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

MARCIANO PLATA , et al.,

Plaintiffs

v.

ARNOLD SCHWARZENEGGER, et al.,

Defendants,

NO. C01-1351-T.E.H.

RECEIVER'S REPORT RE OVERCROWDING

TABLE OF CONTENTS

TABLE OF CONTENTS

Page

TABLE OF CONTENTS

TABLE OF CONTENTS

Page

I.

INTRODUCTION

In the Order filed February 15, 2007 the Court directed "the Receiver to report to the Court within 90 days of the date of this Order, his best assessment of the manner, and extent to which, overcrowding is interfering with his ability to successfully remedy the constitutional violations at issue." *Order* at 4:3 - 13. The Order also called for the Receiver to provide the Court with information concerning the "types of obstacles" that overcrowding presented to the Receivership. *Id.*

This report responds to the Order. It is organized as follows:

Section II. summarizes the findings which led to the Receivership. It also references the Receiver's Plan of Action concerning those remedial programs necessary to bring California's prisons up to constitutional standards.

Section III explains the special characteristics of prison overcrowding in California. As explained below, the specifics of prison crowding are far worse than previously explained by State officials. Furthermore, the characteristics of overcrowding within California's massive prison system have especially adverse consequences concerning the delivery of medical, mental health, and dental care. The impact of overcrowding presents complicated problems, challenges which further complicate the already difficult remedial challenge faced by the Receivership. Thus, very specific information relative to the real-life impact of overcrowding is necessary to provide relevant background data concerning the types and the scope of crowding related obstacles that interfere with the remedial programs developed by the Receiver.

Section IV summarizes the manner by which overcrowding interferes with the Receiver's remedial projects, discussing both "substantive" and "process" related interference.

Section V analyzes the real life impact of the recent 2007 California Legislation.

Section VI provides a conclusion concerning the Court's directives of February 15, 2007.

II.

CONSTITUTIONAL VIOLATIONS AT ISSUE

A. Introduction.

The California Department of Corrections and Rehabilitation ("CDCR") has failed to deliver constitutionally adequate medical care to the more than 170,000 prisoner/patients presently incarcerated in the State of California. There are three relevant frameworks of analysis within which it is possible to summarize the "constitutional violations at issue" referenced in the Court's February 15, 2007 Order.

B. Court's Findings of Fact and Conclusions of Law of October 3, 2005.

The Court's Findings of Fact and Conclusions of Law re Appointment of Receiver filed October 3, 2005 set forth facts which demonstrated that California' prison medical delivery system was broken beyond repair, holding that future injury and death was virtually guaranteed in the absence of drastic action. Those findings will not be repeated here; however, the Receiver believes it important to point out the following. As found by the Court, California's prison medical care crisis has persisted for decades. And while the State had ample opportunity to improve medical conditions, it failed to do so. The failure was caused, to a significant degree, by institutional paralysis and a lack of will. The State's response to decades of overcrowding is similar; despite various task forces, numerous studies and reports, and Special Sessions, California has not instituted any effective response to the worsening overcrowding crisis.

C. The Receiver's Bi-Monthly Reports.

The Receiver has submitted four Bi-Monthly Reports. Each provides up-to-date information concerning the deplorable state of California's prison medical care delivery. To summarize, the Receiver concludes that the degree of operational chaos within the CDCR, the institutional paralysis in many State agencies, and trained incompetence are even worse than indicated by the Court's findings.

D. Defendants' Inability to Provide Basic Medical Care Services Required by Plata Stipulations.

1. *Introduction.*

The final relevant measure of the "unconstitutional violation at issue" is the twenty-eight basic prisoner/patients services called for by the June 13, 2002 Stipulation for Injunctive Relief. These are the services which the State, for more than five years, had failed to provide.

2. *Provisions for Prisoner/Patient Services.*

1. Health screening: A process for screening all patients for communicable disease, such as tuberculosis and sexually transmitted disease, and chronic disease, such as diabetes, renal disease, seizure disorders, cardiovascular disease, and pulmonary disease; screening for cancer; review of vital signs, blood pressure, pulse, and weight; review of current medications; and nurse review and referral for patients with urgent or acute conditions; history and physical examination for all patients within 14 days of arrival at Reception Center; and routine laboratory tests, such as serum pregnancy, cholesterol screening, and optional HIV testing. (Stipulated Injunction ¶ 4)

2. Health transfer: Process to ensure continuity of care when patients transfer to another institution, transfer between levels of care, or are paroled, including continuity of medications, specialty referrals, and other treatment. (Stipulated Injunction ¶¶ 4, 6)

3. Access to Primary Care (Sick Call): System that allows patients to self-refer for medical treatment, including nurse review to identify the need for immediate referral to urgent or emergency treatment, an urgent walk-in procedure, and follow-up services; policies require face-to-face nurse triage for patients with symptoms within 24 hours, and an appointment with a primary care provider within 5 days for patients classified as urgent and within 14 days for patients classified as routine. (Stipulated Injunction ¶ 4)

4. Priority Ducat System: System for ensuring that custody staff treat health care appointments as high-priority. (Stipulated Injunction ¶¶ 4, 6)

5. Patient Health Care Education: Program to provide patients with instruction in wellness, lifestyle changes, disease prevention, newly diagnosed illness or disease, treatment

plans or procedures, pre- and post-operative care, chronic care morbidity reduction. (Stipulated Injunction ¶ 4)

6. Preventive Services: Services to prevent disease and mitigate morbidity and mortality due to existing disease provided to select patient populations based upon risk factors, such as age and chronic conditions, that include cancer screening, immunizations, and health education (education regarding diet, exercise, smoking cessation, etc.). (Stipulated Injunction ¶ 4)

7. Outpatient Specialty Services: Program for providing specialty services, including procedures for urgent and routine referrals and required follow-up; policies require that high-priority consultations or procedures occur within 14 calendar days and routine consultations or referrals within 90 calendar days, with follow-up by a primary care provider within 14 calendars days after the consultation or procedure. (Stipulated Injunction ¶ 4)

8. Physical Therapy: Program to ensure timely access to physical therapy services, including specifications for the follow-up by primary care providers and provisions for transferring to an institution with these services if the home institution does not provide them. (Stipulated Injunction ¶ 4)

9. Diagnostic Services: Program for the appropriate processing of laboratory tests and other diagnostic testing, including procedures for prioritizing the urgency of laboratory orders (STAT, critical, urgent, routine) and required timeframes for review and follow-up of results (routine laboratory tests processed within 14 days of order, x-ray examinations completed within 30 days of order, primary care provider review of lab results within two business days of receipt, notification of patient of results within 14 days of receipt). (Stipulated Injunction ¶ 4)

10. Medication Management: Services to dispense, administer, and distribute pharmacotherapeutic treatments, including provisions for medication error reporting, medication follow-up counseling, medication renewals and refills, medication for parole, and continuity of medication upon transfer; policies require that prescriptions for formulary medications be filled by the following day and that "stat" medications be issued within 1 hour. (Stipulated Injunction ¶ 4)

11. Urgent / Emergent Response: Program for the provision of urgent care services and 24-hour emergency medical treatment that includes basic life support, emergency response, and physician on-call services; policies require follow-up within five days for patients whose urgent encounter was due to chronic disease. (Stipulated Injunction ¶¶ 4, 6)

12. Medical Emergency Response Documentation and Review: Process for the review of deaths, suicide attempts, and calls for emergency assistance to determine compliance with existing policies and procedures, adequacy of response time, and appropriateness of custody and medical response and patient treatment, with follow-up actions to address identified deficiencies. (Stipulated Injunction ¶ 4)

13. Outpatient Housing Unit and Licensed Care: Specialized treatment services for varying levels of acuity, including outpatient services requiring specialized housing (Outpatient Housing Unit care), licensed skilled nursing facility care (Correctional Treatment Center care), General Acute Care Hospital care, and palliative care; policies require physician evaluation within 24 hours of admission to a Correctional Treatment Center and an evaluation by a primary care provider within 5 days for all patients returning from an inpatient acute care facility. (Stipulated Injunction ¶ 4)

14. Outpatient Therapeutic Diets: Program for the provision of nourishments and supplements for patients who are pregnant, diabetic, immunocompromised, malnourished, or have oropharyngeal conditions causing difficulty eating regular diets and special diets for patients with renal failure or hepatic failure, or who require a Heart Healthy diet, gluten-free diet, or diet to preclude food allergies. (Stipulated Injunction ¶¶ 4, 6)

15. Medical Report of Injury or Unusual Occurrence: Process for documentation of patients' on-the-job injuries, physical contact with a staff member during an incident, and any self-reported injury due to self-injury or altercation, Administrative Segregation Unit placement, use of force, or other medical emergency situation. (Stipulated Injunction ¶ 4)

16. OC Contraindications: Process for the evaluation and treatment of patients prior to or after the use OC. (Stipulated Injunction ¶ 4)

17. Medical Evaluation of Patients Involved in Assaults: Process for the evaluation of patients who have been involved in the use of force, including review of the patient's mental health record. (Stipulated Injunction ¶¶ 4, 6)

18. Hygiene Intervention: Process for the identification, evaluation, and referral of patients who demonstrate poor hygiene or whose hygiene compromises the sanitation/hygiene of their personal and immediate housing area. (Stipulated Injunction ¶ 4)

19. Inmate Hunger Strike: Process for the identification, evaluation, and treatment of inmates on hunger strike, including required coordination and reporting between custody and health care staff. (Stipulated Injunction ¶ 4)

20. Comprehensive Accommodation Chrono: Process for the authorization and review of special equipment, housing accommodations, or other accommodations that are medically necessary or are required under the Americans with Disabilities Act. (Stipulated Injunction ¶ 4)

21. Pregnant Patient Care and the Birth of Children: Prenatal care and post-delivery services, including required screenings, frequency of prenatal treatment visits, vitamin and nutritional requirements, referrals for child placement services, and post-partum follow-up; policies require that patients be seen by a obstetrics provider within 7 calendar days of determination of pregnancy that each patient be provided six-weeks post-delivery for follow-up. (Stipulated Injunction ¶ 4)

22. Nursing Services and Protocols: Clinical protocols for nurses in the appropriate evaluation and treatment of patients presenting with specific systemic conditions or complaints. (Stipulated Injunction ¶¶ 4, 6)

23. Health Record Services: Provisions for the management, content, and archiving of patient health records, including policies for disclosure of information. (Stipulated Injunction ¶ 4)

24. Chronic Care Program: Diagnosis and management of chronic disease (diseases lasting longer than 6 months), including identification and treatment of high-risk patients; policies require an initial intake evaluation within 30 days for patients referred to the Chronic

Care Program, and ongoing evaluations every 90 days. (Stipulated Injunction ¶¶ 4, 6)

25. Pharmacy Services: Provisions governing pharmacy operations, including pharmacy licensing, emergency drug supplies, drug storage, consultation with a pharmacist, prescription requirements, and the ordering, stocking, and receiving of medications. (Stipulated Injunction ¶ 4)

26. Public Health and Infection Control: Program for infection control, communicable disease reporting, and bloodborne pathogen control. (Stipulated Injunction ¶ 4)

27. Telemedicine Services: Program for the provision of specialty services through videoconferencing. (Stipulated Injunction ¶ 4)

28. Utilization Management: System to facilitate appropriate use of resources for patients requiring higher levels of care and select specialty services and medications, including reviews to determine placement at appropriate level of care and appropriate utilization of specialty care and pharmacy resources. (Stipulated Injunction ¶ 4)

3. *The Receiver's Plan of Action.*

On May 10, 2007 the Receiver filed his initial Plan of Action to remedy the unconstitutional medical care system in California's prisons. (Exhibit 1.)[1] As set forth in the Plan, the CDCR requires an entirely new infrastructure of medical delivery before necessary programs of clinical remediation can be effectively implemented in a sustainable manner. Therefore, when considering "the manner, and extent to which, overcrowding is interfering with his ability to successfully remedy the constitutional violations at issue," the Receiver necessarily referred not only to the stipulated injunctions re medical delivery (standards agreed to by the attorneys in this case), but also to the substance of the Plan of Action that will be necessary to successfully remedy the unconstitutional medical conditions in California's prisons.

[1] All exhibits referenced in this report are found in the Appendix of Exhibits Supporting the Receiver's Report Re Overcrowding filed concurrently with this Report.

E. Unconstitutional Medical Conditions Are Only One Part of an Unconstitutional Prison Health Care Delivery System.

Context is critical. The State of California has allowed its massive prison system to operate with unconstitutional levels of medical care. At the same time, however, the State is under Federal Court mandated remedial plans concerning the delivery of Mental Health, Dental, and Americans With Disability Act services. Under the best of circumstances, correcting medical problems present a significant challenge; however when the medical remedial plan must also consider the legitimate remedial objectives of the *Coleman*, *Perez*, and *Armstrong* class actions, in addition to uncontrolled overcrowding, the scope, duration, and cost of Federal Court intervention may increase dramatically, as explained below.

III.

THE SCOPE AND CHARACTERISTICS OF PRISON OVERCROWDING IN CALIFORNIA

A. Introduction.

From the perspective of a Receivership tasked with creating a medical delivery system that meets constitutional minima, the size, scope, pervasiveness and specifics of overcrowding in California's prisons have special negative consequences, as explained below.

B. The Pervasiveness of Prison Overcrowding in California.

1. *Introduction.*

Prison overcrowding is not a new phenomenon in California. To the contrary, overcrowding has been a way of life in the CDCR for twenty years. For example, as demonstrated below, overcrowding is ingrained in the CDCR style of constructing and managing prisons. Crowding related policies that do not provide adequate clinical and program space are now an accepted practice of CDCR prison planning, as is California's practice of offering inadequate salaries and failing to provide adequate hiring programs which have created crisis levels of shortages of clinical personnel and correctional officers.

2. *The Long Term Continuation of California Prison Overcrowding.*

Despite spending billions of dollars on construction, the level of overcrowding in California's prison system has not decreased; indeed, despite waves of prison expansion overcrowding has now reached crisis levels.

Exhibit 2 charts prison by prison and system-wide overcrowding from June 30, 1997 to May 4, 2007.[2] To summarize, in 1997 there were a total of 32 prisons within the CDCR with an average overcrowding rate of 196.0 percent for Males and 175.3 percent for Females. In 2002 there were 33 institutions (with the additional of Substance Abuse Treatment Facility ["SATF"]) and an average overcrowding rating of 191.3 percent for Males and 155.9 percent for Females. In 2007 the number of institutions remained at 33.[3] The Statewide overcrowding average for Male inmates increased to 196.4 percent and the Female overcrowding rating increased to 175.8 percent. In 1997 there were 11 institutions at or above 200 percent of overcrowding. By 2002 that number had increased to 12 institutions. By 2007, 19 institutions were at or above 200 percent of overcrowding. To summarize, despite massive waves of construction, prison overcrowding has grown worse in California.

3. *The Consequences of Decades of Overcrowding.*

No one disputes the consequences of decades of prison overcrowding; indeed, both formal studies and official proclamations affirm the crisis nature of today's overcrowding. For example:

a. Corrections Independent Review Panel.

Three years ago, June 30, 2004, an independent panel of experts, chaired by former Governor George Deukmejian issued a report entitled "Reforming Corrections." In a section titled "Inmate/Parole Population Management" the panel found California's prisons "filled to the

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[2] The chart was created based on the data obtained from the CDCR's Data Analysis Unit (from the "Monthly Report" for the dates specified).

[3] Kern Valley State Prison ("KVSP") was activated and Northern California Women's Facility ("NCWF") was deactivated.

breaking point," exceeding both "safe and reasonable capacity" and "far exceeding operable capacity." (Exhibit 3.)[4] The panel also found that numbers alone understated the impact of overcrowding, that staffing reductions have accompanied overcrowding, and that overcrowding and inadequate staffing impedes programming. The panel made a number of crowding related recommendations, none of which have been implemented.

b. Little Hoover Commission Report.

On January 25, 2007 California's Little Hoover Commission issued a report entitled "Solving California's Corrections Crisis - Time is Running Out" finding that California's prisons are swelled past capacity, that as a result of crowding there was little room or budget for rehabilitation, that California had a recidivism rate of 70 percent (near the highest in the United States), and that thousands of correctional officer shortages have created huge overtime bills and mounting stress for those officers on duty. (Exhibit 4.)

c. Governor Schwarzenegger's Declaration of Emergency.

On October 4, 2006 Governor Arnold Schwarzenegger proclaimed a State of Emergency because of prison overcrowding, declaring that "the current severe overcrowding in 29 CDCR prisons has caused a substantial risk to the health and safety of . . . the inmates housed in them . . . The declaration further stated that overcrowding puts prisoner/patients in "increased, substantial risk for transmission of infectious illnesses."

4. *A Progressive Lowering of Standards: CDCR Facilities Master Plans.*

A telling example of the CDCR's institutionalized acceptance of overcrowding and the lowering of correctional standards to accommodate overcrowding is found in CDCR "Facility Master Plan" documents. Exhibits 5, 6, and 7 contain relevant sections from the CDCR's Facility Master Plan for 1993-1998, 1995-2000, and 1998-2003. Reviewed in sequence, they provide insight into a correctional mindset that allows *overcrowding* rather than *sound correctional management* to drive crucial construction and prisoner management policy. Note

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[4] The entire "Reforming Corrections" report is found at cpr.ca.gov/report/indrpt/corr.

the following:

1. No Master Plan addresses overcrowding driven problems with the delivery of medical services. All the plans focus on corrections, as if medical, mental health, and dental care have no place in prison design, prison construction, or prison management.

2. As the CDCR failed to "build its way out" of the overcrowding crisis, crowding restrictions were steadily lowered, until by the issuance of the 1998-2003 Plan there were essentially no restrictions. For example, the 1993-1998 Master Plan (Exhibit 5) limited celled crowding to 130 of design percent and dormitory crowding to 120 percent of design capacity. By the 1995-2000 Master Plan (Exhibit 6), however, a 170 percent crowding standard was utilized for *the highest security prisoners, Level IV.* The 1998-2003 Master Plan (Exhibit 7) allowed for a 190 percent crowding rate at almost all prisons (and for the housing of prisoners in gyms). During these same years various CDCR housing definitions were repeatedly modified, and new terms were instituted such as "crisis" and "nontradtional" (the CDCR's designation for prisoners housed in classrooms, hallways, etc.). Prison staff refer to such beds as "ugly" beds.

C. California Prison Overcrowding Is Accompanied by Severe Staffing Shortages.

1. *Clinical Staffing Shortages.*

The Receiver has previously reported to the Court about the serious clinical vacancy rates throughout the CDCR's medical delivery system. Likewise, reports have issued concerning staffing shortages in the *Coleman* and *Perez* class actions. When considering the manner and extent to which overcrowding is interfering with his ability to successfully remedy the constitutional violations at issue, the Receiver must take into consideration the fact that overcrowding is accompanied by serious staffing shortfalls for both clinical providers and correctional officers.

For example, Exhibit 8 provides a snap shot comparison of clinical staffing shortages between January 31, 2002 and January 31, 2007.[5] Concerning every clinical category except for

[5] One difficulty encountered by the Receiver when preparing this report is that limited and at times inaccurate staffing data is maintained by the CDCR. The figures in Exhibit 8 were obtained

registered nurses, vacancies are worse today than five years ago.[6]

The true scope of clinical staff shortfalls is actually *far worse* than the numbers set forth in Exhibit 8 because there are additional staffing needs projected in each of the health care class actions as well as upcoming time-phased "roll-outs," none of which are yet listed on the chart.

2. *Custody Staffing Shortages.*

Correctional officer vacancies on April 30, 2002 were 1,179. As of January 31, 2007 "budgeted" correctional officer vacancies had risen to 1,915.[7] However, the actual total of officer vacancies is several hundred higher than the "budgeted" vacancies due to the practice of assigning "unbudgeted" positions for posts such as medical guarding at community hospitals, and monitoring and providing services for prisoners confined to "nontraditional" beds. CDCR officials estimate the actual officer shortage to be somewhere between 2,400 and 2,700.

Based on response to numerous inquiries by the Office of the Receiver, there appear to be no innovative or unique CDCR program that has been developed to address the correctional officer shortage. To the contrary, the existing system of recruitment and hiring is experiencing bottlenecks in its recruitment process that may have an adverse impact on the number of cadets admitted to future academy classes. For example, according to CDCR personnel, as of Friday, May 11, 2007 there were somewhere between four to seven thousand "unassigned" background verifications awaiting processing (background checks are required for correctional officer applicants who successfully complete the CDCR's initial testing programs). The exact backlog is not known in that the background unit is behind in entering data into its computer tracking

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from the State Controller's Office; thus, there may be a time lag in the reporting of actual staffing shortfalls, as well as hires. Nevertheless, these numbers represent accurate "ball park" estimates of the scope of staffing shortages between 2002 and 2007. These numbers do not, however, consider future staffing enhancements and roll-outs. According to CDCR staff, hundreds of additional dental, medical, and mental health clinicians will be needed to comply with remedial plan standards.

[6] Improved rates of hiring and retaining registered nurses are the result of the Receiver's salary increase and the Receivership's streamlined clinical hiring process.

[7] These figures were provided by the CDCR's Human Resources Division based on State Controllers Office data.

system.

3. *Managerial and Executive Staffing Shortages.*

In addition to the severe staffing shortfalls within the ranks of clinicians and correctional officers, the CDCR has also experienced very significant turnover among its executive and managerial ranks, ranging from Secretaries to Wardens. Likewise, given the unconstitutional conditions in health services, turnover among prison Chief Medical Officers and Chief Physicians and Surgeons remains excessive.

D. The Short Average Length of Sentences Among California Prisoners.

According to CDCR statistical records, the average sentence for a California prisoner is 46.7 months, and the average time served is 24.1 months. (Exhibit 9.) Given the fact that California confines thousands of prisoners facing Life or Life Without the Possibility of Parole sentences, the CDCR average time served is indicative of two distinct classes of California prisoners: (1) longer term prisoners, a significant portion of whom (but not all) are confined to Level III and Level IV prisons; and (2) a group of short term prisoners (of whom a significant percentage are parole violators) who come into and go out of the CDCR with such frequency that the average length of CDCR sentences is pushed down to two years.

Each class of prisoner has different and distinct medical needs. Therefore, when implementing the Plan of Action, the Receiver must consider this characteristic of California prison crowding. Lifers, for example, will eventually age and require special housing as infirm patients. On the other hand, the constant churning of parolees into and out of the CDCR (and between CDCR institutions) requires special clinical and correctional support staff at reception centers and in the "receiving and release" units at each state prison.

E. The Impact and Severity of California Prison Overcrowding Varies By Institution.

1. *Introduction.*

The California prison system is unique not only in terms of its overall size and prisoner population, but also because of a wide variety of different types of prisons, the remote location of most prisons, and the different impacts of overcrowding at each specific institution. As a

result, overcrowding related negative impacts on the Plan of Action become both complicated and interrelated. There is no single fixed strategy that can be employed by the Receiver to bring medical care delivery in California's prisons up to constitutional standards. Invariably, the overcrowding problems at each specific prison are unique, and specialized remedial programs must be developed for each.

2. *Factors Which Determine the Impact of Overcrowding In California's Prisons.*

1. Degree of Overcrowding: As shown in Exhibit 2, not all CDCR prisons suffer from the same degree of overcrowding. The challenge of providing constitutional medical care at a prison with more than two hundred percent overcrowded will be different from the challenge at a prison that is less crowded.

2. Institution Size: California opted to construct mega-prisons in the 1980s and 1990s, a strategy rejected by other jurisdictions. In addition, California has a policy of adding new prisons to sites with older prisons, creating a number of prison complexes (e.g. the California Institute for Men ["CIM"] and the California Correctional Institution at Techachapi ["CCI"]). Ultra-large prisons and prison complexes which are severely overcrowded, as they are today, create special medical delivery challenges, as well as recruitment difficulties.

3. Remote Location: Many of mega-prisons constructed in the 1980s and 1990s have been sited in remote locations, far from the urban centers where it may be possible to recruit adequate numbers of competent clinicians. With the remote prisons so severely overcrowded, recruitment problems have intensified, not only for clinical personnel but also for correctional officers.

4. Institutional Design: Because of overcrowding, many California prisons which should have been de-commissioned decades earlier remain not only fully operational, but operate at 200 percent of their design capacity. Thus in terms of real life remedial fixes, it is a far different problem addressing the impacts of overcrowding on the aged, poorly maintained and diverse housing units at San Quentin or Old Folsom, compared to the impacts of crowding presented by

a prisoner population of more than 260 percent of design capacity as at the more modern but sprawling and remotely-located prison located at Avenal.

5. Institution Mission: Many CDCR prisons have been charged with special "missions." Because there has been no adequate long-term planning in CDCR, prison specific missions have been assigned in a manner that inhibits the establishment of a safe and effective medical remedial plan. In most cases the designation of CDCR prison "missions" are comprehendible only in a historical context. The diversity, lack of organization among missions, ad hoc and incompetent changes in mission combined with severe crowding will complicate the timely and cost effective implementation of the Plan of Action, especially when the Plan calls for assigning the appropriate patient to the appropriate medical delivery facility.

For example, Avenal State Prison has been designated for *Armstrong* class members and for housing older, low security prisoners – despite its remote location and the resulting difficulties hiring adequate numbers of clinicians. Salinas Valley State Prison contains a long term "Intermediate" mental health facility for high security inmates, despite being hundreds of miles from outpatient mental health units at Pelican Bay State Prison ("PBSP") and California State Prison-Sacramento (which feed patients into and accept patients from the Intermediate unit). Prisoners with medical conditions that may make them especially vulnerable to Valley Fever, for example, patients with serious kidney problems, are housed in prisons in the Central Valley, the primary locus of Valley Fever spores, because those facilities have been designated for the delivery of dialysis treatment. Correcting these types of anomalies will be difficult, requiring an entirely new program of cohorting patients, which will in turn require modifications to the manner by which CDCR classifies inmates and assigns them to specific prisons. This challenge is rendered far more difficult, however, because of the extent of the CDCR's overcrowding.

F. The Velocity of Prisoner Movement Within the CDCR.

1. *Introduction.*

Overcrowding creates increased prisoner movement as correctional officials struggle to

manage crowding by transferring prisoners from institution to institution in a constant search for "open" beds. This form of crowding driven movement adversely impacts on health care delivery in at least six important ways. First, adequate health care in the correctional environment requires some form of "intake" or "reception" screening whenever a prisoner arrives at an institution. The health care screening (medical, mental health, and dental) that takes place at a CDCR Reception Center is necessarily wider in scope and more complete than the intake screenings which take place as a result of inter-prison transfers; nevertheless, both processes call for specific clinical reviews, reports, and the coordination of necessary follow-up care. Thus, an increase in prisoner movement equals an increased workload concerning screening. Second, all "out" transfers from a CDCR prison require action by health care staff, including, in some cases, an evaluation of whether the prisoner is fit for transfer. Third, the appropriate medical records must accompany the transferring prisoner. However, given the existing transportation process, the speed by which transfers need to be effectuated, and the absence of any form of electronic record, this means that a paper record must be assembled, updated, transported to the intake and release area and physically placed inside the transportation vehicle with the transferring prisoner for delivery to the reception nurse at the receiving institution in time for the intake screening. Not surprisingly, many prisoners are transferred without their records. Fourth, some percentage of inmates who are transferred must be provided with medication during the transfer process, and plans must be initiated for the timely renewal of medications at the receiving institution, placing an additional work load on physicians, pharmacy personnel, nurses and correctional officers. Fifth, some percentage of transferring inmates must be afforded special transportation (and in some cases must be accompanied by clinical personnel) during the transfer, a staff intensive procedure for both clinical and correctional personnel. Finally, transfer often adversely impacts patient clinician relationships and clinical programs (whether medical, mental health, or dental oriented). Given the scope of overcrowding, however, and an unceasing need for more and more transfers, the present CDCR system functions in a manner whereby classification driven decisions are primary, with medical/mental health/dental issues assuming a secondary and in

every instance unacceptably low level of importance.

2. *The Scope of Prisoner "Moves."*

Given the State's decision to construct very large correctional facilities and given the decision to site many prisons in remote locations, it is not surprising that CDCR effectuates hundreds of thousands of prisoner moves each year. Movement into and out of the CDCR, as well as between CDCR prisons has now reached crisis proportions. For example, Exhibits 10 through 12 provide a prison-by-prison summary of inmate movement into and out of specific institutions, as well as a systemic total, for the months of January, February, and March 2007.[8] In total there were *more than 170,000 prisoner moves during the first quarter of calendar year 2007 alone.* CDCR reception centers were especially hard hit. For example, the California Institution for Men ("CIM"), a male reception center, averaged *more than 11,000 prisoner moves* each month.

3. *Mission Change and "Yard-Flips."*

In addition to an increasing velocity of prisoner movement and its adverse impact on attempts to deliver constitutionally adequate medical care, correctional officials in the CDCR are forced, because of the pressures of overcrowding, to constantly re-evaluate the correctional mission of each CDCR institution and to periodically alter those missions in order to provide housing for classifications of inmates for whom bed shortages have become especially acute.

Yard flips (a procedure whereby housing units or yards within a prison are designated for a different classification of prisoner) and mission changes (a procedure whereby an entire prison is designated for a different classification of prisoner) exemplifies yet another characteristic of California prison overcrowding: *the real life impact of crowding is not only in the overall numbers, but also in the population pressures created by a lack of beds for specific classifications of prisoners.* For example, an increase in long term violent offenders classified as

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[8] Official CDCR statistics are reported by counting a prison transfer "out" and the resulting prison transfer "in" (at a different institution) as only one move. However, because both the transfer out and the transfer in require some form of health care intervention, this report totals all moves.

Level IV prisoners requires an increase in celled housing. An increase in short term non-violent offenders calls for increased housing in dormitories/lower security housing.[9]

Yard flips and mission changes are necessitated by classification related housing shortage. In essence, one classification of prisoner is moved out of a specific yard or prison and transferred to other institutions while a different classification of prisoner is moved into those units. Exhibit 13 summarizes CDCR bed conversions from February 2003 through May 2007.

It is important to emphasize that with increasing overcrowding, yard flips and missions changes have become an unceasing process. *See*, for example, Exhibits 14 - 16, three CDCR Memorandums issued the same day – March 30, 2007. The first calls for 11 emergency revisions to previously issued "Institution Activation Schedules," the second converts Facility D of the California State Prison at Los Angeles County ("LAC") from a Level IV General Population housing unit into a Reception Center, and the third converts Centinela State Prison from a Level III prison to a Level IV prison.

4. *The Heightened Negative Impact of Overcrowding on CDCR Reception Centers.*

Because of overcrowding, the Plan of Action faces special challenges relative to CDCR reception centers. For example:

1. One of the factors driving California prison overcrowding is the State's failure to implement rehabilitation programs. Therefore, in California, high percentages of paroled prisoners either "violate" their conditions of parole or "re-offend" with a new crime.

2. Thus CDCR reception centers have, during the past twenty years, encountered ever increasing prisoner movement pressures as more and more prisoners flow into the CDCR for relatively short terms of incarceration. As demonstrated by Exhibits 10 - 12, this flow into the CDCR has a special impact on reception centers such as CIM, SQ, the Deuel Vocational Institute ("DVI").

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[9] As explained below, when analyzing the impact Assembly Bill 900, creating additional CDCR dormitories will not address the crisis shortage of Level IV cells.

3. Reception centers are institutions which must be staffed and have the appropriate clinical space to provide a level of medical care and clinical evaluations above that of the general population institutions. When a former prisoner violates parole or re-offends, he or she returns to the CDCR through a reception center where a medical/mental health/dental health care appraisal must be performed. Once that appraisal is completed the newly received prisoner is transferred to an open bed at a prison which has been designated for his or her classification. However, none of the CDCR's designated reception centers were designed or constructed with adequate clinical space. To make matters worse, as the original prisons designated for reception became overwhelmed by the influx of parole violators, the CDCR was forced to "convert" general population prisons into reception centers. These "conversions," however, were not accompanied by adequate additions to clinical staff or clinical space. For example when San Quentin, the State's oldest prison, converted to a reception center it was allocated an entirely inadequate temporary relocatable structure, which until the Receiver began his San Quentin Pilot Project, had not been renovated or replaced.

The degradation of CDCR reception process continues to this day. As Exhibit 15 demonstrates, because of overloads at other reception centers, slowly but surely, yard by yard, LAC is mutating into a full blown reception center. Although chapels and libraries have been converted into some additional clinical space, LAC has neither the staffing nor the clinical space to accomplish the health care elements of reception.

G. The State's Failure to Plan, Design, and Build Appropriate Clinical Space In Its Newest and Most Modern Prisons.

The Receiver has discovered that the Plan of Action, as it relates to overcrowding, cannot assume adequate prison medical clinics/treatment area infrastructure exists even in California's newest and most modern prisons. To the contrary, when measuring the impact of overcrowding on his remedial efforts, the Receiver is forced to consider the following two facts:

(1) the newest CDCR prisons were designed with clinic space which is *only one-half that necessary for the real-life capacity of the prisons;* and

(2) while millions of dollars have been allocated for prison health care space projects during the past five years, the great majority of the project were never completed; indeed, some projects do not appear to exist.

1. *Inadequate Clinical Support Space in the State's Newest and Most Modern Prisons.*

In the beginning of the prison construction boom in the early 1980s, the CDCR developed a "Prototypical Prison Policy Design Criteria." (Exhibit 17.) This policy has been revised over the years and continues to reflect CDCR and the State's policy on what will be built at each new prison. In 1988 the policy was revised to clearly reflect the reality of overcrowding in the prison system even at that time. The policy states that at Level II, III, IV and reception centers, certain functional areas of the new prison will be built to accommodate 130 percent overcrowding. Those functional areas included *only* personnel, accounting, inmate records, procurement, receiving and release and family visiting. The policy goes on to mandate that the infrastructure at new prisons, (which includes *only* water, wastewater, electrical, mechanical) will be designed to accommodate 190 percent overcrowding in celled prisons and 140 percent overcrowding in dormitory prisons. Thus, at a policy level, by default, the CDCR short-changed by at least 50% all health care related space needs.

Therefore, while the overcrowded populations of the modern facilities approach or exceed two hundred percent, and regardless of how the CDCR attempts to *characterize* the level of crowding, the available clinic space is *one half of what is necessary for daily operations.*

This CDCR policy and practice, for more than twenty years, to limit health care space, including staff offices, examination/treatment rooms and medical beds, to only the base staffing level of the institution, ignoring pre-existing plans to double-cell the prison up to 200 percent of capacity, adversely impacts the daily medical, mental health, and dental operations at the following prisons.

1. Avenal State Prison
2. California State Prison-Calipatria

3. California State Prison-Centinela
4. California State Prison-Corcoran
5. California State Prison-Solano
6. Chuckawalla Valley State Prison
7. California State Prison-Sacramento
8. High Desert State Prison
9. Mule Creek State Prison
10. Ironwood State Prison
11. Kern Valley State Prison
12. California State Prison-Los Angeles County
13. North Kern State Prison
14. Pelican Bay State Prison
15. Pleasant Valley State Prison
16. R.J. Donovan Correctional Facility
17. Substance Abuse Treatment Facility
18. Salinas Valley State Prison
19. Wasco State Prison

2. *A Case Study of How CDCR Construction Planning Ignores the Crowding Related Clinical Space and Staffing Needs of the CDCR Health Services Program - Kern Valley State Prison.*

Kern Valley State Prison ("KVSP"), the CDCR's newest prison, opened in June of 2005, was built to a standard of "base staffing", except for water, wastewater, electrical, mechanical. (Exhibit 18.) To summarize, absolutely no consideration was given to the real life impact on the prison's health care program that would result by the CDCR's plans to immediately double cell the entire prison. As a result of this policy, at KVSP the health care space on each of the four semi-autonomous facilities was limited to accommodate one Primary Care Provider's office based on the ratio of 1 doctor for every 500 inmates. Each of the four facilities was also built

with one Examination/treatment room, a medication distribution/sick call window, and a dental operatory/office.

Likewise, in KVSP's Central Health Care Services space the number of "infirmary beds" was determined by the prison's "design" bed capacity, even though CDCR officials knew before the construction began that the prison would be overcrowded. A Correctional Treatment Center ("CTC") was subsequently constructed in lieu of infirmary beds. KVSP has a design capacity of 2,448 inmates. Based on the CDCR's space standards this would then require KVSP to have 1 medical bed for every 125 inmates for a total of 19 beds. In fact KVSP has a total of 24 CTC beds. However, KVSP now confines not 2,448 inmates but, as of April 4, 2007, 4,952 inmates (202.3 percentage of overcrowding).

Based on the level of overcrowding at KVSP they should have at least 38 medical beds in order to accommodate the inmate-patient needs. Likewise KVSP now needs, even under the CDCR's own standards (which the Receiver finds inadequate as explained below) twice the number of clinical offices, clinical space, and infirmary beds as presently exist. In essence, KVSP was planned, designed, and subsequently constructed knowing full well that the medical, mental health, and dental space and staffing would be entirely insufficient for the prison's actual population.

3. *Millions of Dollars Allocated for Prison Health Care Space Projects and Little to Show for It.*

A summary of health care services Capital Outlay projects for the past five fiscal years is set forth in Exhibit 19. This information is significant when evaluating CDCR efforts to address the pervasive lack of health care space within its prison system. As stated above, each and every prison approved, funded and built by the State over the past twenty plus years was constructed to only accommodate "base staffing" only – except for infrastructure, water, wastewater, electrical, mechanical and certain other functions (such as receiving and release, family visiting, and accounting). The policy to build only to base staffing levels has left the CDCR in crisis regarding the clinical space needed to provide constitutional levels of access to health care.

In a small effort to attempt to improve this flawed system, CDCR had obtained in the past five years approval to go forward with a limited number of health care space projects. For example, in fiscal year 2002/03 a total of $6.917 million was approved, one-third of which was for a Ambulatory Care Center at CMF, which has in fact been completed. Many other projects, however, such as $375,000 allocated for a CTC at SQ and $1.9 million for a "Hospital" at DVI have not come to fruition. SQ does not have a CTC, nor does DVI have a hospital. Unfortunately, the CDCR construction program has a tendency to invest significant funds for the planning of projects which fail to come to fruition. For example, in fiscal year 2003/04 Ironwood State Prison ("ISP") received approved for an expenditure of $3.8 million for the completion of a CTC. These funds were in addition to $50,000 approved in 2002/03. As of this date the CTC has not been completed, as of today it does not house a single inmate or provide any health care services to inmates at ISP. Likewise, during fiscal year 2004/05 $1 million was approved for a nineteen chair dialysis center at SATF. The construction has finally, years later, been completed; however due to litigation over the contracting-out for the dialysis services, the operation of the chairs is not fully implemented. In fiscal year 2006/07 $2.5 million was approved for a "Hospital" at DVI, in addition to a fiscal year 2002/03 allocation of $1.9 million. After inquiries, the Receiver's staff were informed that this particular CDCR allocation is in fact controlled by the Department of General Services for a "seismic retrofit" of an "infirmary building." The Receiver has not approved this project; in fact, he was not aware of it until the preparation of this report, despite the allocation of $4.4 million.

In addition to the above projects, each year the CDCR has been allocated approximately $5 million for "Minor Capital Outlay" projects. These funds were allocated on a priority basis as determined by CDCR officials. Through this process, some CDCR institutions have received funds to provide additional health care space. For example, at Wasco State Prison a triple-wide trailer has been added for clinician office space, primarily utilized by mental health staff. A new health care building has been constructed next to the existing Central Health Clinic at Avenal State Prison, which, unfortunately, is located hundreds of yards of away from inmate housing

units. This space is primarily utilized for staff offices. At California State Prison Solano, a building was constructed on the Facility IV grounds approximately eight to ten years ago, to be utilized by mental health staff. In 2006 at R.J. Donovan custody staff moved out of their offices for use by health care staff, and a trailer has been placed in a plaza area for use as additional health care offices. At Sierra Conservation Camp ("SCC") an office has been converted into a telemedicine clinic, and at Mule Creek State Prison a former vocational area on Facility B has been converted into mental heath clinics and offices. Nevertheless it cannot be disputed that, based on the CDCR budget of the last five years, very little health care space has been added to any of the prisons which now confined at least twice as many inmates as they were designed to hold.

IV.

THE MANNER IN WHICH OVERCROWDING INTERFERES WITH THE RECEIVER'S ABILITY TO SUCCESSFULLY IMPLEMENT TIMELY PROGRAMS WHICH WILL REMEDY THE UNCONSTITUTIONAL VIOLATIONS AT ISSUE

A. Introduction.

Overcrowding interferes with the Receiver's ability to successfully remedy the constitutional violations at issue in two significant ways: (1) substantive interference; and (2) process interference.

B. Crowding Related Substantive Interference With the Receiver's Remedial Programs.

As explained in the Plan of Action, in order to implement adequate and sustainable programs which will bring California's prisons up to constitutional standards of medical delivery, the Receiver needs to both establish the necessary correctional care infrastructure and to implement time phased, coordinated medical delivery programs. Overcrowding will inhibit this process in a number of significant ways.

1. *Crowding Related Obstacles to the Recruitment, Hiring, and Retention of Competent Medical Personnel.*

The Receiver's top priority during the next two years will involve recruitment, hiring and

the implementation of orientation and training programs to improve retention of necessary clinical staff (including physicians, mid-level providers, registered nurses, licensed vocational nurses), as well as support staff ranging from information technology staff to office assistants. Overcrowding adversely impacts this efforts in three ways:

a. The long-standing nature of California's prison overcrowding and the CDCR's policy of deliberately short changing the need for clinical space, combined with crisis levels of staffing shortages creates adverse barriers to the Receiver's ability to recruit and retain necessary, competent medical care staff. The Receivership will be building from "the ground up" a medical delivery system within a prison culture where what should be a relatively simple task – bringing a patient to a prison clinic – presents an almost insurmountable challenge because the number of patients who need care far exceeds the number of correctional officers available for escorts. Concerning some of the most basic elements of an adequate medical delivery system, the Receiver has found that the State's long standing acceptance of overcrowding, combined with staffing shortages, has created a culture of cynicism, fear, and despair which makes hiring and retaining competent clinicians extremely difficult.

b. The total number of clinicians and support staff needed because of the present levels of overcrowding is far above the number that would have been needed if all CDCR prisons operated at their design capacity. For the same reasons, the difficulties that would have been faced recruiting competent medical providers for the CDCR's remote prisons is also intensified, requiring necessary but costly remedial programs such as developing an air force to transport physicians out of urban areas to and from work assignments in rural prisons.[10]

c. Some of the special characteristics of California prison overcrowding will require

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[10] In similar fashion, overcrowding will render other infrastructure programs set forth in the Plan of Action more difficult to effectuate. For example, an increase in the number of clinicians needed to care for prisoner/patients will require an increase in the number of computer terminals that will eventually be installed as part of a new information technology system. Likewise the number of medical records needs to increase as the inmate population increases, and therefore additional space must be constructed for medical records. In similar fashion the amount of medical supplies must be increased, as well a pharmacy services, etc.

significant numbers of additional clinical personnel. For example, the number of additional clinical staff that will be needed at CIM to provide health assessments, monitor medical records, provide follow-up care, and ensure that appropriate medications are provided for more than 12,000 inmate moves each month will be significant to say the least.

To summarize, the cost and the duration of the remedial effort of the Receiver's recruitment, hiring and retention programs will increase significantly because of overcrowding. In some rural counties, the number of clinicians and support staff needed to bring local prisons up to constitutional standards may well require additional salary increases for CDCR clinicians and a resulting disruptive impact on the availability of clinicians for county and private health care programs.

2. *Crowding Related Obstacles Re the Development of Competent Managers and Executives.*

In similar fashion, overcrowding has an adverse impact on the Receiver's ability to recruit and retain competent health care managers and executives. As the Court is aware the Receiver has filed a motion to establish Receiver Career Executive Assignment ("RCEA") positions. Given on-going intensification of overcrowding, not only will the recruitment of such personnel be more difficult, but the larger the remedy, the more managers and executive who will be necessary.

To summarize, the cost and the duration of the remedial effort of the Receiver's recruitment, hiring and retention of managers and executives will increase significantly because of overcrowding.

3. *Crowding Related Obstacles Preventing the Establishment of Constitutionally Adequate Reception Center And Inter-Prison Transportation Procedures.*

The stipulated *Plata* injunction, as set forth above, calls for adequate reception center health care appraisals and the appropriate programs to protect prison medical conditions during inter-prison transportation. However the present velocity of prisoner movement into and out of reception centers as well as between prisons creates a serious obstacle to meeting these

objectives. Given present conditions, hundreds of additional "budgeted" correctional officers and clinical staff will be required to appropriately manage the hundreds of thousands of inmate moves that take place every year, not to mention a vast fleet of transportation vans and escort vehicles.

To summarize, the cost and duration of the remedial effort of the Receiver's programs for adequate reception centers and inter-prison transportation practices will increase significantly because of the velocity of prisoner movement in the CDCR.

4. *Crowding Related Obstacles Concerning Provisions for an Adequate Number of Health Care Beds.*

An adequate number of different levels of medical care beds are an absolutely necessary component of the Plan of Action. Overcrowding presents an obstacle to achieving this objective because, as explained by the Receiver in his bi-monthly reports, three different types of additional construction will be necessary:

1. The addition of approximately 5,000 new medical beds to provide the appropriate treatment, care, and sheltered living for CDCR prisoner/patients. To a significant degree, these beds are necessary because the CDCR has neither planned for nor provided adequate medical beds for disabled prisoners, aged inmates, and prisoners who need some form of sheltered living due to their medical or mental health conditions.

2. The construction of an as yet undetermined amount of additional clinical space at existing CDCR prisons, primarily because of (a) the existing level of overcrowding and (b) the CDCR's long standing policy and practice of constructing new prisons with design capacity limitations on clinical space and thereafter operating those facilities at 200 percent of design capacity.

3. The construction of an as yet undetermined amount of clinical offices, medical records storage areas, medical supply warehouses, etc., primarily because of (a) the existing level of overcrowding and (b) the CDCR's long standing policy and practice of constructing new prisons with design capacity limitations on clinical space and thereafter operating those facilities at 200

percent of design capacity.

To summarize, the cost and duration of the remedial effort of the Receiver's construction programs will increase significantly because of overcrowding.

5. *Crowding Related Obstacles Concerning Medical Delivery Support Services.*

California prison overcrowding will also impact those elements of the Plan of Action which provide for necessary medical support services. For example, the Office of the Receiver is presently involved with a program to completely restructure the CDCR's medical contracting process. Very positive initial results have been achieved. However an increasing number of prisoners in the more remote prisons has placed a heavy burden on a very limited number of hospitals and speciality providers which in turn has created obstacles in the Receiver's efforts to achieve a more efficient, patient oriented, and less wasteful contracting process. Overcrowding presents similar obstacles to other support services. For example, the use of telemedicine should be, and will be expanded for both improved patient care and cost containment purposes. However, even the most simple of necessary expansion steps; for example, finding a room adequate for telemedicine purposes often presents an unsurmountable barrier because California's prisons were constructed without adequate clinical or office space for the numbers of inmates housed at the prison.

To summarize, the cost and the duration of the remedial effort of the Receiver's Plan to implement necessary medical care support services will increase significantly because of overcrowding.

C. Crowding Related Process Interference With The Receiver's Remedial Program.

1. *Introduction.*

Every element of the Plan of Action faces crowding related obstacles. Furthermore, overcrowding does not only adversely impact the Receiver's substantive plans, it also adversely impacts on the very process of implementing remedies because overcrowding, and the resulting day to day operational chaos of the CDCR, creates regular "crisis" situations which call for action on the part of the leadership of the Receivership and take time, energy, and person power

away from important remedial programs. Examples of crowding related crisis/chaos situations which impact on Receivership's remedial activities include the following.

2. *Out of State Transfers.*

The Receiver and his staff worked in a diligent manner to support the Governor's efforts to effectuate out of state transfers. This effort required the implementation of a formalized health screening process; training nursing staff on screening; allocating staff to conduct screenings; allocating staff to inspect the private out-of-state prisons where CDCR prisoners would be confined; and reviewing contracts with private prisons to ensure that mechanisms existed to provide compliance with Court orders, etc. Suddenly, however, the process was halted due to State Court decisions. Recently, however, plans for out of state transfers have begun again due to the passage of Assembly Bill 900, although questions apparently remain concerning future State Court processes. Starting, then stopping, and then restarting these support efforts must be managed in a careful manner so that the Receivership does not begin to experience the day to day chaos which afflicts the CDCR.

3. *Responding to Mission Changes and Yard Flips.*

In a similar manner, the Receiver has attempted to work with CDCR concerning the various mission changes and yard flips associated with increased overcrowding. However it has been necessary on occasion to stop changes which would have put prisoner/patients in increased jeopardy of receiving inadequate medical care. Needless to say, monitoring mission changes and yard flips has become a full time activity. It may be necessary for the Receiver to provide direct oversight over CDCR yard flips and mission changes at some time in the future should this problem further exacerbate efforts to implement the Plan of Action.

4. *Disturbances.*

CDCR reports an increasing number of overcrowding related prisoner disturbances. Most disturbances are followed by prisoner "lock downs," and on occasion the lock downs are protracted. Lockdowns call for a radically different form of medical delivery than the services provided under normal general population conditions. Under normal operating procedures,

inmates housed in general population leave their housing units to go to yard clinics to see medical providers, to receive medications, etc. Under lockdown conditions, clinical staff must go from cell to cell to see the prisoner/patient, or small groups or individual prisoners must be escorted by correctional officers to and from clinic areas. In either case, lockdowns inhibit the delivery of medical care and increase the staffing necessary for such care. As crowding related disturbances increase, the Receiver may need to modify the Plan of Action in order to establish special clinical and correctional officer staffing standards for those institutions which function under lockdown conditions on a regular basis.

5. *Infectious/Communicable Disease Management.*

As reported in the Fourth Bi-Monthly Report, overcrowding has increased the number and seriousness of infectious and communicable diseases, jeopardizing prisoners, staff, and the public. Thus far system wide outbreaks have been avoided, however, given the number of prisoners, conditions in gyms and hallways converted to housing units, the velocity of prisoner movement between institutions and in and out of the CDCR itself, the risk of such an outbreak cannot be underestimated.

6. *The Inability to Deliver Basic Health Care Services Due to Staffing Shortage and Increased Numbers of Inmates.*

Many CDCR prisons are unable to sustain the basic delivery of medical, mental health, and dental services because of limited staffing (clinical and custody) and an overwhelming number of prisoner/patients who require care. Every day, many California prison wardens and health care managers make the difficult decision as to which of the class actions, *Coleman*, *Perez*, *Armstrong* or *Plata* they will fail to comply with because of staff shortages and patient loads. This in turn creates crisis conditions (as described in the Fourth Bi-Monthly Report concerning Avenal State Prison) which, because it requires immediate attention, diverts the Receiver's resources from Plan of Action related activities.

7. *Class Action Coordination Issues Aggravated by Overcrowding.*

Overcrowding combined with twenty years of CDCR construction practices has created

competition and tensions between medical and mental health providers concerning use of clinical space. For example, because of the failure, for more than fifteen years, to provide an adequate number of inpatient beds for prisoners with very serious mental illnesses, prison CTC beds confined many patients in a mental health "crisis" creating shortages of CTC beds for medical needs which, at times, pits medical staff against mental health staff. In similar fashion, the failure by the CDCR to plan for and construct beds for aged and disabled prisoners has lead to a practice of using the CTC beds for sheltered living housing, creating similar tensions. While these issues are being addressed in monthly coordination meetings between the Receiver, the Special Master in *Coleman*, and the Court experts in *Perez*, they present another series of serious, constant problems which divert attention from Plan of Action remedial programs.

The Receiver recognizes that he is responsible for a prison medical delivery system in crisis and therefore regular crisis situations, and the appropriate response, are to be expected. However, without question, overcrowding and the resulting chaos in the CDCR has an adverse impact on the Receiver's efforts to implement the Plan of Action, and the day to day problems created by overcrowding will increase both the cost and the duration of his remedial efforts.

V.

THE IMPACT OF ASSEMBLY BILL 900

A. Introduction.

This report would not be complete without the Receiver commenting on the possible impacts of Assembly Bill ("AB") 900. A summary of the bill follows.

B. Summary of AB-900.

Section 1. Name of Act.

Names act as "the Public Safety and Offender Rehabilitation Services Act of 2007."

Section 2. Prison Construction—Phase I

Requires the CDCR to add up to 7,484 beds at 10 specified prisons.[11]

Requires the CDCR to add an additional 4,516 beds after site assessments are completed

[11] Government Code 15819.40(a)(1)(A).

at other facilities.[12]

Requires that the above beds be supported by rehabilitation programming.[13]

Declares that purpose of new beds built under this phase is to replace "temporary beds"—not to house additional inmates.[14]

Authorizes construction of reentry program facilities for up to 6,000 inmates.[15]

Authorizes construction of new buildings at existing CDCR facilities "to provide medical, dental, and mental health treatment or housing for 6,000 inmates."[16]

Subjects all projects to approval and administrative oversight of State Public Works Board.[17]

Authorizes the State Public Works Board to issue bonds to finance construction.[18] Authorized costs for medical, dental and mental health construction are $857,100,000.[19]

Section 3. Prison Construction—Phase II

In addition to the construction required in Phase I, authorizes the CDCR to construct 4,000 beds at existing prison facilities, and requires that such beds be supported by rehabilitation programming.[20]

In addition to the construction authorized in Phase I, authorizes the CDCR to construct new buildings at existing CDCR facilities "to provide medical, dental, and mental health treatment or housing for 2,000 inmates."[21]

In addition to the construction authorized in Phase I, authorizes the CDCR to construct reentry program facilities that will house up to10,000 inmates.[22]

Subjects all projects to approval and administrative oversight of State Public Works

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[12] Government Code 15819.401(a)(1)(B).
[13] Government Code 15819.40(a)(2).
[14] Government Code 15819.401(a)(3).
[15] Government Code 15819.40(b).
[16] Government Code 15819.40(c).
[17] Government Code 15819.401.
[18] Government Code 15819.403.
[19] Government Code 15819.403.
[20] Government Code 15819.41(a).
[21] Government Code 15819.41(b).
[22] Government Code 15819.41(c).

Board.[23]

Authorizes the State Public Works Board to issue bonds to finance construction.[24]

Authorized costs for medical, dental and mental health construction under Phase II are $285,700,000.[25]

Provides that the board may not release funds for Phase II construction until a 3-member panel, composed of the State Auditor, the Inspector General and an appointee of the Judicial Council of California, has certified that 13 specified requirements have been met.[26]

Authority provided for Phase II construction expires on January 1, 2014, but projects already commenced may be completed.[27]

Sections 4 & 5. County Jail Facilities

Relates to the financing and construction of county jail facilities, and authorizes the issuance of up to up to $750,000,000 in bonds for that purpose.

Authorizes the issuance of an additional $470,000,000 in bonds for county jail construction if the 3-member panel has certified that certain conditions have been met.

Section 6. Rehabilitation Incentives

Requires CDCR to implement a system of incentives to increase inmate participation in academic and vocational education.[28]

Section 7. Management Deficiencies

Requires CDCR to implement a plan to address management deficiencies.[29]

Section 8. Rehabilitation Plan

Requires CDCR to implement a plan to obtain additional rehabilitation and treatment services for prison inmates and parolees.[30]

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[23] Government Code 15819.411.
[24] Government Code 15819.413(a).
[25] Government Code 15819.413(a).
[26] Government Code 15819.417; Penal Code 7021.
[27] Government Code 15819.417.
[28] Penal Code 2054.2.
[29] Penal Code 2061.
[30] Penal Code 2062.

Section 9. Inmate Payments; Report to Legislature

Requires CDCR to report to the Legislature on whether existing laws related to payments to inmates released from prison are hindering the success of parolees and resulting in their rapid return to prison for parole violations.[31]

Section 10. Substance Abuse Treatment

Requires CDCR to expand substance abuse treatment services in prisons to accommodate at least 4,000 additional inmates.[32]

Section 11. Interdisciplinary Assessments

Requires CDCR to conduct interdisciplinary assessments for the purpose of program placement.[33]

Section 12. Day Treatment and Crisis Care for Parolees

Authorizes CDCR to obtain day treatment, and to contract for crisis care services, for parolees with mental health problems.[34]

Section 13. Prison to Employment Plan

Requires CDCR to develop an Inmate Treatment and Prison-to-Employment Plan.[35]

Sections 14 & 15. OIG: California Rehabilitation Oversight Board

Creates within the OIG the California Rehabilitation Oversight Board, which will examine and report on CDCR mental health, substance abuse, educational and employment programs.[36]

Section 16. Reentry Program Facilities

Relates to the establishment and operation of the re-entry program facilities authorized in Phases I and II of construction described above.

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[31] Penal Code 2713.2.
[32] Penal Code 2694.
[33] Penal Code 3020.
[34] Penal Code 3073.
[35] Penal Code 3105.
[36] Penal Code 6140 & 6141.

Section 17. Master Plan

Expands provisions defining facilities "master plan" to include the department's plans to activate or remove temporary beds in dayrooms, gyms, and other areas.[37]

Sections 18 & 19. Submission of Plans and Reports to Joint Legislative Budget Committee

Requires CDCR to submit to the Joint Legislative Budget Committee (prior to submissions of preliminary plans to the State Public Works Board) (1) a preliminary facility plan, (2) an operating cost estimate, (3) a staffing plan, (4) a plan for medical, dental and mental health care, and (5) a programming plan.[38]

Requires CDCR to submit annual and quarterly reports to the Joint Legislative Budget Committee regarding the status of funded projects, including medical, mental health and dental projects.[39]

Section 20. Communication with Local Governments

Requires CDCR to meet with representatives of cities or counties related to new permanent housing units prior to CEQA review.[40]

Section 21. [Repeals]

Section 22. Phase II Construction Panel

Creates 3-member panel charged with verifying whether certain conditions have been met before the State Board of Public Works may release funds for Phase II construction.[41]

Section 23. Temporary Construction

Authorizes use of portable or temporary buildings for housing and rehabilitation programming.[42]

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[37] Penal Code 7000.
[38] Penal Code 7003.
[39] Penal Code 7003.5
[40] Penal Code 7004.5.
[41] Penal Code 7021.
[42] Penal Code 10007.

Sections 24-26. Out-of-State Transfers

Temporarily authorizes (until 2011) out-of-state transfers of inmates, without inmate consent.[43]

Provides that "no inmate with serious medical or mental health conditions, as determined by the Plata Receiver, or an inmate in the mental health delivery system at the [EOP] level of care or higher may be committed or transferred to an institution outside the state unless he has executed a written consent to the transfer."[44]

Section 27. Training Academy

Authorizes CDCR to establish a training academy for correctional officers in southern California.[45]

Section 28. Supplemental Infrastructure Capacity & Rehabilitation Funding

Appropriates $350,000,000 from the General Fund to CDCR for capital outlay to renovate, improve, or expand infrastructure capacity at existing prison facilities and to supplement funds for rehabilitation and treatment of prison inmates and parolees.

Section 29. Urgency Statute

Provides that Act goes immediately into effect.

C. CDCR Does Not Have An Adequate Plan to Create "In-Fill" Beds With the Necessary Support (Including Health Care Clinic) Space.

1. *Introduction.*

Following a first review by his staff of AB 900 and an evaluation of CDCR plans to implement AB-900, the Office of the Receiver can provided initial findings concerning possible impacts of the bill, as set forth below.

2. *Inadequate Space Allocations For Health Care Services.*

The CDCR's Infill Bed Plan is included as Exhibit 20. A summary of the space proposed to be allocated for health care space (medical, mental health, and dental) is attached as

[43] Penal Code 11191(a).
[44] Penal Code 11191(b).
[45] Penal Code 13602.1.

Exhibit 21. As is apparent from the summary, the clinical space allocated to different prisons are wildly disparate, and in many cases obviously inadequate. For example, for clinical purposes, the proposed administrative segregation unit at Avenal (190 beds) is allocated 2,970 square feet of space, while the administrative segregation unit at Calipatria (190 beds) is allocated 2,127 square feet of space and the administrative segregation unit at Centinela (190 beds) is allocated 1,779 square feet of space.[46]

The Receiver has not been informed concerning what elements of the January 2007 Infill Bed Plan will be utilized under AB-900. Regardless, there exists a fundamental error in the manner in which CDCR has traditionally approached health care clinic construction (in addition to the past practice of allocating only one-half as much space as actually necessary given the real prisoner population intended for new prisons). CDCR allocates *space only*, ignoring the real life differences in clinical requirement based on the characteristics of the patient population, security level and escort officers requirements, the need for clinical privacy, equipment requirements, and other critical factors.

In terms of all future clinic construction, the Receiver believes that, consistent with standards promulgated by the National Commission on Correctional Health Care ("NCCHC") and because of the vast differences among facilities, design, number of facilities in any given prison complex, and the age of buildings, rather than specifying square footage adequate space will be based on a number of different standards including the type of service provided, the need for pharmacy services, equipment need, inmate classification, supply needs, examination services, etc. (Exhibit 22.)

3. *Inadequate Overall Health Care Space Allocations.*

It must be noted that the existing CDCR construction related space allocations for clinics

[46] In addition to requiring medical and dental treatment, inmates confined to administrative segregation require heightened levels of mental health care and monitoring. Historically, a very high percentage of CDCR suicides take place in administrative segregation housing units. Therefore it is essential that the planning and construct of administrative segregation housing provides for enhanced space for mental health clinical interview and staff offices. The January 2007 Infill Plan appears to ignore this.

and clinical office space are inadequate. For example, the CDCR allocation of 60 square feet for a nursing station, given the need for examination equipment, escorts, records, etc. is grossly inadequate. Exhibit 23 provides a summary of certain of the major shortfalls of current CDCR allocations.

4. *Conclusion.*

The existing CDCR Infill Bed Plan, if allowed to be implemented without oversight by the Receiver, the Special Master in *Coleman*, and the Court representatives in *Perez* and *Armstrong* will jeopardize prisoner/patient care and have a serious adverse impact on the Receiver's ability to implement the Plan of Action in a timely and cost effective manner.

D. AB-900 Will Not Reduce the Number of "Temporary ("Ugly") Beds at the Ten CDCR Prisons Subject to AB-900.

Phase I of AB-900 identifies ten prisons that will have a total of 7,184 beds added to their design capacity. The stated intent of AB-900 is to build new prison capacity which will "replace the temporary beds currently in use, and they are not intended to house additional inmates." AB-900 defines temporary beds as "those that are placed in gymnasiums, classrooms, hallways, or other public spaces that were not constructed for the purpose of housing inmates."[47] The CDCR, in its Master Bed List refers to these same beds as "non-traditional overcrowding beds."

In order to determine if AB-900, if fully implemented as written will reduce the existing and overcrowding levels at these ten prisons, Exhibit 25 was created. The first column of this exhibit lists the ten prisons as specified by AB-900 followed by the current security level and number of "temporary beds". The third column sets forth the CDCR's proposed Infill Bed Plan for each of the ten prisons by security level. For example, at Pleasant Valley State Prison there currently exists 774 Level III "temporary" beds and 150 Level IV "temporary" beds. However, the CDCR Infill Bed Plan proposes to add only 600 Level II beds.

From what the CDCR has provided, it appears that the total number of beds that will be "replaced" as required by AB-900 will be limited to 472 reception center beds. Eight of the ten

[47] A summary of "temporary beds," also know as "ugly beds" is attached as Exhibit 24.

prisons will have zero temporary beds replaced based on CDCRs In-Fill Bed Plan. Based on the fact that only 472 reception center temporary beds will be taken down per AB-900, the remaining 4,280 exiting temporary beds at these ten institutions will remain filled with inmates.

It may be possible to fill proposed Infill beds at these ten prisons with inmates from other prisons. However in Phase I of AB-900 the vast majority of the 7184 new beds being created are Level II beds (4,300 beds). The movement of Level II inmates from other institutions' "temporary beds" into the new housing units may have a positive impact on the sending institutions, *but only if they are then prohibited from back filling those temporary beds.* However considering the CDCR's history and practice of filling all available beds, coupled with the fact that AB-900 does not prohibit such action, we should anticipate that CDCR will continue to house inmates in these temporary beds even *after inmates are moved to the ten institution's new housing units*. In reality, therefore, AB-900 will serve only to increase the number of prisoner/patients who will required medical, mental health, and dental care.

E. AB-900 Does Not Address The CDCR's Most Serious Need For Additional Prison Beds.

The Infill Bed Plan proposes total (Phase I and II) addition of 16,238 beds, of which 9,440 are Level II beds, which will have some impact on the severe crowding at lower level prisons. The Infill Bed Plan, however, does nothing to address the serious levels of crowding within the CDCR's most dangerous high security prisons.

The top chart in Exhibit 26 summarizes the CDCRs projected Male population needs by security level from fiscal year 2007/08 through fiscal year 2011/12.[48] The first column identifies the fiscal year, the second through the eighth columns identifies the security level, and the last column is the projected grand total of Male inmates. The CDCR projects that the Male population for all security levels except Protective Housing Unit will increase over the next five fiscal years. The greatest increase is projected to be at security level IV with 3,830 additional

[48] This information was obtained from the CDCRs Spring 2007 Adult Population Projections 2007-2012 report.

Male inmates to be accommodated within the existing overcrowded institutions. Level IV prisoners are considered by the CDCR to be the most dangerous in terms of escape risk and potential for in-prison misbehavior.

The lower chart compares *only* the additional projected Male population needs with the CDCRs proposed In-Fill Bed Plan. Based on this comparison, there appears to be a significant disconnect between the CDCR's projected housing needs, especially in its most dangerous prisons, and what the CDCR is planning to build. For example, CDCR projects an increase of 3,840 Level IV inmates while the CDCR's Infill Bed Plan does not include a single Level IV bed. The same is true for Security Housing Unit (SHU) inmates with a projected increase of 425 inmates with no plan to increase the SHU beds by even one bed/cell.

Given current levels of overcrowding at two of the CDCR's Level IV and SHU institutions, a serious need for additional Level IV and SHU beds is clearly demonstrated. For example, as of April 4, 2007 Pelican Bay State Prison ("PBSP"), a SHU and Level IV institution was operating at 154.5% of design capacity. Salinas Valley State Prison ("SVSP") another Level IV institution as of April 4, 2007 was operating at 206.8% of design capacity. The failure to plan for additional Level IV beds based on the current level of overcrowding and the projected increase of Level IV and SHU bed needs, will create additional severe overcrowding within the CDCR's most dangerous and difficult to manage prisons at this time. If overcrowding intensifies in the CDCR's highest security institutions, the Receiver's effort to implement the Plan of Action will require more time and additional funding.

F. AB-900 Re-Entry Facilities.

AB-900 proposes to site and construct numerous re-entry facilities throughout the State. Each of those facilities will require clinical staff to provide intake and exit health care assessments. In addition, each facility will require on-site health care staff to delivery needed care. In essence AB-900 calls for a new set of institutions to be included in the existing Federal Court remedial plans. Given the record in this case, the Receiver must assume that adding more CDCR institutions will increase the cost and the time necessary to implement the Plan of Action.

G. Staffing.

It is easy to talk of constructing prisons and jails. It is more difficult and expensive to staff correctional institutions with the appropriate clinical personnel and correctional officers. AB-900, however, is silent about how the jails and prisons beds cited in the bill will be staffed and managed. Unless and until adequate staffing is provided, the Receiver anticipates that the additional beds proposed in AB-900 institutions will increase the cost and the time necessary to implement the Plan of Action.

VI.

CONCLUSIONS

The Receiver summarizes his best assessment of the manner and extent to which overcrowding is interfering with his ability to successfully remedy the constitutional violations as follows:

1. The Receiver's Plan of Action will work. Failure is not an option. Over time the CDCR's medical delivery system will be raised to constitutional levels. However, the time this process will take, and the cost and the scope of intrusion by the Federal Court cannot help but increase, and increase in a very significant manner, if the scope and characteristics of CDCR overcrowding continue. For example, the Receiver can, over time and with great expense, develop a reception center medical delivery system that will appropriately handle the more than 11,000 prisoner moves into and out of CIM each month. The cost of such effort, however, may all but bankrupt the State of California and create a medical delivery problem in Riverside and San Bernardino counties because there may not be enough competent clinicians to both provide medical care for an unlimited number of State prisoners and for the public also. Thus, when the Court considers the issue of intrusion relative to controlling overcrowding, it should also consider the scope of intrusion that will be necessary to provide constitutionally adequate medical care in California's prisons if overcrowding is not managed.

2. The manner by which overcrowding is managed will have a fundamental and perhaps irrevocable impact on the Plan of Action. For example, if the State's response is limited to

effectuating out of state transfers, and thereafter filling empty beds behind departed prisoners, the overcrowding related challenges to the Plan of Action will only increase and it will take the Receiver longer and it will cost more to correct the constitutional violation at issue. Likewise, if the State charges off to construct infill beds in remote locations without adequate support services space, including adequate clinical space, overcrowding related challenges to the Plan of Action will only increase, and as a result, it will take the Receiver longer and it will cost more to correct the constitutional violation at issue. Finally, unless steps are taken to stop the revolving door of a failed parole system and thereby manage the out-of-control number of prisoner moves, the churning related challenges to the Plan of Action will continue and it will take the Receiver longer and it will cost more to correct the constitutional violation at issue.

3. Finally, and perhaps more important, it is critical that the Court and counsel understand that the motion for a three judge panel can be separated and distinguished from the fundamental challenges faced by Receivership. While the attorneys for plaintiffs have filed three separate requests for a three judge panel in three different cases, it is important to emphasize that even if a three judge panel is appointed and even if the California prison system is, over time, capped, and even if its population is reduced by, for example, twenty-five percent (thereby releasing from existing housing units as many as 42,500 prisoners), the challenges faced by the Receiver and the Courts in *Armstrong*, *Coleman*, *Perez*, and *Plata* would remain a daunting one: to provide constitutional levels of prison health care for 125,000 prisoner/patients who will remain confined thirty-three inadequately constructed prison that function far above their correctional design capacity. Thus, even when assuming some form of population management, it will take years of effort and significant State resources to address the prison health care problems faced by the Federal Courts in California at this time.

To summarize, those who believe that the challenges faced by the Plan of Action are uncomplicated and who think that population controls will solve California's prison health care problems, are simply wrong. Population limits may help effectuate a more timely and cost effective remedial process. However, the cure to existing health care problems will be difficult

and costly to implement, regardless of population control efforts.

4. The following remedial actions in *Plata* are warranted now:

a. The CDCRS "in-fill" bed project, if allowed to proceed without oversight by the Receiver may well jeopardize prisoner patient health care. The Receiver recommends that the Court issue an order compelling the Secretary of the CDCR to file, within fifteen days, a report to this Court and to the *Armstrong*, *Coleman*, and *Perez* Courts concerning all aspects of the "infill" project, *including all studies and expert reports* that have been conducted relative to the issue of whether adequate space exists to construct additional non-medical beds with the appropriate support services, including clinical space. The Receiver has reviewed prior CDCRS submissions and recommends that the order should specifically require an executive summary of all proposed infill programs not to exceed ten pages.

b. The CDCR's long standing failure to hire an adequate number of correctional officers jeopardizes prisoner patient heath care. The Receiver recommends that the Court issue an Order to Show cause compelling the Secretary of the CDCRS to file, within fifteen days, a response as to why the Receiver should not begin to provide direct oversight over the CDCR's correctional officer recruitment and hiring program.

c. The Office of the Governor will be filing responsive pleadings to the Court's February 15, 2007 Order concurrently with this filing by the Receiver. The Receiver recommends that the Court consider whether the Governor should create his Plan of Action concerning how California will address the serious correctional problems afflicting the CDCR. Thus far, the Governor has worked to encourage the initial successes of the Receivership; however, for the Receiver's Plan of Action to be implemented in the most timely and cost effective manner possible, the State should develop a CDCR Plan of Action. As pointed out in this report, the CDCR's lack of planning, the day to day chaos within the CDCR, and its long standing failure to effectively perform basic correctional functions including prison construction and correctional officer hiring jeopardize prisoner patient medical care. The development of and adherence to a complementary correctional Plan of Action will enhance efforts by the Federal

Courts to bring California's prison health care up to constitutional standards of access and quality and will thereby hasten the return of the system back to the State.

Dated: May 14, 2007.

Robert Sillen
Receiver

PROOF OF SERVICE BY MAIL

I, Kristina Hector, declare:

I am a resident of the County of Alameda, California; that I am over the age of eighteen (18) years of age and not a party to the within titled cause of action. I am employed as the Inmate Patient Relations Manager to the Receiver in *Plata v. Schwarzenegger*.

On May15, 2007 I arranged for the service of a copy of the attached documents described as RECEIVER'S REPORT RE OVERCROWDING on the parties of record in said cause by sending a true and correct copy thereof by pdf and by United States Mail and addressed as follows:

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I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on May 15, 2007 at San Francisco, California.

Kristina Hector