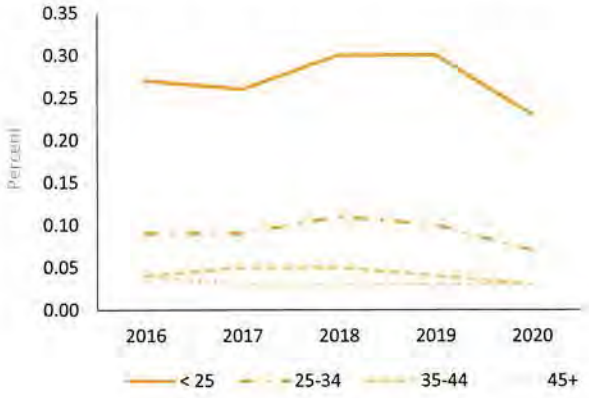
Incidence of Heat Stroke and Heat Exhaustion, AC Service Members, 2016–2020

The percentages of Service members affected by heat exhaustion increased slightly between 2017 and 2018, leveled off in 2019, and then decreased in 2020, while the percentages who experienced heat stroke remained stable during the five-year period.



Incidence of Heat Exhaustion by Age Group, AC Service Members, 2016–2020

The percentages of Service members under 25 years old who experienced heat exhaustion increased slightly between 2017 and 2018, leveled off in 2019, and then decreased in 2020.



Incidence of Heat Stroke by Age Group, AC Service Members, 2016–2020

The percentages of Service members from all age groups who experienced heat stroke remained relatively stable between 2016 and 2020.

Behavioral Health

Like injury, behavioral health (BH) conditions are a leading cause of morbidity among AC Service members, accounting for over 2 million (11% of total) outpatient encounters and nearly 18,000 inpatient encounters (29% of total) in 2020.[20,21]

To determine the proportion of AC Service members (including those who were deployed) with a BH diagnosis during a given 12-month period, the annual prevalence of BH conditions was calculated. A Service member was identified as having a BH disorder if they had at least two inpatient, outpatient, or in-theater encounters for a BH condition of any type within 365 days with at least one of the diagnoses occurring during 2020.[6]

Prevalence estimates of specific BH conditions (adjustment disorders, alcohol-related disorders, substance-related disorders, anxiety disorders, bipolar disorder, depressive disorder, psychoses, and posttraumatic stress disorder [PTSD]) during 2020 were also calculated.[22] To be considered a case, two encounters for the same BH condition within a 365-day period were required.

To determine the proportion of AC Service members that had ever been diagnosed with a BH condition, the "lifetime" prevalence of BH disorders was calculated. Service members on active duty during December 2020 were used for this analysis and were considered to have a lifetime history of a BH condition if they had two BH disorder diagnoses of the same type within 365 days at any time between 2002 and 2020.

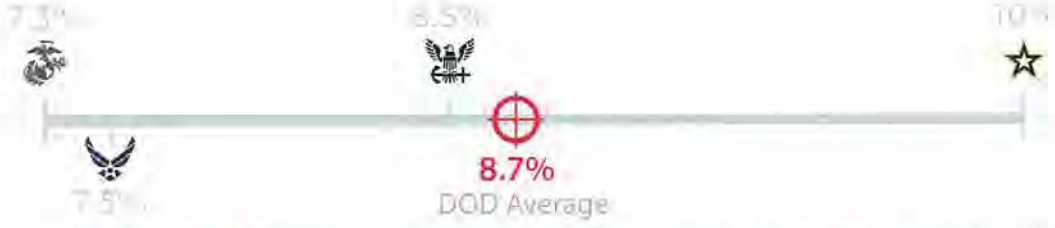
Overall, 8.7% of AC Service members had medical encounters for a BH disorder in 2020. The annual prevalence of BH disorders remained relatively stable from 2016 to 2020, fluctuating between 8.3% and 8.7%. Female Service members were more likely to have medical encounters for BH disorders (14%) when compared to male members (7.5%). Service members in the youngest age category (less than 25 years) had the highest prevalence of BH disorders in both sexes.

Almost 12% of Service members with any BH disorder were hospitalized, resulting in a total of 158,827 bed days in 2020. Cases of psychoses had the highest hospitalization rate (29%), followed by bipolar disorder (19%). However, cases of depressive disorders had the highest total number of bed days (46,350), followed by alcohol-related disorders (39,129).

Among both male and female AC Service members, adjustment disorder was the leading BH diagnosis in 2020 followed by anxiety disorder and depressive disorder.

Among AC Service members on active duty during December 2020, 27% of female and 16% of male members (18% overall) had a history (lifetime prevalence) of a BH disorder. The lifetime prevalence of BH disorders ranged from 11% to 21% across Services.

A previous *MSMR* report looking at trends of BH diagnoses between 2007 and 2016 found incidence of most BH conditions to be higher in female Service members, except for alcohol- and substance-related disorders which were higher in male members.[23] The *MSMR* report also found the incidence of several BH conditions to be higher among Army members and those in motor transport occupations. To provide help for Service member with BH issues or concerns, the MHS offers several resources including free hotlines (e.g., Military OneSource, DoD Safe Helpline, Military Crisis Line),[24] outreach centers (e.g., Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury Outreach Center), and connections to additional support programs (e.g., National Resource Directory).



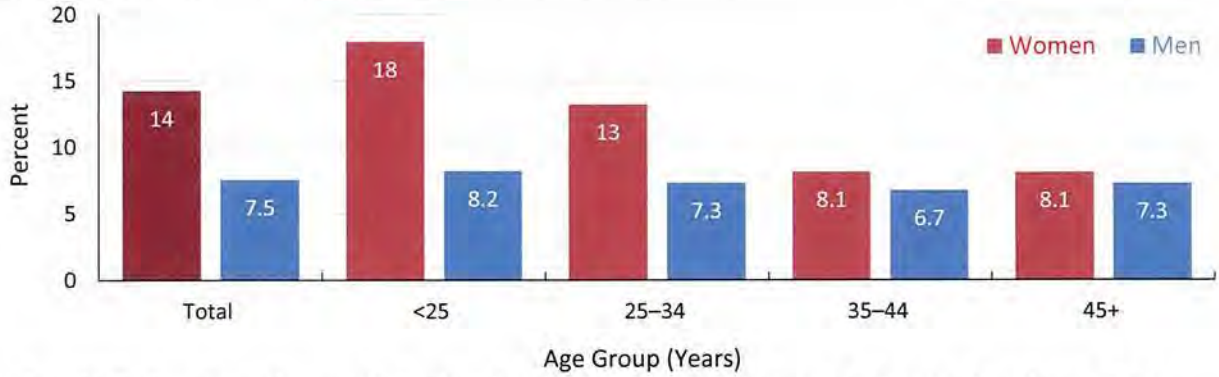
Overall, 8.7% of AC Service members had an encounter for a BH disorder in 2020.

Rates ranged from 7.3% to 10% across Services.

Army Navy Marine Corps Air Force

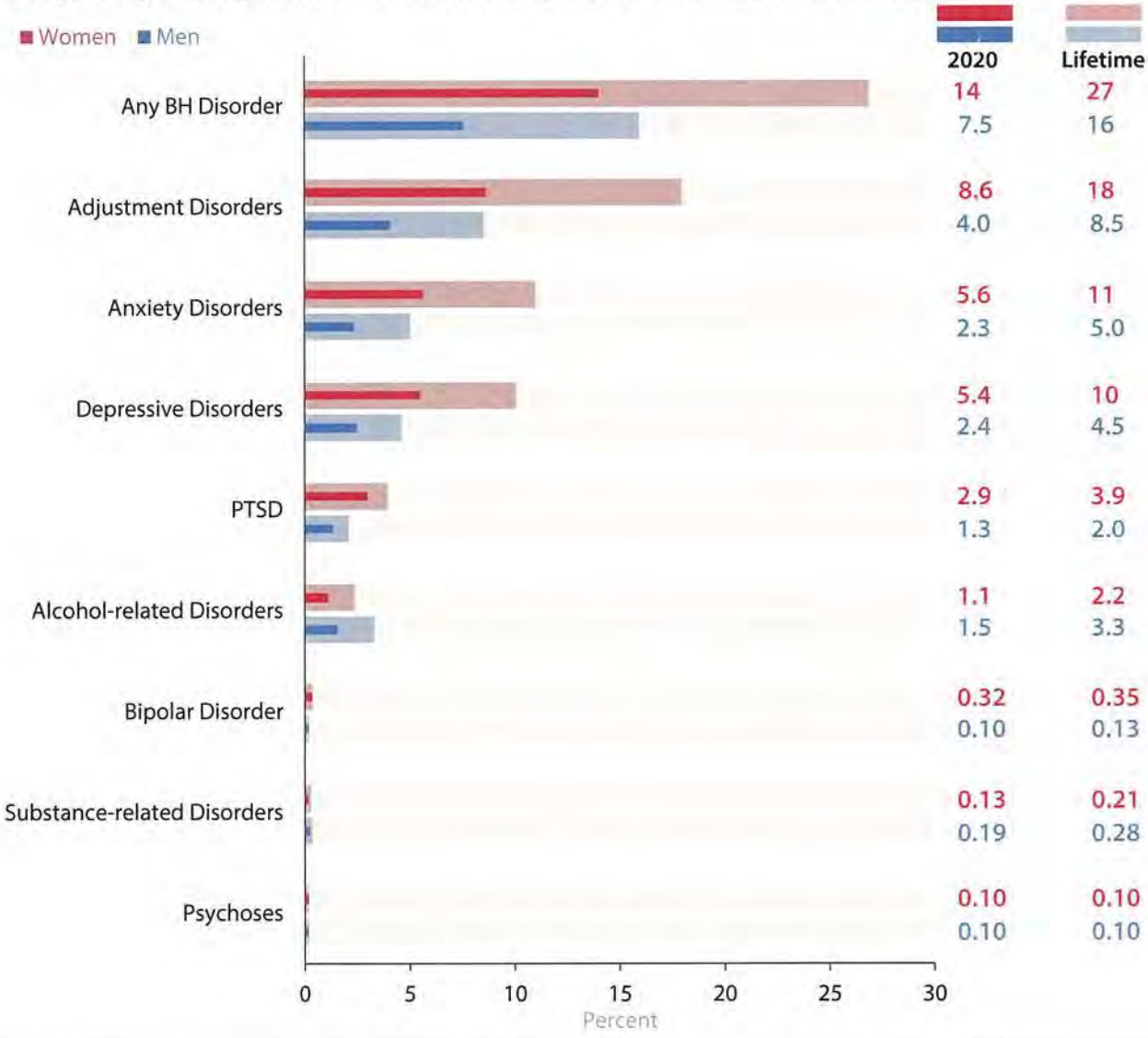
Prevalence of BH Disorders by Sex and Age Group, AC Service Members, 2020

Female Service members were more likely to be diagnosed with BH disorders compared to male members, and those in the youngest age group were more likely to be diagnosed compared to older Service members.



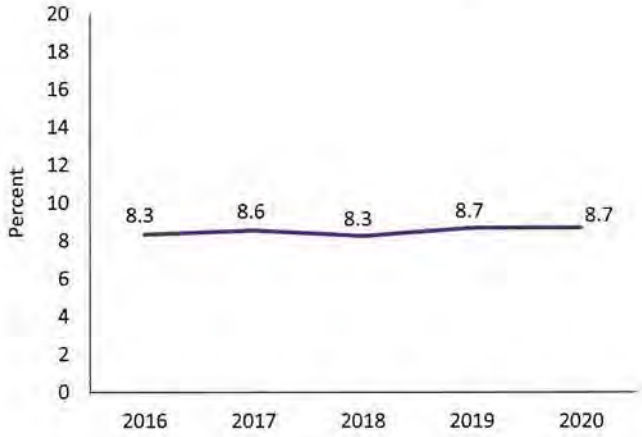
Annual and Lifetime Prevalence of BH Disorders by Sex and Condition, AC Service Members, 2020

Overall, 18% of Service members (27% of female and 16% of male members) received diagnoses of a BH disorders between 2002 and 2020. The percentages were higher for female compared to male Service members for most BH disorders.



Prevalence of BH Disorders, AC Service Members, 2016–2020

The prevalence of BH disorders remained relatively stable between 2016 and 2020.

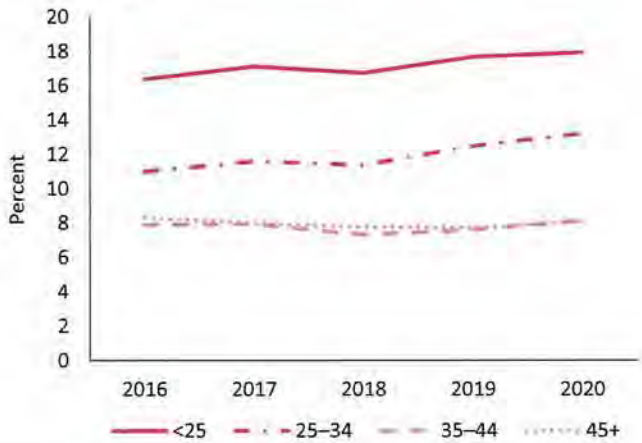


Prevalence of BH Disorder by Age Group, Male AC Service Members, 2016–2020

Between 2016 and 2020, the prevalence of BH disorders remained relatively stable among male Service members in all age groups.

Prevalence of BH Disorder by Age Group, Female AC Service Members, 2016–2020

The prevalence of BH disorders increased slightly between 2016 and 2020 among female Service members under age 34, and remained relatively stable for those in the oldest age groups.



Sexually Transmitted Infections

Sexually transmitted infections (STIs) are relevant to Service members because of their relatively high incidence, adverse impact on individual readiness, and potential for serious medical sequelae if left untreated.[25] Two of the most common bacterial STIs are caused by *Chlamydia trachomatis* (chlamydia) and *Neisseria gonorrhoeae* (gonorrhea). Trichomoniasis, caused by the parasite *Trichomonas vaginalis,* is another common STI. The overall incidence and time trends related to these three STIs (chlamydia, gonorrhea, and trichomoniasis) among AC Service members in 2020 are reported here.

In 2020, 25 per 1,000 AC Service members were diagnosed with or tested positive for one of the three STIs. Female Service members had higher rates of STIs compared to male members, particularly among the younger age groups. **Chlamydia was most common (21 per 1,000), followed by gonorrhea (3.7 per 1,000) and trichomoniasis (0.7 per 1,000).** Among both male and female Service members, STIs were most common in the youngest age groups. AC Service members less than 25 years of age were almost three times more likely to have an STI compared to those aged 25–34 years.

The annual incidence rates of chlamydia and gonorrhea among AC Service members increased between 2016 and 2019, but decreased from 2019 to 2020. These trends were primarily attributed to Service members under age 25. Rates of trichomoniasis decreased between 2016 and 2020.

Previous studies have demonstrated increases in the incidence rates of chlamydia and gonorrhea among AC Service members during the past five years,[25] with consistently higher rates among female Service members. The decline in STI rates in 2020 is likely related to the COVID-19 pandemic, since there were limitations on appointments during this time and Service members may have avoided coming in for appointments. The pandemic may have also caused a temporary reduction in sexual risk behaviors as sexual networks may have been limited as a result of social distancing recommendations. However, at the time of the analysis, no data were available to test this hypothesis. Higher rates of most STIs among female compared to male Service members can likely be attributed to implementation of the Services' screening programs. Continued behavioral risk reduction interventions are needed to counter the increasing incidence of some STIs and maintain any decreases.

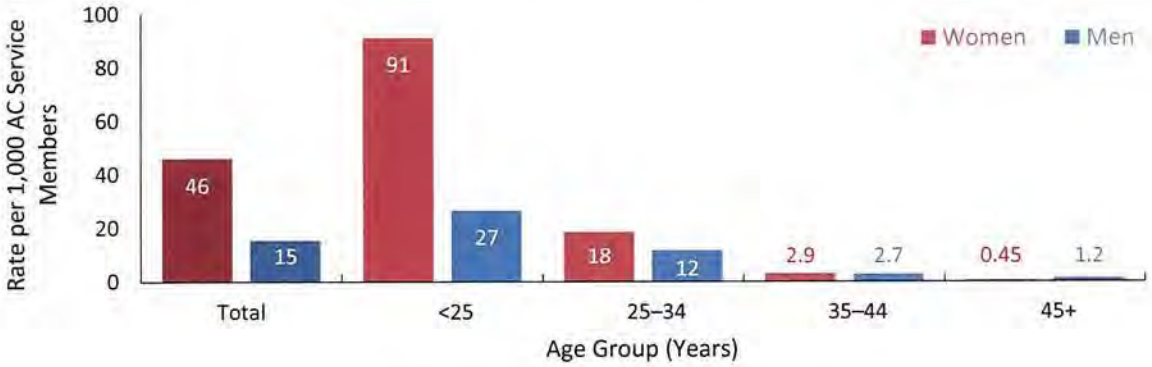
Overall, there were 25 cases of STIs (chlamydia, gonorrhea, or trichomoniasis) per 1,000 AC Service members in 2020.

Rates ranged from 19 per 1,000 to 30 per 1,000 across Services.

Army | Navy | Marine Corps | Air Force

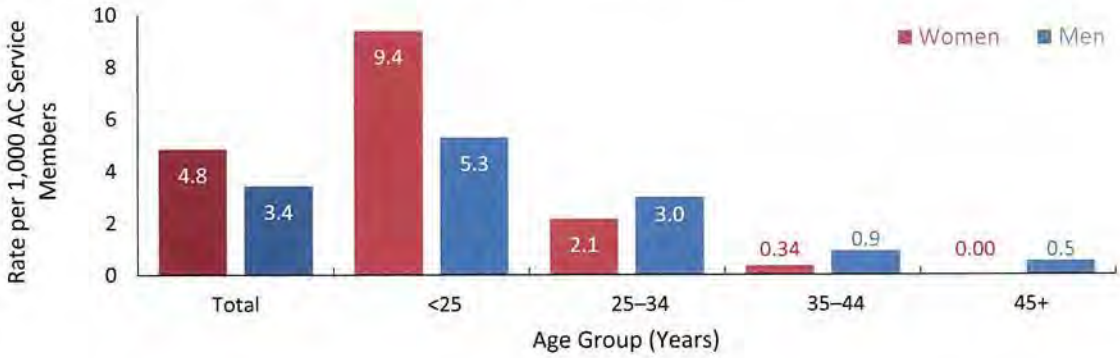
Incidence of Chlamydia by Sex and Age Group, AC Service Members, 2020

In 2020, female Service members had higher rates of chlamydia compared to male members, particularly among those in younger age groups.



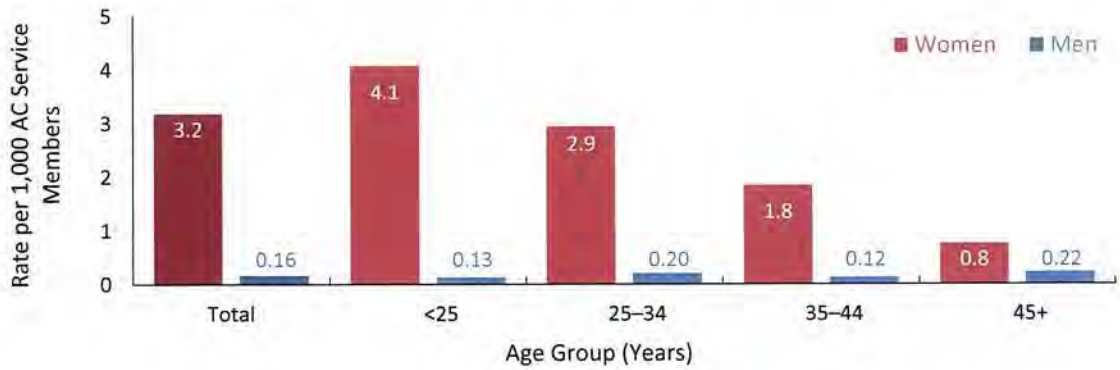
Incidence of Gonorrhea by Sex and Age Group, AC Service Members, 2020

In 2020, female Service members had higher overall rates of gonorrhea compared to male members; this difference was driven by those in the youngest age group.



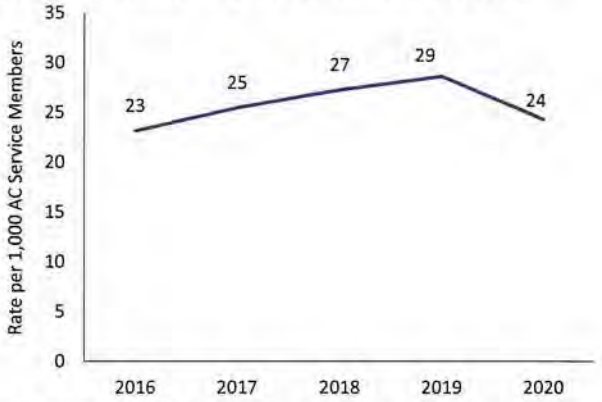
Incidence of Trichomoniasis by Sex and Age Group, AC Service Members, 2020

Overall, female Service members had higher rates of trichomoniasis compared to male members.



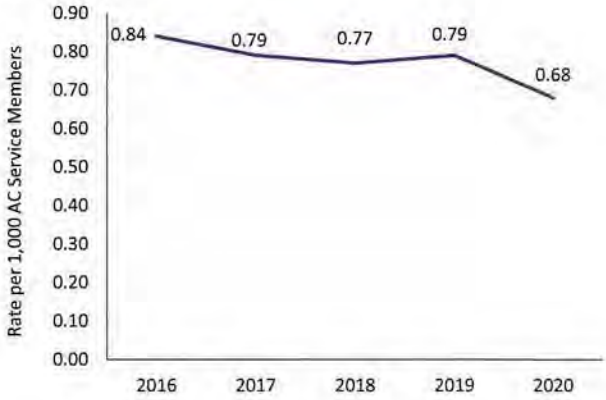
Incidence of Chlamydia and Gonorrhea, AC Service Members, 2016–2020

The incidence of chlamydia and gonorrhea increased from 2016 to 2019, and decreased slightly between 2019 and 2020.



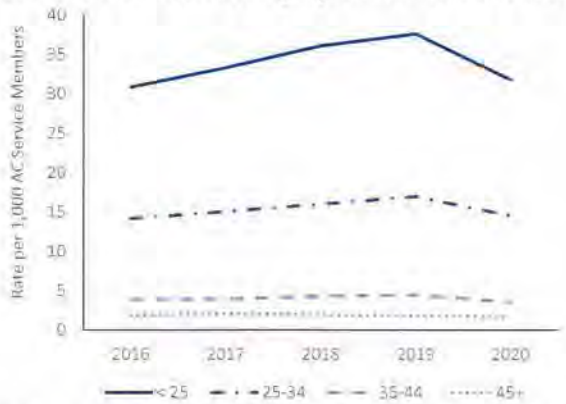
Incidence of Trichomoniasis, AC Service Members, 2016–2020

The incidence of trichomoniasis decreased between 2016 and 2020.



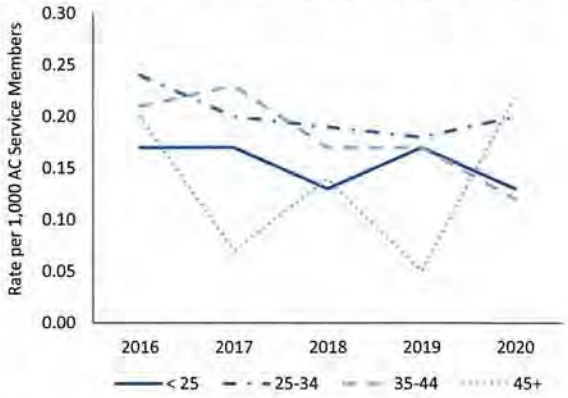
Incidence of Chlamydia and Gonorrhea by Age Group and Sex, AC Male Service Members, 2016–2020

Among male Service members in the youngest age groups, the incidence of chlamydia and gonorrhea increased between 2016 and 2019 and then decreased slightly between 2019 and 2020.



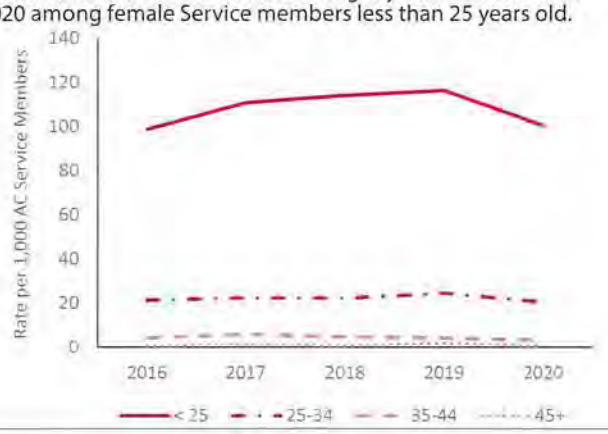
Incidence of Trichomoniasis by Age Group, AC Male Service Members, 2016–2020

The incidence of trichomoniasis decreased between 2016 and 2020 among male Service members less than 35 years old.



Incidence of Chlamydia and Gonorrhea by Age Group and Sex, AC Female Service Members, 2016–2020

The incidence of chlamydia and gonorrhea increased between 2016 and 2019 and then decreased slightly between 2019 and 2020 among female Service members less than 25 years old.



Incidence of Trichomoniasis by Age Group, AC Female Service Members, 2016–2020

Between 2016 and 2020, the incidence of trichomoniasis decreased among female Service members under 45 years old. Among those 45 years or older, the incidence of trichomoniasis increased from 2016 to 2019 and then decreased between 2019 and 2020.

Sleep Disorders

The American Academy of Sleep Medicine recommends at least seven hours of sleep per night for adults aged 18–60 years.[26] Lack of sleep can impair cognitive function, decreasing performance and increasing the risk for injury and accidents. Insufficient sleep is also associated with a number of chronic diseases including diabetes, heart disease, obesity, and depression.[27] The overall prevalence and time trends related to sleep disorders (including sleep apnea, insomnia, hypersomnia, circadian rhythm disorders, narcolepsy, parasomnia, and sleep-related movement disorders) among AC Service members in 2020 are reported here, along with the prevalence of the most commonly diagnosed sleep disorders.

In 2020, 12% of AC Service members had a medical encounter for at least one sleep disorder. Proportions were similar for male and female Service members (13% and 11%, respectively). **The most commonly diagnosed sleep disorders were sleep apnea and insomnia (6.8% and 4.5%, respectively).** Male Service members were more likely to have an encounter for sleep apnea than female members (7.6% and 3.2%, respectively), while a greater percentage of female than male Service members had a medical encounter for insomnia (6.3% and 4.1%, respectively).

The prevalence of sleep disorders among AC Service members remained relatively stable during 2016–2020. However, the prevalence of sleep disorders among male Service members 45 years or older increased slightly from 45% in 2016 to 49% in 2020.

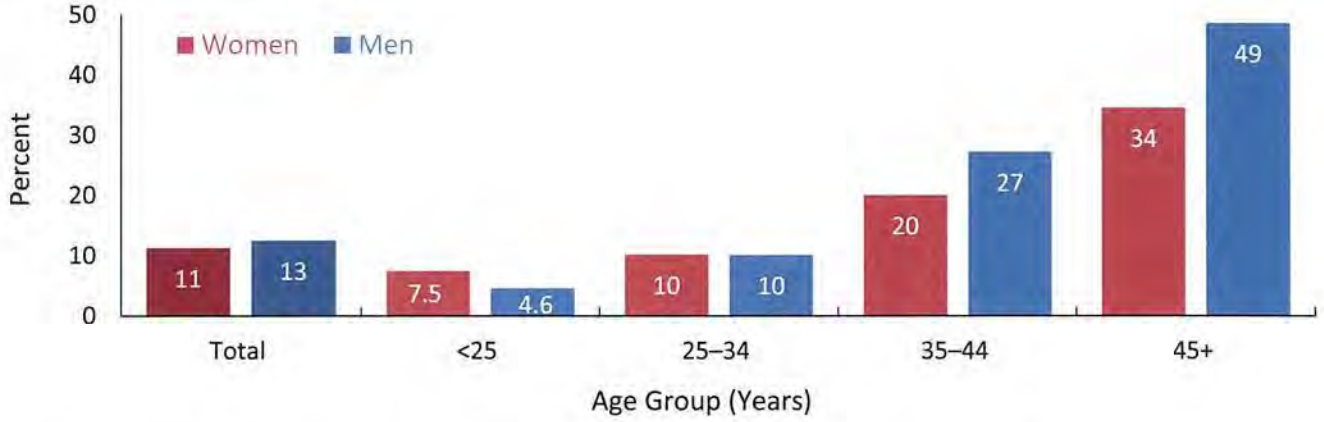
Previous studies have demonstrated increases in the incidence rates of some conditions, including sleep disorders, when comparing rates during the early, middle, and last phases of Service members' careers.[12] These increases were independent of age and thought to be due in part to increased reporting during separation and retirement physicals.[28] The impact of career phase was not evaluated here and may be important to consider in the future.

Overall, 12% of AC Service members had a sleep disorder in 2020.
Rates ranged from 6.9% to 16% across Services.

Army Navy Marine Corps Air Force

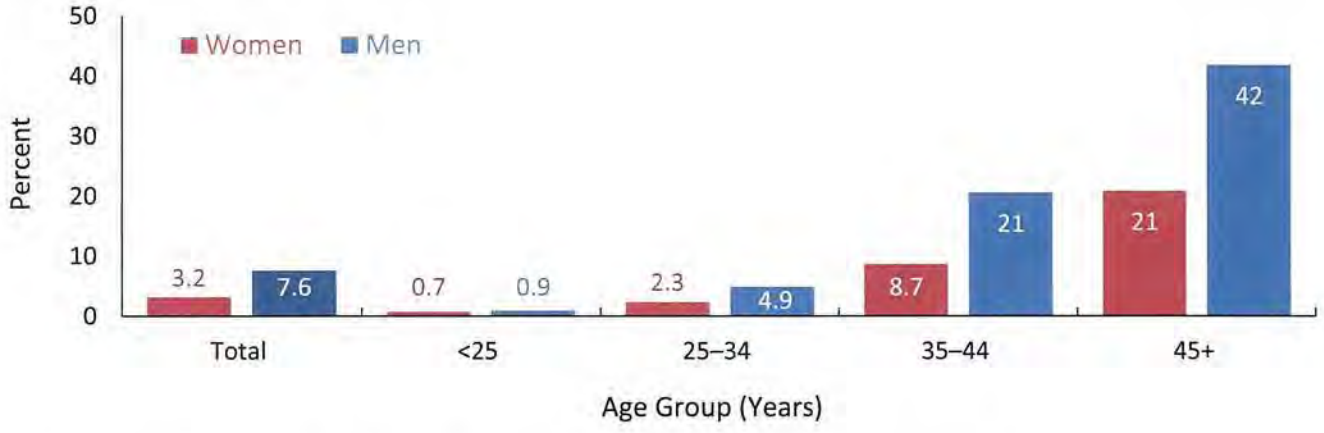
Prevalence of Sleep Disorders by Sex and Age Group, AC Service Members, 2020

The prevalence of sleep disorders was similar among male (13%) and female Service members (11%) and increased with increasing age among both sexes.



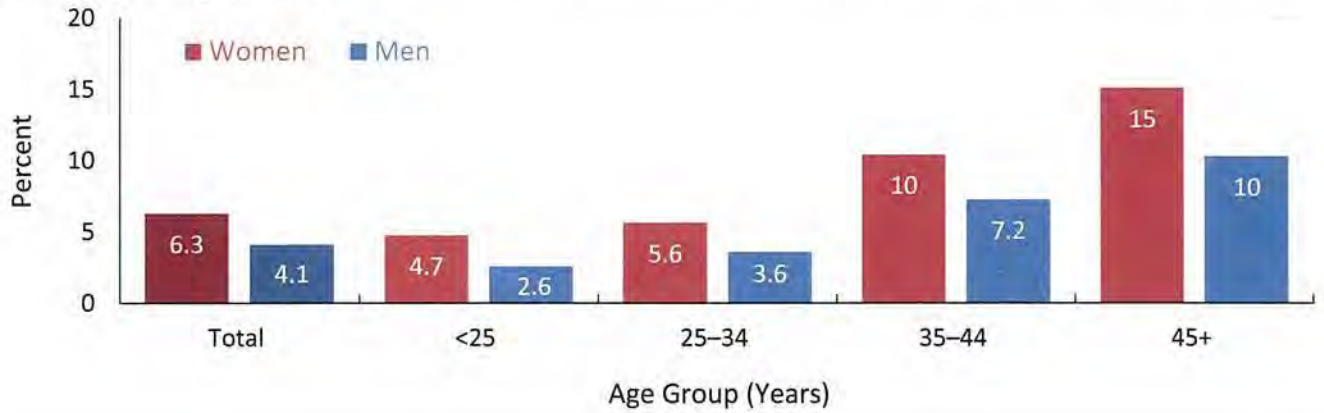
Prevalence of Sleep Apnea by Sex and Age Group, AC Service Members, 2020

The prevalence of sleep apnea was higher for male (7.6%) compared to female Service members (3.2%), and the prevalence increased with increasing age among both sexes.



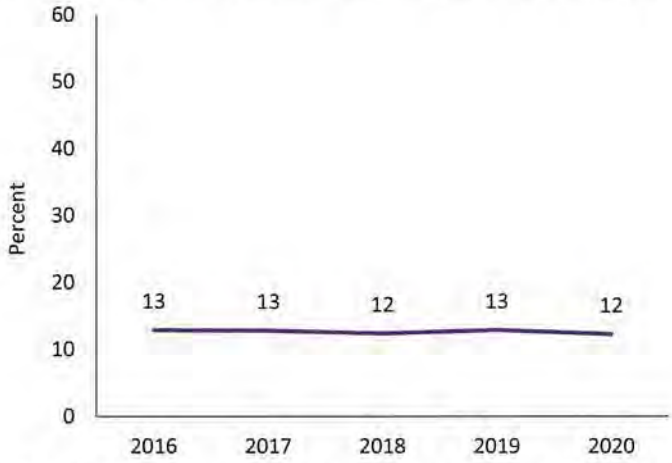
Prevalence of Insomnia by Sex and Age Group, AC Service Members, 2020

The prevalence of insomnia was higher for female (6.3%) compared to male Service members (4.1%), and the prevalence increased with increasing age among both sexes.



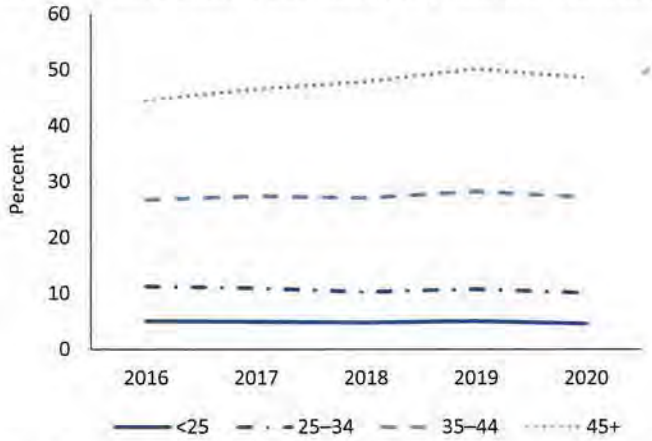
Prevalence of Sleep Disorders, AC Service Members, 2016–2020

The prevalence of sleep disorders among Service members remained relatively stable between 2016 and 2020.



Prevalence of Sleep Disorders by Age Group, Male AC Service Members, 2016–2020

The prevalence of sleep disorders among male Service members remained relatively constant for all age groups between 2016 and 2020, except for those 45 years or older, for whom prevalence increased slightly from 45% in 2016 to 49% in 2020.



Prevalence of Sleep Disorders by Age Group, Female AC Service Members, 2016–2020

Between 2016 and 2020, the prevalence of sleep disorders remained relatively stable among female Service members under 45 years old. Among those in the oldest age group, prevalence increased slightly between 2016 and 2019 and then decreased slightly in 2020.

Obesity

Obesity negatively impacts physical performance and military readiness and is associated with long-term health problems such as hypertension, diabetes, coronary heart disease, stroke, cancer, and risk for all-cause mortality. Studies also suggest that health care utiliza-tion is higher among obese Service members than their normal-weight counterparts.[29]

The Clinical Data Repository (CDR) vital sign table and Genesis vitals table within the MHS Data Repository (MDR) were used to identify all records for AC Service members with a height and weight measurement available on the same day; pregnant Service members were excluded. Body mass index (BMI) was calculated utilizing the latest height and weight record in a given year. In accordance with the Centers for Disease Control and Prevention (CDC), a BMI ≥30 was considered obese.[30]

The overall prevalence of obesity among AC Service members was 19% in 2020. Obesity rates were higher among male (20%) compared to female Service members (15%). The lowest prevalence of obesity was in Service members less than 25 years old (11%) and the highest was among those aged 35–44 years (30%). **The overall prevalence of obesity increased slightly between 2016 and 2020.**

Prior studies have demonstrated an increasing trend of obesity among Service members in all branches and sociodemographic groups.[31,32] To combat this concerning rise, there should be an increased focus on evidence-based initiatives to reduce obesity such as programs to provide healthier food and beverage options on military bases, technology-based approaches to improving fitness, and sustainable weight management training and follow-up services.[33]

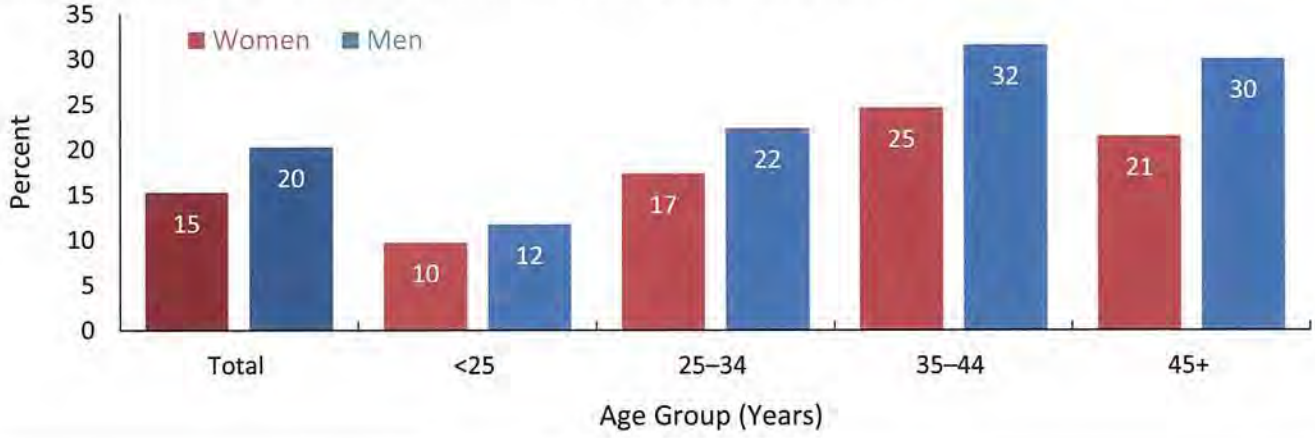
Overall, 19% of AC Service members were classified as obese in 2020.

Rates ranged from 9.8% to 25% across Services.

Army Navy Marine Corps Air Force

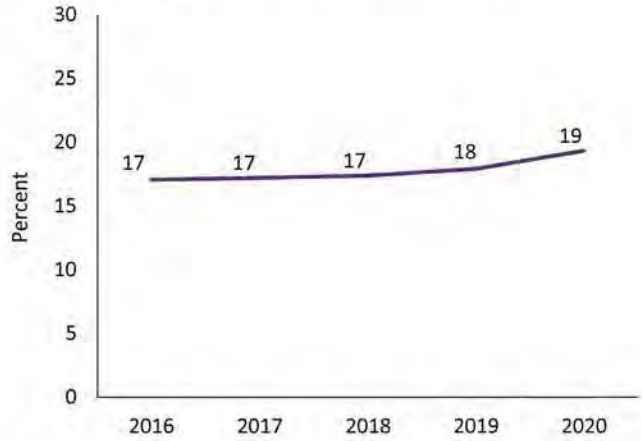
Prevalence of Obesity by Sex and Age Group, AC Service Members, 2020

Obesity rates were higher among male (20%) compared to female Service members (15%). The prevalence of obesity increased with increasing age through 35–44 years then decreased among those aged 45 years or older.



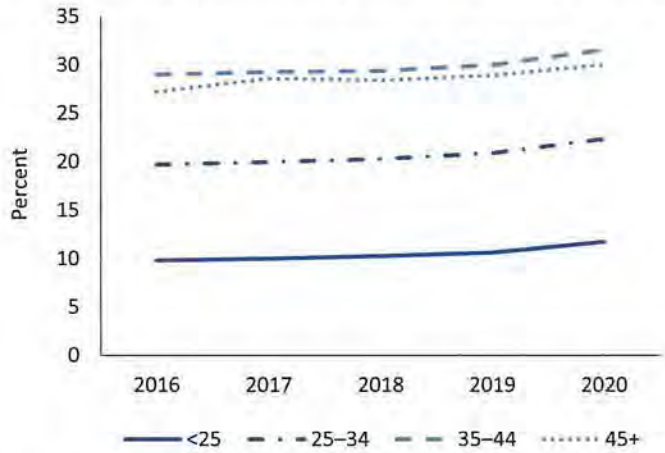
Prevalence of Obesity, AC Service Members, 2016–2020

The prevalence of obesity increased from 17% in 2016 to 19% in 2020.



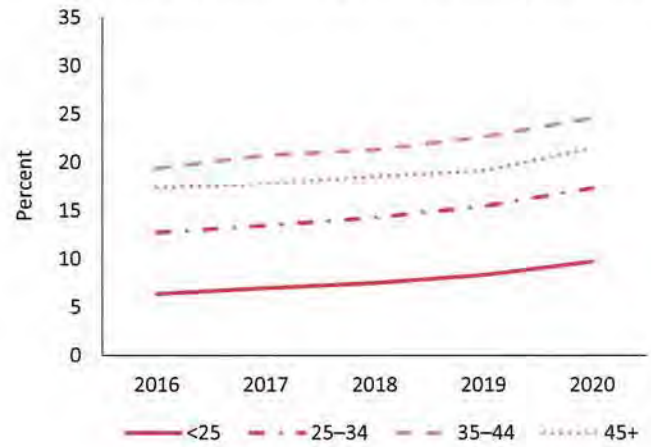
Prevalence of Obesity by Age Group, Male AC Service Members, 2016–2020

Between 2016 and 2020, the prevalence of obesity increased among male Service members in all age groups.



Prevalence of Obesity by Age Group, Female AC Service Members, 2016-2020

Between 2016 and 2020, the prevalence of obesity increased among female Service members in all age groups.



Acute Respiratory Illnesses

Outbreaks and epidemics of acute respiratory illnesses can have adverse effects on individual and military unit readiness. The Armed Forces have long recognized the special risks of respiratory illnesses among Service members who live in congregate settings, mix with Service members from other geographic regions, undergo the stresses of military training and operations, and travel to foreign countries. To counter the threat of such illnesses, the Armed Forces have for many years emphasized both preventive measures as well as continuous surveillance for respiratory infections. Vaccines are required for or offered to new Service members to prevent a variety of respiratory diseases caused by bacteria (diphtheria, pertussis, and meningococcal infections) and viruses (adenovirus, influenza, measles, mumps, rubella, varicella, and most recently, COVID-19). This report summarizes temporal trends of specific respiratory infections and syndromes as well as specific symptoms of respiratory illness. For this metric, data are also presented separately for recruits.

On average, 20 per 1,000 AC Service members were diagnosed with acute respiratory infections each month during 2020, with rates highest in March (39 per 1,000) and lowest in May (6.5 per 1,000). Female Service members had higher monthly rates of acute respiratory infections and respiratory symptoms compared to male members. Those in the youngest age category (less than 25 years old) had the highest rates of acute respiratory infections, but those in the oldest age group had the highest rate of respiratory symptoms. **Com-pared to AC Service members overall, recruits had higher average monthly rates of acute respiratory infections (53 per 1,000), but lower average rates of respiratory symptoms (9.3 per 1,000) in 2020.**

Monthly rates of respiratory infections among AC Service members remained relatively stable between 2016 and 2019, but decreased sharply in April 2020. Recruits had consistently higher rates of acute respiratory infections compared to AC Service members, with an even more pronounced decline in April 2020. The decline in April 2020 coincides with the beginning of the COVID-19 pandemic, when Military Treatment Facilities (MTFs) began limiting access to non-essential services.[34] The required use of face masks and social distancing likely also reduced rates of other respiratory infections besides COVID-19 during this time period. Monthly rates of respiratory symptoms were relatively stable among AC Service members between 2016 and 2019, but spiked in March 2020, again coinciding with the COVID-19 pandemic. Recruits had higher rates of respiratory symptoms compared to AC Service members throughout most of the period, except in 2020. **There were noteworthy patterns of seasonal increases (in winter) and declines (in summer) for both AC Service members overall and for recruits.**

A total of 270,314 Service members had at least one acute respiratory infection diagnosis in 2020. Of these Service members, 1,204 (0.5%) were hospitalized, resulting in 5,774 total bed days.

Rates among trainees were likely higher because of the spread of infections among trainees in congregate settings during basic training, strict requirements for sick trainees to receive medical care, and more thorough surveillance of trainees, including collection of specimens to identify etiologic pathogens. For both the trainees and AC service members, the rates of diagnoses of respiratory symptoms were considerably lower than the rates of specific acute respiratory illnesses. This observation indicates that health care providers recorded specific diagnoses much more often than nonspecific symptom diagnoses during encount-ers for acute respiratory illnesses.

On average, 20 per 1,000 AC Service member per month were diagnosed with acute respiratory infections in 2020.

Average monthly rates varied by Service and ranged from 18 to 23 per 1,000 AC Service members.

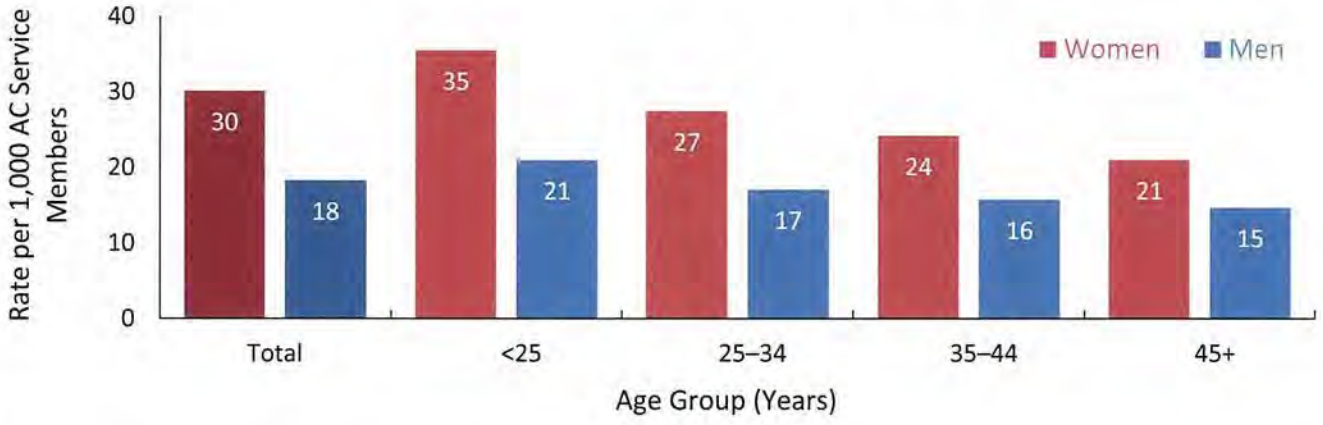
On average, 12 per 1,000 AC Service members per month were diagnosed with respiratory symptoms in 2020.

Average monthly rates varied by Service and ranged from 8.2 to 15 per 1,000 AC Service members.

Army Navy Marine Corps Air Force

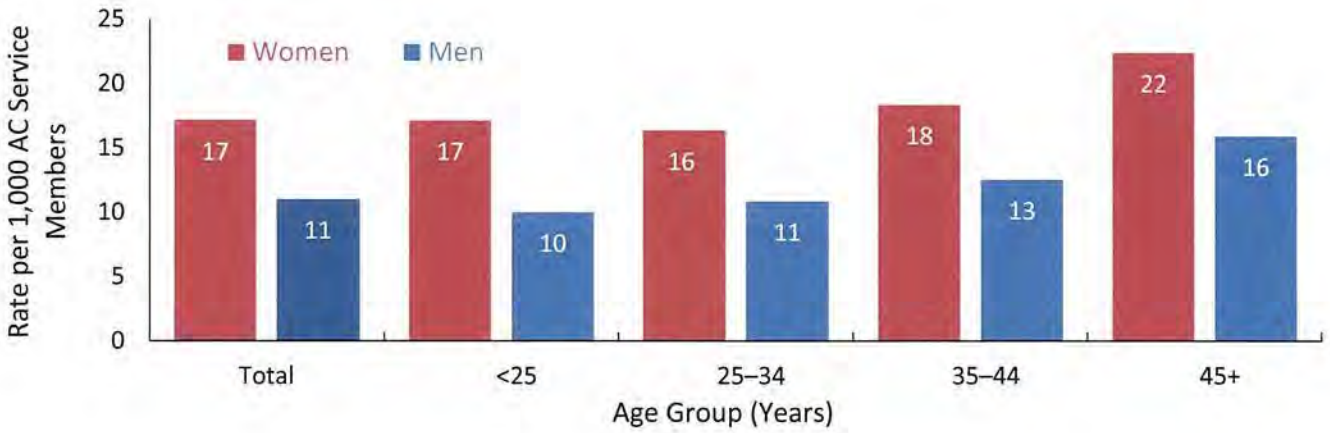
Average Monthly Incidence of Acute Respiratory Infections by Sex and Age Group, AC Service Members, 2020

Service members in the younger age groups had higher average monthly rates of acute respiratory infections than those in the older groups. Compared to male Service members, female members had higher rates within each age group.



Average Monthly Incidence of Respiratory Symptoms by Sex and Age Group, AC Service Members, 2020

Female Service members had higher rates of respiratory symptoms compared to male members. Rates were highest among Service members aged 45 years or older.



Incidence of Acute Respiratory Infections, AC Service Members and Recruit Trainees, 2016–2020

Monthly rates of respiratory infections among AC Service members remained relatively stable between 2016 and 2019, but declined in April 2020. Recruits had consistently higher rates of acute respiratory infections compared to AC Service members, with an even more pronounced decline in April 2020.

Incidence of Respiratory Symptoms, AC Service Members and Recruit Trainees, 2016–2020

Similar to acute respiratory infections, rates of respiratory symptoms displayed seasonal increases in winter months and declines in summer months. Monthly rates of respiratory symptoms were relatively stable among AC Service members between 2016 and 2019, spiked in March 2020, and then decreased through May 2020. Recruits had higher rates of respiratory symptoms compared to AC Service members throughout most of the period, except in 2020.

COVID-19

COVID-19 is an infectious disease caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). Continuous person-to-person spread of the virus has occurred worldwide since December 2019. On January 31, 2020, the U.S. Secretary of Health and Human Services declared a public health emergency in the U.S. in response to the spread of COVID-19.[35] COVID-19 spreads primarily through respiratory droplets produced when an infected person breathes, coughs or sneezes, and is more likely to infect people in close contact with one another. Infected individuals may be asymptomatic or experience mild to severe illness.[36] By the end of 2020, over 19.7 million cases had been reported domestically.[37] The COVID-19 pandemic has significantly affected military operations through movement restrictions, workspace capacity limits, and testing protocols for Service members.[38]

The overall incidence of reported or laboratory-confirmed COVID-19 infection was 5.9% in 2020. Female Service members (6.5%) had a higher incidence of COVID-19 infection compared to male members (5.8%). Younger Service members had a higher incidence of COVID-19 infection than those in older age groups.

A total of 412 (0.5%) AC Service members were hospitalized for COVID-19 in 2020, resulting in 2,512 total bed days. However, this is likely an underestimate since it relied on the diagnosis of COVID-19 using ICD-10 code U07.1, which did not become available until several weeks after the beginning of the pandemic.

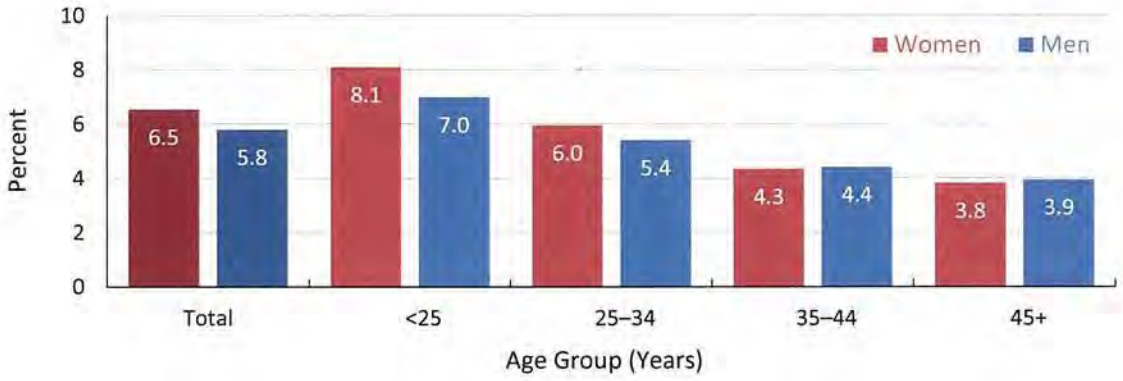
Surveillance of COVID-19 among Service members and other DoD personnel is ongoing. Information and resources on latest DoD policy, guidance, and resources, as well as case counts, information about vaccine availability, and travel restrictions for DoD installations are available at https://www.defense.gov/explore/spotlight/coronavirus/.

Overall, 5.9% of AC Service members were infected with COVID-19 in 2020.
Rates ranged from 5.3% to 6.6% across Services.

Army Navy Marine Corps Air Force

Incidence of COVID-19 by Sex and Age Group, AC Service Members, 2020

Service members in the younger age groups had a higher incidence of COVID-19 than those in the older age groups. Female Service members (6.5%) had a higher incidence compared to males (5.8%).



Incidence of Reported or Laboratory-Confirmed COVID-19 Infection by Month, AC Service Members, 2020

Monthly incidence of COVID-19 peaked in July 2020 and December 2020 for AC Service members and recruits. Incidence was higher among recruits compared to overall AC Service members since the start of the pandemic.

Army

Service Profile (2020):[a]

Population: Approximately 473,000 Army Service members
77% under 35 years old, 15% female

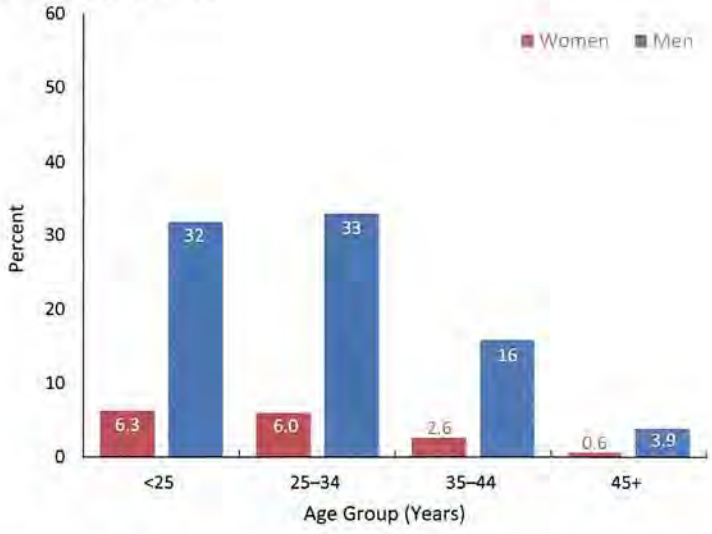
HEALTH INDEX MEASURES[b]

MEASURE	ARMY VALUE[c]	DOD AVERAGE	DOD RANGE
Acute Injury (rate per 1,000)	**269**	211	147–269
Cumulative Traumatic Injury (rate per 1,000)	**1,257**	948	599–1,257
TBI (%)	**2.0**	1.3	0.7-2.0
Noise-induced Hearing Injury (%)	**5.2**	4.1	2.7-5.2
Heat Illness (%)	**0.26**	0.16	0.04–0.35
Behavioral Health 1-Year (%)	**10**	8.7	7.3–10.2
Behavioral Health Lifetime (%)	**21**	18	11–21
STIs (rate per 1,000)	**30**	25	19–30
Sleep Disorders (%)	**16**	12	6.9–15.8
Obesity (%)	19	19	9.8–24.8
Acute Respiratory Illness (average rate per 1,000 per month)	20	20	18–23
Respiratory Symptoms (avgerage rate per 1,000 per month)	**14**	12	8.2–15.3
COVID-19 (%)	**6.6**	5.9	5.3-6.6

ADDITIONAL INFORMATION

Injury rates including TBI and noise-induced hearing were found to be higher in the Army than in the other Services. Mission-specific training and operational requirements likely contribute to the risk for injury among Soldiers. Rates of BH conditions, STIs, and sleep disorders were also higher among Soldiers than in Sailors, Airmen, and Marines. Given the potential for each of these conditions to contribute to decreased performance, disability, and separation, further exploration of potential causes and interventions is warranted.

DEMOGRAPHICS



[a] Number of AC Service members, June 2020; see Appendix for details.
[b] See Appendix for details regarding measure computations.
[c] Values ≥ 10 are rounded to the nearest integer. Bold values represent Service values above the DoD average.

Navy

Service Profile (2020):[a]

Population: Approximately 335,000 Navy Service members
77% under 35 years old, 20% female

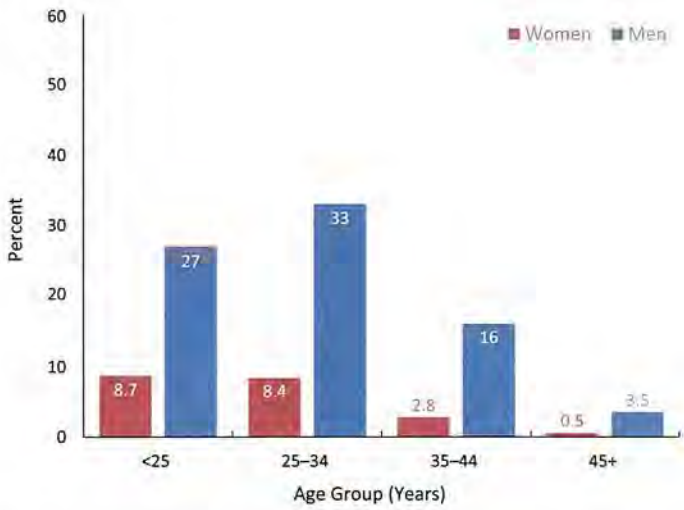
HEALTH INDEX MEASURES[b]

MEASURE	NAVY VALUE[c]	DOD AVERAGE	DOD RANGE
Acute Injury (rate per 1,000)	147	211	147–269
Cumulative Traumatic Injury (rate per 1,000)	599	948	599–1,257
TBI (%)	0.7	1.3	0.7-2.0
Noise-induced Hearing Injury (%)	2.7	4.1	2.7-5.2
Heat Illness (%)	0.04	0.16	0.04–0.35
Behavioral Health 1-Year (%)	8.5	8.7	7.3–10.2
Behavioral Health Lifetime (%)	17	18	11–21
STIs (rate per 1,000)	24	25	19–30
Sleep Disorders (%)	11	12	6.9–15.8
Obesity (%)	**25**	19	9.8–24.8
Acute Respiratory Illness (average rate per 1,000 per month)	18	20	18–22
Respiratory Symptoms (average rate per 1,000 per month)	8.2	12	8.2–15.3
COVID-19 (%)	5.5	5.9	5.3-6.6

ADDITIONAL INFORMATION

While injury, sleep disorders, and BH conditions remain important threats to Navy readiness, this report highlights obesity as an important health concern among Sailors. Obesity contributes to hypertension, diabetes, coronary heart disease, stroke, cancer, all-cause mortality, and increased health care costs. It also contributes to failure of Sailors to meet physical fitness standards.

DEMOGRAPHICS



[a] Number of AC Service members, June 2020; see Appendix for details.
[b] See Appendix for details regarding measure computations.
[c] Values ≥ 10 are rounded to the nearest integer. Bold values represent Service values above the DoD average.

Air Force

Service Profile (2020):[a]

Population: Approximately 329,000 Air Force Service members
77% under 35 years old, 21% female

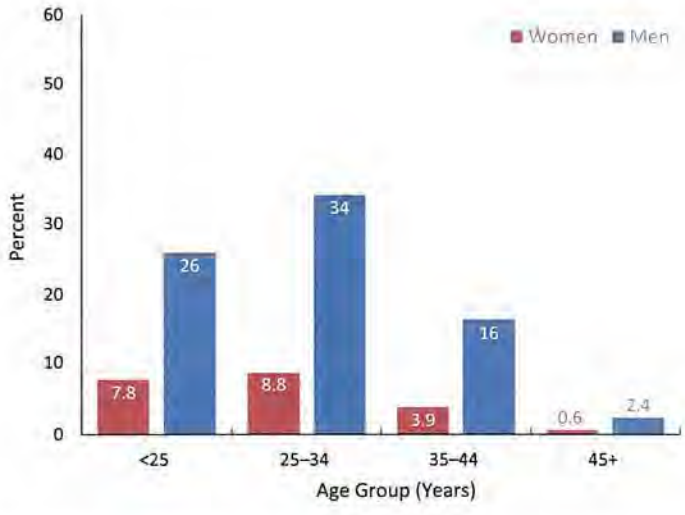
HEALTH INDEX MEASURES[b]

MEASURE	AIR FORCE VALUE[c]	DOD AVERAGE	DOD RANGE
Acute Injury (rate per 1,000)	186	211	147–269
Cumulative Traumatic Injury (rate per 1,000)	894	948	599–1,257
TBI (%)	0.7	1.3	0.7-2.0
Noise-induced Hearing Injury (%)	3.3	4.1	2.7-5.2
Heat Illness (%)	0.04	0.16	0.04–0.35
Behavioral Health 1-Year (%)	7.5	8.7	7.3–10.2
Behavioral Health Lifetime (%)	**18**	18	11–21
STIs (rate per 1,000)	19	25	19–30
Sleep Disorders (%)	12	12	6.9–15.8
Obesity (%)	**20**	19	9.8–24.8
Acute Respiratory Illness (average rate per 1,000 per month)	**23**	20	18–23
Respiratory Symptoms (average rate per 1,000 per month)	**15**	12	8.2–15.3
COVID-19 (%)	5.6	5.9	5.3-6.6

ADDITIONAL INFORMATION

In this analysis, acute respiratory infections, respiratory symptoms, obesity, and lifetime BH disorders were found to affect Airmen at higher than average rates. Airmen should continue to take preventive measures to protect against respiratory infections. Future efforts to address obesity and efforts to better understand the interplay of obesity with other comorbidities also have the potential to improve the readiness of Airmen.

DEMOGRAPHICS



[a] Number of AC Service members, June 2020; see Appendix for details.
[b] See Appendix for details regarding measure computations.
[c] Values ≥ 10 are rounded to the nearest integer. Bold values represent Service values above the DoD average.

Marine Corps

Service Profile (2020):[a]

Population: Approximately 183,000 Marine Corps Service members
88% under 35 years old, 9.0% female

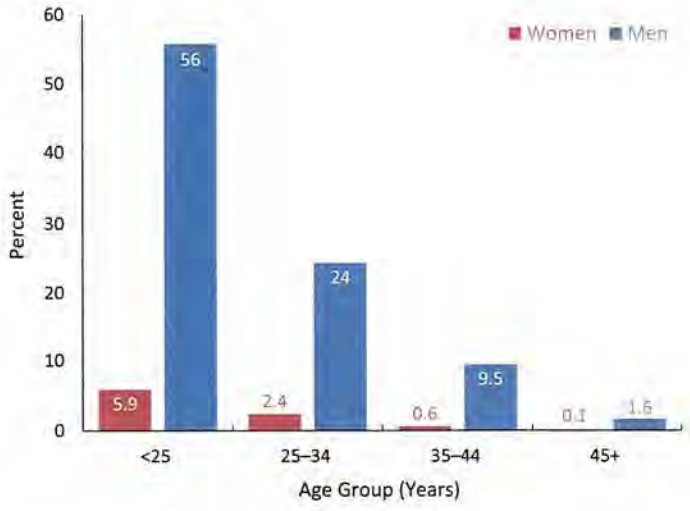
HEALTH INDEX MEASURES[b]

MEASURE	MARINE CORPS VALUE[c]	DOD AVERAGE	DOD RANGE
Acute Injury (rate per 1,000)	**222**	211	147–269
Cumulative Traumatic Injury (rate per 1,000)	885	948	599–1,257
TBI (%)	**1.5**	1.3	0.7-2.0
Noise-induced Hearing Injury (%)	**5.2**	4.1	2.7-5.2
Heat Illness (%)	**0.35**	0.16	0.04–0.35
Behavioral Health 1-Year (%)	7.3	8.7	7.3–10.2
Behavioral Health Lifetime (%)	11	18	11–21
STIs (rate per 1,000)	**26**	25	19–30
Sleep Disorders (%)	6.9	12	6.9–15.8
Obesity (%)	9.8	19	9.8–24.8
Acute Respiratory Illness (average rate per 1,000 per month)	**21**	20	18–23
Respiratory Symptoms (average rate per 1,000 per month)	8.4	12	8.2–15.3
COVID-19 (%)	5.3	5.9	5.3-6.6

ADDITIONAL INFORMATION

Marines had relatively low rates of BH diagnoses, sleep disorders, and obesity compared to the other Services. However, heat illnesses, TBI, and noise-induced hearing injuries emerged as important areas of focus for prevention efforts. Attention to reducing these injuries as well as acute injuries in the field and in recruit training has the potential to improve health and readiness of Marines.

DEMOGRAPHICS



[a] Number of AC Service members, June 2020; see Appendix for details.
[b] See Appendix for details regarding measure computations.
[c] Values ≥ 10 are rounded to the nearest integer. Bold values represent Service values above the DoD average.

METHODS

Acute and Cumulative Traumatic Injury

Data were derived from records routinely maintained in the Defense Medical Surveillance System (DMSS). These records document ambulatory encounters and hospitalizations of AC Service members in fixed military and civilian (if reimbursed through the MHS) treatment facilities worldwide. Acute and cumulative traumatic injuries were identified using ICD-10-CM diagnosis codes from the U.S. Army Public Health Center's (APHC) 2021 Injury Taxonomy.[3] Service members were identified as having an injury if they had a qualifying injury diagnosis in any position of an inpatient or outpatient medical encounter. A 60-day gap rule was used to identify incident injuries. To be counted as a new case, at least 60 days must have passed since the last qualifying injury for the same nature of injury and body region affected, as defined by the injury taxonomy. Encounters with a documented "war"- or "battle"-related cause of injury were excluded from the analysis. Causes of injuries were assessed based on North Atlantic Treaty Organization Standard Agreement (STANAG) 2050 and ICD-10-CM "external cause of injury" codes. The denominator was all AC Service members during June of the year of interest.

Among those who were identified as an incident acute or cumulative traumatic injury case in 2020, hospitalization status and total number of hospital bed days were determined. An individual was counted as being hospitalized for an acute or cumulative traumatic injury if they had an inpatient encounter in 2020 with an injury diagnosis in the primary diagnostic position. Bed days were calculated among all inpatient encounters with an injury diagnosis in the primary diagnostic position in 2020. In addition, for all incident injuries, the frequency and percentage of the nature of injury and body region affected were described.

Limitations:

1. The transition from International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) to ICD-10-CM in October 2015 presented a significant artifact for acute injury surveillance. ICD-10-CM has more than 15 times the number of acute injury codes than ICD-9-CM, and they are far more specific. It is not possible to directly compare rates of highly specific acute injuries captured in ICD-10-CM to the non-specific injuries captured in ICD-9-CM. For this reason, rates of acute injuries captured under ICD-9-CM were not reported here.
2. This report is meant to describe nondeployment-related injuries; however, some deployment-related injuries may have been captured if the war- or battle-related cause of injury was not documented.
3. Diagnosing an acute injury is subjective and provider-dependent. Incident and subsequent diagnoses rendered by different providers introduces error that can result in both undercounting and overcounting of injuries.
4. It is not always possible to differentiate incident injuries from reinjuries using surveillance data. The 60-day gap rule is sufficient for the vast majority of injuries, which are generally not severe, but may lead to overcounting of severe injuries if the subsequent encounters are erroneously coded as incident injuries.

Noise-Induced Hearing Injury

Data were derived from records routinely maintained in the DMSS. A case of noise-induced hearing injury was defined as having an inpatient, outpatient, or Theater Medical Data Store (TMDS) medical encounter with a diagnosis for sensorineural hearing loss (ICD-9: 389.10, 389.11, 389.15-389.18; ICD-10: H90.3, H90.41, H90.42, H90.5), noise-induced hearing loss (ICD-9: 388.10-388.12; ICD-10: H83.3*, S09.31*), tinnitus (ICD-9: 388.3, 388.30-388.32; ICD-10: H93.1*), or significant threshold shift (ICD-9: 794.15, ICD-10: R94.120) in any diagnostic position.[39] A Service member could be counted as a case of noise-induced hearing injury once per calendar year for each of the specific types of injury, and could be counted as a case of noise-induced hearing injury (any type) once per year. The denominator was all AC Service members during June of the year of interest.

Limitations:

1. Data from audiometric testing were not included.
2. Hearing injuries associated with blasts or head injuries, such as ear drum perforation, were not included.

TBI

Data were derived from records routinely maintained in the DMSS. A case of TBI was defined as having an inpatient, outpatient, or TMDS medical encounter with a diagnosis of TBI in any diagnostic position.[40] For the full list of ICD-9 and ICD-10 codes used in the analysis, please refer to the Armed Forces Health Surveillance Division (AFHSD) surveillance case definition.[40] Note that for this analysis, the "personal history of traumatic brain injury" codes were not included because the intent was to capture Service members who had an encounter for a prevalent TBI. However, the ICD-10 codes indicating "subsequent encounter" and "sequelae" for a TBI were included. A Service member could be counted as a case of TBI once per calendar year, with more severe cases being counted over more mild cases (i.e., penetrating cases were counted over severe cases, which were counted over moderate cases, and moderate cases were counted over mild cases). The denominator was all AC Service members during June of the year of interest.

Among those who were identified as a TBI case in 2020, hospitalization status and total number of hospital bed days were determined. An individual was counted as being hospitalized for a TBI if they had an inpatient encounter in 2020 with a TBI diagnosis in the primary diagnostic position. Bed days were calculated among inpatient encounters with a TBI diagnosis in the primary diagnostic position in 2020.

Limitations:

1. Cases were identified using administrative records of medical care if reimbursed through the MHS. Records of care outside of this system would not be captured.
2. Ascertainment of the severity of the TBI relies on accurate coding and documentation by the medical provider.

Heat Illness

Data were derived from records routinely maintained in the DMSS. A case of heat illness was defined as having an inpatient or outpatient medical encounter with a diagnosis for heat stroke (ICD-9: 992.0; ICD-10: T67.0*) or heat exhaustion (ICD-9: 992.3–992.5; ICD-10: T67.3*–T67.5*) in the first or second diagnostic position or by having a reportable medical event report for heat illness. A service member could be counted as a case of heat illness once per calendar year. Heat stroke was prioritized over heat exhaustion if the individual had indication of both occurring in the same year. These methods are consistent with those applied in the annual *MSMR* reports on heat illness.[19] The denominator was all AC Service members during June of the year of interest.

Among those who were identified as a heat illness case in 2020, hospitalization status and total number of hospital bed days were determined. An individual was counted as being hospitalized for a heat illness if they had an inpatient encounter in 2020 with a heat illness diagnosis in the primary diagnostic position. Bed days were calculated among inpatient encounters with a heat illness diagnosis in the primary diagnostic position in 2020.

Limitations:

1. Similar heat-related clinical illnesses are likely managed and reported differently at different locations and in different clinical settings.
2. Heat illness during deployment was not ascertained.
3. Reporting guidelines for heat illnesses were modified in the 2017 and 2020 revisions of the Armed Forces guidelines. In these updated guidelines, the heat injury category was removed, leaving only case classifications for heat stroke and heat exhaustion. This may cause some variations in reporting.

BH Disorders

Data were derived from records routinely maintained in the DMSS. Health care encounters of deployed Service mem-bers are documented in records that are maintained in the Theater Medical Data Store (TMDS), which is included in the DMSS. It is important to note that because the TMDS has not fully transitioned to ICD-10-CM, ICD-9-CM codes appear in this analysis.

Service members were identified as having a BH disorder if they had at least two BH disorder diagnoses (ICD-9-CM: 290–319.; ICD-10-CM: F01-F99) within 365 days in any diagnostic position. However, diagnoses for postconcussion syndrome, intellectual disabilities, nicotine dependence, and pervasive and specific developmental disorders were excluded (ICD-9: 299.*, 305.1, 310.2, 315.*, 317.* –319.*; ICD-10-CM: F07.81, F70–F79, F17.*, F80.*–F82.*, F84.*, F88–F89).[23] Diagnoses could occur in inpatient, outpatient, or in-theater medical encounters. At least one of these diagnoses had to occur during of the year of interest. The denominator was all AC Service members during June of the year of interest.

For specific BH conditions (adjustment disorders, alcohol-related disorders, anxiety disorders, bipolar disorder, depressive disorders, psychoses, PTSD, and substance-related disorders), ICD-9-CM and ICD-10-CM codes from the AFHSD surveillance case definitions were used.[22] A Service member was considered to have a specific BH condition if they had two diagnoses for the same condition within 365 days of each other. At least one of these diagnoses had to occur during of the year of interest. The denominator was all AC Service members during June of the year of interest.

History ("lifetime" prevalence) of a BH disorder was also measured. Service members were considered to have a history of BH disorder if they had two BH disorder diagnoses within 365 days at any time between 2002 and 2020 and were in service during December 2020 (the last month of the surveillance period). The denominator was all AC Service members during December 2020.

Among those who were identified as a BH disorder case in 2020, hospitalization status and total number of hospital bed days were determined. An individual was counted as being hospitalized for a BH disorder if they had an inpatient encounter in 2020 with a BH disorder diagnosis in the primary diagnostic position. Bed days were calculated among inpatient encounters with a BH disorder diagnosis in the primary diagnostic position in 2020.

Limitations:

1. Service members do not always seek or receive care for a BH condition within the MHS, and BH disorders may be underestimated here.
2. Some diagnoses may be miscoded or incorrectly transcribed on centrally transmitted records.
3. Some encounters (e.g., screening visits) may have been erroneously diagnosed or miscoded as BH disorders.

STIs

Diagnoses of STIs were ascertained from medical administrative data and reports of notifiable medical events routinely maintained in the DMSS for surveillance purposes. STI cases were also derived from positive laboratory test results recorded in the Health Level 7 (HL7) chemistry and microbiology databases maintained by the Navy and Marine Corps Public Health Center at the EpiData Center.

An incident case of chlamydia or trichomoniasis was defined by any of the following: 1) a case defining diagnosis of chlamydia (ICD-9: 099.41, 099.5*; ICD-10: A56.*) or trichomoniasis (ICD-9: 131.*; ICD-10: A59.*) in the first or second diagnostic position of a record of an outpatient or in-theater medical encounter, 2) a confirmed notifiable disease report (for chlamydia only), or 3) a positive laboratory test for chlamydia or trichomoniasis (any specimen source or test type). An incident case of gonorrhea was similarly defined by 1) a case-defining diagnosis (ICD-9: 098.*; ICD-10: A54.*) in the first or second diagnostic position of a record of an inpatient, outpatient, or in-theater encounter, 2) a confirmed notifiable disease report for gonorrhea, or 3) a positive laboratory test for gonorrhea (any specimen source or test type). For each type of STI, an individual could be counted as having a subsequent case only if there were more than 30 days between the dates on which the case-defining diagnoses were recorded. These case definitions were derived from those used in the *MSMR* annual STI report.[25]

The denominator was all AC Service members during June of the year of interest.

Limitations:

1. STI cases may not be captured if coded in the medical record using symptom codes (e.g., urethritis) rather than STI-specific codes.
2. Cases may be underestimated because some affected Service members may be diagnosed and treated through nonreimbursed, non-military care providers (e.g., county health departments or family planning centers). In addition, laboratory tests that are performed in a purchased care setting, a shipboard facility, a battalion aid station, or an in-theater facility are not captured.
3. Differences in rates between Services may be at least partially due to different practices regarding screening, testing, treatment, and reporting.

Sleep Disorders

Data were derived from records routinely maintained in the DMSS; TMDS data were included. Service members were identified as having a sleep disorder if they had a qualifying diagnosis **(Table 1)** in any diagnostic position during the year of interest. It is important to note that because the TMDS has not fully transitioned to ICD-10-CM, ICD-9-CM codes appear in this analysis. The denominator was all AC Service members during June of the year of interest.

Limitations:

1. Service members do not always seek care for sleep disorders, and sleep disorders may be underrepresented here.
2. Increased screening associated with required medical encounters such as retirement and separation physicals may result in an increased frequency of diagnoses of sleep disorders.

Table 1. ICD-9-CM/ICD-10-CM codes used to identify sleep disorders.

	ICD-9-CM	ICD-10-CM
Any sleep disorder	780.5*, 327.00–327.02, 327.09, 327.10–327.15, 327.19, 327.2*,327.3*, 327.4*, 327.5*, 327.8, 347.*, 307.4*	G47*, F51*
Insomnia	780.52, 327.00, 327.01, 327.09	G47.0*
Hypersomnia	327.10–327.14, 327.19, 780.54	G47.1*
Circadian rhythm sleep disorders	327.30–327.37, 327.39, 780.55	G47.2*
Sleep apnea	327.20–327.27, 327.29, 780.51, 780.53, 780.57	G47.3*
Narcolepsy	347.00, 347.01, 347.10, 347.11	G47.4*
Parasomnia	327.40–327.44, 327.49	G47.5*
Sleep-related movement disorders	327.51–327.53, 327.59	G47.6*

*Represents any subsequent digit/character.

Obesity

The CDR vital sign table and Genesis vitals table within the MDR were used to identify all records for AC Service members with a height and weight measurement available on the same day. Female Service members with an ICD-9-CM or ICD-10-CM code for pregnancy during any inpatient or outpatient encounter in the same year were excluded. Height and weight data were then matched to the AFHSD DMSS to identify the date of birth, sex, and Service for all records. If the Service member could not be identified in the DMSS or any demographic information was missing from the DMSS, then the height and weight record was excluded. Only the latest height and weight record for each Service member per year was retained. BMI was then calculated from height and weight. Records with BMI measurements less than 12 and greater than 45 and records with erroneous heights or weights (e.g., a weight of 8 pounds) were excluded from the analysis. Cases of obesity were assigned using BMI greater than or equal to 30, according to the CDC definition of obesity.[30]

The CDR and Genesis vitals data were used to assess BMI because not all Services had complete height and weight records available from Service members' Physical Fitness Tests (PFTs). BMIs calculated from CDR data were reviewed by APHC and U.S. Air Force School of Aerospace Medicine (USAFSAM) in a previous analysis and found to be comparable to BMIs from PFTs. This method of estimating obesity is similar to the Defense Health Agency's Better Health Prevalence Measure of overweight and obesity.[41]

Limitations:

1. Service members with higher lean body mass may be misclassified as obese based on their BMI.
2. Not all Service members had a height or weight measurement available in the CDR Vital sign data each year.
3. BMI measures should be interpreted with caution, as some of them can be based on self-reported height and weight.

Respiratory Conditions

Data were derived from records routinely maintained in the DMSS. Service members were identified as having an acute respiratory infection if they had an inpatient, outpatient, or TMDS encounter with a qualifying diagnosis **(Table 2)** in the first diagnostic position. For cases of respiratory symptoms, an individual was required to have an inpatient, outpatient, or TMDS encounter with a qualifying diagnosis **(Table 3)** in any diagnostic position. For both acute respiratory infections and respiratory symptoms, at least 14 days had to have passed between encounters to count as a new case. The denominator was AC Service members in service during the month and year of interest. To calculate rates among recruits, the denominator was the number of people with a recruit training period overlapping with the month and year of interest. To qualify as a case for a recruit, the qualifying encounter also needed to have occurred within the recruit basic training period.

Among those who were identified with an acute respiratory infection in 2020, hospitalization status and total number of hospital bed days were determined. An individual was counted as being hospitalized for an acute respiratory infection if they had an inpatient encounter in 2020 with an acute respiratory infection in the primary diagnostic position. Bed days were calculated among inpatient encounters with an acute respiratory infection diagnosis in the primary diagnostic position in 2020.

Limitations:

1. Laboratory confirmation of cases was not ascertained.
2. Rates could be overestimated if miscoded as screening encounters.
3. Rates could be underestimated because of service members not seeking care for mild illness.

Table 2. ICD-9-CM/ICD-10-CM codes used to identify acute respiratory infections.

	ICD-9-CM	ICD-10-CM
Nasopharyngitis	460*	J00*
Sinusitis	461*	J01*
Acute pharyngitis	462*	J02*
Acute laryngitis and tracheitis	464.0, 464.10, 464.20, 464.30, 464.50	J04*
Acute obstructive laryngitis and epiglottitis	464.01, 464.11, 464.21, 464.31, 464.4, 464.51	J05*
Acute upper respiratory infections of unspecified site	465*	J06*
Influenza due to certain identified flu viruses	488*	J09*
Influenza due to other identified flu virus	487*	J10*
Influenza due to unidentified flu virus	NA	J11*
Viral pneumonia not elsewhere classified	480*	J12*
Pneumonia due to Streptococcus pneumoniae	481*	J13*
Pneumonia due to Haemophilus influenzae	482.2	J14*
Bacterial pneumonia not elsewhere classified	482*	J15*
Pneumonia due to other infectious organisms	484*, 483.0, 483.1, 483.8	J16*
Pneumonia in diseases classified elsewhere	517.1, 484.8, 484.7, 115.95, 115.15, 073.0	J17*
Pneumonia unspecified organism	486, 485	J18*
Acute bronchitis	466	J20*
Acute bronchiolitis	466.1*	J21*
Unspecified acute lower respiratory tract infection	519.8	J22*
Acute tonsillitis	463, 034.0	J03*
Peritonsillar abscess	475	J36
Retropharyngeal and parapharyngeal abscess	478.22, 478.24	J39.0
Other abscess of pharynx	478.21	J39.1
Diphtheria	032.0, 032.1, 032.3, 032.9	A36.0, A36.1, A36.2, A36.9
Scarlet fever	34.1	A38*
Whooping cough	033.0, 033.9, 033.8	A37*
Adenovirus	NA	B34.0
Measles	055.0, 055.1, 055.2, 055.8, 055.9	B05*
Rubella	056.00, 056.01, 056.09, 056.79, 056.9	B06*
Streptococcus group A	41.01	B95.0
Streptococcus pneumoniaeas the cause of disease classified elsewhere	41.09	B95.3
Mycoplasma pneumoniae	41.81	B96.0
Klebsiella pneumoniae	41.3	B96.1
Haemophilus influenzae	41.5	B96.3
Adenovirus	79	B97.0
Coronavirus	NA	B97.2*, B34.2, U07.1
Respiratory syncytial virus (RSV)	79.6	B97.4
Otitis media	381.0*, 382.00, 382.01	H65.0*, H65.1*, H66.00*. H66.01*

*Represents any subsequent digit/character.
NA, not applicable.

Table 3. ICD-9-CM/ICD-10-CM codes used to identify respiratory symptoms.

	ICD-9-CM	ICD-10-CM
Cough	786.2	R05
Dyspnea	786.02, 786.05, 786.09	R06.0*
Wheezing	786.07	R06.2
Sneezing	NA	R06.7
Sore throat	784.1	R07.0
Pleurodynia	786.52	R07.81
Pleurisy	511.*	R09.1
Abnormal sputum	786.4	R09.3
Nasal congestion	NA	R09.81
Postnasal drip	784.91	R09.82
Fever	780.60	R50.9

*Represents any subsequent digit/character
NA, not applicable.

COVID-19

Cases of COVID-19 were identified using the AFHSD surveillance case list of MHS beneficiaries with COVID-19. This list is updated daily and comprises Composite Health Care System (CHCS) Health Level 7 (HL7)-formatted and MHS Genesis laboratory positive antigen and PCR positive test results extracted by the Navy and Marine Corps Public Health Center EpiData Center, as well as medical event reports of laboratory confirmed and probable COVID-19 infections reported to the Disease Reporting System Internet (DRSi), and validated by the U.S. Army Public Health Center and the U.S. Air Force School of Aerospace Medicine. The COVID-19 incident date is defined as the date of onset reported in DRSi, or the earliest positive PCR or antigen test specimen collection date. For this analysis, cases were included if they occurred within 90 days of an active component Service member demographic record maintained in the DMSS. The denominator was AC Service members in service during June of 2020. To calculate rates among recruits, the denominator was the number of people with a recruit training period overlapping with 2020. To qualify as a case for a recruit, the COVID-19 incident date needed to have occurred within the recruit basic training period.

Among those who were identified as a case of COVID-19, hospitalization status and total number of hospital bed days were determined. An individual was counted as being hospitalized for COVID-19 if they had an inpatient encounter in 2020 with a diagnosis of COVID-19 (ICD-10: U07.1) in the primary diagnostic position. Bed days were calculated among inpatient encounters with a COVID-19 diagnosis in the primary diagnostic position in 2020.

Limitations:

1. Services members tested for COVID-19 outside of the MHS system were not captured and the number of infections was likely underestimated in this report.
2. Hospitalizations for COVID-19 were likely underestimated in this report because the ICD-10 code for COVID-19 (ICD-10: U07.1) was not in use until several weeks after the beginning of the COVID-19 pandemic.

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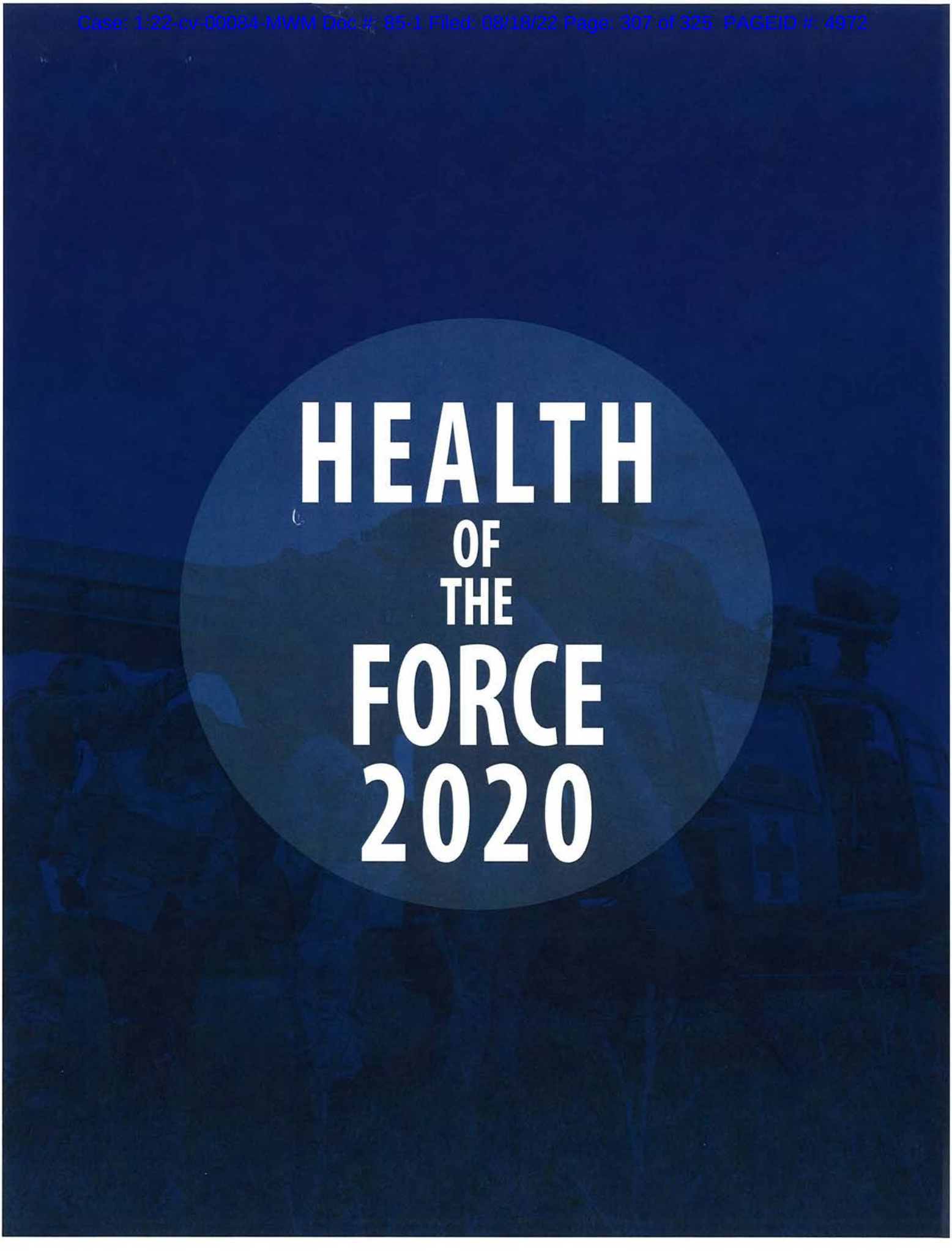
HEALTH
OF
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2020

SECRETARY OF DEFENSE
1000 DEFENSE PENTAGON
WASHINGTON, DC 20301-1000

JUN 0 6 2022

MEMORANDUM FOR SENIOR PENTAGON LEADERSHIP
COMMANDERS OF THE COMBATANT COMMANDS
DEFENSE AGENCY AND DOD FIELD ACTIVITY DIRECTORS

SUBJECT: Policy Regarding Human Immunodeficiency Virus-Positive Personnel Within the Armed Forces

In view of significant advances in the diagnosis, treatment, and prevention of Human Immunodeficiency Virus (HIV), it is necessary to update DoD policy with respect to individuals who have been identified as HIV-positive. Individuals who have been identified as HIV-positive, are asymptomatic, and who have a clinically confirmed undetectable viral load (hereinafter, "covered personnel") will have no restrictions applied to their deployability or to their ability to commission while a Service member solely on the basis of their HIV-positive status. Nor will such individuals be discharged or separated solely on the basis of their HIV-positive status. This definition of "covered personnel" will be added to the affected DoD Instructions.

Accordingly, effective immediately I direct the following actions:

- Accession:
  - DoD Instruction 6130.03, "Medical Standards for Military Service: Appointment, Enlistment, or Induction," volume 1, section 5: Disqualifying Conditions, 5.23.b., is revised by adding the following language in boldface: "Presence of human immunodeficiency virus or laboratory evidence of infection for false-positive screening test(s) with ambiguous results by supplemental confirmation test(s) **is not, in itself, disqualifying with respect to covered personnel (including Military Service Academy cadets and midshipmen, contracted SROTC cadets and midshipmen, and other participants in in-service commissioning programs) seeking to commission while a Service member). Such covered personnel will be evaluated on a case-by-case basis."**
  - DoD Instruction 6485.01, "Human Immunodeficiency Virus (HIV) in Military Service Members," section 3.a., is revised to read: "It is DoD policy to . . . Deny eligibility for Military Service to persons with laboratory evidence of HIV infection for appointment (**other than covered personnel who are seeking to commission while a Service member**), enlistment, pre-appointment, or initial entry training for Military Service pursuant to DoDI 6130.03."
- Retention: DoD Instruction 6130.03, "Medical Standards for Military Service: Retention," volume 2, section 5.23.b.(1), is revised by adding the following language in boldface: "A Service member with laboratory evidence of Human Immunodeficiency Virus infection will

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OSD004582-22/CMD005839-22

be referred for appropriate treatment and a medical evaluation of fitness for continued service in the same manner as a Service member with other chronic or progressive illnesses, **including evaluation on a case-by-case basis. Covered personnel will not be discharged or separated solely on the basis of their HIV-positive status.**

- Deployability: Covered personnel are not non-deployable solely for the reason that they are HIV-positive. Decisions on the deployability of covered personnel will be made on a case-by-case basis and must be justified by the Service member's inability to perform the duties to which he or she would be assigned. DoD Instruction 1332.45, "Retention Determinations for Non-Deployable Service Members," will be implemented consistent with this direction.

- The Director of Administration and Management will make the revisions directed above in the cited DoD Instructions.

- The Under Secretary of Defense for Personnel and Readiness will convene a working group, chaired by his designee and composed of members named by himself, the Secretaries of the Military Departments, the Chairman of the Joint Chiefs of Staff, the Office of the Secretary of Defense, and the General Counsel of the DoD. The working group shall:

  - Develop proposed standards for conducting the case-by-case determinations directed above. Included in such standards will be the period during which, and method by which, covered personnel must exhibit an undetectable viral load and be symptom free. The Under Secretary of Defense for Personnel and Readiness will report those proposed standards to me within six months from the date of this memorandum.

  - Consider such additional matters as may be referred to it by the Under Secretary of Defense for Personnel and Readiness.

- The Secretaries of the Military Departments and the Commanders of the Combatant Commands, will, as necessary, revise their respective regulations, policies, and other guidance consistent with this memorandum and no later than 60 days from the date of this memorandum.

- The Secretaries of the Military Departments will report to the Under Secretary of Defense for Personnel and Readiness on a semi-annual basis beginning six months from the date of this memorandum: (1) the number of HIV-positive Service members in their respective Services who have been separated; and (2) the number of HIV-positive individuals, who are asymptomatic with a clinically confirmed undetectable viral load, and who have been refused accession.

ROUTINE
R 281524Z JUN 22 MID200001895078U
FM CNO WASHINGTON DC
TO NAVADMIN
INFO CNO WASHINGTON DC
BT
UNCLAS
NAVADMIN 142/22
PASS TO OFFICE CODES:
FM CNO WASHINGTON DC//N1//
INFO CNO WASHINGTON DC//N1//
MSGID/NAVADMIN/CNO WASHINGTON DC/N1/JUN//
SUBJ/FISCAL YEAR 2022 ACTIVE COMPONENT ENLISTED FORCE MANAGEMENT ACTIONS//
REF/A/DOC/COMNAVPERSCOM/23AUG06//
REF/B/DOC/COMNAPERSCOM/06JUN20/
REF/C/DOC/COMNAVPERSCOM/06JUN20/
NARR/REF A IS MILPERSMAN 1300-500, REASSIGNMENT FOR HUMANITARIAN REASONS (HUMS).
REF B IS 1910-108, SEPARATION BY REASON OF CONVENIENCE OF THE GOVERNMENT - EARLY RELEASE TO FURTHER EDUCATION.
REF C IS MILPERSMAN 1910-102, SEPARATION BY REASON OF CHANGES IN SERVICE OBLIGATION (ACTIVE DUTY AND INACTIVE NAVY RESERVISTS).
RMKS/1. The purpose of this NAVADMIN is to announce implementation of key force management (FM) personnel policy actions in the enlisted active component (AC) to ensure Navy remains fully manned and operationally ready. As the Navy shifts into an environment of sustainment, retention of every capable Sailor will be critical to the operational readiness of the Navy. Due to the uncertainty regarding COVID-19 Pandemic vaccination losses and the recruiting environment, where competition for talent is especially tough, the Navy is opening the aperture for additional FM personnel policy levers to retain Sailors. This requires retention of the right talent, at a time of uncertainty to ensure sustainment of the force.
2. Early Separation Cancellation. Retention of every capable Sailor will be critical to the operational readiness of the Navy. Therefore all enlisted early out programs and time in grade requirement waivers are cancelled. Service commitments such as enlistment contracts, service obligations for accepting permanent change of station orders, advancements, bonuses, training, etc., are expected to be fulfilled. Service Members experiencing difficulty in fulfilling obligated service requirements are encouraged to work with their chain of command and respective detailers to examine available alternatives to complete their obligation, to include reassignments to other duties for humanitarian reasons, in line with reference (a). Unless otherwise directed, this policy expires 30 September 2023.
a. Commanding Officers retain 90-day early out authority for policy outlined in references (b) and (c).
b. Service Members previously granted approval, or who have an existing request pending at Commander, Navy Personnel Command

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(COMNAVPERSCOM) as of the release of this NAVADMIN, will not be affected by this policy change.

c. Sailors pursuing commissions in the Navy and other branches of Service can still submit such requests, each request will be handled on a case by case basis.

d. United States Space Force applicants are not affected by this policy change.

3. Voluntary Extension Opportunity. The Navy is accepting applications from enlisted personnel, except COVID-19 vaccination refusers, who desire to delay their separation or retirement. Service Members with an approved separation or retirement date before 30 September 2022 are eligible to submit a request to their detailer to have their separation or retirement date delayed between 6 and 12 months. All Service Members interested in extending, are invited to apply, but priority for approval will be given to those Service Members filling sea duty and critical billets. Requests must be received by 30 June 2022. Command endorsed requests to delay a separation or retirement date should be initiated through the appropriate PERS-40 detailer. Approved extension request, will not go beyond 30 September 2023.

a. Service Members who are separating or retiring due to High Year Tenure (HYT) may apply for a waiver of their current HYT gate. HYT waivers will be considered for up to an additional 12 months for enlisted Sailors filling critical operational billets both at sea and shore. Requests will be approved on a case-by-case basis. Sailors will submit a command endorsed form 1306/7 Enlisted Personnel Action Request (ePAR) to My Navy Career Center (MNCC) via MyNavy Portal or by emailing the ePAR request directly to askmncc(at)navy.mil.

b. Service Members with an approved separation or retirement date that are in a sea duty billet, will remain on sea duty if their request for voluntary extension is approved.

(1) Sailors with an approved separation or retirement date who are in billets that are eligible for Sea Duty Incentive Pay (SDIP) and who are approved for a voluntary extension as described above will receive SDIP for those extensions.

(2) Exceptions to the timeline to request SDIP and to the length of extension for SDIP have been approved to accommodate these requests. The latest SDIP eligibility chart can be found at https://www.mnp.navy.mil/group/pay-and-benefits. This chart is updated periodically so check for recent additions. For Sailors who are in an SDIP eligible billet, a Form 1306/7 ePAR should be submitted to MNCC at askmncc(at)navy.mil and your detailer.

d. While all Service Members are encouraged to apply, the following will not be approved:

(1) Service Members who have executed any portion of their separation or retirement orders (e.g., terminal leave, household goods shipment)

(2) Service Members pending mandatory separation or retirement for age.

(3) Service Members approved for disability separation or retirement.

(4) Service Members being separated for misconduct.

(5) Service Members who are COVID-19 vaccination refusers.

Not in Class

4. If you have any questions regarding delaying a Service Members separation or retirement date contact the appropriate detailer, enlisted community manager, or the MNCC at: askmncc(at)navy.mil or phone: 1-833-330-MNCC MNCC. Questions regarding SDIP should be directed to, Mr. Keith Tucker, PERS-40DD, 1-901-874-3545 or Keith.Tucker(at)Navy.mil.//

5. Released by Vice Admiral Richard J. Cheeseman, Jr., N1.//

BT

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UNCLASSIFIED//

FISCAL YEAR 2022 ACTIVE COMPONENT ENLISTED FORCE MANAGEMENT ACTIONS (CORRECTED COPY):

ROUTINE
R 281524Z JUN 22 MID2000018999300
FM CNO WASHINGTON DC
TO NAVADMIN
INFO CNO WASHINGTON DC
BT
UNCLAS

NAVADMIN 142/22

PASS TO OFFICE CODES:
FM CNO WASHINGTON DC//N1//
INFO CNO WASHINGTON DC//N1//
MSGID/NAVADMIN/CNO WASHINGTON DC/N1/JUN//

SUBJ/FISCAL YEAR 2022 ACTIVE COMPONENT ENLISTED FORCE MANAGEMENT ACTIONS (CORRECTED COPY)//

REF/A/MSG/CNO WASHINGTON DC/192000ZNOV20//
REF/B/MSG/CNO WASHINGTON DC/131504ZDEC17//
REF/C/MSG/CNO WASHINGTON DC/311911ZMAR22//
REF/D/DOC/COMNAVPERSCOM/06JUN20//
REF/E/DOC/COMNAVPERSCOM/06JUN20//
REF/F/DOC/COMNAVPERSCOM/08MAY18//
REF/G/DOC/BUPERS/07FEB22//

NARR/REF A IS NAVADMIN 307/20, MODIFICATION TO EARLY SEPARATION POLICY NAVADMIN CANCELLATIONS.
REF B IS NAVADMIN 288/17, EARLY SEPARATION POLICY NAVADMIN CANCELLATIONS.
REF C IS NAVADMIN 084/22, TRANSITION OF ENLISTED SERVICE MEMBERS FROM ACTIVE COMPONENT TO RESERVE COMPONENT.
REF D IS MILPERSMAN 1910-108, SEPARATION BY REASON OF CONVENIENCE OF THE GOVERNMENT - EARLY RELEASE TO FURTHER EDUCATION

GOVERNMENT - EARLY RELEASE TO FURTHER EDUCATION.
REF E IS MILPERSMAN 1910-102, SEPARATION BY REASON OF CHANGES IN SERVICE OBLIGATION (ACTIVE DUTY AND INACTIVE NAVY RESERVISTS).
REF F IS MILPERSMAN 1160-120, HIGH YEAR TENURE.
REF G IS BUPERSINST 1430.16G CH-1, ADVANCEMENT MANUAL FOR ENLISTED PERSONNEL OF THE U.S. NAVY AND U.S. NAVY RESERVE.

RMKS/1. The purpose of this NAVADMIN is to implement key force management personnel policy actions in the enlisted active component to ensure the Navy remains fully manned and operationally ready. References (a) and (b) are hereby updated for enlisted personnel. For those who have decided to separate, please review reference (c) for additional career progression opportunities in the Navys Selected Reserves. Navy encourages all qualified Sailors to stay Navy. See your career counselor for more information. While we strive to retain all qualified Sailors, commanding officers should continue to exercise their obligation to document performance and adjust their recommendation for retention, accordingly.

2. Sailors are encouraged to look for selective reenlistment bonus (SRB) updates frequently to take advantage of the opportunities published on the Navy's SRB website at: https://www.mynavyhr.navy.mil/References/Pay-Benefits/N130D/. Please keep in mind SRB levels may be adjusted up or down depending on rating health.

3. Early Separation Cancellation. Effective immediately, all enlisted early out programs and new time in grade requirement waivers are hereby cancelled. Service commitments such as enlistment contracts, service obligations for accepting permanent change of station orders, advancements, bonuses, training, etc., will be fulfilled. Service members experiencing difficulty in fulfilling obligated service requirements are encouraged to work with their chain of command and respective detailers to examine available alternatives to complete their obligation.

a. Commanding officers still retain the 90-day early out authority for policy outlined in references (d) and (e).

b. Service members previously granted approval will not be affected by this policy change.

c. Service members interested in pursuing commissions in the Navy are still encouraged to submit requests. As always, these requests will be considered on a case by case basis.

d. United States Space Force applicants are not affected by this policy change.

4. Delaying separation or retirement. The Navy is accepting applications from enlisted personnel who desire to delay their

separation or retirement. The deadline for application submission is 31 August 2022.

a. Service members with an approved separation or retirement date on or before 31 March 2023 are eligible to submit a request to their detailer to have their separation or retirement date delayed and projected rotation date (PRD) extended, up to 30 September 2023, if the billet they are in upon submission of the request will be gapped upon their departure. Requests to extend beyond 30 September 2023 will be considered on a case by case basis for expected gaps in operational billets.

b. All Service members interested in extending retirements are invited to apply to their PERS-40 detailer to have their PRD extended no later than 90 days prior to the start of their previously requested terminal leave date or retirement date, (whichever comes first), via their chain of command utilizing their previously submitted Navy Standard Integrated Personnel System (NSIPS) voluntary retirement request. For example, if the Service members terminal leave date starts on 8 May 2023, then the request will have to be submitted on or before 7 February 2023 into NSIPS. NOTE: A form 1306/7 Electronic Personnel Action request (ePAR) is not required for previously submitted or approved retirements. Priority for approval will be given to those Service members filling sea duty and critical billets that would otherwise be gapped.

c. In line with reference (f), Service members who are separating or retiring due to high year tenure (HYT) may apply for a HYT waiver of their current HYT gate. HYT waivers will be considered for up to an additional 12 months for enlisted Sailors filling critical operational billets both at sea and shore that would otherwise be gapped, while maintaining the service members eligibility for advancement. Those service members will submit a command-endorsed ePAR to MyNavy Career Center (MNCC) via MyNavy Portal or by emailing the ePAR request directly to askmncc@navy.mil. Requests will be approved on a case by case basis.

d. Service members with an approved separation or retirement date that are in a sea duty billet, will remain on sea duty if their request for voluntary extension is approved.

(1) Sailors with an approved separation or retirement date who are in billets that are eligible for Sea Duty Incentive Pay (SDIP), and who are approved for a voluntary extension that exceeds their prescribed sea tour by at least 12 months, will receive SDIP.

(2) Exceptions to the timeline to request SDIP and to the length of extension for SDIP will be granted by Enlisted Distribution Division (PERS-40) to accommodate these requests. The latest SDIP eligibility chart can be found at https://www.mynavyhr.navy.mil/References/Pay-Benefits/SDIP/.

This chart is updated periodically so check for recent additions. For Service members who are in a SDIP eligible billet, an ePAR should be

submitted to MNCC at askmncc@navy.mil and their detailer.

(3) Service members approved for extension under this policy remain eligible to participate in the Navy wide advancement exam, or may be considered for advancement determination by a selection board if eligible, as long as they meet terminal eligibility date requirements set forth in reference (g).

c. While all service members are encouraged to apply, the following will not be considered:

(1) Service members who have executed any portion of their separation or retirement orders (e.g., household goods shipment).

(2) Service members pending mandatory separation or retirement for age.

(3) Service members approved for disability separation or retirement.

(4) Service members being separated for misconduct.

5. If you have any questions regarding delaying a Service members separation or retirement date contact the appropriate detailer, their Enlisted Community Manager, or the MNCC at: askmncc@navy.mil or phone: 1-833-330-MNCC(6622). Questions regarding SDIP should be directed to, PERS-40DD, 1-901-874-3545 or mill_sdip@navy.mil//

6. Released by Vice Admiral Richard J. Cheeseman, Jr.//

BT
#0001
NNNN
UNCLASSIFIED//

Exhibit C: Errata Sheet

Andrew E. Carmichael, Esquire
andrew.e.carmichael@usdoj.gov

RE: U.S. Navy Seals 1-3 Et Al v. Austin, Lloyd J. III Et Al
6/30/2022, William K. Lescher (#5289637)

The above-referenced transcript is available for review.

Within the applicable timeframe, the witness should read the testimony to verify its accuracy. If there are any changes, the witness should note those with the reason, on the attached Errata Sheet.

The witness should sign the Acknowledgment of Deponent and Errata and return to the deposing attorney. Copies should be sent to all counsel, and to Veritext at cs-midatlantic@veritext.com

Return completed errata within 30 days from receipt of testimony.

If the witness fails to do so within the time allotted, the transcript may be used as if signed.

Yours,

Veritext Legal Solutions

U.S. Navy Seals 1-3 Et Al v. Austin, Lloyd J. III Et Al

William K. Lescher (#5289637)

E R R A T A S H E E T

PAGE_____ LINE_____ CHANGE_____

SEE ATTACHED

REASON_____

PAGE_____ LINE_____ CHANGE_____

REASON_____

PAGE_____ LINE_____ CHANGE_____

REASON_____

PAGE_____ LINE_____ CHANGE_____

REASON_____

PAGE_____ LINE_____ CHANGE_____

REASON_____

PAGE_____ LINE_____ CHANGE_____

REASON_____

8/15/22

William K. Lescher Date

U.S. Navy Seals 1-3 Et Al v. Austin, Lloyd J. III Et Al
William K. Lescher (#5289637)

ACKNOWLEDGEMENT OF DEPONENT

I, William K. Lescher, do hereby declare that I have read the foregoing transcript, I have made any corrections, additions, or changes I deemed necessary as noted above to be appended hereto, and that the same is a true, correct and complete transcript of the testimony given by me.

William K. Lescher — Date: 8/15/22

*If notary is required

SUBSCRIBED AND SWORN TO BEFORE ME THIS 15 DAY OF August, 2022

NOTARY PUBLIC
LCDR Will Burroughs, JAG, USN

PAGE: NA LINE: NA CHANGE "vice chief" to "Vice Chief" (throughout)

REASON Proper title/noun

PAGE: NA LINE: NA CHANGE "joint staff surgeon" to "Joint Staff Surgeon" (throughout)

REASON Proper title/noun

PAGE: NA LINE: NA CHANGE "striker" to "Strike Group" (throughout)

REASON Proper title/noun correct term

PAGE: NA LINE: NA CHANGE "examplar" to "example" (throughout)

REASON spelling

PAGE__18__ LINE__15___ CHANGE "of the O6 level" to "at the O6 level"

REASON Correct preposition

PAGE__22__ LINE__19_ CHANGE "force of employment" to "force employment"

REASON Mistranscription

PAGE__33__ LINE__8-11___ CHANGE after "I personally do not" add period. Start new sentence with "I have

REASON Mistranscription

PAGE__37__ LINE__13_ CHANGE "unware" to "unaware

REASON Incorrect phrase

PAGE__39__ LINE 14-15_CHANGE "excellent intel" to "exfil capability"

REASON Mistranscription

PAGE__44_ LINE _15__CHANGE Insert comma (,) between "been" and "because

REASON Punctuation

PAGE__44__LINE__16__CHANGE_period (.) to comma (,) and make the "I" "It's" lower case to create one sentence

REASON Punctuation

PAGE__45__LINE__4__CHANGE_Add "the" after "So"

REASON Punctuation

PAGE__45__LINE__21__CHANGE_Remove "that"

REASON Mistranscription

PAGE__54__LINE__9__CHANGE_"the shore" to "ashore"

REASON Incorrect Term

PAGE__55__LINE__1 CHANGE "on" to "in"

REASON Incorrect Term

PAGE__55__LINE__2_CHANGE "in" to "and"

REASON Incorrect Term

PAGE__58__LINE__2_CHANGE add commas (,) on either side of the term "the commander"

REASON Punctuation

PAGE__59__LINE__2_CHANGE "the" to "their"

REASON Incorrect Term

PAGE__66__LINE__6 CHANGE Comma (,) after accommodation

REASON Punctuation

PAGE__71__LINE__6 and 18 CHANGE "depo" to depot"

REASON Incorrect Term

PAGE__78__LINE__8__CHANGE add comma (,) after adversary

REASON Punctuation

PAGE__82__LINE__14__CHANGE add I before "iterated"

REASON Mistranscription

PAGE__83__LINE__3__CHANGE remove "it"

REASON Mistranscription

PAGE__92__LINE__2__CHANGE "of NAV" to "OPNAV"

REASON Incorrect Term

PAGE__93__LINE__1_CHANGE "shop" to "shot"

REASON Incorrect Term

PAGE__93__LINE__12_CHANGE "residence" to "resident"

REASON Incorrect Term

PAGE__95__LINE__12_CHANGE Comma (,) after "rep"

REASON Punctuation

PAGE__95__LINE__15_CHANGE Add "it' before appears

REASON Mistranscription

PAGE__97__LINE_2-3_CHANGE replace "entered" with "nature of"

REASON Mistranscription

PAGE__116__LINE_21_CHANGE "some" to "same"

REASON Mistranscription

PAGE__122__LINE_2_CHANGE Remove "it led

REASON Mistranscription

PAGE__130__LINE_8_CHANGE _"at the RDC" to "FFRDC"

REASON Mistranscription

PAGE__130__LINE_12_CHANGE remove "the"

REASON Mistranscription

PAGE__131__LINE_11_CHANGE add "an" before "incremental"

REASON Missing term

PAGE__132__LINE_4__CHANGE _"Although" to "All of"

REASON Incorrect term

PAGE__146__LINE_13_CHANGE "expeditiously" to "expeditionary"

REASON Mistranscription

PAGE__155__LINE_12_CHANGE "shop" to "shot"

REASON Incorrect Term

PAGE__157__LINE_12_CHANGE replace "inconsistent" with "consistent"

REASON Mistranscription

PAGE__158__LINE_16_CHANGE "it" to "it's"

REASON Incorrect Term

PAGE__168__LINE_18_CHANGE delete "It's central, yeah" with "conceptually"

REASON Mistranscription

PAGE__174__LINE_14_CHANGE replace "trans medical readiness" with "transmissibility [sic]" (sounds likes "transmittinglyness")

REASON Mistranscription

PAGE__180__LINE_16_CHANGE "bases" to "basis"

REASON Mistranscription

PAGE__184__LINE_7_CHANGE add "that" before "these"

REASON Missing Term

PAGE__184__LINE_16_CHANGE add "of" before "specific conditions"

REASON Missing Term

PAGE__185_ LINE 16 CHANGE "so" to "is"

REASON Missing Term

PAGE__187_ LINE 5 CHANGE "higher tenure" to "high year tenure"

REASON Mistranscription

PAGE__187__LINE_7_CHANGE "opening to aperture" to "opening the aperture"

REASON Incorrect Term

PAGE__187__LINE_9_CHANGE "are" to "or"

REASON Incorrect Term

PAGE__188__LINE_13_CHANGE add comma (,) after"sustaining"

REASON Punctuation

PAGE__194__LINE_20_CHANGE "based" to "base"

REASON Incorrect Term

PAGE__198__LINE_9__CHANGE "Yard" to "Air"

REASON Incorrect Term

PAGE__198__LINE_13__CHANGE add "was" after "and"

REASON Missing Term

PAGE__198_LINE_18__CHANGE "squad" to "squadron"

REASON Incorrect Term

PAGE__199_LINE_1__CHANGE remove "a" before command

REASON Incorrect Term

PAGE__200_ LINE 2-3_CHANGE remove "4" replace with "forward" and remove "-" between "5-1" and "5-9" to read "51" and "59"

REASON Mistranscription

PAGE__200_ LINE 6-7__CHANGE replace "with – employes" with "which employs"

REASON Incorrect phrase

PAGE__202_LINE 9-10__CHANGE change "within side" to "with inside"

REASON Mistranscription

PAGE__205_ LINE 1-2 CHANGE "Navy component commanders and the combatant commanders" to "Navy Component Commanders and the Combatant Commanders"

REASON Proper noun/mistranscription

PAGE__209_ LINE 9 CHANGE Add "the" before "measures"

REASON Missing Term

PAGE__209_ LINE 14 CHANGE "so to" to "then to"

REASON Incorrect Term

PAGE__215_ LINE 2 CHANGE "talking" to "talked"

REASON Mistranscription

PAGE__215__LINE 8_CHANGE add "the" after "standard"

REASON Missing Term

PAGE__216_ LINE 7 CHANGE add "the" after "meet"

REASON Missing Term

PAGE__218_ LINE 4 CHANGE add "about the" after "today"

REASON Missing Term

PAGE__218_ LINE 4 CHANGE "are" to "is"

REASON Incorrect Term

PAGE__218_ LINE 12-14 CHANGE add "this" after doing

REASON Mistranscription

William K. Lescher August 15, 2022

IN THE UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF OHIO – Cincinnati Division

HUNTER DOSTER, et. al.	:	Case No.: 1:22-cv-00084
Plaintiff	:	
v.	:	
Hon. FRANK KENDALL, et. al.	:	
Defendants	:	

THIRD DECLARATION OF CHRISTOPHER WIEST

Pursuant to 28 U.S.C. §1746, the undersigned, Christopher Wiest, makes the following declaration, under penalty of perjury under the laws of the United States of America, that the facts contained herein are true and correct to the best of my knowledge and belief and that such facts are made based on my personal knowledge:

1. My name is Christopher Wiest, and I am one of the Class Counsel in this matter.
2. Attached hereto is a true and accurate copy of an email I sent to Government Counsel, with a proposed agreed order on August 18, 2022.
3. They did not respond, and thus did not agree.

Pursuant to 28 U.S.C. §1746, I declare under penalties of perjury under the laws of the United States of America that the foregoing Declaration is true and correct to the best of my knowledge and belief and that such facts are made based on my personal knowledge.

Executed on August 18, 2022.

Christopher Wiest

chris@cwiestlaw.com

From: chris@cwiestlaw.com
Sent: Wednesday, August 17, 2022 2:18 PM
To: 'Snyder, Cassandra M (CIV)'; 'Yang, Catherine M (CIV)'; 'Avallone, Zachary A. (CIV)'; 'Carmichael, Andrew E. (CIV)'
Cc: 'Wendy Cox'; 'Aaron Siri'; 'Elizabeth Brehm'; 'Tom B. Bruns'
Subject: Doster v. Kendall, Agreed Order
Attachments: AgreedOrderClass-8-17-22.docx

Counsel:

We have read your most recent filing. We were surprised to see some of the contents and claims being made about the order, because we believe that the order is clear and unambiguous.

We are not interested in any "gotchas," and to that end, we are sending over a proposed agreed to, which should satisfy a majority of the issues you recently raised. We are sure that both Judge McFarland and the Sixth Circuit, would appreciate narrowing the issues to those that actually involve material differences between the parties.

Please see the attached order. We are, obviously, willing to agree to it.

Because you have asked Judge McFarland for action on your motion by 8/19, we intend to submit this clarifying motion (for your client's benefit) to the Court, in a short response we intend to file tomorrow, if this does not meet your agreement.

Sincerely,

Christopher Wiest
Chris Wiest, Attorney at Law, PLLC
25 Town Center Blvd, Ste. 104
Crestview Hills, KY 41017
513-257-1895 (v)

IN THE UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF OHIO – Cincinnati Division

HUNTER DOSTER, et. al.	:	Case No.: 1:22-cv-00084
Plaintiff	:	
v.	:	
Hon. FRANK KENDALL, et. al.	:	
Defendants	:	

AGREED ORDER BETWEEN THE PARTIES CLARIFYING THE SCOPE OF THE PRELIMINARY INJUNCTION

The parties, through Counsel, in order to resolve certain issues that have arisen between them concerning the scope of the preliminary injunction entered on July 27, 2022 [Doc. 77], hereby agree to the following agreed order. Nothing in this agreed order waives any party's appellate arguments. The parties therefore agree, as a matter of clarification:

1. That the injunction, in paragraph 2, is confined to the class definition, in paragraph 1, of Doc. 77. The injunction, by its terms, only applies to members of the class, and thus only applies to "[a]ll active-duty, active reserve, reserve, national guard, inductees, and appointees of the United States Air Force and Space Force , including but not limited to Air Force Academy Cadets, Air Force Reserve Officer Training Corps (AFROTC) Cadets, Members of the Air Force Reserve Command, and any Airman who has sworn or affirmed the United States Uniformed Services Oath of Office or Enlistment and is currently under command and could be deployed," with all of the past tense language in that definition meaning that those individuals had met that definition, as of the date of the class modification, July 27, 2022 [Doc. 77], who: "(i) submitted a religious accommodation request to the Air Force from the Air

Force's COVID-19 vaccination requirement, where the request was submitted or was pending, from September 1, 2021 to the present" (i.e. July 27, 2022, the date of the order); "(ii) were confirmed as having had a sincerely held religious belief substantially burdened by the Air Force's COVID-19 vaccination requirement by or through Air Force Chaplains; and (iii) either had their requested accommodation denied or have not had action on that request." Those requirements, also with language in the past tense, indicates that the requirements had to have been met by the date of the modified class order (i.e. July 27, 2022), for someone to be a member of the class and for the injunction to provide relief to them.

2. Further, the injunction, which provided "Defendants shall not refuse to accept for commissioning or enlistment any inductee or appointee due to their refusal to get vaccinated for COVID-19 due to their sincerely held religious beliefs. Further, Members who submitted requests for religious accommodation may cancel or amend previous voluntary retirement or separation requests or request to transfer to the Air Force Reserve," is confined to people who met the class definition as of July 27, 2022.
3. Finally, insofar as the restrictions on National Guard are concerned, the application of the injunction is limited to the enforcement of the Secretary of the Air Force's vaccine mandate, for those meeting the class definition, and would not apply to any vaccine requirement that was separately imposed by any Governor, State Adjutant General, state legislature, or separate state authority.

IT IS SO ORDERED:

_____

Have Seen and Agree

_____
Zach Avallone, Counsel for Defendants

_____
Christopher Wiest, Counsel for the Class/Plaintiffs

IN THE UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF OHIO – Cincinnati Division

HUNTER DOSTER, et. al.	:	Case No.: 1:22-cv-00084
Plaintiff	:	
v.	:	
Hon. FRANK KENDALL, et. al.	:	
Defendants	:	

DECLARATION OF PATRICK POTTINGER

Pursuant to 28 U.S.C. §1746, the undersigned, Patrick Pottinger, makes the following declaration, under penalty of perjury under the laws of the United States of America, that the facts contained herein are true and correct to the best of my knowledge and belief and that such facts are made based on my personal knowledge:

1. My name is Major Patrick Pottinger, and I am a class representative in *Doster v. Kendall*. I am currently assigned to Randolph Air Force Base as an instructor pilot. In my current position, I am responsible for training Air Force fighter pilots in the Introduction to Fighter Fundamentals. This is an intense eight-week course that introduces Air Force pilots to tactical aviation. Classes start approximately every 3 weeks, and at any given time we have between 40-60 future fighter pilots training in our unit.
2. On March 28, 2022, I was removed from flying status due to my unvaccinated status. My request for religious accommodation had already been disapproved and my removal from flying status was used to coerce me into taking the COVID-19 vaccination against my religious beliefs.

3. After the initial preliminary injunction granted by Judge McFarland on March 31, 2022, my commander informed me that I would not be restored to flight status or operations at that time.
4. On April 22, 2022, my immediate commander informed me that he was restoring me to flying status administratively, but would continue to ground me from flying due to his "personal concerns" about me (all dealing with my refusal to vaccinate). While grounded I was directed by my commander to do meaningful work in support of the flying operation, and I was upgraded to an Operations Supervisor (Ops Sup).
5. For the next 13 weeks, I worked as the Ops Sup, where I was responsible for the execution of the daily flying schedule. In this role I was the primary liaison between squadron operations and aircraft maintenance during flying execution. I was also responsible for managing pilots' risk and had the final say as to whether they were cleared to fly. I made these decisions based on my own assessments of the readiness of the pilots and aircrew, the central Texas weather, the status of Randolph AFB, near airfield statuses, and my own prior experience as a 12+ year USAF veteran pilot. At the end of each shift, I was required to debrief the next Ops Sup as well as squadron leadership about pilots or aircraft involved in an unusual situation, in-flight emergencies, weather diverts, etc. I was not allowed to fly the airplanes myself, but I was allowed to send USAF Pilots, aircrew, and student Fighter Pilots out the door to fly after making assessments (in close proximity to them) about their own safety and readiness.

6. On June 8, 2022, I was returned to flying status and flew my first flight after being grounded for 13 weeks. I was informed that this was, in no small part, because of the pilot shortage.

7. I am generally aware that there is a significant pilot shortage Air Force wide, just as I am aware that the Air Force has failed to meet its accession (officer and enlisted) needs.[1]

8. Any delay in training these students will have a significant impact in further expanding that shortage as it takes approximately 2 years to train a fighter pilot, and that is just as a wingman. To build a combat ready 4-ship flight lead, who is ready to employ the standard fighting unit (a 4-ship) alongside multiple USAF Assets, it is closer to 5 years. I learned this as an F-22 Fighter Weapons Officer and while serving during 3 operational tours on Active Duty.

9. Suffice to say, pilots are not fungible, and thus the loss of pilots who are unvaccinated are not replaced with personnel who are. The pipeline for other career fields that are short (and there are many of them) are in the same predicament.

Pursuant to 28 U.S.C. §1746, I declare under penalties of perjury under the laws of the United States of America that the foregoing Declaration is true and correct to the best of my knowledge and belief and that such facts are made based on my personal knowledge.

Executed on August 18, 2022.

Patrick Pottinger

[1] https://www.nbcnews.com/news/military/every-branch-us-military-struggling-meet-2022-recruiting-goals-officia-rcna35078 (last visited 8/18/2022).

https://www.airforcetimes.com/news/your-air-force/2022/01/21/air-forces-enlisted-recruitment-pipeline-is-drying-up-general-warns/ (last visited 8/18/2022).