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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, et al.,

Plaintiffs,

v.

EDMUND G. BROWN, Jr., et al.,

Defendants.

Case No. Civ S 90-0520 LKK-JFM

DECLARATION OF MICHAEL W. BIEN IN SUPPORT OF PLAINTIFFS' OPPOSITION TO DEFENDANTS' MOTION TO TERMINATE

Judge: Hon. Lawrence K. Karlton
Date: March 27, 2013
Time: 10:00 a.m.
Crtrm.: 4

I, Michael W. Bien, declare:

I am an attorney admitted to practice law in California, a member of the bar of this Court, and a partner in the law firm of Rosen Bien Galvan & Grunfeld LLP, counsel of record for Plaintiffs. I have personal knowledge of the matters set forth herein, and if called as a witness I could competently so testify. I make this declaration in support of Plaintiffs' Opposition to Defendants' Motion to Terminate.

1. Attached hereto as **Exhibit 1 is** a true and correct copy of the CDCR Offender Information Services Branch Weekly Population Report as of February 27, 2013, which was downloaded by one of our paralegals from CDCR's public website located at http://www.cdcr.ca.gov/Reports_Research/Offender_Information_Services_Branch/WeeklyWed/TPOP1A/TPOP1Ad130227.pdf. According to the data provided in this Report, CDCR institutions were at 149% of capacity on February 27, 2013.

2. Attached hereto as **Exhibit 2 is** a true and correct copy of a CDCR Report entitled, "EOP Cases Assigned Bus Seats for the Week of February 11, 2013" and a CDCR Report, entitled, "CCCMS Cases Assigned Bus Seats for the Week of February 11, 2013," produced by Defendants as DPRD2-000075 to DPRD2-000076.

3. Attached hereto as **Exhibit 3** is a true and correct copy of a January 25, 2013 Report analyzing 6 years of suicides in the CDCR. The report is entitled "CDCR Suicides: Results of Recent Analysis," and is a report by Dr. Robert Canning that was attached to an e-mail by Amy Eargle to Maria Jones on Monday February 11, 2013. This was produced as part of a large group of documents in response to plaintiffs' document request and was not bates-stamped.

4. Attached hereto as **Exhibit 4** is a true and correct copy of the Transcript of the Deposition of Jacqueline Moore, RN, PhD. taken on February 21, 2013 excerpted at 162:11 -163:7 and 163:10 –163:13.

5. Attached hereto as **Exhibit 5** is a true and correct copy of the Transcript of the Deposition of Jacqueline Moore, RN, PhD. taken on February 21, 2013 excerpted at 166:4 - 168:9.

6. Attached hereto as **Exhibit 6** is a true and correct copy of the Transcript of the Deposition of Jacqueline Moore, RN, PhD. taken on February 21, 2013 excerpted at 179:5 - 180:12.

7. Attached hereto as **Exhibit 7** is a true and correct copy of an email produced by Defendants in response to plaintiffs' document request, from James Telander, dated January 30, 2013 with the subject line: MCSP SRE Mentor Program, but was not bates-stamped.

8. Attached hereto as **Exhibit 8** is a true and correct copy of the Pulitzer Bogard Associate Report on CDCR Prison Capacity Planning, dated October 3, 2011, produced by defendants in their electronic discovery as Bates DPRD Email 011437 responsive to Plaintiffs' Request for Production 90a. Defendants have waived any claims of privilege.

9. Attached hereto as **Exhibit 9**, a true and correct copy of the OIG Report on August 2009 Riot at CIM, dated April 22, 2010. A paralegal in my office downloaded this report from the Office of Inspector General public website at http://www.oig.ca.gov/pages/reports.php.

10. Attached hereto as **Exhibit 10**, a true and correct copy of the OIG Report on CIM Quadrennial and Warden Audit, dated November 20, 2008. A paralegal in my office downloaded this report from the Office of Inspector General website at http://www.oig.ca.gov/pages/reports.php.

11. Attached hereto as **Exhibit 11**, a true and correct copy of the CCPOA Steve Weiss Letter to CDCR Office of Labor Relations Re Implementation of Pilot Program for ATOM, dated December 16, 2011. An attorney in my office did at search at the CCPOA public website for information on the ATOM chair pilot program and downloaded the information from http://www.ccpoa.org/files/Dec_MC_AltTreatment1.pdf.

12. Attached hereto as **Exhibit 12**, a true and correct copy of the CCI Group Therapy Schedule, dated February 22, 2013, with bates stamp CCI 2, which was provided to plaintiffs following the expert tour by Craig Haney on February 22, 2013.

13. Attached hereto as **Exhibit 13**, a true and correct copy of the CDCR CCI Weekly Population Summary, dated February 21, 2013, with bates stamp CCI 3. This document was provided to plaintiffs following the expert tour by Craig Haney on February 22, 2013.

14. Attached hereto as **Exhibit 14** is a true and correct copy of the December 2012 American Psychiatric Association Position Statement on Segregation of Prisoners with Mental Illness, which was downloaded by me on March 15, 2013, from the APA website, www.psychiatry.org/advocacy--newsroom/position-statements.

15. Attached hereto as **Exhibit 15** is a true and correct copy of the Coleman Program Guides, 2009 Revision, Chapter 8, pages 12-8-1 to 12-8-3. Chapter 8 concerns treatment in Security Housing Units, or "SHU" units, and the excepted contains the SHU exclusionary criteria adopted for Pelican Bay State Prison by this Court.

16. Attached hereto as **Exhibit 16** is a true and correct copy of a section from the 2009 revision to the Coleman Program Guides, from Chapter 5, the section on Mental Health Crisis Beds. The section concerns so-called "psych and return procedures" designed to ensure that a patient discharging from an MHCB unit is returned to a prison which can provide an appropriate level of care. The attached exhibit includes pages 12-5-27 to 12-5-28.

17. Attached hereto as **Exhibit 17** is a true and correct copy of a section from the 2009 revision to the Coleman Program Guides, from Chapter 6, the section on the Department of Mental Health Programs, now called Department of State Hospitals. The section concerns so-called "psych and return procedures" designed to ensure that a patient discharging from a DMH unit is returned to a prison which can provide an appropriate EOP level of care. The attached exhibit includes page 12-6-13.

18. Attached hereto as **Exhibit 18** is a true and correct copy of the MCSP 25th Round Management Report, which was created by mental health managers at Mule Creek State Prison in connection with the Special Master's 25th round monitoring visit to the institution in the summer of 2012. This report covers the period from December 1, 2011 to

May 31, 2012 and the report was produced by defendants in response to plaintiffs' document request and was given the following bates stamp range by the defendants: DRPD 1 00358-00374.

19. Attached hereto as **Exhibit 19** is a true and correct copy of the California Institute for Men (CIM) 25th Round Management Report, which was created by mental health managers at CIM in connection with the Special Master's 25th round monitoring visit to the institution on April 25, 2012. This report covers the period from October 1, 2011 to March 31, 2012. The document has been bates-stamped DRPD 1 00095-1 00115 by the defendants.

20. Attached hereto as **Exhibit 20**, a true and correct copy of the COR 25th Round Management Report, which was created by mental health managers at COR in connection with the Special Master's 25th round monitoring visit to the institution on August 20-23, 2012. This report covers the period from January 1, 2012 to June 30, 2012. The document has been bates-stamped DRPD 1 00199-1 00217 by the defendants.

21. Attached hereto as **Exhibit 21**, a true and correct copy of the CCI 25th Round Management Report, which was created by mental health managers at CCI in connection with the Special Master's 25th round monitoring visit to the institution on July 30, 2012 to August 1, 2012. This report covers the period from December 1, 2011 to May 31, 2012. The document has been bates-stamped DRPD 1 00045-1 00056 by the defendants.

22. Attached hereto as **Exhibit 22** is a true and correct copy of an article by Dr. Heriberto G. Sánchez, PhD. California Men's Colony, CDCR, in the Journal of Correctional Health Care entitled "Suicide Prevention in ASU: What is Missing?" The article is dated February 2013.

23. Attached hereto as **Exhibit 23** is a true and correct copy of the Encl 3: HCPOP Mental Health Population by Institution, date January 18, 2013, excerpted from Defendants' January Coleman Monthly Data, which is provided to plaintiffs via their FTP site. These monthly statistical packages are routinely provided every month in the course

of this case by defendants to plaintiffs and the Special Master. This document was uploaded to an FTP site used by the parties to facilitate document transfers by defendants and downloaded by a paralegal in my office.

24. Attached hereto as **Exhibit 24** is a true and correct copy of the CDCR OISB Weekly Population Report as of April 18, 2012, which was downloaded by one of our paralegals from CDCR's public website located at http://www.cdcr.ca.gov/Reports_Research/Offender_Information_Services_Branch/WeeklyWed/TPOP1A/TPOP1Ad130227.pdf.

25. Attached hereto as **Exhibit 25** is a true and correct copy of the Encl 3: HCPOP Combined Mental Health Population Per Institution, dated August 8, 2008, excerpted from Defendants' August 2008 Coleman Monthly Data Report which is provided to Plaintiffs via their FTP site. These monthly statistical packages are routinely provided every month in the course of this case by defendants to plaintiffs and the Special Master. This document was uploaded to an FTP site used by the parties to facilitate document transfers by defendants and downloaded by a paralegal in my office.

26. Attached hereto as **Exhibit 26** is a true and correct copy of the CCWF 25th Management Report, which was created by mental health managers at CCWF in connection with the Special Master's 25th round monitoring visit to the institution on May 16, 2012. This report covers the period from October 1, 2011 to March 31, 2012. The document has been bates-stamped DRPD 1 00057-1 00078 by the defendants.

27. Attached hereto as **Exhibit 27** is a true and correct copy of the Moore February 21, 2013 Deposition Transcript, 180:6 - 181:12

28. Attached hereto as **Exhibit 28** is a true and correct copy of the June 18, 2012 e-mail from Robert Canning to Lindsay Hayes with the statement, "Obviously when your report landed it was not roundly applauded and in fact was buried," produced by Mr. Hayes on February 5, 2013 in response to Plaintiffs' February 4, 2013 Deposition Notice and Subpoena.

29. Attached hereto as **Exhibit 29** is a true and correct copy of the Excerpts from Defendants' Coleman Trial Exhibit X.1338, California Department of Corrections, Final Report, Mental Health Services Delivery System Study, February 16, 1993, by Western Consortium for Public Health in association with Scarlett Carp and Associates, Inc. ["The Scarlett Carp Report"], Executive Summary, at i and vi and page 10.

30. Attached hereto as **Exhibit 30** is a true and correct copy of two letters, dated January 23, 2013 and February 12, 2013 to Department of State Hospitals Salinas Valley Psychiatric Program (SVPP) Executive Director Charles DeSilva, from each of the psychiatrists then working in the Salinas Valley Psychiatric Program. These letters were authenticated and are Exhibits 1 and 2 to the Deposition of John Brim in this case.

31. Attached hereto as **Exhibit 31** is a true and correct copy of the document dated January 23, 2013 entitled "DSH Monthly Staffing and Staffing Vacancies Report for all DSH Facilities." The report includes staffing and vacancy data for various Department of State Hospitals Programs as of January 1, 2013, and it was emailed to the parties in the Coleman case by Debbie Vorous, counsel for CDCR, on February 15, 2013. A true and correct copy of Ms. Vorous's cover e-mail attaching the document is also included in the attached exhibit.

32. Attached hereto as **Exhibit 32** is a true and correct copy of enclosure 2 to the Coleman Monthly Statistical Package, which was provided to plaintiffs and is dated March 1, 2013. These monthly statistical packages are routinely provided every month in the course of this case by defendants to plaintiffs and the Special Master. This document was uploaded to an FTP site used by the parties to facilitate document transfers by defendants and downloaded by a paralegal in my office. Exhibit 2 is entitled "Mental Health Institution Vacancy Summary By Institution and By Classification," and contains data about staffing vacancies in the CDCR, system-wide and at each specific institution. The data in the report reflects staffing as of January 2013.

33. Attached hereto as **Exhibit 33** is a true and correct copy of an excerpt from enclosure 2 to the Coleman Monthly Statistical Package, which was provided to plaintiffs

dated July 3, 2012. These monthly statistical packages are routinely provided every month in the course of this case by defendants to plaintiffs and the Special Master. The monthly documents are uploaded to an FTP site used by the parties to facilitate document transfers by defendants and then downloaded by a paralegal in my office. Exhibit 2 is entitled "Mental Health Institution Vacancy Summary By Institution and By Classification," and contains data about staffing vacancies in the CDCR, system-wide and at each specific institution. The data in the report reflects staffing at Salinas Valley State Prison as of May 2012.

34. Attached hereto as **Exhibit 34** is a true and correct copy of an excerpt from enclosure 2 to the Coleman Monthly Statistical Package, which was provided to plaintiffs dated April 2, 2012. These monthly statistical packages are routinely provided every month in the course of this case by defendants to plaintiffs and the Special Master. The monthly documents are always uploaded to an FTP site used by the parties to facilitate document transfers by defendants and then downloaded by a paralegal in my office. Exhibit 2 is entitled "Mental Health Institution Vacancy Summary By Institution and By Classification," and contains data about staffing vacancies in the CDCR, system-wide and at each specific institution. The data in the report reflects staffing at CSP-Sacramento as of February 2012.

35. Attached hereto as **Exhibit 35** is a true and correct copy of an excerpt from enclosure 2 to the Coleman Monthly Statistical Package, which was provided to plaintiffs dated July 3, 2012. These monthly statistical packages are routinely provided every month in the course of this case by defendants to plaintiffs and the Special Master. The monthly documents are always uploaded to an FTP site used by the parties to facilitate document transfers by defendants and then downloaded by a paralegal in my office. Exhibit 2 is entitled "Mental Health Institution Vacancy Summary By Institution and By Classification," and contains data about staffing vacancies in the CDCR, system-wide and at each specific institution. The data in the report reflects staffing at CSP-Los Angeles County as of May 2012.

36. Attached hereto as **Exhibit 36** is a true and correct copy of an excerpt from enclosure 2 to the Coleman Monthly Statistical Package, which was provided to plaintiffs dated May 2, 2012. These monthly statistical packages are routinely provided every month in the course of this case by defendants to plaintiffs and the Special Master. The monthly documents are always uploaded to an FTP site used by the parties to facilitate document transfers by defendants and then downloaded by a paralegal in my office. Exhibit 2 is entitled "Mental Health Institution Vacancy Summary By Institution and By Classification," and contains data about staffing vacancies in the CDCR, system-wide and at each specific institution. The data in the report reflects staffing at RJ Donovan Correctional Institution as of March, 2012.

37. Attached hereto as **Exhibit 37** is a true and correct copy of an excerpt from enclosure 2 to the Coleman Monthly Statistical Package, which was provided to plaintiffs dated July 3, 2012. These monthly statistical packages are routinely provided every month in the course of this case by defendants to plaintiffs and the Special Master. The monthly documents are uploaded to an FTP site used by the parties to facilitate document transfers by defendants and then downloaded by a paralegal in my office. Exhibit 2 is entitled "Mental Health Institution Vacancy Summary by Institution and by Classification," and contains data about staffing vacancies in the CDCR, system-wide and at each specific institution. The data in the report reflects staffing at San Quentin State Prison as of May 2012.

38. Attached hereto as **Exhibit 38** is a true and correct copy of an excerpt from enclosure 2 to the Coleman Monthly Statistical Package, which was provided to plaintiffs dated August 3, 2012. These monthly statistical packages are routinely provided every month in the course of this case by defendants to plaintiffs and the Special Master. The monthly documents are uploaded to an FTP site used by the parties to facilitate document transfers by defendants and then downloaded by a paralegal in my office. Exhibit 2 is entitled "Mental Health Institution Vacancy Summary By Institution and By Classification," and contains data about staffing vacancies in the CDCR, system-wide and

at each specific institution. The data in the report reflects staffing at Salinas Valley State Prison as of June 2012.

39. Attached hereto as **Exhibit 39** is a true and correct copy of a page produced by defendants following the expert inspection on January 29, 2013 at CSP-Sacramento by Dr. Pablo Stewart. The page was produced by defendants following the tour after Dr. Stewart asked for information about current clinical staffing at the institution during the tour. Defendant bates-stamped the documents they produced and this page of the post-tour documents was bates stamped SAC 115 and was produced in an e-mail to plaintiffs' counsel from William Downer.

40. Attached hereto as **Exhibit 40** is a true and correct copy of the Mental Health Manager's Report created by mental health managers at CSP-Sacramento in connection with the Special Master's 25th round monitoring visit to the institution in the summer of 2012. This report covers the period from December 1, 2011 to May 31, 2012 and the report was produced by defendants in response to plaintiffs' document request and was given the following bates stamp range by the defendants: DRPD 1 00450-00479.

41. Attached hereto as **Exhibit 41** is a true and correct copy of a page produced by defendants following the expert inspection at CSP-Sacramento by Dr. Pablo Stewart on January 29, 2013. The page was produced by defendants following the tour after Dr. Stewart asked for information about current EOP treatment hours at the institution during the tour. Defendant bates-stamped the documents they produced and this page of the post-tour documents was bates stamped SAC 31 and was produced in an e-mail to plaintiffs' counsel from William Downer.

42. Attached hereto as **Exhibit 42** is a true and correct copy of the Mental Health Manager's Report created by mental health managers at CSP-Los Angeles County in connection with the Special Master's 25th round monitoring visit to the institution in June of 2012. This report covers the period from October 1, 2011 to March 31, 2012 and the report was produced by defendants in response to plaintiffs' document request and was given the following bates stamp range by the defendants: 1 00338-00357.

43. Attached hereto as **Exhibit 43** is a true and correct copy of a page produced by defendants following the expert inspection at CSP-Los Angeles County by Dr. Pablo Stewart on January 31, 2013 and February 1, 2013. The page was produced by defendants following the tour after Dr. Stewart asked for information about current EOP treatment hours at the institution during the tour. Defendant bates-stamped the documents they produced and this page of the post-tour documents was bates stamped LAC 146 and this document was produced in an e-mail to plaintiffs' counsel from William Downer, counsel for the state defendants.

44. Attached hereto as **Exhibit 44** is a true and correct copy of the Mental Health Manager's Report created by mental health managers at Salinas Valley State Prison in connection with the Special Master's 25th round monitoring visit to the institution in the summer of 2012. This report covers the period from December 1, 2011 to May 31, 2012 and the report was produced by defendants in response to plaintiffs' document request and was not given a bates stamp range by the defendants.

45. Attached hereto as **Exhibit 45** s a true and correct copy of the Mental Health Manager's Report created by mental health managers at San Quentin State Prison in connection with the Special Master's 25th round monitoring visit to the institution in the summer of 2012. This report covers the period from December 1, 2011 to May 31, 2012 and the report was produced by defendants in response to plaintiffs' document request and was given the following bates stamp range by the defendants: DRPD 1 00533-00545.

46. Attached hereto as **Exhibit 46** is a true and correct copy of the Mental Health Manager's Report created by mental health managers at RJ Donovan in connection with the Special Master's 25th round monitoring visit to the institution in the summer of 2012. This report covers the period from January 1, 2011 to June 30, 2012 and the report was produced by defendants in response to plaintiffs' document request and was given the following bates stamp range by the defendants: DRPD 1 00431-00449

47. Attached hereto as **Exhibit 47** is a true and correct copy of documents produced by defendants following the expert inspection at RJD by Dr. Pablo Stewart on

February 12, 2013. These documents were produced by defendants following the tour after Dr. Stewart asked for information about medication management at the institution during the tour. Defendant bates-stamped the documents they produced and these post-tour documents were bates stamped RJD 53 and 54 by defendants and were produced in an e-mail to plaintiffs' counsel from William Downer.

48. Attached hereto as **Exhibit 48** is another page from the document production following the February 12, 2013 inspection tour at RJD by Dr. Stewart. This document was in the same e-mail from Mr. Downer and was bates stamped RJD 55.

49. Attached hereto as **Exhibit 49** is a true and correct copy of a true and correct copy of an internal CDCR report entitled "Annual Report of Quality Improvement Plans in Suicide Reports for 2010." It is an internal Annual CDCR report on suicides and suicide prevention efforts in the CDCR for the calendar year 2010. It appears to have been prepared by Dr. Robert Canning and it was produced by defendants in response to plaintiffs document request to defendants' expert, Dr. Dvoskin. It was given the bates stamp marking DEXP 103750-103778 by the defendants.

50. Attached hereto as **Exhibit 50** is a true and correct copy of a report by CDCR consultant Lindsay Hayes dated August 16, 2011. Mr. Hayes produced documents on February 5, 2013 in response to Plaintiffs' February 4, 2013 Deposition Notice and Subpoena. It is a report to CDCR official outlining various findings and recommendations for reducing the rate of suicides within CDCR based upon his analysis of suicides in the calendar year 2010, his inspections of three prisons, and his review of current CDCR policies and practices for suicide prevention, training and emergency response.

51. Attached hereto as **Exhibit 51**, a true and correct copy of an email from defendants producing a variety of documents including a series of charts that summarize the number of prisoners in alternative housing placements at many different CDCR institutions during the last seven months of 2012. The email was sent by counsel for defendants, Jay Russell, on February 20, 2013. In the email, Mr. Russell explains that "as we agreed [at a meet and confer on Friday February 15, 2013] defendants will produce in

native format all responsive charts and other documents that cannot be practically viewed in PDF or hard-copy form." Among the PDF format documents produced as attachments to the e-mail was a multi-page document called "Summary of Cases in Alternative Housing, May 18, 2012 – December 27, 2012."

52. Attached hereto as **Exhibit 52** are true and correct copies of documents produced by defendants following the inspection tour by plaintiffs' expert Dr. Stewart at Salinas Valley State Prison on January 28, 2013. During the tour, Dr. Stewart asked for, or plaintiffs' counsel asked on his behalf for copies of Welfare Check Logs from the Enhanced Outpatient Program (EOP) Administrative Segregation Unit on Facility D, Buildings 1 and 2. Attached hereto as Exhibit 52 are true and correct copies of those logs, which were produced by defendants in an email from William Downer following the tour and to which defendants gave the bates numbers SVSP 23-28.

53. Attached hereto as **Exhibit 53** are true and correct copies of documents produced by defendants following the inspection tour by plaintiffs' expert Dr. Stewart at Salinas Valley State Prison on January 28, 2013. During the tour, Dr. Stewart asked for, or plaintiffs' counsel asked on his behalf for copies of Welfare Check Logs from the Stand-Alone Administrative Segregation Unit at the prison. Attached are true and correct copies of those logs, which were produced by defendants in an email from William Downer following the tour and to which defendants gave the bates numbers SVSP 29-44.

54. Attached hereto as **Exhibit 54** is a true and correct copy of a document produced by defendants following the inspection tour by plaintiffs' expert Dr. Stewart at CSP-Sacramento on January 29, 2013. During the tour, Dr. Stewart asked for, or plaintiffs' counsel asked on his behalf for copies of Welfare Check Logs from the Facility A, Building 5 EOP Administrative Segregation Unit at the prison. Attached is a true and correct copies of the one-page log in the unit at the time of the tour, which were produced by defendants in an email from William Downer following the tour and to which defendants gave the bates number Bates No. SAC 32.

55. Attached hereto as **Exhibit 55** are true and correct copies of documents produced by defendants following the inspection tour by plaintiffs' expert Dr. Stewart at CSP-Sacramento on January 29, 2013. During the tour, Dr. Stewart asked for, or plaintiffs' counsel asked on his behalf for copies of Welfare Check Logs from the B-Facility, Building 4 Administrative Segregation Unit at the prison. Attached are true and correct copies of those logs, which were produced by defendants in an email from William Downer following the tour and to which defendants assigned the bates numbers SAC 40-86.

56. Attached hereto as **Exhibit 56** are true and correct copies of documents produced by defendants following the inspection tour by plaintiffs' expert Dr. Stewart at CSP-Los Angeles County on January 31, 2013 and February 1, 2013. During the tour, Dr. Stewart asked, or plaintiffs' counsel asked on his behalf, for copies of Welfare Check Logs from the Building A-4 EOP Administrative Segregation Unit at the prison. Attached are true and correct copies of those logs, which were produced by defendants in an email from William Downer following the tour and to which defendants assigned the bates numbers LAC 43-97.

57. Attached hereto as **Exhibit 57** are true and correct copies of documents produced by defendants following the inspection tour by plaintiffs' expert Dr. Stewart at CSP-Los Angeles County on January 31, 2013 and February 1, 2013. During the tour, Dr. Stewart asked, or plaintiffs' counsel asked on his behalf, for copies of Welfare Check Logs from the CSP-Los Angeles County Building A-5 CCCMS Administrative Segregation Unit at the prison. Attached are true and correct copies of those logs, which were produced by defendants in an email from William Downer following the tour and to which defendants assigned the bates numbers LAC 31-41.

58. Attached hereto as **Exhibit 58** are true and correct copies of documents produced by defendants following the inspection tour by plaintiffs' expert Dr. Stewart at CSP-Los Angeles County on January 31, 2013 and February 1, 2013. During the tour, Dr. Stewart asked, or plaintiffs' counsel asked on his behalf, for copies of Welfare Check Logs

from the Stand-Alone Administrative Segregation Unit at the prison. Attached are true and correct copies of those logs, which were produced by defendants in an email from William Downer following the tour and to which defendants assigned the bates numbers LAC 1-28.

59. Attached hereto as **Exhibit 59** is a true and correct copy of documents produced by defendants on the morning of the expert inspection at RJD by Dr. Pablo Stewart on February 12, 2013. The document was handed to plaintiffs' counsel and to Dr. Stewart at the morning meeting with institutional staff members and it reflects the places at the institution where alternative placements for suicide watch are conducted.

60. Attached hereto as **Exhibit 60** are true and correct copies of documents produced by defendants following the inspection tour by plaintiffs' expert Dr. Stewart at San Quentin State Prison on February 26, 2013. During the tour, Dr. Stewart asked, or plaintiffs' counsel asked on his behalf, for copies of Welfare Check Logs from the Carson EOP Administrative Segregation Unit at the prison. Attached are true and correct copies of those logs, which were produced by defendants in an email from William Downer following the tour and to which defendants assigned the bates numbers SQ 606-735.

61. Attached hereto as **Exhibit 61**, a true and correct copy of E-mails Regarding SRE Mentor Training Program at CSP-Sacramento. These emails are Exhibits 12 and 13 to the Beard Deposition. These emails include a series of e-mails from Shama Chaiken, the Chief of the Mental Health Programs at CSP-Sacramento, to her superiors in Sacramento about the status of suicide risk assessment mentoring and training at the institution and about the upcoming tour at the institution by the plaintiffs' expert and were produced in response to plaintiffs' document requests, without bates numbers.

62. Attached hereto as **Exhibit 62**, a true and correct copy of the E-mail dated February 4, 2013 from Rachel Chen to Kathleen O'Meara Regarding suicide risk evaluation training at San Quentin, dated February 4, 2013 and an excel spreadsheet showing that 33 out of 61 individuals being trained have not completed the training process. These emails were portions of a large transmission of electronic discovery from defendants and were not bates stamped. The attached spreadsheet shows that only about

half of the clinicians who needed to be trained in the new SRE mentoring program at the institution had been trained.

63. Attached hereto as **Exhibit 63** are true and correct copies of notes produced by the defendants in this case in response to a request for documents relevant to the preparation of the opinion of defendants' expert Dr. Scott. These pages of Dr. Scott's notes were bates stamped DEXP 110940-110941.

64. Attached hereto as **Exhibit 64** is a true and correct copy of the American Correctional Association's (ACA) Wellness Check Standards, 4-4257, which are published in the Standards for Adult Correctional Institutions, Fourth Edition, American Correctional Association, January 2003, at p. 71.

65. Attached hereto as **Exhibit 65**, a true and correct copy of the Monthly Report on Licensure of Intermediate Care Treatment Programs at the California Department of State Hospitals – Vacaville and California Department of State Hospitals – Salinas Valley dated February 1, 2013, which was produced by Defendants to the Special Master and Plaintiffs via email on February 15, 2013 from Debbie Vorous, counsel for Defendants. This report is provided to Plaintiffs every month and reports on the patient census and waitlist for the DSH units located in DSH-Vacaville and DSH-Salinas Valley. A true and correct copy of the e-mail is also attached hereto.

66. Attached hereto as **Exhibit 66** is a true and correct copy of the Summary of Inter-Institutional Mental Health Crisis Bed Referrals and Transfers for January 2013, as excerpted from Defendants' January 2013 Coleman Monthly Data Report, which was provided to plaintiffs and is dated March 1, 2013. These monthly reports are routinely provided every month in the course of this case by defendants to plaintiffs and the Special Master. The monthly documents are uploaded to an FTP site used by the parties to facilitate document transfers by defendants and then downloaded by a paralegal in my office. This is the same report used to create the chart which was Plaintiffs' Exhibit 76 admitted in the 2008 overcrowding trial. A comparison of the data in Exhibit 66 and Exhibit 76 shows that in August 2008, clinicians referred 322 patients to HCPOP for

assistance in finding an available mental health crisis bed, and of those 322 patients, 135 were actually placed into an MHCB by HCPOP, while in January of 2013, clinicians referred 332 patients to HCPOP for placement assistance and of those 332, 155 were actually placed into an MHCB by HCPOP.

67. Attached hereto as **Exhibit 67** are true and correct copies of excerpts from the Moore February 21, 2013 Deposition Transcript, 180-181

68. Attached hereto as **Exhibit 68** are true and correct copies of excerpts from the Brim March 1, 2013 Deposition Transcript; 18-35, 38, 53-65, 77-79, 88-98

69. Attached hereto as **Exhibit 69** are true and correct copies of excerpts from the Dvoskin February 27, 2013 Deposition Transcript, 177-178.

70. Attached hereto as **Exhibit 70** are true and correct copies of excerpts from the Beard March 5, 2013 Deposition Transcript, 169-174.

71. Attached hereto as **Exhibit 71**, a true and correct copy of an email, dated March 4, 2013, sent by Deputy Special Master Jones to counsel for plaintiffs and defendants and CDCR officials, entitled "Sustainable Process, APP Waitlist." Deputy Special Master Jones states that on February 28, 2013, the APP waitlist was 32, with 4 additional prisoners waiting for acceptance.

72. Attached hereto as **Exhibit 72**, a true and correct copy of a chart created under my supervision and the supervision of other attorneys in my office by my paralegal Abigail Haney. The chart was created from Enclosure 9 from the Coleman Monthly Statistical Reports for each month from January 2011 through January 2013. Enclosure 9 is a document that reports the total number of EOP bus seats request for transferring prisoners into EOP programs, and the EOP bus seats provided for transfers to an available EOP beds. True and correct copies of the underlying data from the statistical reports are provided as part of this Exhibit.

73. Attached hereto as **Exhibit 73** is a true and correct copy of two charts prepared by my paralegal Abigail Haney under my supervision and the supervision of other attorneys in my office that analyzes data provided by the Department of State

Hospitals every month to the parties in the Coleman case. The data package is called the "DSH Bed Utilization Report." Because the DSH report contains the names of patients, it is confidential and the report is filed under seal in this court and emailed to Plaintiffs after it is filed with the court. The DSH Report, which is the underlying documents containing the relevant data, are attached to the Kahn Confidential Declaration filed under seal as Exhibits 43 and 44 to that Declaration. **Ex. 73** summarizes data concerning transfers to the Salinas Valley Psychiatric Program (SVPP), an intermediate inpatient program, and to a variety of acute and intermediate inpatient care programs at the Vacaville Psychiatric Program (VPP) for the months of December 2012 and January 2013, and includes the total length of a prisoner on the waiting lists' wait from the time of referral until they are actually placed into a bed. Plaintiffs have repeatedly raised our concerns with defendants, that their method of tracking and reporting program guide compliance with transfer timelines to DSH program is inaccurate because it does not track the entire period from the decision to refer a patient, to their actual arrival at the inpatient program and placement into the bed. *See* Exhibit 106 attached hereto, which is a copy of the program guide transfer timeline that reflects the relevant time period for tracking timeline.

74. Attached hereto as **Exhibit 74** is a true and correct copy of a document created by the Healthcare Placement Oversight Program, also known as "HCPOP" which is a summary of the total number of prisoners placed in Outpatient Housing Units between May and December of 2012. This document was Exhibit 13 to Rick Johnson's Deposition and is authenticated therein by Mr. Johnson who recently retired as Chief of HCPOP. The document was produced pursuant to the deposition notice for Mr. Johnson's Deposition.

75. Attached hereto as **Exhibit 75** is a true and correct copy of a chart that was a trial exhibit (Plaintiffs' Trial Exhibit P-263) in the three-judge court overcrowding trial in August 2008. The Chart is entitled "MHCB Unmet Need, Nov 2006 - Aug 2008." The data source for the trial exhibit is the CDCR's Monthly Summary of Inter-institutional Mental Health Crisis Bed Referrals and Transfers prepared by HCPOP and provided to plaintiffs as part of the Coleman Monthly Data Report. These monthly data packages are

routinely provided every month in the course of this case by defendants to plaintiffs and the Special Master and are uploaded to an FTP site used by the parties to facilitate document transfers by defendants and then downloaded by a paralegal in my office.

76. Attached hereto as **Exhibit 76**, a true and correct copy of the Enclosure 20: January 2013 Monthly Data re Inter-institutional transfers, excerpted from Defendants' January 2013 Coleman Monthly Data Report provided to the Special Master and Plaintiffs. These monthly data packages are routinely provided every month in the course of this case by defendants to plaintiffs and the Special Master and are uploaded to an FTP site used by the parties to facilitate document transfers by defendants and then downloaded by a paralegal in my office.

77. Attached hereto as **Exhibit 77** is a true and correct copy of an excerpt from the 2009 Revision to the Coleman MHSDS Program Guides, from Chapter 7 (Administrative Segregation) at page 12-7-11. The section covers a requirement that individuals with mental health concerns must be excluded from the newer stand-alone ASU, and dictates that any class members inadvertently placed in one of those units must be transferred out within 24 hours.

78. Attached hereto as **Exhibit 78** is a true and correct copy of an email produced by defendants in this case dated January 27, 2012 from Eric Monthei, the chief of mental health at San Quentin who is responsible for the Specialized Care Program for the Condemned, to officials in CDCR headquarters. The e-mail attaches a memorandum from January 25, 2012 from Dr. Monthei Regarding the Specialized Care Program entitled "Specialized Care for the Condemned: CTC Expansion." This document was produced in response to plaintiffs' document request and was not given a bates stamp range by the defendants.

79. Attached hereto as **Exhibit 79** is a true and correct copy of the Mitchell Pleadings: Docket 160 to 160-7, filed on 3/5/13 in Case 2:08-cv-01196-JAM-EFB.

80. Attached hereto as **Exhibit 80**, is a true and correct copy of excerpts from the transcript of the deposition of Jeffrey A. Beard taken Tuesday, March 5, 2013 in Sacramento, California and lodged with this Court on March 15, 2013.

81. Attached hereto as **Exhibit 81**, is a true and correct copy of excerpts from the transcript of the deposition of Tim Belavich, taken February 22, 2013 in San Francisco, California and lodged with this Court on March 15, 2013.

82. Attached hereto as **Exhibit 82**, is a true and correct copy of excerpts from the transcript of the deposition of John Brim taken March 1, 2013 in San Francisco, California and lodged with this Court on March 15, 2013.

83. Attached hereto as **Exhibit 83**, is a true and correct copy of excerpts from the transcript of the deposition of Joel Dvoskin taken February 27, 2013 in San Francisco, California and lodged with this Court on March 15, 2013.

84. Attached hereto as **Exhibit 84**, is a true and correct copy of excerpts from the transcript of deposition of Lindsay M. Hayes taken February 18, 2013 in Boston, Massachusetts and lodged with this Court on March 15, 2013.

85. Attached hereto as **Exhibit 85**, is a true and correct copy of excerpts from the transcript of the deposition of Richard Johnson taken February 25, 2013 in San Francisco, California and lodged with this Court on March 15, 2013.

86. Attached hereto as **Exhibit 86**, is a true and correct copy of excerpts from the transcript of the deposition of Steve J. Martin taken February 28, 2013 in San Francisco, California and lodged with this Court on March 15, 2013.

87. Attached hereto as **Exhibit 87**, is a true and correct copy of excerpts from the transcript of the deposition of Christopher Richard Meyer taken February 27, 2013 in San Francisco, California and lodged with this Court on March 15, 2013.

88. Attached hereto as **Exhibit 88**, is a true and correct copy of excerpts from the transcript of the deposition of Jacqueline Moore taken February 21, 2013 in San Francisco, California and lodged with this Court on March 15, 2013.

89. Attached hereto as **Exhibit 89**, is a true and correct copy of excerpts from the transcript of the deposition of Charles Scott taken March 8, 2013 in Davis, California and lodged with this Court on March 15, 2013.

90. Attached hereto as **Exhibit 90**, is a true and correct copy of excerpts from the transcript of the deposition of Diana Toche taken February 22, 2013 in San Francisco, California and lodged with this Court on March 15, 2013.

91. Attached hereto as **Exhibit 91** is a true and correct copy of the Expert contracts/agreements for Dvoskin, Scott, and Martin which were produced by defendants to plaintiffs as DEXP 103091, DEXP 109511, DEXP 102002-4.

92. Attached hereto as **Exhibit 92** is a true and correct copy of the Compendium of suicide recommendations, which is attached to a series of emails from Michael Morrison, Health Care Specialist, Statewide Mental Health Program to Diana Toche and Ben Rice and others on January 27, 2013. These emails and the attached Compendium were produced by defendants electronically in response to plaintiffs request for production of documents.

93. Attached hereto as **Exhibit 93** is a true and correct copy of the defendants' Monthly Activation Schedule Report for February 2013, dated February 25, 2013. This document was received by my office from defendants as an attachment to an email dated March 1, 2013 from Debbie Vorous, counsel for the CDCR, to Special Master Lopes and various parties to the Coleman Litigation. A true and correct copy of the e-mail is also attached hereto.

94. Attached hereto as **Exhibit 94** is a true and correct copy of the Capital Outlay Budget Change Proposal, Budget Year 2012-13. This document was filed with the Court in the case and is Docket No. 4331-2, which is authenticate as an exhibit to the Declaration of Steve Fama.

95. Attached hereto as **Exhibit 95** is a true and correct copy of a section from Chapter 5 of the 2009 revision to the Coleman Program Guides, the section on Mental Health Crisis Beds. The section concerns Referral and Transfer to MHCBs, 12-5-3 to 12-

5-7, and sets forth the procedures for contacting HCPOP if there are no available MHCBs and lists the alternative placements by "preferred locations." This excerpt was made Exhibit 2 to the Transcript of the Johnson Deposition taken on February 25, 2013.

96. Attached hereto as **Exhibit 96** is a true and correct copy of the Statewide SPR FIT Teleconference/Webinar docs, dated Feb 2011, which were produced electronically by defendants in response to a document request by plaintiffs as DPRD2-27-000008-9.

97. Attached hereto as **Exhibit 97** is a true and correct copy of the Division of Correctional Health Care Services (DCHCS) Suicide Prevention and Response-Focused Improvement Team ("SPR FIT") Meeting Agenda, dated January 28, 2013, which is an agenda for a meeting that took place on the agencies' Elk Grove Campus. This is an agenda that was produced electronically by defendants in response to plaintiffs' document requests. Item 1 and 2 of the agenda under a heading "ongoing items" is (1)"update on proposal for new ASU screening tool" and (2) "Changes to referral criteria for RC screening (from [] suicide review)."

98. Attached hereto as **Exhibit 98** is a true and correct copy of the Cover email from Dr. Canning, dated October 10, 2012 and entitled, "Draft of new ASU screener – comments requested," and (Draft) Proposal for new ASU Screening Measure, both of which was produced electronically by defendants in response to plaintiffs' document requests, without bates numbers.

99. Attached hereto as **Exhibit 99** is a true and correct copy of the email chain re (Draft) Proposal for new ASU Screening Measure, from 10/10/12 at 9:32 a.m. through 10-11-12 2::42 p.m., which was produced electronically by defendants in response to plaintiffs' document requests.

100. Attached hereto as **Exhibit 100** is a true and correct copy of a section from the 2009 revision to the Coleman Program Guides, from Chapter 2, Reception Center Mental Health Assessment, 12-2-1, which highlights the importance of reception center screening to identify prisoners who may require more in-depth clinical evaluations.

101. Attached hereto as **Exhibit 101** is a true and correct copy of a section from the 2009 revision to the Coleman Program Guides, from Chapter 7, Administrative Segregation, PG 12-7-2 to 12-7-6, which discusses the importance of screenings, including the screening questionnaire completed within 72 hours after placement in the ASU for prisoners who are not on the mental health caseload to assess the need for a mental health referral, "utilizing the 31-question mental health screening questionnaire also used in the Reception Centers." 12-7-6.

102. Attached hereto as **Exhibit 102** is a true and correct copy of a photograph provided by the defendants and bearing the bates-stamp RJD 3. This is a photograph that was taken on the inspection tour of RJ Donovan Correctional Institution on February 12, 2013 by plaintiffs' expert Dr. Pablo Stewart.

103. Attached hereto as **Exhibit 103** is a true and correct copy of the December 16, 2011 Memo from Jeffrey Beard to Benjamin Rice re Assessment of Need for a higher LOC and CDCR's sustainable self-monitoring process (Coleman case), which was produced by Defendants with documents associated with the Deposition of Secretary Beard. **Ex. 103** was authenticated as Exhibit 9 to the Deposition of Secretary Beard on March 5, 2013.

104. Attached hereto as **Exhibit 104** is a true and correct copy of emails dated from January 23, 2013 from Kathleen O,Meara to Chief of Mental Health at CMF and the Northern Region Senior Psychologist Specialist about the status of the SRE Mentor Program at CMF. These emails were produced electronically by defendants in response to plaintiffs' request for documents as DPRDEmail1000029.

105. Attached hereto as **Exhibit 105** is a true and correct copy of an e-mail from my associate Krista Stone-Manista to the Special Master and Defendants dated December 10, 2012, attaching my letter regarding a November 2012 SVPP suicide and DHS and SVPP staffing shortages. Also attached is a true and correct copy of my November 10, 2012 letter and attachments. On December 14, 2012, I attended a meeting with my co-counsel and representatives of Defendant CDCR, Diana Toche, Tim Belavich, Nathan

Stanley, Rick Johnson, Judy Burleson, Kathy O'Meara, and in-house counsel, Ben Rice and Katherine Tebrok, the Deputy Attorneys General Debbie Vorous and William Donner, representatives from DSH, Cindy Rodriguez and Sterling Price, the Special Master and representatives from his Team, in Sacramento, in a conference room in the Federal Court House. One subject on the agenda was my letter of December 10, 2012, where I had raised questions for the third time in 2012. about reports of inadequate staffing levels at DSH facilities, but especially at SVPP, which had experienced its first suicide in late November 2012. Ms. Rodriguez reported that SVPP "Staffing is full per licensing standards. We have at least the minimum day-to-day, through registry." Ms. Rodriguez repeated that she had "confirmation of full staffing," stating that they used registry and overtime. Jane Kahn and I pointed out that, once again, the monthly staffing documents filed with the Court by DSH showed large vacancies and very limited or no use of contractors. Defendants had told us earlier in 2012 that the massive vacancies reported to the Court were "inaccurate." Ms. Rodriguez said that "I review different reports than what plaintiffs get." Ms. Vorous said she would look in to the problem with the reporting of staffing numbers. I also asked about the suicide and Ms. Rodriguez said that "on that day, there was full staffing."

106. Attached hereto as **Exhibit 106** is a true and correct copy of section 12-1-16, the transfer timeline chart from the 2009 revision of the Coleman Program Guides. The Program Guides in this section define transfer timelines to DSH inpatient programs from the date a prisoner is referred to the program, not from the date of acceptance, which is the date now employed by the defendants in tracking their compliance with these requirements.

107. Attached hereto as **Exhibit 107**, a true and correct copy of Exhibit 8 to the Deposition taken of John Brim on March 1, 2013, which is a document entitled "DSH Number of Seclusion Episodes by Month and Facility per 1,000 patient day, 2012, " which was downloaded from the DHS public website http://www.dsh.ca.gov on February 28, 2013 by one of my staff.

108. Attached hereto as **Exhibit 108** is a true and correct copy of Exhibit 18 to the Deposition taken of John Brim on March 1, 2013, which is a document entitled " DSH Actual Cost Savings Achieved FY 2011-12," which was downloaded from the DHS public website http://www.dsh.ca.gov on February 28, 2013 by one of my staff.

109. Attached hereto as **Exhibit 109 is** a true and correct copy of the Sacramento Bee Article entitled "*Gov. Jerry Brown says Federal Prison Oversight a Waste of Money*." The article is dated March 12, 2013. The article was downloaded by a paralegal in my office from the Sacramento Bee public website at www.Sacbee.com.

110. Attached hereto as **Exhibit 110** is a true and correct copy of a document produced by defendants in the course of electronic discovery relating to their experts work for the department. It is a document entitled "Coleman Audit Best Practice Recommendations for Use of Force," and it was Exhibit 6 to the Deposition of Steven Martin on February 28, 2013 and it is authenticated in that deposition.

111. Attached hereto as **Exhibit 111** is a true and correct copy of Exhibit 1 to the Brim Deposition, which is the January 23, 2013 Letter from the SVPP Psychiatrists to Silva, which is authenticated in that deposition.

112. Attached hereto as **Exhibit 112** is a true and correct copy of Exhibit 2 to the Brim Deposition, which is the February 12, 2013 Letter from the SVPP Psychiatrist to Silva, which is authenticated in that deposition.

113. Attached hereto as **Exhibit 113** is a true and correct copy of the Hayes-CDCR Agreement: Suicide Expert Consultant Services for CDCR's Suicide Prevention Program, which is an excerpt (pages 1-5) of Exhibit 3 to the Deposition of Lindsay Hayes, taken on February 18, 2013, and was authenticated at that time.

114. Attached hereto as **Exhibit 114** is a true and correct copy of an Office of Inspector General Report Entitled "Initial Report on Use of Force within the California Department of Corrections and Rehabilitation and which is dated November 2011." It is a public report that was downloaded in PDF format by a paralegal in my office from the

website of the Office of the Inspector General at for the CDCR at http://www.oig.ca.gov/pages/reports.php.

115. Attached hereto as **Exhibit 115** is a true and correct copy of a chart that was created at the request of Dr. Stewart under my supervision and the supervision of other attorneys in my firm, by a paralegal in my firm, Marc Shinn-Krantz, using Microsoft Excel. The chart appears in the Declaration of Dr. Pablo Stewart in paragraph 204. The chart is based on data concerning the number of prisoners in alternative housing placements at many different CDCR institutions during the last seven months of 2012. Attached as part of Exhibit 115, behind the chart created by Mr. Shinn-Krantz, is a true and correct copy of an email from defendants producing a variety of different alternative housing data and documents in both native and PDF formats. The email was sent by counsel for defendants Jay Russell on February 20, 2013. A true and correct copy of this e-mail is attached as part of Exhibit 115. In the email, Mr. Russell explains that "as we agreed [at a meet and confer on Friday February 15, 2013] defendants will produce in native format all responsive charts and other documents that cannot be practically viewed in PDF or hard-copy form." Among the PDF format documents produced as attachments to the e-mail was a multi-page document called "Summary of Cases in Alternative Housing, May 18, 2012 – December 27, 2012." A true and correct copy of the document is attached as part of Exhibit 115 behind the e-mail from Mr. Russell. Mr. Shinn-Krantz used this document to create the chart (using Microsoft Excel's graphing features) graphing and summarizing the data onto a single chart. This chart is the first page of the documents attached hereto as Exhibit 115 and the chart that appears in paragraph 204 of Dr. Stewart's Declaration.

116. Attached hereto as **Exhibit 116** is a true and correct copy of an email chain regarding "LOS Data" sent from Chris Yi, CDCR to Laura Ceballos, Tim Belavich, Debbie Vorous, with copies to various other individuals. Pages 2 and 3 of the emails include a discussion between Defendants and their attorney, Debbie Vorous, about how to

report the data so that "it will look better." These emails were produced by defendants electronically in response to plaintiffs' request for production and were not bates stamped.

117. Attached hereto as **Exhibit 117** is a true and correct copy of Exhibit 3 to the Deposition of Jacqueline Moore, RN, PhD., taken on February 21, 2013, which was authenticated in her deposition as a page from her notes taken during her prison tours and meetings with Defendants.

118. Attached hereto as **Exhibit 118** is a true and correct copy of Exhibit 13 to the Deposition of Joel Dvoskin, M.D., taken on February 27, 2013, which was authenticated in his deposition as a page from his notes taken during his prison tours and meetings with Defendants.

119. Attached hereto as **Exhibit 119** is a true and correct copy of Exhibit 14 to the Deposition of Jacqueline Moore, RN, PhD., taken on February 21, 2013, which was authenticated in her deposition as a page from her notes taken during her prison tours and meetings with Defendants.

120. Attached hereto as **Exhibit 120** is a true and correct copy of Exhibit 21 to the Deposition of Charles Scott, M.D., taken on March 8, 2013, which was authenticated in his deposition as a page from his notes taken during his prison tours and meetings with Defendants.

121. Attached hereto as **Exhibit 121** is a true and correct copy of Exhibit 6 to the Deposition of Joel Dvoskin, M.D., taken on February 27, 2013, which was authenticated in his deposition as a page from his notes taken during his prison tours and meetings with Defendants.

122. Attached hereto as **Exhibit 122** is an email from Dr. Dvoskin to Dr. Moore and Dr, Scott, with copies to defense attorneys Debbie Vorous and Patrick McKinney, dated December 10, 2012, produced by defendants in response to plaintiffs' request for document production as DEXP 103070.

123. Attached hereto as **Exhibit 123** is the Executive Summary to "The Blueprint" The Future of California Corrections, downloaded from the CDCR public

website by staff in our office at: http://www.cdcr.ca.gove/2012plan/docs/plan/exec-summary.pdf.

I declare under penalty of perjury under the laws of the United States and the State of California that the foregoing is true and correct, and that this declaration is executed at San Francisco, California this 15th day of March, 2013.

Michael W. Bien

Exhibit 1

Data Analysis Unit
Estimates and Statistical Analysis Section
Offender Information Services Branch

Department of Corrections and Rehabilitation
State of California
March 4, 2013

WEEKLY REPORT OF POPULATION
AS OF MIDNIGHT February 27, 2013

TOTAL CDCR POPULATION

	FELON/ OTHER #1	CIVIL ADDICT	TOTAL	CHANGE SINCE 02/29/12 NO.	CHANGE SINCE 02/29/12 PCT.	DESIGN CAPACITY	PERCENT OCCUPIED	STAFFED CAPACITY
A. TOTAL IN-CUSTODY	132,296	138	132,434	-8,695	-6.1			
I. IN-STATE	123,590	138	123,728	-7,906	-6.0			
(MEN, Subtotal)	117,761	102	117,863	-6,474	-5.2			
(WOMEN, Subtotal)	5,829	36	5,865	-1,432	-19.6			
1. INSTITUTIONS/CAMPS	122,682	132	122,814	-7,813	-5.9	84,439	145.4	122,481
INSTITUTIONS	119,014	132	119,146	-7,360	-5.8	79,959	149.0	118,243
CAMPS(CCC, CIW & SCC)*	3,668		3,668	-453	-10.9	4,480	81.9	4,238
2. IN-STATE CONTRACT BEDS	673	6	679	-65	-8.7	2,679	25.3	
CCF PRIVATE	601		601	0	-	2,557	23.5	
PRISONER MOTHER PGM	17		17	-4	-19.0	47	36.2	
FRCCC(BAKERSFIELD)	55	6	61	+43	+238.8	75	81.3	
3. DMH STATE HOSPITALS	235		235	-28	-10.6			
II. OUT OF STATE(COCF)	8,706	0	8,706	-789	-8.3			
ARIZONA	4,476		4,476	-109	-2.3			
MISSISSIPPI	2,561		2,561	0	-			
OKLAHOMA	1,669		1,669	-680	-28.9			
B. PAROLE	55,554	603	56,157	-40,118	-41.6			
COMMUNITY SUP(Active)	53,083	603	53,686	-31,902	-37.2			
COOP CASES (Active) #3	1,766		1,766	+244	+16.0			
MNRP & NRP (Inactive)	705		705	-8,460	-92.3			
C. NON-CDC JURISDICTION #4	1,172	0	1,172	-233	-16.5			
OTHER STATE/FED. INST.	510		510	-1	-0.1			
OUT OF STATE PAROLE	494		494	-204	-29.2			
OUT OF STATE PAL	20		20	-18	-47.3			
CYA-W&IC 1731.5(c) INSTITUTIONS #5	148		148	-10	-6.3			
D. OTHER POPULATIONS #6	9,807	90	9,897	-2,950	-22.9			
INMATES								
OUT-TO-COURT, etc.	1,217	18	1,235	-238	-16.1			
ESCAPED	206		206	-11	-5.0			
PAROLEES (PAL/RAL)	8,384	72	8,456	-2,701	-24.2			
TOTAL CDCR POPULATION	198,829	831	199,660	-51,996	-20.6			

CHANGE FROM LAST WEEK			
A. TOTAL IN-CUSTODY	+11	-8	+3
(MEN, Subtotal)	+36	-10	+26
(WOMEN, Subtotal)	-8	+2	-6
B. PAROLE	-450	-6	-456
D. PAROLEES (PAL/RAL)	+148	-1	+147

This report contains the latest available reliable population figures from OBIS. They have been carefully audited, but are preliminary, and therefore subject to revision.

*Figure excludes institution based camps. Total persons in camps, including base camps, are 3,686. Base camp at CMC is included in institution counts.

Report # TPOP-1W. Questions: (916) 322-4255.

WEEKLY INSTITUTION/CAMPS POPULATION DETAIL — MIDNIGHT February 27, 2013

INSTITUTIONS/CAMPS	FELON/ OTHER	CIVIL ADDICT	TOTAL	DESIGN CAPACITY	PERCENT OCCUPIED	STAFFED CAPACITY
MALE						
ASP (AVENAL SP)	4,819		4,819	2,920	165.0	4,333
CCC (CAL CORRECTL CTR)	4,734		4,734	3,883	121.9	4,718
CCI (CAL CORRECTL INSTITN)	4,530		4,530	2,783	162.8	4,130
CIM (CAL INSTITN FOR MEN)	4,626	2	4,628	2,976	155.5	4,455
CMF (CAL MEDICAL FACIL)	2,327		2,327	2,361	98.6	2,634
CMC (CAL MEN'S COLONY)	5,030		5,030	3,838	131.1	5,157
CRC (CAL REHAB CTR, MEN)	3,319	93	3,412	2,491	137.0	3,381
CAL (CAL SP, CALIPATRIA)	3,450		3,450	2,308	149.5	3,833
CEN (CAL SP, CENTINELA)	3,132		3,132	2,308	135.7	3,483
COR (CAL SP, CORCORAN)	4,486		4,486	3,116	144.0	4,494
LAC (CAL SP, LOS ANGELES CO)	3,743		3,743	2,300	162.7	3,866
SAC (CAL SP, SACRAMENTO)	2,382		2,382	1,828	130.3	2,743
SQ (CAL SP, SAN QUENTIN)	3,945		3,945	3,082	128.0	3,710
SOL (CAL SP, SOLANO)	3,961		3,961	2,610	151.8	3,940
SATF (CAL SATF AND SP - COR)	5,594	1	5,595	3,424	163.4	5,365
CVSP (CHUCKAWALLA VALLEY SP)	2,702		2,702	1,738	155.5	2,453
CTF (CORRL TRAING FAC)	5,454	1	5,455	3,312	164.7	5,480
DVI (DEUEL VOCATL INSTITN)	2,240	4	2,244	1,681	133.5	2,478
FOL (FOLSOM SP)	2,435		2,435	2,469	98.6	2,895
HDP (HIGH DESERT SP)	3,480		3,480	2,324	149.7	3,560
IRON (IRONWOOD SP)	3,337		3,337	2,200	151.7	3,275
KVSP (KERN VALLEY SP)	3,772		3,772	2,448	154.1	4,194
MCSP (MULE CREEK SP)	2,868		2,868	1,700	168.7	2,671
NKSP (NORTH KERN SP)	4,709	1	4,710	2,694	174.8	4,397
PBSP (PELICAN BAY SP)	2,884		2,884	2,380	121.2	3,188
PVSP (PLEASANT VALLEY SP)	3,521		3,521	2,308	152.6	3,558
RJD (RJ DONOVAN CORR FACIL)	3,503		3,503	2,200	159.2	3,340
SVSP (SALINAS VAL SP)	3,580		3,580	2,452	146.0	3,484
SCC (SIERRA CONSERV CTR)	4,769		4,769	3,736	127.6	4,576
VSPM (VALLEY SP MEN)	2,433		2,433	1,980	122.9	1,932
WSP (WASCO SP)	5,164		5,164	2,984	173.1	4,997
MALE TOTAL:	116,929	102	117,031	80,834	144.8	116,720
FEMALE						
CIW (CAL INST FOR WOMEN)	2,008	16	2,024	1,398	144.8	2,042
CCWF (CENT CAL WOMEN'S FACIL)	3,585	14	3,599	2,004	179.6	3,519
FWF (FOLSOM WF)	160		160	203	78.8	200
FEMALE TOTAL:	5,753	30	5,783	3,605	160.4	5,761
TOTAL:	122,682	132	122,814	84,439	145.4	122,481

Data Analysis Unit
Estimates and Statistical Analysis Section
Offender Information Services Branch

Department of Corrections and Rehabilitation
State of California
March 4, 2013

WEEKLY REPORT OF POPULATION
NOTES
AS OF MIDNIGHT February 27, 2013

#1 Felon/Other counts are safekeepers, federal cases and inmates from other states, felons, county diagnostic cases and Youth Authority wards.

#3 Cooperative Cases are parolees from other states being supervised in California.

#4 Non-CDC Jurisdiction are California cases being confined in or paroled to other states or jurisdictions.

#5 Welfare and Institution Code (W&IC) 1731.5(c) covers persons under the the age of 21 who were committed to CDCR, had their sentence amended, and were incarcerated at the California Youth Authority for housing and program participation.

#6 Other Population includes inmates temporarily out-to-court, inmates in hospitals, escapees, and parole and outpatient absconders.

Exhibit 2

CCCMS cases for the week of FEB. 11, 2013
(Seats Requested / Provided for Endorsed Cases)

FROM	TO: AVE	TO: CCI	TO: CIM	TO: CMC	TO: CMF	TO: CRC	TO: COR	TO: WSP	TO: CTF	TO: FSP	TO: HDSP	TO: KVSP	TO: LAC	TO: MCSP	TO: NK	TO: PBSP	TO: PVSP	TO: RJD	TO: SAC	TO: SATF	TO: SCC	TO: SOL	TO: SQ	TO: SVSP	TO: VSP	Total Reqstd	Total Provided
AVE	0	2/0	4/3	0	0	4/2	1/0	0	2/0	2/2	0	0	0	1/0	0	0	2/2	0	0	2/0	0	0	0	0	2/0	22	9
CAL	0	0	0	0	0	0	0	0	0	0	0	0	1/1	0	0	0	0	0	0	0	0	0	0	0	0	1	1
CRC	1/1	1/0	9/1	1/1	0	0	0	0	0	0	0	0	0	0	0	0	1/1	1/0	0	15/0	0	0	0	0	2/0	31	4
CCI	0	0	1/0	0	0	1/1	4/0	0	12/2	0	0	28/0	0	1/1	0	0	0	0	2/1	5/0	0	0	0	0	0	54	5
CEN	0	0	0	0	0	0	0	0	0	0	0	0	3/3	0	0	0	1/1	2/2	0	0	0	0	0	0	0	6	6
CMC	14/0	9/0	3/1	0	1/0	1/0	0	0	23/0	1/1	0	1/0	0	0	0	0	0	0	1/0	7/0	3/0	0	1/1	0	0	65	3
CMF	0	1/0	0	0	0	0	1/0	0	1/0	0	0	0	0	0	0	0	0	0	0	0	0	1/1	0	0	0	4	1
COR	0	4/0	1/0	0	0	0	0	0	5/1	0	0	46/1	0	5/0	0	0	3/3	4/0	0	2/0	9/0	0	0	3/3	0	82	8
CTF	0	2/2	4/0	0	0	0	2/1	0	0	7/7	0	0	0	12/0	0	0	3/3	0	1/0	0	0	0	0	2/0	0	33	13
CVSP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1/1	0	0	0	1	1
FSP	0	1/0	0	0	0	0	1/0	0	3/0	0	3/3	0	0	1/0	2/2	0	1/1	0	0	0	0	0	0	0	0	12	6
HDSP	1/0	9/0	0	0	2/0	0	2/0	0	1/0	1/1	0	0	2/0	8/0	0	0	12/0	3/0	0	4/0	14/0	0	0	9/0	0	68	1
ISP	0	0	0	0	0	0	0	0	0	0	0	0	1/1	1/1	0	0	1/1	0	0	0	0	0	0	0	0	3	3
KVSP	0	5/0	0	0	0	1/0	15/0	0	2/0	0	0	0	1/1	12/2	0	0	5/5	0	0	40/0	12/0	0	0	2/1	0	95	9
LAC	0	5/0	0	0	0	1/0	6/0	0	5/0	0	0	0	0	28/1	0	0	4/0	5/0	0	10/2	26/0	0	0	4/4	0	94	7
MCSP	0	1/1	8/0	0	0	0	2/0	0	0	0	0	1/0	0	0	0	0	0	2/0	1/0	6/1	5/0	0	0	1/0	8/8	35	10
PBSP	0	0	0	0	0	0	25/0	0	0	0	0	6/0	1/1	1/0	0	0	1/0	0	2/1	4/0	0	0	0	8/0	0	48	2
PVSP	9/2	13/0	0	0	1/0	2/0	28/0	0	8/3	10/10	0	12/5	0	6/0	0	0	0	12/2	1/0	7/1	11/0	1/1	0	0	38/13	159	37
RJD	4/2	5/0	4/1	0	0	6/1	2/0	0	6/0	0	0	3/0	1/1	2/0	0	1/1	2/0	0	0	6/0	7/0	0	0	1/0	1/0	51	6
SAC	0	2/1	0	0	0	0	10/0	0	0	1/1	1/1	10/0	2/1	4/0	0	0	4/4	1/0	0	4/0	4/0	0	0	9/3	0	52	11
SATF	0	0	4/2	0	0	1/1	12/0	0	11/0	0	0	0	2/2	5/1	0	0	2/1	4/0	0	0	16/0	0	0	10/4	4/4	71	15
SCC	1/0	1/0	4/1	0	0	2/0	0	0	1/0	0	1/1	0	0	0	0	0	0	0	0	2/0	0	0	0	0	12/0	24	2
SOL	1/1	0	1/1	0	2/0	0	2/0	0	4/0	5/5	0	0	0	1/0	1/1	0	1/1	3/0	0	1/0	0	0	0	0	1/0	23	9
SQ	0	0	1/0	0	0	0	1/0	0	3/0	0	0	0	0	0	0	0	0	1/0	0	0	0	0	0	0	0	6	0
SVSP	0	14/0	0	0	0	0	18/0	0	0	0	0	1/1	2/2	8/0	0	0	4/1	0	0	5/1	12/0	0	0	0	0	64	5
CIM-RC	0	0	0	0	0	5/5	1/0	0	4/0	0	0	0	0	0	0	0	0	0	0	2/0	0	1/1	1/1	0	13/13	27	20
DVI-RC	1/1	0	3/3	1/1	0	0	4/0	0	24/0	0	1/1	0	0	0	0	1/1	1/1	2/0	0	6/0	0	1/1	1/1	0	0	46	10
NKSP-RC	4/4	8/8	9/4	0	1/0	3/3	0	1/1	23/0	0	2/2	1/1	0	0	0	0	0	1/0	0	5/0	0	0	0	0	1/1	59	24
SQ-RC	0	0	0	0	0	0	2/0	0	8/0	0	0	0	0	1/0	0	0	0	0	1/0	2/0	1/1	0	0	1/1	0	16	2
WSP-RC	1/1	8/8	26/10	1/1	0	47/16	1/0	0	58/0	0	0	0	0	1/0	0	0	0	3/1	0	33/0	0	1/1	0	1/1	2/2	183	41
TOTAL:	37/12	91/20	82/27	3/3	7/0	74/29	140/1	1/1	204/6	27/27	8/8	109/8	16/13	98/6	3/3	2/2	48/25	44/5	9/2	168/5	120/1	6/6	3/3	51/17	84/41	1435	271
	TO: AVE	TO: CCI	TO: CIM	TO: CMC	TO: CMF	TO: CRC	TO: COR	TO: WSP	TO: CTF	TO: FSP	TO: HDSP	TO: KVSP	TO: LAC	TO: MCSP	TO: NK	TO: PBSP	TO: PVSP	TO: RJD	TO: SAC	TO: SATF	TO: SCC	TO: SOL	TO: SQ	TO: SVSP	TO: VSP	Total Reqstd	Total Provided

Final

1435	271

DPRD2-49-000075

EOP CASES ASSIGNED BUS SEATS FOR THE WEEK OF FEB. 11, 2013
(# Seats Requested / # Seats Provided for Endorsed Cases)

FROM:	TO: CMC	TO: CMF	TO: COR	TO: KVSP	TO: LAC	TO: MCSP III	TO: MCSP IV	TO: PBSP	TO: RJD III	TO: RJD SNY	TO: SAC	TO: SATF COD	TO: SATF SNY	TO: SVSP	TO: CCWF	TO: CIW	Total Reqstd	Total Provided
ASP	0	0	0	0	0	1/0	0	0	0	0	0	0	2/0	0	0	0	3	0
CAL	0	0	0	0	1/1	0	0	0	0	0	0	0	0	0	0	0	1	1
CCC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CCI	0	0	0	0	0	0	0	0	0	0	0	0	2/0	0	0	0	2	0
CCWF	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CEN	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CIW	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CMC	0	3/0	0	1/1	0	3/0	3/0	0	5/0	0	0	0	3/0	0	0	0	18	1
CMF	0	0	0	0	1/1	1/0	0	0	0	0	0	0	0	0	0	0	2	1
COR	0	0	0	0	1/1	7/0	3/0	0	0	3/0	0	0	0	0	0	0	14	1
CRC	0	0	0	0	0	0	0	0	0	0	0	1/1	1/0	0	0	0	2	1
CTF	0	0	0	0	0	0	0	0	0	0	0	0	2/1	0	0	0	2	1
CVSP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
FSP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
HDSP	0	0	0	0	0	0	1/0	0	0	0	0	0	0	0	0	0	1	0
ISP	0	0	1/1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
KVSP	0	0	0	0	0	4/0	2/0	0	0	1/0	0	0	0	0	0	0	7	0
LAC	1/1	3/2	2/1	0	0	20/0	4/0	0	5/0	1/0	1/1	0	1/1	0	0	0	38	6
MCSP	0	0	2/2	0	0	0	0	0	0	3/0	0	0	32/0	0	0	0	37	2
PBSP	0	0	1/1	0	0	0	0	0	2/0	0	1/1	0	0	0	0	0	4	2
PVSP	0	0	0	0	0	0	0	0	0	1/0	0	0	1/0	0	0	0	2	0
RJD	2/2	0	0	0	0	12/0	0	0	0	0	0	0	1/1	0	0	0	15	3
SAC	1/1	0	2/0	0	1/1	5/0	4/0	0	5/0	2/0	0	0	0	1/1	0	0	21	3
SATF	0	0	0	0	0	1/0	0	0	1/0	1/0	0	0	0	0	0	0	3	0
SCC	1/1	0	0	0	0	0	0	0	0	0	0	0	1/0	0	0	0	2	1
SOL	0	1/1	0	0	0	0	0	0	2/0	0	0	0	0	0	0	0	3	1
SQ	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
SVSP	0	1/0	3/2	0	0	0	3/0	0	2/0	3/0	1/1	0	1/1	0	0	0	14	4
VSP	0	0	0	0	0	0	0	0	0	0	0	0	2/0	0	0	0	2	0
CCWF-RC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1/1	1	1
CIM-RC	0	0	0	0	0	3/0	1/0	0	0	0	0	0	11/0	0	0	0	15	0
DVI-RC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
NKSP-RC	0	0	0	0	1/0	0	0	0	0	0	0	1/1	10/0	0	0	0	12	1
SQ-RC	0	0	0	0	0	1/0	0	0	0	0	0	0	0	0	0	0	1	0
WSP-RC	0	0	0	0	0	0	0	0	1/0	0	0	0	9/0	1/1	0	0	11	1
TOTALS:	5/5	8/3	11/7	1/1	5/4	58/0	21/0	0	23/0	15/0	3/3	2/2	79/4	2/2	0	1/1	234	32
	TO: CMC	TO: CMF	TO: COR	TO: KVSP	TO: LAC	TO: MCSP III	TO: MCSP IV	TO: PBSP	TO: RJD III	TO: RJD SNY	TO: SAC	TO: SATF COD	TO: SATF SNY	TO: SVSP	TO: CCWF	TO: CIW	Total Reqstd	Total Provided

Final

Exhibit 3

From: Eargle, Amy@CDCR
Sent: Monday, February 11, 2013 9:04 AM
To: Jones, Maria@CDCR
Subject: Suicide Workgroup materials
Attachments: Data Review Jan 2013.pdf

CDCR SUICIDES: RESULTS OF RECENT ANALYSES

The DHCS Suicide Prevention Program has, over the last month, analyzed a variety of data collected as part of the suicide prevention program. We have focused on the years 2007 through 2012 since these six years have seen intense activity on suicide prevention, starting with the court-ordered plan to prevent suicides in administrative segregation units. Below is a summary of some of the findings from this recent review and analysis.

Individual Characteristics of Inmates Who Have Died by Suicide

Since the beginning of 2007, there have been 195 suicides of inmates in CDCR. Of these deaths, 57% were in mainline housing units including dorms, celled housing, community correctional facilities, medical facilities within CDCR, and out of state facilities. Thirty-three percent occurred in administrative segregation and another 10 percent in other segregated settings (condemned, SHU, and PSU).

Sixty-three percent were participants in the MHSDS at the time of their deaths. The average age was forty.

Classification, offense, and term (Tables 1-3): Inmates at the Level IV classification level predominated among those who died by suicide. Of those classified (CDCR does not classify reception center and female inmates) 46% were Level IV, 21% Level III, 16% Level II, and only 5% were Level I. Since the beginning of 2007 seventy-seven percent of inmates who have died by suicide in CDCR were incarcerated for a violent crime (defined as a crime against a person). Eighteen percent were guilty of a sex crime.

Lengthy and life sentences predominated among those who committed suicide during this period. Seventy-one percent of the suicides were committed by inmates with lengthy (10 years or more), life-term (indeterminate life and life without parole), or condemned sentences. Thirty-four inmates had indeterminate life sentences and were eligible for parole. Of these, forty-one percent were housed in segregated settings at the time of their death. Seven condemned inmates died by suicide.

Administrative Segregation (ASU): Segregated settings have traditionally been considered higher risk settings when it comes to suicide. In particular, ASU has been a particular focus of suicide prevention efforts by CDCR going back over a decade. Despite a spike in the percentage of suicides in ASU in 2004, the average over the years has been about 35% of all suicides occur in ASU, with another 10% occurring in SHU, PSU, and on condemned units (see tables).

The 2006 court-ordered plan to reduce suicides in ASU focused on the first few days and weeks in ASU, requiring up to ten days in an "intake" cell and 30-minute welfare checks for the first three weeks. Data developed prior to the plan suggested that the first week to ten days was a critical period. Data collected since then on the length of stay in ASU prior to suicide have

reinforced this finding. Since the beginning of 2007, 49% of inmates who died by suicide in ASU had spent less than 21 days in ASU at the time of their death. For MHSDS inmates, 43% of CCCMS and 36% of EOP inmates had been in ASU 21 days or less at the time of their death. Thirteen MHSDS inmates and 12 non-MHSDS inmates had been in ASU less than 10 days at the time of death.

CDCR screens all inmates prior to placement and non-MHSDS inmates within 72 hours of entry to ASU. Health care staff administers the pre-placement screening and as yet the data on this is spotty because of the lack of clear rules for data entry in the institutions. The same problems have plagued tracking of the post-placement screening. DHCS Mental Health Program has recently directed the institutions to assure that this data is entered. A recent report from MHTS.net shows that of 8,629 inmates screened after entry to ASU, over 3,000 had negative screens, 434 were positive (referred for mental health evaluation) but over 5,000 were simply entered as "completed." (It should also be noted that only inmates who are not currently in the MHSDS are screened.) This result is complicated by the fact that on average only 58% of inmates entering ASU are reported as being screened. This low figure may be due to staffing problems, poor data entry, or misinterpretation of the MHTS.net business rules. In addition, in many institutions, the refusal rate for ASU post-placement screenings is high due to gang culture and other reasons. Currently the Mental Health Program HQ SPR FIT is planning to replace the current screening measure (which is grounded in DSM-III) and replace it with one that is shorter and targeted at distress and suicidality rather than general mental health needs.

Another measure of mental health services in ASU is the elapsed time from entry to first clinical interview (for MHSDS inmates). In 2012, over all institutions, the median length of time to first clinician visit in ASU was 4.9 days for CCCMS inmates and 2.8 days EOP inmates. These numbers are within program guidelines. When the institutions polled are limited to those with large mental health programs (typically EOP programs) the time to first visit for CCCMS drops to 3.6 days and for EOP to 2.3 days.

Finally, data collected by suicide evaluators found that many inmates who housed in ASU at the time of their deaths are placed there not for disciplinary reasons, but for safety reasons. Although there are many complexities surrounding these situations, it is worth noting that placement in ASU of already fearful inmates may only serve to make them even more fearful and anxious, which may precipitate a state of panicked desperation, and the urge to die.

Mental Health Issues (Table 4): Suicide is most commonly associated with serious mental disorders. In CDCR, more than half of all suicides are committed by inmates in the MHSDS. As of the end of 2012 over 75% of mental health inmates were diagnosed with one of the "Coleman" qualifying disorders (Schizophrenia, Bipolar Disorders, Major Depressive Disorder, and other psychotic and mood disorders).

The "sustainable process" has included clinical procedures to flag "high risk" inmates – typically those who qualify for treatment in DSH settings – particularly Intermediate Care programs. The Mental Health Program tracks these high-risk inmates and using these criteria reviewed the 2012 suicide deaths. Of the 18 inmates who died by suicide in 2012 and were participants in MHSDS, one had been identified as high risk by MHSDS criteria and at the time of his death was, in fact, housed in a DSH program. The 17 other MHSDS inmates had been screened several times in their IDTT's and had not met criteria for listing as "high risk." Two-thirds (12) of the MHSDS inmates who died by suicide were at the CCCMS level of care at the time of their death. (It should be noted that the term "high risk" does not necessarily denote high risk for suicide, but rather that the inmate may have met criteria for treatment in a DSH program.)

Medical Issues (Tables 5 & 6): Both in the community and in prison medical issues can raise the risk for self-harm and suicide. In CDCR, where medical morbidity is higher than in the community many inmates who commit suicide have co-morbid medical disorders and/or chronic pain issues. Among the 195 suicides in CDCR since the beginning of 2007, 51 inmates (26%) were identified as suffering from a chronic medical or painful condition. Of these, 13 were housed in ASU, four were condemned, three were housed in SHU, one was in a medical setting, and the remainder housed in mainline housing.

After several suicides involving chronic pain and medication issues were reviewed, the Mental Health Program found that almost one in seven (13.4%) MHSDS inmates were prescribed medications for pain. Of these inmates, over seven percent were prescribed opiate analgesics. As would be expected, the older age groups predominated: inmates 55 and older received 46% of all chronic pain medications prescribed MHSDS inmates, yet only comprised 13% of the total MHSDS population.

Suicide Trends (Figures 1-6): The CDCR Mental Health Program has considered suicide trends since the beginning of the *Coleman* monitoring of suicides, which began over ten years ago. Attached to this report are several charts which show trends in both rate and frequency of suicide overall in CDCR and also the trend in the percentage of total CDCR suicides.

Both the overall raw rate (Figure 1) and the frequency (Figure 3) of suicide in CDCR have trended upward since 2000. However, we believe that developments and changes in the CDCR and the Mental Health Program since the beginning of 2007 warrant a more fine-grained analysis.

Figures 2 and 4 show the raw rate and frequency broken into periods: 2000-2006 and 2007-2012. The year 2007 was chosen as the "break year" because: 1) between 2000 and 2006 the Department had a seven percent increase in inmate population, peaking at over 172,500 inmates in 2006 (almost 200% of design capacity); 2) 2007 was the first full year of the federal Receivership; 3) by the beginning of 2007 the Mental Health Program was filling many vacancies that had hampered efforts to meet policy guidelines; and 3) the number of beds for

higher levels of mental health care was beginning to increase. As can be seen, both the rate and frequency of suicide began to stabilize (denoted by decreasing fluctuation), and the trend began to flatten, and in the case of suicide frequency, decline.* Overall, then, 2000-2006 saw fluctuating rates and frequencies of suicide with an overall upward trend, while since the beginning of 2007 there has been an overall decrease in frequency and a flattening of the trend in rate.

ASU suicides show a similar pattern, although not as striking. Since 2000, the percentage of suicides occurring in ASU statewide has been less than 40%. There was an upward spike in 2004 that contributed to the upward trend. But since 2007, the percentage of suicides occurring in ASU has remained stable and with a "flat" trend.

Summary: The Mental Health Program believes that the frequency of suicide in CDCR institutions may be on the decline. There has been a negative trend in the last few years and an absolute decrease in frequency of almost ten percent in the last three years. This being said, long term rates can fluctuate and at least two more years of data are needed to see a clear trend.

Recent analyses reinforce evidence collected by the Mental Health Program over the last dozen years that long prison terms, medical problems, serious mental health problems, conviction for a violent crime, and high security classification are among the most important chronic risk factors for suicide for CDCR inmates. These factors (plus advancing age) are long-term characteristics of several thousand CDCR inmates that are not amenable to mental health interventions alone, but are more likely changeable through interventions that cross boundaries and require the collaboration of mental health, education, custody, and medical programs. For instance, over the past decade, a number of suicides have been linked to the "lifer" process – a number of inmates who have had a negative interaction with the Board of Parole Hearings or whose efforts to become suitable for parole have been set back by an incident have lost hope and committed suicide. The Lifer Work Group, which has recently been chartered, and includes many of the domains mentioned above, may directly and indirectly influence the lives of hundreds of inmates with many of these vulnerabilities. In addition, new programs such as depression screening in primary care clinics and continued public health prevention programs are needed to reach the non-mental health population in CDCR.

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Suicide Prevention Coordinator
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Chris Yi, B.A.
Analyst

January 25, 2013

*The simultaneous increase in rate and decrease in frequency may seem anomalous, but the increase in rate is due to the approximate 30,000 inmate drop in prison population since AB 109 went into effect in late 2011.

Table 1. CDCR Suicides 2007-2012: Violent Commitment Offense

Year	Violent Crime?		
	Yes	No	n/a
2007	80%	20%	0%
2008	69%	28%	3%
2009	72%	28%	0%
2010	80%	17%	3%
2011	79%	21%	0%
2012	81%	16%	3%
Total	77%	21%	2%

Table 2. CDCR Suicides 2007-2012: Sex Offender

Year	Sex Offender?		
	Yes	No	n/a
2007	20%	80%	0%
2008	28%	72%	0%
2009	12%	84%	4%
2010	17%	74%	9%
2011	18%	79%	3%
2012	9%	91%	0%
Total	18%	80%	3%

Table 3. CDCR Suicides 2007-2012: Classification Level

Year	Classification Level Breakdown				
	I	II	III	IV	n/a
2007	3%	14%	23%	51%	9%
2008	11%	22%	17%	31%	19%
2009	8%	16%	16%	52%	8%
2010	3%	14%	23%	43%	17%
2011	3%	9%	33%	52%	3%
2012	3%	19%	13%	53%	13%
Total	5%	16%	21%	46%	12%

Table 4. MHSDS Inmates: Frequency of Diagnosis, as of 12/26/2012

Total Number of Inmates in MHSDS	30586		
Serious Mental Illnesses	# of inmate-patients	% of MHSDS	Corresponding DSM IV codes
Schizophrenia (All subtypes)	1387	4.53%	295.10, 295.20, 295.30, 295.60, 295.90
Delusional Disorder	144	0.47%	297.1
Schizophreniform Disorder	7	0.02%	295.40
Schizoaffective Disorder	2316	7.57%	295.70
Brief Psychotic Disorder	14	0.05%	298.8
Psychotic Disorder NOS	1976	6.46%	298.9
Major Depressive Disorders	10295	33.66%	296.30-36, 296.20-26
Bipolar Disorder I	2410	7.88%	296.00-06, 296.40-46, 296.50-56, 296.60-66
Bipolar Disorder II	352	1.15%	296.89
Mood Disorder NOS*	4269	13.96%	296.90
Total	23170	75.75%	
Total without Mood Disorder NOS	18901	61.80%	
*Not on the list of Serious Mental Illnesses in the Program Guide			

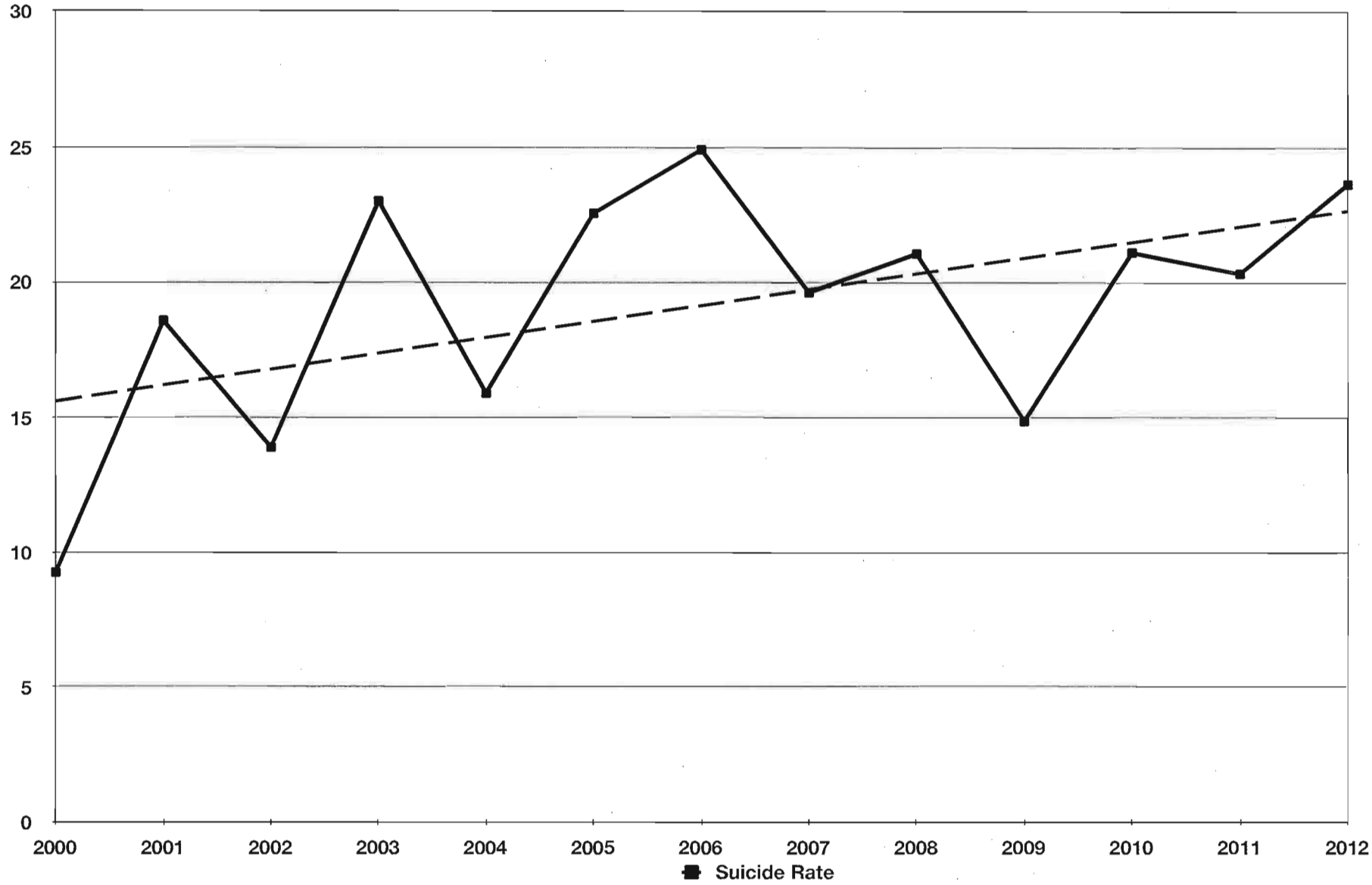
Table 5. MHSDS Patients Currently Receiving Chronic Pain Medications

Mental Health Level of Care	Total Population	Currently Receiving Chronic Pain Meds	Pct %	Adjuvant Med Only	Opioid Med Only	Opioid & Adjuvant
CCCMS	27447	3843	14.0%	1779 (6.5%)	1612 (5.9%)	452 (1.6%)
EOP or Higher	5522	570	10.3%	272 (4.9%)	225 (4.1%)	73 (1.3%)
MHSDS	32969	4413	13.4%	2051 (6.2%)	1837 (5.6%)	525 (1.6%)

Table 6. MHSDS Patients Receiving Chronic Pain Medications, By Age Group

Age Group Breakdown	Total Population	Currently Receiving Chronic Pain Meds	Pct %
18-24	2432 (7%)	47	1.9%
25-34	8229 (25%)	477	5.8%
35-44	8786 (27%)	1086	12.4%
45-54	9057 (27%)	1719	19.0%
55-64	3718 (11%)	925	24.9%
65+	747 (2%)	159	21.3%
MHSDS	32969	4413	13.4%

Figure 1. CDCR Rate of Suicide, 2000-2012



NOTE: The rate for 2012 is higher than the rate for 2011 despite having one less suicide in 2012. This is because of the substantial drop in CDCR population due to AB 109, which took effect in late 2012. If the rate for 2012 had been calculated using the population from 2011, the trend for 2007-2012 would be almost flat, rather than slightly positive.

Figure 2. Total CDCR Suicide Rate: 2000-2006 & 2007-2012, with trends

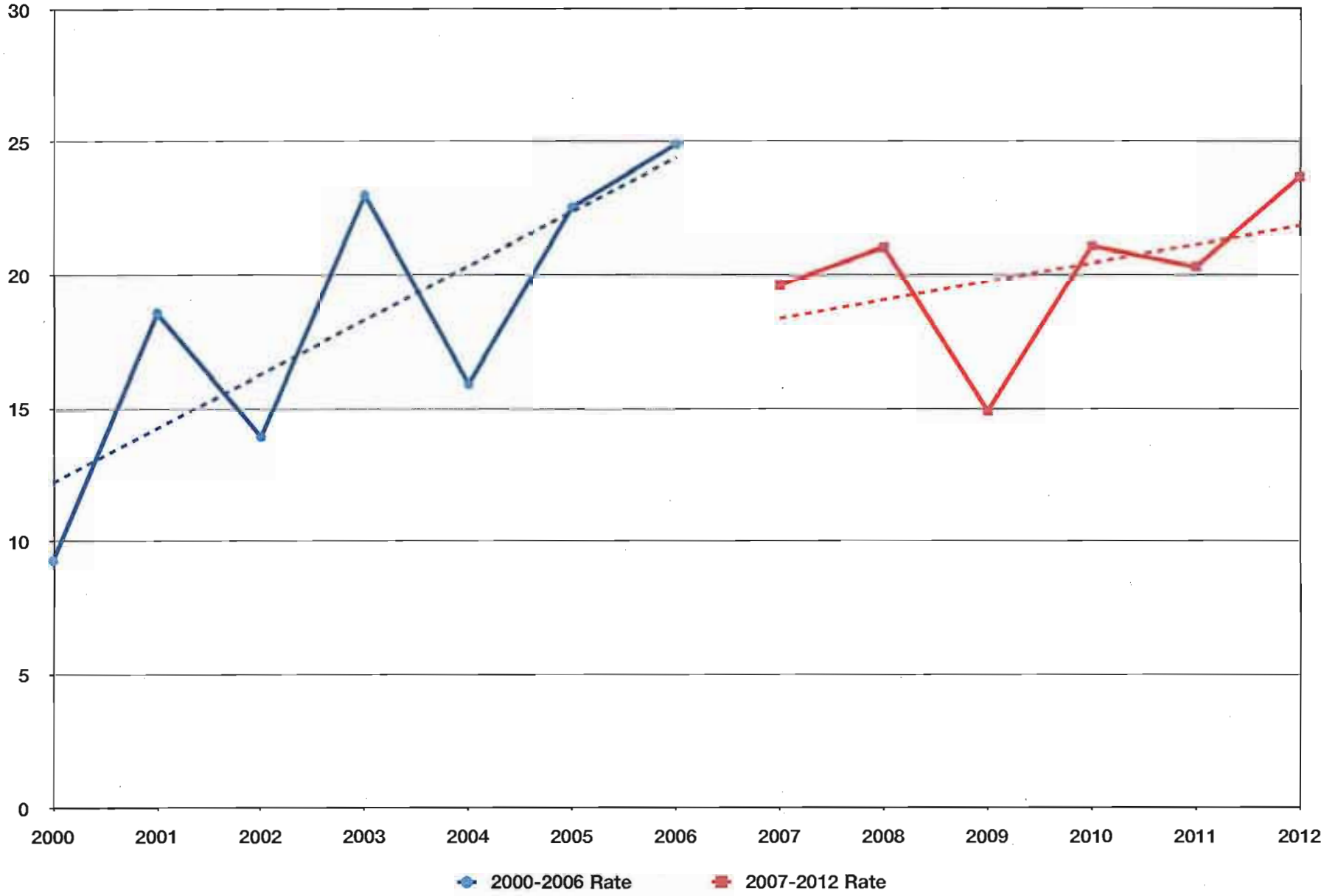


Figure 3. Total Frequency of Suicides, 2000-20012, with trend

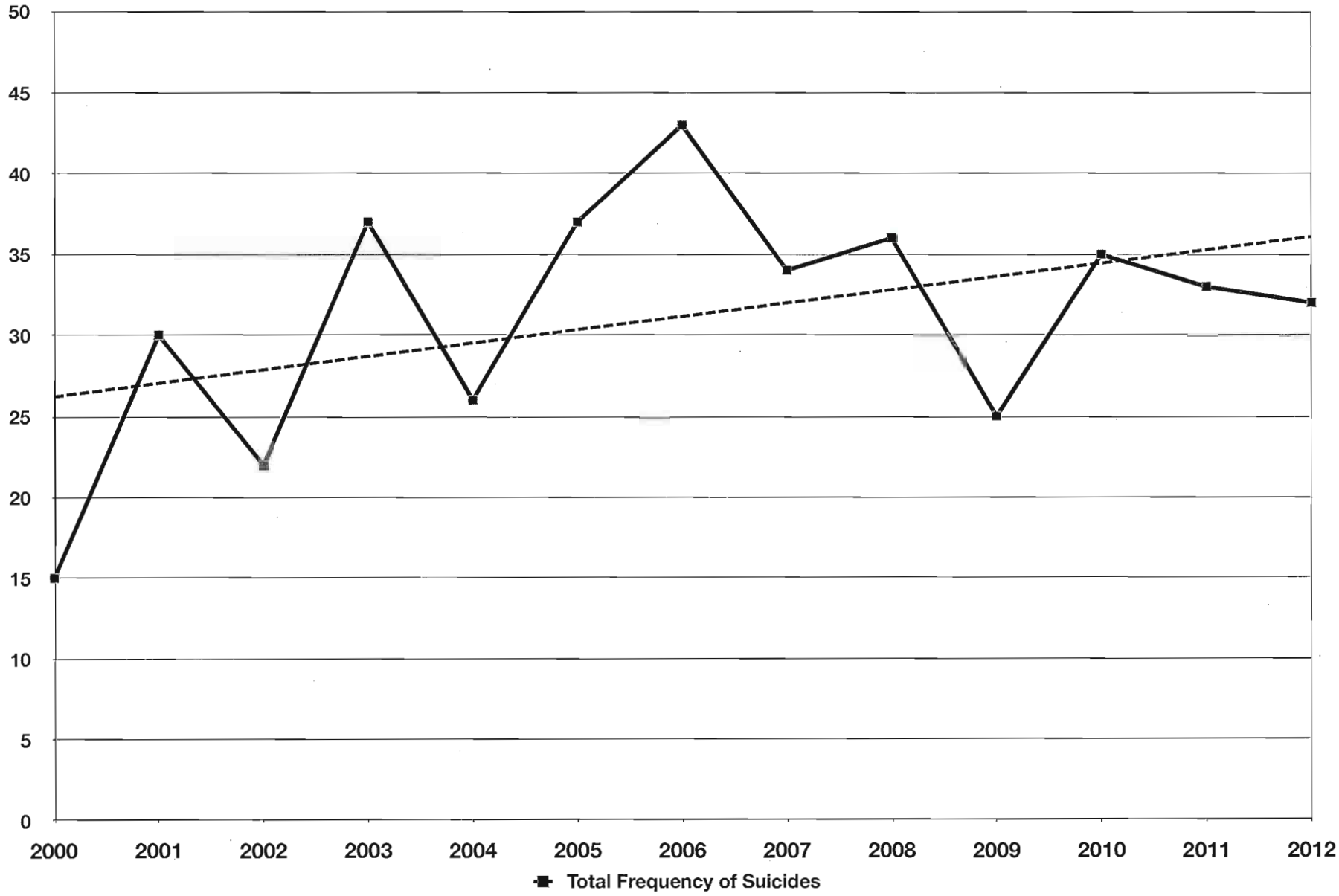


Figure 4: Total Frequency 2000-2006 & 2007-2012, with Trends

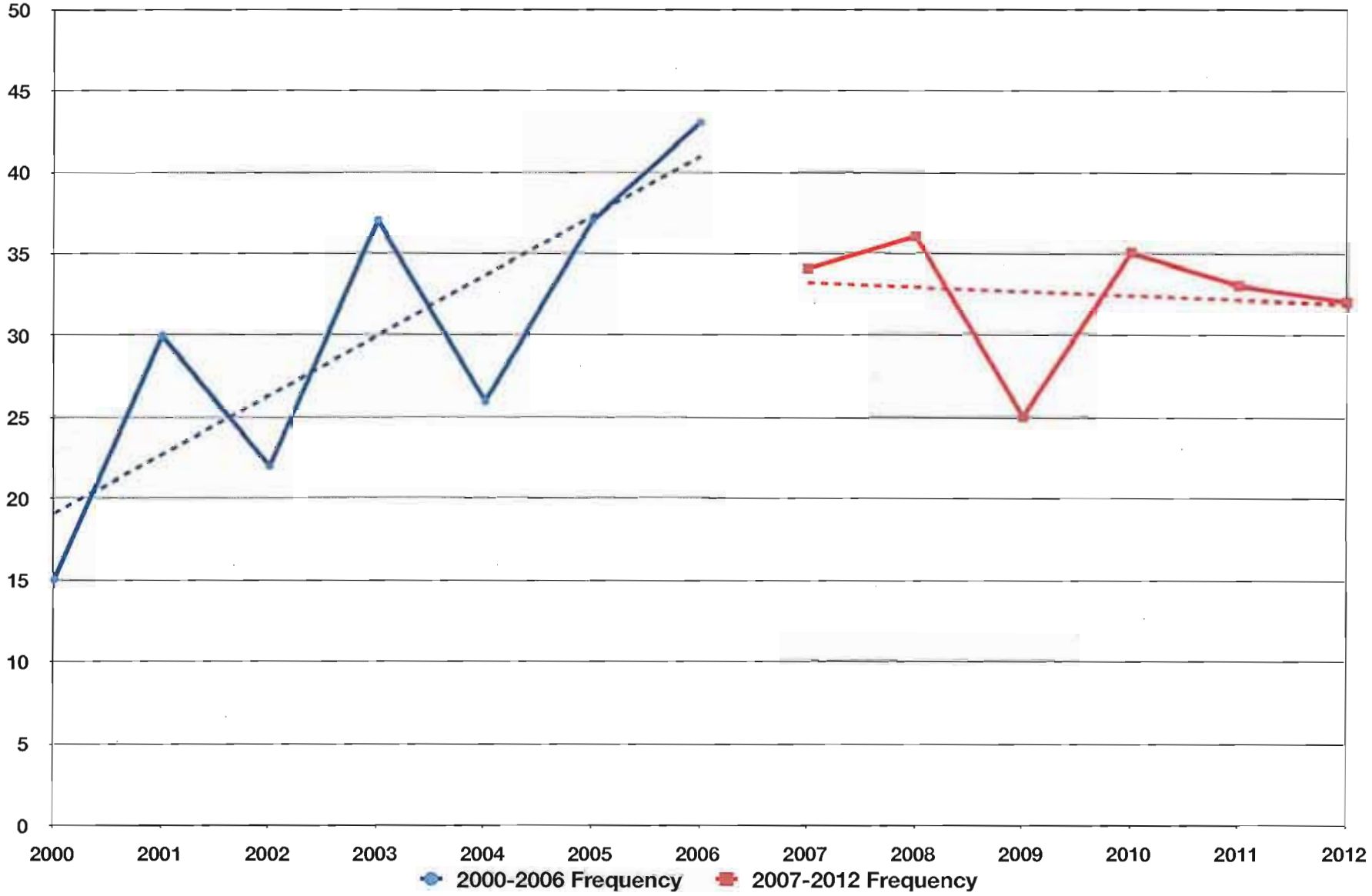


Figure 5. CDCR Suicides: Percent in ASU, 2000-2012, with trend

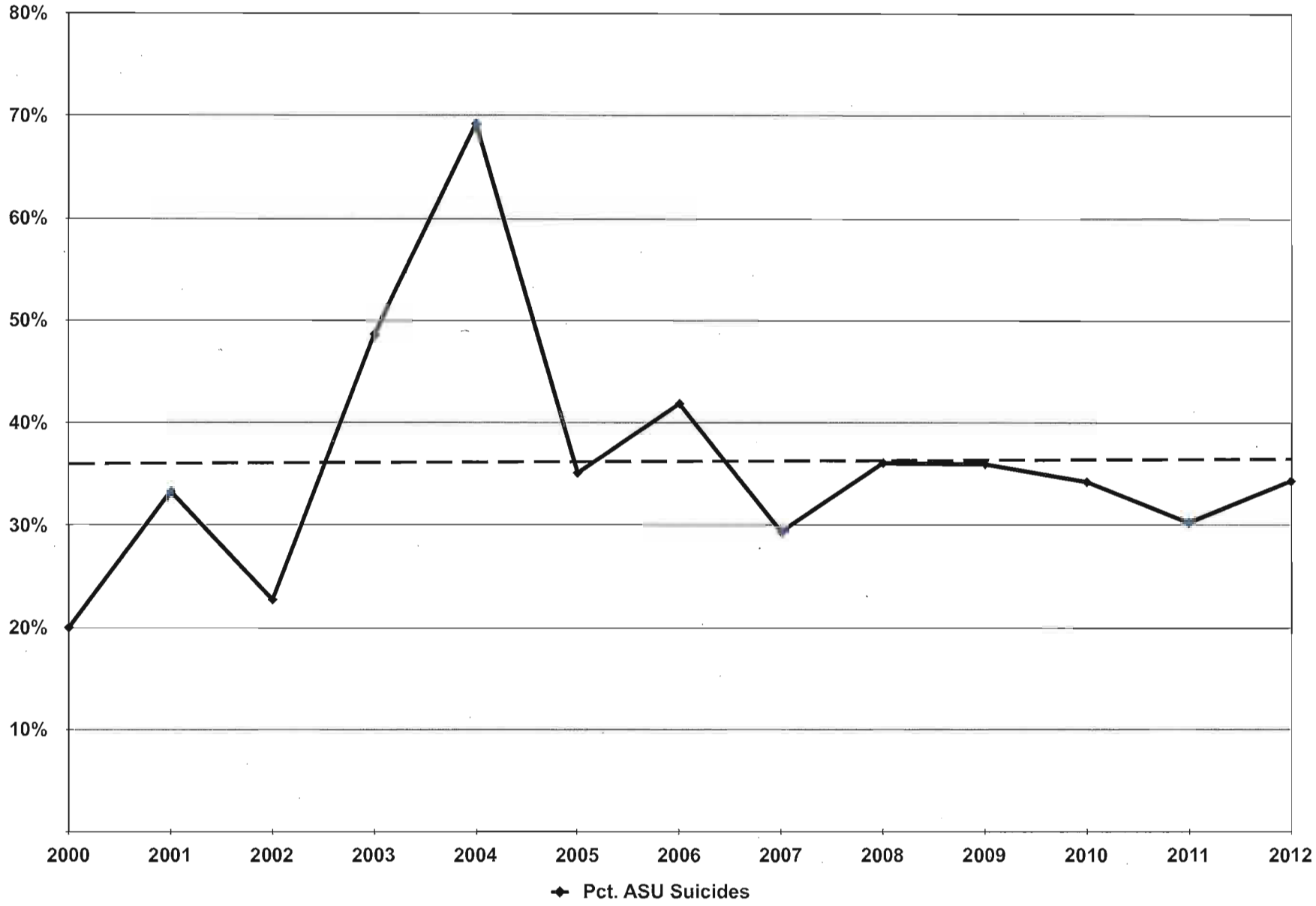


Figure 6. Percent of Total CDCR Suicides in ASU, 2000-2006 & 2007-2012, with trends

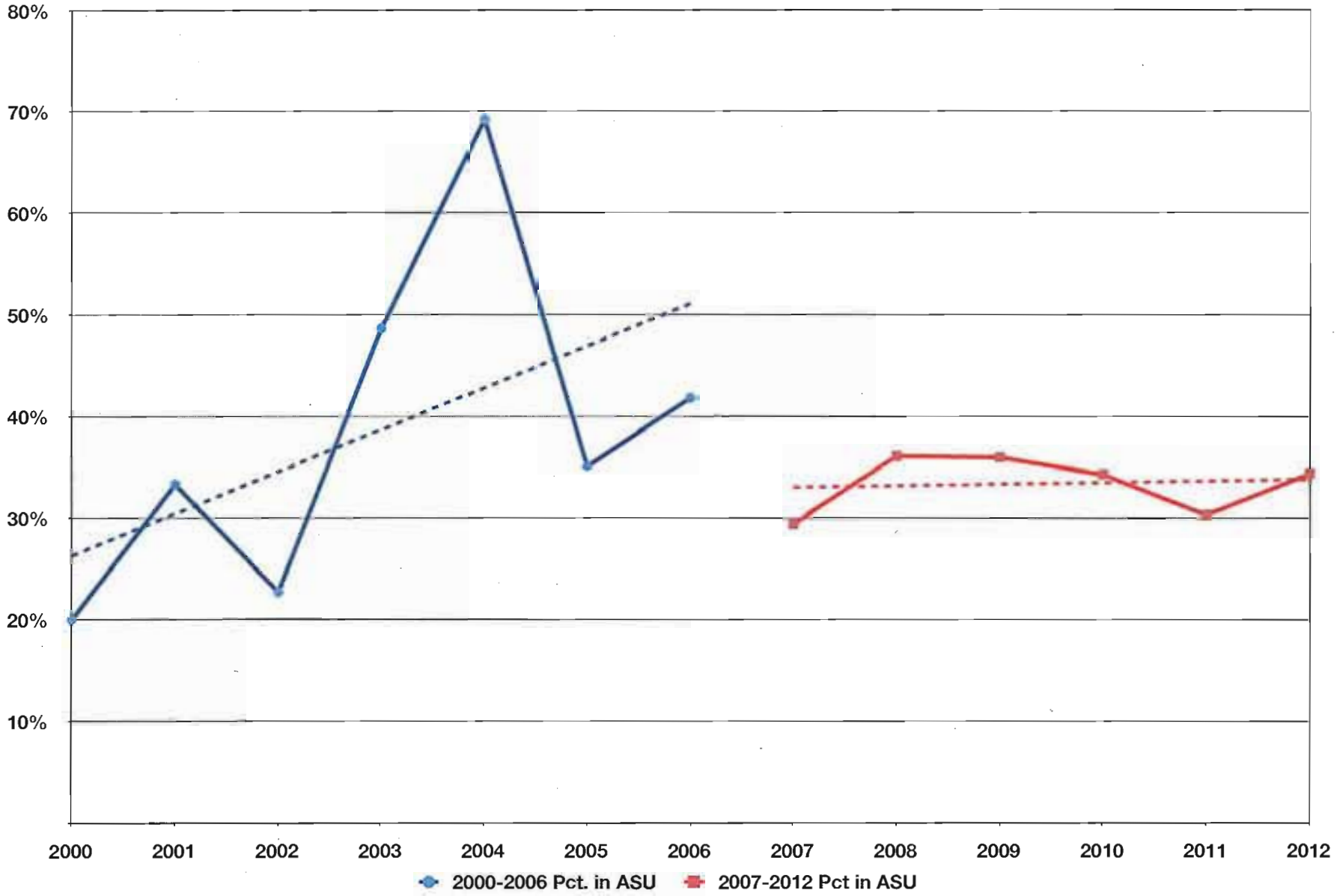


Exhibit 4

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, ET AL., Plaintiffs, vs. EDMUND G. BROWN, JR., ET AL., Defendants.	CASE NO.: S 90-0520 LKK-JFM

DEPOSITION OF

JACQUELINE MOORE, RN, PH.D.

THURSDAY, FEBRUARY 21, 2013, 8:50 A.M.

SAN FRANCISCO, CALIFORNIA

REPORTED BY: MEGAN F. ALVAREZ, RPR, CSR NO. 12470

THORSNES LITIGATION SERVICES, LLC

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, ET AL.,	)	
	)	
Plaintiffs,	)	
	)	CASE NO.:
vs.	)	S 90-0520 LKK-JFM
	)	
EDMUND G. BROWN, JR., ET AL.,	)	
	)	
Defendants.	)	
	)	

The Deposition of JACQUELINE MOORE, RN, PH.D., taken on behalf of the Plaintiffs, before Megan F. Alvarez, Certified Shorthand Reporter No. 12470, Registered Professional Reporter, for the State of California, commencing at 8:50 a.m., Thursday, February 21, 2013, at the Rosen, Bien, Galvan & Grunfeld, LLP, 315 Montgomery Street, 10th Floor, San Francisco, California.

APPEARANCES OF COUNSEL:

FOR PLAINTIFFS:

BY: AARON J. FISCHER, ESQ.
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916.324.5345
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DEBBIE.VOROUS@DOJ.CA.GOV

during your tours?

MS. VOROUS: Let me clarify. During her tours -- not Mule Creek.

BY MR. FISCHER:

Q. I recognize that the experts did not go to Mule Creek. But were there other similar treatments settings that you observed at other institutions?

A. Not that I'm aware of.

Q. Not that you're aware of?

A. Not that I recall.

Q. In this photograph, there are three modules filled with inmates with two clinicians conducting one-to-one treatments.

Did you observe individual treatment being conducted in this manner on any of your tours?

A. Not that I recall. Sorry.

Q. Do you have any concerns about conducting one-to-one treatment in such a setting?

MS. VOROUS: Objection. Lacks foundation. Argumentative.

Go ahead.

THE WITNESS: My concern would be the confidentiality of the interview.

BY MR. FISCHER:

Q. Because they're so close?

A. Because they're so close.

And especially the -- inmate at the end has nothing better to do than to listen.

Q. Inmate on the left side is just listening?

A. Right.

Q. Would a more appropriate treatment space be an individual office for these individual contacts?

MS. VOROUS: Objection. Lacks foundation. Speculative. Argumentative.

THE WITNESS: Do you want an answer?

BY MR. FISCHER:

Q. Uh-huh.

A. If it was available.

Q. You're aware from some of your tours that individual treatment space is not available at some of the institutions at this time?

A. Yes.

Q. Let me go back for one more minute to Exhibit 13.

In your experience what is the impact that -- or the effect of having one-to-one contacts in a nonconfidential setting similar to what you see here?

MS. VOROUS: Objection. Lacks foundation as far as her experience in having this kind of experience.

THE WITNESS: The inmate will not be as

CERTIFICATE OF REPORTER

I, MEGAN F. ALVAREZ, a Certified Shorthand Reporter, hereby certify that the witness in the foregoing deposition was by me duly sworn to tell the truth, the whole truth and nothing but the truth in the within-entitled cause;

That said deposition was taken down in shorthand by me, a disinterested person, at the time and place therein stated, and that the testimony of the said witness was thereafter reduced to typewriting, by computer, under my direction and supervision;

I further certify that I am not of counsel or attorney for either or any of the parties to the said deposition, nor in any way interested in the events of this cause, and that I am not related to any of the parties hereto.

DATED: February 25, 2013

_____

MEGAN F. ALVAREZ

RPR, CSR 12470

Exhibit 5

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, ET AL., Plaintiffs, vs. EDMUND G. BROWN, JR., ET AL., Defendants.	CASE NO.: S 90-0520 LKK-JFM

DEPOSITION OF

JACQUELINE MOORE, RN, PH.D.

THURSDAY, FEBRUARY 21, 2013, 8:50 A.M.

SAN FRANCISCO, CALIFORNIA

REPORTED BY: MEGAN F. ALVAREZ, RPR, CSR NO. 12470

THORSNES LITIGATION SERVICES, LLC

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, ET AL., Plaintiffs, vs. EDMUND G. BROWN, JR., ET AL., Defendants.	CASE NO.: S 90-0520 LKK-JFM

The Deposition of JACQUELINE MOORE, RN, PH.D., taken on behalf of the Plaintiffs, before Megan F. Alvarez, Certified Shorthand Reporter No. 12470, Registered Professional Reporter, for the State of California, commencing at 8:50 a.m., Thursday, February 21, 2013, at the Rosen, Bien, Galvan & Grunfeld, LLP, 315 Montgomery Street, 10th Floor, San Francisco, California.

APPEARANCES OF COUNSEL:

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BY: AARON J. FISCHER, ESQ.
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DEBBIE.VOROUS@DOJ.CA.GOV

A. Okay.
Q. Are you aware?
A. Yes. Yes.
Q. Okay. Did you visit the administrative segregation unit at CIM? I think you said you did.
A. Um.
Q. Direct you to top of the 10266, top two issues: "EOP not transfer fast enough. That's not getting 10 hours RX" --
A. Treatment.
Q. "RX" is treatment?
A. Treatment.
Q. "Now nine in seg."
Were you documenting that there were nine EOPs awaiting transfer in this segregation unit?
A. Yes.
Q. And they were not there for disciplinary reasons; is that your understanding?
A. Yes.
Q. They were there because they were awaiting for a bed to open?
A. Yes.
Q. Okay. On the page just before that, 102620, near the bottom you write: "Lack of beds."
Is this related to same issue?

A. Lack of beds in general population.

Q. So there were lack of beds for EOP and there were lack of beds for -- related to the general population?

A. Yes.

Q. Were there more inmates than appropriate beds?

A. Yes.

Q. It's your understanding?

Were there more EOPs than appropriate beds in the system?

MS. VOROUS: Objection.

BY MR. FISCHER:

Q. Trying to understand what your --

A. More EOPs -- they couldn't transfer EOPs to other institutions.

Q. For lack of available beds?

A. Lack of available beds.

Q. Okay. Do you recall, did you interview any of the EOPs in segregation awaiting transfer when you were at CIM?

A. This -- these may have been the inmates on page 102626.

Q. Uh-huh.

Based on your interviews with these inmates, were you able to reach an opinion as to whether they

were receiving appropriate level of care treatment?

A. They were sick inmates. They were very sick inmates. And --

Q. Do you remember anyone specifically?

A. No. Just by what I'm -- I wrote down about the fact that -- that they were hearing voices or that they were having auditory hallucinations or that one inmate was seeing signs of his grandmother. They were sick inmates; they needed to be somewhere else.

Q. In your opinion, was the administrative segregation unit an appropriate area for these inmates?

MS. VOROUS: Objection. Assumes that these inmates were ad seg.

THE WITNESS: If these inmates were in ad seg.

BY MR. FISCHER:

Q. Based on your memory, you interviewed inmates in ad seg?

A. I thought these were the inmates in ad seg. I'm not sure. I'd have to look at the numbers to be sure.

Q. On the page after which you were reading where it again says "Seg" at the top. This is 102627.

About halfway down, it says "LOB" -- "Make a note LOB." Does that stand for lack of bed?

MS. VOROUS: Are you asking her whether --

CERTIFICATE OF REPORTER

I, MEGAN F. ALVAREZ, a Certified Shorthand Reporter, hereby certify that the witness in the foregoing deposition was by me duly sworn to tell the truth, the whole truth and nothing but the truth in the within-entitled cause;

That said deposition was taken down in shorthand by me, a disinterested person, at the time and place therein stated, and that the testimony of the said witness was thereafter reduced to typewriting, by computer, under my direction and supervision;

I further certify that I am not of counsel or attorney for either or any of the parties to the said deposition, nor in any way interested in the events of this cause, and that I am not related to any of the parties hereto.

DATED: February 25, 2013

_____

MEGAN F. ALVAREZ

RPR, CSR 12470

Exhibit 6

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, ET AL., Plaintiffs, vs. EDMUND G. BROWN, JR., ET AL., Defendants.	CASE NO.: S 90-0520 LKK-JFM

DEPOSITION OF

JACQUELINE MOORE, RN, PH.D.

THURSDAY, FEBRUARY 21, 2013, 8:50 A.M.

SAN FRANCISCO, CALIFORNIA

REPORTED BY: MEGAN F. ALVAREZ, RPR, CSR NO. 12470

THORSNES LITIGATION SERVICES, LLC

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, ET AL.,	)	
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Plaintiffs,	)	
	)	CASE NO.:
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DEBBIE.VOROUS@DOJ.CA.GOV

components I looked at.

Q. One of the audit tool components for your --

A. For my criteria, yes. And so the nurse brought me to this meeting.

Q. And so do I understand that your finding was that there were more CCCMS prisoners than there were staff to be able to do discharge planning, including patrol medications with them?

MS. VOROUS: Objection. Misstates testimony.

THE WITNESS: No, no, no.

BY MR. FISCHER:

Q. Go ahead.

A. No, no, no. The parole meds were done differently than the discharge planning.

My premise was that there weren't enough discharge planners to fill out the social security applications, make sure people had housing, other therapies.

Q. Various aspects of discharge planning were not done for the CCCMS population?

A. Correct.

Q. Okay. Thank you for clarifying. Maybe I can get my question correct this time.

Your finding was that there were more CCCMS prisoners at CIM than there were staff available to do

discharge planning at the institution?

MS. VOROUS: Objection. Misstates her testimony.

THE WITNESS: Yes.

BY MR. FISCHER:

Q. Okay. And one last thing on CIM I wanted ask you about in your notes on the final page, 102633.

Most of the way down next to No. 5, it says: "Nurse UNFAM, SE, psy meds."

What does that note refer to?

A. Nurses were unfamiliar with the side effects of psychiatric meds.

Q. I imagine that's on your radar because you're a nurse?

A. I asked them.

Q. Why did you ask this question?

A. I asked all the institutions. That was one of the criteria on my audit tool.

Q. And here -- SE is side effects?

A. Side effects.

Q. And is this particular CIM of concern to you in your analysis?

A. Yes.

Q. Why is that?

A. Because it's a common practice that nurses

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I further certify that I am not of counsel or attorney for either or any of the parties to the said deposition, nor in any way interested in the events of this cause, and that I am not related to any of the parties hereto.

DATED: February 25, 2013

_____

MEGAN F. ALVAREZ

RPR, CSR 12470

Exhibit 7

From: Wheeler, (Ralph) David@CDCR
Sent: Monday, February 04, 2013 2:34 PM
To: Prudhomme, Catherine@CDCR
Subject: FW:
Attachments: SRE Mentoring Program Email.docx; SRE PEER MENTOR SCHEDULE 2013 3rd Edit.xlsx

FYI

D. Wheeler, PsyD
Chief Psychologist
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CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

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From: Ponder, John@CDCR
Sent: Wednesday, January 30, 2013 8:45 AM
To: Wheeler, (Ralph) David@CDCR
Subject: FW:

SRE Mentor Program Model from MCSP.

From: Telander, Jim@CDCR
Sent: Wednesday, January 30, 2013 8:39 AM
To: Wagle, Rinata@CDCR; Branman, Eric@CDCR; Esposito, George@CDCR; Friel, Sally@CDCR; Laughlin, Debra@CDCR; Olson, Edward@CDCR; O'Meara, Marie@CDCR; Towner, Kristina@CDCR; West, George@CDCR; Anand, Karuna@CDCR; Colley, Jeremy@CDCR; Fowler, Fred@CDCR; Haspel, Thomas@CDCR; John, Biju@CDCR; Kecskes, Diane@CDCR; Lanzano, Gia-Evita@CDCR; Rose, Scott@CDCR; Smith, Michael W.@CDCR; Suskauer, Sheldon@CDCR; Wagle, Rinata; Young, Gregory@CDCR; Anderson, Carol(Psy.D.)@CDCR; Andres, Allison@CDCR; Andrews, Siara@CDCR; Arnold, Bob@CDCR; Babrah, Pritam@CDCR; Beckel, Debra@CDCR; Bressi, Dominique@CDCR; Coffin, Demetri@CDCR; Cordosi, David@CDCR; Custer, Oral@CDCR; Fang, Ko@CDCR; Fisher, Janelle; Keller, Kate@CDCR; Kim, Mike@CDCR; Landry, Robert@CDCR; Leigh, Sandra@CDCR; Liddell, Alysia@CDCR; Lisle, Douglas@CDCR; Meeker, Edward@CDCR; Minor, Shelly@CDCR; Montes, Melton@CDCR; Ortigo, Richard@CDCR; Pickering, Victoria@CDCR; Pifferini, Brian@CDCR; Ponder, John@CDCR; Scott, James D.@CDCR; Sutterfield, Kim@CDCR; Wilcox, Jean@CDCR; Wilcox, Lawrence@CDCR
Cc: Neuner, Suzie@CDCR; Dahl, Rick@CDCR; Davison, James@CDCR; Deans, Pamela; Gransee, Edith@CDCR; Heuer, Lori@CDCR; Kirkman, Julie@CDCR; Lintern, Ray@CDCR; Telander, Jim@CDCR; Wood, Patricia@CDCR
Subject:

All MCSP Clinical staff,

Welcome to the kick off for the SRE mentor program. Attached is a memo describing the program and a draft rough schedule for the first few months. Dr. Arnold and Dr. Andres will be heading up the project, and I expect that there will be some obstacles to work through, so your patience is appreciated. Mentors have been identified and trained, but will also be participating in being observed. I appreciate your anticipated cooperation in this process. Thank you.

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Chief Psychologist
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CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

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To all MCSP mental health clinicians,

This is the introduction to the newly renamed Suicide Risk Evaluation Mentoring Program (SRE-MP), which was previously named the Proctoring and Mentoring Program (PMP). The program evolved from a Coleman Court Order that discovered that 82% of suicide risk assessments or evaluations revealed some deficiencies. Thus, the guidelines for the SRE-MP out of Headquarters are very intensive and detailed. This letter is to further aid in understanding and preparing for this important process.

The goals of SRE-MP are to provide a collegial environment for peer review and support during the completion of the *most challenging clinical tasks for any clinician-completing a suicide risk assessment*. In addition, this process will increase the protection against legal liabilities. It is important to remember this is a clinical process and not a disciplinary process. It is not an administrative task; the program is designed to further develop clinical skills and competence as well as confidence in doing suicide risk assessments and crisis interventions within CDCR. Dr. Arnold and Dr. Andres will be heading up this project at this time.

There is a formal process that may include:

1. Routine review of completed SREs by SPR-FIT Coordinator (Dr. Arnold) and the SRE-MP Head Mentor Dr. Andres.
2. Initial assessment of existing suicide risk assessment skills via scheduled one-on-one mentoring meeting (s), by Dr. Arnold, Dr. Andres and a pool of others trained to be a mentor.
3. Utilizing the SRE Quality of Care Review Tool to guide the rating of existing suicide risk assessment skills.
4. Didactic training in completing suicide risk assessments and crisis interventions, including discussion of relevant research and literature.
5. Observing the mentor conduct one or more SREs for an at-risk patient during a suicide risk assessment/crisis intervention.
6. Completion of one or more SREs in the mentor's presence during a suicide risk assessment and crisis intervention of an at-risk patient.
7. Ongoing performance evaluation and feedback of the mentee's administration of the SRE with mentoring on the whole suicide risk assessment process.
8. Ongoing review by utilizing the SRE Quality of Care Review Tool until 80% compliance is reached.

As expected, the process of completing the requirements of this program will involve a significant degree of collaboration between the designated mentors and clinicians. Your patience and understanding is anticipated and appreciated as we initiate the SRE-MP program.

Until you are chosen as a mentee it is a good idea to be cognizant of your current approach to completing the SRE. If you would like any review and/or recommendations regarding the completion of SREs prior to your rotation as a mentee, Dr. Arnold and/or Dr. Andres would be happy to assist you.

Respectfully,

James Telander, Psy.D.
Chief of Mental Health/Chief Psychologist

MCSP PEER MENTORING SCHEDULE 2013

JANUARY

Mentor	Mentee	Date Completed
Shirikian	J. Fisher	
	S. Leigh	
	C. Anderson	
Arnold	G. West	

FEBRUARY

Mentor	Mentee	Date Completed
Andres	L. Wilcox	Week 1
Arnold	K. Sutterfield	
Babrah	M. O'Meara	
Bressi	K. Fang	Week 2
Towner	G. Esposito	
Cordosi	K. Towner	
Deans	M. Montes	
Pifferini	E. Meeker	
Scott	Anand	Week 3
Wood	Rose	
Andres	R. Landry	
Arnold	E. Branman	
Babrah	Lanzano	
Bressi	R. Ortigo	
Colley	M. O'Meara	
Cordosi	L. Wilcox	Week 4
Deans	D. Bressi	
Pifferini	O. Custer	
Scott	R. Ortigo	
Wood	P. Babrah	

MARCH

Mentor	Mentee	Date Completed
Andres	Anand	Week 1
Arnold	Towner	
Babrah	Esposito	
Bressi	Kim	
Colley	Lanzano	
Cordosi	Custer	
Deans	Laughlin	
Pifferini	B. John	Week 2

Scott	Anderson	
Wood	Esposito	
Arnold	Andres	
Andres	West	
Towner	Pifferini	
Bressi	Olson	
Colley	Babrah	
Deans	Lisle	
Scott	Anderson	
Wood	Fang	Week 3
Andres	Coffin	
Arnold	Beckel	
Babrah	Aspinall	
Bressi	Keller	
Colley	Wagle	
Cordosi	Olson	
Scott	Smith	
Arnold	Coffin	Week 4
Towner	Laughlin	
Babrah	Scott	
Cordosi	Haspel	
APRIL		
Mentor	**Mentee**	**Date Completed**
Deans	Arnold	Week 1
Pifferini	Friel	
Scott	Beckel	Week 2
Wood	Scott	
Babrah	Minor	
Bressi	Montes	Week 3
Scott	Friel	
Cordosi	Coffin	
Deans	Towner	
Pifferini	Laughlin	
Colley	Kecskes	Week 4

Exhibit 8

California Department of Corrections and Rehabilitation
Prison Capacity Planning

FINAL REPORT

ATTORNEY-CLIENT WORK PRODUCT

October 3, 2011

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Executive Summary

The California Department of Corrections and Rehabilitation (CDCR) has for several decades measured its capacity using an approach referred to as Design Capacity. This approach is based on one inmate per cell, single bunks in dormitories, and no beds counted in capacity if the space was not designed for housing. When the State added 23 institutions to the correctional system between 1985 and 2005, the capacity of the new and expanded institutions was predicated on the Design Capacity concept.

The design capacity measure, however, has proven to be flawed for a variety of reasons. First, even with an enormous increase in capacity, single celling and bunking was never a reality, and from shortly after CDCR embarked on the major systemwide expansion the agency recognized that it would have to put more than one inmate in many cells and rely on double (and frequently triple) bunks in many dormitories as the systemwide population increased substantially. Second, national standards governing single celling, particularly those promulgated by the American Correctional Association (ACA), have changed markedly from the 1980's until today. Previous requirements for single celling and single bunking have been modified over time to the point that they are no longer considered to be the norm. In lieu of broad rules identifying which stratifications of inmates must be single celled (e.g., maximum custody, segregation, etc.), standards now emphasize decision making on an individual inmate basis, based on classification factors in determining the appropriate housing assignment.

In 2009, the Three Judge Panel in the *Coleman and Plata* cases issued a decision to limit systemwide overcrowding to 137.5% of Design Capacity as a primary mechanism designed to bring about improvements to health care.[1]

It was with this history that CDCR decided in 2010 to pursue a new, alternative approach to measuring capacity. In June of 2010, CDCR contracted with Pulitzer/Bogard & Associates (P/BA) to obtain expert advice and assistance "in determining a Manageable Operational Capacity (MOC)[2] for each prison based on established criteria and recognized industry standards." This effort was intended to provide CDCR with new management tools and established systems to better assess and measure the capacity of its 33 prisons individually, and as a system.

This approach was intended to be methodical, evidence based, supported by the ACA national standards, and consistent with (although not necessarily identical to) approaches used by other large state prison systems and the Federal Bureau of Prisons. The new approach would draw upon concepts and principles used by Federal Courts throughout the country. It was also to reflect key concerns of the *Coleman* and *Plata* courts concerning crowding in general, and also regarding access to medical and mental health care.

[1] *Coleman & Plata v. Schwarzenegger*, 2009 U.S. Dist. Lexis 76943 (Aug. 4, 2009)
[2] This term was subsequently changed to Prison Operating Capacity (POC).

This new methodology yields a primary capacity measurement-- Prison Operating Capacity (POC). POC is based first on the application of applicable ACA standards, but then allows for an adjustment to the standard based calculation where mitigation thresholds of out-of-cell activity are achieved. Although not all classifications are eligible for mitigation, most are and the potential impact of this paradigm on agency wide policy, operations and capacity planning and measurement is substantial. The main premise is that the sufficiency of living space is directly impacted by the number of hours an inmate is confined to that space and that increased out-of-cell activity has multiple benefits, including the positive effect of reducing density.

In 2011 the U.S. Supreme Court, in *Brown v. Plata,* accepted the use of Design Capacity as the measurement of capacity as it affirmed the Three Judge Panel's adoption of 137.5% of design capacity as the constitutional limit on capacity for the CDCR.[3] As such, this new approach to capacity planning is not intended to be indicative of a constitutional standard for defining the capacity of the CDCR's prisons. Rather, the results of this effort would represent solely a professional, standards-driven, policy informed approach to calculating capacity.

P/BA collaborated with a CDCR Working Group, which consisted of experienced staff representing decades of experience in institutional management, classification, facility design, mental health care, inmate programs, and security. P/BA took the lead in analyzing the current capacity methodology's shortcomings, conceptualizing the alternative approach, developing the information to support and inform the new approach, and in developing key documents to support the process of redefining how capacity may be viewed and measured in CDCR's institutions. Members of the Working Group took the lead on developing all the data collection tools, capturing the data during pilot tests at six prisons, and analyzing the data of those pilot tests. The Working Group also enlisted the support of a large group of officials from the Division of Adult Institutions (DAI), who provided the lion's share of the field work necessary to survey CDCR's 33 prisons using the tools associated with the new capacity methodology. The bulk of the quality assurance work and data analysis was performed by the Working Group as well.

CDCR executive and legal staff were briefed at key points in the developmental process relative to the methodology, the results of the pilot surveys at six institutions, and the findings obtained after application of the new methodology at all 33 CDCR prisons.

This report represents a first phase of the CDCR's new approach to capacity measurement and planning—the "what is." Beyond this point, should the State decide to fully pursue this methodology and adopt it as CDCR policy, there are myriad steps that need to be taken to achieve full implementation of both the methodological components of this approach as well as the inherent policy components. Recommendations for the next phase are included in Chapter V of this report.

Table 1-1 below illustrates how three calculated capacity figures- ACA, POC, and Potential Prison Operating Capacity (the maximum possible capacity that could be obtained if full mitigation was achieved at all housing units at all institutions) - compare with the existing CDCR's design capacity, the Supreme Court's cap (137.5% of design capacity) and the Department's current "overcrowding capacity."

[3] 563 U.S. __(2011)

Table 1-1: Summary of Capacity Analysis

Prison	ACA	POC	PPOC	Health Care Adjustment
CIW	997	1,668	1,767	0
CCWF	1,999	1,996	2,568	0
VSPW	2,068	2,056	2,562	0
Female Sub Total	**5,064**	**5,720**	**6,887**	0
CIM	3,399	3,713	4,553	0
SQ	3,249	3,501	3,501	0
DVI	1,743	1,868	2,683	0
RJD	2,220	2,262	3,792	0
NKSP	2,984	3,094	4,899	0
WSP	3,431	3,540	5,507	0
LAC	2,392	2,494	4,034	0
CCI	2,836	3,326	3,776	0
COR	4,391	4,139	5,269	0
SAC	3,412	2,957	2,957	0
HDSP	3,434	3,379	4,279	0
KVSP	4,576	4,352	4,352	0
PBSP	3,384	3,275	3,275	0
SVSP	3,287	3,180	4,080	0
CMF	2,400	2,571	2,933	0
CMC	4,266	4,895	4,895	0
SATF	4,044	4,536	5,390	0
CAL	2,400	2,506	4,216	0
CEN	2,361	2,452	4,162	0
MCSP	1,796	1,909	3,039	0
PVSP	2,365	2,452	4,162	0
ASP	4,147	5,769	5,769	0
CCC	1,870	2,330	2,690	0
CRC	3,819	5,233	5,243	0
SOL	3,264	4,023	4,923	0
CVSP	2,631	3,428	3,428	0
CTF	3,553	3,886	4,998	0
FSP	2,132	2,244	2,532	0
ISP	2,286	2,386	4,096	0
SCC	1,651	2,030	2,390	0
Male Sub Total	**89,627**	**97,750**	**121,813**	-
Institution Sub Total	**94,691**	**103,470**	**128,700**	-
Off Site Camps*				
CIW	320	320	320	0
CCC	2,150	2,150	2,150	0
SCC	2,010	2,010	2,010	0
Camps Sub Total	**4,480**	**4,480**	**4,480**	
Grand Total	**99,171**	**107,950**	**133,180**	

I. INTRODUCTION

I. Introduction

In June of 2010 the California Department of Corrections and Rehabilitation (CDCR) contracted with Pulitzer/Bogard & Associates (P/BA) to obtain expert advice and assistance "in determining a Manageable Operational Capacity (MOC)[4] for each prison based on established criteria and recognized industry standards." This effort was intended to provide CDCR with management tools and established systems to better assess and measure the capacity of its 33 prisons individually, and as a system.

Prior to the inception of this process, CDCR's capacity had long been determined using an approach referred to as "design capacity." This approach is based on one inmate per cell, single bunks in dormitories, and no beds counted in capacity if the space was not designed for housing. When the State added 23 institutions to the correctional system between 1985 and 2005, the capacity of the new and expanded institutions was predicated on the design capacity concept. All cells were assumed to be for only one inmate and all dormitories were assumed to house inmates on single bunks. During the course of this expansion program, a policy decision was made to expand infrastructure such as water, waste water and electrical systems to accommodate short-term overcrowding. In addition, two bunks and two lockers were placed in each cell. However, no additional program, support, treatment and/or health care space was included in the designs to accommodate an inmate population above design capacity.

Even with an enormous increase in capacity, single celling and bunking was not to become a reality, however, and from the start the CDCR recognized that it would have to put more than one inmate in many cells and rely on double (and frequently triple) bunks in many dormitories as the systemwide population increased substantially. The Department then began using a second capacity figure—Overcrowding Capacity—whereby inmates would be housed in excess of design capacity based on the application of a series of "overcrowding" percentages. These percentages of overcrowding permitted housing inmates in lower custody dormitories at 200%, higher custody general population and reception at 190% of design capacity, while others would be housed at 100% of design capacity based on the various classifications.

This has been the capacity measurement and institutional planning approach employed by CDCR for almost 30 years. There are, however, several problems and limitations inherent in this approach.

The first problem is the fact that the design capacity was based on outdated notions of capacity determinations. When the institutions were planned and built in the 1980s-1990s there was still some degree of acceptance that single celling was preferred and, in fact, national standards strongly encouraged that approach. The 1990 edition of the Standards for Adult Correctional Institutions Standards of the American Correctional Association (ACA), on which CDCR based its designs, required single cells for all security levels, except for minimum custody.[5] Since that time, the standards governing capacity of cells have changed significantly. In 1991, the standards were

[4] This term was subsequently changed to Prison Operating Capacity (POC).
[5] ACA Third Edition ACI Standard 3-4128-1.

changed to allow multiple occupancy cells for medium custody inmates;[6] the requirement for single celling segregation inmates was deleted in 2004; [7]and by 2005 the requirement to house maximum custody inmates in single cells was also eliminated.[8] ACA replaced the imperatives for single celling with a requirement that single cells be available when indicated by "a determination made by the classification system, medical diagnosis, or other professional conclusions."[9]

In other words, the foundation on which CDCR based its design capacity in the 1980s no longer existed by the 1990s and mid-2000s. Single celling is no longer the default expectation for measuring capacity according to national standards, yet it remains at the core of the CDCR's capacity measurement system. Thousands of cells that were rated for one inmate under the older standards could now potentially be used for two persons if the classification system deemed it appropriate and if certain space requirements were satisfied regarding unencumbered space.

A second significant problem with the CDCR's capacity measurement approach is the application of the "overcrowding" percentages. The use of the term overcrowding suggests that housing any more than one inmate in a cell is per se "overcrowding." But that, of course, is based on now defunct readings of national standards. Moreover, the allowable overcrowding percentages, as reflected in the CDCR's Overcrowding Capacity (OC), are arbitrary, with no foundation in contemporary standards or evidence based principles. Across the board percentages have served as a practical means to adjust the capacity to something that reflects actual inmate population needs, and wardens and other CDCR professionals have learned to live with these percentages, but those are different issues than defining capacity.

Compounding the inherent problem with relying on design capacity as a baseline and applying arbitrary overcrowding percentages is the fact that that this approach was used in the litigation arena, with the force of law. The August 2009 Opinion and Order of the Three Judge Panel cited extensive testimony concerning the "correct overcrowding percentage" that should be used, with some individuals arguing for 130%, others for 145%. The testimony before the Three Judge Panel focused, however, on percentages of crowding not based on design capacity but rather based on capacity measurements as used in other correctional systems that almost uniformly are higher than what they would be under strict application of design capacity. The Three Judge Panel, in turn, considered the various opinions about the "correct" percentage and decided to limit systemwide overcrowding to 137.5% of design capacity.[10] The Supreme Court's recent decision in *Brown v. Plata* accepted the use of design capacity without comment, and then affirmed the Three Judge Panel's adoption of 137.5%.[11]

It was with this history that CDCR decided in 2010 to pursue a new, alternative approach to measuring capacity. This approach was intended to be methodical, evidence based, supported by the ACA national standards, and consistent with (although not necessarily identical to) approaches

[6] ACA Fourth Edition ACI Standard 4-4132
[7] ACA 2006 Supplement clarifying ACI 4-4141
[8] ACA 2010 Supplement states that the standard 4-4131, which required single cells for maximum custody inmates, was deleted by the Standards Committee.
[9] ACA 2006 Supplement ACI 4-4133
[10] *Coleman & Plata v. Schwarzenegger*, 2009 U.S. Dist. Lexis 76943 (Aug. 4, 2009)
[11] 563 U.S. __(2011)

used by other large state prison systems and the Federal Bureau of Prisons. The new approach would draw upon concepts and principles used by Federal Courts throughout the country. And, it was also to reflect key concerns of the *Coleman* and *Plata* courts concerning crowding in general, and also regarding access to medical and mental health care.

This new approach to capacity planning was not intended to suggest that it would be indicative of a constitutional standard for defining the capacity of the CDCR's prisons; the results of this effort represent solely a professional, standard driven, policy informed approach to calculating capacity.

For the past year, P/BA has been working in collaboration with a Working Group of CDCR professionals in developing a new paradigm for realistically calculating capacity within CDCR prisons. P/BA took the lead in analyzing the current capacity methodology's shortcomings, conceptualizing the alternative approach, developing the information to support and inform the new approach, and in developing key documents to support the process of redefining how capacity may be viewed and measured in CDCR's institutions.

The Working Group consisted of experienced CDCR staff, representing decades of experience in institutional management, classification, facility design, mental health care, inmate programs, and security. P/BA and the Working Group met numerous times and had myriad conference calls over the year and worked closely in all aspects of this effort. Members of the Group were not only partners in all aspects of the conceptual process, but they also took the lead on developing all the data collection tools, capturing the data during the pilot tests, and analyzing the data of those pilot tests. The Working Group also enlisted the support of a large group of officials from the Division of Adult Institutions (DAI), who provided the lion's share of the field work necessary to survey CDCR's 33 prisons using the tools associated with the new capacity methodology. The bulk of the quality assurance work and data analysis was performed by the Working Group as well.

CDCR executive and legal staff were briefed at key points in the developmental process relative to the methodology and results of the pilot surveys at six institutions.

This Report is the final product of the year-long effort. Subsequent sections of this Report will discuss the research into best national practices and national standards, the principles underlying the proposed capacity approach, the process of field testing the approach and the tools that were developed to measure capacity consistent with the new approach, the results of the pilot tests, the systemwide measurements and calculations of capacity, and the next steps required to institutionalize the new approach within CDCR.

II. CAPACITY METHODOLOGY

II. Capacity Methodology

Goals and Objectives

In the early stages of the capacity planning project, P/BA and the Working Group discussed goals for the new capacity methodology. The goals that were mutually agreed to were as follows:

- Performance Standards Based on national standards- The Working Group determined that the methodology employ standards that were not merely static and quantitative, but also included a measure of "performance" i.e., that it be based on achieving certain levels of positive correctional performance that could be measured. In doing so, the idea was that the capacity methodology could serve as a catalyst to bring about positive changes in the prison system. At the same time, it was agreed that the performance measures and the standards developed or employed, should be based on national standards, most notably those promulgated by the American Correctional Association.

- Build on other systems' approaches- A goal for which there was unanimous consent was that the CDCR methodology draw upon and build on the experience of other large correctional systems. This would serve the dual purposes of allowing CDCR to benefit from the experiences of other like agencies, but also providing a measure of defensibility.

- Applicable to unique California issues and context- While the Working Group aimed to draw upon national standards and the experience of other correctional agencies, at the same time it was agreed that the methodology needed to be responsive and sensitive to the unique circumstances and context present in California. Positive (and negative) historical lessons learned needed to be considered along with issues such as the myriad consent decrees and court orders that govern or impact on many aspects of the CDCR's prisons' operations. Moreover, while this capacity methodology project was not viewed as a direct response to the Coleman/Plata case, at the same time there was a recognition that concerns or key concepts that emerged in that litigation should be incorporated into the methodology where appropriate.

- Safety of staff and inmates- Paramount in the minds of members of the Working Group was that the capacity methodology not jeopardize staff and inmate safety and, conversely, that it potentially be able to contribute to creating a safer environment in the prisons. These goals clearly took precedence over any ideas pertaining to achieving a particular target number for future bed capacity or any notions of maintaining the status quo relative to how the prisons currently operate.

- Fiscally sound/practical- While fiscal concerns were not the overarching concern driving the general concepts and specific decisions, at the same time the Working Group was clearly cognizant of and expressed concern about how to appropriately (and safely) maximize existing resources. One example of this concern arose during discussions about the continued use of very small cells. The CDCR currently has more than 8,000 cells that are less than 55 square feet, including more than 2,800 cells that are less than 40 square feet. In most cases, these

cells hold two inmates, even though they would not be large enough (per ACA standards) for even one inmate. The decision was made early on that while these cells would not be considered eligible for double bunking under the new methodology, at the same time they could not just be considered unusable and taken off line.

- Replicable- The Working Group identified replicability as another key requirement. CDCR staff, or outside entities, should be able to review the data on which capacity calculations were based and arrive at the same conclusions as staff that conducted the field assessments. This requires that the field documentation and calculation methods be relatively simple and that policies and procedures and automated systems be developed to support the system of assessing capacity.

- Focus on "what is"- One final note of introduction—CDCR will initially apply this methodology to assess the current state of capacity and out-of-cell activity in the prisons -- the "what is." In the course of applying the tools at each prison, it will become apparent that there may or may not be opportunities in the near future to alter practices related to out-of-cell time, or to repurpose housing areas for different classifications in order to increase capacity. The impediments to increased capacity, or the opportunities available to increase capacity -- the "what if," -- will be identified in the course of the initial round of capacity measurement at all institutions. The opportunities will then become the subject of policy decisions relative to resources and sound practices at each prison.

Ultimately, it was one additional goal that in many respects became the defining feature of the resultant capacity methodology. That goal was to have an essential component of the capacity methodology driven by program opportunities, access to services and out-of-cell activity. This focus proved to be unique relative to other large correctional agencies' approaches to measuring capacity, although substantial support was identified for it from a variety of other sources, including national standards, the California litigation, fiscal concerns, and staff and inmate safety considerations. Moreover, it was determined that there was a long history of Federal Courts considering out-of-cell time as an important consideration in crowding cases.

Each of these goals will be referred to or discussed further in subsequent discussions within this section of the Report.

Survey of other System's Approaches

Prior to recommending a methodology to determine CDCR's capacity, P/BA proposed that a survey be conducted of the approaches to measuring capacities that are employed by other large states and the Federal Bureau of Prisons (FBOP). Review of these systems' approaches helped to inform the process that would be developed for CDCR by building on the experience of these other large correctional systems. This survey would also serve the dual purposes of allowing CDCR to benefit from the experiences of other like agencies and also providing a measure of defensibility.

P/BA began its research on capacity analysis approaches in other states by first reviewing the states identified in a Bureau of Justice Statistics (BJS) data report on State Prison Capacities for 2008.[12] The BJS list is limited by the fact that all states were not respondents (or only completed segments of their survey).

There were a number of state systems we identified for purposes of culling their methodological approach to capacity that also responded to the BJS survey using the BJS definitions and approaches in determining institutional capacity, namely:

Rated Capacity: the number of beds or inmates assigned by a rating official(s) within the jurisdiction.

Operational Capacity: the number of inmates that can be accommodated based on a facility's staff, existing programs, and services.

Design Capacity: the number of inmates that planners and architects intended for the facility.

Of the 10 states with the largest prison populations, the breakdown of how they determined their capacities as reflected in their responses to the BJS survey and definitions were as follows:

- California: Operational and Design
- Florida: Operational and Design
- Georgia: Operational
- Illinois: did not respond to the survey
- Louisiana: Rated and Operational capacities
- Michigan: Operational
- New York: Rated, Operational and Design Capacities
- Ohio: Rated capacity
- Pennsylvania: Responded to each category for capacity with the same figures/totals
- Texas: Rated, Operational, Design Capacities

Because the respondents may not have totally conformed with BJS's definitions for rated, operational or design capacity, P/BA proceeded to gather additional information from each of these states to determine:

- what specific methodology they utilized in arriving at their prison system capacities and,
- under what authority (state law/penal code, court orders, etc) were they acting

P/BA queried those same states with the following questions:

1. What is your agency's definition of capacity?

[12] Sabol, William J. et al (April 2010). Prisoners in 2008, BJS Bulletin.

2. How has your agency determined its institutional capacities?
3. What are the specific criteria or formulas used in determining the capacity of your agency's institutions?
4. What is the particular type of analysis and/or process that your agency uses in determining its institutional capacity?
5. Are there any lessons learned concerning your agency's process in determining capacity?

P/BA received information from Florida, Michigan, Tennessee and Pennsylvania. Massachusetts was also included as P/BA had been a team member in a Statewide Master Plan that included establishing new capacities for all of the state's institutions.

In addition, P/BA researched how the Federal Bureau of Prisons calculates institutional capacity.

Two particularly salient findings emerged from the research that was conducted by P/BA. First, no other state or the FBOP relies exclusively on original design capacity at single celling to define institutional capacity as does California. Second, none of the states surveyed or the FBOP have a methodology that directly factors in health care to the overall equation in determining institutional capacity.

Additional general findings from this limited survey include:

- There is no standard definition of capacity or how an agency calculates its systemwide bed capacity
- Other states do not count short-term health care beds in calculations of their permanent capacity.
- Several states have different levels of capacity calculations that may exclude and/or include medical and segregation beds
- ACA standards are the basis of determining systemwide capacity for the majority of agencies surveyed
- All the agencies surveyed have facilities with a variety of inmate housing configurations including planned double or multiple occupancy cells and dormitories

Agency specific findings include the following:

- While Florida uses the term "Design Capacity" it is a measure derived as a result of litigation. The calculation uses a formula primarily based on available square footage per inmate and is not based on the number of cells or dormitory beds as originally constructed, as is the case with CDCR's Design Capacity.
- Massachusetts recently modified its design capacity definition and is moving to a new method of capacity calculation based on ACA standards and life safety.
- Pennsylvania employs four capacity calculations: "Operational Bed Capacity," "Maximum Bed Capacity," "Emergency Bed Capacity" and, "Fill to Bed Capacity." All are grounded in a set of ACA driven policy standards.
- Michigan uses "Rated," "Actual" and "Current" capacity to define their systemwide prison bed capacity. While their rated capacity is based on design capacity, their 'true' capacity calculations are based on several variables including the structure of the facility, its security

needs and capabilities, the type/custody of prisoner to be housed in that institution and how much space each prisoner needs to have based on ACA standards.

- Tennessee officially uses "Operating" (Designated) capacity which is based upon the number of total beds and their designated usage available to house inmates. Excluded from operating capacity special purpose beds such as medical, mental health, disciplinary segregation, protective custody, etc.
- The following are key factors that the Federal Bureau of Prisons utilizes in computing their systemwide bed capacity:
  - "Rated" capacity excludes beds designated for hospital/infirmary, administrative detention, and disciplinary segregation. Their "Total" capacity includes all beds.
  - The FBOP capacity calculations are grounded in the ACA standards but set overall square footage parameters depending on custody level. For example, for high security inmates, rooms, cells and cubicles, are rated as single occupancy if they are less than 75 square feet. If they are 75 square feet or more, but less than 120 square feet, 25% of rooms, cells and cubicles are rated for double occupancy, and 75% for single occupancy. If they are 120 square feet or more, the rated capacity is computed by dividing the total space of each sleeping area or unit by 80 square feet.
  - In multiple occupancy housing areas, if the room or dormitory is 120 square feet or more, rated capacity is computed by dividing the total space of each sleeping area or unit by 80 square feet.
  - Permanently converted housing (e.g. office space converted into housing) counts in the capacity calculations while temporary housing does not.
  - In planning new facilities, the FBOP provides adequate infrastructure, treatment, program and support spaces to accommodate the maximum rated capacity for the proposed facility, although this was not necessarily the case for some of its older prisons.

Overview of the Proposed Methodology

P/BA and the Working Group reviewed the results and key findings of the survey of other systems to arrive at a methodology that was grounded in the experience of other large correctional systems yet tailored for the unique needs of the CDCR. The proposed methodology is described herein.

American Correctional Association (ACA) standards are the most widely accepted source of national standards and best practices.[13] Many state correctional departments rely on ACA standards as a basis for operational policies and procedures and physical plant design criteria, and a large number are also participating in the ACA accreditation process. In fact, CDCR has committed to seeking accreditation for three of its prisons. As such, a great deal of emphasis was placed on incorporating these standards into this CDCR capacity development process.

The three core components of the proposed methodology are as follows:

1. Determination of capacity using application of selected ACA standards;

[13] State prisons are governed by the Adult Correctional Institution standards (4th Edition and 2010 Supplement) of the American Correctional Association.

2. A process of adjusting (expanding) ACA capacity based on mitigation of living space standards via out-of-cell activity for selected inmate classifications;
3. Adjustments to capacity (limiting) where current medical and mental health care resources are deemed insufficient to meet the demands of the proposed capacity.

This approach draws directly on ACA standards concerning housing space and measurement of capacity. It also incorporates and expands the application of a long-standing construct in the ACA standards, which recognizes that the minimum amount of living space required is affected by the amount of time the inmate remains in his cell, i.e., the more time an inmate is confined to his cell or living area, the more space is needed for individual exercise and movement. The precise interplay and application of these standards in this methodology is unique and has been tailored to meet the CDCR's needs for a measurable and defensible baseline calculation of institutional (and systemwide) capacity.

Two key components of the ACA standards form the foundation for this methodology—unencumbered square footage and out-of-cell time as a mitigating factor. While the early versions of ACA standards for inmate housing established minimum cell sizes, for the past two decades there has been a shift towards requiring a certain amount of unencumbered square footage per inmate in cells or in multiple occupancy living environments such as dormitories and locked wards. Unencumbered square footage is defined by ACA as, "the amount of space available for each occupant that is free of equipment and fixtures and therefore available for circulating and in-cell exercise".[14]

Additionally, there has also been a long-standing premise in the ACA standards that more space is required in cells when inmates are confined to their cells for longer periods. Standards manuals dating back to the 1980s called for larger cells when inmates were confined to their cells for more than 10 hours a day because it was deemed necessary to allow for in-cell activity if out-of-cell time was limited. This has been reflected directly in the language of specific standards as well as a theme consistently incorporated in the comments accompanying standards, especially those governing segregation cells.[15] In fact, over time there has been a distinct trend in the standards to virtually eliminate any specific requirements for single cells, except under very broadly defined circumstances at the discretion of prison classification officials.[16]

The focus on out-of-cell access also has roots in the approach that many Federal Courts have applied in crowding litigation. Courts have consistently looked at out-of-cell time as a vital factor in determining whether crowding in housing areas is unconstitutional, i.e., they have been more likely to find unconstitutional crowding when inmates are double or triple celled in substandard sized

[14] This approach differs from that employed by the Federal Bureau of Prisons (FBOP), which establishes a set gross cell size for rooms and cells. The FBOP approach, set forth in a June 1997 BOP Program Statement, does not reflect the current ACA/ACI Standards' emphasis on unencumbered space.

[15] See ACA/ACI Standard 4-4132, which states: "When confinement exceeds ten hours per day, there are at least 80 square feet of total floor space per occupant."

[16] See ACA/ACI Standard 4-4133, which requires single cells "when indicated" for inmates with severe medical disabilities, seriously mentally ill inmates, sexual predators, and inmates likely to be exploited or victimized.

cells for many hours of the day with limited out-of-cell opportunities.[17]In other words, out-of-cell time has been found to be an important mitigating factor relative to cell size and multiple occupancy (or even single occupancy) of substandard sized cells.

The American Correctional Association is not the only professional organization that has emphasized the importance of out-of-cell activity and integrated this into specific standards. Drawing on the concerns articulated by many courts, the American Bar Association in 2010 issued a new set of standards governing correctional institutions.[18] Those standards specifically address the importance of out-of-cell time.[19]

The Working Group fully realized that there are barriers to maximizing out-of-cell activity in the CDCR prisons as a result of staff shortages, physical space limitations, and current practices that often interfere with out-of-cell opportunities. Nevertheless, the Group elected to proceed with out-of-cell activity as a critical component of the capacity measurement process despite the fact that these limitations would initially have a negative effect on expanding capacity.

Key aspects of the methodology described, include:

- It incorporates significant elements and long-employed constructs of the ACA Standards
- It draws on elements of capacity measurement approaches employed by the Federal Bureau of Prisons and several large state corrections systems.
- It reflects essential California regulatory and court driven requirements.
- It establishes a mechanism for mitigation of sub-standard living space based on out-of-cell activity.
- It establishes a capacity for each prison (Prison Operational Capacity or POC). and for the CDCR system as a whole. .
- In light of the *Plata/Coleman* litigation focusing on crowding and the impact it has on health care, this methodology includes access to medical and mental health care as an important capacity driving element of the Operational Capacity.

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[17] Boston, J., & Manville, D., (2010) *Prisoners' Self Help Litigation Manual.* New York: Oceana. Pages 19-20.

[18] American Bar Association Standards on the Treatment of Prisoners, Third Edition, February 2010.

[19] Standard 23-3.6 Recreation and out-of-cell time

(a) To the extent practicable and consistent with prisoner and staff safety, correctional authorities should minimize the periods during the day in which prisoners are required to remain in their cells.

(b) Correctional authorities should provide all prisoners daily opportunities for significant out-of-cell time and for recreation at appropriate hours that allows them to maintain physical health and, for prisoners not in segregated housing, to socialize with other prisoners. Each prisoner, including those in segregated housing, should be offered the opportunity for at least one hour per day of exercise, in the open air if the weather permits.

(c) Correctional authorities should whenever practicable allow each prisoner not in segregated housing to eat in a congregate setting, whether that is a specialized room or a housing area dayroom, absent an individualized decision that a congregate setting is inappropriate for a particular prisoner. Prisoners should be allowed an adequate time to eat each meal.

- It excludes from capacity "non-traditional beds", i.e., living spaces that are currently in place in gymnasiums, day spaces and other areas not intended or designed for housing purposes.
- It also excludes from capacity specialized medical and mental health beds in which inmates typically spend 30 days or less.

While physical space is, of course an important component of capacity, this approach is a dynamic and multi-faceted one in that the calculation of capacity can expand or retract based on policy and resource decisions concerning out-of-cell time activities and health care resources. The new methodology views capacity not as a static figure, determined exclusively by reference to decades-old prison policy and design decisions, but rather it is dynamic in that it incorporates operational decisions and policies into the equation. It is intended to replace design capacity as the baseline against which overcrowding is measured with a more contemporary standard and best practices driven approach. While design capacity is a fixed measure, the determination of operational capacity is a more fluid one, subject to periodic changes as policy decisions, operational practices and physical resources impact on the core criteria.

The ASCA Out of Cell Time Survey

In view of the Working Group's commitment to using out-of-cell time as an essential component of the new capacity methodology, it was decided that research into national approaches and norms relative to out-of-cell time would inform the process and decisions to be made concerning applicable thresholds. As such, the Working Group designed a survey instrument to capture information pertaining to policies and practices employed by other large correctional systems concerning the number of hours of out-of-cell activity afforded minimum, medium and maximum custody general population inmates (comparable to CDCR's Levels I-IV).

With the assistance of the Association of State Correctional Administrators (ASCA), the surveys were developed and sent to 49 states and the FBOP in October 2010. Preliminary responses were received back in December 2010 and additional follow up calls were made by CDCR Working Group team members and staff of DAI to gain additional information and clarifications. The follow-up process was important from a quality assurance perspective and that process concluded in March 2011. At the conclusion of this effort, CDCR received complete information from 13 states and the FBOP. This represented a 27% response rate, but more importantly the survey was able to capture out-of-cell data from those agencies housing the largest number of inmates in the Unites States, including Florida, New York, Pennsylvania, Texas and the FBOP. The results of the survey appear in the following table:

Table 2-1: ASCA OUT-OF-CELL (OOC) TIME SURVEY RESULTS

Agencies	Maximum Custody OOC (avg.in hrs)	Medium Custody OOC (avg.in hrs)	Minimum Custody OOC (avg.in hrs)
NY DOC	15	16	16
MI DOC	8	11	15
IN DOC	10	16	16
PA DOC	8	9	9
MO DOC	9	14	14
MN DOC	13	13	15
ID DOC	6	13.5	14
SC DOC	14.5	14.5	14.5
WV DOC	15	15	15
FL DOC	11	11	11
WY DOC	10.5	12.5	12.5
KS DOC	12	14.5	15
TX DOC	8.5	10.5	12
FBOP	15	15	15
Average	11.11	13.25	13.86

The data was thoroughly reviewed by the Working Group and a recommendation was made to the Secretary and the Executive Management team of CDCR that the average hours of out-of-cell time received in the survey (rounded) be adopted for those inmate populations where mitigation of the space standards was applicable. In those instances the minimum out-of-cell time threshold would be:

- Minimum Custody: 14 hours
- Medium Custody: 13 hours
- Maximum Custody: 11 hours

Detailed Description of the Methodology

What is Included in Capacity

A condition precedent to measuring Prison Operating Capacity was for the CDCR Working Group to identify which classifications would be included in the determination of operational capacity. Drawing on the approaches used by other correctional agencies and professional organizations[20] it was decided that all classifications and housing categories would be included in determining the systemwide capacity with the exception of the following health care related housing:

- Mental Health Crisis Beds
- CTC or Infirmary Medical Outpatient Housing
- Mental Health Observation Cells
- Correctional Treatment Centers
- DMH state hospitals[21]
- General Acute Care Hospitals
- Hospice Beds

These categories were excluded either because of their temporary nature (generally less than 30 day placements) or because the beds are located within Department of Mental Health State hospitals or community public or private hospitals.

However, the decision was made to count Administrative Segregation beds as part of systemwide capacity. While some correctional systems do and others do not count this category as part of their capacities, the fact that inmates in these housing areas are generally not short-term or temporary placements in CDCR was a key reason for including them. Given the complexities of operating prisons in California, including the very long sentences, lack of statutory incentives for program participation due to mandatory sentencing and the high incidence of gangs, administrative segregation beds generally remain filled and are long-term placements.

Also excluded from capacity are those beds that are "temporary" in nature and have been located in gymnasiums, dayrooms or other locations that were not designed for or otherwise legitimately converted to appropriate housing space—the non-traditional or "bad beds." This decision by the Working Group mirrors the language which was incorporated into the AB 900 legislation. [22] In

[20] The Association of State Correctional Administrators (ASCA) defines operational capacity as follows: Total bed capacity across all DOC facilities throughout the agency on the last day of a given month. The capacity of a facility is the number of beds authorized for safe and efficient operation of the facility. Do not include beds reserved for discipline, investigations, infirmary, or other temporary holds because these beds are used for temporary or special purposes. When the special purpose(s) or circumstances do not apply, the beds are not occupied. Source: "ASCA Performance Standards, Measures, and Key Indicators, May 27, 2008" obtained at http://www.nicic.gov/Library/023147.

[21] These hospitals include ASH (Atascadero State Hospital), PSH (Patton State Hospital) and CSH (Coalinga State Hospital).

[22] http://www.leginfo.ca.gov/pub/07-08/bill/asm/ab_0851-0900/ab_900_bill_20070503_chaptered.html. The legislation noted that: "The purpose of beds constructed pursuant to this section is to replace the temporary beds currently in use, and they are not intended to house additional inmates. For the purposes of this section, "temporary beds" shall be defined as those that are placed in gymnasiums, classrooms, hallways, or other public spaces that were not constructed for the purpose of housing inmates."

addition, the former Governor, in an official proclamation, voiced serious objections to and concerns about the use of prison areas that were not intended for housing to be used as such.[23]

Calculating Prison Operating Capacity (POC)

The foundation of this methodology is housing capacity and the availability of appropriately sized single cell or multiple occupancy living space. The proposed methodology here draws heavily on the ACA standards in that the focus is on unencumbered square feet per inmate (USF) requirements for each housing type and category of offender.

The first step in determining Prison Operating Capacity under this methodology is the application of ACA living space standards to existing housing areas for eligible classifications. The Working Group identified the current and/or more appropriate housing configurations (type of living arrangement) and the applicable corresponding ACA standard to be applied for each classification category. Architectural plans and field surveys were used to determine the capacity of each living space (cell, multiple occupancy cells, dormitory) in each housing unit in each of CDCR's 33 prisons. For single, double and multiple occupancy cells, scaled drawings (with field verifications) of the cells were used to analyze and calculate the amount of USF. For dormitories, the capacity is measured by applying a formula for total square footage required for each occupant, assuming ACA's 25 USF per person plus allocations for double stacked bunks, individual lockers and circulation areas to access the bunks. This calculated out to an average of 50 square feet total per inmate, including both unencumbered space and beds, lockers and a desk. [24]

The second step of the analysis focuses on out-of-cell time and corresponding mitigation impacts. In certain cases the ACA standard represents a floor, below which it would be inadvisable or inappropriate to suggest less space per person—in these cases the ACA standard for assessing capacity remains the standard and no adjustment is possible. A number of classification categories were determined to be exempt from mitigation because the nature of their confinement suggests that extensive out-of-cell activity is not practical. This is not to say that out-of-cell opportunities are not essential for inmates in administrative segregation, condemned housing, hospice, psychiatric services units (PSU) and for inmates in secure housing units (SHU). Rather, the methodology assumes that feasible out-of-cell procedures and practices will not be sufficiently extensive as to provide the mitigation necessary to adjust the ACA standard driven housing requirements. For these populations, then, the ACA standard becomes the POC, with no mitigation based adjusted space standard. It bears repeating, however, where no out-of-cell mitigation is feasible pursuant to this methodology that does not mean that out-of-cell time and activity should not be provided — it only means that the ACA standard-based housing capacity should not be adjusted as a result of that activity.

For other classifications of inmates, however, this methodology incorporates an element of mitigation based on out-of-cell activity in that it permits an adjusted (lesser) requirement for unencumbered square footage when the inmates are routinely allowed access to out-of-cell

[23] See, Prison Overcrowding State of Emergency Proclamation, October 4, 2006. ttp://gov.ca.gov/news.php?id=4278
[24] See Appendix 1 for an illustration of how the 50 square foot figure was calculated,

activities for a pre-determined number of hours a day. This approach recognizes that the potentially negative impacts of excessive spatial density[25], the result of putting too many people in too little space, can be mitigated by reducing the amount of time that people are actually in that space. By increasing out-of-cell activity, the inmates are less affected by density, even if the living space may be less than that called for in the ACA standards. It also reflects an awareness of the positive aspects of constructive activities in a prison setting and places a value on rehabilitation and reentry programming.

For purposes of the mitigation aspects in this approach, the following activities comprise out-of-cell time activity:

- "Inmate Services"- yard time, gym, dining, dayroom use, hobby crafts, visiting, family visiting, canteen, religious services and library.
- "Program Assignments"-substance abuse, education, vocational education, prison industries, support services jobs, self help groups and treatment services.
- "Healthcare"- group counseling, individual counseling, IDTT, sick call, treatment, medication management, dental, pill line, specialty services and recreation therapy.

The emphasis here is on *access* to *out-of-cell* activities as a means of mitigating density. As such, in-cell dining, education or any other activity that may be performed in the cell or cell-side does not meet the criteria set forth here. While there is clearly value associated with certain forms of in-cell programming, in-cell activities do not reduce housing density and, as such, they do not constitute mitigation and are not counted for these purposes.

One population potentially eligible for mitigation-EOPs-was carefully considered by the Working Group in terms of clinical indicators and amenability to double celling, whether under the applicable ACA standard or due to mitigation as a result of out-of-cell activity. Evidence based practice data was collected and showed that approximately 48% of EOPs were categorized as requiring a single cell ("S Suffix") by classification staff with input from clinical professionals. As such, the Working Group determined that double celling of EOPs in any housing unit, whether a function of ACA standards or achieved mitigation, would be limited to 50%.

It is important to note that other classifications were determined to not be eligible for mitigation because extensive out-of-cell opportunities are not practical or advisable, e.g., Administrative

[25] *Spatial density* refers to crowding that is mostly related to decreases in available space for any individual or group of individuals. *Social density* refers to conditions where increased crowding is a function of an increase in the numbers of people in a space and with whom any individual has to face and deal. These two concepts are clearly overlapping, e.g., housing two hundred inmates in a dormitory designed for 100 impacts both *Spatial* density (the available living space is reduced by half placing inmates very close to each other and minimizing circulation space) and *Social* density (one inmate has to interact and navigate among almost two hundred others rather than one hundred). Research on crowding has found that increased social density has more profound effects, especially on issues of special concern in corrections facilities, such as tension and aggression. That assumes, however, that spatial density is not also severe or unduly limited. Source: "Assessment of Strategies to Manage Crowded Direct Supervision Jails," *Unpublished Monograph prepared for the National Institute of Corrections*, D. Bogard and R. Wener, 2007.

Segregation.[26] Although evidence based analysis of single cell requirements suggested that almost three quarters of this classification could be double celled, the Working Group determined that double celling for these populations, if permitted by ACA standards, would be limited to 50%, consistent with current CDCR policy.

Members of the Working Group developed an approach to calculating out-of-cell time as follows:

- It is to be determined on a housing unit by unit basis, within each facility and within each prison;
- It is based on the typical number of hours of "access" to out-of-cell activities;[27]
- It is measured by documenting typical out-of-cell time periods as derived from interviews with unit officers, review of unit logs, daily movement sheets, and program documents;
- It focuses on the "typical" inmates in a unit, not those on program restrictions or program enhancements

The precise method of calculating out-of-cell access for each eligible population involves a number of activities performed in each applicable housing unit of each prison. Trained staff use a variety of techniques, including interviews, unit schedules, institutional schedules, post orders, unit logs and inmate assignment lists to collect and cross verify data in each location. An out-of-cell data collection instrument was designed to capture this data and to guide the actual calculation of the average (mean) out-of-cell access for all inmates in the respective housing units. A copy of this form is included with this report as an attachment.

When the calculated average out-of-cell time access for the inmates in a particular housing unit meets or exceeds the thresholds as set forth in the methodology , then the capacity of that specific area is adjusted accordingly (beyond the ACA capacity). Conversely, when the average out-of-cell time falls below the threshold, the official capacity of the housing unit is limited to the ACA capacity.

An additional consideration, as discussed previously, is that some classes of housing will not be factored into the Prison Operating Capacity. "Non-traditional housing" areas including gymnasiums, dayrooms, warehouses, etc. will not be counted as capacity. In addition, housing that is considered temporary in nature—the agreed upon criteria was for 30 days or less—would be excluded from capacity. Exclusion of these types of highly specialized, temporary medical and mental health beds is a routine practice in capacity calculating approaches employed by other jurisdictions.

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[26] Administrative Segregation units all have an intake process that involves complex due process elements, disciplinary and classification hearing processes and investigative and case factor evaluations. Inmates are single celled during these intake processes as well as on a case-by-case basis using established Title 15 criteria after the intake process is completed.

[27] The Working Group determined that calculations would be based on weekdays only. This is because the majority of staffing resources for inmate rehabilitation and program activities are assigned during weekdays and because other out-of-cell activities are available during weekends.

In the case of adjusted USF standards predicated on out-of-cell time, the analysis was performed and sketches created to develop a reduced USF requirement that would still allow for sufficient space for inmates to circulate and engage in routine in-cell activities safely and appropriately. For example, the ACA space standard for a single cell is 80 total square feet, including 35 USF[28] ; this figure is based on an assumption that the inmate is confined to the single cell for many more hours per day than those housed in a multiple occupancy living space.[29] By contrast, the current ACA standard for multiple occupancy cells[30] requires a minimum of 25 USF per inmate. Although a lesser USF per person was used by ACA in the case of multiple occupancy cells, the fact that plumbing fixtures and desks are shared by the cell occupants still results in a significant amount of available space for in-cell activities such as exercise using that standard. In the case of this methodology, where out-of-cell time meets certain thresholds, an adjusted standard is applied in recognition of the economies of the shared space. Therefore, in a mitigated scenario with adequate out-of-cell time, a *total* of 25 USF (as opposed to that amount per person) is proposed in double and multiple occupancy cells to allow for sufficient room for circulation, in-cell exercise, sitting at a writing surface and for personal hygiene needs.

Therefore, while a cell might provide a total of 35 USF, which under strict application of ACA standards would mean its capacity was only one, this approach says that two inmates can be safely and appropriately housed in that cell (using a total of 25 USF) *if* they are routinely and typically permitted access to out-of-cell activities for a certain number of hours a day. In other words, out-of-cell mitigation would in effect expand the capacity of that cell from one to two inmates.

As stated above, the ACA standards require 25 unencumbered square feet per inmate in large multiple occupancy cells (those that are larger than a two-person cell) as well as in dormitories. In addition to the unencumbered square feet, the Working Group agreed that additional square feet per inmate be allocated in the calculations that accounts for the circulation area immediately adjacent to the inmate bunks and that provide direct access to these sleeping areas. Primary circulation corridors that access hygienic facilities, for example, were not included in these calculations. To facilitate the calculations in a variety of dormitory configurations that exist throughout CDCR, a formula was developed that incorporated the unencumbered square footage, as well as the space occupied by the bunks, lockers and a writing surface. The diagram in Appendix 1 illustrates the calculations based on a typical dormitory configuration, which resulted in an ACA compliant calculation of 50 square feet per inmate.

Similar, to the approach taken with inmates housed in cells, a mitigation formula was developed for application in housing areas with large multiple occupancy cells and/or dormitories in which out-of-cell eligibility thresholds are achieved. Appendix 2 is an illustration of how the calculations were performed for a dormitory where mitigation is achieved. The major difference between the ACA calculations and the mitigation formula is the unencumbered square foot per inmate. The

[28] ACA ACI-Standard 4-4133, revised August 2005.
[29] In fact for many years, ACA linked standard 4-4133 to be limited to those inmates who were confined for greater than 10 hours per day, including those inmates spending upwards of 23 hours per day in a cell where most daily living activities including eating, exercising and even programming would be occurring within the cell.
[30] ACA ACI-Standard 4-4132, revised January 2007.

assumption is that a seven foot (7'-0") clearance between a pair of double bunks is sufficient to allow inmates from opposite bunks to perform a variety of physical actions when they are not in their bunks or in an adjacent day room area. These include sitting on the lower bunk, allowing two inmates to climb down from opposing bunks at the same time, or space to allow two inmates to exercise at the same time in the circulation spaces between the bunks. This translates into 14.2 unencumbered square feet per inmate. The total square feet per inmate, including the unencumbered square feet, bunks, lockers, a writing surface and adjacent circulation, is 37 square feet per inmate.[31]

The steps associated with the assessment of housing capacity are as follows:

1. Identify classification of all housing spaces within a particular unit
2. Exclude beds in temporary medical/mental health categories
3. Exclude any non-traditional housing
4. Measure dorm capacity and double/multiple occupancy cell capacity based on ACA's USF standard (25 s.f.) to determine ACA housing capacity
5. Measure single cells based on ACA's 80 s.f./35 USF standard to determine ACA housing capacity
6. Identify which housing areas and units, by classification, are eligible to be measured under the adjusted capacity due to the out-of-cell time mitigation standard for that classification category
7. Quantify out-of-cell time access for eligible classifications
8. Determine whether units are subject to special considerations as a result of lockdowns or modified programs
9. Where a unit's occupants meet the out-of-cell mitigation standard, identify adjusted capacity (POC) by classification; if not, the ACA standard becomes the POC
10. Apply any health care adjustments as required (see discussion to follow)

A number of special methodological considerations were identified before and after the Pilot Tests (see Chapter III). These important issues were fully discussed within the Working Group and with the Executive Team. The issues were as follows:

Calculation of Reception Capacity- Subsequent to the pilot studies, the Working Group decided that there should be one departure from the use of out-of-cell time as the sole mitigating factor for cell size in reception housing areas. Reception housing was determined to be not easily amenable to out-of-cell activities and, in many respects, excessive out-of-cell activity can be viewed as undesirable from a security and safety perspective given how little is known about inmates during this portion of their incarceration. As such, the Working Group determined that adopting a standard that aims to minimize the overall duration that inmates spend in this status was preferable and potentially more practical than focusing on the issue of how many hours a day these inmates

[31] Since this mitigation standard falls below the 25 square feet per occupant required by ACA/ACI 4-4132, an accreditation audit will likely make a finding of non-compliance with that standard. However, CDCR will have sufficient justification (as set forth in this report) to qualify for a waiver or to select this standard as one eligible for "Discretionary Compliance."

can be out-of-cell. The decision, made in concert with the leadership of DAI, was to strictly apply ACA housing standards for reception inmates unless the institution is able to move inmates out of reception status and into a permanent institutional placement within 30 days, in which case adjustments could be made to cell capacity so as to expand capacity beyond the actual ACA standard. This approach draws directly on ACA Standards that require the reception process be completed within 30 days after admission.[32]

Measuring capacity of small cells- The CDCR currently has more than 8,000 cells that are less than 55 square feet, including more than 2,800 cells that are less than 40 square feet. In most cases, these cells currently hold two inmates, even though they would not be large enough (using USF per ACA standards) for even one inmate. These cells currently are used to house inmates in the following classifications: General Population, Administrative Segregation, and EOP's.

While use of these small cells is not acceptable in principle, the reality is that it is not practical to simply take them off line and remove them entirely from inclusion in CDCR's systemwide capacity. In this instance, this methodology would permit them to be used for *one inmate only*, even though they fall below the ACA standard and even where there is very limited out-of-cell time and no potential mitigation.

Measurement of capacity in units subject to lockdowns or modified programs- A difficult question arose during the field testing of the out-of-cell access instrument—how to calculate out-of-cell time when the unit is on lockdown or modified programming as a result of investigations of significant incidents, post-investigation limited movement control mechanisms or budgetary cutbacks respectively. Although only one prison (SVSP) was subject to such restrictions during the pilot tests, and the approach used there was to count out –of-cell activity as it currently existed due to the length of the limitations on movement. During the field tests at 33 sites, however, these circumstances were found at several prisons. The approach employed there was to focus on the duration of the out-of-cell limitations--when the restrictions had been imposed very recently (within the past few days), the out-of-cell activity schedule in place prior to the restrictions was used, while units that had been on restrictions for a longer time were evaluated based on the more limited out-of-cell activity schedule in place at the time of the field visit. In considering the results and evaluating the methodology after the pilot tests and field visits, P/BA and several members of the Working Group raised concerns about the need to better define and standardize the approach to evaluating out-of-cell activity in units subject to short-term or longer restrictions due to lockdowns or modified programs.

For purposes of calculating capacities for this Final Report and future capacity assessments, a decision was reached that a distinction be drawn between lockdowns and modified program and that the impact on capacity be determined differently. *Lockdowns* should refer to the limited timeframe during which inmates are confined to their cells or bunks in order to allow for a criminal investigation to occur. These investigations should normally require seven days or less to be completed, and units in this status during a capacity audit would be evaluated as if the "normal" schedule was in effect, i.e., out of cell time assessments for mitigation purposes would be

[32] ACA ACI-Standard 4-4287, revised January 2006.

measured based on the actual practice and documentation in place prior to the lockdown. *Modified program*, in contrast, would refer to restrictions placed on inmate out of cell activity and movement imposed for operational reasons such as security concerns and post-investigation separations of inmate subgroups or due to budget restrictions, staffing reductions, etc. Modified program is a program change that typically is of a significant duration, and thus out of cell time assessments for inmate housing units on modified program status would be determined by the out of cell activity levels observed and documented during the actual timeframe of the capacity assessment.

Calculation of capacity in 270 degree dormitories- Subsequent to the pilot studies a modification was made relative to the calculation of the 25 unencumbered square foot per inmate in dormitories, specifically those in the 270 degree configuration. In the case of a 270 degree dormitory, the tier space in front of the pony walls is included in the calculations, which has the effect of increasing the capacity of those areas.

Inclusion of a factor for operational flexibility- The Working Group determined that there was a need to incorporate into the POC a factor for "operational flexibility" to reflect the reality and accepted correctional practice that every bed cannot and should not be filled at all times. This is due to a variety of factors, including: the classifications and behavior profiles of inmates do not match perfectly with bed inventory or cell-mate compatibility; cells will occasionally be unusable due to maintenance reasons; and, because some bed space must be reserved to accommodate peaks in population levels. As such, a 5% operational flexibility factor[33] was applied to all general population celled and multiple occupancy celled housing units *that achieve maximum mitigation*. The 5% factor was also applied to any housing units where mitigation is not feasible yet where the strict application of the ACA standards would result in 100 % double occupancy, resulting in a scenario where no beds would be available for operational flexibility.[34] The 5% factor was not applied to POC for housing units that did not achieve maximum mitigation, nor was it applied in dormitories because of the potential availability of sufficient second bunks to provide the necessary flexibility.

Mitigation Matrix

The "CDCR Housing Capacity Standards and Mitigation Matrix." appears on the following page. This Matrix provides the essential criterion that is applied to determine both the ACA housing capacity and the Prison Operational Capacity for each classification and inmate sub-grouping, including:

[33] CDCR's current policy is to use a 5% vacancy/operational flexibility factor for celled general population housing, with no factor for dorms and program-specific figures for unique populations such as Security Housing Unit, Administrative Segregation Unit, and Enhanced Outpatient Program.

[34] For example, this situation arises primarily in the 180-design celled housing units where ACA capacity, due to the larger cell size, would allow for all cells to house two inmates in conformance with the ACA 25 square foot/inmate unencumbered square footage standard. Accordingly this would result in a maximum capacity of 256 inmates in a typical "180" housing unit that has 128 cells. Therefore, applying the 5 % Operational Flexibility factor in this scenario would result in housing a maximum of 243 inmates, leaving 13 available beds for operational flexibility.

- All current CDCR housing assignment categories that are included in the capacity calculations
- Applicable ACA space standard for each housing type (except for reception where it is a duration in status driven standard)
- The required number of hours of out-of-cell time required for mitigation eligibility
- The adjusted space standard applied when mitigation eligibility is satisfied

It is worth noting that a number of the housing assignment categories have a N/A shown in the columns designating the number of hours of out-of-cell activity necessary for mitigation and the corresponding column identifying the adjusted space standard. As has been pointed out previously, certain housing categories are not eligible for this mitigation for a variety of reasons as follows:

- Requirements for space and programming for Mental Health housing operated by the Department of Mental Health (DMH) is governed by and licensed pursuant to Title 22;

- Housing categories including Administrative Segregation and Behavior Modification are not subject to mitigation because of the inherent limits on out-of-cell time that cannot reasonably be increased to a point that it would be significant enough to qualify for mitigation;

- Housing categories including condemned housing, Psychiatric Services Unit (PSU) and Secure Housing Unit (SHU) must be single celled so additional out-of-cell time will not lead to adding a second inmate to the cell;

- The capacity of Camp program beds is driven not by square footage but rather by programmatic requirements established for fire fighting.

We must reiterate that ineligibility for mitigation does not suggest that out-of-cell opportunities are unnecessary or should not be maximized for inmates in that category based on programmatic and security considerations. It only means that, regardless of out-of-cell activity, additional inmates should not be added to a living area beyond what would be permitted under ACA standards or CDCR policy.

It is also noteworthy that two populations, EOPs and Administrative Segregation inmates (those housed in 180 design units), are subject to a policy derived cap of 50% double celling.

Table 2-2: CDCR Housing Capacity Standards and Potential Mitigation Matrix

CLASSIFICATION	Short Hand	CURRENT CDCR HOUSING TYPE (Typical)	ACA HOUSING TYPE	ACA Standard	# HOURS OUT OF CELL FOR MITIGATION ADJUSTMENT	Approved Space Standard
Acute Psychiatric Program (DMH)	APP	Single cell	Licensed Under Title 22	Licensed Under Title 22	N/A	N/A
Administrative Segregation Unit	ASU	Single cell	Special Management Single (ACI: 4-4133)	35 USF/occupant	N/A	N/A*
	ASU	Double cell	Double cell (ACI: 4-4132)	25 USF/occupant	N/A	N/A*
Behavior Modification Unit	BMU	Double cell	Double cell (ACI: 4-4132)	25 USF/occupant	N/A	N/A
Camp Program Beds	CMP	Dorm	Dorm (ACI: 4-4132)	N/A (per program need)	N/A	N/A
Condemned Housing	DR	Single Cell	Special Management Single (ACI: 4-4133)	35 USF/occupant	N/A	N/A
Enhanced Outpatient Program	EOP	Double Cell	Double cell (ACI: 4-4132)	25 USF/ occupant	11,13 or 14 depending on custody level	25 USF/cell*
	EOP	Multiple Occup. Cell	Mult. Occup. (ACI: 4-4132)	25 USF/ occupant;(50 total sf/occupant)	11,13 or 14 depending on custody level	37 SF/person*
LI-GP	LI-GP	Double cell	Double cell (ACI: 4-4132)	25 USF/occupant	14	25 USF/cell
	LI-GP	Dorm	Dorm (ACI: 4-4132)	25 USF/ occupant;(50 total sf/occupant)	14	37 SF/person
LII-GP	LII-GP	Double Cell	Double cell (ACI: 4-4132)	25 USF/occupant	14	25 USF/cell
	LII-GP	Dorm	Dorm (ACI: 4-4132)	25 USF/ occupant;(50 total sf/occupant)	14	37 SF/person
LIII-GP	LIII-GP	Double Cell	Double cell (ACI: 4-4132)	25 USF/occupant	13	25 USF/cell
LIV-GP	LIV-GP	Double cell	Double cell (ACI: 4-4132)	25 USF/occupant	11	25 USF/cell
Intermediate Care Facility (DMH)	ICF	Single cell	Licensed Under Title 22	Licensed Under Title 22	N/A	N/A
	ICF	Double cell	Licensed Under Title 22	Licensed Under Title 22	N/A	N/A
	ICF	Dorm	Licensed Under Title 22	Licensed Under Title 22	N/A	N/A
Protective Housing Unit	PHU	Double Cell	Double cell (ACI: 4-4132)	25 USF/occupant	11,13 or 14 depending on custody level	25 USF/cell
Psychiatric Services Unit	PSU	Single Cell	Special Management Single (ACI: 4-4133)	35 USF/occupant	N/A	N/A
Reception	RC	Double Cell	Double cell (ACI: 4-4132)	25 USF/occupant	<30 days	25 USF/cell
	RC	Dorm	Dorm (ACI: 4-4132)	25 USF/ occupant;(50 total sf/occupant)	<30 days	37 SF/person
Substance Abuse Treatment Unit	SATU	Multiple Occup. Cell	Mult. Occup. (ACI: 4-4132)	25 USF/ occupant	11,13 or 14 depending on custody level	37 SF/person
Secure Housing Unit	SHU	Single Cell	Special Management Single (ACI: 4-4133)	35 USF/occupant	N/A	N/A
Transitional Housing Unit	THU	Double Cell	Double cell (ACI: 4-4132)	25 USF/occupant	11	25 USF/cell
Women	W	Double Cell	Double cell (ACI: 4-4132)	25 USF/occupant	11,13 or 14 depending on custody level	25 USF/cell
	W	Dorm	Dorm (ACI: 4-4132)	25 USF/ occupant;(50 total sf/occupant)	11,13 or 14 depending on custody level	37 SF/person
	W	Multiple Occup. Cell	Mult. Occup. (ACI: 4-4132)	25 USF/ occupant	11,13 or 14 depending on custody level	37 SF/person

* No more than 50% of cells can be double cells.

Prison Health Care Capacity Adjustments (PHCC)

ACA's approach to capacity is predicated solely on housing space. While the CDCR capacity methodology reflects that approach in the first instance, the new methodology takes into account the *Plata* and *Coleman*[35] cases and the concerns that have been articulated by the courts relative to facility capacity and how it affects the delivery of healthcare services. Healthcare capacity is integrated here in several different contexts.

First, participation in medical and mental health activities is considered an out-of-cell activity for purposes of mitigation in the housing capacity analysis. Second, designated housing spaces for specialized medical and mental health offenders/patients are included as categories of housing and subject to a mitigation analysis. And third, access to health care will be considered an overriding capacity driver that can potentially limit housing capacity. In other words, once the Prison Operational Capacity (POC) is calculated, the issue then becomes whether the *existing* health care resources are sufficient to provide the required access for the proposed capacity. Health care capacity would be based on <u>current</u> space, staffing and availability of services and measured using access to medical and mental health care data currently measured and produced by the Health Care Receiver. [36]

While there are limitations to the data contained in the Health Care Receiver's Monthly Healthcare Access data, nevertheless this data has been determined to be useful by the courts and the Office of Inspector General as long as the limitations to it are acknowledged, namely:

- The Receiver's data measures that an inmate arrived to a scheduled appointment; it does not measure ordered treatment that has not been scheduled.
- The access to care data collection methodology is inconsistent across CDCR in that some facilities ducat only scheduled appointments while others also include treatment that occurs within the housing unit.
- The Mental Health Tracking System, developed by CDCR, no longer captures access to care for individual mental health populations such as EOP or CCCMS.

Formulas were developed to calculate if and how much the access to care data will affect the POC if current healthcare resources (space, staffing, etc.) remain in place. The formulas include medical and mental health care access.

Once measured and the formula applied, if the health care resources and access to care data showed that resources are sufficient for the prison's current population/capacity, then it will be deemed likewise sufficient for a reduced capacity if that is the result of the new POC capacity calculation. If it is lower, then downward adjustments would be made to the POC only *in those areas and classifications where the access to care is insufficient*.

[35] The working group took the position that the *Perez* case, addressing dental care, does not impact on overall capacity or is not impacted by capacity in a manner that is directly measurable or sufficiently direct as to become an overall capacity driver.

[36] Monthly Health Care Access Quality Report, a report published by the Health Care Receiver on health care access for medical, mental health, diagnostic/specialty services and dental services.

The Working Group, with the advice of P/BA, determined that using 80% and above (moderate adherence) as an acceptable level of access to care; any percentage below this was considered unacceptable. Typically, the methodology required an average of three months of the Receiver's data (March through May 2011) to avoid making a determination based on an atypical one month percentage for that facility. If the percentages for that time period were considered unacceptable, further inquiries were made to determine the reason.

The calculation of current healthcare capacity in each facility included separate measures for medical and mental health care. To measure impact on the POC, it was important to identify the specific populations that are assigned to specific housing types or services.

Healthcare Calculation If Applicable will be an Adjustment

The calculation is based on a proportional change equal to the proportion of the beds for that particular population. Therefore, if all inmates including those who are in designated medical or mental health beds receive ducats to go to sick call, then 100% of the occupancy of the facility was included in access to medical care with a focus on sick call. However if only a portion of the population is expected to have a particular access to care, and there are designated beds for that population, then access to that care was based only on the designated beds for that population or population specific capacity. Therefore, if there is an impact on the operational capacity it is likely to require adjustments of particular types of beds, not the entire population of the facility.

Healthcare Calculations

Four separate calculation formulas were developed to address the access to health care for those inmate population groups in the prison system that could affect the final POC based on the capacity methodology:

- access to sick call for inmates housed in the general population;
- access to mental health care for CCCMS for those inmates receiving outpatient mental health care who are housed in general population;
- access to mental health care for EOP population, a specialized housing area of general population;
- access to care when there is overlap between medical and mental health care such as sick call and mental health care.

A decision tree was developed for each of the calculations,[37] including two calculations that address when there is an overlap between medical and mental health populations (such as sick call and CCCMS) to address any duplication.[38]

[37] See Appendices 4-9.
[38] See Appendices 10-11.

Before applying any calculation, the Receiver's access to care statistics for a designated three month period are averaged to determine medical and mental health access to care statistics for each facility.

If the access to either medical or mental healthcare statistic is below the 80% threshold, the appropriate calculation for each population is then performed to assess whether there is a healthcare impact on the POC.

For each calculation, the essential question is whether the averaged percentage is 80% or above. If it is, there will be no impact on the POC. However, if the average is below 80%, further analysis of the Receiver's data is required to determine if the reason that access to care is below the acceptable percentage is due to custody issues, healthcare provider issues, other issues or a combination thereof.

A distinction must be drawn between the one population that has designated beds, i.e., EOP, and CCCMS that do not have designated beds but rather are simply a component of general population or other specialized housing categories. In keeping with the overall healthcare methodology, the premise is that if there is a reduced density of CCCMS, the existing staff will be better positioned to provide the necessary access to care for this population. As such, a reduction in the POC will presumably serve as a means to increase access to care for this population beyond the 80% threshold.

III. PILOT TESTS

III. Pilot Tests

Once there was general agreement concerning the new methodology to be employed for measuring institutional capacity, the Working Group decided that a series of pilot field surveys should be used to test the efficacy of the methodology. These pilot tests would allow for the identification of potential flaws in the process as well as offer an opportunity to test the instruments that would be used and set the stage for the full implementation of the methodology at all 33 institutions.

Six prisons were selected, comprising a sample of approximately 20% of all institutions. The sites were selected to satisfy several criteria, including representing different architectural styles, both male and female facilities, degrees of specialized healthcare environments, ranges of custody levels, and different facility sizes. The six prisons selected for the pilot tests were:

- Mule Creek
- Salinas Valley
- Duel Vocational Institute
- CCWF
- Avenal
- California Medical Facility

Prior to initiating the field tests, substantial preparation work was undertaken, including developing out-of-cell questionnaires and survey forms, collecting all available architectural plans for the subject prisons, and compiling advance measurements of dorms and cell areas from the plans so that the field component would serve as field verification. Wardens of the six prisons were notified that survey teams would be visiting and out-of-cell questionnaires were submitted ahead of time to allow for a degree of preparation by the prisons in advance of the actual site visit. Wardens were requested to have their executive teams available for an introductory meeting and to assign the necessary number of escorts to accommodate the survey teams.

The field tests were conducted jointly by representatives of the Working Group and P/BA staff in October and November 2010. The pilot teams were divided into two groups, with one group focusing on physical plant measurements and verifications and the other for interviews and data collections relative to out-of-cell activity and potential mitigation. Two to three days were allotted for each field visit, although it became apparent that longer periods would be required for certain prisons where there are numerous housing types and diverse inmate populations such as at CMF; in fact, pilot teams returned to CMF after the initial site visit to obtain additional information required to complete the pilot surveys.

All field tests began with a meeting with the warden and the executive team. A representative of the pilot team, a person with decades of line and top level operations experience, led the briefing which explained the purposes of the pilot tests, the activities that would occur, the locations to be visited, how prison staff would be affected by the survey work and what was required from officers assigned as escorts.

The "physical plant team," consisting of a P/BA representative, at least one Working Group/CDCR architect and typically accompanied by a representative of the prison's maintenance/physical plant staff, visited all housing areas to measure typical cells and dormitories and to validate information contained on architectural plans. The team also visited healthcare areas to review existing clinical and support spaces. (see discussion below)The "out-of-cell team," also comprised of a P/BA representative and two or more Working Group/CDCR operations representatives visited all housing areas that could potentially be eligible for mitigation due to out-of-cell activity time pursuant to the Capacity Methodology Matrix. The out-of-cell team interviewed unit officers (2nd and 3rd shift officers who had been assigned to that post and watch tour for at least 30 days) at their posts or in supervisor's offices when relief was available. The team reviewed the responses to questionnaires that had been submitted ahead of the filed visit, explained the objectives of the pilot tests, and queried the officers about a myriad of issues concerning out-of-cell activity and opportunities in that unit. The team did not rely exclusively on representations made by the officers and while in the unit, the team reviewed or requested secondary documentation of out-of-cell time, including:

- Log books
- Inmate assignment rosters
- Post orders
- Movement sheets
- Ducat lists
- Unit schedules
- Institutional schedules
- Program schedules
- Daily activity reports
- Inmate orientation manuals
- Group treatment schedules
- Master population count reports
- Architectural plans of all housing units

Salinas Valley State Prison (SVSP) was the only pilot test site prison with units on lockdown status or on a restricted modified program. Interviews determined both the current out-of-cell activities as well as what the unit schedule was before the lockdown/program modification was implemented. Because SVSP's lockdowns/program modifications had all been in place for several months, the out-of-cell time assessment was based on the program at the time of the site visit, i.e., very limited out-of-cell time, which was below the mitigation threshold.

Inquiries about access to medical and mental healthcare services were made at each pilot site. Of particular interest was which healthcare activities were ducated and which were not. The ducat lists are an important driver of the Receiver's data collection process. All health care areas were toured; clinicians and officers were interviewed about access to care, waiting lists, scheduling processes, barriers to inmate access to care, and improvements in access to care within the last year. Health care spaces were reviewed with attention to whether healthcare spaces were adequate for the number of inmates; whether healthcare space was being used for its original intent (healthcare spaces being used to provide healthcare services) and whether the healthcare spaces in use had

been converted from space that had been designed for other purposes (such as program space, offices, closets, storage) but were now being used to provide healthcare services. While on-site, the field team collected schedules of medical and mental health care services and treatment programs, and lists of scheduled appointments and where available the most recent access to care data for that facility.

Following the field tests, numerous activities were conducted by the Working Group, in concert with P/BA, including initiation of an internal quality assurance process to review the validity of the data collected.[39] Once there was confidence in the validity of the data, the Working Group:

- Developed accurate CAD drawings for square footage data
- Calculated out-of-cell time based on primary and secondary documentation
- Calculated ACA capacities
- Calculated adjusted capacities (where applicable) based on mitigation criteria and healthcare adjustments

With respect to the health care adjustments, P/BA relied on the Receiver's access to medical and mental health care data for August, September and October (the most recent available) and calculated each facility's mean access to care percentages. All six facilities were above the 80% threshold for medical care. Only one, SVSP, was below the threshold for mental health care at an average of 70%. When applying the healthcare adjustment to the proposed POC for EOP beds, it was determined that a further reduction of 26 EOP beds would be necessary to increase the access to care to the 80% threshold.

Table 3-1: Receiver's Access to Care Data Applied to Pilot Tests

Prison		ASP	CCWF	CMF	DVI	MCSP	SVSP	
Medical								
	Aug-10	90	94	96	91	98	88	
	Sep-10	90	90	94	91	98	89	
	Oct-10	89	94	97	92	98	88	
	Avg.	89.7	92.7	95.7	91.3	98.0	88.3	
Mental Health								
	Aug-10	88	86	97	97	91	72	
	Sep-10	88	88	95	97	94	67	
	Oct-10	87	87	93	96	91	71	
	Avg.	87.7	87.0	95.0	96.7	92.0	70.0	

[39] This quality assurance effort was significantly expanded during the actual field survey of 33 institutions. See Chapter IV for additional details in this regard.

Lessons Learned

In addition to compiling the actual results of the pilot tests, the Working Group and P/BA used the pilot test process as a means of identifying lessons learned to be applied when the process was to be extended to all 33 institutions. Accordingly, a report was prepared by the Working Group and P/BA in December 2010 describing the results of the pilot tests and recommendations concerning any refinements that were required to enhance the methodology. The report was then presented to Secretary Cate and the executive staff showing the results of the capacity analyses for the five[40] pilot sites. It is also noteworthy that the preliminary findings as to mitigation for eligible categories of inmates and respective housing areas were based on an across the board threshold of ten hours for all eligible categories; this was because information from the ASCA surveys was still pending.

At the conclusion of the presentation, Secretary Cate asked the Working Group to identify what the potential Prison Operational Capacity would be for the six pilot prisons if all eligible out-of-cell mitigation could be realized. In other words, while the pilot effort identified the current POC based on existing mitigation practices (i.e., "what is"), the inquiry asked "what if" out-of-cell activities for eligible inmate classifications could be maximized in conformance with the mitigation matrix methodology and the capacity thereby fully realized. This theoretical construct was referred to as Potential Prison Operating Capacity (PPOC).

The Working Group and P/BA were also directed to establish unique out-of-cell mitigation thresholds for each of three primary custody levels, with fewer hours required for higher custody levels and more for lower ones, once the ASCA survey was finalized.[41]

In its efforts to calculate a PPOC for the six pilot institutions, the Working Group determined that there was a need to incorporate into the POC a factor for "operational flexibility" to reflect the reality and accepted correctional practice that every bed cannot and should not be filled at all times. This was due to a variety of factors, including: the classifications and behavior profiles of inmates do not match perfectly with bed inventory or cell-mate compatibility; cells occasionally are unusable due to maintenance reasons; and, because some bed space must be reserved to accommodate peaks in population levels. As such, the 5% factor was to be applied to any housing units where mitigation is not feasible yet where the strict application of the ACA standards would result in 100% double occupancy, resulting in a scenario where no beds would be available for operational flexibility (Prison Operational Capacity). For example, this situation arises primarily in the 180-design celled housing units where ACA capacity, due to the larger cell size, would allow for all cells to house two inmates in conformance with the ACA 25 square foot/inmate unencumbered square footage standard. There would be no mitigation possible because the cell already meets ACA standards for double capacity. Accordingly this would result in a maximum capacity of 256 inmates in a typical "180" that has 128 cells. Therefore, applying the 5% Operational Flexibility factor in this scenario would result in housing a maximum of 243 inmates, leaving 13 available beds for operational flexibility.

[40] Data for the California Medical Facility (CMF), the sixth pilot site, was not complete at that time.
[41] Based on the ASCA survey data, the methodology established the following custody-specific mitigation thresholds for out-of-cell time: 11 hours for maximum (Level IV), 13 hours for medium (Level III), and 14 hours for minimum (Level I and Level II)

The Potential Prison Operational Capacity reflects the highest possible capacity attainable if CDCR were to achieve full mitigation for eligible populations in every unit within a prison. For the same reasons expressed above, the Working Group decided that an operational flexibility factor would also need to be included in any PPOC calculation. (Note: the 5% factor was not applied to POC or PPOC for housing units that did not achieve maximum mitigation or to housing units not subject to mitigation). The summary table on the following page includes each of the capacity figures for the six pilot prisons, including the 5% operational factor where applicable.

Additional lessons learned fell into two groups: process changes and methodology changes. Process changes included:

- Consistency of field survey teams was essential to obtaining valid data
- Information obtained via interviews had to be verified through multiple forms of secondary data and documentation
- Consistent scripts and verbal instructions were necessary for interviews with line and supervisory institutional staff participating in the field surveys
- More time had to be budgeted for field surveys of larger and more complex prisons
- Adequate preparation time had to provided before the field surveys, and sufficient debriefing time after the field work was completed
- The six pilot prison sites needed to be reassessed along with the remaining 27 due to changes in methodology and processes.

Methodology changes included the following items, previously discussed in Chapter II:

- *Calculation of Reception Capacity*
- *Measurement of capacity in units subject to lockdowns or modified programs*
- *Calculation of capacity in 270 degree dormitories*

Table 3-2: Pilot Capacity Analysis Summary Table

Prison Acronym	Census (# inmates) on Day of Field Review	CDCR's Existing Design Capacity	CDCR's Existing Overcrowd. Capacity	ACA Capacity	Current Prison Operational Capacity (POC)	Current Prison Operational Capacity w/ 5% Operational Flexibility	Potential Prison Operational Capacity w/ 5% Operational Flexibility	Bed Differential Design Capacity vs. PPOC w/ 5% Operational Flexibility
MCSP	3,742	1,700	3,138	1,797	1,909	1,888	3,138	1,438
SVSP	3,734	2,452	4,400	3,148	3,250	3,230	4,130	1,678
DVI	3,829	1,673	3,037	1,738	1,867	1,846	2,675	1,002
CCWF	3,810	2,004	3,921	2,002	2,002	2,002	2,472	468
ASP	6,113	2,920	5,776	3,225	4,413	4,197	4,197	1,277
CMF	2,575	2,297	3,680	2,430	2,580	2,551	3,050	753
Totals	23,803	13,046	23,952	14,340	16,021	15,714	19,662	6,616

Column headings are as follows:

Column 1: Prison Acronym – The six pilot institutions surveyed.

Column 2: Census (# Inmates) on Day of Field Review – The number of inmates at the prison on the first date the field review was conducted for each of the six pilot prisons.

Column 3: CDCR's Existing Design Capacity – For celled housing, one person per cell, regardless of the size of the cell. Per CDCR's Design and Policy Construction Guidelines, the minimum cell size is 80 square feet for new construction; CDCR's existing design capacity for dormitory housing is a single bed on the floor and, for new construction, 25 square feet of unencumbered floor space per occupant.

Column 4: CDCR's Existing Overcrowding Capacity – By policy, CDCR's existing prison capacity is derived by applying CDCR's standard overcrowding rates against design capacity. The standard overcrowding rate is 190% for celled general population housing and 200% for dormitories. Unique overcrowding rates also exist for various programs, housing types, and inmate populations.

Column 5: ACA Capacity – The calculated capacity based on the methodology as defined in standards 4-4129, 4-4132, 4-4133 and 4-4141 for Standards Compliant Bed Capacity (2010 *Standards Supplement, Adult Correctional Institutions*, 4th edition).

Column 6: Current Prison Operational Capacity (POC) – The calculated POC is the capacity based on application of the ACA standards coupled with mitigation variables for out-of-cell time for eligible inmate populations and inclusive of operational flexibility on the date the field review was conducted for each of the six pilot prisons.

Column 7: Current Prison Operational Capacity (POC) with 5% Operational Flexibility – The POC inclusive of a 5% factor for operational flexibility.

Column 8: Potential Prison Operational Capacity (PPOC) with 5% Operational Flexibility – The PPOC inclusive of a 5% factor for operational flexibility. The calculated PPOC is the capacity figure that would reflect the maximum possible mitigation adjustments for out-of-cell time and inclusive of operational flexibility.

Column 9: Bed Differential of Design Capacity vs. PPOC with 5% Operational Flexibility.

IV. SYSTEMWIDE APPLICATION

IV. Systemwide Application

The Process

In December 2010, with the pilot test process complete and numerous lessons learned and methodological refinements made, the Secretary authorized the Working Group to commence with the capacity review at all 33 institutions. The field work was slated to begin in February 2011 with a June deadline established for a Final Report.

It was determined that staff of the Division of Adult Institutions (DAI) would take the lead on collection of out-of-cell information, while CDCR architectural staff assigned to the Working Group would continue to conduct the work associated with field measurements and confirmations relative to cell and dormitory sizes and occupancies. Members of the Working Group who led efforts to measure out-of-cell time during the six pilots were assigned to train DAI staff who would be conducting the extensive field work. This training not only focused on describing the activities that needed to occur at all institutions, but was intended to insure consistency of methods employed among and between teams in the field.

Between February and May, teams moved across the state to conduct capacity evaluation data collection. Four teams of DAI personnel completed site evaluations at seven prisons, while one team completed five institutions. Working Group representatives attended the initial field visits to continue the training process and then turned the work over completely to DAI teams.

The out-of-cell time information collection phase entailed site visits to each institution, collection of prison program information, collection of out-of-cell time data for each housing unit within the institutions, and collection of information on cell or dormitory conversions to accommodate disability placement program/disability placement wheelchair (DPP/DPW) inmates, mental health observation functions, or other uses such as office space, conference rooms, storage, etc.

At the conclusion of each site evaluation, the teams returned to their assigned prisons to evaluate the data collected and to transpose the out-of-cell time data into the OOC calculation worksheets. Once completed, the worksheets were submitted, along with all supporting documents to members of the Working Group who were charged with conducting the quality assurance process (see the description of this process below).

Quality Assurance Program

A vitally important component of the process was the establishment and implementation of a quality assurance process for data collected in the field. The Working Group was fully cognizant of the fact that the information that would be generated about capacity would only be as good as the quality of the underlying data. As such, a process of reviewing the data collected from the field and the preliminary calculation performed by the DAI staff was established.

The CDCR architect assigned to the Working Group reviewed all architectural plans and dimensions received from the field, verifying the information and measurements. The quality assurance process revealed many discrepancies between plans and actual field conditions, even

among facilities that were allegedly identical. Valid information was crucial to the calculation of cell sizes, dormitories and establishing mitigated occupancies for eligible classifications. Additionally, this process resulted in creating an extraordinary data base of all the prisons surveyed as housing floor plans were accurately documented and dimensioned on CADD.

Members of the Working Group used the QA Checklists[42] to validate the field visit team calculations and supporting documentation. Conference calls were then conducted with each team to address discrepancies and areas requiring recalculation or follow-ups, after which documents were returned to the teams to make the necessary corrections. As each team completed their site evaluations, they met with the Working Group's QA leaders to finalize the QA process, which included a peer review process.

The quality assurance phase for out-of-cell data collection included the following tasks:

- Validating that all supporting documents for each institution were collected and available.
- Validating that all OOC worksheets and OOC calculation worksheets were completed and available.
- Completing a quality review of the OOC worksheets and OOC calculation worksheets.
- Comparing the data collected at the housing unit level with the institutions' inmate assignment rosters.
- Comparing the cell conversion information collected during the institution site visits with the building design information provided by the institutions' plant operations departments.
- Finalizing the OOC time calculations for each housing unit by inmate classification groups, program groups, release/recall times and meal/recreation functions.
- Validating the average number of OOC hours per inmate for each housing unit within each institution.
- Crosschecking the number of inmates listed on the housing unit OOC worksheets against the inmate assignment rosters to ensure that the number of inmates listed on the OOC calculation worksheet by classification category and program group was accurate.
- Crosschecking all release/recall times listed on the housing unit OOC worksheets with meal, recreation, and inmate assignment release/recall schedules to validate all OOC time calculations documented on the OOC time calculation worksheets.

An important component of this quality assurance process was that copious notes were taken to document all reviews of data, calculations that were returned to field reviewers for corrections or

[42] See Appendix 12.

recalculations and all data validation steps and associated documentation were preserved for the record during this process.

Findings

Once the quality assurance process was completed, members of the Working Group initiated the painstaking work of applying the methodology to calculate the ACA capacity, POC and PPOC for each of the 33 CDCR institutions. This process occurred during July through August 2011. CDCR staff collected, organized and analyzed all of facility data and determined the three capacity calculations for each housing unit of every institution and provided this information to P/BA. P/BA provided overview support for the quality assurance process and identified areas for which further inquiry or analysis was necessary. Once the POC's were finalized, P/BA then reviewed the corresponding access to care data for each institution to determine whether any healthcare adjustments to the POC were necessary for any prison with medical and/or mental health access to care falling below the acceptable threshold of 80% during the three month period of March through May, 2010.

In fact, only two prisons presented possible capacity adjustments due to sub-par access to care statistics—SVSP and Corcoran- and in both only access to mental health care were concerns. In both cases POC related capacity reductions already resulted in a revised capacity below the adjustment required to meet the 80% access to care threshold. At SVSP, the three month average access to mental health care was very low at 57.3% requiring a 22.7% reduction in EOP beds to meet the 80% threshold; however, the POC reduction was 72 beds or a 30.7% reduction. Therefore no further reduction was necessary to meet the access to care threshold.

An important caveat is necessary as it concerns the use of this data. Specifically, the capacity calculations prepared in this report have not considered the quality and condition of current housing areas in the prisons. While a substantial portion of CDCR's bed inventory is relatively new and in reasonable condition, there are also housing areas that are substandard. This could affect future POC or PPOC calculations and therefore should be further evaluated for during the next phase of the capacity planning project.

Table 4-1 below presents the results of the three types of capacity calculations for all 33 prisons.[43] It reveals that, based on the initial application of the new capacity methodology, the systemwide Prison Operating Capacity is currently 103,570. It also suggests that if full out-of-cell mitigation could be achieved systemwide, the PPOC could be as high as 128,700. While we recognize that this PPOC number exceeds the capacity of 109,519 beds in the *Plata* decision, it nonetheless serves to illustrate that CDCR can, by increasing out-of-cell activity, increase the current calculated POC at least as high as the systemwide population cap via application of this new methodology at all or selected CDCR prisons. Note that all three capacity figures above exclude 4,480 beds in off-site fire camps because the *Plata* decision did not address these beds.

[43] Summary calculation sheets for each of 33 prisons appear in Appendix 15.

Table 4-1: Summary of Capacity Analysis

Prison	ACA	POC	PPOC	Health Care Adjustment
CIW	997	1,668	1,767	0
CCWF	1,999	1,998	2,658	0
VSPW	2,068	2,056	2,562	0
Female Sub Total	**5,064**	**5,720**	**6,887**	**0**
CIM	3,399	3,713	4,553	0
SQ	3,249	3,501	3,501	0
DVI	1,743	1,868	2,683	0
RJD	2,220	2,282	3,782	0
NKSP	2,984	3,094	4,899	0
WSP	3,431	3,640	5,507	0
LAC	2,392	2,494	4,034	0
CCI	2,838	3,326	3,776	0
COR	4,391	4,139	5,269	0
SAC	3,412	2,957	2,957	0
HDSP	3,434	3,379	4,279	0
KVSP	4,576	4,352	4,352	0
PBSP	3,384	3,275	3,275	0
SVSP	3,267	3,180	4,060	0
CMF	2,400	2,571	2,933	0
CMC	4,268	4,895	4,895	0
SATF	4,044	4,536	5,390	0
CAL	2,400	2,808	4,216	0
CEN	2,361	2,452	4,162	0
MCSP	1,796	1,909	3,039	0
PVSP	2,365	2,452	4,162	0
ASP	4,147	5,769	5,769	0
CCC	1,870	2,330	2,690	0
CRC	3,819	5,233	5,243	0
SOL	3,264	4,023	4,923	0
CVSP	2,531	3,428	3,428	0
CTF	3,553	3,886	4,998	0
FSP	2,132	2,244	2,532	0
ISP	2,286	2,386	4,096	0
SCC	1,651	2,030	2,390	0
Male Sub Total	**89,627**	**97,750**	**121,813**	**-**
Institution Sub Total	**94,691**	**103,470**	**128,700**	**-**
Off Site Camps*				
CIW	320	320	320	0
CCC	2,150	2,150	2,150	0
SCC	2,010	2,010	2,010	0
Camps Sub Total	**4,480**	**4,480**	**4,480**	
Grand Total	**99,171**	**107,950**	**133,180**	

Table 4-2 below illustrates how the three calculated capacity figures-ACA, POC, and PPOC- compare with the existing CDCR's Design Capacity, the systemwide cap (137.5% of design capacity) and the Department's current "overcrowding capacity."

Table 4-2: Summary of Capacity Analysis – Other Capacities

Prison	DC	137.5% of DC	CC	ACA	POC	PPOC	PPOC / DC (%)
CIW	1,036	1,425	2,012	997	1,668	1,767	171%
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
VSPW	1,980	2,723	3,897	2,068	2,056	2,562	129%
Female Sub Total	**5,020**	**6,903**	**9,830**	**5,064**	**5,720**	**6,887**	**137%**
CIM	2,976	4,092	5,410	3,309	3,713	4,553	153%
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
DVI	1,681	2,311	3,053	1,743	1,868	2,683	160%
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
NKSP	2,604	3,704	5,193	2,984	3,094	4,899	182%
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
LAC	2,300	3,163	4,150	2,392	2,494	4,034	175%
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
COR	3,116	4,285	5,288	4,391	4,139	5,269	169%
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
HDSP	2,324	3,196	4,350	3,434	3,379	4,279	184%
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
PBSP	2,380	3,273	3,426	3,384	3,275	3,275	138%
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
CMF	2,297	3,158	3,680	2,400	2,571	2,933	128%
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
SATF	3,424	4,708	6,635	4,044	4,536	5,390	157%
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
CEN	2,308	3,174	4,368	2,361	2,452	4,162	180%
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
PVSP	2,308	3,174	4,368	2,365	2,452	4,162	180%
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
CCC	1,733	2,383	3,384	1,870	2,330	2,690	155%
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
SOL	2,610	3,589	5,070	3,264	4,023	4,923	189%
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
CTF	3,312	4,554	6,333	3,553	3,886	4,998	151%
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
ISP	2,200	3,025	4,185	2,286	2,386	4,096	186%
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Male Sub Total	**74,630**	**102,616**	**136,657**	**89,627**	**97,750**	**121,813**	**163%**
Institution Sub Total	**79,650**	**109,519**	**146,487**	**94,691**	**103,470**	**128,700**	
Off Site Camps*							
CIW	320	320	320	320	320	320	
CCC	2,150	2,150	2,150	2,150	2,150	2,150	
SCC	2,010	2,010	2,010	2,010	2,010	2,010	
Camps Sub Total	**4,480**	**4,480**	**4,480**	**4,480**	**4,480**	**4,480**	
Grand Total	**84,130**	**113,999**	**150,967**	**99,171**	**107,950**	**133,180**	

V. RECOMMENDATIONS AND NEXT STEPS

V. Recommendations and Next Steps

In the wake of the decision by the U.S. Supreme Court in *Brown v. Plata*, it is a challenge at this juncture to clearly determine the next steps concerning the application of the methodology described herein and applied systemwide in the first half of 2011. That said, there are numerous directions that CDCR can possibly take relative to the application of this methodology. These include:

- Approach the Three Judge Panel to urge that this methodology be substituted for Design Capacity as the means by which to measure the capacity of the CDCR system;
- Apply the new methodology to the design of and determination of capacity for any new prisons to be constructed by the state or when significant renovations or modifications are made;
- Apply the lessons learned and the prison operational underpinnings of this new methodology, irrespective of whether it directly or indirectly impacts on calculations of capacity, to the CDCR system.

In addition, because the Supreme Court approached the 137.5% cap as a systemwide limit, leaving discretion to the State as to how to determine capacity at each institution, this new methodology may be used by CDCR to decide how to apportion inmates at individual institutions. By way of illustration, CDCR could allow for higher numbers above design capacity in prisons that meet the out-of-cell mitigation criteria while limiting those that do not.

In the event that CDCR determines that it can or will proceed with systemwide adoption and implementation of the new capacity methodology, there are a number of steps that must be considered. Since this is a point-in-time approach to measuring capacity, the process needs to be nimble so that re-calculations can occur pursuant to a schedule but also at reasonable junctures when changed circumstances dictate that a reassessment is appropriate and necessary due to changes in operations or physical plant. The following twelve major recommendations should be considered by CDCR:

1. We recommend that CDCR utilize the POC's developed through this process as a basis for establishing minimum staffing levels for all CDCR prisons for budgetary planning for the upcoming fiscal year. Some adjustments may be necessary due to re-purposing of several prisons as a result of the re-alignment process.

2. We recommend that CDCR identify an official or entity within the Department that will be responsible for maintaining the capacity measurement system and overseeing its ongoing implementation in practice.

3. We recommend that responsibility for data collection rest with DAI but review, approval and reporting of CDCR's operational capacity rest with FPCM.

4. We recommend that CDCR develop policy and procedures to govern the use of the capacity methodology and affix internal responsibility for the components of the process (e.g., capacity assessments/ data collection, approval, reporting) on an ongoing basis. Furthermore, we recommend that:

a. there be a routine process by which wardens advise DAI on an annual basis of any operational or physical changes that would trigger a new capacity assessment
b. wardens be able to request on a quarterly basis a new capacity reassessment based on changed operational or physical plant considerations;
c. institutions being considered for a mission change be re-evaluated based on the resources necessary to implement the PPOC for the new mission and population level;
d. CDCR develop standardized forms to be used for out-of-cell time calculations, housing unit capacity calculations, and prison capacity calculations and that they are included in CDCR's operational capacity policy.

5. We recommend that CDCR's Office of Audits and Compliance complete the quality control assessment of any operational capacity assessments completed by DAI.

6. We recommend that CDCR develop a sustainable data base to manage this process.

7. We recommend that CDCR develop a training program to train staff at each prison, the associate directors and their staff, and selected staff within the Office of Audits and Compliance and FPCM to continue the updates of POC and PPOC. If possible the DAI personnel who conducted the initial surveys would be assigned to this effort on an on-going basis.

8. We recommend that CDCR complete a survey and analysis of all existing program space, support space and health care space to determine what enhancements are required to accommodate the POC or PPOC at each prison.

9. We recommend that CDCR consider the impact of how the original 12 prisons, with some original housing units more than 50 years old, will ultimately fit into the POC and PPOC capacity assessment process.

10. We recommend that CDCR conduct a staffing analysis at each prison to determine staffing requirements necessary to achieve the out-of-cell time mitigation thresholds with a target of reaching PPOC capacity levels at each prison.

11. We recommend that CDCR develop an overall strategy and departmental policy to minimize inmate idleness.

12. We recommend that CDCR revise the CDCR *Design & Construction Policy Guidelines* to establish housing standards in conformance with the criteria delineated in this report and establish thresholds for program, support and health care space to be incorporated into all new and existing facilities to support the potential prison operating capacity (PPOC).

VI. PARTICIPANTS/
RESOURCES

VI. Participants/Resources

The following professionals were active and essential participants in the development of the work that is described in this Final Report.

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APPENDICES

Appendices

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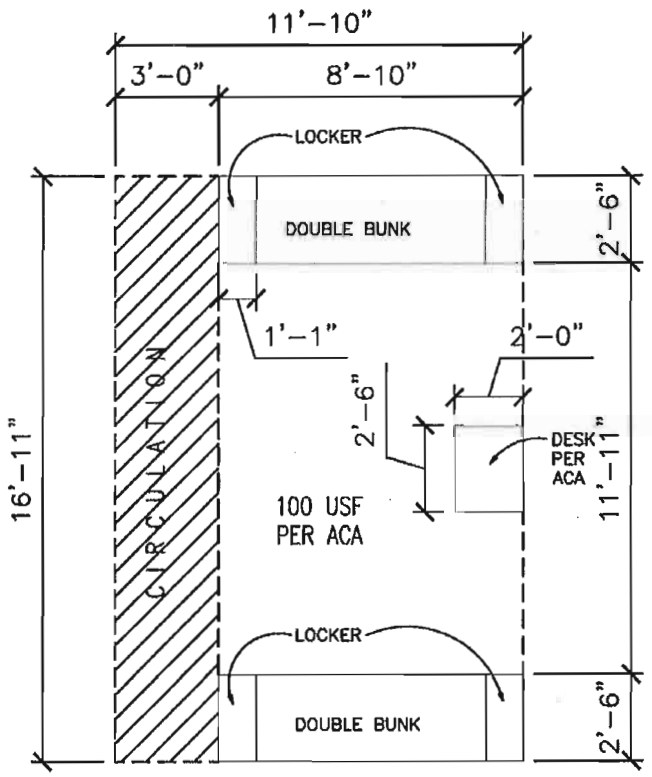
APPENDIX #1

Appendix #1



SCALE: 1/4"=1'–0"

CALCULATIONS
11.832' x 16.888' = 199.819 SQ. FT. / 4 =
49.95 ~ 50 SQ. FT./ INMATE

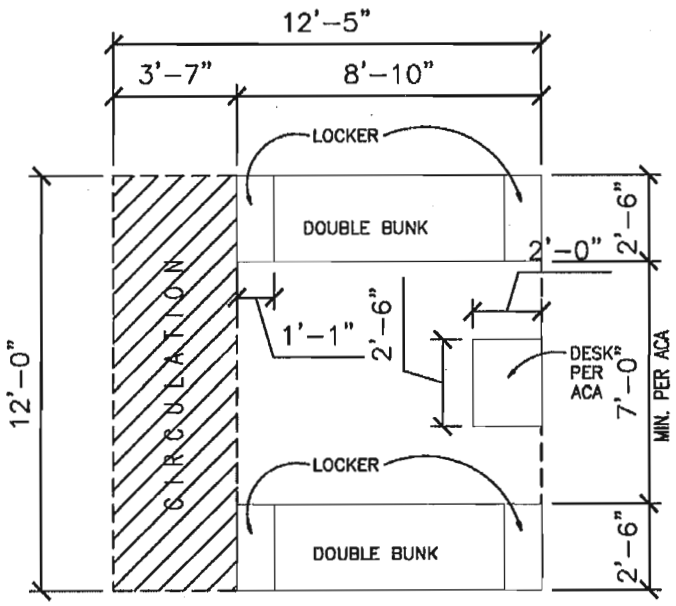
50 SQ. FT. PER INMATE ILLUSTRATION

STATE OF CALIFORNIA
DEPT. OF CORRECTIONS AND REHABILITATION
- RATED CAPACITY ASSESMENT

PULITZER & ASSOCIATES, LLC BOGARD

APPENDIX #2

Appendix #2



SCALE: 1/4"=1'–0"

CALCULATION METHODOLOGY
1. MAINTAIN 7'–0" CLEAR BETWEEN BUNKS.
2. INCLUDE CIRCULATION IN ACHEIVING 100 USF.

USF CALCULATIONS: 7.0 x 8.832' (–5 SQ. FT. FOR DESK) = 56.824 SQ. FT.
3.598' x 12.0' = 43.176 SQ. FT.
TOTAL USF = 100 USF

TOTAL SF/ INMATE: 12.43' x 12.0' = 149.16 SQ. FT. / 4 = 37.29 SQ. FT.
~ 37 SQ. FT./ INMATE

37 SQ. FT. PER INMATE ILLUSTRATION

STATE OF CALIFORNIA
DEPT. OF CORRECTIONS AND REHABILITATION
- RATED CAPACITY ASSESMENT

PULITZER & ASSOCIATES, LLC
BOGARD

APPENDIX #3

Appendix #3

Housing Unit Out of Cell Time Calculation Worksheet

Prison SVSP
Facility D
Unit 4
Date of Review 10-20-10 & 11-17-2010
Reviewer's Name D. Espinosa
Officer Interviewed Gibbons

Out of Cell Release Period	Full-Time Assigned Program/work schedule	Full-time Assigned schedule OOC Time	Part-Time Assigned/Academic Ed/Leisure schedule	Part-time Assigned/Academ/Leisure schedule OOC time	Notes
Early Dayroom Activity					
Morning chow	0700-0730	0.5	0700-0730	0.5	Fed in dining room
Support Services - Treatment	0900-1130/1300-1530	5			Majority of workers return to H.U.
Morning Dayroom/Yard/Academics			0900-1130	1.25	Program every other day
Afternoon Dayroom/Yard/Academics			1300-1530	1.25	Program every other day
Evening Chow	1600-1630	0.5	1600-1630	0.5	Fed in dining room
Evening Dayroom/Yard					
Late Dayroom Activity					
TOTAL		6		3.5	

Unit Population Data	Total Number	Out of Cell Time	Notes	Calculation: # Inmates x out of cell time
Classification (s)	Level 4		EOP General Population	
Total Number of Inmates	104			
Number of Orientation Inmates	3	3.5		10.5
Number of Close A Inmates	10	3.5		35
Number of A2B Status Inmates				0
Number of C Status Inmates				0
Full Time Assigned Inmates (Daytime Workers)	27	6	Support Services-Treatment	162
Full Time Assigned Inmates Early/Late Workers	29	8	Support Services-Treatment	232
Part Time - Unassigned Inmates	35	3.5	Part time assignments (Academics)-Unassigned inmates	122.5
				562

Average # Out of Cell Hours/Inmate	5.4
Mitigation standard	10
Mitigation Standard Met (Yes/No)	No

Notes / Assumptions

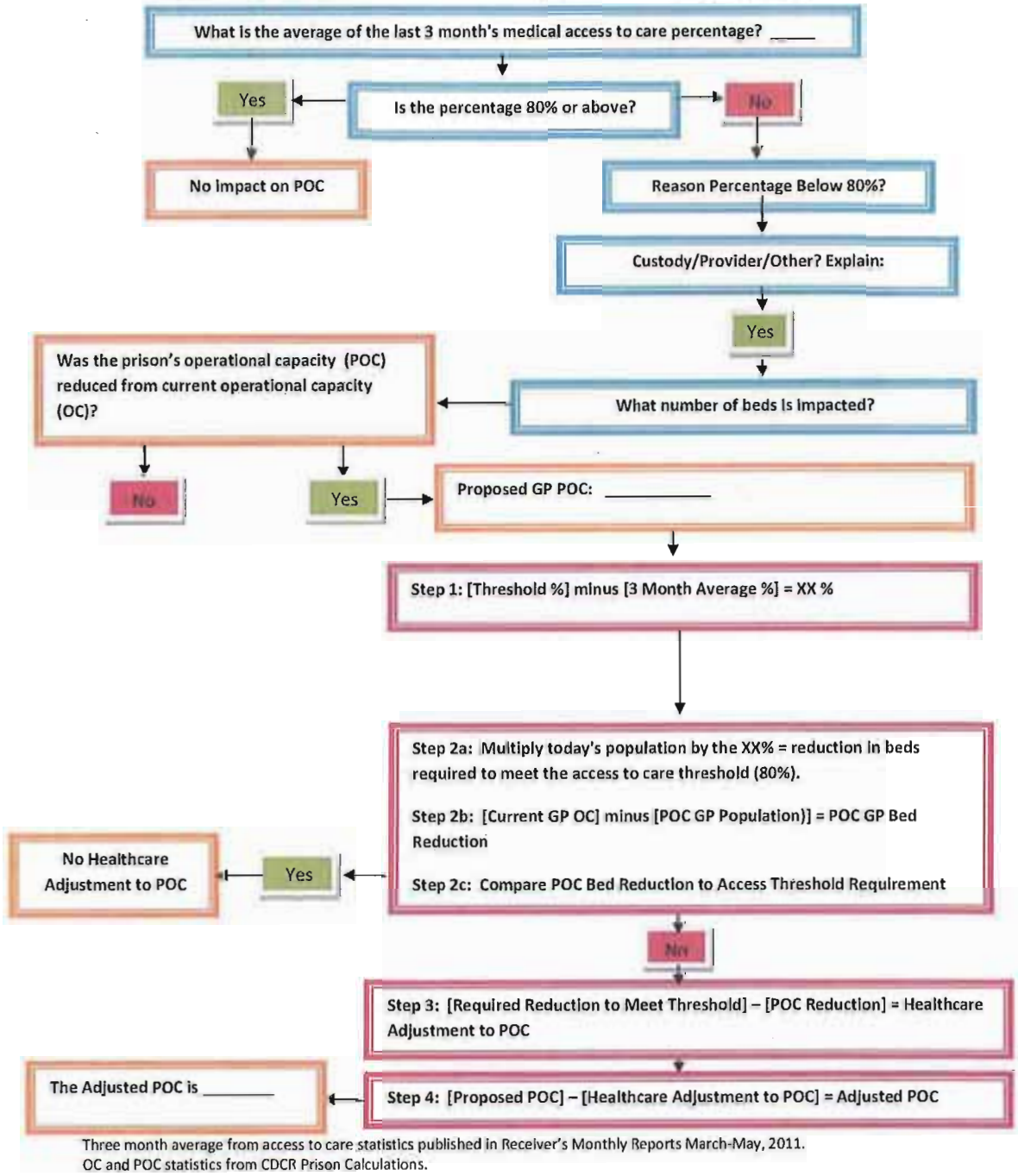
APPENDIX #4

Appendix #4

Appendix 4: Sick Call Adjustment to POC Methodology

Institution: Date:

Targeted Population: Sick Call *Prison's Current Operational Capacity____*



Three month average from access to care statistics published in Receiver's Monthly Reports March-May, 2011.
OC and POC statistics from CDCR Prison Calculations.

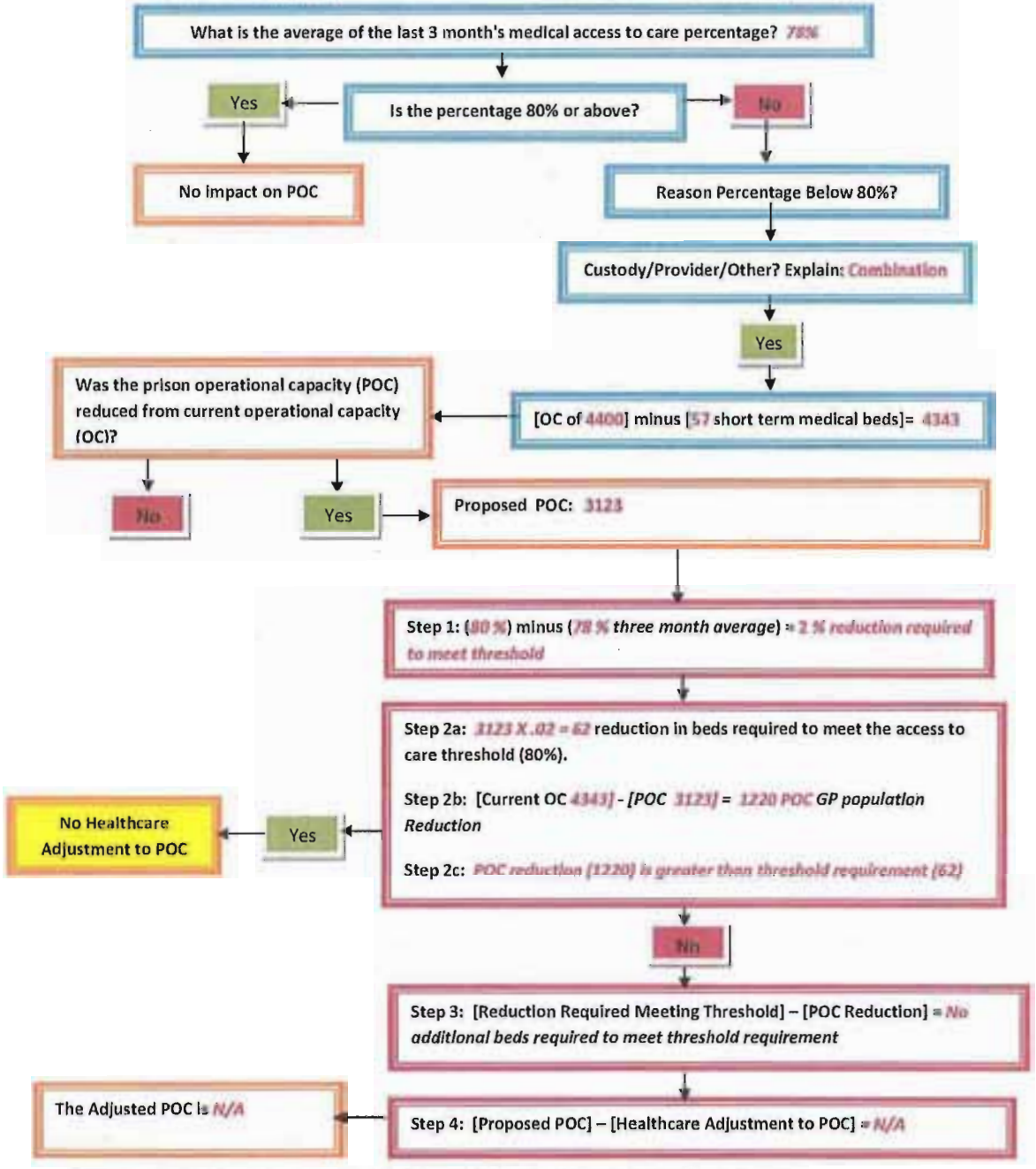
APPENDIX #5

Appendix #5

Appendix 5: Sick Call Adjustment to POC EXAMPLE

Institution: Date:

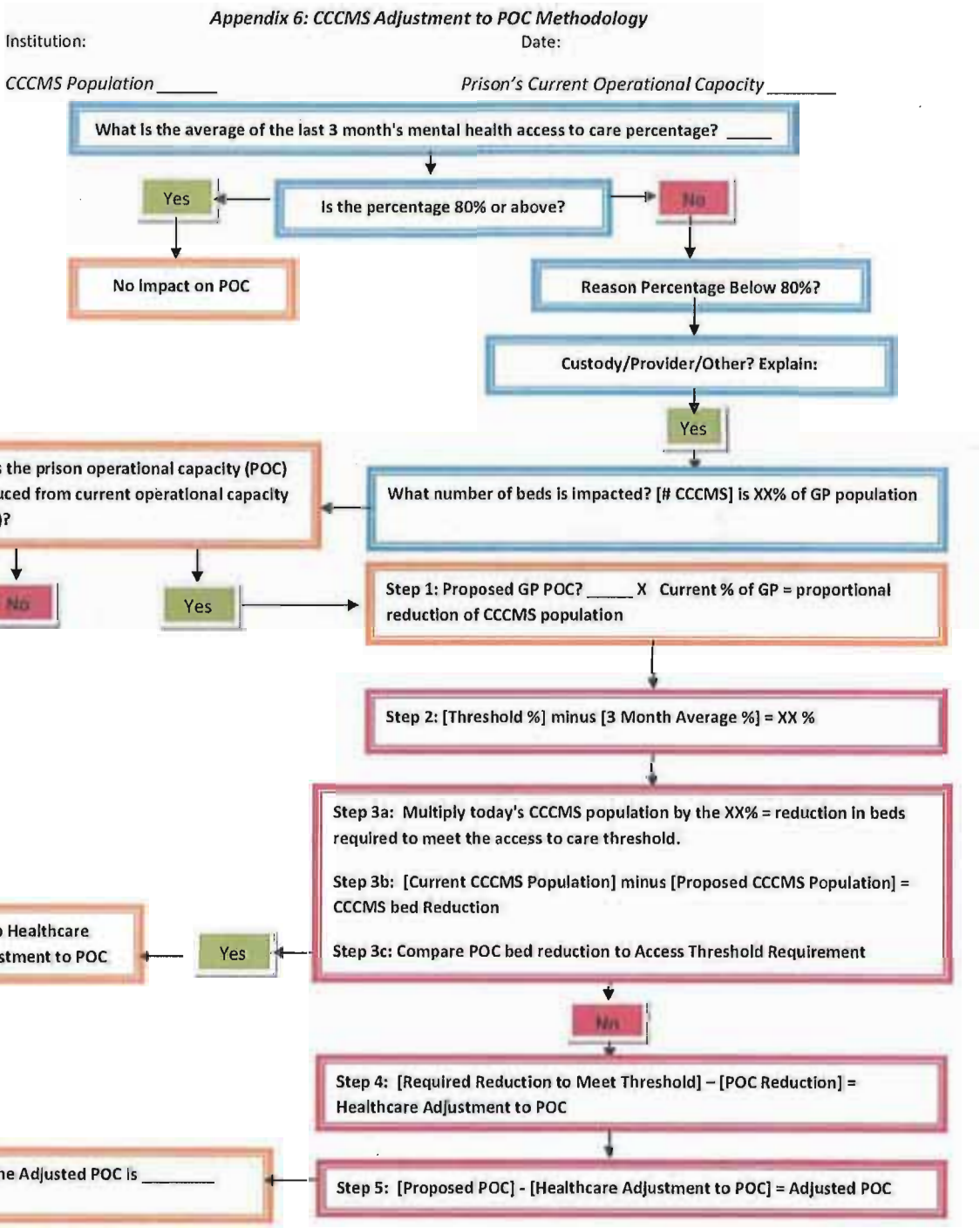
Targeted Population: *Sick Call* *Prison's Current Operational Capacity 4400*



Three month average from access to care statistics published in Receiver's Monthly Reports March-May, 2011.
OC and POC statistics from CDCR Prison Calculations.

APPENDIX #6

Appendix #6



Three month average from access to care statistics published in Receiver's Monthly Reports March-May, 2011.
OC and POC statistics from CDCR Prison Calculations.

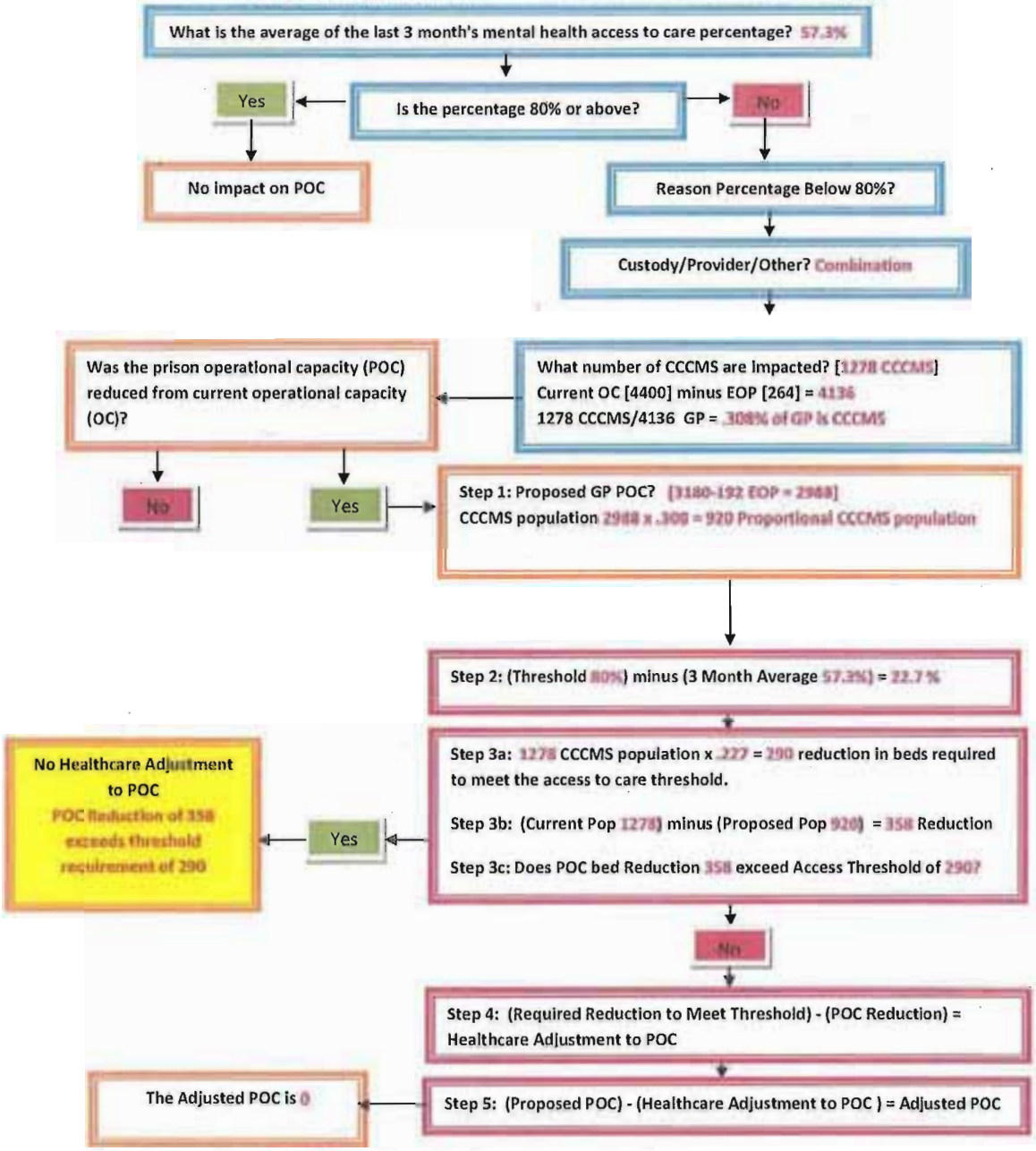
APPENDIX #7

Appendix #7

Appendix 7: CCCMS Health Care Adjustment Example

Institution: SVSP Date: Spring 2011

Targeted Population: 1278 CCCMS MH Population *Prison's Current Operational Capacity: 4400*



Three month average from access to care statistics published in Receiver's Monthly Reports March-May, 2011.
OC and POC statistics from CDCR Prison Calculations.

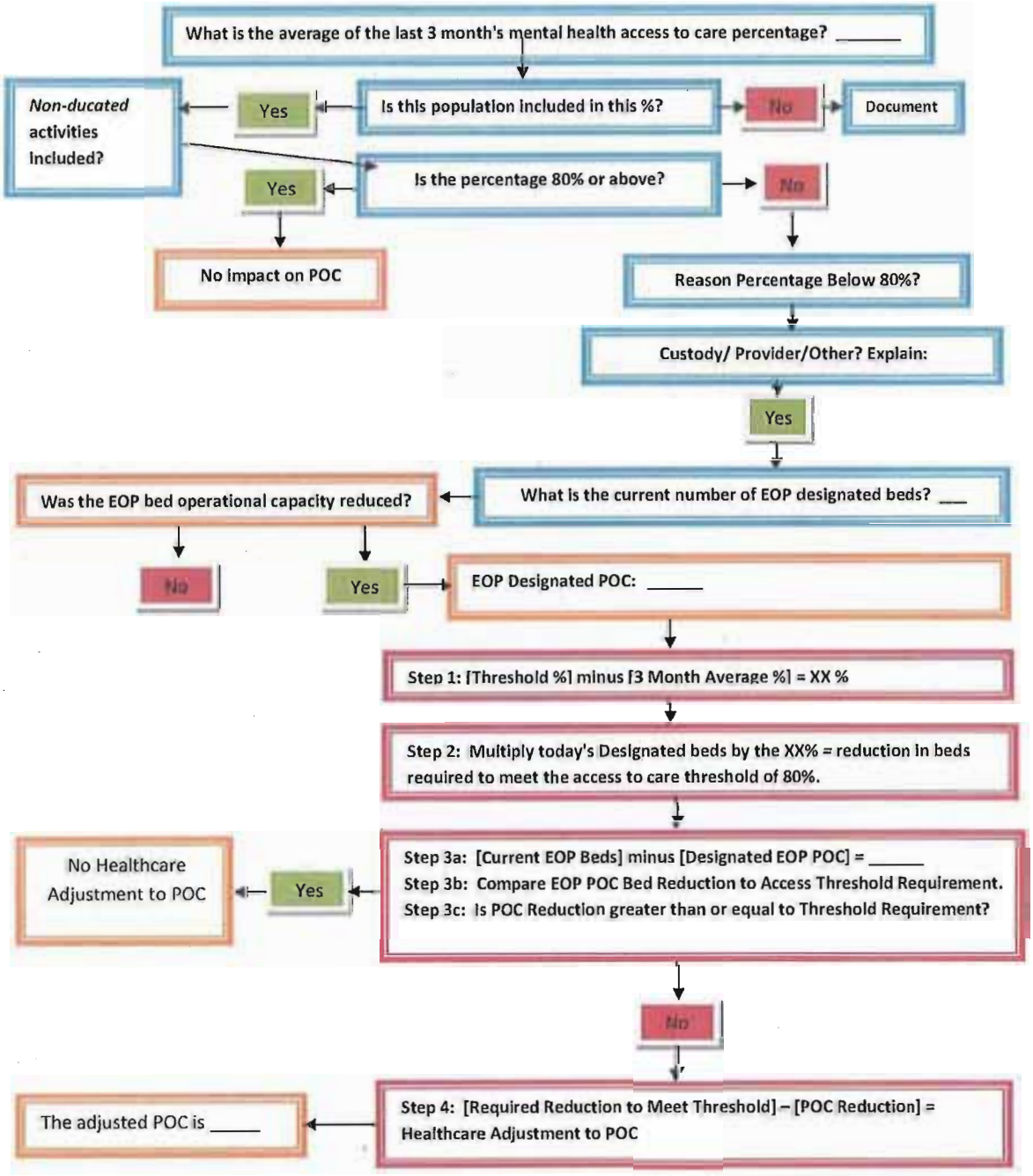
APPENDIX #8

Appendix #8

Appendix 8: EOP Health Care Adjustment to POC Methodology

Institution: Date:

Designated EOP Population:



Three month average from access to care statistics published in Receiver's Monthly Reports March-May, 2011.
OC and POC statistics from CDCR Prison Calculations.

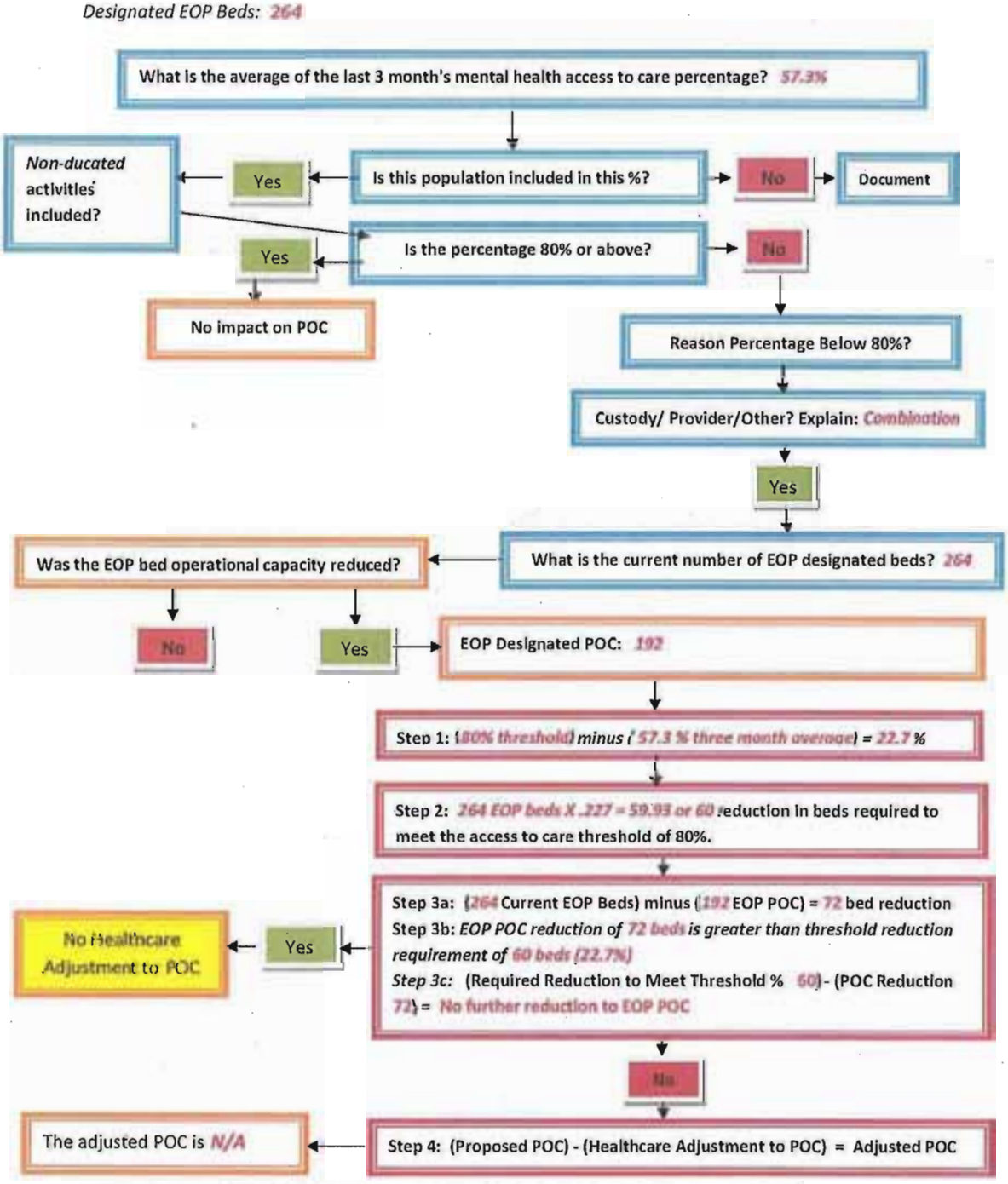
APPENDIX #9

Appendix #9

Appendix 9: EOP Health Care Adjustment to POC

Institution: SVSP Date: Spring 2011

Designated EOP Beds: 264



Three month average from access to care statistics published in Receiver's Monthly Reports March-May, 2011.
OC and POC statistics from CDCR Prison Calculations.

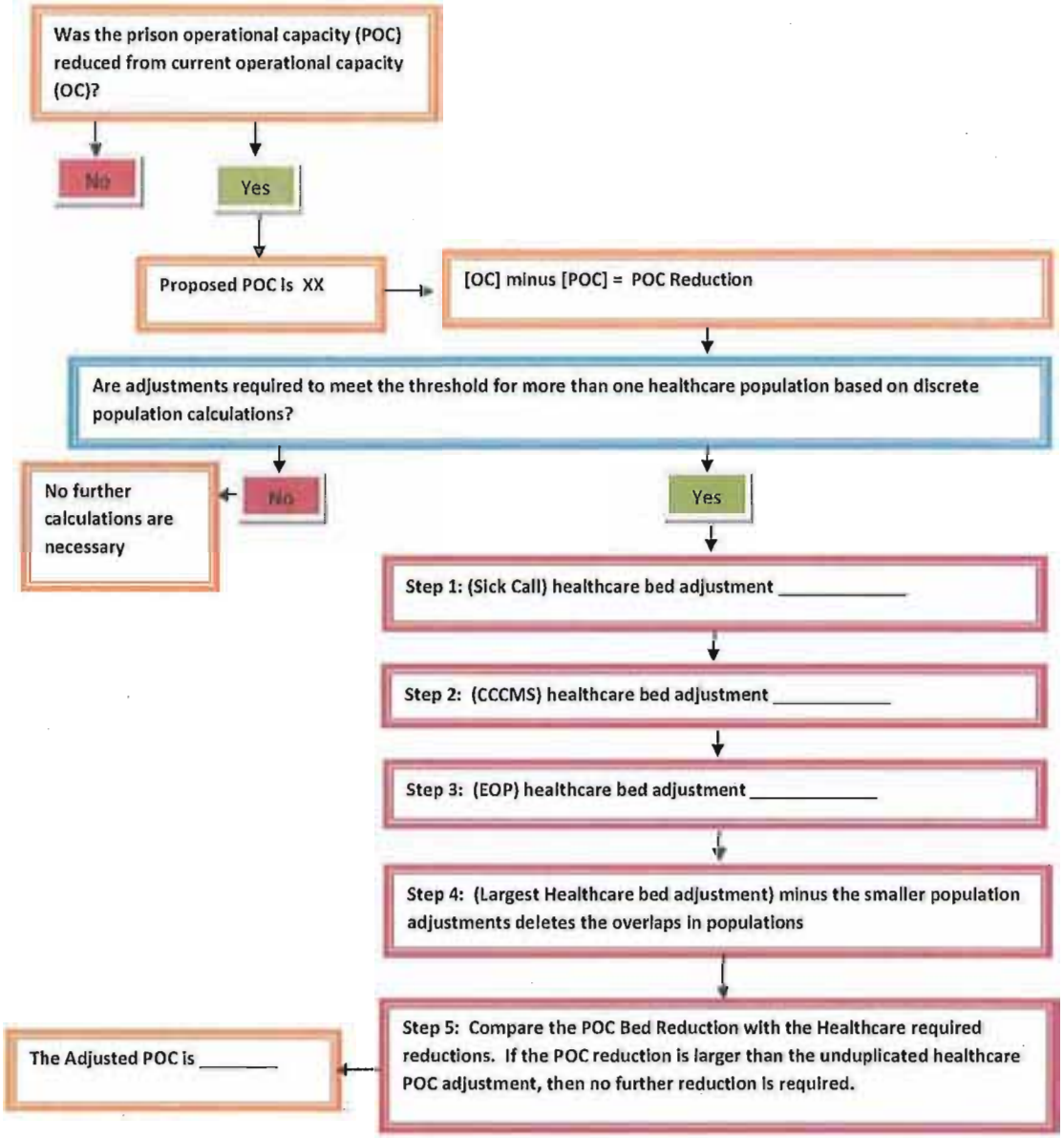
APPENDIX #10

Appendix #10

Appendix 10: Medical and Mental Health Population Overlap Adjustment to POC Methodology

Institution: Date:

Targeted Population: Overlapping Populations *Prison's Current Operational Capacity* _____



Based on Sick Call, EOP and CCCMS populations previously calculated (Appendices 4-10) demonstrate that a POC adjustment is required for more than one healthcare population there is an assumption that populations overlap. The largest adjustment will be used with specific population(s) adjustments subsumed within that larger adjustment to avoid duplicating reductions.
OC and POC statistics from CDCR Prison Calculations.

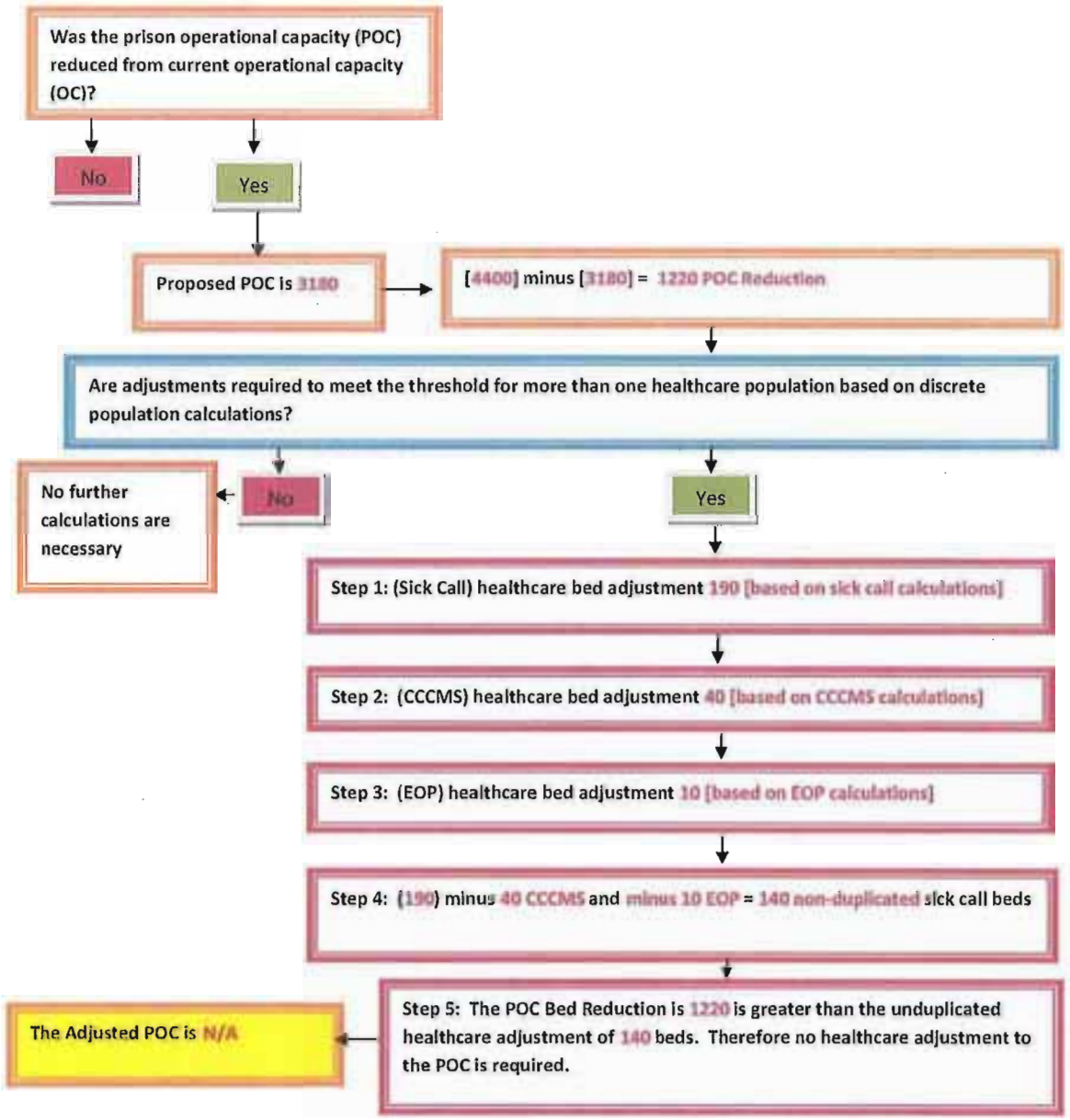
APPENDIX #11

Appendix 11

Appendix 11: Medical and Mental Health Population Overlap Adjustment to POC Methodology

Institution: Date:

Targeted Population: Overlapping Populations *Prison's Current Operational Capacity_____*



If Sick Call, EOP and CCCMS populations previously calculated (Appendices 4-10) demonstrate that a POC adjustment is required for more than one healthcare population there is an assumption that populations overlap. The largest adjustment will be used with specific population(s) adjustments subsumed within that larger adjustment to avoid duplicating reductions. Despite adjusting for overlap, the bed reduction strategy will still need to meet the threshold requirement of the CCCMS and EOP populations pursuant to those calculations.
OC and POC statistics from CDCR Prison Calculations.

APPENDIX #12

Appendix #12

There are three questionnaires attached to this e-mail titled 'out-of-cell tool worksheet'. There is a questionnaire for a first, second and third watch officer to complete. The questionnaires need to be printed out and delivered to each of the prison's housing units for completion. Since this is a snapshot in time, the three questionnaires need to be completed on the same date for all housing units. The day selected shall be a week day – not Saturday or Sunday. Have the staff member complete the questionnaire reflecting the inmate movement on the date of review. The supporting documents listed below need to reflect the same date as when the questionnaire is filled out.

- Master count sheet – snapshot of prison population
- Daily Movement Sheet – inmate program movement/work release
- Daily Activity Report – overview of prison activity (counts, meals, yard, etc.)
- Master ducat list – depicts inmate participation in various medical/non medical programs
- EOP program schedule
- Weekly/monthly education schedule, religious and self help program schedules, dayroom or yard schedules for the week of the site visit
- Prisons 3% reduction plan – details inmate program modification due to staff redirection
- Unlock Report (Inmate assignment roster) sorted by housing unit – verify work schedules, work hours and number of participants per housing unit

Please place the completed questionnaires and supporting documents in binders grouped in the following manner:

- Questionnaires - first, second and third watch together for each housing unit, separated by facility and housing unit in alphabetical/numerical order
- Supporting documents in a separate binder or binders in the order listed above

In addition to completing the three questionnaires, please have the institution's DPP coordinator or other appropriate resource fill out the DPW and Modifications template (attachment titled DPW and Modifications Template). The purpose of this form is to identify and confirm all DPW beds in the prison (by specific location) and to identify any non standard modifications for the DPW beds (ex. two standard cells converted to one DPW cell, bunks removed, other). The other half of this template should be used to identify any unique physical plant modifications for non-DPW cells/dorms (ex. cells modified as observation/suicide watch cells, cells conversions to other uses). Please have this template completed and available to the mission-based team that will be touring the prison. The team will be validating the data during their field review of the housing units.

APPENDIX #13

Appendix #13

Out of Cell Time Worksheet

The intent of this Out of Cell Time Worksheet is to capture an accurate assessment of inmate out-of-cell time, or the time inmates are not restricted to their bunk areas for dormitory housing units. This information is important to CDCR in determining the actual (housing/program) capacity of this prison. It is requested that the staff member who is most familiar with the housing unit program complete this worksheet. Please print your name legibly on the bottom of the worksheet. A follow up interview could be necessary to verify the information you have provided.

Date of review: _____ / _____ / _____

Prison: _____ **Facility:** _____ **Housing Unit:** _____ (Name/Number)

Questions for Second Watch:

Early morning culinary workers

1. Release for this housing unit is at what time? _____
2. How many days of the week does this activity occur? _____
3. How many inmates are released? _____
4. What time do the inmates return? _____
5. The duration of time out the cell/dorm is? _____
6. When the inmates return to the housing unit are they required to return to their cells/bed areas when they enter the housing unit? (Yes / No) Are they allowed to shower or access the yard/dayroom (Yes / No)? Length of time? _____

Breakfast release

1. Do you cell feed the inmates? (Yes / No) If no, complete the following questions:
2. Breakfast release for this housing unit is at what time? _____
3. How many days of the week does this activity occur? _____
4. How many inmates are released for the breakfast meal? _____
5. What time do the inmates return from breakfast? _____
6. The duration of time out of the cell/dorm for the breakfast meal is? _____

7. When the inmates return to the housing unit are they required to return to their cells/bed areas when they enter the housing unit? (Yes / No) Are they allowed to shower or access the yard/dayroom (Yes / No)? Length of time? _____

PIA Release

1. Release for this housing unit is at what time? _____
2. How many days of the week does this activity occur? _____
3. How many inmates are released? _____
4. What time do the inmates return? _____
5. The duration of time out of the cell/dorm is? _____
6. When the inmates return to the housing unit are they required to return to their cells/bed areas when they enter the housing unit? (Yes / No) Are they allowed to shower or access the yard/dayroom (Yes / No)? Length of time? _____

Academics

1. Release for this housing unit is at what time? _____
2. How many days of the week does this activity occur? _____
3. How many inmates are released? _____
4. What time do the inmates return? _____
5. The duration of time out of the cell/dorm is? _____
6. When the inmates return to the housing unit are they required to return to their cells/bed areas when they enter the housing unit? (Yes / No) Are they allowed to shower or access the yard/dayroom (Yes / No)? Length of time? _____

Work

1. Release for this housing unit is at what time? _____
2. How many days of the week does this activity occur? _____
3. How many inmates are released? _____
4. What time do the inmates return? _____
5. The duration of time out of the cell/dorm is? _____

6. When the inmates return to the housing unit are they required to return to their cells/bed areas when they enter the housing unit? (Yes / No) Are they allowed to shower or access the yard/dayroom (Yes / No)? Length of time? _____

Work

1. Release for this housing unit is at what time? _____
2. How many days of the week does this activity occur? _____
3. How many inmates are released? _____
4. What time do the inmates return? _____
5. The duration of time out of the cell/dorm is? _____
6. When the inmates return to the housing unit are they required to return to their cells/bed areas when they enter the housing unit? (Yes / No) Are they allowed to shower or access the yard/dayroom (Yes / No)? Length of time? _____

Porters

1. Release for this housing unit is at what time? _____
2. How many days of the week does this activity occur? _____
3. How many inmates are released? _____
4. What time do the inmates return? _____
5. The duration of time out of the cell/dorm is? _____
6. When the inmates return to the housing unit are they required to return to their cells/bed areas when they enter the housing unit? (Yes / No) Are they allowed to shower or access the yard/dayroom (Yes / No)? Length of time? _____

Dayroom

1. Release for this housing unit is at what time? _____
2. How many days of the week does this activity occur? _____
3. How many inmates are released? _____
4. What time do the inmates return? _____
5. The duration of time out of the cell/dorm is? _____

Dayroom

1. Release for this housing unit is at what time? _____
2. How many days of the week does this activity occur? _____

3. How many inmates are released? _____
4. What time do the inmates return? _____
5. The duration of time out of the cell/dorm is? _____

Yard

1. Release for this housing unit is at what time? _____
2. How many days of the week does this activity occur? _____
3. How many inmates are released? _____
4. What time do the inmates return? _____
5. The duration of time out of the cell/dorm is? _____
6. When the inmates return to the housing unit are they required to return to their cells/bed areas when they enter the housing unit? (Yes / No) Are they allowed to shower? (Yes / No) Length of time? _____

Yard

1. Release for this housing unit is at what time? _____
2. How many days of the week does this activity occur? _____
3. How many inmates are released? _____
4. What time do the inmates return? _____
5. The duration of time out of the cell/dorm is? _____
6. When the inmates return to the housing unit are they required to return to their cells/bed areas when they enter the housing unit? (Yes / No) Are they allowed to shower? (Yes / No) Length of time? _____

Religious Services

1. Release for this housing unit is at what time? _____
2. How many days of the week does this activity occur? _____
3. How many inmates are released? _____
4. What time do the inmates return? _____
5. The duration of time out of the cell/dorm is? _____
6. When the inmates return to the housing unit are they required to return to their cells/bed areas when they enter the housing unit? (Yes / No) Are they allowed to shower or access the yard/dayroom (Yes / No)? Length of time? _____

Canteen

1. Release for this housing unit is at what time? _____
2. How many days of the week does this activity occur? _____

3. How many inmates are released? _____
4. What time do the inmates return? _____
5. The duration of time out of the cell/dorm is? _____
6. When the inmates return to the housing unit are they required to return to their cells/bed areas when they enter the housing unit? (Yes / No) Are they allowed to shower or access the yard/dayroom (Yes / No)? Length of time? _____

Visiting Program

1. Release for this housing unit is at what time? _____
2. How many days of the week does this activity occur? _____
3. How many inmates are released? _____
4. What time do the inmates return? _____
5. The duration of time out of the cell/dorm is? _____
6. When the inmates return to the housing unit are they required to return to their cells/bed areas when they enter the housing unit? (Yes / No) Are they allowed to shower or access the yard/dayroom (Yes / No)? Length of time? _____

Diabetic / Medication Line

1. Release for this housing unit is at what time? _____
2. How many days of the week does this activity occur? _____
3. How many inmates are released? _____
4. What time do the inmates return? _____
5. The duration of time out of the cell/dorm is? _____
6. When the inmates return to the housing unit are they required to return to their cells/bed areas when they enter the housing unit? (Yes / No) Are they allowed to shower or access the yard/dayroom (Yes / No)? Length of time? _____

Diabetic / Medication Line

1. Release for this housing unit is at what time? _____
2. How many days of the week does this activity occur? _____
3. How many inmates are released? _____
4. What time do the inmates return? _____
5. The duration of time out of the cell/dorm is? _____

6. When the inmates return to the housing unit are they required to return to their cells/bed areas when they enter the housing unit? (Yes / No) Are they allowed to shower or access the yard/dayroom (Yes / No)? Length of time? _____

Diabetic / Medication Line

1. Release for this housing unit is at what time? _____
2. How many days of the week does this activity occur? _____
3. How many inmates are released? _____
4. What time do the inmates return? _____
5. The duration of time out of the cell/dorm is? _____
6. When the inmates return to the housing unit are they required to return to their cells/bed areas when they enter the housing unit? (Yes / No) Are they allowed to shower or access the yard/dayroom (Yes / No)? Length of time? _____

Medical / Mental Health Treatment

1. Release for this housing unit is at what time? _____
2. How many days of the week does this activity occur? _____
3. How many inmates are released? _____
4. What time do the inmates return? _____
5. The duration of time out of the cell/dorm is? _____
6. When the inmates return to the housing unit are they required to return to their cells/bed areas when they enter the housing unit? (Yes / No) Are they allowed to shower or access the yard/dayroom (Yes / No)? Length of time? _____

Medical / Mental Health Treatment

1. Release for this housing unit is at what time? _____
2. How many days of the week does this activity occur? _____
3. How many inmates are released? _____
4. What time do the inmates return? _____
5. The duration of time out of the cell/dorm is? _____

6. When the inmates return to the housing unit are they required to return to their cells/bed areas when they enter the housing unit? (Yes / No) Are they allowed to shower or access the yard/dayroom (Yes / No)? Length of time? _____

Medical / Mental Health Treatment

1. Release for this housing unit is at what time? _____
2. How many days of the week does this activity occur? _____
3. How many inmates are released? _____
4. What time do the inmates return? _____
5. The duration of time out of the cell/dorm is? _____
6. When the inmates return to the housing unit are they required to return to their cells/bed areas when they enter the housing unit? (Yes / No) Are they allowed to shower or access the yard/dayroom (Yes / No)? Length of time? _____

Housing Unit Information:

Number of cells: _____ ***Number of dorms:*** _____ ***Total bed count:*** _____

Inmate Information:

Please answer the below questions regarding the inmate population in the housing unit:

Total inmate count for the building/housing unit: _____. Of the total count, how many are:

A1/A (assigned to a job) _____ A1/A (unassigned) _____ A2/B _____ Close A _____ C Status _____

CCCMS _____ GP _____ R/C GP _____ R/C SNY (SPU) _____

Name of person completing form: _____

APPENDIX #14

Appendix #14

Criteria for Quality Control Review

OOC Time Calculation Worksheets (typed forms)

- Full-Time Assigned Program/Work Schedule
  - Are morning/evening chow times clearly identified?
  - PIA-Vocation-Support Services-Treatment hours accurately documented?
  - Dayroom/Yard opportunities accurately documented?
  - Is the 3% redirection (cost savings) factored in to the OOC times?
  - Did the notes clarify any discrepancies?
  - Are the notes clear and understandable?
  - Did the hours total up correctly?
- Part-Time Assigned/Academic Education/Leisure Schedule
  - Are morning/evening chow times clearly identified?
  - Morning/afternoon dayroom/yard/academic OOC accurately documented?
  - Are the education/academic days/hours accurately documented?
  - Is the 3% redirection (cost savings) factored in to the OOC times?
  - Did the notes clarify any release/recall time discrepancies?
  - Are the notes clear and understandable?
  - Did the hours total up correctly?
- Unit Population Data section
  - Is the prison classification level correct?
  - Does the total number of inmates listed match the Master Count Sheet?
  - Do the numbers in the Total Number column match the total number of inmates for the housing unit?
  - Are the OOC times accurate for each column (Ort/Close A/A2B/C)?
  - Are the full time assigned inmates clearly identified?
  - Are the part time / unassigned inmates clearly identified?
  - Are the notes clear and understandable?
- Notes / Assumption section
  - Do the notes clarify any discrepancies listed in the above categories?
  - Are the lockdown/modified program changes noted?
  - Is the 3% redirection (cost savings) explained in this area?
  - Does the number of inmates recorded on the OOC Time Calculation Worksheet, for each category, reconcile with the inmate assignment roster?
    - Orientation
    - Close A
    - A2B
    - C Status
    - Full Time Assigned (Daytime Workers)
    - Full Time Assigned (Early/Late Workers)
    - Part Time – Unassigned Inmates

APPENDIX #15

Appendix #15
(33 pages)

Avenal State Prison
Capacity Calculations

ACA	POC	PPOC	Custody Level & Program	Comments
100	100	100	Administrative Segregation Unit	Not subject to mitigation
4,132	5,659	5,659	Level II General Population	Achieved mitigation threshold
15	10	10	Firehouse Dorm	Capacity Established by CDCR Program

4,247	5,769	5,769	BED Totals
		28	Short-Term Health Care Beds
		5,797	Total Potential Capacity

STANDARD DEFINITIONS AND NOTES
DEFINITIONS
ACA Beds: Bed Capacity calculations based on American Correctional Association (ACA) square footage standards for all types of inmate housing units.
POC Beds: Current Prison Operational Capacity (POC) calculations based on the Prison's ability to achieve mitigation thresholds [5% Management Flexibility Factor for celled housing units].
PPOC Beds: Potential Prison Operational Capacity (PPOC) calculations assume achieving all mitigation thresholds [5% Management Flexibility Factor for celled housing units].
Short-Term Health Care Beds: Health Care beds programmed for treatment typically requiring inmate stay of 30 days or less.
Total Potential Capacity: The PPOC plus all Short-Term Health Care Beds

NOTES
POC and PPOC capacities for: Firehouse, Dorms, and CDF Fire Camps are established by CDCR and CDF per program requirements.
ASU overflow beds are calculated as General Population beds in the PPOC Calculation.
EOP celled housing units are capped at a double celling rate of 150% of Design per CDCR policy.
ASU/SHU cells with 50 sq ft or more of unencumbered space available in each cell are capped at a double celling rate of 150% per CDCR policy.
Small cells with less than 55 sq ft gross, will be considered single cells for all Capacity Calculations

AVENAL STATE PRISON NOTES:
A 18 Bed Infirmary is available for Short-Term Health Care needs.
Non-Traditional Housing Unit beds are not counted in capacity calculations.

Calipatria State Prison Capacity Calculations				
ACA	**POC**	**PPOC**	**Custody Level & Program**	**Comments**
200	200	200	Administrative Segregation	Not subject to mitigation
1,900	1,900	3,610	Level IV General Population	Did not achieve mitigation threshold
292	396	396	Minimum Support Facility	Achieved mitigation threshold
8	10	10	Firehouse Dorm	Capacity established by CDCR program needs
2,400	2,506	4,216	BED Totals	
		18	Short-Term Health Care Beds	
		4,234	Total Potential Capacity	

STANDARD DEFINITIONS AND NOTES
DEFINITIONS
ACA Beds: Bed Capacity calculations based on American Correctional Association (ACA) square footage standards for all types of inmate housing units.
POC Beds: Current Prison Operational Capacity (POC) calculations based on the Prison's ability to achieve mitigation thresholds [5% Management Flexibility Factor for celled housing units].
PPOC Beds: Potential Prison Operational Capacity (PPOC) calculations assume achieving all mitigation thresholds [5% Management Flexibility Factor for celled housing units].
Short-Term Health Care Beds: Health Care beds programmed for treatment typically requiring inmate stay of 30 days or less.
Total Potential Capacity: The PPOC plus all Short-Term Health Care Beds

NOTES
POC and PPOC capacities for: Firehouse, Dorms, and CDF Fire Camps are established by CDCR and CDF per program requirements.
ASU overflow beds are calculated as General Population beds in the PPOC Calculation.
EOP celled housing units are capped at a double celling rate of 150% of Design per CDCR policy.
ASU/SHU cells with 50 sq ft or more of unencumbered space available in each cell are capped at a double celling rate of 150% per CDCR policy.
Small cells with less than 55 sq ft gross, will be considered single cells for all Capacity Calculations

CALIPATRIA STATE PRISON NOTES:
An 18-bed infirmary is available for short-term health care needs.

California Correctional Center
Capacity Calculations

ACA	POC	PPOC	Custody Level & Program	Comments
100	100	100	Adminstrative Segregation	Not subject to mitigation
400	400	760	Level III General Population	Did not achieve mitigation threshold
1,140	1,520	1,520	Level II General Population	Achieved mitigation threshold
220	290	290	Minimum Support Facility	Achieved mitigation threshold
10	20	20	Firehouse Dorm	Capacity established by CDCR program needs

1,870	2,330	2,690	BED Totals
		19	Short-Term Health Care Beds
		2,709	Total Potential Capacity

STANDARD DEFINITIONS AND NOTES
DEFINITIONS
ACA Beds: Bed Capacity calculations based on American Correctional Association (ACA) square footage standards for all types of inmate housing units.
POC Beds: Current Prison Operational Capacity (POC) calculations based on the Prison's ability to achieve mitigation thresholds [5% Management Flexibility Factor for celled housing units].
PPOC Beds: Potential Prison Operational Capacity (PPOC) calculations assume achieving all mitigation thresholds [5% Management Flexibility Factor for celled housing units].
Short-Term Health Care Beds: Health Care beds programmed for treatment typically requiring inmate stay of 30 days or less.
Total Potential Capacity: The PPOC plus all Short-Term Health Care Beds

NOTES
POC and PPOC capacities for: Firehouse, Dorms, and CDF Fire Camps are established by CDCR and CDF per program requirements.
ASU overflow beds are calculated as General Population beds in the PPOC Calculation.
EOP celled housing units are capped at a double celling rate of 150% of Design per CDCR policy.
ASU/SHU cells with 50 sq ft or more of unencumbered space available in each cell are capped at a double celling rate of 150% per CDCR policy.
Small cells with less than 55 sq ft gross, will be considered single cells for all Capacity Calculations

CALIFORNIA CORRECTIONAL CENTER NOTES:
A 19 Bed OHU is available for Short-Term Health Care needs.
Non-traditional housing unit beds are not included in capacity calculations.

California Correctional Institution
Capacity Calculations

ACA	POC	PPOC	Custody Level & Program	Comments
185	185	185	Administrative Segregation Unit	Not subject to mitigation
810	810	810	Security Housing Unit	Not subject to mitigation
500	500	950	Reception Center Processing	Did not achieve mitigation threshold
720	972	972	Level II General Population	Achieved mitigation threshold
605	849	849	Level I General Population	Achieved mitigation threshold
18	10	10	Firehouse Dorm	Capaityestablished by CDCR program needs

2,838	3,326	3,776	BED Totals
		21	Short-Term Health Care Beds
		3,797	Total Potential Capacity

STANDARD DEFINITIONS AND NOTES
DEFINITIONS
ACA Beds: Bed Capacity calculations based on American Correctional Association (ACA) square footage standards for all types of inmate housing units.
POC Beds: Current Prison Operational Capacity (POC) calculations based on the Prison's ability to achieve mitigation thresholds [5% Management Flexibility Factor for celled housing units].
PPOC Beds: Potential Prison Operational Capacity (PPOC) calculations assume achieving all mitigation thresholds [5% Management Flexibility Factor for celled housing units].
Short-Term Health Care Beds: Health Care beds programmed for treatment typically requiring inmate stay of 30 days or less.
Total Potential Capacity: The PPOC plus all Short-Term Health Care Beds

NOTES
POC and PPOC capacities for: Firehouse, Dorms, and CDF Fire Camps are established by CDCR and CDF per program requirements.
ASU overflow beds are calculated as General Population beds in the PPOC Calculation.
EOP celled housing units are capped at a double celling rate of 150% of Design per CDCR policy.
ASU/SHU cells with 50 sq ft or more of unencumbered space available in each cell are capped at a double celling rate of 150% per CDCR policy.
Small cells with less than 55 sq ft gross, will be considered single cells for all Capacity Calculations

CALIFORNIA CORRECTIONAL INSTITUTION NOTES:
A 16 Bed Infirmary provides 16 OHU-swing beds for Short-Term Health Care needs.
Facility IV-A, housing unit H-48, Ad Seg, Section B, Cells 101, 102, 103, 104 & 105 have all furnishings removed for use as short term mental health crisis rooms.
Non-traditional housing unit beds are not included in capacity calculations.

Central California Women's Facility
Capacity Calculations

ACA	POC	PPOC	Custody Level & Program	Comments
45	45	45	Administrative Segregation Unit/Condemned	Not subject to mitigation
356	356	510	Reception Center Processing	Did not achieve mitigation threshold
49	49	73	Medium Security Enhanced Outpatient Program	Did not achieve mitigation threshold
1,536	1,536	1,920	Medium Security General Population	Did not achieve mitigation threshold
13	10	10	Firehouse Dorm	Capacity established by CDCR program needs

1,999	1,996	2,558	BED Totals
		45	Short-Term Health Care Beds
		2,603	Total Potential Capacity

STANDARD DEFINITIONS AND NOTES
DEFINITIONS
ACA Beds: Bed Capacity calculations based on American Correctional Association (ACA) square footage standards for all types of inmate housing units.
POC Beds: Current Prison Operational Capacity (POC) calculations based on the Prison's ability to achieve mitigation thresholds [5% Management Flexibility Factor for celled housing units].
PPOC Beds: Potential Prison Operational Capacity (PPOC) calculations assume achieving all mitigation thresholds [5% Management Flexibility Factor for celled housing units].
Short-Term Health Care Beds: Health Care beds programmed for treatment typically requiring inmate stay of 30 days or less.
Total Potential Capacity: The PPOC plus all Short-Term Health Care Beds

NOTES
POC and PPOC capacities for: Firehouse, Dorms, and CDF Fire Camps are established by CDCR and CDF per program requirements.
ASU overflow beds are calculated as General Population beds in the PPOC Calculation.
EOP celled housing units are capped at a double celling rate of 150% of Design per CDCR policy.
ASU/SHU cells with 50 sq ft or more of unencumbered space available in each cell are capped at a double celling rate of 150% per CDCR policy.
Small cells with less than 55 sq ft gross, will be considered single cells for all Capacity Calculations

CENTRAL CALIFORNIA WOMEN'S FACILITY NOTES:
A 39 Bed Skilled Nursing Facility is available for Short-Term Health Care needs.
Facility A, Building 504 EOP/ASU/Condemned has 6 cells with furnishings removed and are used as Mental Health Crisis Beds. These cells are not counted in the Capacity Calculations.

Centinela State Prison
Capacity Calculations

ACA	POC	PPOC	Custody Level & Program	Comments
200	200	200	Adminstrative Segregation	Not subject to mitigation
500	500	950	Level IV General Population	Did not achieve mitigation threshold
1,400	1,400	2,660	Level III General Population	Did not achieve mitigation threshold
254	342	342	Minimum Support Facility	Achieved mitigation threshold
7	10	10	Firehouse Dorms	Capacity established by CDCR Program needs
2,361	2,452	4,162	Bed Totals	
		18	Short-Term Health Care Beds	
		4,180	Total Potential Capacity	

STANDARD DEFINITIONS AND NOTES
DEFINITIONS
ACA Beds: Bed Capacity calculations based on American Correctional Association (ACA) square footage standards for all types of inmate housing units.
POC Beds: Current Prison Operational Capacity (POC) calculations based on the Prison's ability to achieve mitigation thresholds [5% Management Flexibility Factor for celled housing units].
PPOC Beds: Potential Prison Operational Capacity (PPOC) calculations assume achieving all mitigation thresholds [5% Management Flexibility Factor for celled housing units].
Short-Term Health Care Beds: Health Care beds programmed for treatment typically requiring inmate stay of 30 days or less.
Total Potential Capacity: The PPOC plus all Short-Term Health Care Beds

NOTES
POC and PPOC capacities for: Firehouse, Dorms, and CDF Fire Camps are established by CDCR and CDF per program requirements.
ASU overflow beds are calculated as General Population beds in the PPOC Calculation.
EOP celled housing units are capped at a double celling rate of 150% of Design per CDCR policy.
ASU/SHU cells with 50 sq ft or more of unencumbered space available in each cell are capped at a double celling rate of 150% per CDCR policy.
Small cells with less than 55 sq ft gross, will be considered single cells for all Capacity Calculations

CENTINELA STATE PRISON NOTES:
An 18 Bed Correctional Treatment Center is available for Short-Term Health Care needs.
Non-Traditional housing unit beds are not included in capacity calculations.

California Institution for Men
Capacity Calculations

ACA	POC	PPOC	Custody Level & Program	Comments
204	204	204	Administrative Segregation Unit	Not subject to mitigation
2,384	2,384	3,224	Reception Center Processing	Did not achieve mitigation threshold
630	849	849	Level II General Population	Achieved mitigation threshold
176	266	266	Level I General Population	Achieved mitigation threshold
5	10	10	Firehouse Dorm	Capacity established by CDCR program needs

3,399	3,713	4,553	BED Totals
		80	Short-Term Health Care Beds
		4,633	Total Potential Capacity

STANDARD DEFINITIONS AND NOTES
DEFINITIONS
ACA Beds: Bed Capacity calculations based on American Correctional Association (ACA) square footage standards for all types of inmate housing units.
POC Beds: Current Prison Operational Capacity (POC) calculations based on the Prison's ability to achieve mitigation thresholds [5% Management Flexibility Factor for celled housing units].
PPOC Beds: Potential Prison Operational Capacity (PPOC) calculations assume achieving all mitigation thresholds [5% Management Flexibility Factor for celled housing units].
Short-Term Health Care Beds: Health Care beds programmed for treatment typically requiring inmate stay of 30 days or less.
Total Potential Capacity: The PPOC plus all Short-Term Health Care Beds

NOTES
POC and PPOC capacities for: Firehouse, Dorms, and CDF Fire Camps are established by CDCR and CDF per program requirements.
ASU overflow beds are calculated as General Population beds in the PPOC Calculation.
EOP celled housing units are capped at a double celling rate of 150% of Design per CDCR policy.
ASU/SHU cells with 50 sq ft or more of unencumbered space available in each cell are capped at a double celling rate of 150% per CDCR policy.
Small cells with less than 55 sq ft gross, will be considered single cells for all Capacity Calculations

CALIFORNIA INSTITUTION FOR MEN NOTES:
• 80 beds are available at CIM for short-term health care needs as follows:
o 44 medical out patient beds
o 36 mental health crisis beds

• Non traditional housing unit beds are not included in these capacity calculations.

• The second floor of South Dorm, CIM - minimum, is condemned, thus, will not be included in these capacity calculations.

• Pine Hall, CIM - minimum, was deactivated at the time of the DAI team review but will be included in these capacity calculations.

• Mariposa Dorm, CIM – West, was used as a recreation/education space at the time of the DAI team review, therefore, it will not be included in these capacity calculations as an inmate housing unit.

• Willow Hall, CIM – minimum, was used for RC processing/ad. seg. inmates. Willow Hall will be included as RC processing dorm in these capacity calculations.

• Birch Hall and Madrone Hall, CIM – RC Central, have cells with 47.8 gross square feet each, thus, can house a maximum of one inmate per cell.

• Birch Hall, CIM – RC Central, house RC processing/Level III general population inmates at the time of review. Birch Hall will be included as RC processing in these capacity calculations.

California Institution for Women
Capacity Calculations

ACA	POC	PPOC	Custody Level & Program	Comments
100	100	100	Ad Seg/R.C. Overflow	Not subject to mitigation
110	110	209	R.C. Processing	Did not achieve mitigation threshold
47	70	70	Medium security EOP (SCU)	Achieved mitigation threshold
20	20	20	Psychiatric Services Unit	Capacity established by CDCR, single celled unit
720	1,368	1,368	Medium security G.P.	Achieved mitigation threshold

997	1,668	1,767	BED Totals
		25	Short-Term Health Care Beds
		1,792	Total Potential Capacity

STANDARD DEFINITIONS AND NOTES
DEFINITIONS
ACA Beds: Bed Capacity calculations based on American Correctional Association (ACA) square footage standards for all types of inmate housing units.
POC Beds: Current Prison Operational Capacity (POC) calculations based on the Prison's ability to achieve mitigation thresholds [5% Management Flexibility Factor for celled housing units].
PPOC Beds: Potential Prison Operational Capacity (PPOC) calculations assume achieving all mitigation thresholds [5% Management Flexibility Factor for celled housing units].
Short-Term Health Care Beds: Health Care beds programmed for treatment typically requiring inmate stay of 30 days or less.
Total Potential Capacity: The PPOC plus all Short-Term Health Care Beds

NOTES
POC and PPOC capacities for: Firehouse, Dorms, and CDF Fire Camps are established by CDCR and CDF per program requirements.
ASU overflow beds are calculated as General Population beds in the PPOC Calculation.
EOP celled housing units are capped at a double celling rate of 150% of Design per CDCR policy.
ASU/SHU cells with 50 sq ft or more of unencumbered space available in each cell are capped at a double celling rate of 150% per CDCR policy.
Small cells with less than 55 sq ft gross, will be considered single cells for all Capacity Calculations

CALIFORNIA INSTITUTION FOR WOMEN NOTES:
CIW has 25 beds available for short-term health care needs as follows: 7 OHU-swing beds, 8 correctional treatment center beds, and 10 mental health crisis beds.
Non-traditional housing unit beds are not included in capacity calculations.

California Men's Colony
Capacity Calculations

ACA	POC	PPOC	Custody Level & Program	Comments
314	309	309	Administrative Segregation Unit	Not subject to mitigation
570	570	570	Level III Enhanced Outpatient Program	Small cells.
1,500	1,500	1,500	Level III General Population	Small cells.
1,595	2176	2,176	Level II General Population	Achieved mitigation threshold
212	288	288	Level I Minimum Support Facility	Achieved mitigation threshold
64	40	40	CDF Firecamp Dorm	Capacity established by CDF/CDCR Program needs.
13	12	12	Firehouse Dorm	Capacity established by CDCR Program needs.

4,268	4,895	4,895	BED Totals
		57	Short-Term Health Care Beds
		4,952	Total Potential Capacity

STANDARD DEFINITIONS AND NOTES
DEFINITIONS
ACA Beds: Bed Capacity calculations based on American Correctional Association (ACA) square footage standards for all types of inmate housing units.
POC Beds: Current Prison Operational Capacity (POC) calculations based on the Prison's ability to achieve mitigation thresholds [5% Management Flexibility Factor for celled housing units].
PPOC Beds: Potential Prison Operational Capacity (PPOC) calculations assume achieving all mitigation thresholds [5% Management Flexibility Factor for celled housing units].
Short-Term Health Care Beds: Health Care beds programmed for treatment typically requiring inmate stay of 30 days or less.
Total Potential Capacity: The PPOC plus all Short-Term Health Care Beds

NOTES
POC and PPOC capacities for: Firehouse, Dorms, and CDF Fire Camps are established by CDCR and CDF per program requirements.
ASU overflow beds are calculated as General Population beds in the PPOC Calculation.
EOP celled housing units are capped at a double celling rate of 150% of Design per CDCR policy.
ASU/SHU cells with 50 sq ft or more of unencumbered space available in each cell are capped at a double celling rate of 150% per CDCR policy.
Small cells with less than 55 sq ft gross, will be considered single cells for all Capacity Calculations

CALIFORNIA MEN'S COLONY NOTES:
37 Bed General Acute Care Hospital is available for Short-Term Health Care needs.
42 Beds in Bldg D-7 are assigned as Mental Health Crisis Beds. 20 have all furnishings removed and therefore counted as Short-Term Health Care beds.
Cells 101 through 112 in ASU Central and all Cells in Bldgs 1-8 have 38.59 gross square feet each, thus, can only house one inmate per cell.
CMC West Dorms 28 and 34 were Deactivated during the DAI review, but are included in the Capacity Calculations.

California Medical Facility Capacity Calculations				
ACA	**POC**	**PPOC**	**Custody Level & Program**	**Comments**
330	330	330	Administrative Segregation	Not subject to mitigation
332	332	332	DMH Licensed APP, ITP, ICF	Capacity established by licensure standards
162	162	162	Medical Out Patient Units	Capacity established by CDCR policy
283	302	422	Level IV EOP	Only N-3 achieved mitigation threshold
904	919	1,161	Level III G.P./Medical/CCCMS	Only 4 dorms achieved mitigation threshold
185	250	250	Level II G.P.	Achieved mitigation threshold
190	260	260	Minimum Support Facility	Achieved mitigation threshold
14	16	16	Firehouse Dorm	Capacity established by CDCR program needs
2,400	2,571	2,933	BED Totals	
		121	Short-Term Health Care Beds	
		3,054	Total Potential Capacity	

STANDARD DEFINITIONS AND NOTES
DEFINITIONS
ACA Beds: Bed Capacity calculations based on American Correctional Association (ACA) square footage standards for all types of inmate housing units.
POC Beds: Current Prison Operational Capacity (POC) calculations based on the Prison's ability to achieve mitigation thresholds [5% Management Flexibility Factor for celled housing units].
PPOC Beds: Potential Prison Operational Capacity (PPOC) calculations assume achieving all mitigation thresholds [5% Management Flexibility Factor for celled housing units].
Short-Term Health Care Beds: Health Care beds programmed for treatment typically requiring inmate stay of 30 days or less.
Total Potential Capacity: The PPOC plus all Short-Term Health Care Beds

NOTES
POC and PPOC capacities for: Firehouse, Dorms, and CDF Fire Camps are established by CDCR and CDF per program requirements.
ASU overflow beds are calculated as General Population beds in the PPOC Calculation.
EOP celled housing units are capped at a double celling rate of 150% of Design per CDCR policy.
ASU/SHU cells with 50 sq ft or more of unencumbered space available in each cell are capped at a double celling rate of 150% per CDCR policy.
Small cells with less than 55 sq ft gross, will be considered single cells for all Capacity Calculations

CALIFORNIA MEDICAL FACILITY NOTES:
- 121 rooms at CMF are available for short-term health care needs as follows:
  - o Correctional Treatment Center 47
  - o General Acute Care Hospital 7
  - o Hospice Care 17
  - o Mental Health Crisis Care 50
  - Total 121

- DMH licensed APP, ICF, and ICF high security unit's capacities, at CMF, are established by licensure standards.

- Medical out patient housing unit's capacities, at CMF, are established by CDCR policy.

- Cells in T, U, and V wings have 37.55 gross square feet each, thus, only house a maximum of one inmate per cell.

- Typical cells in W wing have 42 gross square feet each, thus, only house a maximum of one inmate per cell.

California State Prison Corcoran Capacity Calculations				
ACA	**POC**	**PPOC**	**Custody Level & Program**	**Comments**
300	300	300	Adminstrative Segregation	Not subject to mitigation
2,048	1,536	1,536	Security Housing Units/PHU	50% Cells double bunked per CDCR policy
100	100	150	Level III & IV EOP	50% Cells double bunked per CDCR policy
300	300	570	Level IV General Population	Did not achieve mitigation threshold
400	400	760	Level III & IV General Population	Did not achieve mitigation threshold
500	500	950	Level III General Population	Did not achieve mitigation threshold
727	995	995	Minimum Supporty Facility	Achieved mitigation threshold
16	8	8	Firehouse Dorm	Capacity established by CDCR Program needs
4,391	4,139	5,269	BED Totals	
	75	75	Short-Term Health Care Beds	
	4,214	5,344	Total Potential Capacity	

STANDARD DEFINITIONS AND NOTES
DEFINITIONS
ACA Beds: Bed Capacity calculations based on American Correctional Association (ACA) square footage standards for all types of inmate housing units.
POC Beds: Current Prison Operational Capacity (POC) calculations based on the Prison's abiilty to achieve mitigation thresholds [5% Management Flexibility Factor for celled housing units].
PPOC Beds: Potential Prison Operational Capacity (PPOC) calculations assume achieving all mitigation thresholds [5% Management Flexibility Factor for celled housing units].
Short-Term Health Care Beds: Health Care beds programmed for treatment typically requiring inmate stay of 30 days or less.
Total Potential Capacity: The PPOC plus all Short-Term Health Care Beds

NOTES
POC and PPOC capacities for: Firehouse, Dorms, and CDF Fire Camps are established by CDCR and CDF per program requirements.
ASU overflow beds are calculated as General Population beds in the PPOC Calculation.
EOP celled housing units are capped at a double celling rate of 150% of Design per CDCR policy.
ASU/SHU cells with 50 sq ft or more of unencumbered space available in each cell are capped at a double celling rate of 150% per CDCR policy.
Small cells with less than 55 sq ft gross, will be considered single cells for all Capacity Calculations

CALIFORNIA STATE PRISON-CORCORAN
A 75-bed General Acute Care Hospital is available for short term health care needs.
Non traditional housing unit beds are not included in capacity calculation
MSF buildings H01 and H03 were deactivated during the DAI field review. These two dorms are included in these capacity calculations.

California Rehabilitation Center
Capacity Calculations

ACA	POC	PPOC	Custody Level & Program	Comments
28	28	38	Reception Center Processing	Deactivated
3,700	5,070	5,070	Level II General Population	Achieved mitigation threshold
66	126	126	CDF Fire Camp	Capacity established by CDCR/CDF Program needs
25	9	9	Firehouse Dorm	Capacity established by CDCR Program needs

3,819	5,233	5,243	BED Totals
		10	Short-Term Health Care Beds
		5,253	Total Potential Capacity

STANDARD DEFINITIONS AND NOTES
DEFINITIONS
ACA Beds: Bed Capacity calculations based on American Correctional Association (ACA) square footage standards for all types of inmate housing units.
POC Beds: Current Prison Operational Capacity (POC) calculations based on the Prison's ability to achieve mitigation thresholds [5% Management Flexibility Factor for celled housing units].
PPOC Beds: Potential Prison Operational Capacity (PPOC) calculations assume achieving all mitigation thresholds [5% Management Flexibility Factor for celled housing units].
Short-Term Health Care Beds: Health Care beds programmed for treatment typically requiring inmate stay of 30 days or less.
Total Potential Capacity: The PPOC plus all Short-Term Health Care Beds

NOTES
POC and PPOC capacities for: Firehouse, Dorms, and CDF Fire Camps are established by CDCR and CDF per program requirements.
ASU overflow beds are calculated as General Population beds in the PPOC Calculation.
EOP celled housing units are capped at a double celling rate of 150% of Design per CDCR policy.
ASU/SHU cells with 50 sq ft or more of unencumbered space available in each cell are capped at a double celling rate of 150% per CDCR policy.
Small cells with less than 55 sq ft gross, will be considered single cells for all Capacity Calculations

CALIFORNIA REHABILITATION CENTER NOTES:
A 10 Bed Infirmary is available for Short-Term Health Care needs.
The second florr of building 104 (Dorm 400) has been converted to health care space, thus is not included in these capacity calculations.
Dorms 105, 112, 114, 206,208 and 302 were deactivated at the time of the DAI review. These dorms are included in these capacity calculations.

Exhibit 9

SPECIAL REPORT

AUGUST 2009 RIOT AT THE CALIFORNIA INSTITUTION FOR MEN

OFFICE OF THE INSPECTOR GENERAL

DAVID R. SHAW
INSPECTOR GENERAL

STATE OF CALIFORNIA
APRIL 2010

David R. Shaw, Inspector General

Office of the Inspector General

April 22, 2010

Matthew L. Cate, Secretary
California Department of Corrections and Rehabilitation
1515 S Street, Room 502 South
Sacramento, California 95814

Dear Mr. Cate:

Enclosed is the Office of the Inspector General's special report concerning the August 2009 riot at the California Institution for Men in Chino (CIM). The purpose of the special report was to identify the conditions and circumstances leading up to the riot and to evaluate the institution's and the department's actions in addressing the riot and re-establishing normal operations in the riot's aftermath.

The report concludes that despite being warned of the inherent risks of housing reception center inmates in the open dormitories of CIM's Reception Center West, the department took no substantive action to alleviate the security risks in that facility's design. Additionally, although the report concludes that CIM heeded warnings from past reviews and audits by enhancing its emergency medical preparedness, there are still areas in which CIM and the department could have improved their performance.

If you have any questions concerning this report, please contact Jerry Twomey, Chief Assistant Inspector General, Bureau of Audits and Investigations, at (916) 830-3600.

Sincerely,

David R. Shaw
Inspector General

cc: Scott Kernan, Chief Deputy Secretary, Adult Operations, CDCR
George Giurbino, Director, Adult Institutions, CDCR
Michele Minor, Chief Deputy Secretary (A), Adult Programs, CDCR
Kim Holt, External Audits Manager, CDCR

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Executive Summary

At approximately 8:30 p.m. on Saturday, August 8, 2009, a riot involving more than 1,000 inmates occurred at the California Institution for Men's (CIM) Reception Center West facility (RC West). The rioting inmates caused damage so severe that seven of the eight housing units at the facility were rendered uninhabitable. During the four hours of fighting, the inmates fashioned weapons from a variety of materials on hand, including pieces of metal bed frames, shards of porcelain bathroom fixtures, glass from broken windows, broom handles, and broken wood. In the aftermath of the riot, nearly 200 inmates sustained injuries—including 54 that needed transportation to local hospitals for treatment.

Findings in Brief

The Office of the Inspector General finds that:

- The Department of Corrections and Rehabilitation failed to house a suitable inmate population at CIM's Reception Center West
- Despite the liabilities of the facility's design, CIM staff responded effectively to the August 2009 riot at Reception Center West

Despite the inherent dangers of housing reception center inmates in an open dormitory setting—as was the case with RC West—the California Department of Corrections and Rehabilitation (CDCR) took no substantive action that could have prevented a riot of this magnitude. RC West's recent history included a riot in December 2006 involving about 800 inmates that required correctional staff twelve hours to contain. At least three more riots at RC West have occurred since then, leading up to the August 2009 riot that severely damaged the facility.

In addition to the history of significant riots at RC West, CDCR also received information from outside agencies warning against housing reception center inmates in an open dormitory setting. In a November 2007 report filed after touring the one of RC West's dormitories, the former director of the Texas Department of Corrections, Wayne Scott, declared, "The housing unit was a serious disturbance waiting to happen. If the prisoners wanted to take over the dorm they could do so in a second and no one would know." In November 2008, the Office of the Inspector General (OIG) also warned that "placing inmates with histories of disruptive or assaultive behavior in an open setting where they can roam freely and where fights among inmates can quickly escalate and spread creates a more dangerous environment for inmates and staff members."

Prior to April 2008, CDCR even received documentation from its own experts advising that the RC West facility should be replaced, as well as "negative documentation" issued by the Office of the State Fire Marshall, advising CDCR that RC West didn't meet building codes and fire safety requirements.

However, CDCR did not alleviate the risky security conditions inherent in RC West's design. Those conditions contributed to the severity and duration of the August 2009 riot. CDCR later acknowledged that less volatile inmates would be a more suitable population for RC West, and stated that it plans to place level-II inmates there to prevent a recurrence after it repairs the housing units.

In the absence of detailed contingency plans to house large numbers of inmates in the event of a major incident, CIM used holding cells and outdoor exercise areas to secure displaced inmates until beds could be found for them in the days immediately following the riot. Within 72 hours after the incident began, CDCR relocated the majority of RC West's 1,154 displaced inmates to an empty housing unit at nearby Heman G. Stark Youth Correctional Facility (Stark), and the remainder to other institutions.

Although the OIG had concerns regarding inadequate living conditions during the immediate post-riot period, CIM provided evidence that the prison generally provided inmates with food, medications, clothing, blankets, and hygiene supplies and found housing for most inmates within days of the riot. However, in the post-riot environment, the nature and extent of services provided to inmates clearly were less than would be provided under normal circumstances.

CDCR is now in the process of repairing the damaged housing units at an estimated cost of $5.2 million. CDCR also plans to convert Stark to an adult prison at an estimated cost of $130 million. Included in that estimate are plans for a new electrified fence, gun towers, buildings to house reception center inmates, and medical facilities.

In contrast to CDCR's inaction in addressing the on-going security risks inherent in RC West's design, CIM heeded the recommendations from outside agencies to enhance its emergency preparedness, and those actions likely reduced the number of inmates needing hospitalization during the August 2009 riot.

Days before the riot, staff learned of a particular inmate group's intention to cause an institution-wide riot. As a result, the prison's investigative staff searched key inmates and discovered handwritten notes instructing inmates to participate in a large-scale riot throughout the institution. In response, the prison placed the institution on modified program status to restrict inmate movement and added more employees on RC West to prepare for the potential disturbance. Nonetheless, given the structural limitations at RC West, the staff at CIM was unable to prevent the large, coordinated riot.

Once the riot started, the prison promptly activated an emergency operations center (EOC), which coordinated the response at all levels throughout the prison during the incident and in its aftermath. Overall, the OIG found that the prison had reasonably planned and prepared for such an emergency and coordinated its efforts with those of other prisons and community emergency service agencies to restore security and provide emergency medical care. About 200 inmates received injuries ranging from minor to serious. The prison's medical staff conducted triage and provided immediate medical attention to inmates as needed. During this time, custody staff was forced to conduct fingerprint identification of hundreds of inmates who lost or abandoned their identification cards.

By effectively executing its emergency medical response plan, CIM efficiently evaluated and treated many inmates' injuries, which minimized the number of inmates requiring treatment at outside hospitals. In addition, community emergency service agencies responded quickly, providing essential services that supplemented the institution's efforts and greatly assisted

CIM in containing the riot and giving medical care. Concurrently, CIM's crisis response team assembled and acted to regain control of the facility.

Nevertheless, several problems surfaced that indicate deficiencies in the prison's and in CDCR's emergency response. First, there were an insufficient number of armed correctional officers to provide security for inmates transported outside the institution for medical care. Second, CDCR personnel were unable to communicate by radio directly with the outside agencies on the scene because CDCR lacks access to radio frequencies compatible with outside agencies' frequencies. Third, CIM's lethal electric fence impeded a local fire department's efforts to suppress fires. Fourth, because CDCR's reliance on hard-copy ID cards, CIM was challenged to quickly identify inmates immediately following the riot. Fifth, CIM and CDCR's lack of a contingency plan to house large numbers of inmates in the event of a major incident resulted in delays in quickly placing inmates in replacement housing.

Finally, conflicting orders from one of CIM's managers delayed the tactical operations of CIM's crisis response team, a group of officers specially trained and equipped to respond to high-risk situations. The manager's actions interfered with the team's approved plan of operations and undermined established procedures.

Recommendations

The Office of the Inspector General recommends that the California Department of Corrections and Rehabilitation:

- Proceed with its plans for changing RC West's mission so that it no longer houses reception center inmates, given its current open dormitory design. Even if the department changes the mission, the Office of the Inspector General questions the future use of RC West's dormitories to house the number of inmates (1,300) they held prior to the riot. Therefore, while we support the change in mission, if CDCR decides to house such numbers of inmates in these dormitories, we also recommend that it identify and complete all security and staffing modifications necessary to house those inmates safely.
- Ensure that emergency operation plans for CIM and all other prisons provide adequate housing, food, clothing, medical attention, and other essential services to large numbers of inmates who may be displaced by major events such as riots or natural disasters.
- Share critical lessons from the CIM riot that have universal application to the state's other prisons to help them improve their own emergency operations plans. Universally applicable lessons from the CIM riot include information on identifying inmates who no longer have ID cards, and information on identifying medical facilities with capacity to accept inmate patients.

The Office of the Inspector General further recommends that the California Institution for Men:

- Establish emergency operation procedures to assure that the institution can summon a sufficient number of trained and properly equipped peace officers to transport or escort injured inmates to outside medical care facilities.

- Provide for direct communication between its Emergency Operations Center and community emergency service agencies by obtaining compatible radios and radio frequencies or having representatives of key agencies present in the EOC.
- Obtain field-deployable equipment capable of rapidly identifying inmates who have become separated from their ID cards. Such equipment should be capable of using any combination of fingerprints, iris scans, or facial photos
- Establish in emergency protocols a means to access the data system that shows real-time availability and location of local hospital beds to enhance efficient transfer of injured inmates.
- Develop procedures and contingencies for fire suppression activities in the vicinity of a lethal electrified fence.
- During emergency response training, emphasize the importance of establishing a tactical command post near the emergency scene and of respecting the chain of command established by the Emergency Operations Plan.

CDCR's Response

In its response, the department agreed with the findings of this report and expressed its intent to change RC West's mission from housing reception center inmates to that of housing general population inmates classified at a low security ("level II"). Further, the department stated that all deficiencies identified will be evaluated and addressed in a corrective action plan to be monitored by its Office of Audits and Compliance.

Background

Overview of the California Institution for Men

The California Institution for Men (CIM), located in Chino, San Bernardino County, opened in 1941 and is the California Department of Corrections and Rehabilitation's (CDCR) third-oldest adult institution. CIM serves as a reception center for male parolees returning to custody and felons newly committed to CDCR. Covering 1,600 acres, CIM is comprised of four separate self-contained facilities: Reception Center Central (RC Central), Reception Center West (RC West), Reception Center East (RC East), and a minimum support facility that houses inmate workers and those at the lowest risk for disruptive behavior. The separate facilities are one to two miles apart.

Through its three reception centers, CIM receives about 600 inmates weekly for initial screening and processing into the state prison system. These inmates are initially evaluated at RC Central, where employees apply CIM's local operational policy to assign inmates to each of its reception centers. Generally, inmates are classified into one of four "levels" using a point system based on various factors, including the inmate's commitment offense, sentence length and behavior while in custody. The classification score thus determines the security conditions under which an inmate can be housed.

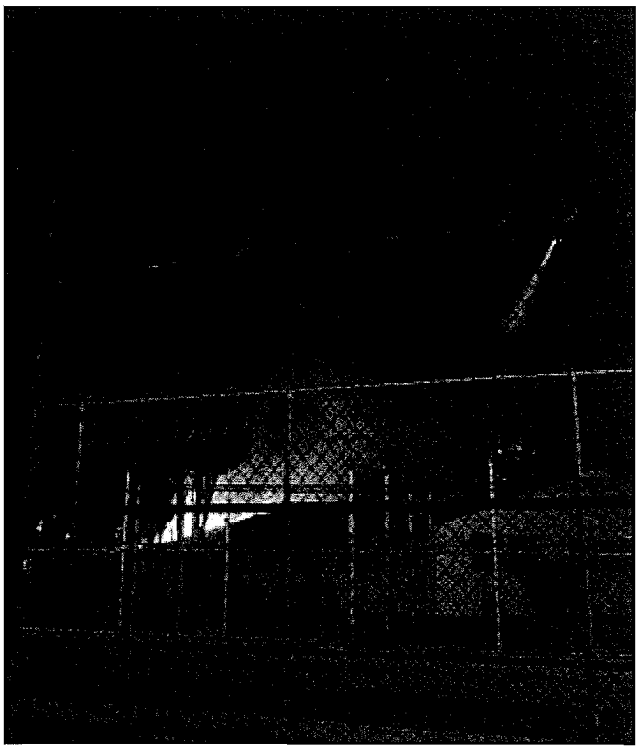


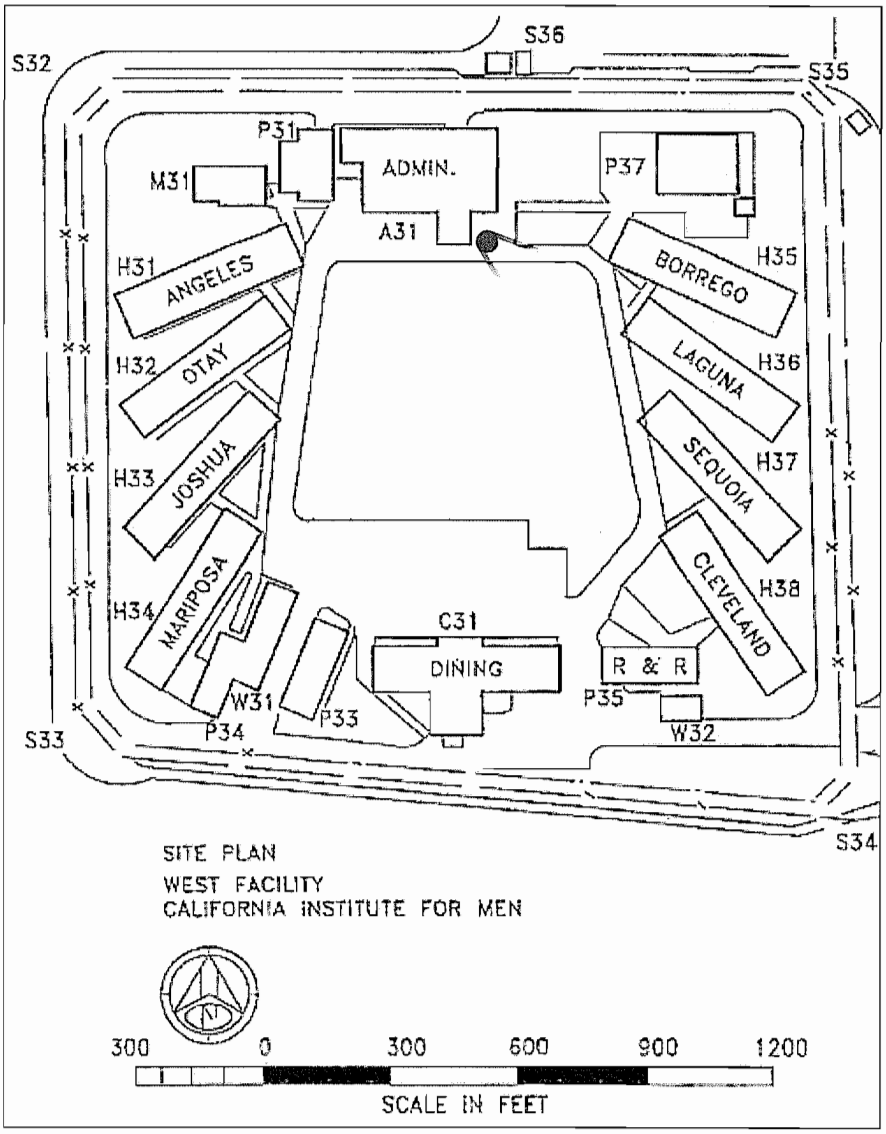
Photo 1: View of RC West fence during fire.
Note helicopter providing illumination overhead.
(Source: Chino Valley Fire Department)

Generally, inmates evaluated as the highest safety and security risk, and those who are en route from one institution to another, are retained in RC Central. For example, inmates with histories of assaulting officers or other inmates are retained in RC Central's administrative segregation unit where their contact with other inmates is limited and their movement is restricted and closely controlled. Inmates with the next highest security needs are assigned to RC East, which contains mostly celled housing, while inmates with lower security needs are transferred to dormitories at RC West, where up to 1,500 inmates may live in eight open dormitories with two correctional officers supervising each dormitory. Inmates inclined to violence are best housed in celled facilities, which divide the population into smaller groups of inmates who live in contained units. Inmates at low risk for violence can be permitted to interact in larger numbers, living in larger, more open spaces like dormitories.

Above: Photo 2: View of RC West yard looking southeast at Laguna, Sequoia and Cleveland buildings. (Source: Office of the Inspector General, August 11, 2009)

Left: Figure 1: Site map of RC West (Source: CDCR)

Photo point of view:



RC Central often does not have enough beds for all inmates who arrive during the day, according to staff members working there. To avoid having to use temporary overflow holding cells at RC Central, staff members must quickly decide which inmates to transfer out, even though some inmates' classification information may be temporarily unavailable or incomplete when transfer decisions must be made. Thus, while classification staff strive to avoid doing so, inmates with disruptive tendencies may be transferred into the dormitory environment of RC West where the consequences of their negative behavior is magnified.

As a reception center, RC West's mission is to house inmates returning to prison for parole violations or convictions for new crimes, as well as inmates entering state prison for the first time. Accordingly, its inmate population is composed of approximately 1,300 inmates with a broad range of commitment offenses, gang affiliations, and behavioral histories.

Like the populations at all reception centers, the inmate population at RC West is not only varied but fluid: inmates typically remain in RC West for a relatively short period of time, ranging from 60 days to one year, until CDCR either transfers them to prisons more suitable to their particular security and treatment needs or releases them back to the community on parole. RC West's inmate population changes daily, thereby continually changing the population dynamics which may result in a potentially volatile mix of inmates living in relatively low security dormitories.

Yet another factor to be taken into account is that CIM is overcrowded. On August 5, 2009, CIM housed 5,867 adult inmates within the four facilities, nearly twice its design capacity of 2,976. On this same date, RC West held 1,335 inmates, which was more than twice its design capacity of 615.

Compounding the inmate overcrowding, CIM's buildings suffer from long-standing maintenance and repair shortfalls that may soon require replacement of many of these buildings. Among the worst of the buildings were the eight wooden barracks that housed inmates on RC West. Against this backdrop of overcrowding and deteriorating buildings, CIM has a history of critical incidents. In addition to the tragic death of one of its correctional officers at the hands of an inmate in 2005, riots in December 2006, March 2007, and in February and April 2008 disrupted the institution's operations, resulted in serious injuries, and required many staff hours to contain. In light of these incidents and structural deterioration, the OIG reported in its November 2008 audit of CIM that "CIM's condition will reach a level of degradation by 2014 that independent facilities management experts throughout the industry would recommend demolishing and replacing the entire institution."

Photo 3: Inside Mariposa Hall (Source: OIG, August 11, 2009)

The August 8, 2009 Riot on the Reception Center West Facility

At approximately 8:30 p.m., inmates on RC West began fighting in their dormitories, eventually forcing their way out to the yard, causing vastly outnumbered correctional officers — generally, two officers in each dormitory of nearly 200 inmates — to retreat for their own safety before returning with additional officers in organized skirmish lines. Rioting inmates damaged nearly all of RC West's housing units, rendering them uninhabitable. In fact, one of the buildings—Joshua Hall—was set on fire and destroyed. CDCR's damage assessment noted that nearly all of the windows in each unit were destroyed and that half of the exterior doors suffered damage. The riot left substantial damage to walls and doors separating day rooms from bunk areas, damage to some gas piping and electrical conduit and outlets, and broken pipes behind walls and ceilings. CDCR noted that porcelain fixtures in the bathrooms were heavily damaged, most having been removed and broken into pieces for use as weapons.

Photo 4: (left):
Inside Sequoia Hall

Photo 5 (bottom):
Borrego Hall.

(Source: OIG, August 11, 2009)

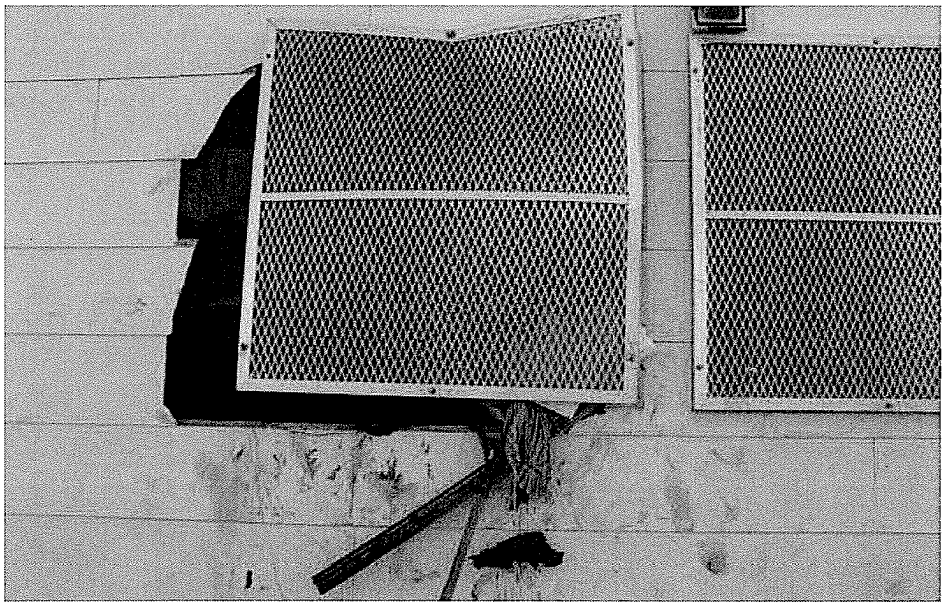
During the incident, inmates fashioned weapons from a variety of materials on hand, including shards of porcelain bathroom fixtures, pieces of metal bed frames, glass from broken windows, broom handles, and broken wood.

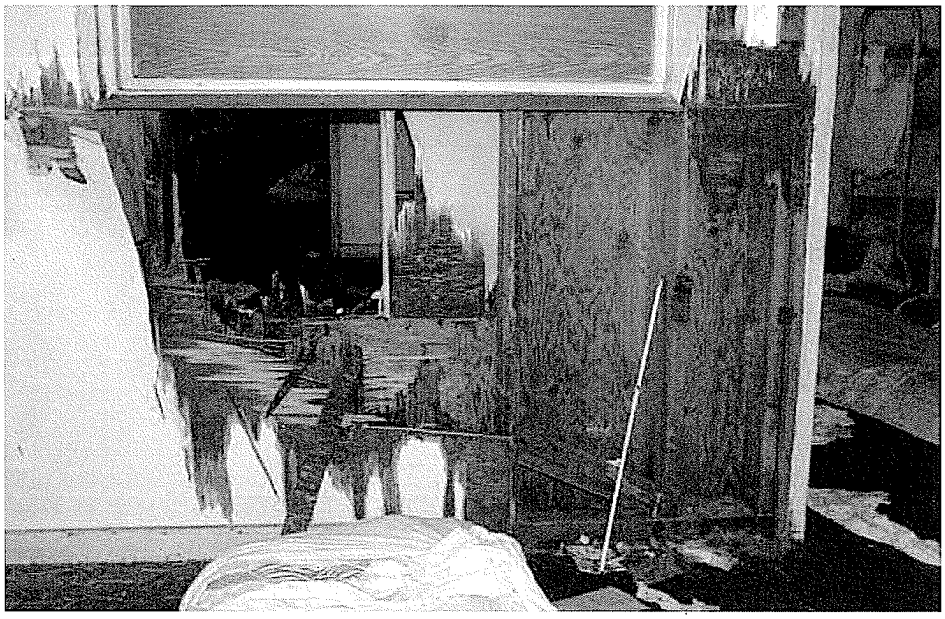
The fighting ended after four hours, quelled by the prison's correctional staff, with help from special teams sent from the California State Prison, Los Angeles County in Lancaster and the Richard J. Donovan Correctional Facility in San Diego County. Staff from several other prisons also arrived to render assistance. The area was completely secured by 7:00 a.m. on Sunday, August 9, 2009. Nearly 200 inmates sustained injuries during the riot, and medical staff from the prison and other responding agencies provided medical treatment. Fifty-four inmates suffering moderate to serious injuries required transportation to local hospitals.

Photo 6 (right): rear window of Mariposa Hall

Photo 7 (bottom): inside Mariposa Hall

(Source: OIG, August 11, 2009)





Objectives, Scope, and Methodology

The purpose of this special review is to evaluate the August 8, 2009 inmate riot at the California Institution for Men, to examine the conditions and circumstances that may have caused it, and to evaluate CIM's and CDCR's actions to address the riot and meet the challenges of re-establishing normal operational processes. Representatives of the Office of the Inspector General's Bureau of Independent Review arrived on scene hours after the riot began, with additional staff arriving a few days later to gather information and observe the scene. These teams limited their review to the riot and the events taking place during the three days following it.

During the course of the review, the Office of the Inspector General performed the following procedures:

- Reviewed various laws, policies and procedures, and other criteria related to key systems, functions, and processes.
- Conducted physical inspections of various areas of the facility, including the riot scene.
- Reviewed institutional files, logs and other relevant documents.
- Interviewed appropriate senior management and other employees, including facility captains, housing unit officers, and records staff.
- Met with and obtained information from community emergency service providers.
- Observed activities and processes at the emergency operations center.
- Monitored the transport of inmates for purposes of medical treatment.
- Met with departmental employees responsible for facilities planning, maintenance, and construction projects.
- Talked with inmates affected by the riot.

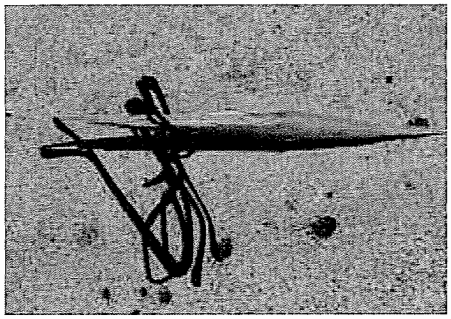
Finding 1

The Department of Corrections and Rehabilitation Failed to House a Suitable Inmate Population at Reception Center West

CDCR ignored the dangerous incompatibility of RC West's open wooden dormitories, which had numerous security deficiencies including blindspots and no gun coverage, with a large population of reception center inmates who, for a variety of reasons, are typically housed in a celled environment. RC West's recent history included a riot in December 2006 involving about 800 inmates from five of the dormitories. That riot required correctional staff twelve hours to contain, and the prison's medical staff treated 66 inmates and sent 30 others outside the institution for emergency treatment. Other riots at the reception center included a March 19, 2007 incident involving 40 inmates, an incident involving 30 inmates on February 1, 2008, and a riot involving 200 inmates on April 4, 2008. All of these smaller riots were contained within a single dormitory.

In addition to the history of significant riots at RC West, CDCR also received information from outside sources warning CDCR against its use of RC West to house reception center inmates. In a November 2007 report that he filed in federal court after touring one of RC West's

Photo 8: Damage in Joshua Hall. (Source: OIG, August 11, 2009)



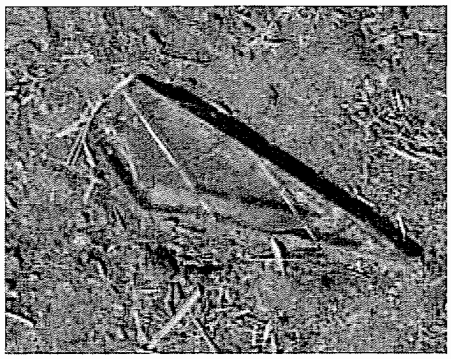


Photo 9 (top): Handmade weapon

Photo 10 (bottom): Weapon fashioned from safety glass.

(Source: OIG, August 11, 2009)

dormitories, former director of the Texas Department of Corrections Wayne Scott asserted, "The housing unit was a serious disturbance waiting to happen. If the prisoners wanted to take over the dorm they could do so in a second and no one would know."[1]

In a November 2008 report, the Office of the Inspector General (OIG) warned, "Placing inmates with histories of disruptive or assaultive behavior in an open setting where they can roam freely and where fights among inmates can quickly escalate and spread creates a more dangerous environment for inmates and staff members."[2]

In an April 2008 document to CDCR requesting funds to replace the dormitories at RC West, CIM argued that both the Office of the State Fire Marshall and the Architectural and Engineering Section of CDCR reported that the buildings do not comply with California Building Codes for their current occupancy groups nor have fire alarm protection.

Despite these prior incidents and warnings, CDCR did not alleviate risky security conditions inherent in RC West's design, such as wooden construction, numerous blind spots, glass windows and porcelain bathroom fixtures that could be broken and used for weapons, and no fire suppression systems or gun coverage. Those conditions contributed to the severity and duration of the August 2009 riot.

In the aftermath of the riot, CDCR began repairing RC West's damaged housing units to their pre-riot condition, with minimal additional security upgrades. However, after inquiries by the OIG related to CDCR's October 5, 2009 Activation Proposal, which describes the future of the repaired RC West units, CDCR acknowledged that the design of RC West is not well-suited to house reception center inmates and stated that it plans to place level II inmates there after it repairs the housing units.

The physical structure of RC West contributed significantly to the scope of the August 2009 RC West riot and hindered correctional staff in quelling the riot.

When it first opened, RC West's mission was to house fire camp inmates who are at relatively low risk for in-prison violence. Accordingly, RC West was designed without the safety and security features customarily built into facilities housing higher-risk inmates. For example, RC

1 Scott's report was filed in connection with his testimony before a three-judge panel convened for the *Coleman* and *Plata* cases to examine crowding in California prisons.

2 The entire report can be viewed at the following address: http://www.oig.ca.gov/pages/reports/bai-audits.php Click on the title, "Quadrennial and Warden Audit 2008-11 CA Institution for Men.pdf"

West's living units are wooden structures containing open dormitories filled with rows of bunk beds rather than individual cells. Over the years CDCR changed RC West's mission from a fire camp to a reception center, a change that required it to house a higher-risk inmate population. Yet CDCR did not change the facility's physical structure and inherent security features to accommodate the higher-risk population.

The open dormitory setting hampered the officers' ability to quickly suppress the riot and control the inmate violence. At the time of the riot, each of the eight dormitories on RC West housed between 100 to 200 inmates, yet was supervised by only two correctional officers. The dorms also lacked gun coverage—an elevated and secure area from which an officer can deploy lethal or less-than-lethal force. Considering these security weaknesses, there was little to deter the inmates from rioting. In contrast, at RC Central and RC East, almost all inmates are housed in separate celled units so that disturbances can be limited to a smaller number of inmates and quickly controlled. In his November 2007 report, former director of the Texas Department of Corrections Wayne Scott warned of the riot danger at CIM. In describing his tour of Cleveland Hall, one of RC West's dormitories, Scott wrote, "I saw 198 prisoners with only two officers to keep order, one in an office, with the other roving. Half of the dorm was in another building connected by the shower/bathroom area, and one room in the back was completely out of sight. It is impossible to provide any type of security or proper services under these circumstances."

The Office of the Inspector General also noted the potential risks associated with housing reception center inmates at the open dormitory setting of RC West. In its November 2008 report, the OIG noted that in an open dormitory setting where fights among inmates can quickly escalate and spread, it is difficult for officers to gain control of inmates who assault staff members or other inmates. In these dorms, inmates move freely in areas crowded with two-tier bunks and inmates' personal items, potentially obstructing the officers' line of sight and inhibiting the officers' ability to control volatile situations before they escalate to violence.

After the August 2009 riot, CDCR sought repair funds and acknowledged the shortcomings of the RC West facility.

In response to our inquiries regarding the future of RC West, CDCR acknowledged that RC West was not suited to be a reception center and provided its Activation Proposal for repairing RC West's dormitories and housing a more suitable inmate population there. According to its Activation Proposal dated October 5, 2009, CDCR announced that it is taking steps to prevent a reoccurrence of an inmate disturbance of this magnitude. The proposal recognizes that "as demonstrated, the design of [RC West] is not best suited to house reception center inmates due to the wooden structure design." Accordingly, CDCR plans to change RC West's mission to house only non-reception center, level II inmates, up to 50 percent of whom may be inmates serving life sentences, a stable population more invested in maintaining order in their housing environment. CDCR's proposal argues that changing the facility's mission in this way would enhance security because such inmates would be appropriate for RC West, which would remain an open dormitory.

In September 2009, CDCR requested $7.2 million for repairing RC West's housing units and for responding to the riot. This amount includes $4 million to repair seven of the eight housing

units, $1.2 million to rebuild the housing unit that was damaged by fire, and $2 million for one-time operating costs relating to stopping the riot and transferring inmates, as well as other unspecified operational costs. CDCR's scope of repairs for seven of the eight housing units proposes to replace glass windows with safety glazing and install stainless steel toilets and basins instead of porcelain fixtures to minimize their potential for use as weapons. CDCR estimated that it could repair the first seven dormitories by the end of April 2010 and repair the eighth dormitory by mid-June 2010. However, the repairs will not change the overall design of the open dormitory setting.

CDCR was challenged to find appropriate housing for RC West inmates in the aftermath of the riot.

Absent a detailed plan to house inmates displaced by such a large scale event, CIM resorted to use of holding cells and outdoor exercise areas to secure approximately 1,100 displaced inmates until beds could be found for them in the days immediately following the riot. While CIM's Emergency Operations Procedure contemplates the possibility of having to relocate large numbers of inmates, it simply states that inmates will be transported to "nearby local institutions" or "local county jails" without discussing the logistics involved in such an undertaking. Fortuitously, a nearby state youth correctional facility was nearly empty, and the August weather was generally conducive to temporarily containing inmates outdoors, otherwise the time required to provide displaced inmates with adequate housing and essential services might have been considerably longer than it was.

Based on inmate counts, by Monday, August 10, 2009 the number of inmates in holding cells and exercise areas had fallen from over 1,100 to just over 400 as inmates were moved to other prisons. On Tuesday, August 11, there were approximately 50 inmates remaining in holding cells and exercise areas awaiting housing. However, because the majority of inmates had lost or abandoned their identification cards, the records of inmate movements are limited to overall counts and generally do not track the movement of individual inmates during this period. CIM provided evidence that the prison took measures to supply the holding-cell inmates with food, medications, clothing, blankets, and hygiene supplies to the extent possible given the post-riot conditions, and found housing for most of the displaced inmates within three days of the riot. Nonetheless, for several days after the riot the normal services and privileges provided to inmates were interrupted.

In the aftermath of the riot, CDCR sent 1,154 inmates to five prisons throughout the state. The majority of these inmates went to the Heman G. Stark Youth Correctional Facility (Stark), located next door to CIM. Although built as a youth facility, Stark had celled housing available that was suitable to immediately house adult inmates. However, CDCR found that the facility had a number of shortcomings to address. For example, nearly 200 of the cells were equipped with only one bunk, but the number of adult inmates sent there required most of the cells in the housing unit to be double-bunked. Consequently, many inmates had to sleep on mattresses placed on the floor. Another drawback was that the small recreational yards adjacent to the housing unit lacked razor wire and other security features.

Figure 2: CDCR Relocated 1,154 Inmates After the Riot:

To address these issues, CDCR began short-term emergency modifications at Stark on September 15, 2009. According to CDCR's documents, these modifications included adding second bunks to 196 cells, installing razor wire and making access areas for the deployment of chemical agents to two group recreational yards.

On November 6, 2009, CDCR formally announced its plans to convert Stark to an adult prison. Ultimately, CDCR estimated that it would house roughly 1,800 general population inmates and approximately 940 reception center inmates at Stark at an estimated $441 million in related costs. As of December 2, 2009, this amount was comprised of $130 million for conversion costs, such as installing an electric fence, perimeter guard towers, and other security enhancements; $250 million for construction of a new reception center; and $61 million for construction of new mental health crisis beds.

Recommendations

The Office of the Inspector General recommends that the California Department of Corrections and Rehabilitation:

- Proceed with its plans for changing RC West's mission so that it no longer houses reception

center inmates, given its current open dormitory design. Even if the department changes the mission, the Office of the Inspector General questions the future use of RC West's dormitories to house the number of inmates (1,300) they held prior to the riot. Therefore, while we support the change in mission, if CDCR decides to house such numbers of inmates in these dormitories, we also recommend that it identify and complete all security and staffing modifications necessary to house those inmates safely.

- Ensure that emergency operation plans for CIM and all other prisons provide adequate housing, food, clothing, medical attention, and other essential services to large numbers of inmates who may be displaced by major events such as riots or natural disasters.

Finding 2

Despite the Liabilities of the Facility's Design, CIM Staff Responded Effectively to the August 2009 Riot at Reception Center West

Using past experiences, current gang intelligence, and recommendations from outside agencies including the Office of the Inspector General, CIM improved its emergency operations procedures and was therefore better prepared to respond to the August 8, 2009 riot. However, as with the disturbances preceding it, the August 8, 2009 riot itself provided additional opportunities for CIM and CDCR to enhance emergency preparedness by learning from challenges that arose during the event.

The California Institution for Men used lessons from previous incidents to improve its emergency medical response procedures.

Past inmate riots and other emergencies identified weaknesses in CIM's emergency preparedness. These weaknesses were documented by CDCR, the Office of the Inspector General, and others in reports prepared in the aftermath of those incidents. Two major events that shaped CIM's emergency medical response procedures were the death of one its correctional officers in 2005, and a riot at RC West in December 2006.

On January 10, 2005, Correctional Officer Manual A. Gonzales was attacked and killed by an inmate at CIM's RC Central facility. The Office of the Inspector General's ensuing review uncovered serious deficiencies in CIM's emergency response, including insufficient medical supplies and equipment and the failure of medical professionals to act effectively in their life-saving efforts. Notably, CIM had not established an emergency operations center or instituted an emergency operations plan.[3] Our review also provided recommendations for improvements by CDCR, as well as by CIM.

After the December 2006 riot at RC West, CDCR's regional health care administrator wrote a January 2, 2007 memo to CDCR's Director of Correctional Health Care Services, critiquing the institution's medical response to that incident. The regional administrator noted that CIM's medical department did not maintain a list identifying the medical professionals to be contacted during emergencies, nor those responsible for contacting them. Further, the regional administrator found that medical staff had no policies or procedures for responding to mass-casualty events, and that poor communication between institution medical staff and community emergency service providers impaired the emergency response. The regional administrator also found that members of CIM's medical staff were not initially represented in the institution's emergency operations center (EOC), thus impairing critical communications between medical and custody personnel during the emergency.

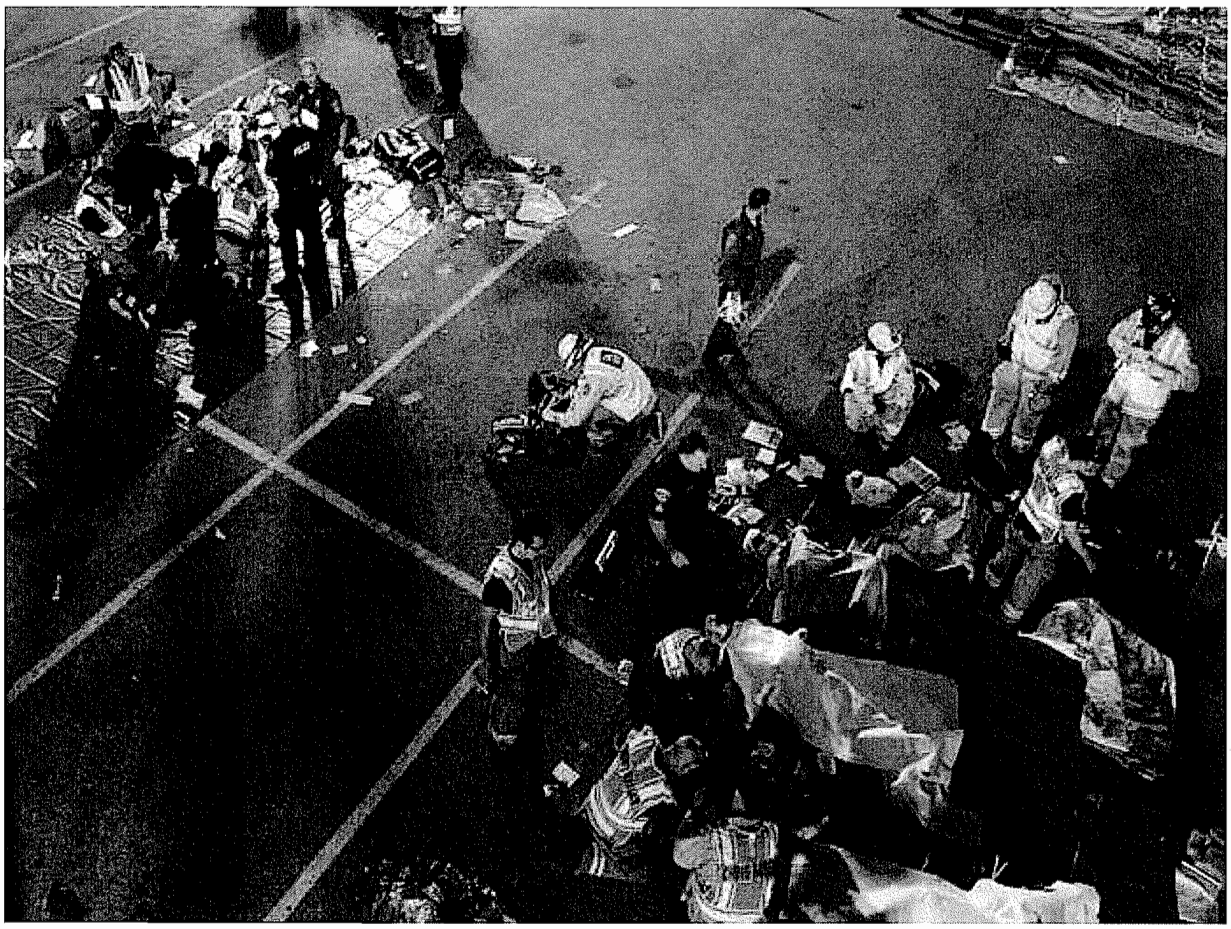
3 The Office of the Inspector General reported on deficiencies associated with the January 10, 2005 murder of Manual A. Gonzales in a report, *Special Review Into the Death of Correctional Officer Manuel A. Gonzalez, Jr. on January 10, 2005 at the California Institution for Men*, March 16, 2005.

In response to these past shortcomings, on January 14, 2008, CIM adopted a local operating procedure entitled "Medical Emergency Response in Disastrous Situations." Its purpose is "[t]o establish a fast and effective medical response to mass casualties at CIM in the event of an incident or natural disaster." This procedure created an immediate and unambiguous command structure by identifying the Medical Emergency Incident Commander (MEIC) when an incident occurs. Under the procedure, the designated MEIC reports to the emergency operations center to coordinate the institution's medical response. The MEIC assesses the severity of the emergency, summons on-duty physicians and nurses, and may also contact off-duty physicians and place them on standby status.

In addition to establishing a medical command structure, the local operating procedure also directs responders to establish an on-site medical emergency command center, designates those responsible for delivering medical supplies and equipment to the emergency site, and gives guidelines for categorizing injuries (performing triage).

Subsequent to the stabbing of Officer Gonzales and the 2006 riot, CIM also increased its capacity to address medical emergencies. Recognizing the high cost of medical treatment and custodial

Photo 11: Medical personnel working in separate triage areas during the riot. (Source: Chino Valley Fire Department)



resources needed to send inmates outside the institution for medical care, CIM hired medical staff with emergency medical experience. According to CIM's director of nursing, the number of inmates transported by ambulance for outside emergency medical care has been reduced from about 60 per month to 15 per month. This increased capacity may be credited, in part, to the fact that CIM has hired nurses certified in advanced cardiac life support and who also possess either military emergency responder experience or a background in emergency room care.

Finally, key supervisors on CIM's medical staff worked with community emergency service agencies to improve coordination of services. Before the August 8, 2009 riot, for example, medical staff arranged a tour of the institution for the Chino Valley Fire District to enhance their knowledge of institution policies and familiarize them with barriers they might encounter in an actual emergency.

Knowledge of building gang tensions and the potential for an upcoming incident increased the institution's state of alert.

On August 5, 2009, CIM's inmate appeals office received a handwritten note, referred to in inmate slang as a "kite." The kite indicated that one group of inmates would attack another group on the yard at RC East in retaliation for an earlier incident involving the same groups. After corroborating evidence was discovered the next day during routine searches by officers, members of CIM's Investigative Services Unit (ISU) deemed the kite to be credible.

CIM Institutional Gang Investigators (IGI) began interviews and cell searches of key inmates to learn more about the threat detailed in the kite and to institute appropriate steps to mitigate the threatened event. On August 6, 2009, IGI and ISU investigators conducted several searches resulting in the discovery of numerous additional kites. Two of the kites contained detailed instructions for inmates affiliated with a particular gang to strategically assault rival inmates institution-wide. The kites also indicated that the assaults were sanctioned by an influential inmate who later confirmed to ISU investigators that a major incident was planned in retaliation for an earlier altercation between the two groups. Following receipt of this information, CIM modified its inmate programs to limit and control inmate movement, and brought in additional staff in anticipation of violence.

The growing tensions led to a riot between the two rival gangs involving approximately 100 inmates in RC East on August 7, 2009. On the same day, RC Central had a riot involving approximately 20 inmates. These tensions escalated to a larger scale in RC West on the evening of August 8, 2009, involving over 1,000 inmates.

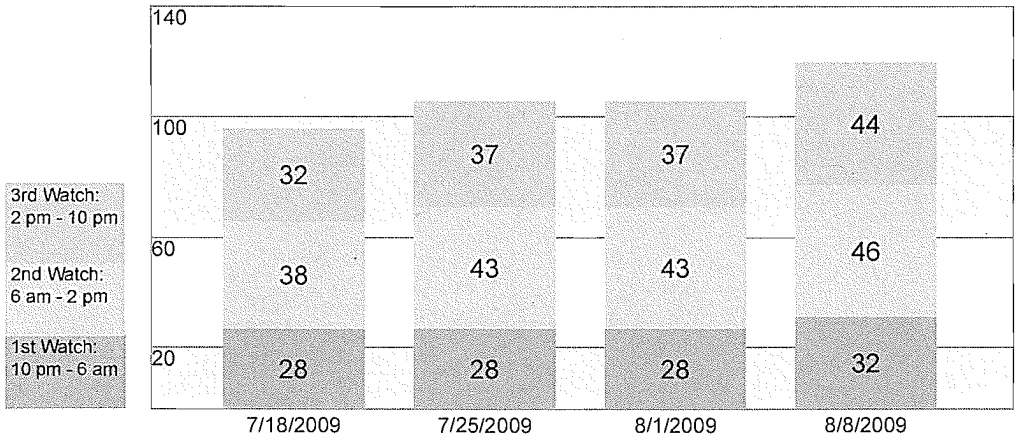
The institution increased its staffing levels on RC West in response to growing tensions.

According to CIM's warden and chief deputy warden, CIM increased staffing levels on RC West on August 7, 2009, even before the riot occurred. The chief deputy warden indicated that CIM added "disturbance control" positions to RC West on each eight-hour shift, or watch,[4] in

4 Prison employees work around the clock in three shifts, or "watches." Generally, 1st watch is 10 p.m. to 6 a.m., 2nd watch is 6 a.m. to 2 p.m., and 3rd watch is 2 p.m. to 10 p.m..

Figure 3: CIM Officers on Duty by Watch.

Based on intelligence gathered in the course of duty, CIM increased staffing levels in the days preceding the riot (measurements taken on Saturdays preceding the riot).



preparation for the potential disturbance. Based on employee timesheets, at the time the riot started, there were six additional officers present at RC West.

We reviewed the employee time-keeping records for RC West for the period July 29, 2009 through August 8, 2009 and confirmed that CIM began to modify its staffing levels on August 7, 2009. Records confirm that the institution added one disturbance control position on Friday, August 7, 2009 during the second watch and three positions during the third watch. The institution continued to increase staffing levels on Saturday, August 8, 2009, the day of the riot. The OIG found that staffing levels on that day exceeded those of the two preceding Saturdays by 14 officers, as CIM added four officers at the beginning of the first watch, three at the beginning of second watch, and seven officers at the beginning of the third watch (see Figure 3).

Yet, given the physical design limitations of RC West, CIM was not able to prevent or even quickly contain the large coordinated riot, even with additional staff.

The combined efforts of outside agencies and CIM's personnel resulted in an effective emergency response, but several challenges arose during the event.

CIM effectively executed its emergency medical response plan, which likely minimized the number of inmates requiring treatment at outside hospitals. Meanwhile, community emergency service agencies responded quickly, delivering essential services complementing the institution's efforts, greatly assisting CIM in containing the riot, and providing medical care. At the same time, CIM's crisis response team assembled to regain control of the facility. However, several challenges surfaced during the coordinated response. These included an insufficient number of correctional officers to provide security for inmates traveling outside the institution for medical care, the inability to communicate directly with outside agencies because CDCR personnel lacked access to compatible radio frequencies, conflicting orders to the crisis response team from an institutional manager operating outside the EOC protocol, and

the lethal electric fence impeding a local fire department's efforts.

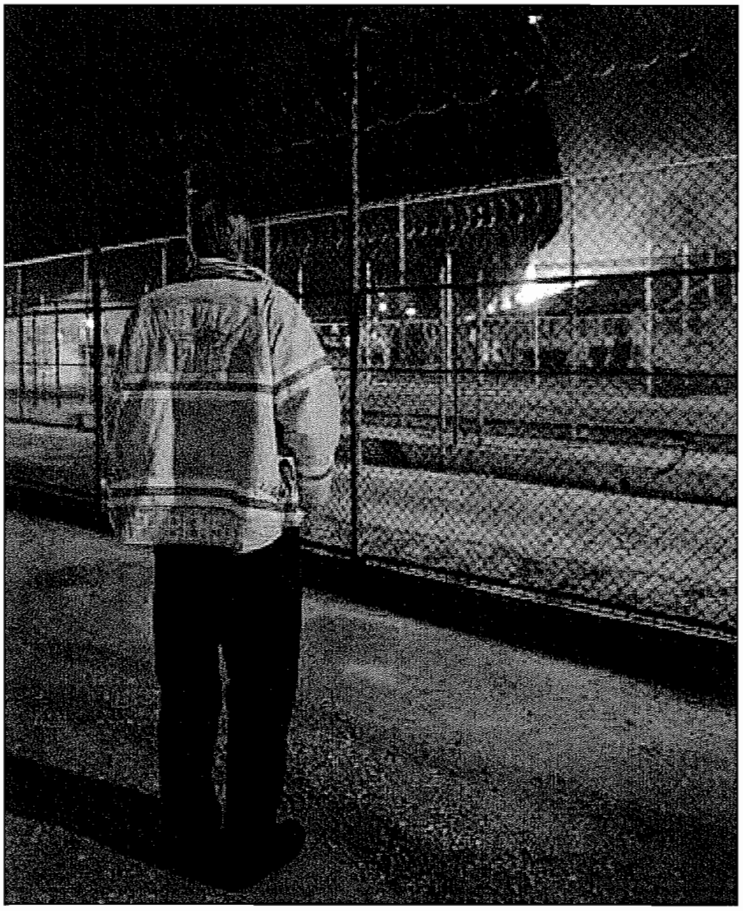


Photo 12: RC West's lethal electric fence initially impeded fire fighters' efforts. (Source: Chino Valley Fire Department)

Preceding the August 8, 2009 riot, the medical staff at CIM refined their procedures for reacting to emergencies, hired staff qualified in emergency medicine, and planned effective responses to a mass casualty event. During the riot, with few exceptions, CIM's response to the disaster was competently executed, with no loss of inmate life. However, improvements are necessary in communications between CIM's responders and community resources, in identification of inmates during and following the riot, and in quickly determining where to send inmates to ensure continuity of medical services.

CIM's prompt activation of its emergency operations center (EOC) led to generally good coordination of medical efforts, but communication issues hindered its ability to coordinate medical efforts with outside agencies.

CIM's chief medical officer and other medical staff were on heightened alert before the weekend of August 8, 2009. The medical officer on-call arrived at 8:00 p.m. on August 8, 2009 to review an x-ray, and had been alerted to stay near the institution by the chief physician. As he was leaving the institution at around 8:30 p.m., he heard an alarm. After learning that a riot had erupted in RC West, he called the chief physician and another doctor.

The chief deputy warden contacted the chief medical officer (CMO) at about 8:40 p.m. Upon arriving, the CMO assumed his duties as the medical coordinator in the EOC, which had been activated minutes after the riot began. By 10:00 p.m., several nurses had also responded, including all of the designated "first responder" nurses from the institution's clinics, along with supervising nurses who were initiating a triage process. Medical personnel established two triage areas, thereby keeping members of the rival factions separated.

CIM's medical personnel evaluated 1,127 inmates, determining 895 to be uninjured. Only 54 inmates were sent to outside medical facilities, returning to prison within days of the

riot. Of 232 inmates requiring treatment, all but the 54 transported to community hospitals received treatment from CIM physicians and nurses, prompting community emergency service responders to remark that there was not a single unnecessary transport. However, while CIM's medical staff provided good triage and treatment, some seriously injured inmates were not transported to outside hospitals for three hours or more because of an insufficient number of armed CDCR custody personnel to act as transport or escort officers. CDCR requires that each inmate transported to outside medical facilities must be escorted by two armed officers. Eventually, parole agents from the CDCR Office of Correctional Safety arrived to assist the institution's correctional officers in providing transport services.

CIM's emergency medical efforts were also hindered by communication issues. Community emergency service agencies arriving at the riot had no means of determining how many inmates required transportation for emergency care because emergency service responders were unable to communicate directly with the institution's medical staff inside the prison. This communication void occurred because local emergency service agencies did not have a member representative in the prison's EOC. Because community medical responders initially did not know how many hospital beds and other resources would be needed, they were concerned about overwhelming local hospitals and clinics with potentially hundreds of riot casualties.

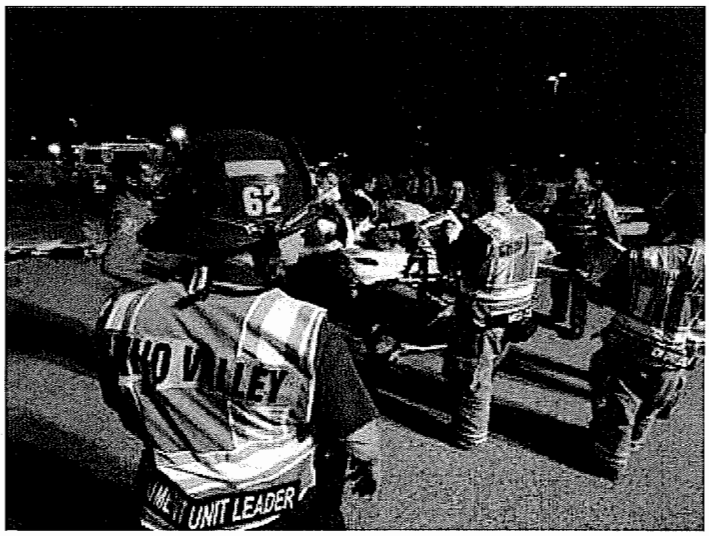


Photo13: Personnel from several agencies coordinating transportation of an inmate during the riot. (Source: Chino Valley Fire Department)

Eventually, the communication void was filled after CIM's Emergency Medical Services Liaison Nurse arrived sometime between 11:00 p.m. and midnight. He successfully resolved most communications issues and provided a more accurate assessment of the number of inmates likely requiring transportation to area hospitals. Community medical providers, including receiving hospitals, commended the liaison nurse's work in coordinating inmate transports. They attributed his success to his pre-incident preparation with community providers and to his capable management during the incident.

The San Bernardino County Fire Dispatch Center also assisted in determining how injured inmates would be distributed to area hospitals by providing the institution information about available bed space at those hospitals. However, information that could have been provided to the hospitals about the number of injured inmates and the nature of their injuries was delayed because no one at the scene had access to the computerized tracking system used by the hospitals. CIM officials later learned that temporary access to the system can be provided in the event of future emergencies, thus facilitating CDCR's ability to provide and receive timely

Figure 4: Multiple Organizations Provided Assistance During the Riot

- *Chino Independent Fire District*
- 48 ambulances provided by *American Medical Response* (*Rancho Cucamonga, Victorville, Riverside, Redlands,* and *Irwindale* divisions)
- Four ambulances provided by *Cole Schaefer Ambulance Company*
- Two helicopter ambulances provided by *Mercy Air*
- *Arrowhead Regional Medical Center*
- *Chino Valley Medical Center*
- *Kaiser, Fontana*
- *Loma Linda University Medical Center*
- *Montclair Hospital Medical Center*
- *Pomona Valley Hospital Medical Center*
- *Redlands Community Hospital*
- *Riverside Community Hospital*
- *Riverside County Regional Medical Center*
- *San Antonio Community Hospital*
- *Chino Police Department*
- *Rancho Cucamonga Police Department*
- *Chino Hills Police Department*
- *Ontario Police Department*
- *San Bernardino County Sheriff's Department*

Photo 14: A fire crew suppresses the fire in Joshua Hall. (Source: Chino Valley Fire Department)

information using the hospital tracking system.

CIM received effective and competent support from outside fire and law enforcement agencies responding to the riot, but had to overcome logistical and communication challenges.

The response from community emergency service agencies included assistance from law enforcement, fire departments, and emergency medical resources. The institution contacted local law enforcement agencies within minutes after the riot began, and the Chino Valley Independent Fire District arrived with its first unit at 8:41 p.m.

Responding law enforcement agencies included the police departments from Chino, Rancho Cucamonga, Chino Hills, and Ontario, in addition to the San Bernardino County Sheriff's Department. Personnel from these departments provided valuable assistance outside the prison by placing patrol cars around RC West's perimeter in case inmates were able to get past the fence line, and by closing nearby thoroughfares to vehicle traffic until the institution re-established control of the yard. With this outside security coverage, CDCR officers were free to concentrate on containing the riot and providing transportation security for inmates evacuated to outside hospitals.

A patrol helicopter from the San Bernardino County Sheriff's Department also assisted by providing lighting and serving as an intelligence resource for those on the ground. Local law enforcement officers also

provided a valuable service by identifying inmates. Many of the inmates requiring transport to outside hospitals lacked identification cards, having lost or discarded them during the event. Identifying inmates is critical because law enforcement would be greatly disadvantaged in attempts to recapture unidentified inmates. To address this issue, local law enforcement agencies used portable fingerprint scanners to identify inmates before they were transported to outside hospitals. In addition, the identities of some inmates were corroborated by using mobile data terminals in local law enforcement patrol cars to access databases containing other identifying information, such as tattoos. Chino Valley Independent Fire District took the primary role in suppressing the fire in Joshua Hall, while engine companies from other local communities also responded and CAL Fire provided food for personnel assigned to the riot. Initially, fire fighters planned to shoot water from outside of the fence to suppress the fire in Joshua Hall, but the lethal electrified fence surrounding the area presented a safety concern. Once fire fighters gained access to the yard, they limited the fire damage to the building of the fire's origin.

Photo 15: Several agencies coordinate communications during the riot. (Source: Chino Valley Fire Department)

While local law enforcement and fire fighting agencies could communicate with one another on common radio frequencies, CDCR radio equipment does not allow CDCR employees direct communication with outside law enforcement, thereby delaying delivery of information. CDCR's access to local police and fire radio frequencies would provide for immediate communication during future events requiring aid from outside agencies.

CIM's Crisis Response Team responded effectively, but was hampered by conflicting communications.

The Crisis Response Team took about two hours to deploy from the time the riot was first reported during which the team's members traveled from home, obtained emergency equipment, participated in a situation briefing, and conducted a rescue operation. The team's subsequent activities were delayed for 45 minutes by conflicting orders given by different personnel at the scene.

CIM's Crisis Response Team (CRT) is a group of officers specially trained and equipped to respond to high-risk situations, such as inmate riots. In response to the riot, CIM requested assistance from other state prisons in the region. CIM deployed its CRT, which was later

reinforced by CRT members from California State Prison, Los Angeles County and the Richard J. Donovan Correctional Facility in San Diego County.

The CRT initially deployed at 10:35 p.m. and within minutes successfully rescued unharmed a correctional officer who had secured himself with 16 inmate workers inside the RC West kitchen. The CRT's tactical operations after the kitchen rescue were delayed due to conflicting orders. Following the kitchen rescue, the team received orders from the Emergency Operations Center (EOC), located in the prison's administration building, to clear the inmates from the Borrego Hall dormitory. Witnesses told the OIG that one of CIM's managers at the scene gave conflicting orders — redirecting the CRT from clearing Borrego Hall to another task. Upon receiving the manager's conflicting orders, a CRT team member contacted the EOC for confirmation of the new orders.

The CRT team waited approximately 45 minutes for confirmation until the field incident commander at RC West noted the team had not begun clearing Borrego Hall and ordered them to clear Borrego Hall as previously directed by the EOC. While the team was doing so, the manager separately questioned the field incident commander about not following the manager's order. The field incident commander responded by asserting his own authority under established emergency protocols and allowed the CRT to continue as he initially directed.

The conflicting orders and resulting delay likely would not have occurred if CIM had established an incident command post.

CIM's Emergency Operations Procedures specifically provide for an on-scene incident command post, stating, "in the event of a mass disturbance, the activation of a tactical command post near the site is essential for coordinating the efforts of on-site teams and maintaining direct contact with the EOC." CIM's Emergency Operations Procedures also establish the lieutenant on-duty at an incident scene as the designated field incident commander, responsible to the emergency commander in the EOC and responsible for controlling the disturbance and keeping the emergency commander apprised of the situation. Without the command post, the EOC and personnel at RC West worked independently and communicated with each other only minimally, thus allowing the manager's intervention to temporarily disrupt the CRT's operations until the field incident commander took charge pursuant to his designated role.

Recommendations

The Office of the Inspector General recommends that the California Department of Corrections and Rehabilitation share critical lessons from the CIM riot that have universal application to the state's other prisons to help them improve their own emergency operations plans. Universally applicable lessons from the CIM riot include information on identifying inmates who no longer have ID cards, and information on determining medical facilities with capacity to accept inmate patients.

The Office of the Inspector General further recommends that the California Institution for Men:

- Establish emergency operation procedures to assure that the institution can summon a

sufficient number of trained and properly equipped peace officers to transport or escort injured inmates to outside medical care facilities.

- Provide for direct communication between its Emergency Operations Center and community emergency service agencies by obtaining compatible radios and radio frequencies or having representatives of key agencies present in the EOC.
- Obtain field-deployable equipment capable of rapidly identifying inmates who have become separated from their ID cards. Such equipment should be capable of using any combination of fingerprints, iris scans, or facial photos
- Establish in emergency protocols a means to access the data system that shows real-time availability and location of local hospital beds to enhance efficient transfer of injured inmates.
- Develop procedures and contingencies for fire suppression activities in the vicinity of a lethal electrified fence.
- During emergency response training, emphasize the importance of establishing a tactical command post near the emergency scene and of respecting the chain of command established by the Emergency Operations Plan.

California Department of Corrections and Rehabilitation's response to the special report

STATE OF CALIFORNIA—DEPARTMENT OF CORRECTIONS AND REHABILITATION ARNOLD SCHWARZENEGGER, GOVERNOR

OFFICE OF THE SECRETARY
P.O. Box 942883
Sacramento, CA 94283-0001

April 13, 2010

Mr. David R. Shaw
Inspector General
Office of the Inspector General
P.O. Box 348780
Sacramento, CA 95834-8780

Dear Mr. Shaw:

This letter is being submitted in response to the Office of the Inspector General's (OIG) report titled ***Special Report: August 2009 Riot at the California Institution for Men*** (CIM), dated April 2010. During this review, the main concern the OIG identified was that the California Department of Corrections and Rehabilitation (CDCR) housed an unsuitable inmate population at CIM's West Facility. Specifically, the OIG noted the potential risks associated with housing reception center inmates in an open dormitory setting and for not alleviating the risky security conditions inherent in this dormitory design. To mitigate that risk in the future, CDCR intends to house general population inmates, those classified as level II, in the West Facility dorms per the established criteria set forth in the California Code of Regulations. However, it should be noted that 92 percent of the reception center population housed in the West Facility met the criteria for level III housing prior to the riot.

CIM has employed both past experiences and recommendations from outside agencies to improve its emergency operations and we appreciate and thank the OIG for recognizing the tremendous effort achieved during this crisis. First, CIM's medical staff, administration, and mutual aid responders medically evaluated over 1,100 inmates efficiently and effectively, lessoning the fiscal impact to transport inmates to outside hospitals. Secondly, CIM and staff statewide rapidly transferred 1,154 displaced inmates to other facilities within 3 days with little to no disruptions to the daily operations of CDCR. And thirdly, the overwhelming response from community emergency service agencies allowed CDCR officers to concentrate on containing the riot, resulting in an effective emergency response. While we recognize the lessons learned from this and prior emergency operations, we feel all those involved should be highly praised for this coordinated effort. We would like to commend CIM staff, CDCR staff statewide, and those local fire and law enforcement agencies that responded to the riot.

We would like to thank the OIG for your continued professionalism and guidance in the CDCR's efforts to improve its operations. All deficiencies identified will be evaluated and addressed in a corrective action plan submitted to CDCR's Office of Audits and Compliance for follow-up and monitoring. If you should have any questions or concerns, please call my office at (916) 323-6001.

Sincerely,

SCOTT KERNAN
Undersecretary, Operations

SPECIAL REPORT

AUGUST 2009 RIOT AT THE CALIFORNIA INSTITUTION FOR MEN

OFFICE OF THE INSPECTOR GENERAL

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INSPECTOR GENERAL

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CHIEF DEPUTY INSPECTOR GENERAL (A)

Jerry Twomey
CHIEF ASSISTANT INSPECTOR GENERAL

Howard Moseley
CHIEF ASSISTANT INSPECTOR GENERAL

William Shepherd
DEPUTY INSPECTOR GENERAL, IN-CHARGE

STAFF
Inez Azcona • Bryan Beyer • Chris Eagle
Jordan Esten • Larry Finney • Tom Hansen
Debra Maus • Steve Miller • Elva Nunez • Basil Richards
Neil Robinson • Kobia West

STATE OF CALIFORNIA
APRIL 2010

WWW.OIG.CA.GOV

Exhibit 10

CALIFORNIA INSTITUTION FOR MEN

QUADRENNIAL AND WARDEN AUDIT

OFFICE OF THE INSPECTOR GENERAL

DAVID R. SHAW
INSPECTOR GENERAL

STATE OF CALIFORNIA

NOVEMBER 2008

November 20, 2008

Matthew L. Cate, Secretary
California Department of Corrections and Rehabilitation
1515 S Street, Room 502 South
Sacramento, California 95814

Dear Mr. Cate:

Enclosed is the Office of the Inspector General's audit report concerning the California Institution for Men (CIM) and the performance of its warden. The purpose of the audit was to satisfy our statutory requirement to audit each warden one year after appointment and to audit each correctional institution at least once every four years.

The report revealed that Warden Michael Poulos has a reputation for integrity and professionalism, and he has gained many supporters among the employees at CIM. Interviews and surveys reveal that most staff members feel Poulos is an effective leader who is usually accessible to the staff and responsive to institution problems. Further, many staff members cited improvements at CIM under Poulos' tenure, such as the reopening of a gymnasium formerly used for inmate housing and the rededicating of the Marine Technology Training Center. Managers also praise Poulos' performance as warden, giving him an average rating of "outstanding" on our survey.

Nevertheless, we found that staff members believe Poulos could do more to address CIM's poor maintenance and general state of disrepair, even though the infrastructure problems predate Poulos' arrival. Although he inherited a neglected institution that receives inadequate financial support from the department, our inspectors found areas where the warden could use his existing resources more effectively. For instance, our report recommends that Poulos continue his efforts to address plant operations vacancies, hold plant operations employees accountable for accurately reporting their time, and enforce a policy requiring a work order coordinator to reduce duplicate work orders.

The report contains the results of our review of CIM's operations and programs and presents six findings and 17 recommendations. In addition to the issues discussed above, other problem areas include weapons training and a lack of surveillance equipment for the institution's visiting yard.

Thank you for the courtesy and cooperation extended to my staff during the audit. Please call Bill Shepherd, Deputy Inspector General, In-Charge, at (916) 830-3600 if you have any questions.

Sincerely,

David R. Shaw
Inspector General

cc: Michael Poulos, Warden, CIM
Scott Kernan, Chief Deputy Secretary, Adult Operations
Suzan Hubbard, Director, Division of Adult Institutions
Kim Holt, External Audits Coordinator

Enclosure

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The department's available funding allocation to CIM for maintenance and repairs is inadequate to keep the institution in an acceptable state of repair.

- Finding 2 22

Despite the formidable gap between available repair and maintenance funding for CIM and the institution's actual needs, CIM can still take actions to mitigate its infrastructure problems.

- Finding 3 27

Staff at CIM's central reception center inappropriately approved some dangerous, high-risk inmates for housing in crowded dormitories.

- Finding 4 32

CIM allows peace officers who have not attended mandatory quarterly firearms training sessions to assume armed posts at the institution and off-site in local hospitals.

Finding 5 40

The visiting area for CIM's Minimum Support Facility accommodates hundreds of inmates and visitors, but the institution lacks an effective means of monitoring visiting activities to control the exchange of contraband.

Finding 6 43

Supervisors are conducting fewer than half of the required fire/emergency evacuation drills in their work areas, which may leave employees and inmates ill-prepared to respond to a crisis.

California Department of Corrections and Rehabilitation's Response 45

Executive Summary

This report presents the results of an audit by the Office of the Inspector General (OIG) concerning the operations of the California Institution for Men (CIM) and the performance of its warden. The audit was performed under California Penal Code section 6126(a)(2), which requires the Inspector General to audit each warden one year after his or her appointment, and to audit each correctional institution at least once every four years.

Our team of inspectors examined CIM's operations and programs to identify problem areas and recommend workable solutions. The institution gave our inspectors full access to its records, logs, and reports. In addition, site visits allowed us to observe CIM's day-to-day operations. We also interviewed various staff members and inmates, and we surveyed three distinct groups: managers from CIM and the California Department of Corrections and Rehabilitation (the department), CIM employees, and key government and union stakeholders. In all, our inspectors made six audit findings and 17 recommendations, which are detailed in Chapter 2 of this report.

Warden Poulos is an experienced, effective administrator, but he must do more to address CIM's deteriorating infrastructure

Warden Michael Poulos has nearly 30 years of experience with the California Department of Corrections and Rehabilitation, and this experience has made him a valuable asset to the department and to CIM. Interviews and surveys reveal that most staff members feel Poulos is an effective leader who is usually accessible to the staff and responsive to institution problems. Further, many staff members cited improvements at CIM under Poulos' tenure, such as the reopening of a gymnasium formerly used for inmate housing and the rededicating of the Marine Technology Training Center. Managers also praise Poulos' performance as warden, giving him an average rating of "outstanding" on our survey.

Nevertheless, we found that staff members believe Poulos could do more to address CIM's poor maintenance and general state of disrepair, even though the infrastructure problems predate Poulos' arrival. Although he inherited a neglected institution that receives inadequate financial support from the department, our inspectors found areas where the warden could use his existing resources more effectively. For instance, our report recommends that Poulos continue his efforts to address plant operations vacancies, hold plant operations employees accountable for accurately reporting their time, and enforce a policy requiring a work order coordinator to reduce duplicate work orders.

CIM's crumbling infrastructure causes hazardous working and living conditions while its limited available resources could be better leveraged

While our evaluation of the warden's performance was mostly positive, staff surveys and interviews revealed that CIM's employees are deeply concerned about the institution's poor condition. CIM's most significant problems include an ineffective water treatment system, failing plumbing, dilapidated housing units, leaking roofs, and hazardous materials in need of removal. Unfortunately, many improvement projects approved by the department remain unfunded.

The department and the state Legislature are aware that CIM has fallen into an unacceptable state of repair due to years of neglect. However, the department received $96 million in fiscal year 2007–08 for maintenance and special repairs for all its facilities, and it only allocated an average of $4 million a year for maintenance and special repairs at CIM. An outside consultant hired by the department estimates that seven times that amount—$28 million annually—is needed to maintain CIM in its present "poor" condition, neither improving it nor allowing it to degrade further. Moreover, the consultant's data shows that, if funding is not dramatically increased, CIM's condition will reach a level of degradation by 2014 that independent facilities management experts throughout the industry would recommend demolishing and replacing the entire institution.

Despite CIM's funding gap for maintenance and repairs, we found that the institution has inefficiencies it could correct to maximize the effectiveness of its existing plant operations resources. Specifically, we discovered that CIM could aggressively recruit to fill plant operations vacancies, take full advantage of an established system for tracking and planning maintenance activities, and assign a work order coordinator to spot duplicate work orders. By correcting these existing inefficiencies and leveraging its available resources, CIM can reduce unnecessary work, allow supervisors to effectively manage maintenance activities, and provide objective evidence for the department's use in establishing equitable maintenance funding allocations to CIM.

Safety and security problems in some areas may endanger CIM employees, inmates, and the surrounding community

Our inspectors made several findings related to safety and security problems at CIM. The most significant finding involved central reception center staff inappropriately approving certain inmates for open dormitory housing when those inmates' histories indicate they are better suited for celled housing. We found that staff members did not always follow procedures for reviewing inmates' classification scores to ensure those scores did not exceed the limit for dormitory housing. As a result, the staff members improperly placed some unsuitable inmates in crowded dormitories that are supervised by only two correctional

officers. Inmate disturbances can quickly escalate in these dormitories, making it difficult for officers to gain control of inmates who assault staff members or other inmates.

Quarterly weapons qualifications were another area of deficiency. Despite a process for identifying officers who fail to attend mandatory quarterly qualification sessions, many of these officers continue to work armed posts instead of being redirected to a non-armed post pending completion of the missed qualification session. In addition, the department continues to follow a November 2004 memorandum that permits peace officers who are not quarterly qualified to work armed posts through shift swaps or overtime. We feel that this practice conflicts with various California statutes and regulations, as well as department policies, which require officers to complete quarterly firearms training sessions before assuming armed posts. Further, regular qualification with a firearm helps an officer maintain his or her weapons skills. Allowing an officer to work an armed post without a current weapons qualification could endanger employees, inmates, and the public and expose the state to litigation if the officer uses deadly or less-lethal force.

Our audit also found that the visiting area for CIM's Minimum Support Facility lacks an effective means of monitoring visiting activities. Even though inmates often use visiting as an opportunity to smuggle contraband into the institution, only two officers are assigned to monitor the expansive visiting yard, which accommodates hundreds of inmates and visitors. In addition, there are no surveillance cameras to allow for continuous monitoring of suspicious activity. Video recordings could also serve as a resource to successfully identify visitors and inmates possessing or passing contraband.

Finally, we found that CIM's supervisors are conducting fewer than half of the required quarterly fire/emergency evacuation drills. Although we found that fire/emergency drill compliance has improved in the most recent quarters we examined, supervisors are still not conducting a significant number of drills. Clearly, fire/emergency drills prepare employees and inmates to respond quickly and safely during a fire or other emergency. Regular fire drills are especially critical for CIM, since the aging institution has inadequate fire sprinkler coverage, and high inmate turnover frequently introduces new inmates who must be prepared in case of a fire or other emergency.

Institution Overview

The California Institution for Men (CIM) opened in 1941, making it the California Department of Corrections and Rehabilitation's third-oldest adult institution. Covering about 1,600 acres, CIM occupies more area than any other department institution. Moreover, CIM's layout is unique among the state's 33 institutions because it comprises four separate facilities that are not physically connected. As of June 30, 2008, CIM housed 6,052 adult inmates within the four facilities, or 203 percent of its design capacity of 2,976.

In 1941, CIM opened with inmates housed in two cellblock-style living units known as South Dorm and West Dorm within what is now known as the Minimum Support Facility (MSF), which covers about 62 acres and houses more inmates than any other MSF in the state—roughly 2,400 inmates. The MSF consists of 13 dormitory and cellblock housing units surrounded by a fenced perimeter with four gun towers. The MSF also housed inmates in the gymnasium to accommodate an overflow population until a recent decrease in population made this unnecessary. Also within the MSF's secured perimeter are the institution's fire department, plant operations, medical infirmary, substance abuse programs, and academic and vocational education programs.

In 1951, CIM opened a new Reception Center Central (RCC) facility. RCC processes reoffending parolees and newly committed inmates into the prison system. Reception Center West (RCW), opened in 1960, houses inmates in eight barracks-style, open-bay living units. Reception Center East (RCE), opened in 1974, is about a mile away from the other three facilities. Designed with cellblock housing, RCE houses protective custody, Level III,[1] and reception center inmates.

Inmate Programs

CIM inmates may participate in various programs to prepare them for successful reintegration into the community. For example, inmates gain work experience participating in the plumbing, masonry, printing, landscaping, and carpentry vocational programs. In addition, inmates needing educational assignments are enrolled in programs for adult basic education, pre-release, and English as a second language. CIM also offers Arts in Corrections, Alcoholics Anonymous, Narcotics Anonymous, and religious programs. Inmates may also participate in CIM's substance abuse program, which can serve up to 400 inmates.

[1] The department has four general classification levels; Level I through Level IV is the range from the lowest to the highest security level.

Prison Industry Authority Operations

The Prison Industry Authority (PIA) offers several work opportunities for CIM inmates. Eligible inmates may work in the PIA's juice packaging plant, which packages 3,500 gallons of juice a day for consumption in prisons and state hospitals. Inmates may also work in the PIA's laundry facility, which processes 500,000 pounds of clothing and linens a month for CIM, Lanterman and Patton State Hospitals, two other state prisons, and one youth correctional facility. In addition, on December 1, 2006, the PIA reopened its Marine Technology Training Center within the institution's secured perimeter. The training center's 11-month program trains inmates to become commercial divers in areas such as underwater construction, dam repair and maintenance, welding, harbor diving, and offshore oil drilling. Upon their release from CIM, training center graduates can earn salaries ranging from $50,000 to $100,000 a year when working in private industry.

Budget and Staffing

For fiscal year 2007–08, Warden Mike Poulos managed an operating budget of about $183.6 million, which included 2,111 budgeted positions, of which 1,203 positions (57 percent) were custody staff. The table below summarizes CIM's budgeted and filled positions as of June 30, 2008. As the table shows, almost 94 percent of the authorized positions were filled.

Staffing Levels at the California Institution for Men*

Position	Filled Positions	Budgeted Positions	Percent Filled
Custody	1,165	1,203	96.8%
Support	320	345	92.8%
Medical	269	297	90.6%
Trades	169	191	88.5%
Education	43	57	75.4%
Management	16	18	88.9%
Total	**1,982**	**2,111**	**93.9%**

Source: California Department of Corrections and Rehabilitation, COMPSTAT, 2nd Quarter 2008 (as of June 30, 2008), California Institution for Men
**Note: unaudited data*

Chapter 1:
One-Year Evaluation of Warden Michael Poulos

California Penal Code section 6126(a)(2) requires the Office of the Inspector General (OIG) to audit each warden one year after his or her appointment, and to audit each correctional institution at least once every four years. To satisfy this requirement at the California Institution for Men (CIM), our inspectors audited the warden's performance and the institution's operations simultaneously.

Objectives, Scope, and Methodology

To understand how employees and other stakeholders view the warden's performance, we surveyed three distinct groups. Specifically, we sent surveys to 34 officials at CIM and at the California Department of Corrections and Rehabilitation (the department). Of those surveys, we received 22 responses. We also delivered surveys to 204 CIM employees and received 58 responses. Finally, we sent surveys to 16 key stakeholders, including selected members of the Legislature, representatives of unions and associations, a local district attorney, and a court-appointed special master. However, we received only two responses.

Our staff inspected CIM to gain an understanding of the environment where the warden must perform. We also interviewed key staff members and reviewed the institution's records in the following areas:

- Health care
- Inmate discipline
- Inmate records
- Educational and vocational programs
- Receiving and release
- Perimeter security
- Procurement
- Housing units
- Inmate appeals
- Investigative services
- Inmate assignments
- Plant operations
- Inmate visiting
- Personnel assignment
- Training

We also inspected the areas operated by the Prison Industry Authority (PIA), which includes the juice packaging enterprise, the institutional laundry, and the Leonard Greenstone Marine Technology Training Center. Through our site visits and survey responses, we asked individuals throughout the institution to discuss the warden's performance. These individuals included members of the custody staff and the executive management team, union representatives, education and health care professionals, and representatives from the Inmate Advisory Council.

We also reviewed logs, reports, and other documents related to the warden's performance over the past year, including the results of our institutional audit contained in Chapter 2 of this report.

Background of Warden

Michael Poulos began his career with the California Department of Corrections and Rehabilitation in 1980 as a correctional officer at the Deuel Vocational Institution. He eventually promoted to the rank of correctional captain at Avenal State Prison in 1993, and in 2002, he became a correctional administrator at the California Rehabilitation Center. In 2003, Poulos became chief deputy warden at California State Prison, Corcoran.

In 2005, he transferred to CIM as the acting warden after Correctional Officer Manuel Gonzalez was killed while on duty there. Governor Schwarzenegger appointed Poulos warden of CIM in June 2006.

Discussion of Warden's Strengths

The warden is responsive in addressing problems

Shortly before Poulos' appointment as acting warden, the OIG conducted a special review into Correctional Officer Manuel Gonzalez's death and released a report in March 2005 that listed 20 recommendations directed to the institution and 22 directed to the department. In December 2006, the OIG released a follow-up to the special review and found that, under Poulos' tenure, 15 of the 20 recommendations directed to the institution had been fully implemented, while the remaining five had been either substantially or partially implemented. In addition, the December 2006 follow-up review resulted in two more recommendations directed to the institution, both of which were found to be

Madrone Hall, 2005

Madrone Hall, 2008

Madrone Hall, 2005

Madrone Hall, 2008

fully implemented during the OIG's 2008 Accountability Audit.[2]

When we conducted the special review into the correctional officer's death at CIM in early 2005, it appeared that the institution's managers had little interest in the maintenance, cleanliness, and general appearance of the institution. Trash covered many areas, weeds were overgrown, and many windows were broken in inmate housing units. Under Poulos' leadership, however, routine maintenance and landscaping have improved, and the institution grounds appear cleaner. Although much work remains to improve maintenance at the aging institution, Poulos has made great strides despite limited financial resources.

The warden has overseen other improvements at CIM

Further accomplishments during Poulos' tenure include reopening a gymnasium formerly used for housing inmates and now used for inmate recreation and rededicating the Leonard Greenstone Marine Technology Training Center, which prepares inmates for careers in the underwater construction industry. Thirteen inmates graduated from the training center in February 2008 after completing the yearlong course that included classes in general education, physics, diving medicine, blueprint reading, seamanship, and underwater welding.

Moreover, in March 2008, Poulos helped CIM acquire a Type 1 fire truck suitable for fighting structure fires to supplement the institution's Type 2 trucks that are primarily suited for fighting brushfires.

Staff surveys rate Poulos as an effective leader

We received 58 responses from CIM staff members to the statement, "Considering all institutional challenges, the current warden is an effective leader." Respondents rated this statement on a 5-point scale with 5 indicating

[2] *Accountability Audit: Review of Audits of the California Department of Corrections and Rehabilitation, 2000-2006* (April 2008) may be found on the OIG's Web site: http://www.oig.ca.gov/reports/pdf/2008_Accountability_Audit_WEB_FINAL.pdf

"strongly disagree" and 1 indicating "strongly agree." Fifty-nine percent of respondents (34 of 58) agreed with this statement, while only 19 percent (11 of 58) disagreed. Twenty-two percent of respondents (13 of 58) were neutral. One correctional officer commented, "Overall, I think that the warden is doing a good job but we all still have some more work to do."

Poulos is accessible to staff members

Several staff members we interviewed cited personal interactions with Poulos, describing him as "responsive and accessible" and "open, personable, and approachable." Thirty-eight percent of respondents (22 of 58) agreed with the statement, "The warden is accessible to you to discuss issues," while 26 percent (15 of 58) disagreed; the remaining 36 percent (21 of 58) were neutral.

Poulos received a favorable overall rating from management

Twenty-three of the 24 individuals representing management and key stakeholders who responded to our survey provided an overall rating for Poulos. One declined to provide a rating. Twenty of 23 respondents (87 percent) rated the warden as either "outstanding" or "very good."

Warden's Overall Performance Rating

Rating	Respondents	Percentage
Outstanding	16	70%
Very Good	4	17%
Satisfactory	3	13%
Improvement Needed	0	0%
Unacceptable	0	0%
Total	**23**	**100%**

Survey results from this group also indicate a favorable overall rating for Poulos' management skills in six rating categories based on the following 1-to-5 scale, with 1 being the highest: "outstanding," "very good," "satisfactory," "improvement needed," and "unacceptable." The survey respondents' average rating of 1.43 corresponds most closely with a qualitative rating of "outstanding."

Warden Rating of Management Skills and Qualities: Rating on a Scale of 1 to 5

Category	Average Response
Leadership	1.35
Communication	1.48
Decision Making	1.64
Organization/Planning	1.74
Relationships with Others	1.48
Personal Characteristics/Traits	1.39
Overall Rating: Outstanding	**1.43**

Discussion of Warden's Criticisms

CIM and the department need to do more to address the institution's poor condition

As discussed in Chapter 2 of this report, CIM has fallen into an unacceptable state of disrepair due to years of neglect. Two questions on our staff survey concerned facility maintenance, asking respondents to agree or disagree with the statements that the institution's inmate and employee areas, respectively, are adequately maintained. Respondents disagreed more strongly with these two statements than with any others on the survey. Forty-nine of the 58 surveys returned to us included written comments, and 57 percent of those respondents (28 of the 49) remarked on the poor condition of the institution's plumbing, the lack of climate control, and other maintenance problems.

Poulos has been CIM's warden for a relatively short time, and infrastructure problems existed long before he came to the institution. Although he has made significant physical improvements since becoming CIM's warden, he cannot bring the institution into an acceptable state of repair without maximizing his available resources and working with the department to obtain much-needed additional resources, as is discussed further in Chapter 2.

Warden's Response to Criticisms

In an October 23, 2008, discussion with OIG staff members, Poulos expressed his preference to address criticisms in writing. His four-page response included other topics, and we summarized the following comments from his response.

Poulos said that since his arrival at CIM in 2005, he has made many improvements with support from the department. He cited, for example, significant security enhancements to housing units at Reception Center Central, including solid-front cell doors in Cypress Hall and the administrative segregation units in Palm Hall, security mesh over open bars in cells and shower areas, and extended tier railing to prevent intentional or accidental falls from upper tiers. He noted that enhancements to secure outside cell windows at Reception Center East were completed, while Reception Center West now has fencing around individual housing units and is having fire alarm systems added. The institution's water denitrification plant is undergoing renovation and, when completed, will help to resolve many conditions related to bad water at CIM. The warden said that while he continues to address deficiencies, significant infrastructure projects have been approved but still await needed funding.

Poulos acknowledged that he could do more to ensure that his staff understands the reasons behind CIM's general state of disrepair. He said unfamiliarity with the

processes of obtaining project approvals and funding can cause frustration among staff members as they observe degraded facilities and critical repair needs that are not fixed immediately.

In addition, Poulos cited the difficulty of filling vacancies in plant operations as a critical obstacle to addressing infrastructure problems. He said CIM's challenging workload makes even recruiting employees from other institutions difficult because other institutions do not typically experience the maintenance challenges plaguing CIM.

Poulos emphasized that CIM's staff members remain committed to making CIM as safe as possible for staff and inmates, thus ensuring that the public and the surrounding communities are safe, which is his ultimate goal. He recognized the efforts of the institution's staff, saying that it is because of them that the institution continues to carry out the critical mission of the department as they perform under extraordinary conditions and circumstances.

Summary Discussion

Poulos has nearly 30 years of experience with the California Department of Corrections and Rehabilitation, having worked his way though the ranks, from correctional officer to warden. His years of experience have made him a valuable asset to the department and to CIM, and staff interviews and surveys demonstrate that most staff members believe Poulos is an effective leader who is accessible and responsive to problems. Managers also praise his leadership skills, giving him an average rating of "outstanding" on our survey. Nevertheless, we found that staff members feel the warden could do more to address CIM's poor maintenance and general state of disrepair, even though the infrastructure problems predate Poulos' arrival.

In summary, Warden Michael Poulos is performing his duties well, despite inheriting a neglected institution that receives inadequate financial support from the department. We are confident that—with the support of his staff and the department—he can eventually address many of the problems facing CIM.

Chapter 2:
Quadrennial Audit Findings and Recommendations

Objectives, Scope, and Methodology

We gained an understanding of CIM's mission, safety and security procedures, and management practices by reviewing applicable laws and regulations, department and institution policies and procedures, and other criteria related to key facility systems, functions, and processes. As detailed in Chapter 1, we also inspected the institution, observed its general operations, and interviewed employees and inmates during the warden evaluation process. In addition, we surveyed selected employees and key stakeholder groups, and we reviewed prior audit reports and statistical data that pertain to the institution.

After assessing the institution's operations and the survey results, we focused our audit on three areas:

- Institutional infrastructure
- Institutional safety and security
- Inmate programs

In conducting our work, we performed the following procedures:

- To determine why CIM's infrastructure is deteriorating structurally and operationally, we surveyed institution staff members, reviewed data and reports obtained from the plant operations and personnel staff, and interviewed various members of the headquarters staff. We also reviewed and evaluated data and reports obtained from the institution's Standard Automated Preventive Maintenance System (SAPMS), institution and department data compiled by an independent consultant, and data from other state agencies. Finally, we toured the institution's grounds and buildings. Findings 1 and 2 discuss our finding results and recommendations in this area.

- To determine whether CIM places appropriate inmates at its Reception Center West (RCW), we interviewed various institution and headquarters staff members and reviewed inmate information in the department's Offender Based Information System (OBIS) and Distributed Data Processing System (DDPS). Finding 3 discusses our finding results and recommendations in this area.

- To determine whether correctional officers in armed posts meet firearms proficiency requirements, we interviewed members of the in-service training and personnel assignment staff and examined the custody staff's employee roster, firearms training records, and post assignment histories. Finding 4 discusses our finding results and recommendations in this area.

- To determine whether CIM provides adequate security at the Minimum Support Facility's visiting area to minimize introduction of contraband, we conducted an unannounced site visit in April 2008 to observe the visiting officers' process for checking in visitors and the officers' ability to effectively monitor the visiting area. We also interviewed members of the investigative services unit and staff members responsible for supervising visiting. In addition, we reviewed daily incident reports related to incidents that occurred during visiting at various adult institutions. Finding 5 discusses our finding results and recommendation in this area.

- To determine whether CIM conducts quarterly fire/emergency evacuation drills, we interviewed fire department personnel and examined compliance reports summarizing quarterly fire evacuation drills and individual area fire evacuation drills. Finding 6 discusses our finding results and recommendation in this area.

Finding 1

The department's available funding allocation to CIM for maintenance and repairs is inadequate to keep the institution in an acceptable state of repair.

For the past five years, the department has allocated an average of $4 million a year for maintenance and special repairs at CIM, an institution that suffers significant infrastructure problems. Yet a consultant hired by the department to assess the condition of CIM and other California prisons estimates that seven times that amount—$28 million annually—is needed to maintain CIM in its present "poor" condition, neither improving it nor allowing it to degrade further. The consultant's data shows that, if funding is not dramatically increased, the institution's condition will reach a level of degradation by 2014 that facilities management experts would recommend demolishing and replacing CIM. In addition, the department lacks a comprehensive data system on which to base maintenance funding allocations, and this lack of reliable data contributes to the underfunding of CIM's maintenance and repair needs.

The department contracted with an independent consultant to assess the physical condition of its adult prisons and establish the baseline funding level necessary to maintain them

Vanderweil Facilities Advisors (VFA)[3] provided an independent assessment at each of the department's institutions, including CIM, to evaluate the condition of each institution's "assets" and estimate the costs to repair or replace them. "Assets" include buildings and related infrastructure such as electrical, plumbing, heating and cooling, and security systems.

In early 2008, VFA completed a detailed assessment of CIM's facilities. The assessment determined the condition of the institution's assets, identified repair priorities, and calculated each asset's anticipated repair cost. The assessment resulted in a "facility condition index" (FCI),[4] which the consultant calculated by dividing the cost to repair CIM's assets by the current replacement value of those assets as shown below:

$$\text{FCI} = \frac{\text{Near-term system renewal costs}^{5} + \text{requirement costs}^{6}}{\text{Asset current replacement value}^{7}}$$

[3] According to its Web site, VFA is the leading provider of integrated software and services for facilities asset management and capital planning and has assessed assets for state correctional departments in Missouri, Virginia, and Idaho. Other clients include Raytheon, Bank of America, and Kaiser Permanente.
[4] The facility condition index (FCI) is an industry-standard index that measures the relative condition of a facility by considering the costs of deferred maintenance and repairs as well as the value of the facility.
[5] The near-term renewal costs are the costs of repairing those assets that will reach the end of their useful lives during the next fiscal year.
[6] Requirement costs are the costs of renewing, or repairing, assets that have already reached or exceeded their useful lives.

In simple terms, the FCI is a ratio of an asset's repair costs compared to its replacement value. The lower an asset's FCI, the better its overall condition. In general, as an asset's FCI approaches 1.00, it becomes more cost-effective to replace the asset rather than repair it.

The FCI is recognized in the facilities management industry as a useful means of measuring the condition of buildings and their component systems.

CIM's overall FCI places it beyond "poor" condition, and many of its buildings rate far worse

The cumulative FCI for all of CIM's collective assets as of August 2008 was 0.409. However, VFA's ratings for CIM's individual assets show many rated at 0.60 and higher—the same index rating at which some experts recommend replacement. For example, seven of the 12 inmate living units within CIM's Minimum Support Facility are rated 0.70 and higher, with three scoring over 0.90. At CIM's Reception Center West (RCW), all eight living units have an FCI over 0.60. Although interpretation of the numeric ratings may vary, an FCI rating greater than 0.10 is considered within the industry to be "poor" while a rating of 0.60 or greater suggests the asset should be replaced. The following table illustrates the qualitative ratings associated with various FCI levels by 11 different facilities management entities.

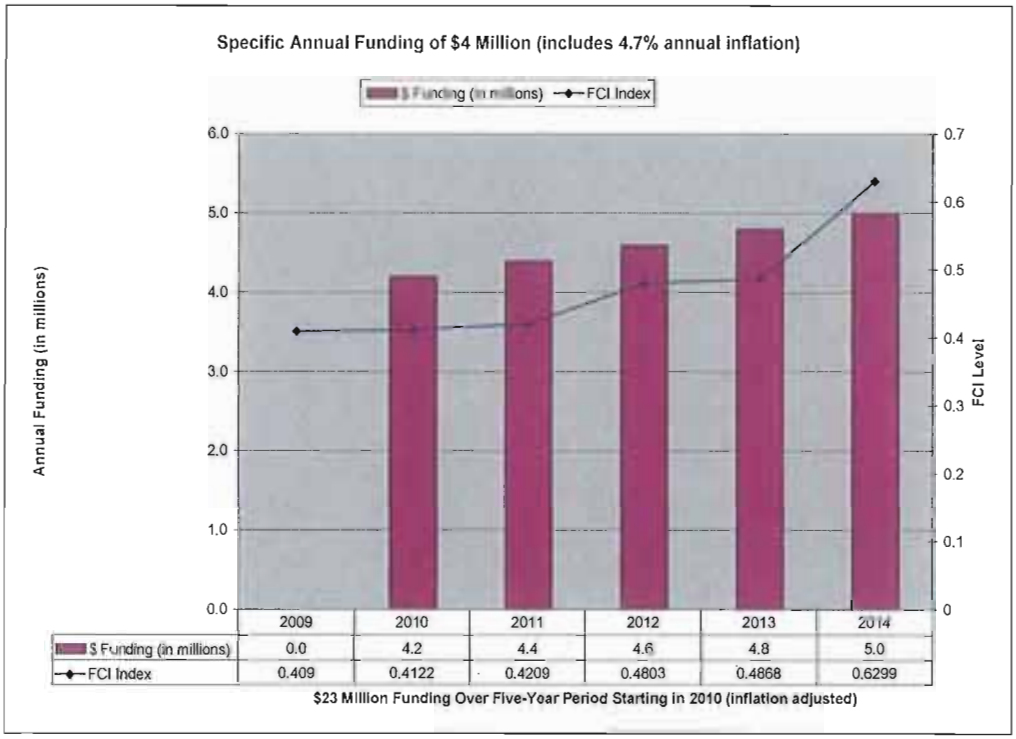
Facility Condition Index (FCI) Ratings Comparison

	FCI Rating Categories							
	Excellent	Very Good	Good	Adequate	Fair	Poor	Very Poor	Replace
CDCR – VFA (contractor)	.00 – .05		.05 – .10		.10	> .10		
U.S. Dept. of Energy, Oak Ridge National Laboratory	.00 – .02		.03 – .05	.06 – .10	.11 – .25	> .25		
U.S. Office of the Architect of the Capitol	< .02		.02 – .05		.05 – .10	> .10		
Portland, Oregon, Parks and Recreation		< .05	. 05 – .10		.11 – .30	.31 – .50	> .50	
Kentucky Council on Postsecondary Education			< .05		.05 – .10	> .10		
Virginia State Council of Higher Education, George Mason Univ.			< .05		.05 – .10	> .10		
National Assoc. of College & Business Officers			< .05		.05 – .10	> .10		
Port of Seattle, Seattle Port Commission			< .05		.05 – .10	.11 – .59		> .60
NASA – Nextor (contractor)	.00 – .02	.02 – .04	.04 – .06		.06 – .10	> .10		> .30
University of Colorado, Boulder								.30
Santa Monica College – 3D/I (contractor)			< .10		< .10	> .10		.50

[7] The asset replacement value is the current cost to replace an asset.

The department's current spending levels are inadequate and will lead to rapid degradation of CIM

The following graph depicts the effect on the FCI of maintaining a $4 million specific annual level of funding for repair and maintenance of CIM, adjusted for annual inflation using a factor of 4.7 percent. This specific annual funding is based on the department's actual average allocations to CIM for repair and maintenance for fiscal years 2003–04 through 2007–08.

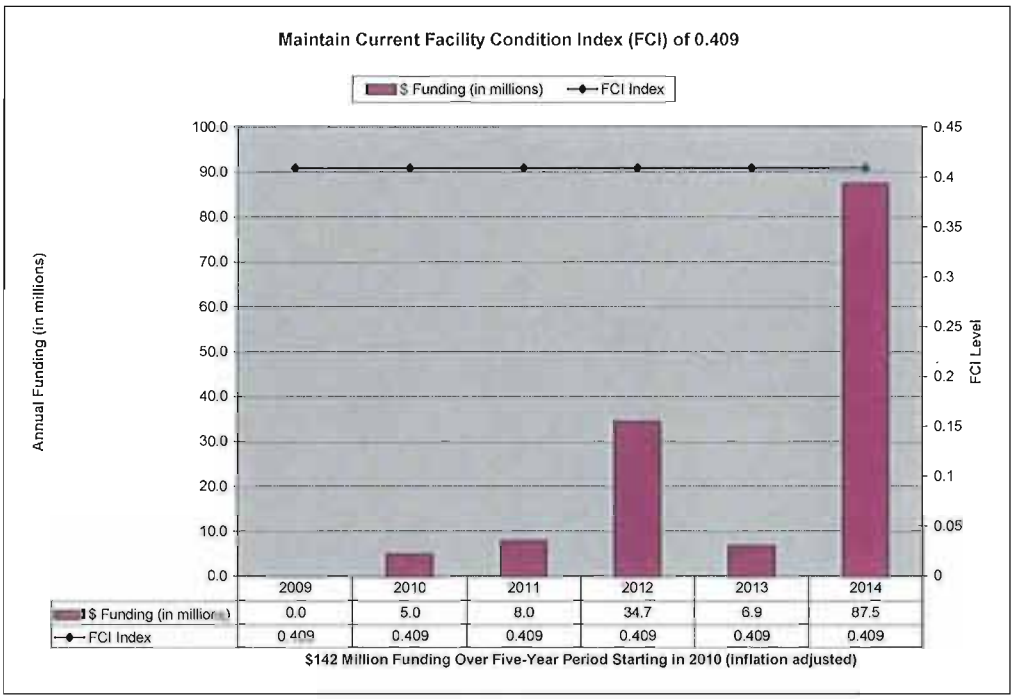


Based on the consultant's model, the department's present level of funding, if continued, will result in a steadily increasing FCI projected to exceed 0.60 by 2014. As noted above, industry experts recommend replacement of an asset when it reaches the 0.60 FCI level.

Maintaining CIM at its current condition will cost roughly a third of the department's annual maintenance and repair spending for its entire adult prison system

The graph below projects the annual maintenance expenses that would be needed to maintain CIM's current FCI level of 0.409 without improving the institution or allowing it to deteriorate further. Simply maintaining CIM's present FCI at 0.409, according to the consultant's model, will require an investment of over $5 million

in 2010 and more than $142 million during the next five years, averaging over $28 million annually during that period.



This $28 million annual average need is significantly more than the $4 million currently allocated to CIM by the department, and in fact, represents nearly one-third of the department's entire maintenance and repair budget. Specifically, in fiscal year 2007–08, the department was allocated $49 million for maintenance and $47 million for special repairs for all its prisons.[8] According to the department's chief deputy secretary of facility planning, construction, and management, the department's estimated total current maintenance and special repair need is about ten times greater than its current allocation.

The department lacks a centralized system to provide relevant, reliable, and complete data on which to base funding allocations to its prisons

According to a February 2007 report by the Legislative Analyst's Office (LAO),[9] the department lacks an objective and systematic maintenance funding method. The LAO's report noted that the formula used by the department to determine

[8] This amount does not include funds approved by the Legislature for capital outlay.
[9] *Analysis of the 2007–08 Budget Bill: Judicial and Criminal Justice,* February 2007, http://www.lao.ca.gov/analysis_2007/crim_justice/cj_05_anl07.aspx

each prison's maintenance allotment does not consider a prison's age, physical size, mission, or inmate population. Consequently, in the past the formula did not allocate resources in a way that ensured they were used in prisons that needed them the most. According to the department's chief deputy secretary of facility planning, construction, and management, beginning in fiscal year 2007–08 the department moved toward a more analytical method that involves examining unique characteristics and needs of individual institutions in considering budget allotments. The new method allocates funding after considering various institution factors, including acreage, square footage, age, environment, and inmate population.

Nonetheless, the lack of a comprehensive system in the past that considered a prison's mission, age, inmate population, and geography for allocating maintenance and repair funds has contributed to underfunding of CIM's maintenance needs. In turn, this underfunding leads to a growing deferred maintenance backlog and greater long-term costs. Deferred maintenance results when routine and preventive maintenance is inadequate and special repair projects are not accomplished as needed. If repairs to buildings and infrastructure components are constantly deferred, normal decay is accelerated; eventually, prisons will require more expensive investments, such as emergency repairs, capital outlay projects, or full replacement. Besides the risk of experiencing increased material and labor costs in the future, the long-term effects of deferring maintenance and repairs often include additional costs, such as loss of use of a facility or asset, and lawsuits over health or safety conditions.

Underfunding has left CIM with significant maintenance problems

CIM's plant operations managers led us on a tour of the institution to show us examples of the most significant problems, including an ineffective water treatment system, failing plumbing, dilapidated housing units, leaking roofs, and hazardous materials in need of removal.

Water and plumbing

CIM sits on an underground aquifer from which it produces water to supply itself and the adjacent California Institution for Women, Heman G. Stark Youth Correctional Facility, and Prado Fire Camp, delivering roughly three million gallons of water daily during peak demand times. The area surrounding CIM previously consisted of dairies, and cow manure from the dairies

Copper pipe clogged by mineral deposits at CIM

left the groundwater high in nitrates. According to CIM's plant operations supervisor, high-nitrate water causes pipes to clog by forming a crystallized buildup that prevents normal water flow, especially in hot water pipes (see photo). The restricted water flow also requires water pumps to work harder, subjecting them to more frequent repair. Inmates routinely complain about lack of hot water and the related hygiene issues. CIM's widely spread campus provides more opportunities for the nitrate problem to manifest itself because water pipes travel over such a large area within the institution's 1,600 acres. Further, heat exchangers used to produce the institution's hot water require frequent cleaning to maintain the flow of hot water, diverting plant operations staff from other maintenance and repair projects.

A major factor in CIM's water quality problems is its failed denitrification plant. Built in 2000, according to the plant's supervisor, the plant is insufficient to mitigate CIM's nitrate levels. Water high in nitrates is associated with health problems in pregnant women, affecting the neighboring California Institution for Women, which must buy bottled water for its female inmate population at an approximate cost of $40,000 a month.

Bathroom in Pine Hall dorm showing water damage from plumbing leaks

The high nitrate levels in CIM's water have also drawn the attention of the California Department of Public Health's Drinking Water Program enforcement unit, which visited the institution in 2007 and threatened enforcement action. According to an official from the Department of Public Health, the enforcement action could result in an order to cease-and-desist operations at the water plant if the condition is not fixed. According to the department's chief deputy secretary of facility planning, construction, and management, a construction project to repair the plant is currently underway, and the plant is expected to be operational in September 2009.

Dormitories at Reception Center West

According to CIM's plant operations management, the Office of the State Fire Marshal and the department's Architectural and Engineering Section determined that none of RCW's eight housing units comply with current California building codes, nor do they have any fire protection systems. Consequently, the Architectural and Engineering Section recommended that CIM replace all eight housing units.

Reception Center Central

CIM's current receiving and release building, Reception Center Central (RCC), lacks adequate space to safely and securely process the incoming inmate population. The original building design can no longer process the high volume of inmates efficiently. Prior building modifications to accommodate the increasing number of inmates have resulted in poor air circulation, cramped quarters, and line-of-sight problems resulting in blind spots that create safety issues for officers and inmates.

Hazardous materials

The institution's environment contains significant levels of known allergens and hazardous materials. Lead paint and mold affect many structures, which lack modern air filtration systems and modern insulation, especially in inmate bathrooms. For example, lead paint chips can take on the form of dust that can be hazardous if inhaled. Asbestos, also recognized as a hazardous material, can be found in CIM's buildings. The proper removal of asbestos, lead, and other contaminants must meet federal government guidelines and can be an expensive and time-consuming process, but this process is required whenever repairs or renovations are performed on areas containing such materials. According to the department's chief deputy secretary of facility planning, construction, and management, the department has sought and obtained funding to add environmental staff to help prisons respond to hazardous materials.

Roofing

Several living units require roof repairs to fix water leaks that, if not repaired, can lead to further structural damage and therefore increase overall repair expenses.

CIM's infrastructure problems are familiar to department management and to the Legislature, but approved projects remain unfunded

The department's former undersecretary of operations toured CIM in March 2006 while still the chief deputy director of the Division of Adult Institutions. In a subsequent memorandum to the deputy director of the department's Facilities Management Division, the then-chief deputy director wrote about the "painfully obvious [state] of the aging infrastructure within the institution. In fact, there are plumbing chase doors that are so dilapidated that the doors are literally hanging off their hinges and cannot be secured to the framing because of the prolonged rust and deterioration. In one unit, the sub flooring is rusted and the plumbing is so bad that the unit is

Rusted subflooring, South Dorm

not being used for inmate housing (South Dorm at the Minimum Support Facility).... Furthermore, there are serious calcification problems throughout the institution due to high nitrates in their water supply."

The memorandum further expresses the chief deputy director's desire to meet with the division chief of the Facilities Management Division to map out a strategic plan addressing CIM's needs. In the interim, the memorandum's author became the department's undersecretary of operations until August 2008, yet the number of approved but unfunded special repair projects at CIM reached 21 in May 2008, the highest of any prison in the department, totaling $9.6 million.

The Legislative Analyst's Office (LAO) also cited the department's infrastructure problems in its February 2007 report, recognizing the department's failure to maintain the infrastructure of its adult prisons. The LAO also reported that the state's failure to perform preventive maintenance is becoming a liability for the department as small problems grow and require more costly special repairs.

According to the department's chief deputy secretary of facility planning, construction, and management, the department has addressed some of the LAO's concerns by developing a Maintenance Services Branch to oversee plant operations, set standards, and ensure compliance statewide.

Recommendations

The Office of the Inspector General recommends that the department secretary require that the California Department of Corrections and Rehabilitation:

- Develop and use reliable data on current and future maintenance and repair needs on which to base funding allocations and plan for maintenance and special repair expenditures. The VFA project will provide the groundwork for developing this information, but the department must commit to using the information to full advantage and to supplementing it with its own data collection and monitoring efforts.

- Direct the newly created Maintenance Services Branch to work with CIM to complete an analysis by December 2009 to determine whether performing the necessary repairs and modifications identified by VFA to bring present structures into a condition that meets the department's current needs is more cost-effective than constructing a new prison on CIM's present site.

Finding 2

Despite the formidable gap between available repair and maintenance funding for CIM and the institution's actual needs, CIM can still take actions to mitigate its infrastructure problems.

While the funding gap, discussed in Finding 1, is a major factor contributing to CIM's infrastructure problems, CIM has inefficiencies it could correct to maximize the effectiveness of its existing plant operations resources. These inefficiencies include failing to fill plant operations vacancies, neglecting to take full advantage of an established system for tracking and planning maintenance activities, and allowing duplicate work orders to clutter its system. By correcting these problems, CIM can reduce unnecessary work, improve local supervisors' capacity to manage maintenance activities, and provide objective evidence for the department's use in establishing equitable maintenance funding allocations to CIM.

CIM officials cite difficulties in hiring and filling vacant positions as a key factor limiting the institution's ability to address infrastructure problems

CIM's plant operations manager reported that as of July 22, 2008, CIM had 14 vacant positions in its plant operations unit, a 19 percent vacancy rate (14 of 73). According to the institution's personnel staff, two factors contribute to plant operations vacancies:

- Departmentwide examinations for plant operations positions are geared toward journey and supervisory levels, leaving the institution responsible for its own recruiting and hiring of entry-level plant operations employees. However, local response to open "spot exams" for entry-level plant operations positions has not been strong, and not enough candidates apply for the open spot exams.

- An emphasis on inmate medical care requires the personnel office to focus its recruitment and examination efforts on health care positions while neglecting recruitment of entry-level plant operations workers. Thus, there are no open certification lists for plant operations positions at CIM.

CIM's inability to fill its 14 vacant plant operations positions hinders the institution's ability to promptly address needed repairs and maintenance and places an additional burden on existing plant operations employees. Further, the inability to promptly respond to needed repairs contributes to the deterioration of the physical plant and ultimately increases costs.

CIM's staffing vacancies, combined with a prevalence of emergency projects, challenge the maintenance staff's ability to perform preventive maintenance work

In its February 2007 report, the Legislative Analyst's Office (LAO) recognized that maintenance workers responsible for preventive maintenance at prisons are also tasked with performing emergency repairs, which take priority over preventive maintenance. We found this to be true at CIM.

Representatives at the institution and in various department divisions at headquarters said that reception centers such as CIM tend to suffer more abuse from inmates than other types of prisons. According to the representatives, inmates at reception centers stay for relatively short terms during their initial processing and thus have no incentive to keep their cells in working order, and they often act out by intentionally damaging their cells. As a result, CIM's plant operations staff must continuously repair inoperable cells to prepare them for occupancy by a flow of newly arriving inmates. Moreover, the institution's maintenance staff incurs what a plant operations supervisor termed "a ridiculous amount of overtime," which he said exceeded a half-million dollars in fiscal year 2006–07, while preventive maintenance is neglected altogether.

Besides having plant operations vacancies, CIM may be receiving an inadequate allocation of such positions relative to its size and mission

We found that CIM, despite being the state's third oldest prison, is one of several prisons that had never received a baseline "staffing package," according to the Program Support Unit in the department's Division of Adult Institutions. Since the 1980s, the department has developed staffing packages for its prisons based primarily on inmate population. The staffing package determines the number of custody and support staff members allocated to each prison.

When compared to Kern Valley State Prison (KVSP), which was activated in 2005, CIM's staffing allocation appears inadequate. The following table compares the authorized staffing levels for plant operations for the two prisons.

Comparison of CIM and KVSP Inmate Population to Plant Operations Positions Authorized

	CIM	KVSP	Difference
Inmate population as of March 31, 2008	5,925	4,734	1,191
Plant operations positions authorized, fiscal year 2007–08*	72.5	78.6	(6.1)
Ratio of inmate population to plant operations positions	81.7	60.2	

**Per Governor's Budget, Salaries Wages Supplement, FY 2008–09, as listed under "Facilities Operations" and omitting fire department, auto mechanic, and warehouse positions.*

Thus, while CIM houses 25 percent more inmates, KVSP has more authorized plant operations positions. Since the department's staffing packages consider inmate population the primary factor in allocating positions to an institution, this comparison suggests CIM is understaffed in plant operations positions. If the 60.2 inmate-to-staff ratio at KVSP were applied to CIM based on its inmate population, CIM would have 98 plant operations positions instead of 73.

Further, CIM is over 60 years old, yet it has fewer authorized plant operations positions than a three-year-old prison with fewer inmates and must use its plant operations staff primarily on emergency repair work while preventive maintenance is neglected. The inconsistent nature of the department's allocation of plant operations positions was also noted in the LAO's February 2007 report, which said that the complement of plant operations staff members established by the department for its individual prisons "is not based on any objective measure of their repair needs, such as their size, age, or mission." We discussed these issues with the department's chief deputy secretary of facility planning, construction, and management, who said that the department is actively pursuing a baseline adjustment to plant operations staff for all its institutions to take into account the age of each facility and its required maintenance needs.

CIM does not fully use a computer system developed to track preventive maintenance, which may be contributing to its maintenance funding gap

The department implemented the Standard Automated Preventive Maintenance System (SAPMS) statewide in fiscal year 2001–02 to provide tracking, scheduling, recording, analysis, and retrieval of maintenance and operational data to manage institutional maintenance. Although data from this system is a factor in allocating maintenance funding, CIM is significantly underreporting the number of maintenance workers' hours.

The plant operations unit at each adult prison reports its SAPMS data through a local area network with the ability to produce comprehensive reports on the condition of all physical plant assets, as well as projections for preventive and corrective maintenance. The SAPMS also includes a time-tracking database to account for staff time worked, training time, and time off.

We found that CIM's plant operations staff falls far short of complete accountability in recording hours in the SAPMS database. We analyzed the hours recorded in CIM's SAPMS database for calendar year 2007 and concluded that the plant operations staff failed to account for 72,804 hours, or roughly 35 state personnel years.

CIM's Operational Procedure #031, *Maintenance Work Requests, Work Orders and Project Requests*, requires staff members to provide documentation of an

eight-hour workday, as well as any overtime, training, and time off, on the Plant Operations Daily Work Log. Completed work is to be recorded on this document to ensure tracking and accountability for all work performed by the plant operations staff. This document must be submitted to the plant operations office daily, with completed work orders recorded on the document, for SAPMS processing.

Assuming conservatively about 40 to 45 staff members charge hours to the SAPMS database during the year, we calculated the expected number of hours that should have been charged each month if each non-supervisory employee recorded 40 hours a week. We found that actual hours recorded in the SAPMS for 2007 totaled only 39,925, while our predictive test calculated 89,592 hours. When factoring in the 23,137 overtime hours charged by staff members, the unaccounted difference was even more significant, totaling 72,804 hours (89,592 expected regular hours, plus 23,137 overtime hours, minus 39,925 hours actually recorded), or approximately 35 personnel years. CIM's management cited frequent emergency repairs and overtime as significant barriers that prevent staff members from consistently recording their activity in the SAPMS.

This significant under-recording of activity leaves decision-makers with faulty data from which to make asset-allocation decisions and may negatively affect CIM's efforts to obtain funding for maintenance and repairs. The Facilities Management Division introduced a formula in fiscal year 2007–08 to allocate maintenance funding for each prison using a scoring system. According to the Facilities Management Division, the funding formula is based in part on past expenditures for which the SAPMS will serve as a primary source. By failing to record activity in the SAPMS, CIM is understating the maintenance and repair activity on which funding is based and consequently may not receive its full funding allocation from the department.

CIM's failure to follow its own operating procedure causes duplicate work orders and creates unnecessary work for the plant operations staff

The plant operations analyst responsible for entering work orders into the SAPMS database showed us a stack of about 1,000 duplicate work orders accumulated from 2006 to 2008. Work orders not immediately recognized as duplicates are entered in the SAPMS database, causing the list of open work orders to be overstated and leading to unnecessary time spent by plant operations staff members, who may be dispatched to perform repairs that have already been completed.

CIM's Operational Procedure #031, *Maintenance Work Requests, Work Orders and Project Requests*, requires a designated work order coordinator for each facility in the institution. The work order coordinator is responsible for tracking

all maintenance work requests for his or her facility by maintaining a logbook and copies of all maintenance requests submitted, as well as assigning a tracking number to each request.

If CIM followed this operating procedure, duplicate work orders would be reduced significantly because the work order coordinator for each facility would be able to identify duplicates and prevent them from being submitted to plant operations for action.

Recommendations

The Office of the Inspector General recommends that the warden at CIM:

- Continue to aggressively recruit and conduct examinations for plant operations positions to fill existing vacancies, soliciting assistance from department headquarters if necessary.

- Hold plant operations employees accountable for recording all of their time in the SAPMS database.

- Enforce the local policy requiring a work order coordinator at each facility to reduce duplicate work orders.

Finding 3

Staff at CIM's central reception center inappropriately approved some dangerous, high-risk inmates for housing in crowded dormitories.

When staff members at Reception Center Central (RCC) approved some inmates to be housed at the institution's Reception Center West (RCW), they did not follow procedures for reviewing the inmates' classification scores to ensure those scores do not exceed the limit for RCW. As a result, the staff placed unsuitable inmates at RCW, where two correctional officers supervise about 200 inmates in each of seven open dormitories and about 100 additional inmates in another open dormitory. CIM's inmate eligibility criteria for RCW exclude certain inmates because their classification scores are too high or are unknown; a high classification score often results from repeated bad behavior while in prison. Moreover, in an open dormitory setting where fights among inmates can quickly escalate and spread, it is difficult for officers to gain control of inmates who assault staff members or other inmates.

CIM local policy clearly establishes inmate eligibility criteria for the institution's reception centers

CIM receives about 600 inmates weekly at its RCC for initial screening and processing into the state prison system. Generally, inmates who represent the highest safety and security risk and those en route from one institution to another are retained at RCC. Transportation unit staff at RCC must evaluate the remaining inmates to identify those eligible for transfer to one of CIM's other two reception centers, Reception Center East (RCE) or Reception Center West (RCW).

CIM's local operational policy establishes criteria for inmate eligibility for each reception center. Inmates with higher security needs are moved to RCE, which contains mostly celled housing. Inmates with lower security needs are transferred to dormitories at RCW, where roughly 1,500 inmates live in eight open dormitories with two correctional officers supervising each dormitory. In these dorms, inmates move freely in areas crowded with two-tier bunks and inmates' personal items, potentially obstructing the officers' line of sight and inhibiting the officers' ability to control volatile situations before they escalate to violence.

An inmate's classification score, which is an indicator of the inmate's behavior in prison, is one criterion the officers at RCC must consider when assigning housing. The classification score is based on various case factors, including the inmate's sentence length and behavior while in prison. Points are added to an inmate's classification score when the inmate is found guilty of a serious rules violation. For example, an inmate found guilty of possessing a deadly weapon is assessed an additional 16 points. Points are subtracted when the inmate has no serious

disciplinary problems during annual review periods. California Code of Regulations, Title 15, section 3375(d) states that a lower placement score indicates lesser security control needs while a higher placement score indicates greater security control needs.

Inmates with a classification score higher than 35 or whose classification score is unknown are ineligible for placement at RCW. However, an inmate's prior classification score is not always known when RCC staff (which includes correctional counselors) must decide where to house the inmate. For parole violators, who comprise most of CIM's inmate population, the 35-point limit refers to their most recent classification score—their score at the time they last paroled. This score is retained with other information in the department's Distributed Data Processing System (DDPS). But according to a system analyst in the department's DDPS unit, an inmate's record in DDPS is archived upon parole. The analyst explained that in cases where a parole violator returns to the same reception center from which he last paroled, his record in DDPS is still available at that reception center. However, if a parole violator comes into a reception center after paroling from a different institution, his online DDPS record containing the previous classification score is not available to that reception center until the next day. After the reception center staff enters the inmate's arrival date and other information into DDPS, the system updates itself and restores the inmate's archived record during its overnight update process.

Staff did not follow procedures that provide a safety net in instances when they must move inmates before knowing their classification scores

We reviewed the classification scores of inmates living at RCW on April 4, 2008, and on May 1, 2008, and we identified 19 inmates who should not have been housed at RCW because their classification scores were either too high or unknown. Specifically, ten of the 19 inmates had classification scores higher than 35, and the other nine inmates had a "999" code instead of a classification score, meaning their score was unknown. CIM's desk procedures for RCW do not allow such inmates to be housed at RCW. Although the inmates' scores were not available at the time the staff transferred the inmates, the staff did not follow up the next day when the scores became available.

RCC does not have enough beds for all inmates who arrive during the day, according to a CIM associate warden who previously managed operations there. To avoid having inmates spend the night in temporary overflow holding cells at RCC, staff members must decide which inmates to transfer out of RCC, although some of those inmates' classification scores may still be unavailable. The associate warden explained that because about 85 percent of the inmates who come into RCC remain there for at least 24 hours, their scores are available for staff members to review. The remaining 15 percent may not have their prior

classification scores available for consideration when staff members must decide which inmates can be transferred out of RCC.

Sometimes inmates must be transferred out of RCC on the same day they arrive because of capacity issues. If the inmates' previous classification scores are unavailable, staff members must evaluate other information about the inmates before initially approving them for RCW. Specifically, staff members told us that they evaluate historical information in the department's Offender Based Information System (OBIS) regarding inmates' movement within the prison system to identify case factors that may exclude them from RCW. For example, the information may show that before paroling, an inmate transferred to an outside hospital, to a medical clinic within the institution, or to an administrative segregation unit. Staff members use this information to identify inmates with histories of medical or mental health problems or other behavioral problems.

Staff members said they also consider the nature of the institution at which the inmate lived just before paroling. For example, disregarding all other exclusionary factors, most inmates who parole from Avenal State Prison are probably eligible for placement at RCW because most of Avenal's inmates are Level I or Level II, meaning their classification scores should not be higher than 27. However, Avenal also houses a small percentage of Level III inmates whose classification scores may be as high as 51, which is 16 points more than CIM allows for inmates at RCW. Thus, while the RCC staff makes an educated assessment of inmates' transfer eligibility, those assessments are not without risk.

To mitigate this risk, according to the staff, when it becomes necessary to transfer inmates to RCW before the inmates' classification scores are available, staff members follow a "safety net" process by reviewing those inmates' classification scores when they become available the next day. If staff members identify inmates whose scores are higher than 35, they immediately transfer them out of RCW. However, the staff did not follow this procedure for the 19 inmates we identified at RCW on April 4, 2008, and May 1, 2008, because these inmates had all been at RCW for more than one day. In fact, one inmate with a classification score of 82 was at RCW for over five weeks before the staff realized and transferred him to RCE.

When we discussed our audit findings with an associate warden, he suggested that the staff could use another system, called DECS (Disability and Effective Communication System), to check parole violators' classification scores. The associate warden explained that DECS has been available to the staff in CIM's receiving and release unit at RCC for several months. Unlike the Distributed Data Processing System (DDPS), DECS is designed to provide CIM the classification score on all returning inmates, not just those who paroled from CIM. The receiving and release unit staff use DECS to identify inmates with disabilities, but the transportation unit staff has not yet been required to use it.

Even when inmates' classification scores are available, staff members do not always review them before deciding to transfer the inmates to RCW

We found that CIM staff members failed to check the classification scores of five of the 19 inmates before approving their transfer to RCW, even though the staff had ample time to do so. One inmate whose classification score was 38 was at RCC for six days before the staff transferred him to RCW. Four of the inmates with the 999 code were at RCC for more than 24 hours—one of them for seven days—before the staff transferred them to RCW.

When notified of the presence of inmates with classification scores over 35 points at RCW, one of CIM's chief deputy wardens remarked that because RCW's design includes an electrified perimeter fence, it qualifies as a Level III facility, so inmates with classification scores as high as 51 points can technically be placed there. However, by setting a lower score limit for the inmates it is willing to house at RCW, CIM's management recognizes the elevated risk of negative behaviors associated with higher-scored inmates, especially when such inmates are housed in a crowded dormitory supervised by only two correctional officers. While an electrified fence may mitigate escape attempts, it does little to prevent violent behaviors by the inmates living within its perimeter. Placing inmates with histories of disruptive or assaultive behavior in an open setting where they can roam freely and where fights among inmates can quickly escalate and spread creates a more dangerous environment for inmates and staff members. Incidentally, three of the 19 inmates we identified had classification scores above 52, exceeding the "technical limit" of 51 cited by the chief deputy warden. Department regulations require that inmates with scores of 52 and above be placed in a Level IV facility with additional security features, such as cells.

CIM's local operational policy does not reflect the institution's current practice of using classification scores to evaluate inmates for placement at RCW

CIM revised its local operational policy establishing inmate eligibility criteria for its reception center facilities in January 2008, but the revision failed to delete references to "inmates' prior custody level" from the list of criteria—even though this information is no longer available. Since August 2006, DDPS no longer displays an inmate's prior custody level if it was rated below "maximum" at the time of parole. Moreover, CIM's written policy does not reflect its actual practice of using inmates' classification scores to determine which inmates can transfer to RCW. CIM's Operational Supplement requires the institution's management to ensure that staff members review policies annually and ensure that managers revise the policies as necessary to reflect department or institution operational needs. By not revising policies to ensure that they contain accurate information,

CIM's management is not clearly communicating its expectations to employees, which increases the possibility for errors to occur.

Recommendations

The Office of the Inspector General recommends that CIM managers:

- Require transportation staff in the central reception center, who make the decisions to move parole violator inmates to RCW, to check inmates' classification scores in the Disability and Effective Communication System (DECS) before moving them. In instances when overcrowding in the central reception center forces the officers to transfer inmates to RCW before their classification scores are available, assign a staff member the responsibility of checking the scores the next day. If the staff member identifies an inmate who is not eligible for RCW, promptly transfer the inmate out of that facility, and hold the staff member accountable if any inmate with a classification score above 35 is found at RCW more than 24 hours after being transferred there.

- Ensure the institution's local operational policy for inmate eligibility at RCW is updated by deleting the reference to "prior custody level" and replacing it with relevant evaluation factors that may include classification score, behavioral history, and mitigating or aggravating factors.

Finding 4

CIM allows peace officers who have not attended mandatory quarterly firearms training sessions to assume armed posts at the institution and off-site in local hospitals.

Although CIM has a process for identifying peace officers who fail to attend mandatory quarterly qualification sessions, many such peace officers continue to work armed posts instead of being redirected to alternate posts pending completion of quarterly qualification requirements. Furthermore, a departmentwide memorandum issued in November 2004 permits peace officers who are not quarterly qualified to work armed posts through shift swaps or overtime. This practice conflicts with various California statutes and regulations, as well as other department policies, which require officers to complete quarterly firearms training sessions before assuming armed posts. In addition, according to the department's Operations Manual, an officer who fails to attend or qualify at a quarterly session must be redirected to a non-armed post pending completion of the missed session. Allowing peace officers to work armed posts without completing the required quarterly qualification sessions endangers employees, inmates, and the public and exposes the state to litigation if such an officer uses deadly or less-lethal force.

Various statutes, regulations, and department policies require officers to complete quarterly firearms training sessions before assuming armed posts

California Penal Code section 830.5(d) requires quarterly qualification for correctional officers assigned to armed posts. Likewise, Title 15, section 3276(a) of the California Code of Regulations states that only peace officers who have satisfactorily completed firearms training and who are currently qualified to fire department firearms will be assigned to armed posts. The department's Operations Manual section 32010.19.7 requires all department peace officers issued a department weapon as part of their regular or special assignment, such as armed posts, to "complete a proficiency course on a quarterly basis *prior to* assuming the post." [Emphasis added.] The department's Operations Manual requires the watch commander to assign *qualified* transportation officers to transportation details if unscheduled or emergency transportation needs arise. Finally, according to Operations Manual section 32010.19.10, peace officers must notify their supervisor upon assignment to an armed post if they have not met the requalification or quarterly proficiency requirement.

These policies also serve to restrict the activity of peace officers who fail to meet the quarterly firearms qualification requirements. Specifically, Operations Manual section 32010.19.5 states that officers will not be permitted to work in an armed

post or any other assignment that requires them to be armed until they meet the minimum requirements.

CIM has established local procedures to enforce department policy

In a February 2, 2006, memorandum to custody staff, Warden Poulos designated four months (February, May, August, and November) as the quarterly firearms qualification months for CIM's correctional officers. Officers regularly assigned to armed posts as well as officers serving in armed posts as permanent intermittent and relief officers must attend a quarterly qualification session during each of these four months to work at an armed post during the three-month period immediately following the designated qualification month. For example, the February qualification sessions cover the quarter beginning March 1 and ending May 31. Similarly, the May qualification sessions cover the quarter beginning June 1 and ending August 30. Each officer is responsible for ensuring he or she maintains quarterly firearms qualification by attending the mandatory training in each of the four months. The In-Service Training (IST) Unit publishes the dates and times for each quarterly qualification session in the IST bulletin.

CIM's IST manager identifies the peace officers who fail to attend or fail to qualify at the mandatory quarterly qualification sessions and distributes an exception list at the weekly executive staff meeting to all associate wardens. The associate wardens distribute the information down the supervisory chain of command. The memorandum accompanying the list specifies that officers on the list are to be redirected to non-armed posts pending firearms qualification, and any officer who has met the quarterly qualification requirements should provide coverage for redirected officers. The IST armory sergeant prepares a letter of instruction for each peace officer on the exception list, provides the letters to the IST manager for review, and ensures that the employee relations officer receives the letters for distribution to the non-compliant officers.

Although CIM identifies officers who fail to attend or pass mandatory quarterly qualification sessions, those officers continue to work armed posts

We reviewed the March 2008 time sheets of the 43 officers appearing on CIM's February 2008 exception list and found that 34 of the officers (79 percent) had worked in at least one armed post. These officers were out of compliance with CIM's policy because as of March 1, 2008, they failed to qualify at a range session during February 2008. For example, a vacation relief officer who worked four shifts at the gym observation post had not attended a qualification session since May 31, 2007, a period of nine months prior to March 1, 2008. Another vacation relief officer worked five gym gun shifts during March 2008, despite having no record of attending any qualification session from May 1, 2006,

through February 29, 2008, a 23-month lapse. Finally, two training relief sergeants worked armed posts despite appearing on the exception list. One sergeant worked two control shifts and one medical transportation shift even though the sergeant had not attended a qualification session since February 28, 2007, a 12-month lapse. The other sergeant worked three control shifts and two perimeter security shifts despite having not attended a qualification session since September 19, 2007.

Further, CIM supervisors are not working with the IST manager to ensure that subordinates meet the minimum qualification requirements. For example, 18 of the 34 officers working an armed post during March 2008—despite appearing on the February 2008 exception list—were relief officers supervised by the personnel assignments office. The personnel assignments office receives a copy of the exception list and should have redirected the 18 officers to non-armed posts until they made up the missed qualification session. In addition, five of the officers report directly to CIM's watch office, where the watch sergeant receives a copy of the exception list and should have redirected the five officers. Similarly, the remaining 11 officers reported to various facilities within CIM and should have received redirection instructions from their respective supervisors. These 34 officers violated a department policy (Operations Manual section 32010.19.10) requiring them to notify their supervisor at the time of assignment if they had not met the quarterly proficiency requirements.

We discussed our findings with CIM's security operations captain and chief deputy warden, and they both agreed that supervisors were not redirecting non-compliant officers as required. The captain also stated that supervisors were not checking the officers' weapons qualification cards. The day after our discussion, the security operations captain distributed a memorandum to all sergeants instructing them to review the weapons qualification card of each officer to ensure that current qualifications have been met. The memorandum also asked all supervisors assigned to the watch office to familiarize themselves with IST's exception list and to redirect any officers who have not met the qualifications.

The department allows officers who do not meet quarterly firearms qualifications to work armed posts under a department memorandum that contradicts state law

The deputy director of the department's Institutions Division (renamed the Division of Adult Institutions) issued a November 4, 2004, memorandum to all regional administrators and wardens that allows officers who are not regularly assigned to armed posts to work such posts in overtime assignments. The memorandum also permits officers to swap or trade work assignments without regard to their firearms qualifications or training. According to the memorandum, officers working an armed post in overtime status or through shift swaps do so

voluntarily or temporarily and thus should not be required to quarterly qualify before assuming the armed post.

However, we believe that the November 2004 policy is contrary to the formal department rules and state law. As reported in our April 2008 accountability audit,[10] CIM was one of five institutions tested in our audit sample that allowed officers not quarterly qualified to assume armed posts under the departmentwide memorandum. While our April 2008 report took exception to the practice, the report did not evaluate the magnitude of the issue. To evaluate the issue at CIM, we analyzed data from CIM's timekeeping system for March 2008, the month following CIM's designated quarterly qualification month of February 2008, and found a significant number of officers working in armed posts who typically receive only one firearms training session a year.

On any given day, CIM must ensure that about 110 permanently assigned armed posts are filled, as well as a varying number of armed posts in local hospitals for medical guarding and medical transportation escorts, depending on the number of inmates requiring outside medical attention. CIM's timekeeping data revealed that on March 4, 2008, CIM filled 120 predetermined armed posts, 75 medical guard posts, and 19 medical transportation posts—214 armed posts in total. We analyzed the training records of officers working these posts on March 4, 2008, to determine the extent to which non-compliant officers worked in armed posts that day. We also determined the time elapsed since those officers' last qualification sessions. As shown in the following table, CIM's watch office filled 62 of the 214 armed posts (29 percent) with officers who had not met the quarterly firearms qualification requirement. Furthermore, nearly 67 percent of the officers assigned to medical guard posts in local hospitals had not met the quarterly qualification requirements.

[10] *Accountability Audit: Review of Audits of the California Department of Corrections and Rehabilitation, 2000–2006* (April 30, 2008) may be found on the OIG's Web site: http://www.oig.ca.gov/reports/pdf/2008_Accountability_Audit_WEB_FINAL.pdf

March 4, 2008, Analysis of Armed Posts

Type of Armed Post	Total Posts	Total Filled by Regular Quarterly Qualified Officers	Total Filled by Officers Not Quarterly Qualified	Percent Filled with Officers Not Quarterly Qualified	Range of Days Elapsed Since Last Qualification Session (for Officers Not Quarterly Qualified)
Predetermined	120	110	10	8.3%	34 to 356 days
Medical Guard	75	25	50	66.7%	34 to 674 days
Medical Transportation	19	17	2	10.5%	34 to 153 days
Total	**214**	**152**	**62**	**28.9%**	

Source: CIM timekeeping system reports and watch sheets for March 4, 2008, and IST records for officers who worked on March 4, 2008.

The table above also highlights the large range of time elapsed between the 62 non-compliant officers' last qualification sessions and March 4, 2008. For many officers, the time elapsed since their most recent qualification session was well beyond a quarterly requirement. For example, officers assigned to work three tower posts had not been to a qualification session for 265, 293, and 300 days, respectively. In addition, an officer assigned to a front-gate post had not attended a qualification session for nearly a year. Officers working in medical guard posts on March 4, 2008, also had not attended a qualification session for long stretches of time. For example, two of the officers had no record of attending a qualification session from May 1, 2006, to February 29, 2008, over 20 months. Eleven of the officers had not attended a qualification session from 300 to 366 days—the remaining medical guard officers experienced lapses of 34 days to 293 days.

Several officers who were out of compliance worked armed posts through shift swaps

To determine the extent to which CIM permits peace officers not quarterly qualified to swap shifts with officers regularly assigned to armed posts, we analyzed all shift swaps worked during March 2008. We found that 11 officers swapped into armed post shifts despite their lack of quarterly firearms proficiency. Five of the 11 officers had not participated in qualification training since at least September 19, 2007, over five months prior. These five included an officer who swapped into a tower position despite not attending a qualification for ten months at the time of the swap. Another officer swapped into a control post even though the officer had not participated in a qualification session since March 7, 2007.

Medical transportation and medical guarding of inmates requires a significant number of armed officers—and many of these officers were out of compliance

CIM's watch office fills medical guard posts every day, and the number of officers assigned depends on the number and classification level of inmates requiring treatment at outside hospitals. We analyzed the timekeeping summary of all medical guard shifts worked in overtime status during March 2008 and found that 321 officers worked one or more such shifts even though the officers were not quarterly qualified. The elapsed time since each officer's last qualification session varied. For example, 21 of the 321 officers (6.5 percent) had no record of attending a qualification session during the period May 1, 2006, to February 29, 2008 (a 22-month lapse), and one officer had not attended a qualification session since September 13, 2006, 18 months earlier. In another example, 72 of the 321 officers (22.4 percent) had not participated in a qualification session for at least ten months as of March 1, 2008.

Our testing of medical transportation shifts revealed that 75 different officers not quarterly qualified worked one or more medical transport shifts on overtime status during March 2008. For example, four of the 75 (5.3 percent) had no record of attending a qualification session between May 1, 2006, and February 29, 2008. Ten of the 75 (13.3 percent) had their most recent qualification session at least ten months prior to March 2008. Further, 18 of the 75 (24 percent) had no record of attending a qualification session for at least eight months as of March 1, 2008.

Despite assurances to the contrary, we found medical escort teams on which neither officer had met quarterly firearms qualifications

Various CIM officials, including the security operations captain and the chief deputy warden, told us that not all outside hospital posts are armed. For example, in situations where an inmate's custody level necessitates two officers to guard the inmate, only one of the two must be armed. Further, the officials emphasized that CIM's watch office sergeant would ensure that the armed officer would be a quarterly qualified officer. However, we reviewed the outside hospital correctional officer pairings from records maintained in the watch office for March 4, 2008, and found that 14 of the 34 outside hospital pairings were out of compliance with the quarterly qualification requirement. That is, neither of the "paired" officers met the quarterly qualification requirement. The time elapsed since each officer's last qualification session as of March 4, 2008, ranged from 48 days to one year. One pairing included officers who had not participated in a qualification session for at least ten months.

When we informed the security operations captain and the chief deputy warden that we planned to analyze the extent to which non-compliant officers work armed posts, the chief deputy warden agreed that it would be ideal to have all officers

quarterly qualified but said that it is not cost-effective to do so. The captain also said that it would be too expensive for CIM to require all officers to be quarterly qualified before assuming an armed post.

Allowing officers to work armed posts without completing the required qualification sessions endangers employees, inmates, and the public and exposes the state to litigation if a non-compliant officer uses deadly force

Peace officers who have not demonstrated recent firearms proficiency may expose the state to litigation and endanger themselves or others if insufficiently trained. Inmate behavior is unpredictable, and the institution and the department assume great risk by allowing officers who have not satisfied quarterly qualification requirements to work in armed posts. Riots or fights involving inmates occur often enough that any officer in an armed post, including those assigned to medical transports or outside hospitals, may be called on to use deadly force. A recent incident in which an inmate from a Northern California prison escaped from his assigned bed at an outside hospital illustrates this risk. The inmate fled through the fire exit door as one officer drew a state-issued weapon and ordered the inmate to stop. The inmate refused to comply and ran into the hospital's parking lot. The officers ultimately regained control of the inmate without having to fire a weapon. However, the incident could have ended differently. Had the officer discharged the weapon in such a public area, the department's efforts to defend itself in any resultant litigation would have been further complicated because at the time of the incident the officer had gone ten months without a firearms proficiency qualification. Both CIM and the department must consider whether they are willing to continue assuming such risk through continued adherence to the November 2004 policy memorandum. In addition, CIM places itself and the department at risk when it does not enforce various statutes, regulations, and department policies concerning quarterly qualification requirements.

Recommendations

The Office of the Inspector General recommends that the warden take the following actions to ensure that peace officers who assume armed posts have completed quarterly firearms qualification requirements:

- Instruct supervisors to periodically review the master roster to ensure their familiarity with peace officers assigned to armed posts and those who could be assigned to armed posts in a "relief" position.

- Instruct supervisors to examine the weapons qualification card of officers whose qualifications they are unfamiliar with to ensure assigned officers

meet the quarterly qualification requirements before assuming an armed post.

- Ensure that officers who receive a letter of instruction for failing to attend a quarterly qualification session sign and return the letter of instruction to the employee relations officer.

- Hold supervisors accountable for failing to redirect officers from armed posts when those officers fail to meet the quarterly qualification requirement.

- Use the monthly in-service training bulletin, or similar means, to emphasize to the custody staff that qualification must occur before assuming an armed post.

- Limit armed post assignments only to peace officers who complete a quarterly firearms qualification session as required in the department's Operations Manual section 32010.19.7.

- Allow officers who complete an annual qualification session during CIM's designated months of February, May, August, or November to work armed posts through special assignment in the three months following the annual qualification. For example, officers who complete annual qualification sessions during May would be eligible to work armed posts during June, July, or August. Moreover, officers who complete annual qualification sessions during a quarter would be eligible to work armed posts during the remainder of that quarter.

The Office of the Inspector General recommends that the department secretary repeal those provisions of the November 4, 2004, departmentwide memorandum that allow officers to assume armed posts without completing quarterly firearms qualification requirements.

Finding 5

The visiting area for CIM's Minimum Support Facility accommodates hundreds of inmates and visitors, but the institution lacks an effective means of monitoring visiting activities to control the exchange of contraband.

The department recognizes the value of inmate visitation as a way for inmates to maintain family and community connections. However, effective monitoring of visiting is necessary because some inmates use visiting as an opportunity to smuggle drugs and other contraband into the institution. At CIM's Minimum Support Facility (MSF), only two officers are assigned to actively monitor visitor activities, and suspicious behavior may be missed because there are no surveillance cameras. The use of cameras would enable officers to scan various areas of the visiting yard and allow for continual observation of suspicious activity. In addition, video recordings could serve as an additional resource to the investigative services unit officers to successfully prosecute visitors and inmates found with drugs or other contraband.

Only two officers are assigned to monitor CIM's large visiting area

The institution's MSF visiting area is an outdoor yard—roughly 183,000 square feet, or over 4 acres—and it contains 198 picnic tables arranged in two staggered rows under an awning. The tables stretch along the north, south, and east perimeter of the yard, surrounding a large grassy area divided by a walkway in the center of the yard. The west side houses vending machines, visitor restrooms, and a family picture-taking area.

MSF Visiting Yard

The visiting area allows for a maximum of 198 inmates at one time, with one inmate assigned to each table, and on some occasions, the number of visitors has exceeded 300, for a total of over 500 people in the visiting yard. Four officers work in the visiting yard. Two of these officers process the visitors and the inmates in and out of the visiting yard, and two officers roam the yard. Typically,

one of the two roaming officers stays near the picture-taking area and the nearby vending machine area to ensure that picture poses are appropriate and that children stay out of the vending machine area. This leaves only one officer available to walk among the visiting tables.

Visiting is a gateway for contraband to enter an institution even though officers take security precautions

Officers make sure that each visitor walks through a metal detector, and they search visitors' personal belongings before allowing them to enter the visiting yard. In addition, officers ensure that each inmate undergoes an unclothed body search before he returns to the housing unit. However, officers do not always find contraband through these security measures alone. Visitors have successfully passed the initial security checks by hiding non-metal contraband items, and inmates have successfully passed the unclothed body search by either swallowing the items or otherwise secreting the items on their person. For instance, at one institution, officers observed three inmates hide unknown objects on their person. However, when officers conducted unclothed body searches they were unable to find anything on two of the three inmates. After placing one inmate on contraband watch and taking another to a hospital, officers eventually recovered the contraband, which turned out to be drugs. In another instance, an officer observed a female visitor pass what appeared to be contraband to an inmate while the visitor and the inmate kissed. The inmate was placed on contraband watch, and about two days later officers recovered five balloons of heroin from the inmate. In both instances, officer observation was vital to finding contraband that would not be detected by an unclothed body search. Although the MSF visiting officers observe and stop inappropriate behavior between inmates and their visitors and confiscate contraband, it is unlikely that two officers monitoring over 500 people could see every instance of suspicious or inappropriate behavior, especially if the conspirators watch the officers' whereabouts and wait for them to become distracted.

During our observation of a Saturday visiting day, we saw inmates and visitors taking advantage of the commotion caused by an announced, but unexpected, early termination of visiting. Some groups appeared to ignore the initial announcements to exit the visiting yard, others began to slowly gather their belongings and say their goodbyes, while still others began walking toward the exit gates. During the commotion, we observed some inmates and their visitors engage in excessive touching and kissing, violating the rules against prolonged physical contact. Although we did not observe anyone pass contraband, we, like the officers in the yard, could see only those inmates and visitors close to us.

Surveillance cameras in the visiting areas of other institutions have proven to be an effective enhancement to the security measures already in place. For example, during a video surveillance of visiting at one institution, officers observed an

inmate receiving a package from his visitor. As a result, officers confiscated a latex glove containing separately bundled packets of various drugs including heroin. The inmate admitted that he already swallowed another package that also contained heroin.

Taking additional preventive measures, such as using cameras in the MSF visiting yard, benefits the entire institution because some MSF inmates have access to the other facilities within CIM and thus have the opportunity to pass contraband to inmates in those facilities. For instance, some inmates live in the MSF but receive clearances allowing them to work on projects at all three of CIM's reception centers. Furthermore, according to officers from the investigative services unit, inmates have staged fights in an effort to be moved into the administrative segregation unit, located at Reception Center Central, with the intent to pass written correspondence or contraband to inmates housed there.

Recommendation

The Office of the Inspector General recommends that the warden install surveillance cameras with video recording capabilities in the Minimum Support Facility's visiting area and allocate sufficient staff to operate the cameras and monitors.

Finding 6

Supervisors are conducting fewer than half of the required fire/emergency evacuation drills in their work areas, which may leave employees and inmates ill-prepared to respond to a crisis.

We found that quarterly compliance reports for the fourth quarter of calendar year 2007 showed only 13 percent of CIM's reporting areas conducted any fire/emergency evacuation drills. Section 52090.19 of the department's Operations Manual states:

> Evacuation drills shall be held quarterly under varying conditions on all three watches by designated supervisors. Such drills shall be actual unless the drill would cause a security or unusual safety problem with removing the inmates. At the conclusion of fire drills, the area supervisor shall complete a DS 5003 [Fire/Evacuation Drill Report] indicating the necessary information, and forward a copy to the Fire Chief.

Conducting drills prepares employees and inmates to respond quickly and safely in the event of a fire or other emergent need to evacuate a building. CIM's age and state of disrepair, combined with inadequate fire sprinkler coverage throughout the institution, increases the importance of preparing employees to respond. In addition, inmate turnover at CIM introduces new inmates into living units frequently, and supervisors must conduct regular drills to ensure that newly arrived inmates are prepared in case of a fire or other emergency.

Although CIM's fire chief confirmed that compliance with the drill requirement improved during the first and second quarters of calendar year 2008, a significant number of drills are still not conducted. The following table illustrates an increasing compliance rate over three recent calendar quarters, but the most recent quarter reviewed still shows only a 43 percent compliance rate.

Summary of Quarterly Drill Reports

Reporting Period	Drills Conducted	Drills Not Conducted	Drills Required	Noncompliance Percentage
4th Quarter 2007	30	202	232	87%
1st Quarter 2008	113	184	297*	62%
2nd Quarter 2008	169	128	297	43%

**Redistribution of staff and inmates created additional reporting area requirements effective in the first quarter of calendar year 2008.*
Source: CIM Fire Chief

According to a facility captain at CIM, drills are not being conducted because of a lack of supervisor awareness of the requirement and failure to document the drill and forward the information to the fire chief.

Recommendation

The Office of the Inspector General recommends that the warden ensure that supervisors are aware of the quarterly fire/emergency evacuation drill requirement in their areas of responsibility, and that they document the drills and submit copies of documentation to CIM's fire chief as required in section 52090.19 of the department's Operations Manual.

California Department of Corrections and Rehabilitation's Response

OFFICE OF THE SECRETARY
P.O. Box 942883
Sacramento, CA 94283-0001

November 17, 2008

Mr. David R. Shaw
Inspector General
Office of the Inspector General
P.O. Box 348780
Sacramento, CA 95834-8780

Dear Mr. Shaw:

We appreciate the opportunity to have met with representatives from the Office of the Inspector General (OIG) to discuss the preliminary draft of your Quadrennial and Warden Audit conducted at the California Institution for Men (CIM). We are pleased with your acknowledgement of Warden Michael Poulos as an effective administrator who is responsive to institutional issues, and we concur with this assessment. Warden Poulos demonstrates innovation in managing the third oldest adult institution in California and has been praised for his skills. He attributes his performance to the work commitment of CIM staff.

While several areas of deficiency were identified in your report, we appreciate the recognition by the OIG that funding needs for CIM, and indeed of all our prisons, are inadequate to address the overall need to maintain our facilities. Nonetheless, the California Department of Corrections and Rehabilitation (CDCR) is committed to expediting special repair and maintenance projects and to diligently pursuing all avenues to address unfunded needs.

Your report states that despite the disparity between funding for maintenance and repair and the facility's actual needs, CIM could take independent action to mitigate its infrastructure problems by aggressively recruiting for plant operations staff. You also write that CIM is not taking full advantage of an established system for tracking and planning maintenance activities. We agree that CIM encounters distinct difficulties in recruiting and retaining experienced plant operations staff. To mitigate the risk of underreporting the number of maintenance hours for the appropriate allocation of maintenance funding, local procedures have been implemented and reinforced to ensure accurate record maintenance and repair activity in the Standard Automated Preventive Maintenance System.

In response to your concern regarding supervisors conducting fewer than half of the required fire and emergency evacuation drills in work areas, CIM has emphasized the importance of compliance with the quarterly fire and emergency evacuation drill requirements. Complete and full compliance has been achieved for the 2008 third quarter reporting period of CIM fire drills. Ongoing monitoring will be conducted to maintain compliance.

I would like to thank the OIG for allowing us the opportunity to provide comment on the deficiencies identified in your preliminary report. Your audit assists the Department in the refinement of processes and furthers compliance with applicable laws, rules, and regulations. All deficiencies identified will be addressed in a corrective action plan submitted to CDCR's Office of Audits and Compliance for follow-up and monitoring. If you should have any questions or concerns, please call my office at (916) 323-6001.

Sincerely,

Matthew L. Cate

MATTHEW L. CATE
Secretary

cc: Michael Poulos, Warden, California Institution for Men

Exhibit 11

California Correctional
Peace Officers
Association
CCPOA
REPRESENTING
CDCR PEACE OFFICERS
"THE TOUGHEST
BEAT IN THE STATE"

755 Riverpoint Dr., Ste. 200 • West Sacramento, CA 95605-1634 • (916) 372-6060

December 16, 2011

Brigid Hanson, Assistant Secretary (A)
Office of Labor Relations
Department of Corrections & Rehabilitation
1515 S Street, North Building, Room 109
Sacramento, CA 95811

Re: Implementation of Pilot Program for Alternative Treatment Option Models
CCPOA NG #26085
CDCR Log Number: 11-187

Dear Ms. Hanson:

We are in receipt of your notice letter dated December 5, 2011, and received in this office on December 7, 2011. This notice is regarding the California Department of Corrections and Rehabilitation (CDCR), Division of Adult Institutions' (DAI) intent to implement a pilot program for alternative treatment option models, beginning with Corcoran's new ASU-EOP Hub treatment facility, effective January 1, 2012, through January 1, 2014.

This letter is to request a Meet and Confer over the impact of the above-mentioned change to the terms and conditions of employment of those Bargaining Unit 6 employees concerned.

Please advise Mike Lopez at (916) 372-6060, as to your earliest available meeting date.

Sincerely,

Steve J. Weiss
Chief of Labor
California Correctional
Peace Officers Association

SJW:cj
NG #26085/m&c.ltr

Enclosure
cc: Jo Anne Billhimer
Don Benegas
Dave Sanders
Executive Council

OFFICE OF LABOR RELATIONS
P.O. Box 942883
Sacramento, CA 95811-7243

December 5, 2011

VIA FAX & CERTIFIED MAIL # 7008 0150 0001 2283 4366

Mr. Steve Weiss, Chief of Labor
California Correctional Peace Officers Association
755 Riverpoint Drive, Suite 200
West Sacramento, CA 96505-1634

RE: IMPLEMENTATION OF PILOT PROGRAM FOR ALTERNATIVE TREATMENT OPTION MODELS (CDCR Log #11—187-0)

Dear Mr. Weiss:

Effective on or about January 1, 2012, the California Department of Corrections and Rehabilitation (CDCR), Division of Adult Institutions (DAI), intends to implement a pilot program for alternative treatment option models.

The identified site will begin with Corcoran's new ASU-EOP Hub treatment facility. This pilot program will remain in effect for a 24-month period, from January 1, 2012 through January 1, 2014, at which time it will lapse by operation of law or will be promulgated through the Administrative Procedure Act.

The purpose of the pilot program is to establish benchmarks to measure the viability of a CDCR modified variant of the New York Restart Chair, a chair used in group therapy and in which the Inmate/Patients (I/Ps) are secured with restraints, as an Alternative Treatment Option Model (ATOM) to the presently used Therapeutic Treatment Module (TTM), in terms of both security and clinical functionality, during the therapeutic session. These benchmarks will be developed into an assessment tool through collaboration between the Division of Correctional Health Care Services (DCHCS), and the Division of Adult Institutions (DAI).

The criteria for participation in this pilot program are that candidates will be currently housed in a participating Administrative Segregation Unit-Enhanced Outpatient Program (ASU-EOP) or Psychiatric Services Unit (PSU) program in a selected institution(s). Under no circumstances will I/Ps be evaluated, assessed, or chosen for transfer to a selected institution so they can take part in this pilot program. The Interdisciplinary Treatment Team (IDTT), which includes custody staff, will make decisions about whether an I/P should be excluded from the ATOM group. The ATOM will be piloted using several different types of group activities, e.g., writing, reading, or tactile exercises.

The purpose is to provide I/Ps with a more therapeutic environment during group and individual counseling sessions that provides more direct, open contact with the clinician as well as the other group participants, while maintaining a safe environment for all. Staff assigned to place I/P's into and out of the ATOM chair shall be trained in the use of the ATOM chair prior to being required to operate the chair.

This pilot project will remain in effect through January 1, 2014. Data will be collected along the way, including incidents and safety issues associated with both types of treatment models; program participation; and I/P, clinician, and custody satisfaction with the two types of treatment models.

If you believe this implementation creates impact to BU 6 members within scope of bargaining that is not covered by the BU 6 Memorandum of Understanding (MOU), please have your assigned staff person contact Dolores Slaton, Labor Relations Manager, at (916) 327-3405, within ten (10) business days from the date of this notice to identify available dates to meet. It would be extremely helpful, likely to both parties, if the California Correctional Peace Officer Association (CCPOA) would outline the areas of concern it would like to discuss. We appreciate your assistance in this regard.

In providing this notice, CDCR does not represent that this implementation is within the scope of bargaining or has any impact to the members of BU 6.

Respectfully yours,

Dolores Slaton for

BRIGID HANSON
Chief, Office of Labor Relations
California Department of Corrections and Rehabilitation

Enclosures:

cc: Terri McDonald, Director (A), Division of Adult Services
Dolores Slaton, Labor Relations Manager, CDCR Office of Labor Relations
Stephen Booth, Labor Relations Officer, DPA
Raul Lopez, Warden (A), COR
Steven Bylund, Chief of Mental Health, COR
Richard Warren, Labor Relations Advocate, COR

Exhibit 12

Group Therapy Schedule
CCI Tehachapi
2/22/13

Institution	Day/Time	Reason Name	Provider Name	Program
CCI	Thursday 11:30 AM Weekly	A-PSYCHO ED INSOMNIA - ASU	BROADDUS, D. ., PHD	ASU
CCI	Friday 9:00 AM Every other Week	Anger/Stress Management	DEAN, M. ., RT	4A DINING HALL 2
CCI	Friday 9:00 AM Every other Week	Anger/Stress Management	DEAN, M. ., RT	ASU
CCI	Tuesday 9:00 AM Every other Week	Anger/Stress Management	DEAN, M. ., RT	SHU
CCI	Tuesday 11:30 AM Every other Week	Anger/Stress Management	DEAN, M. ., RT	SHU
CCI	Friday 10:30 AM Every other Week	Grieving Group	DEAN, M. ., RT	SHU
CCI	Friday 11:30:00 AM Every other Week	Anger/Stress Management	DEAN, M. ., RT	SHU
CCI	Thursday 10:30 AM Weekly	A-HOUSES OF HEALING - SHU	HOLTROP, M. ., PSYD	SHU
CCI	Friday 12:30 PM Weekly	FAC C-JOURNELING GROUP	SEYMOUR, J. ., PSYD	FAC C CHAPEL

CCI 2

Exhibit 13

WEEKLY POPULATION SUMMARY

CCI

LOCATION	2/21/13	CCCMS	EOP	CRISIS EVALUATION CE	
LEVEL I SNY **Facility E**	All Housing Units	207	1		
LEVEL II SNY **Facility D**	All Housing Units	261	0		
GP SNY LEVEL III **Facility C**	All Housing Units	269	2		
Facility B					
SHU	All Housing Units	93	3		
INFIRMARY	All Housing Units	6	1	1	
Facility A					
ASU	Housing Units 6,7,8	101	5		
SHU	Housing Units 1,2,3,4,5	98	0		
	Grand Total=	**1035**	**12**	**1**	**1048**

Exhibit 14

Position Statement on Segregation of Prisoners with Mental Illness

Approved by the Board of Trustees, December 2012
Approved by the Assembly, November 2012

"Policy documents are approved by the APA Assembly and Board of Trustees...These are...position statements that define APA official policy on specific subjects..." – *APA Operations Manual.*

Prolonged segregation of adult inmates with serious mental illness, with rare exceptions, should be avoided due to the potential for harm to such inmates. If an inmate with serious mental illness is placed in segregation, out-of-cell structured therapeutic activities (i.e., mental health/ psychiatric treatment) in appropriate programming space and adequate unstructured out-of-cell time should be permitted. Correctional mental health authorities should work closely with administrative custody staff to maximize access to clinically indicated programming and recreation for these individuals.

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Background to the Position Statement

The number of persons incarcerated in prisons and jails in the United States has risen dramatically during the past three decades, accompanied by a significant increase in prisoners with serious mental illness. Studies have consistently indicated that 8 to 19 % of prison inmates have psychiatric disorders that result in significant functional disabilities and another 15 to 20 % require some form of psychiatric intervention during their incarceration (1, 2).

Physicians who work in U.S. correctional facilities face challenging working conditions, dual loyalties to patients and employers, and a tension between reasonable medical practices and the prison rules and culture. In recent years, physicians have increasingly confronted a new challenge: the prolonged solitary confinement, or segregation, of prisoners with serious mental illness. This prevalent corrections practice and the difficulties in providing access to care in these settings have received scant professional or academic attention (3).

Segregated inmates are isolated from the general correctional population and receive services and activities apart from other inmates. For the purposes of this position statement, segregation refers to conditions of confinement characterized by an incarcerated person generally being locked in their cell for 23 hours or more per day (4). Inmates may be segregated for institutional safety reasons (administrative segregation), disciplinary reasons (disciplinary segregation), or personal safety (protective custody) (5). Correctional systems vary regarding the specific conditions of confinement in segregation units (e.g., one to two inmates in a cell, inmate access to a radio or television, other property restrictions, visitation privileges, etc.). The definition of "prolonged segregation" will, in part, depend on the conditions of confinement. In general, prolonged segregation means duration of greater than 3-4 weeks.

Several studies have shown that inmates with serious mental illness have more difficulty adapting to prison life than do inmates without a serious mental illness. Morgan, Edwards, and Faulkner (6) reported that seriously mentally ill prisoners were less able to successfully negotiate the complexity of the prison environment, resulting in an increased number of rule infractions leading to more time in segregation and in prison. Lovell and Jemelka (7, 8) found that inmates with serious mental illnesses committed infractions at three times the rate of non-seriously mentally ill counterparts.

Placement of inmates with a serious mental illness in these settings can be contraindicated because of the potential for the psychiatric conditions to clinically deteriorate or not improve (6, 10). Inmates with a serious mental illness who are a high suicide risk or demonstrating active psychotic symptoms should not be placed in segregation housing as previously defined and instead should be transferred to an acute psychiatric setting for stabilization.

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Exhibit 15

MENTAL HEALTH SERVICES DELIVERY SYSTEM

PROGRAM GUIDE

2009 REVISION

Division of Correctional Health Care Services

Department of Corrections & Rehabilitation

CHAPTER 8
Security Housing Unit

A. INTRODUCTION

It is the policy of the Department of Corrections and Rehabilitation (CDCR) to provide inmates in a prison setting with prompt access to mental health services, regardless of their housing designation. Provision of mental health services within a Security Housing Unit (SHU) is part of the Mental Health Services Delivery System (MHSDS). Mental health services within a SHU are provided to all SHU inmate-patients in accordance with the inmate-patient's treatment needs and level of care. Services are designed to achieve symptom management through regular case management activities, medication administration and monitoring, crisis intervention, continuous monitoring for signs or symptoms of a serious mental disorder, and referral to a more intensive as needed.

The CDCR currently has four SHUs located at the institutions listed below. Inmates in the MHSDS receive services as indicated.

- Valley State Prison for Women (females only) – Inmates in this unit receive mental health services in conjunction with inmates in the Administrative Segregation Unit (ASU).

- California Correctional Institution – Inmates are provided Correctional Clinical Case Management Services (CCCMS). Inmates requiring the Enhanced Outpatient Program (EOP) are referred to a Psychiatric Services Unit (PSU) and transferred to an ASU EOP hub while awaiting PSU placement.

- California State Prison, Corcoran – Inmates are provided CCCMS in the SHU. Inmates requiring EOP services are referred to a PSU and transferred to the ASU EOP hub while awaiting PSU placement.

- California State Prison, Sacramento – Inmates are provided CCCMS in the SHU. Inmates requiring EOP services are referred to a PSU.

- Pelican Bay State Prison (PBSP) – Per exclusionary criteria from the federal court, inmates with one of the conditions listed below shall not be admitted to the PBSP SHU.

1. Documented diagnosis or evidence of any of the following Diagnostic and Statistical Manual IV – Axis 1 conditions currently in existence or within the preceding three months:

   Schizophrenia (all sub-types);
   Delusional Disorder;
   Schizophreniform Disorder;
   Schizoaffective Disorder;
   Brief Psychotic Disorder
   Substance-Induced Psychotic Disorder (excluding intoxication and withdrawal);
   Psychotic Disorder Not Otherwise Specified;
   Major Depressive Disorders;
   Bipolar Disorder I and II

2. A diagnosed mental disorder that includes being actively suicidal.

3. A diagnosis of a serious mental illness that is frequently characterized by breaks with reality, or perceptions of reality that leads to significant functional impairment.

4. A diagnosis of "organic brain syndrome" that results in a significant functional impairment if not treated.

5. A diagnosis of a severe personality disorder that is manifested by frequent episodes of psychosis or depression and results in significant functional impairment.

6. A diagnosis of mental retardation.

7. A prior history, which suggests that the inmate will do poorly in the SHU. This includes inmates who have experienced psychotic symptoms that appear to be attributable to incarcerations in a SHU environment. These inmates are those for whom evidence exists of a deterioration in mental health which correlates with placement in SHU or SHU-like environments. Such diagnoses as "Brief Psychotic Episode," "Psychosis NOS," and "Major Depression" which have been assigned during periods of placement in SHU may, for example, be indicative of deterioration of mental health which accompanies SHU placement. Inmates whose history suggests such a causal relationship should be excluded from SHU.

8. A history which includes any of the following within the preceding three months:

   a. Medication prescribed to address any of the "at risk" mental health categories listed above.

b. Therapy and/or supportive services to address any of the "at risk" mental health categories listed above.

c. Frequent (e.g. at least weekly) monitoring for deterioration in mental health condition. This does not include situations in which repeated visits by mental health staff are attributable to repeated referral from the inmate or from custody staff but where no mental health condition is noted.

d. A history which includes a recurrent or "cyclic" mental health condition (e.g. Bipolar Disorder) where the inmate has not currently been symptom free for a period of time that is at least **twice as long** as the longest known period of active symptoms or known to demonstrate recurrent symptoms at intervals of approximately 6 months, would be considered as "positive" on this indicator until they had been symptom free for a continuous period of at least 12 months.

Where the results of the Unit Health Record (UHR) review reveal that any of the above conditions exist, the inmate must be removed from SHU within 96 hours of his arrival on that unit.

Where the results of the UHR review **do not** reveal the existence of any of the above conditions **and** there is evidence that the inmate has been evaluated with the existing 31 item mental health screen or other evaluation (documented on a CDCR 7386, *Mental Health Evaluation*) within the preceding 12 month period, the inmate may be housed in SHU.

Where the results of the UHR are equivocal (as where no clear diagnosis is established but where mental health contact and observations have suggested that symptoms consistent with one or more of the above conditions have been observed) or when no mental health evaluation (a 31 item mental health screen or completion of an evaluation documented on a CDCR 7386, *Mental Health Evaluation*) has occurred the preceding 12 month period, a mental health evaluation shall be conducted.

B. PURPOSE

This chapter outlines program policies and provides institutional operational procedures to assure the effective delivery of mental health services to inmate-patients with serious mental disorders who, for custodial reasons, require housing in a SHU, according to California Code of Regulations, Title 15.

Exhibit 16

MENTAL HEALTH SERVICES DELIVERY SYSTEM

PROGRAM GUIDE

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Division of Correctional Health Care Services

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b. The IDTT shall assess the inmate-patient's need for further medical, psychiatric, psychological, social work, and rehabilitative services; nursing services; education services; and transportation when developing the discharge plan. The plan ensures that needed services are available at the appropriate level of care.

c. The plan shall include participation by the inmate-patient to facilitate inmate-patient responsibility for his or her care and treatment.

d. The plan reflects appropriate coordination with and utilization of MHCB custody staff.

e. The plan includes documentation of contact with the Chief of Mental Health at the institution where the inmate-patient is being transferred.

f. Once the discharge plan is completed, referrals for appropriate aftercare placement shall be documented by an MHCB clinical staff member in the inmate-patient's treatment plan.

g. The assigned CCM or PC at the institution where the inmate-patient is being transferred is responsible for implementing the discharge plan.

h. Treatment shall continue for all inmate-patients clinically discharged until transferred.

Discharge Criteria

Criteria for discharge from the MHCB to an EOP or CCCMS program include:

- stabilization of the crisis behavior; and
- the ability to function in a less clinically structured environment.

Discharge criteria do not necessarily include complete resolution of symptoms but a resolution sufficient to allow continuation of treatment at a less intensive level of care.

Discharge to DMH inpatient care requires the clinical need for inpatient services of a duration greater than ten days.

Procedure

a. Upon completion of MHCB inpatient treatment, cases transferred to the MHCB as "Psychiatric and Return" shall be returned to the sending institution, unless the sending institution does not provide the level of care that the inmate-patient currently requires or the inmate-patient has any other case factor(s) that preclude return to the sending

institution. In those cases, the MHCB will transfer the inmate-patient to an institution that provides the appropriate level of care and security.

b. The MHCB discharge summary shall be completed by the attending psychiatrist or psychologist prior to release from the MHCB. This should include specific recommendations regarding follow-up visits with the CCM or PC and custody staff. The discharge summary, either handwritten or dictated, includes, but is not limited to, the MHCB course of treatment, current medications, response to treatment, condition at time of discharge, and detailed information regarding follow-up care needs. The inmate-patient's participation, which supports inmate-patient responsibility, shall also be included.

c. An inmate-patient shall be discharged only on the written order of the MHCB psychiatrist or psychologist.

d. Each institution with an MHCB shall appoint a Discharge Coordinator who is responsible for notifying the Chief of Mental Health or designee at the institution where the inmate-patient is being transferred of the pending discharge. The notification shall occur prior to discharge and shall include the inmate-patient's discharge summary, custody level, treatment needs, and any significant medical conditions. The Discharge Coordinator shall document the notification in the inmate-patient's discharge plan.

e. The Chief of Mental Health or designee at the institution where the inmate-patient is being transferred shall notify the assigned CCM or PC. If the inmate-patient does not have an assigned CCM or PC, one shall be assigned. If the inmate-patient was admitted to the MHCB for Suicide Precaution or Watch, the Chief of Mental Health shall also notify the mental health clerical staff responsible for the tracking system, clinical staff responsible for weekend or holiday coverage, and the Facility Captain of the housing unit to which the inmate-patient is being transferred so that the required clinical and custody evaluation can be scheduled.

f. No inmate-patient shall be discharged from the MHCB without an IDTT review, or in the event a new IDTT cannot be convened, a consultation with an IDTT member, such as a nurse.

g. At the time of discharge, the original inpatient record is retained at the MHCB institution. The inmate-patient's UHR shall be transferred to the receiving institution at the time of discharge. Certain documents from the Inpatient Record are copied and filed in the Inpatient section of the UHR. This includes copies of the Admission Record, History and Physical, Operative Reports, Physician Orders, Discharge Summary, Consultations, Progress Notes, and Diagnostic Reports.

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3. If requested by DMH, an inmate-patient who has withdrawn informed consent for mental health treatment or psychiatric medication, but for whom continued treatment is otherwise recommended, may be returned to CDCR after all other clinical and legal avenues to obtain authorization to treat have been exhausted, if the following two criteria have been met:

   - Withdrawal of informed consent shall be demonstrated by seven calendar days of continuous refusal to take oral medication or 30 calendar days of continuous refusal to accept scheduled depo-injectable medication, and documentation of discussions between treating DMH psychiatrists and other team members and the patient regarding the risks and benefits of continuing medication.

   - Documentation that the patient has not met criteria for involuntary treatment for at least the last seven calendar days.

Discharge Procedure

1. Inmate-patients will be returned to the institution from which they came per the "psych and return" policy provided that institution can meet the level of care and security needs of the inmate-patient. Generally most inmate-patients will be returned to an institution that has an EOP. The EOP IDTT may decide to discharge the inmate-patient to a lower level of care after the initial 14-28 day evaluation period.

2. Inmates who are paroling and require ongoing treatment will be referred to the Parole and Community Services Division (P&CSD) Transition Case Management Program and to a Parole Outpatient Clinic or to a State hospital per Penal Code 2974.

3. DMH shall fax a copy of the Discharge Summary to the designated "DMH contact", of the receiving institution at the time of notification of discharge. DMH shall also call the receiving institution. The inmate-patient shall then be returned to the CDCR institution within five working days after the time of notification, or resolution of any appeal, whichever occurs later.

4. Appeals for denial of return to CDCR will be reviewed by the Coordinated Clinical Assessment Team (CCAT), Part V of this document.

5. Emergency returns to CDCR, shall be accomplished within twenty-four hours. Such returns will be with prior notification and approval by telephone of the CDCR institution's C&PR staff and Mental Health Program Director, or designee. DMH shall call the receiving institution to provide continuity of care including medication.

Exhibit 18

Mule Creek State Prison

MENTAL HEALTH SERVICES DELIVERY SYSTEM

MANAGEMENT REPORT
Round XXV
On-Site

August 29-31, 2012

William Knipp
Warden

Lawrence Fong, MPH
Chief Executive Officer

James Telander, Psy.D.
Chief, Mental Health Services

GLOSSARY OF TERMS

Acronym	Term
AIMS	Abnormal Involuntary Movement Scale
APP	Acute Psychiatric Program
ASU	Administrative Segregation Unit
CAP	Corrective Action Plan
CC	Correctional Counselor
CCCMS	Correctional Clinical Case Management System
CDCR	California Department of Corrections and Rehabilitation
CHSA	Correctional Health Services Administrator
DMH	Department of Mental Health
DOT	Direct Observation Therapy
EOP	Enhanced Outpatient Program
GP	General Population
HC-POP	Health Care Population Oversight Program
HS	Hour of Sleep
I/P	Inmate-patient
ICC	Institutional Classification Committee
ICF	Intermediate Care Facility
IDTT	Inter Disciplinary Treatment Team
LGB	Local Governing Body
LOC	Level of Care
LOP	Local Operating Procedure
LOS	Length of Stay
LPT	Licensed Psychiatric Technician
MAR	Medication Administration Record
MHCB	Mental Health Crisis Bed
MH-OHU	Mental Health-Outpatient Housing Unit
MHQM	Mental Health Quality Management Subcommittee
MHSDS	Mental Health Services Delivery System
MHTS	Mental Health Tracking System

OHU	Outpatient Housing Unit
PC	Primary Clinician
PSU	Psychiatric Services Unit
QIT	Quality Improvement Team
QM	Quality Management
QMC	Quality Management Committee
R&R	Receiving and Release
RVR	Rules Violation Report
SHU	Security Housing Unit
SPC	Suicide Prevention Coordinator
SPR-FIT	Suicide Prevention and Response-Focused Improvement Team
SRE	Suicide Risk Evaluation
UHR	Unit Health Record

Coleman Site Visit, Round XXV
MENTAL HEALTH MANAGEMENT REPORT

August 29-31, 2012
Mule Creek State Prison

INSTITUTIONAL PROGRAM SUMMARY

a. Overview of all the mental health programs at institution.

The MHSDS at MCSP consists of seven (7) treatment programs:
1) Mainline (ML) Enhanced Outpatient Program (EOP)
2) ASU EOP program
3) ASU EOP HUB
4) ASU CCCMS
5) ML CCCMS
6) MHCB

ML EOP program is an intensive outpatient program designed to treat inmate-patients (I/Ps) via an interdisciplinary approach that includes psychologists, social workers, recreational therapists (RTs), psychiatrists, and licensed psychiatric technicians (LPTs) and offers a minimum of 10 hours a week of structured therapeutic activities. B Facility houses EOP I/Ps in 6 and 7 blocks, with a capacity for 360 I/Ps, mostly level II and III. A Facility houses EOP I/Ps in 5 block, with a capacity of 150 I/Ps, mostly level IV. EOP programming is also provided in ASU, in 12 block, C-facility.

The ASU EOP HUB program is designed to treat severely mentally ill I/Ps who are placed in the ASU. This program provides at least 10 hours of structured therapeutic activities per week.

The ASU CCCMS program is housed in C-Facility, block 12 and 13. The CCCMS population has averaged 80 I/Ps. Individual treatment is offered in *Coleman* treatment cells located on the dayroom floor.

The ML CCCMS program is housed in A, B, and C Facilities with over 1300 CCCMS I/Ps.

The CTC at MCSP consists of 10 beds, 8 of which are dedicated to MHCB. When MHCB is full, inmate/patients are housed in the MHOHU and transferred to MHCB as soon as beds become available. Referrals present to the Triage and Treatment Area (TTA) for evaluation for admission. Between 0600 and 1600 Monday to Friday, the I/P is seen by a staff psychiatrist or psychologist assigned to the TTA for emergency evaluations. After hours and on weekends, the registered nurse on duty evaluates the I/P and consults with the on-call psychiatrist via telephone for placement orders. The psychiatrist on-call completes an evaluation, including a thorough suicide risk evaluation, within 24 hours of admission.

DRPD 1 00361

Each inmate/patient attends MHCB IDTT within the first 72 hours of admission, weekly thereafter and on the day of release. Treatment plans are developed at IDTT consistent with the I/P's clinical needs.

b. New Construction/Remodeling.

Funds from AB 900 have been appropriated to construct a new ASU EOP treatment and office space building; planning is ongoing but a start date for construction has not been established.

MCSP will be installing suicide-resistant beds in its MHCB in July of 2012.

c. New or Anticipated Mission Changes.

There have been no significant mission changes at MCSP. Progress continues to be made in the deployment of various information technology applications, including the Mental Health Tracking System (MHTS.net), electronic unit health record (e-UHR), and Strategic Offender Management System (SOMS). MCSP has been working diligently to reconcile past methods for quality management and completion of audits with new methods via data analysis available through MHTS.net.

d. Major Population Moves.

As a result of AB 109 the population at MCSP has decreased about 500 inmates with less than half being in the MHSDS. At the present time, no reduction in mental health services is anticipated.

e. New or Overflow Administrative Segregation or any other Specialized Housing Units.

None anticipated

f. **Obstacles to Providing Mental Health Services and Adherence to Program Guide Requirements.**

Access to office and treatment space at MCSP has improved, with the exception of the treatment area for ASU EOP and ASU CCCMS.

The Chief Psychiatrist position is advertised but continues to be vacant. In addition a staff psychologist is acting as the senior psychologist supervisor for the ASU Mental Health Program.

Position	Positions Established	Positions Filled	Vacancies	Vacancy Rate	Full-Time Equivalent	Functional Vacancies	Functional Vacancy Rate
Chief Psychiatrist	1	0	1	100%	0	1.0	100%
Chief Psychologist	1	1	0	0%	0	0	0
Senior Psychologist	5	4.0	1	20%	0	1.0	20%
Staff Psychiatrist	11.5	7.25	4.0	35%	3.65	.35	3%
Staff Psychologist	35	26.0	9.0	26%	5.25	3.75	11%
Supervising Social Worker	1	0	1.0	100%	0	1.0	100%
Social Worker	9.5	8.0	1.50	16%	1.50	0	0%
Sup. Registered Nurse	1.0	0	1.0	100%	0	1.0	100%
Registered Nurse	11.62	11.62	0	0%	0	0	0%
Senior Psych Tech	2.0	2.0	0	0%	0	0	0%
Psych Tech	26	22.50	3.5	13%	4.0	(.50)	0%
Recreation Therapist	8.15	8.0	.15	2%	0	.15	2%
Clerical	10	8.0	2.0	20%	0	2	20%
Health Prog. Specialist I	1.0	1.0	0	0%	0	0	0%
Office Services Sup. II	1.0	1.0	0	0%	0	0	0%
Unit Supervisor	1.0	1.0	0	0%	0	0	0%

Telemedicine

Psychiatry telemedicine used?	Number of Hours Per Week
NO	N/A

QUALITY MANAGEMENT

Local Governing Body (LGB)

The LGB is responsible for oversight of health care services and is the ultimate authority for all health care matters. The LGB was scheduled to meet five times during the monitoring period. Five of the five scheduled meetings achieved a quorum.

Attendance regularly includes the Chief Executive Officer for Health Care, Warden, Correctional Health Services Administrator, II (CHSAII), and the Standards and Compliance Coordinator. Agendas and minutes for these meetings are maintained in the Health Care Administrative Office in a Proof of Practice binder. Please see the minutes in the proof of practice binders for a description of the key activities and events addressed in the LGB during the reporting period. See Tab B for copies.

Quality Management Committee (QMC)

The purpose of the QMC is to monitor, assess, and improve the quality of health care. During the reporting period the QMC met with a quorum six times. Agendas and minutes are available in the Proof of Practice binders in the Health Care Administrative Office. The QMC is chaired by the Chief Executive Officer and regularly attended by the Warden (or designee), Associate Warden for Health Care, the Correctional Health Services Administrator II, the Chief Physician Executive, Chief of Mental Health, Director of Nursing, and Chief Pharmacist. The QMC regularly collects reports from each service delivery area (e.g., pharmacy, nursing, and MHSDS). Presentations by each of the departments/subcommittees are data focused, and general communication/coordination issues are discussed. See Tab B for copies.

Mental Health Quality Management Subcommittee (MHQM)

The purpose of the MHQM is to oversee mental health services, review program performance, and monitor, create and implement improvement efforts. The Chief of Mental Health or designee serves as Chair. MHQM is scheduled to meet 12 times. During the reporting period the MHQM met 12 times. A quorum was attained in 100% of the meetings during the reporting period.

Peer Review

Since the last *Coleman* court monitor visit, MCSP has continued with a formal Peer Review coordinated by the Medical Chief of Staff, a psychiatrist, and a staff psychologist, to ensure quality in clinical care and documentation. Parameters monitored include dating and timing of notes, completeness of mental status examinations, treatment appropriate for diagnosis and legibility of records. Peer Review audits of both inpatient and outpatient mental health services at MCSP occurred quarterly, during this period:

Below is a description of the MCSP Peer Review Program:

Peer Review Committees:

DRPD 1 00364

Outpatient peer review (covering clinicians working in CCCMS, EOP, and ASU) consists of peer reviews for psychologist, psychiatrists, and social workers.
Inpatient peer review (covering admissions to the CTC) consists of peer reviews for psychologists, psychiatrists, and medical doctors.

Composition of Each Peer Review Committee:
Outpatient peer review The composition of each peer review committee consists of all regular staff members working at MCSP in their clinical specialties. A small group of staff members are selected each quarter to assist the administrator in reviewing the chart notes of their peers. The group of reviewers changes every quarter.
Inpatient peer review The composition of each peer review committee consists of all regular staff members who are authorized to work in the CTC. A staff member from each specialty is selected each quarter to assist the administrator in reviewing the chart notes of their peers.

Criteria for Review:
Outpatient peer review Chart notes are quasi-randomly selected for review each quarter. The criteria for review include progress note time and date; legibility of note, signature, and title; whether the note includes a review of dangerous to self or others; an assessment of whether the Axis I diagnosis is consistent with documented symptoms. Finally, an additional two items are included for psychiatry – (1) whether medications are appropriate for the diagnosis, signs, or symptoms, and (2) there is documented justification for medication change.
Inpatient peer review Chart notes are quasi-randomly selected for review each quarter. The criteria for review for psychology and psychiatry include progress note time and date; legibility of note, signature, and title; whether the note includes a review of dangerous to self or others; an assessment of whether the Axis I diagnosis is consistent with documented symptoms. Finally, an additional two items are included for psychiatry – (1) whether medications are appropriate for the diagnosis, signs, or symptoms, and (2) there is documented justification for medication change. For medicine, the review consists of a number of items reviewed such as the history and physical exam.

Refer to Binder Tab B "Peer Review Forms" for copies of forms that are used for Outpatient and Inpatient Peer Reviews.

How Feedback is presented to individual Clinicians:
Individual clinicians review feedback if the reviewer noted any significant areas of concern. The (anonymous) review would be given to the individual clinician, with explanation, by the Program Administrator.

The number of Peer Review Meetings for each discipline:
Outpatient peer review There is no peer review meetings per se. The Program Administrator selects appropriate files and recruits peers from each discipline to assist in this process.
Inpatient peer review There was two (2) peer review meetings within the last six (6) months: January 12, 2012 (reviewing months October-December 2011) and April 26, 2012 (reviewing months January-March 2012).

The Number of Clinicians Reviewed:

Forty Outpatient peer review and 6 Inpatient peer review were conducted during the monitoring period, with the number of deficiencies appearing to be stable or declining and with reviewed charts deemed acceptable for clinical care.

QIT Activities

There were a total of three Mental Health QITs active at some point during this reporting period. No new QITs were chartered during the review period. One QIT was resolved with final recommendations sent to the QMC during the review period. One QIT was resolved since the last management report.

QITs initiated:
None

QITs ongoing:

Mental Health Referral Event Entries and Outcome Resolutions

- This QIT is to improve the timely resolution of Mental Health referrals

MHTS.net and e-UHR Agreement

- This QIT is to improve agreement between entries in MHTS.net and the entries scanned into the e-UHR.

QITs resolved during monitoring period:

Mental Health Productivity Standards

MEDICATION MANAGEMENT, PSYCHOTROPIC MEDICATIONS (BINDER TAB C)

Unless otherwise noted, data reported in this section are derived from eUHR audits of 240 randomly selected inmate-patients.

The total number of inmates in the MHSDS receiving psychotropic medications at the end of the reporting period was 1243.

Medication Continuity for New Arrivals (Inter-Institutional CDCR Transfers)

Based on a random sample of 260 charts audited, 69% of IPs receives their first dose of new or changed medications by the next calendar day. Audits have shown improvement from 45% increased to 85% since medications are no longer being filled through Central Fill, but are filled in house.

Medication Continuity for Transfers (Intra-Institutional Transfers)

Based on a random sample of 232 charts, during the reporting period, 98% of I/Ps transferring within the institutions received their prescribed psychotropic medications without interruption.

DRPD 1 00366

This audit included those I/Ps discharged from the MHCB who received their psychotropic medications without interruption.

Medication Continuity for Renewal of Orders/Bridge Orders

Based on a random sample of 240 charts, 99% of inmate-patients received timely renewals of their psychiatric medications. 1% of inmate-patients had a lapse in medication, based on no written medication orders.

Lab Tests/Results for MHSDS Inmates

During the reporting period, 31 UHRs of inmates receiving the psychotropic medications of Cloazine, Depakote, and Lithium were reviewed. Of _the applicable cases, 86_% had laboratory tests ordered when clinically indicated. Psychiatrists reviewed results and documented clinical action in 100% of the cases with significant laboratory results. An Abnormal Involuntary Movement Scale (AIMS) must be completed every 6 months for each inmate prescribed psychotropic medications. During the reporting period, an AIMS was completed within the last 6 months in _100% of the 7 applicable cases

Direct Observation Therapy (DOT) Medication Administration

At the end of the reporting period, 943 inmate-patients were prescribed psychotropic DOT medication. During pill lines, DOT medication administration procedures were followed 99% of the time.

HS Medications (After 2000 Hours)

There are 596 MHSDS inmate-patients receiving HS medications as of the end of the reporting period. HS medications are delivered after 2000 hours. During the reporting period HS medications were administered after 2000 hours 100% of the time.

Medication Non-Compliance Policies and Procedures

Based on the random sample of 231 charts during the reporting period, if an inmate-patient missed doses on 3 consecutive days, or greater than 50% in 7 days, there was a referral to the psychiatrist 87% of the time and 44% of non-compliance cases had documented follow-up appointments with a psychiatrist within 7 days of referral. This non-compliance, in part, is due to staffing shortages, but training is also being done to address repeated referrals, and how to reconcile appointments with medication refusals.

The Medication Administration Record (MAR)

The audited UHRs contained the previous month's MARS 99% of the time, and 82% of UHRs contained MARs that were complete and legible.

Timely Processing of Medication Orders

To verify timely processing, a random sample of 260 orders for DOT medications (MHSDS patients only) was selected. Guardian records the date orders were written and the manifest date (the date the pharmacy sent the medications to the pill window). 69% of changes and newly prescribed medications were received within 24 hours of the date the order was written. These medications are now being filled in house, which has improved service time.

Informed Consent Forms

Based on a random sample of 239 UHR's 82% of I/P's on psychiatric medications had an up-to-date consent forms. Consent forms expire annually.

Pill Lines

MCSP distributes all medications via Pill windows except in ASU which is done cell front. During the reporting period, the average pill line wait was 3 minutes 35 seconds. A supervisor personally observed a randomly chosen pill line and timed how long it takes inmate to reach front of line from back of line. Each point of service is observed once each month on 2nd watch and 3rd watch – a total of 600 observations were conducted during the reporting period.

Hoarding/Cheeking Medications

During the reporting period, there were 27 CDCR-115 Rules Violation Reports (RVRs) written explicitly for hoarding or cheeking medication. Refer to Tab J7.

Parole medications process

Currently, the Classification and Parole Representative notifies pharmacy of all paroling inmates at least 1 day in advance of release dates. During the reporting period, all I/Ps paroled with active prescriptions for psychotropic medications. 100% of existing orders were renewed for 30-days. Paroling inmates are required to sign for receipt for their parole medications. During the reporting period 97% signed manifests acknowledging receipt of their prescription medications.

MAINLINE CCCMS

Timeliness of PC and Psychiatrist Contacts

During the reporting period 1240 I/Ps were provided services in the ML CCCMS mental health program. Of these, 70% received an initial contact with their PC within 10 days during which time the Clinical Intake Assessment was completed. In addition 85% had their initial IDTT within 14 days of arrival or transfer into the program. Thereafter 90% received PC contacts at least once every 90 days (or more often if indicated), and 98% had a scheduled IDTTs at least annually (or more often if indicated). Institutional staff participated in the IDTT with the PC being present 99% of the time, psychiatrist 66% of the time, and I/P 99% of the time. Two of the IDTTs I/Ps failed to attend with an undetermined reason.

During the reporting period, 98% of inmates with prescriptions for psychotropic medications received timely psychiatry appointments. Reasons that inmates did not have timely psychiatry contacts included: 37% inmate refusal, 4% competing appointments 19% lock downs, and 40% clinician unavailability.

Prerelease and Discharge Planning

During the reporting period, 62 I/Ps in the CCCMS level of care paroled from the institution. Of these, 10 received parole planning.

MAINLINE ENHANCED OUTPATIENT PROGRAM (EOP)

During the reporting period, 97% of all new EOP admits were assessed and presented to the IDTT within 14 days of admission, at which point their initial treatment plan was completed and signed by the IDTT attendees. Once admitted to the program, weekly PC contacts (individual or group activity) took place 84% of the time, IDTTs took place at least every 90 days, 100% of the time, and treatment plans were updated at least every 90 days, 100% of the time. IDTTs were attended by their PC 99% of the time, by the psychiatrist 58% of the time, and the I/P 88% of the time. Reasons why the I/P failed to attend the IDTT or why an IDTT was cancelled included; 0% inmate refusal,17% scheduling issues (sick/furlough,), 0% lock downs, 0% lack of escort officers 0% competing appointments, 2% clinician unavailability and 81% were identified as completed with the patient absent. No clear reason was tracked for IP absences from these IDTTs, but training has been done to improve tracking of attendance for IDTTs.

During the reporting period, group therapy was provided for the I/Ps in the EOP LOC. Twenty eight different structured group topics were provided by the primary clinicians and 25 were offered by recreation therapists (RTs). Descriptions are available in TAB M of the binder. On average, I/Ps were offered 6.93 hours of structured therapeutic activity per week. During the reporting period, 16 I/Ps were provided a modified treatment plan. An individual search of each of these IPs records indicated that 100% received monthly IDTTs. This report is not available through MHTS.net.

Prerelease and Discharge Planning

During the reporting period 65 I/Ps in the EOP level of care paroled from the institution. Of these 74% received parole planning.

DEPARTMENT OF MENTAL HEALTH (DMH) REFERRALS

During this period, 332 I/Ps met one or more of the considerations for a higher LOC. Of the identified I/Ps, 5% were referred to DMH, 95% of I/Ps were not referred. At each institution, 25 I/Ps listed on the DMH non-referral log (or all I/Ps on the list if less than 25) were randomly audited. Of those audited, 98 % had a reason for non referral documented on the 7388-B, and 94 % had documented interventions to improve the I/P's level of functioning.

During the reporting period, 17 referrals to DMH were completed: 10 ICF and 7 APP. 40 % of ICF referrals were completed within five working days; 86 % of APP referrals were completed within two working days and posted on SharePoint. The addition of a DMH coordinator has improved compliance by providing supervisors and clinicians with training and increased use of the e-UHR to improve documentation and completion of referral documentation.

During this time period no ICF or APP referrals were rejected by DMH and none were rescinded.

During the reporting period 34 I/Ps returned to the institution from DMH. DMH discharge summaries were received when the I/P returned to the institutions 100% of the time. Clinician-to-clinician contact took place within five working days of the I/P's return to the institution 26 % of the time. Five day follow-ups were completed 100% of the time for returning I/Ps.

MENTAL HEALTH CRISIS BED (MHCB)

The institution has an 8 bed, Mental Health Crisis Bed (MHCB) unit. Inmate-patients are received from internal referrals as well as from other institutions. During the reporting period, 53 referrals were received from within the institution and 1 referral was received from an outside institution.

During the reporting period, the total number of admission to the MHCB unit totaled 54. The average length of stay (LOS) was 9 days. The range was from 0 to 52 days. The number of I/Ps with a LOS longer than 10 days was 14. Reasons for LOS longer than 10 days included; 50% DMH referral awaiting a bed, 0% Keyhea in process, 14% clinically discharged awaiting bed, 0% clinically discharged awaiting transfer back to home institutions, 0 % starting a trial of new psychotropic medication. The percent retained for clinical reason was 36%. When I/Ps on the DMH waiting list were removed from the calculation, the average LOS in the MHCB was 6 days.

Prior to being admitted to the MHCB unit, 100% of the I/Ps admitted during regular working hours were administered a pre-admission screening. Once admitted to the MHCB unit they received their initial IDTT within 72 hours 100% of the time. Thereafter I/Ps were offered at least weekly IDTTs 98% of the time. IDTTs were attended by the PC 96% of the time, psychiatry 100%, CC-I 100% and nursing 100% of the time. Daily contacts by a licensed psychologist or psychiatrist occurred 94% of the time. Of the I/Ps that were admitted due to suicidal threats or behavior, 33% were administered an SRE at the time of placement and 48% received a SRE upon release from the MHCB. Low documentation of SRE delivery is due to documents not being provided to OT's for data entry. This report is now being submitted to SprFit for monthly review and action. 98% received a five day follow up after their release from MHCB according to our internal log. (Refer to Tab I3).

OUTPATIENT HOUSING UNIT (OHU

The institution has 6 OHU beds. During the reporting period there were 125 referrals to OHU and 125 placements. A total of 15 I/Ps housed in the OHU were referred to a MHCB and 15 were admitted. The average length of stay was 3 days, ranging from 0 to 55 days. There were 19 I/Ps with stays longer than 72 hours. Reasons for LOS beyond 72 hours included, 14% awaiting a bed in the MHCB, 29% administratively discharged and as a result of custody placement requirements were waiting for a bed, 0 % of I/P waiting for a bed due to a mental health LOC change, 57 % administratively discharged without changing custody factors or mental health LOC awaiting a bed.

While residing in the OHU, 78% of I/Ps received daily contact from a licensed psychologist or psychiatrist according to the On-Demand Contact Intervals report. (Refer to Tab F6) During the reporting period 99% I/Ps were placed in the OHU due to suicidality. Of those, 100% were administered a SRE at the time of placement and100% received and SRE upon release from OHU, and 100% received a five day follow-up upon their release.

ALTERNATIVE HOUSING

During the reporting period there were 4 I/Ps placed in alternative housing while waiting for a MHCB bed. No inmates were placed on suicide watch and 100% were placed on suicide precaution. None were transferred to a MHCB. The average LOS was 3.5 days, ranging from 0 to 5 days. Reasons for lengths of stay longer than 72 hours included clinical reasons. Of those I/Ps that were placed in alternative housing due to suicidal or serious self-injurious behaviors, 100% were administered a SRE prior to placement (those I/Ps entering after hours when a clinician is not available will receive a SRE by the next day). 100% of I/Ps received a five day follow-up upon their release.

ADMINISTRATIVE SEGREGATION UNIT (ASU)

During the reporting period there were 739 I/Ps housed in ASU programs: 298 at CCCMS level of care (LOC), 290 at EOP LOC and 151 non-MHSDS I/Ps. All patients entering ASU are to receive a nursing pre-placement screening (CDCR Form 128-MH-7). During the reporting period, audits done for this period indicate an average of 66% of the I/Ps received pre-placement screening prior to placement in the ASU setting, with a range from 50% to 85%. Due to the audits and training, these percentages has shown a gradual increase. None of the screenings were conducted in a confidential setting and the lack of confidential space on the ASU has been identified as an issue. Data on the placement of incoming I/Ps housed in identified safety cells is not tracked. However, the ASU has 3 intake cells which are used for up to 72 hours for intake I/Ps. If there are more intakes than cells, intake I/Ps are placed in regular cells. All I/Ps placed in ASU were reviewed for current MHSDS status within one working day following their placement in ASU, and prior to the 114D hearing. 100% of I/Ps received a mental health screening (31-item questionnaire) within 72 hours of placement. Custody documented 30-minute welfare checks during the reporting period 100% of the time, based on audits conducted by the custody supervisor.

ASU-CCCMS

During the reporting period, 298 I/Ps entered the ASU CCCMS program. 91% of the I/Ps were assessed by a clinician within 10 working days. 96% of initial IDTTs were completed within 14 calendar days or prior to ICC, whichever occurred first. Subsequent IDTTs took place at least every 90 days, 99% of the time. 83% of IDTTs were attended by the primary clinician; 86% of IDTTs were attended by a psychiatrist, 100% of IDTTs were attended by the CC; and 65% of IDTTs were attended by the I/P. 100% of the reasons for I/P non-participation in IDTT was refusals.

During the reporting period, 97% of CCCMS I/Ps received at least weekly individual PC contacts, none of these were in a confidential setting. I/Ps are typically seen outside their cells in non-confidential therapeutic modules. Of the completed PC contacts, 34% were completed in the therapeutic modules. 66% of the PC contacts were seen cell-front. The reasons for cell front non-confidential contacts included 13% I/P refusals, 8% due to a staff decision; 79 % did not specify a reason. 99% of I/Ps prescribed psychotropic medications were seen by a psychiatrist at least every 90 days. Daily LPT rounds were documented on the CDCR Form 7230-MH 100% of the time. Daily ASU morning meetings between custody and clinical staff were documented 100% of the time.

ASU-EOP (HUB)

During the reporting period, 290 I/Ps entered the ASU EOP. None of the I/Ps received a comprehensive assessment (7386) prior to the initial IDTT or within 14 calendar days of referral/identification. This is due to ASU staff had the belief this was not to be done. In addition compliance rules have been changed and training has been done consistent with the new compliance rules. 92% of initial IDTTs were completed within 14 calendar days or prior to ICC, whichever occurred first. Subsequent IDTTs took place at least every 90 days, 92% of the time. 87% of IDTTs were attended by the primary clinician; 89% of IDTTs were attended by the psychiatrist; 100% of IDTTs were attended by CC; and 75% of IDTTs were attended by I/P. During this reporting period, MHTS.net reports the reasons for I/P non-participation was due only to I/P refusals. Further training has been done with clinical and clerical staff to improve the accuracy of recording and inputting IDTT information.

During the reporting period the number of I/Ps that had LOS longer than 60 or 90 days can be reviewed in Binder Tab H. One hundred percent of those with a LOS longer than 90 days were reviewed every 30 days by the Classification & Parole Representative. Reasons for LOS longer than 90 days included: 36% were IPs with SHU terms more of than 90 days awaiting to be transferred, 15% were IPs waiting to transfer to GP SNY, 16% were IPs with SHU term less than 90 days, 16% were IPs with Rule Violation Report who were awaiting decisions by the DA, 7% were IP who were waiting for a CSR review for transfer, 5% were I/Ps who had been endorsed and pending transfer to Sac or PBSP PSU and 4% were IPs endorsed and awaiting transfer.

Of the I/Ps in the program during the reporting period, 95% received at least weekly individual PC contacts, There is no identified space on the ASU for confidential PC contacts, however, 2 of contacts took place in a confidential setting; 59% were out of cell, non-confidential contacts, and 41% of contacts were cell-front. Reasons for non-confidential cell front contacts included, 18% I/P refusals, 70% were unspecified; less than 1% were due to custody lockdowns; 2% were due to a lack of custody escorts and 9% were due to staff decision. 92% of I/Ps prescribed psychotropic medications were seen by a psychiatrist at least every 30 days. Daily LPT rounds were documented on the CDCR Form Progress Note 7230-MH 100% of the time. 92% of I/Ps were offered at least ten hours of structured therapeutic activities per week.

During the reporting period, the average number of I/Ps who refused more than 50% of offered treatment during a given week period was 26%. Refer to tab H16 for ASU EOP Fit Data Reports. Those I/Ps who refused more than 50% of offered treatment services, received daily PC contacts during the work week. An average of 6 I/P's per week were on a modified treatment plan. Daily ASU morning meetings between custody and clinical staff were documented 100% of the time.

ASU-Non-MHSDS

During the reporting period, 167 I/Ps entered ASU-Non-MHSDS program. All patients entering ASU are to receive a nursing pre-placement screening (CDCR Form 128-MH-7). During the reporting period, audits done for this period indicate an average of 66% of the I/Ps received pre-placement screening prior to placement in the ASU setting, with a range from 50% to 85%. Due to the audits and training, these percentages has shown a gradual increase. Custody documented 30-minute welfare checks 100% of the time. Nursing documented daily LPT rounds 100% of the time.

SUICIDE PREVENTION

The institution has an active Suicide Prevention and Response Focused Improvement Team (SPR-FIT). See Tab I, Section 1 to review SPR-FIT meeting minutes.

Completed Suicides

During the reporting period, there were no completed inmate suicides in the institution.

During the last two years there were no completed suicides in the institution.

Attempted Suicides during the Reporting Period

Of the 5 serious suicide attempts during the reporting period, 1 of them was by hanging, 2 were by lacerations, none were by overdose, and one was rope and abrasion related. One required outside hospitalization and all five were referred to an MHCB for acute mental health care services, with three being ultimately referred to a DMH facility.

On return to regular housing from a MHCB or OHU, 5-day follow-up was documented 92% of the time. A random sample of 10 Custody wellness checks was reviewed for 1st quarter 2012, showing a 70% completion rate.

Of the six SPR-FIT monthly meetings required during the reporting period, five monthly meetings were documented to have occurred. The SPC coordinates the monthly SPR-FIT. During the reporting period the agendas included review of suicide attempts, training on the 5-day observation procedure, and other local operations (See binder for more details).

During the reporting period, ongoing suicide prevention training consisted of both suicide refresher courses, and initial 6 hour suicide prevention curriculum for new employees.

The self-harm review process remains active. Since the last management report, 3 reviews have been completed and presented to the treatment teams and SPR-FIT for discussion. 1 review is in progress.

Inmate Profile Procedure

All inmate profiles are available on MHTS.net. Profiles for I/Ps on the ASU are pulled and discussed at the morning meetings, particular to individual suicide histories. These profiles are maintained for easy reference while the IP is housed on the ASU.

RVR PROTOCOLS

During the reporting period, 694 MHSDS inmates at the institution received RVRs: 427 CCCMS, 267 EOP, 0 MHCB. 100% of the MHSDS I/P's at EOP and CCCMS LOC who were issued an RVR received a mental health assessment.

USE OF FORCE

A table of all the Use of Force and Non-Use of Force incidents during the reporting period can be found in Tab M. Of the Use of Force Incidents, 88% occurred with MHSDS inmate-patients. For Non-Use of Force Incidents, 76% occurred with MHSDS inmate-patients.

MENTAL HEALTH REFERRALS

- Emergent: Immediately
- Urgent: Within 24 hours
- Routine: Within five working days

During the reporting period, 2823 referrals were received and on the final day of the period, overall 70% were closed in a timely manner. Referral statistics (See Tab R) indicate that 90% of emergent referrals were seen the same day, 72% of urgent referrals were seen within 24 hours,

72% of routine referrals were completed in within 5 business days and 64% of medication non-compliance referrals were completed within 7 calendar days.

MHTS.NET AGREEMENT AUDITS

The Agreement Audit was completed regularly during the reporting period. This audit examines agreement between MHTS.net entries and the eUHR documentation of those contacts. The audit also examined the eUHR to ensure that each documented clinician contact in the eUHR has a corresponding entry in MHTS.net.

Audits were conducted using methodology and tool provided by HQ. Audits in the monitoring period consisted of a review of approximately 600 contacts to determine if PC, psychiatrist, and IDTT documentation were present for each contact as reported in MHTS.net. Results ranged from an agreement rate of 70% to 83%, with a mean of 81%, with monthly agreements as follows: 11/11 – 79%; 11/12 – 79%; 1/12 82%; 2/12 – 79%p; 3/12 83%; 4/12 – 70%.

Discrepancies are generally due to either the clinicians not following the contact log procedures or clerical staff not entering the information correctly.

Exhibit 19

CALIFORNIA INSTITUTION FOR MEN

CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION

MENTAL HEALTH SERVICES DELIVERY SYSTEM
MANAGEMENT REPORT
ROUND 25

October 1, 2011 to March 31, 2012

GARY SANDOR
WARDEN

ROBERT HERRICK
CEO

VICTOR JORDAN, PH.D.
CHIEF OF MENTAL HEALTH

SUBMITTED APRIL 25, 2012

DRPD 1 00095

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GLOSSARY OF TERMS

Acronym	Term
AIMS	Abnormal Involuntary Movement Scale
APP	Acute Psychiatric Program
ASU	Administrative Segregation Unit
CAP	Corrective Action Plan
CC	Correctional Counselor
CCCMS	Correctional Clinical Case Management System
CDCR	California Department of Corrections and Rehabilitation
CHSA	Correctional Health Services Administrator
DMH	Department of Mental Health
DOT	Direct Observation Therapy
EOP	Enhanced Outpatient Program
GP	General Population
HC-POP	Health Care Population Oversight Program
HS	Hour of Sleep
I/P	Inmate-patient
ICC	Institutional Classification Committee
ICF	Intermediate Care Facility
IDTT	Inter Disciplinary Treatment Team
LGB	Local Governing Body
LOC	Level of Care
LOP	Local Operating Procedure
LOS	Length of Stay
LPT	Licensed Psychiatric Technician
MAR	Medication Administration Record
MHCB	Mental Health Crisis Bed
MH-OHU	Mental Health-Outpatient Housing Unit
MHQM	Mental Health Quality Management Subcommittee
MHSDS	Mental Health Services Delivery System
MHTS	Mental Health Tracking System

OHU	Outpatient Housing Unit
PC	Primary Clinician
PSU	Psychiatric Services Unit
QIT	Quality Improvement Team
QM	Quality Management
QMC	Quality Management Committee
R&R	Receiving and Release
RVR	Rules Violation Report
SHU	Security Housing Unit
SPC	Suicide Prevention Coordinator
SPR-FIT	Suicide Prevention and Response-Focused Improvement Team
SRE	Suicide Risk Evaluation
TBH	Transitional Bed Housing
TTA	Triage and Treatment Area
UHR	Unit Health Record

INSTITUTIONAL PROGRAM SUMMARY

OVERVIEW OF ALL THE MENTAL HEALTH PROGRAMS AT INSTITUTION.

Mainline Correctional Clinical Case Management System (ML-CCCMS)

CIM-A (formerly RCW-Reception Center West)

The Mainline CIM-A CCCMS program accommodates Level II SNY CCCMS patients serving a wide range of term periods, from short terms to life sentences. There are currently 2.5 Psychologists, 0.5 Clinical Social Worker (CSW), 0.5 Recreational Therapist (RT), 1 Psychiatrist, 1 Psychiatric Technician (PT) and a 0.5 time Senior Psychologist Supervisor (Program Director). Individual appointments, group therapy and parole planning are provided to this population.

During the monitoring period, the CCCMS population decreased from 315 to 276. A policy change in February 2012 changed the way CIM manages ML CCCMS patient-inmates who are converted to EOPs. These patient-inmates remain on the yard until they are endorsed and transferred to a ML EOP prison. CIM-A currently has 7 EOP's awaiting transfer to EOP LOC programs.

The population reached maximum capacity of 960 inmates by November 30, 2010. It has remained at maximum capacity during this reporting period. CIM-A receives approximately 2-5 new CCCMS intakes per week. CIM-A CCCMS program runs well. It is located in the Administration Building, which is air conditioned. Since there is a full time officer assigned to the program, the heat plan issues implemented in summer are not anticipated to be problematic.

CIM-C (formerly Reception Center East (RCE)

The Mainline CIM-C CCCMS program accommodates Level III SNY CCCMS patients serving a wide range of term periods, from short terms to life sentences. There are currently 2 primary clinicians (PCs). There is 1 psychologist, 1 clinical social worker (LCSW), 1 psychiatrist, 1.2 psychiatric technicians (PT) and a 0.5 time senior supervising social worker (Program Director). Individual appointments, group therapy and parole planning are provided to this population.

During the monitoring period, the mission of the RCE/CIM-C yard has changed. RCE was converted from a Reception Center Yard into a Mainline Yard. As a result, most of the population of inmates changed. Many were endorsed and moved to other prisons and some of the inmates/patients were endorsed as Level III, SNY inmates and stayed at CIM-C. On September 29, 2011, the CCCMS population was 220 and there were 122 EOP's on the yard. By March 29, 2012, the yard was fully transitioned into a Mainline Yard with Level III SNYs. There were approximately 793 Inmates on the yard. Of those, 161 were CCCMS and 4 were EOP. More recently, we have been receiving approximately 2-5 new CCCMS I/P's intakes per week. CIM-C currently has 4 EOP's awaiting transfer to EOP LOC programs.

CIM-D (formerly Minimum Support Facility)

The Mainline CIM-D CCCMS program accommodates Level I, CCCMS patients serving relatively short sentences. There are currently 8 psychologists, 0.5 clinical social worker (CSW), 0.5 recreation therapist (RT), 2 psychiatrists, 1 psychiatric technician (PT) and a 0.5 time senior psychologist supervisor (Program Director). Individual appointments, group therapy and parole planning are provided to this population.

During the monitoring period, the CCCMS population on this yard decreased from 776 to 730.

As of March 29, 2012 there were approximately 2373 Inmates on the yard. Of those 730 were CCCMS. We have been receiving approximately 25-35 new CCCMS I/P's intakes per week. CIM-D currently has 6 EOP's awaiting transfer to EOP LOC programs.

Reception Center Enhanced Outpatient Program (RC-EOP)

EOP I/Ps are located on Yard B (formerly Reception Center Central (RCC). During this reporting period, approximately 25-30 EOP inmates were housed on Yard B at any given time. Interim care services for RC EOP I/Ps at RCC are provided by two psychologists, one psychiatrist, one social worker and one recreation therapist. While in reception, groups and individual contacts occur on a weekly basis and medication management is conducted in the Yard B mental health clinic. Due to the relatively low number of EOP I/Ps, there are very few difficulties in both providing individual contact and groups. All EOP I/Ps are also scheduled to see the psychiatrist every 30 days or more frequently, if clinically indicated. IDTT's happen weekly with regular participation from CCI, nursing, and treatment team members.

Mental Health Crisis Bed Program

The MHCB at CIM continues to operate as a 36-bed unit within an infirmary medical environment. The MHCB program has shown a consistently decreasing census as a result of the dramatic drop in EOP LOC inmate/patients at CIM. Transitional bed housing (TBH) units at CIM have been effectively closed since the end of September. Three clinical teams consisting of one psychologist, one social worker and one psychiatrist provide services to patients in the MHCB. Referrals are screened for admission through the Treatment and Triage Area (TTA). During regular business hours, the CIM-D clinic psychiatrist conducts intake evaluations. After hours, the psychiatrist on call (POC) conducts intake evaluations. Weekday morning meetings allow the treatment team to exchange clinical updates between shifts and plan services for the day. It is attended by all mental health disciplines, custody and a psychologist representative from ASU on Fridays. Special case conferences are convened, as needed, to address critical incidents, difficult cases and/or I/P's requiring expedited custodial processing. All I/Ps are offered an out of cell confidential contact with a clinician or IDTT each day. Currently the MHCB operates with an average daily census of about 20 and compared to 30 in May of 2011 and an average daily admission rate of 2.3 compared to 5.9 in May.

Administrative Segregation

The CIM ASU's mental health program provided services to approximately 602 I/Ps. An average of 19.2 I/Ps were at the EOP level of care and 84.3 were CCCMS. I/Ps were housed in Reception Center Central Cypress Hall, and Palm Hall. Birch Hall overflow was not used during the monitoring period. During this monitoring period, ASU was significantly impacted by staffing issues created by the AB109 mission change. Three psychologists and one social worker were displaced by the SROA process. This resulted in disrupted continuity and chronic understaffing of the program. Group treatment remained suspended throughout the monitoring period. As staffing patterns stabilize, it is anticipated that ASU will improve significantly and return to full programming.

Reception Center Processing

The Reception Center Processing program is staffed by three full time psychologists, who also share DDP and CCCMS case manager duties. As a result of AB109 mission changes, most arrivals to CIM are new commitments from Riverside County, as opposed to the parole violators received in the past. The vast majority of inmates are screened within 24 hours of arrival. 211 inmates were evaluated during the review period. A review of current programming indicates no significant changes over the previous monitoring period. The screening program continues to review the county jail transfer forms whenever available, as in the past monitoring period.

Reception Center Correctional Clinical Case Management System (RC-CCCMS)

There are approximately 150 inmates in the RC CCCMS program. All RC CCCMS I/Ps are seen at the 30-day mark after having been seen for their initial evaluation, and 90 days thereafter. In addition all CCCMS inmates who arrive at RCC from ASU, MHCB or any other facility or prison, are seen 30 days after arrival.

NEW CONSTRUCTION/REMODELING.

There was no new construction or remodeling during the reporting period.

NEW OR ANTICIPATED MISSION CHANGES.

One CIM mission change involved the repurposing of the Reception Center East Facility from a Reception Center into a Mainline Level Three General Population Sensitive Needs Yard Facility now referred to as Facility C. This facility now houses CCCMS Patient-Inmates and, occasionally, EOP Patient-Inmates pending transfer.

MAJOR POPULATION MOVES.

There were several significant population moves during the reporting period due to the implementation of Assembly Bill (AB) 109. In October 2011, the intake of parole violators ceased. Intake remained closed until December 2011. Continuing since that time, CIM is, with few exceptions, primarily receiving new commitments from Riverside County. Between September 28, 2011 and April 11, 2012 there was an overall reduction of the CIM prison population of 898 inmates. Since the beginning of the October 2011 reporting period, there was an overall reduction of approximately 347 MHSDS Patient-Inmates. This reduction included

200 CCCMS, 128 EOP, and 19 MHCB Patient-Inmates. Also included among these reductions, were 4 ASU CCCMS and 17 ASU EOP Patient-Inmates.

NEW OR OVERFLOW ADMINISTRATIVE SEGREGATION OR ANY OTHER SPECIALIZED HOUSING UNITS.

There were no new ASU overflow or SPU units.

OBSTACLES TO PROVIDING MENTAL HEALTH SERVICES AND ADHERENCE TO PROGRAM GUIDE REQUIREMENTS.

There was a hiring freeze for Mental Health positions and, as a result of Assembly Bill 109, a reduction of 2.5 senior psychologist supervisor positions and 14 staff psychologist positions during the reporting period. Simultaneously, there was a reduction in the intake of Reception Center Inmates. The office services supervisor (OSSII) and health program specialist (HPSI) positions could not be filled due to the hiring freeze. This resulted in a significant reorganization of staff assignments throughout the institution and increased supervisory responsibilities.

MENTAL HEALTH ROSTER

Institutional Mental Health Staffing and Telemedicine

October 1, 2011 to March 31, 2012
California Institution for Men

Position	Positions Established	Positions Filled	Vacancies	Vacancy Rate	Full-Time Equivalent	Functional Vacancies	Functional Vacancy Rate
Chief Psychiatrist	1	1	0	0%	0	0	0
Senior Psychiatrist	1	1	0	0%	0	0	0
Chief Psychologist	1	1	1	0%	0	0	0
Senior Psychologist	2	2	0	0%	0	0	0
Staff Psychiatrist	15	12	3	20%	0	0	20%
Staff Psychologist	42	28	14	33%	0	0	33%
Supervising Social Worker	1	1	0	0%	0	0	0%
Social Worker	12	11	1	8%	0	0	8%
Registered Nurse	10.5	10.5	0	0%	0	0	0
Senior Psych Tech	2	2	0	0%	0	0	0
Psych Tech	15.5	15.5	0	0%	0	0	0
Recreation Therapist	4	4	0	0%	0	0	0
Other (specify)							

Telemedicine

Psychiatry telemedicine used?	Number of Hours Per Week
NO	N/A

QUALITY MANAGEMENT

Quality Management Committee (QMC)

QMC is the highest level healthcare committee in the institution. QMC's multidisciplinary committee members include senior representatives from all healthcare disciplines and custody. QMC meets twice per month and the standard agenda includes: old business/follow-ups, reports from all subcommittees, QIT status reports/discussion, and new business. The committee report format allows for an efficient review of actions taken and needed follow up. The QMC met 6 times and achieved quorum at all meetings during the reporting period.

Mental Health Quality Management Subcommittee (MHQM)

The purpose of the MHQM is to oversee mental health services, review program performance, and monitor, create and implement improvement efforts. The Chief of Mental Health or designee serves as Chair. MHQM are scheduled to meet monthly. During the reporting period the MHQM met six times. A quorum was attained in 67% of the meetings during the reporting period.

Peer Review

Based on consultation with the Chief Psychologist for Clinical Practice in Headquarters, CIM modified the Peer Review process from quarterly to semi-annual reviews. Peer review tools for both the psychology/social work disciplines and psychiatry were modified and piloted during the monitoring period. Feedback from clinicians utilizing the tool and the Peer Review Committee were incorporated into the modifications. Both tools were modified to focus on the completeness and quality of the Progress Notes for each discipline. Copies of the revised forms are available in the Proof of Practice Binder.

The Peer Review Committee is comprised of the Peer Review Coordinator/SPR-FIT Coordinator, a staff psychiatrist, a staff psychologist, and a clinical social worker. Meetings are scheduled monthly. During the monitoring period, four committee meetings were held. Two meetings were not held due to scheduling conflicts. Minutes of the meetings are available in the Proof of Practice Binder.

An analysis of the most recent peer review process appears to suggest some positive outcomes in terms of mental health service delivery with regard to completeness and accuracy in recording of clinical encounters via CDCR 7230-MH progress notes. For psychiatry, some areas of service delivery and documentation in need of some improvement appeared to include legibility for written notes and clarity of intervention plans. This general feedback was delivered to psychiatric staff during a recent meeting. For psychology, the peer review feedback tends to run very positive, with isolated and specific suggestions most often related to inclusion of more specific diagnostic information and/or clarification of interventions. For social work, the review feedback closely mirrors the general trends for psychology, with similar feedback regarding diagnostic clarity/specificity. Feedback was delivered electronically via email attachments to individual psychologists and social workers. Feedback regarding the tools and possible need for modification will be addressed in the upcoming Peer Review Committee meetings.

Copies of the current peer review tools and a summary of the previous and most recent review quantitative analysis and qualitative summary of feedback are included in the proof of practice binder.

QIT Activities

One Mental Health QIT was active during this reporting period. No new QITs were chartered during the review period. One QIT, involving reconciliation of mental health evaluations with Unit Health Records, was resolved with final recommendations sent to the QMC during the review period. That QIT was resolved since the last management report. No QITs are ongoing.

MEDICATION MANAGEMENT, PSYCHOTROPIC MEDICATIONS

The total number of inmates in the MHSDS who received psychotropic medications during the reporting period was 6577.

Medication Continuity for New Arrivals (Inter-Institutional CDCR Transfers)

99.10% of new arrivals received medications by the next calendar day. This number includes all medications and it is obtained via MAPIP measure #4.

Medication Continuity for Transfers (Intra-Institutional Transfers)

Based on our current MAPIP audit measure 5, 5a, 5b, 5c and 5da 95% of I/Ps transferring within the institutions received their prescribed psychotropic medications without interruption.

Medication Continuity for Renewal of Orders/Bridge Orders

The current procedure for all I/P coming from other institutions is to have their medications continued automatically according to the received MAR. This occurs during the initial Receiving & Release health screening. Formulary medication are continued for the length of previous order and non-formulary medications are continued for 14 days only and the I/P is scheduled for follow up by a psychiatrist within one week. The maximum length of medication orders by psychiatrists is 90 days.

During the reporting period, 96.5% of inmate-patients received timely renewals of their psychiatric medications based on MAPIP measure 4, 2 and 2a.

Lab Tests/Results for MHSDS Inmates

During the reporting period, 328 randomly selected eUHRs of inmates receiving psychotropic medications were reviewed following MAPIP guidelines. 100% had laboratory tests ordered when clinically indicated. The senior psychiatrist regularly reviewed lab results. Abnormal results and needed actions were discussed with staff. In addition, CIM conducted MAPIP audits with samples of 20 randomly selected inmate/patients measuring key indicators on a Quarterly basis. CIM shows consistently good performance on these indicators

An Abnormal Involuntary Movement Scale (AIMs) must be completed every 6 months for each inmate prescribed antipsychotic medications. During the reporting period, an AIMs was completed within the last 6 months in 86% of the 102 applicable cases.

Direct Observation Therapy (DOT) Medication Administration

At the end of the reporting period, 19 inmate-patients were prescribed psychotropic DOT medication. During pill lines, DOT medication administration procedures were followed 99.81% of the time based on MAPIP measure 9.

HS Medications (After 2000 Hours)

861 MHSDS inmate-patients received HS medications during the reporting period. HS medications are delivered after 2000 hours. During the reporting period HS medications were administered after 2000 hours 100% of the time based on MAPIP measure 7.

Medication Non-Compliance Policies and Procedures

During the reporting period, there was an average of 72.21% of Medication Non Compliance Policies and procedures section of MAPIP 9a and 9e. MAPIP measure 6 for medication non-compliance specific to psychiatric prescribed medication reflects 92.43%. The Medication Administration Record (MAR)

The audit reflected a 95.0% of audited MARs were appropriate reflecting appropriate medication distribution based on MAPIP measure 9b, 5a, 5b, 5d, 9a.

Timely Processing of Medication Orders

The audit reflected a 100% processing per MAPIP audit measure 3 under pharmacy. MAPIP measure 2 and 2a reflect 95.5% of newly processed orders were processed and patients subsequently medicated. MAPIP captures medication compliance < 24 regardless if it is medical or mental health, specific DOT only is not captured.

Informed Consent Forms

For inmate-patients on psychiatric medications, a random sample of 106 current eUHRs was reviewed. 80% of the records contained up-to-date consent forms. These findings revealed that a majority of the 20% deficiency was attributed to back-filed information from other institutions and forms filed in the incorrect tabs of the eUHR.

Pill Lines

Medications are typically distributed via pill lines with the exception of ASU areas. During the reporting period, the average pill line was open for approximately 2 hrs, all IP's received their medication with minimal wait times in each area.

Hoarding/Cheeking Medications

During the reporting period, there were 20 CDCR-115 Rules Violation Reports (RVRs) written explicitly for hoarding or cheeking medication.

Parole medications process

Currently, the Classification and Parole Representative notifies pharmacy of all paroling inmates at least 14 days in advance of release dates. During the reporting period, 869 I/Ps paroled with active prescriptions for psychotropic medications. One hundred percent of existing orders were renewed for 30-days. Paroling inmates are required to sign for receipt for their parole medications. During the reporting period, the following percentages of I/Ps signed manifests acknowledging receipt of their prescription medications:

- Yard A 87.5%
- Yard B 91.8%
- Yard C 92.5%
- Yard D 96.4%

CLINICAL PROGRAMS

MAINLINE CCCMS

Timeliness of PC and Psychiatrist Contacts

During the reporting period 1958 I/Ps were provided services in the Mainline CCCMS mental health program. Of these, 52% received an initial contact with their PC within 10 days, during which time the Clinical Intake Assessment was completed. In addition 54% had their initial IDTT within 14 days of arrival or transfer into the program. Indicators related to initial contacts were impacted by a CIM D yard housing unit where inmates underwent additional processing before transfer to their mainline housing. This issue was addressed during the monitoring period and is expected to show significant progress in the future. 99% received PC contacts at least once every 90 days (or more often if indicated), and 99% had a scheduled IDTT at least annually (or more often if indicated). Institutional staff participated in the IDTT with the PC being present 100% of the time, the Psychiatrist 98% of the time, the Correctional Counselor 60% of the time, and the I/P 94% of the time. Reasons why the I/P failed to attend the IDTT included refusals, lack of an interpreter and no shows. During the reporting period, 96% of inmates with prescriptions for psychotropic medications received timely psychiatry appointments.

Prerelease and Discharge Planning

During the reporting period, 177 I/Ps in the CCCMS level of care paroled from the institution. Of these, 69 received parole planning.

DEPARTMENT OF MENTAL HEALTH (DMH) REFERRALS

Screening for higher levels of care is consistently completed in all IDTTs using the CDCR Form 7388B. During the six month reporting period a monthly audit was completed to monitor for consistent inclusion of all I/Ps to be assessed for possible elevation in level of care. The following report is based on data taken from this monthly report (internal review of 7388B/Screening for Higher Level of Care for all I/Ps who met at least one criterion but were not referred to Higher Level of Care/DMH), the monthly Referral/Non-Referral Log, and internal logs maintained by the DMH Coordinator.

The monthly audit of the 7388B/Screening for Higher Level of Care forms has remained relatively consistent over the monitoring period. There are anticipated changes with the audit tool and the process within the next 1-2 months. The current audit process consists of a review of 100% of all 7388-Bs where there is a positive response to any of the identified criteria. A 7388-B form is generated from every IDTT completed at CIM. A copy of all 7388-B forms where there is a positive response to any of the assessment criteria is then forwarded to the DMH Coordinator. On or before the fifteenth of each month the audit is completed for the 7388-Bs from the previous month (currently 100% inclusion). The results of this monthly audit are reported to the Mental Health Sub-Committee and the excerpt of the minutes of the DMH report is forwarded to Utilization Management staff at Headquarters. The anticipated changes to this process will be outlined in future reports.

During this period, 239 I/Ps (this includes multiple assessments for the same I/P if the I/P had more than one IDTT during the monitoring period) met one or more of the indicators for

consideration for a higher LOC. Of the identified I/Ps, 13 % were referred to DMH, 87 % of I/Ps were not referred. Of those not referred, 98% had a reason for non referral documented on the 7388B, and 94% had documented interventions to improve the I/P's level of functioning while remaining in the institution.

During the reporting period, 32 referrals to DMH were completed: 29 ICF and 3APP. Ninety three percent of ICF referrals, and 100% of APP referrals were completed within specified time frames and posted on SharePoint.

Once a bed was identified at a DMH facility, 100% of transfers took place within the specified time frames. Only one referral (3%) was rejected by DMH because of significant medical concerns that needed a primarily medical environment One referral (3%) was rescinded after the I/P was referred to an Acute care facility. The I/P later reconstituted very well and was able to be housed outside of the MHCB. He was eventually referred to ICF level of care and is currently in that program. There were a number of other referrals which did not result in a placement at DMH; Two (6%) of I/Ps paroled and six (18%) transferred to other CDCR facilities.

Thirty I/Ps that were referred to DMH care by CIM clinical staff were released from a DMH facility during the reporting period. Fifteen I/Ps were discharged to a different CDCR facility to either parole or continue their incarceration. Of the fifteen I/Ps that returned to CIM from DMH, DMH discharge summaries were received 100% of the time. Clinician to clinician contact took place within specified time frames of the I/Ps' return to the institution 93% of the time. Five day follow-ups were completed with 100% of returning I/Ps. One I/P (3%) re-referred to DMH within 30 days of their return to CDCR. This I/P was not accepted by DMH secondary to significant medical concerns.

MENTAL HEALTH CRISIS BED (MHCB)

The institution has a 36 bed, Mental Health Crisis Bed (MHCB) unit. Inmate-patients are received from internal referrals as well as from other institutions. During the reporting period, 516 referrals were received from within the institution and 83 referrals were received from other institutions.

During the reporting period, admissions to the MHCB unit totaled 599. The average length of stay (LOS) was 6.17 days. The range was from 0 to 125 days. The number of I/Ps with a LOS longer than 10 days was 88. Reasons for LOS longer than 10 days included; 18% DMH referral awaiting a bed, 27% Keyhea in process, and 23% clinically discharged awaiting transfer back to home institutions. The remaining inmates were held over for primarily clinical reasons.

Once admitted to the MHCB unit, 84% received their initial IDTT within 72 hours of admission. Thereafter I/Ps were offered weekly IDTTs 74% of the time. Daily contacts by a licensed psychologist or psychiatrist occurred 68% of the time. A randomly sampled MHTS.NET/eUHR audit revealed that, of those I/Ps that were admitted due to suicidal threats or behavior, 100% were administered an SRE at the time of placement and 100% received a SRE upon release from the MHCB. 98% received a five day follow-up after their release from the MHCB.

TRANSITIONAL BED HOUSING (TBH)

The TBH has existed in order to accommodate the great demand for MHCB beds within CIM as well as within the CDCR system. The CIM TBH was last activated officially on September 29, 2011. The TBH was erroneously activated for two days in early October (10-2-11 and 10-3-11), with three patient-inmates placed into Cypress Hall, despite available beds in the MHCB. Thereafter, the TBH remains closed.

ADMINISTRATIVE SEGREGATION UNIT (ASU)

During the reporting period there were 491 participants in the MHSDS housed in ASU programs: 375 I/P's received care at the CCCMS level of care (LOC) and 116 at the EOP LOC. 1989 were non-MHSDS I/Ps. All patients entering ASU receive a nursing pre-placement screening (CDCR Form 7219). RN/PT staff monitor daily intake into ASU via Daily Movement sheets so that in the event that a patient is housed without going through proper processes, the patient will still be screened by the next day. Nursing staff are also responsible for ensuring medication continuity once the patient is identified.

Incoming I/Ps were always placed in identified safety cells, unless space was unavailable. This tended to occur most frequently on 1st Watch when it was difficult accommodate special needs (i.e. lower tier/lower bunk chronos, etc.). 100% of I/P placed in ASU were reviewed for current MHSDS status within one working day following their placement in ASU, and prior to the 114D hearing. Custody documented 30-minute welfare checks during the reporting period 97% of the time. Daily ASU morning meetings between custody and clinical staff were documented 93% of the time.

ASU-CCCMS

375 I/Ps received care at the CCCMS level of care. 77% of the I/Ps were assessed by a clinician within 10 working days. 36% of initial IDTTs were completed within 14 calendar days. Subsequent IDTTs took place at least every 90 days, 79% of the time. Difficulty achieving timelines was primarily attributed to problems with referral and assignment procedures. A corrective action plan has been put in place and will be monitored over the next several months.

86% of I/Ps received at least weekly individual PC contacts, 36% of the time they were seen in a confidential setting; and 62% of the time they were seen cell-front. Reasons for non-confidential contacts included, 48% I/P refusals; 4% custody lockdowns; .3% lack of custody escorts; and 48% unspecified or staff decision. 96% of I/Ps prescribed psychotropic medications were seen by a psychiatrist at least every 90 days. All daily LPT rounds were documented on the CDCR Form 7230-MH.

ASU-EOP

116 I/Ps received care at the EOP LOC. 72% of I/Ps received an initial assessment prior to the initial IDTT or within 14 calendar days of referral/identification. 43% of initial IDTTs were completed within 14 calendar days. Subsequent IDTTs took place at least every 90 days, 93% of the time. Difficulty achieving timelines was primarily attributed to problems with referral and assignment procedures. A corrective action plan has been put in place and will be monitored over the next several months.

The average LOS was 77 days and ranged from 11 to 118 days. 70% of I/Ps had LOS longer than 60 days. 50% had LOS longer than 90 days, of those 100% were reviewed every 30 days by the Facility Captain or CC-II. Four of these were endorsed to the ASU Hub and left CIM with a pending transfer. One was at CIM temporarily while en route to another institution.

Of the I/Ps in the program during the reporting period, 96% received at least weekly individual PC contacts, 36% of contacts took place in a confidential setting and 64% of contacts were cell-front. There were two instances of out of cell, non-confidential contacts. Reasons for non-confidential contacts included, 33% I/P refusals; 4% custody lockdowns; 1% lack of custody escorts; and 62% unspecified or staff decision. 87% of I/Ps prescribed psychotropic medications were seen by a psychiatrist at least every 30 days. Daily LPT rounds were documented on the CDCR Form Progress Note 7230-MH 100% of the time, and 30% of I/Ps were offered at least five hours of structured therapeutic activities per week.

Three I/Ps refused more than 50% of offered treatment during a given week period. The three I/Ps refusing more than 50% of offered treatment services did not receive daily PC contacts during the work week, and no I/Ps were given a modified treatment plan. There were several technical barriers regarding data entry into MHTS.NET that prevented identification of these I/Ps.

ASU-Non-MHSDS

During the reporting period, 1989 non-MHSDS inmates were placed in ASU. All inmates placed in ASU received a timely nursing pre-placement screening (CDCR Form 7219), and all screenings were conducted in a confidential setting. Custody documented 30-minute welfare checks 97% of the time. Nursing documented daily LPT rounds 100% of the time.

SUICIDE PREVENTION

SPR-FIT (Suicide Prevention Focused Intervention Team)

CIM has an active Suicide and Response Improvement Team (SPR-FIT). See Proof of Practice Binder to review SPR-FIT meeting schedules, agendas, minutes and attendance logs.

Completed Suicides

There were no completed inmate suicides in the institution.

Attempted Suicides

Of the 5 serious suicide attempts during the reporting period, 2 of them were by hanging, 1 was by lacerations, 0 were by overdose, 1 was by swallowing razor blades, and 1 was by jumping from a tier. 3 required outside hospitalization and all 5 were referred to an MHCB for acute mental health care services, with 60% ultimately referred to a DMH facility and one was referred for Mainline EOP facility transfer.

For all MHCB psychiatric admissions, upon return to regular housing from a MHCB or MHOHU, full 5-day SPD follow-up was documented between 95.1% and 100% of the time. Custody wellness checks were completed as required 89.6% of the time.

The self-harm review process remains active. Since the last management report, zero reviews have been completed and presented to the treatment teams and SPR-FIT for discussion. Zero reviews are in progress, and Zero are awaiting return of the inmate–patient to the institution from DMH.

Suicide Risk Evaluations (CDCR 7447) in the MHCB were completed at the initial IDTT (within 24 hours unless the admission was on a weekend or holiday, in which case the I/P is on Suicide Watch until IDTT) 100% of the time Discharge SRE's were completed at the final IDTT when discharges were ordered,100% of the time.

SPR-FIT Committee Meetings

Of the six SPR-FIT monthly meetings required during the reporting period, 6 monthly meetings were documented to have occurred. The SPC coordinates the monthly SPR-FIT. During the reporting period the agendas included:

- Suicide Prevention Videoconferencing – Equipment and attendance improvement
- High Suicide Risk Alerts via MHTS.net – Incorporating and managing new source of risk data
- Serious Suicide Attempt Reviews – Continuing monitoring of systemic risks and reduction/management
- Revision and implementation process for OP 14 (Suicide Watch), with particular focus on expansion of SPD discharges to mainline yards and update of 5 day Follow-Up and Custody Wellness Checks
- Development, implementation, and monitoring of Suicide Risk Evaluation Proctoring & Mentoring Program
- Utilization and monitoring of CDCR's "High Risk/High Utilizer" List for specialized assessment and treatment enhancement

During the reporting period, ongoing suicide prevention training consisted of: (List all ongoing suicide prevention activities and training that took place during the reporting period)

- Suicide Risk Evaluations (CDCR 7447) – Training (to entire MH Staff)
  - Review of key SRE elements, goals, procedures, and documentation
- OP 14 (Suicide Watch) Revision and Implementation
  - Training on new discharge process and expansion to new mainline yards.

RVR PROTOCOLS

During the reporting period, 1208 inmates at the institution received RVRs: 766 for GP Inmates, 362 CCCMS, 63 EOP, and 17 MHCB. 100% of the CCCMS, EOP and MHCB RVRs received a mental health assessment.

USE OF FORCE

During the rating period there were a total of 233 Incidents in the Institution.

There were a total of 80 incidents involving the use of force, of those incidents 51 involved MHDS inmates. There were a total of 153 incidents not involving the use of force, of those incidents 78 involved MHDS inmates. A table of all the Use of Force and Non-Use of Force incidents during the reporting period can be found in the proof of practice binder.

RECEPTION CENTER

All new arrivals with MHSDS histories are screened within 72 hours. The inmates arrive twice a week (Wednesday and Friday). Once they are done with their intake in R&R, they are escorted directly to the mental health annex that is across the hallway. If there are any screening packets left over, the inmate clerk knows to bring those inmates back the next day for screening, but this is a rare occurrence. This process ensures a near 100% completion rate within 72 hours for all inmates, not just prior MHSDS.

Initial Health Screenings were conducted on 100% of incoming inmates by nursing staff within 24 hours of arrival.

RC CCCMS

This population is housed primarily in B yard. During the reporting period the percentage of RC I/Ps in the MHSDS has declined from 23% to approximately 9%. The average LOS was 77 days and ranged from 3 to 366 days. 36 % of I/Ps had LOS longer than 90 days. Reasons for lengths of stay longer than 90 days included:

- Pending RVR
- Pending possible prosecution by District Attorney
- Pending transfer to a Level III-SNY
- Pending transfer to a Level-IV-SNY-180
- Pending transfer to a Level IV-GP-180

Clinical contacts for the reporting period are contained in the RC CCCMS Case Manager Contacts audit (Tab N). 68% of I/Ps had initial contacts with their PC within 30 days of arrival. Subsequently, 95% had routine contacts with their PC at least every 90 days.

Those I/Ps that had prescribed psychotropic medications received psychiatry contacts at least every 90 days 99% of the time. Confidential contacts with the PC took place 99% of the time. Reasons for non-confidential contacts included: 100% I/P refusal.

RC EOP

This population is housed primarily on B yard and over the reporting period has declined from 9% of the I/Ps in the MHSDS to approximately 2%. The average LOS was 91days and ranged from 4 to 180 days. 83 % of I/Ps had LOS longer than 60 days. Reasons for lengths of stay longer than 60 days was primarily due to I/Ps who were endorsed and awaiting transfer.

RC EOP I/Ps were seen weekly by their PC 79% of the time, and monthly by their psychiatrist 91% of the time. Confidential contacts with the PC took place 98% of the time. Reasons for non-confidential contacts included: 16% I/P refusal, 12% lock downs, and 72% staff decision

and unspecified. Subsequent to the initial contact I/Ps had IDTTs scheduled monthly 72% of the time. I/Ps were offered at least five hours per week of structured therapeutic activity 41% of the time.

MENTAL HEALTH REFERRALS

- Emergent: Immediately
- Urgent: Within 24 hours
- Routine: Within five working days

During the reporting period, 2007 referrals were received and on the final day of the period, 99% were closed. Referral statistics indicate that 67% of urgent referrals were seen within 24 hours, and 89% of routine referrals were completed in within 5 business days. There were no emergent referrals generated during the monitoring period.

AGREEMENT AUDIT

The UNH-MHT.net audit process has taken place on a monthly basis throughout the monitoring period. The audits have focused on documentation of mental health service provision (Primary Clinician Scheduled Contacts, Psychiatry Visits, IDTT, Group Treatment, etc.) for CCCMS, EOP, and MHCB level of care.

The audits have been completed according to proscribed procedure communicated from Sacramento via the DCHCS Mental Health Program. These procedures include methodology for random selection of CDCR#'s within each Level of Care and Location and utilization of a standardized method for auditing agreement between the UHR and MHTS.net documentation of contacts.

Each monthly audit is conducted via a two-way comparison of MHTS "completed" appointments for primary mental health care with the corresponding documentation of the encounter in the eUHR. Records are reviewed for the month two months prior to the review date (i.e. concordance rates for August are audited in October). 100 contacts generated out of a randomized procedure are audited each month, and the agreement rate is tabulated, with a goal of at least 90% agreement. Agreement rates for the six months during the monitoring period are: 93% (Aug'11); 97% (Sep'11); 95% (Oct'11); 95% (Nov'11); 92% (Dec'11); and 94% (Jan'12). The audit results and trends to date show a high correlation, suggesting a strong likelihood that MHTS.net data can be used to accurately monitor and audit mental health service provision.

Audit Completed	Oct'11	Nov'11	Dec'11	Jan'12	Feb'12	Mar'12
Month Audited	**Aug'11**	**Sep'11**	**Oct'11**	**Nov'11**	**Dec'11**	**Jan'12**
Agreement Rate	**93%**	**97%**	**95%**	**95%**	**92%**	**94%**

Exhibit 20

CSP-CORCORAN

MENTAL HEALTH MANAGEMENT REPORT

ROUND XXV VISIT
AUGUST 20, 2012 TO AUGUST 23, 2012

TERESA MACIAS
CHIEF EXECUTIVE OFFICER, HEALTHCARE

CONNIE GIPSON
WARDEN (A)

SUKHDEEP GREWAL, M.D.
CHIEF OF MENTAL HEALTH

ROBERT FISCHER, PH.D.
CHIEF PSYCHOLOGIST (A)

GLOSSARY OF TERMS

Acronym	Term
AIMs	Abnormal Involuntary Movement Scale
APP	Acute Psychiatric Program
ASU	Administrative Segregation Unit
CAP	Corrective Action Plan
CC	Correctional Counselor
CCCMS	Correctional Clinical Case Management System
CDCR	California Department of Corrections and Rehabilitation
CHSA	Correctional Health Services Administrator
DMH	Department of Mental Health
DOT	Direct Observation Therapy
EOP	Enhanced Outpatient Program
GP	General Population
HC-POP	Health Care Population Oversight Program
HS	Hour of Sleep
I/P	Inmate-patient
ICC	Institutional Classification Committee
ICF	Intermediate Care Facility
IDTT	Inter Disciplinary Treatment Team
LGB	Local Governing Body
LOC	Level of Care
LOP	Local Operating Procedure
LOS	Length of Stay
LPT	Licensed Psychiatric Technician
MAR	Medication Administration Record
MHCB	Mental Health Crisis Bed
MH-OHU	Mental Health-Outpatient Housing Unit
MHQM	Mental Health Quality Management Subcommittee
MHSDS	Mental Health Services Delivery System
MHTS	Mental Health Tracking System

OHU	Outpatient Housing Unit
PC	Primary Clinician
PSU	Psychiatric Services Unit
QIT	Quality Improvement Team
QM	Quality Management
QMC	Quality Management Committee
R&R	Receiving and Release
RVR	Rules Violation Report
SHU	Security Housing Unit
SPC	Suicide Prevention Coordinator
SPR-FIT	Suicide Prevention and Response-Focused Improvement Team
SRE	Suicide Risk Evaluation
UHR	Unit Health Record

Coleman Site Visit, Round XXV
MENTAL HEALTH MANAGEMENT REPORT
August 20, 2012 through August 23, 2012
CSP-Corcoran (COR)

INSTITUTIONAL PROGRAM SUMMARY

Overview of all the Mental Health Programs at the Institution

The MHSDS at California State Prison (CSP) - Corcoran consists of six treatment programs; the Mainline (ML) EOP program, the ASU EOP program, the ASU CCCMS program, the SHU CCCMS program, the ML CCCMS program, and the MHCB.

The ML EOP program is an intensive outpatient program designed to treat I/Ps who, for their own safety, require segregation from the general population. Treatment is provided by a number of disciplines, including psychologists, social workers, recreation therapists (RTs), psychiatrists, and LPTs offering a minimum of ten hours a week of structured therapeutic activities. The population served is housed in 3B01 with a cap of One hundred and fifty I/Ps.

During this reporting period, the ML EOP transitioned, along with the entire 3B yard, from a Level IV GP to a Level IV, SNY. The Level IV GP I/Ps transferred out and, at one point, there were only 30 Level IV SNY in the building. As the transition progressed, and Level IV SNY I/Ps arrived from other institutions, the population increased so that, on 6/29/12, there were One hundred and fourty five EOP SNY I/Ps in 3B01 and six additional in the MHCB. This program has seven PCs and one Psychiatrist.

Due to the change, and the inability to mix SNY and ML I/Ps, the EOP was severely limited in programming. For a time, several groups were canceled. While some programming continued in the housing unit, there were restrictions on interactions of I/Ps. In addition to the I/Ps housed in 3B01, there continued to be up to seventeen I/Ps housed in the 3C01 building. As the transition continued, these I/Ps were either transferred to another institution or integrated into the 3B01 building. At the end of June, there were still eight I/Ps in 3C01, with two of them scheduled to transfer early in July.

The EOP Hub is also designed to treat the more severe mental health EOP I/Ps who require segregation from the regular ASU/SHU I/Ps for their own safety. This program provides at least 10 hours of structured therapeutic activities per week. The EOP Hub provides case management and group therapy to the I/Ps. The EOP HUB has an authorized capacity of Ninety nine I/Ps, nine PCs and one Psychiatrist.

The 3A Gym has been converted to a treatment area. It has been retrofitted with six group treatment rooms and twelve individual modules. There is office space for the clinical staff including clinicians, LPTs, RTs, and the psychiatrist.

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A pilot project was initiated on 4/2/12 involving the Alternative Treatment Module (ATOM) chair for group therapy. This is a trial project, which provides I/Ps with a possible alternative to the traditional treatment module. Training was provided to EOP HUB clinical staff and custody staff assigned to the 3A Gym. Each use of the ATOM chair group room requires a survey to be completed by clinical staff, custody staff, and the I/Ps after each usage. These surveys are compiled and presented to headquarters and institutional staff in a monthly teleconference. There is also an individual cubicle with one ATOM chair available for individual sessions.

The ASU CCCMS program is housed in 3A04, with an overflow into 3A03 and 3A05. The CCCMS population has averaged about one hundred and sixty I/Ps. Individual treatment is offered in *Coleman* treatment cells located on the dayroom floor, and no facilities for group treatment are available. This program has six PCs and one Psychiatrist. CSP-Corcoran also has a stand-alone ASU. While no CCCMS I/Ps are housed there, it is monitored seven days a week for I/Ps displaying mental health symptoms or new arrivals with a MHSDS LOC.

The SHU CCCMS program provides services to approximately four hundred and fifty CCCMS I/Ps, including approximately fifteen expired MERD I/Ps who receive more intensive services as they are considered on ASU status. This program has twelve and a quarter full time PCs and three part-time psychiatrists.

This program has had significant challenges with the availability of Health Care Escorts, which is discussed in detail in the section on "Obstacles to Providing Mental Health Services and Adherence to Program Guide Requirements."

The ML CCCMS program is housed on 3A, 3B, and 3C facilities with over five hundred CCCMS I/Ps. In addition, 3B and 3C are SNY facilities whose MHSDS population is often more demanding. This reporting period, 3B completed transitioning from a Level IV GP facility to a Level IV SNY facility, resulting in a total turnover of the yard with a large volume of intakes and initial IDTTs. As many as seventeen EOP SNY I/Ps have been housed on 3C due to their case factors, awaiting transfer to a more appropriate SNY EOP facility. A modified, more intensive program is offered to these I/Ps. There are currently five PCs and two Psychiatrists assigned to ML CCCMS.

The MHCB unit is in Unit C of the hospital with Twenty four single cells. Of those, Twenty three are available for I/Ps, and one houses a long-term medical I/P. In addition, there is one observation room that is used for an I/P in five-point restraint. Additional housing is available on the Med/Surg unit, Unit B, for overflow beds as an extension of the MHCB. The MHCB is established as a short-term intensive psychiatric unit for I/Ps requiring up to a Ten-day inpatient stay. Most I/Ps are hospitalized for danger to self (DTS), danger to others (DTO) or grave disability (GD). It is staffed Twenty four/ seven by overlapping clinical teams composed of Psychologists, Social Workers, and Psychiatrists. There are also two RTs, one of whom works full-time in the Crisis Unit; the other splits 0.75-time to Unit C and 0.25-time to Units A, B, and D (medical I/Ps). It is also staffed by nursing and custody with Correctional Counselors available two days per week for IDTTs.

The DMH Coordinator reviews all the 7388-Bs provided by the clinicians in conjunction with IDTT. All positive indicators are distributed weekly by the coordinator and discussed at program IDTTs. The 7388-Bs are reviewed by the Coordinator to ensure that positive indicators are listed on the form and that detailed explanations are given for both referrals and non-referrals. If referrals are not made, the modified treatment plan has to be indicated in the 7388-B. In CCCMS, I/Ps who are considered to need a higher level of care are most likely referred to EOP first.

In addition, we had a Behavioral Pain Management Program serviced by one clinician, which had to be suspended due to staffing pressures. We also have a Pre-release Program serviced by one clinician who focuses primarily on EOP I/Ps soon to be released on parole and under Post Release Community Supervision (PRCS). Licensed psychologists are also assigned to the Emergency Room on a rotating basis to provide prescreening of MHCB admissions and act in a gate-keeping fashion. In addition, coverage is maintained on a face-to-face basis until 2200 hours to insure appropriate I/Ps are admitted to the MHCB.

New Construction/Remodeling

Funds have been appropriated through AB900 to construct a new EOP Hub treatment and office space building. Construction has begun on this project. It was initially scheduled for completion in January 2013, but is now scheduled for completion in March 2013.

New or Anticipated Mission Changes

As indicated above, our 3B facility converted from a Level IV GP facility to a Level IV SNY facility last year. During this reporting period, the ML EOP program gradually built up to its cap of One hundred and fifty I/Ps. The CCCMS ML population was also impacted by this transition resulting in a total turnover of the yard with a large volume of intakes and initial IDTTs.

New or Overflow Administrative Segregation or any other Specialized Housing Units

ASU1 and 3A04 are identified as our ASU, and Sections A and B of 3A03 houses our ASU EOP I/Ps. Section C of 3A03 is utilized as an overflow for both ASU CCCMS I/Ps and ASU EOP I/Ps. 3A05, housing our ML CCCMS program, has also been used on an as needed basis as an overflow ASU unit during the reporting period

Obstacles to Providing Mental Health Services and Adherence to Program Guide Requirements

Modified programs have been in effect on 3A and 3B Facilities during the reporting period due to lockdowns. These have resulted in some disruption to mental health services (the Program Status Report is available in the Proof of Practice Binders – Tab O). The EOP ML program was unable to conduct groups for about two weeks on 3B facility due to lockdowns.

Access to care issues continue to impact treatment, particularly in the SHU CCCMS and ASU CCCMS programs. Over the reporting period, the limited escort resources have become further strained due to the increased demand from medical and dental services. In our SHU CCCMS program, both physician and registered nurse (RN) lines have increased, leaving a total of six two-man escort teams available for mental health appointments on the two Facilities serving twelve clinicians. This has resulted in longer wait times for clinicians providing therapeutic services

In ASU CCCMS, two escort officers provide services for six clinicians with mental health appointments for about One hundred and sixty I/Ps seen weekly. The one private office is used for medical lines. IDTT and ICC are now conducted on the dayroom floor in partitioned areas. This escort shortage has required innovative strategies to insure adequate mental health treatment is provided. Mental Health and Custody are working to increase the flexibility in the use of escorts, and ensure greater accountability of both escort and clinical staff

MENTAL HEALTH ROSTER

Institutional Mental Health Staffing and Telemedicine

January 1, 2012 to June 30, 2012
CSP-Corcoran

Position	Positions Established	Positions Filled	Vacancies	Vacancy Rate	Full-Time Equivalent (Contractors and Dual Appointments)	Functional Vacancies	Functional Vacancy Rate
Chief Psychiatrist	1	1	0	0%	0	0	0%
Senior Psychiatrist	0.5	0	0.5	100%	0	0.5	100%
Chief Psychologist	1	1	0	0%	0	0	0%
Senior Psychologist	4	4	0	0%	0	0	0%
Staff Psychiatrist	12.5	2.75	9.75	78%	7.6	2.15	17.2%
Staff Psychologist	33.5	32.75	0.75	2%	2	- 1.25	-3.7%
Supervising Social Worker	1	1	0	0%	0	0	0%
Social	17.4	13.0	4.4	25%	2	2.4	14%

Worker							
Registered Nurse	43.92	41.92	2.0	4.5%	0	2.0	4.5%
Senior Psych Tech	4	4	0	0%	0	0	0%
Psych Tech	37.64	34.0	3.64	9.6%	0	3.64	9.6%
Recreation Therapist	10.5	10	0.5	4.8%	0	0.5	4.8%
Other (specify)	N/A						

Telemedicine

Psychiatry telemedicine used?	Number of Hours Per Week
No	N/A

The staffing above represents the complement of staff and contractors present at the end of the monitoring period. The personnel documentation is available in the Proof of Practice Binders-Tab S.

QUALITY MANAGEMENT

Local Governing Body (LGB)

The LGB is responsible for oversight of health care services and is the ultimate authority for all health care matters. The LGB was scheduled to meet three times during the monitoring period. All of the scheduled meetings achieved a quorum. The agenda and minutes are available in the Proof of Practice Binders-Tab B.

Quality Management Committee (QMC)

The purpose of the QMC is to monitor, assess, and improve the quality of health care. During the reporting period the QMC met 10 times and a quorum was attained at all meetings. Agendas and minutes are available in the Proof of Practice binders-Tab B. The QMC is chaired by the Chief Executive Officer (CEO) and regularly attended by the Chief of Mental Health (CMH), Warden (or designee), Associate Warden (AW) Health Care, the CHSA II, Chief Medical Officer (CMO), the Chief Physician and Surgeon, Chief Nurse Executive, and Pharmacist-in-Charge. The QMC regularly collects reports from each service delivery area (e.g., Pharmacy, Nursing, Medical, Dental and Mental Health). Presentations by each of the departments/ subcommittees are data focused, and general communication/coordination issues are discussed.

Mental Health Quality Management Subcommittee (MHQM)

The purpose of the MHQM is to oversee mental health services, review program performance, and monitor, create, and implement improvement efforts. The CMH or designee serves as Chair.

MHQM is scheduled to meet twice a month. During the reporting period the MHQM met twelve times. A quorum was attained in all of the meetings during the reporting period.

Peer Review

Currently all three clinical disciplines have active peer review committees: psychology, social work, and psychiatry. General procedures are outlined in the Healthcare Quality Management OP 1060.

Psychology Peer Review

The Psychologist Peer Review Team consists of three psychologists, including the team leader. The psychologist supervisor of the peer review and the team leader discuss possible candidates for the peer review team, and the team leader then invites psychologists to participate. There has been little change in the reviewing team over the past six months. All psychologists are welcome to participate in the reviews each month.

These peer reviews are in the Proof of Practice Binders – Tab B.

Psychiatry Peer Review

Peer review is done once a month and one psychiatrist is reviewed. The psychiatrist to be reviewed is picked at the previous meeting. This person in turn prepares a case and a brief written description of case or issues to be discussed. Then, on the last Tuesday of the month, the committee meets at 7:00 AM and the case is presented.
See Proof of Practice Binders – Tab B.

Social Work Peer Review

The Social Work Peer Review committee has had difficulty getting started. A chair of the committee has been chosen and, for the last couple of months, has been setting up a format involving didactic and case presentation. These presentations would then be evaluated by their peers attending on a structured questionnaire (see Proof of Practice Binders-Tab B). No meeting has taken place at this point.

QIT Activities

Two Mental Health QITs have been ongoing since the last *Coleman* audit; one (Emergency Referrals) has been added, and one (Medication Management) was finalized this reporting period.

1. Medication Management QIT – Initially this was developed as a standing QIT to look into issues concerning the administration of medication. Since then, it has become more formalized. The responsibility of the QIT is to examine the monthly MAPIP audit and address areas in which minimal standards are not met, often by further examining the issue and developing a corrective

action plan. This QIT was completed in February 2012 and the Final Recommendation Form is in the Proof of Practice Binder.

2. EOP Hub Treatment Improvement Plan QIT – This has been a standing QIT to examine specific EOP Hub interventions, collect data, and develop innovative treatment strategies to increase participation by the I/P population. This also entails a monthly teleconference involving all Hub institution to share ideas and strategies.

3. MHTS/UHR Agreement QIT – This QIT was initiated last year to examine discrepancies between documentation in the UHR or eUHR and tracking in the MHTS.net. The QIT was established to look into causes for any agreement issues and develop corrective action plans.

4. Emergency Referrals QIT – This QIT was established to evaluate the reasons for a low number of emergency referrals in the MHTS.net when we knew that more referrals had been made. The QIT will also generate suggestions for correcting the procedures so that we capture these referrals.

Miscellaneous Audits:

The audits here are those that are not specific to any program but extraneous to the reports provided in the MHTS.net. The data is available in the Proof of Practice Binders – Tab B.

Program and Supervisory Chart Audits. The Program audits were initiated in March 2009, and are currently conducted quarterly. Until recently, they had been conducted monthly. They are designed to ensure timelines and documentation requirements as outlined in the MHSDS Program Guide are met. Each audit is specifically tailored to meet the requirements for that specific program and may be completed by the line staff or supervisor of the program. Line staff is encouraged to participate as it can also act as an educational tool. The supervisory audit is completed by the supervisor of each program and is designed to look at the more qualitative aspects of documentation in the eUHR.

MEDICATION MANAGEMENT, PSYCHOTROPIC MEDICATIONS

The total number of inmates in the MHSDS receiving psychotropic medications at the end of the reporting period was one thousand four hundred and fourty one. A list of these inmates is available on request. Most of the data used in the below findings were obtained from the results of the MAPIP audits, and the audits as well as protocols are available in the Proof of Practice Binders – Tab C. Unless specifically indicated, the audits were conducted on non-MHSDS, as well as MHSDS I/Ps

Medication Continuity for New Arrivals (Inter-Institutional CDCR Transfers)

We did not have a methodology for capturing the total number of new arrivals on psychotropic medications. R&R keeps these records for one month only. Now a process has been established and is in place to capture this information in future. According to the last month's audit, 100 percent of the inmates in this category received their medications by the next calendar day.

Medication Continuity for Transfers (Intra-Institutional Transfers)

Based on a random sample of twenty charts per month, during the reporting period, 98 percent of I/Ps transferring within the institutions received their prescribed psychotropic medications without interruption. One hundred percent of I/Ps discharged from the MHCB continued to receive their psychotropic medications without interruption.

Medication Continuity for Renewal of Orders/Bridge Orders

During the reporting period, One hundred percent of I/Ps received timely renewals of their psychiatric medications. No I/Ps had a lapse in medication, resulting from medication expiration.

Lab Tests/Results for MHSDS Inmates

During the reporting period, Twenty randomly selected UHRs of I/Ps receiving psychotropic medications were reviewed. Of nineteen applicable cases, eighty nine% had laboratory tests ordered when clinically indicated. Psychiatrists reviewed results and documented clinical action in eighty nine percent of the seventeen cases with significant laboratory results. An Abnormal Involuntary Movement Scale (AIMS) must be completed every six months for each inmate prescribed antipsychotic medications. During the reporting period, an AIMS was completed within the last six months in sixty eight percent of the nineteen applicable cases.

Direct Observation Therapy (DOT) Medication Administration

We have Fourteen thousand eight hundred and ninety two psychotropic DOT medications prescribed at the end of the reporting period. During pill lines, DOT medication administration procedures were followed ninety nine percent of the time.

HS Medications (After 2000 Hours)

There are four hundred and nineteen MHSDS I/Ps receiving HS medications as of the end of the reporting period. HS medications are delivered after 2000 hours. During the reporting period, HS medications were administered after 2000 hours One hundred percent of the time.

Medication Non-Compliance Policies and Procedures

During the reporting period there was an average of Thirty notifications of non compliance per week and sixty three percent of non compliance cases had documented follow up appointments with the Psychiatrist within seven days of the referral.

The Medication Administration Record (MAR)

The audited UHRs contained the previous month's MARS One hundred percent of the time, and hundred percent of UHRs contained MARs that were complete and legible.

Timely Processing of Medication Orders

Guardian records the date orders were written and the manifest date (the date the pharmacy sent the medications to the pill window). One hundred percent of changes and newly prescribed medications were received within twenty four hours of the date the order was written.

Informed Consent Forms

For I/Ps on psychiatric medications, a random sample of the current UHR contained up-to-date consent forms eighty one percent of the time per MAPIP. Consent forms expire annually.

Pill Lines

Medications are typically distributed via pill line in the ML CCCMS facilities. During the reporting period, the average pill line wait was Twenty eight minutes on 3B01 yard

In 3A03 both med lines started at 0720 and ended at 0845. These medications are passed cell to cell, no walk-up med line.

In 3A04 upper tier med line started at 0746 and ended at 0840. These medications are passed cell to cell, no walk-up med line.
In 3A04 lower tier med line started at 0729 and ended at 0830. These medications are passed cell to cell, no walk-up med line.

Hoarding/Cheeking Medications

During the reporting period, there were no CDCR-115 RVRs written explicitly for hoarding or cheeking medication.

Parole medications process

Currently, the Classification and Parole Representative notifies pharmacy of all paroling I/Ps at least fourteen days in advance of release dates. During the reporting period, One hundred percent of paroling I/Ps received a thirty day medication supply at the time of release. Paroling inmates are required to sign for receipt for their parole medications. During the reporting period, One hundred percent signed manifests acknowledging receipt of their prescription medications.

MAINLINE CCCMS

Timeliness of PC and Psychiatrist Contacts

During the reporting period four hundred and eighty nine I/Ps entered the CCCMS mental health program. Of these, fifty one percent received an initial contact with their PC within 10 days during which time the Clinical Intake Assessment was completed. In addition fifty percent had their initial IDTT within fourteen days of arrival or transfer into the program. This shortfall from the guideline standard was due in large part to the conversion of 3B Facility which has since been completed and so the issue has been rectified. Thereafter ninety two percent received PC contacts at least once every ninety days (or more often if indicated), and eighty five percent had scheduled IDTTs at least annually (or more often if indicated). Staff participated in the IDTT with the PC being present one hundred percent of the time, psychiatrist sixty seven percent of the time, and I/P ninety nine percent of the time. The only reason why the I/Ps failed to attend the IDTT was lock downs.

During the reporting period, ninety nine percent of I/Ps with prescriptions for psychotropic medications received timely psychiatry appointments. Reasons that inmates did not have timely psychiatry contacts included: one percent inmate refusal.

Pre-release and Discharge Planning

During the reporting period, fourty four I/Ps in the CCCMS level of care were to parole from the institution according to HQ. Of these, twenty three received parole planning, five paroled or transferred before the parole date, twelve were not scheduled, one refused and one was a scheduling error.

MAINLINE ENHANCED OUTPATIENT PROGRAM (EOP)

During the reporting period, fifty nine percent of all new EOP admits were assessed and presented to the IDTT within 14 days of admission, at which point their initial treatment plan was completed and signed by the IDTT attendees. Again, this low figure was due in large part to the conversion of 3B Facility which has since been completed and so the issue has been rectified. Once admitted to the program, weekly PC contacts (individual or group activity) took place ninety eight percent of the time, IDTTs took place at least every ninety days, eighty four percent of the time, and treatment plans were updated at least every 90 days, sixty nine percent of the time. The issue is due to the quality of the Audit and staff training has been done. IDTTs were attended by their PC one hundred percent of the time, by the psychiatrist eighty six percent of the time, and the I/P eighty three percent of the time. Reasons why the I/P failed to attend the IDTT included; six percent I/P refusal, one percent scheduling issues (sick/furlough), and ten percent lock downs.

During the reporting period, group therapy was provided for the I/Ps in the EOP LOC. Group topics are listed in the Proof of Practice Binder. On average, I/Ps were offered 6.67 hours of structured therapeutic activity per week. Again, this low figure was due in large part to the conversion of 3B Facility which has since been completed and so the issue has been rectified.. During the reporting period, two I/Ps were provided a modified treatment plan. One hundred percent of those who received a modified treatment plan also received a monthly IDTT.
In July of 2012 we began to use individual treatment rooms in the EOP Treatment Building to provide confidential sessions for the I/Ps.

Prerelease and Discharge Planning

During the reporting period, seventeen I/Ps in the EOP level of care were to parole from the institution according to HQ. Of these, eleven received parole planning, five paroled or transferred before the parole date, and one was not scheduled.

DEPARTMENT OF MENTAL HEALTH (DMH) REFERRALS

During this period two hundred and seventy seven I/Ps met one or more of the indicators for consideration for a higher LOC. 244 I/Ps were brought to IDTT and were considered for higher LOC. Of the identified and who were brought to IDTT, 6.9 percent were referred to DMH, 93.1 percent were not referred. During this period 886 IDTTs for all Levels of care were held. This data includes I/Ps who were seen multiple times in IDTT during the reporting period. All I/Ps were considered at IDTT for referrals to higher levels of care, and the 7388Bs were scrutinized by the DMH Coordinator for accuracy, completeness, and possible referral. Twenty-five I/Ps listed on the DMH non-referral log (or all I/Ps on the list if less than twenty five) were randomly audited monthly. Of those audited, one hundred percent had a reason for non-referral documented on the 7388B, and One hundred percent had documented interventions to improve the I/P's level of functioning. This suggests that the DMH referrals were equally well managed and clinically accurate.

During the reporting period, seventeen referrals to DMH were completed: ten ICF and seven APP. Thirty percent (three out of ten) of ICF referrals were completed within five working days, seventy two percent (five out of seven) of APP referrals were completed within two working days and posted on SharePoint.

During this time period none of the ICF or APP referrals were rejected by DMH and only one of the APP referrals was rescinded (fourteen percent).

During the reporting period twenty eight I/Ps returned to the institution from DMH. DMH discharge summaries were received when the I/P returned to the institutions one hundred percent of the time on SharePoint. Clinician-to-clinician contact took place within five working days of the I/P's return to the institution twenty nine percent (eight out of twenty eight) of the time. Five-day follow-ups were completed One hundred percent of the time for returning I/Ps.

MENTAL HEALTH CRISIS BED (MHCB)

The institution has a twenty four-bed MHCB unit. I/Ps are received from internal referrals as well as from other institutions. During the reporting period, three hundred and twenty seven

referrals were received from within the institution and sixty four referrals were received from other institutions.

During the reporting period, the total number of admission to the MHCB unit totaled three hundred and ninety one. The average LOS was 13.4 days. The range was from zero to sixty one days. The number of I/Ps with a LOS longer than ten days was forty eight according to HCPOP. Reasons for LOS longer than ten days included; six percent DMH referral awaiting a bed, zero percent Keyhea in process, forty percent clinically discharged awaiting bed, two percent clinically discharged awaiting transfer back to home institutions, four percent starting a trial of new psychotropic medication. The percent retained for clinical reasons including psychosis, suicidality, depression, poor response to medication treatment, ongoing agitation and mood swings was fourty eight percent. .

Prior to being admitted to the MHCB unit, One hundred percent of the I/Ps admitted during regular working hours were administered a pre-admission screening. Those I/Ps admitted after hours received their screening their screening the next morning. Once admitted to the MHCB unit they received their initial IDTT within seventy two hours of admission ninety three percent of the time. Thereafter, I/Ps were offered at least weekly IDTTs eighty two percent of the time. IDTTs were attended by the PC one hundred percent of the time, psychiatry ninety three percent, CC-I sixty four percent, nursing eighty percent of the time and I/P one hundred percent. Daily contacts by a licensed psychologist or psychiatrist occurred eighty four percent of the time. Of those I/Ps that were admitted due to suicidal threats or behavior, only nine percent were administered an SRE according to MHTS, However based on Audit of EUHR a One hundred percent of initial SRE were completed. Staffs were trained on data input and recording and this has been rectified. One hundred percent I/Ps received a SRE upon release from the MHCB. Ninety percent received a consecutive five-day follow-up after their release from the MHCB.

Alternative Housing

We do not have Alternative Housing here. We only have a medical OHU that is not used for mental health. Alternative housing has never been used in the reporting period.

ADMINISTRATIVE SEGREGATION UNIT (ASU)

During the reporting period, there were four hundred and seventy eight I/Ps that entered the ASU programs: one hundred and ninety six at CCCMS LOC, ninety three at EOP LOC and one hundred and eighty nine non-MHSDS I/Ps. All patients entering ASU are supposed to receive a nursing pre-placement screening. However, during the reporting period only fourty four percent of the I/Ps received pre-placement screening prior to placement in the ASU setting according to audits. Staff have been trained and QIT is being developed to address this issue. One hundred percent of the screenings that were conducted were conducted in a confidential setting. Those not receiving screenings typically came from the SHU. Incoming I/Ps were placed in identified safety cells One hundred percent of the time according to custody audits. One hundred percent

of I/Ps placed in ASU were reviewed for current MHSDS status within one working day following their placement in ASU, and prior to the 114D hearing. Sixty-four percent of I/Ps received a mental health screening (31-item questionnaire) within seventy two hours of placement. Staff have been educated regarding data entry and auditing procedures. Custody documented thirty minute welfare checks during the reporting period ninety nine percent of the time.

ASU-CCCMS

During the reporting period, Six hundred and eighty one I/Ps entered the ASU CCCMS program. Seventy-seven percent of the I/Ps were assessed by a clinician within ten working days. Eighty percent of initial IDTTs were completed within fourteen calendar days. Subsequent IDTTs took place at least every ninety days, ninety six percent of the time. One hundred percent of IDTTs were attended by the primary clinician; ninety four percent of IDTTs were attended by a psychiatrist, zero percent of IDTTs were attended by the CC; The CC and supervisors have been notified. forty five percent of IDTTs were attended by the I/P. The only reason for non-participation included was I/P refusals.

During the reporting period, eighty eight percent of I/Ps received at least weekly individual PC contacts, thirty one percent of the time they were seen in a confidential setting, and sixty nine percent of the time they were seen cell-front. Reasons for non-confidential contacts included: sixty two percent I/P refusals, three percent lack of custody escorts, four percent other (clinician decision which includes running out of time, staff shortage and staff absence). Ninety-three percent of I/Ps prescribed psychotropic medications were seen by a psychiatrist at least every ninety days. Daily LPT rounds were documented on the CDCR Form 7230-MH One hundred percent of the time. Daily ASU morning meetings between custody and clinical staff were documented One hundred percent of the time.

ASU EOP (HUB)

During the reporting period, six hundred and three I/Ps entered the ASU EOP. One hundred percent of I/Ps received a comprehensive assessment (7386) prior to the initial IDTT or within fourteen calendar days of referral/identification. Eighty-eight percent of initial IDTTs were completed within fourteen calendar days. Subsequent IDTTs took place at least every ninety days seventy nine percent of the time. One hundred percent of IDTTs were attended by the primary clinician; eighty three percent of IDTTs were attended by the psychiatrist; eighty three percent of IDTTs were attended by CC; and ninety six percent of IDTTs were attended by I/P. The only reason for non-participation was I/P refusals.

During the reporting period, Fifty-seven percent of I/Ps had LOS longer than sixty days. Thirty-three percent (twenty six I/Ps) had LOS longer than ninety days days; of those, ninety nine percent were reviewed every thirty days by the Facility Captain or CC-II. Reasons for LOS longer than ninety days included: sixteenendorsed awaiting transfer/bed availability, six pending DA referral/RVR, two out to court, one pending DRB, one pending ICC.

Of the I/Ps in the program during the reporting period, One hundred percent received at least weekly individual PC contacts, fifty four percent of contacts took place in an out of cell confidential setting, and fourty six percent of contacts were cell-front. Reasons for cell-front contacts included: twenty six percent I/P refusals; four percent custody lockdowns; and sixteen percent provider initiated which includes running out of time, staff shortage and staff absence. Ninety-two percent of I/Ps prescribed psychotropic medications were seen by a psychiatrist at least every thirty days. Daily LPT rounds were documented on the CDCR Form Progress Note 7230-MH One hundred percent of the time. Fifty-seven percent of I/Ps attended at least ten hours of structured therapeutic activities per week.

During the reporting period, the average number of I/Ps who refused more than fifty percent of offered treatment during a given week period was thirty four percent. I/Ps refusing more than fifty percent of offered treatment services received daily PC contacts during the workweek One hundred percent of the time, and One hundred percent of those I/Ps were given a modified treatment plan. Daily ASU morning meetings between custody and clinical staff were documented ninety five percent of the time. In addition, a list and description of groups being offered is available in the Proof of Practice Binders – Tab O.

ASU Non-MHSDS

During the reporting period, four hundred and nine I/Ps entered ASU-Non-MHSDS program. Of those, One hundred percent received a timely nursing pre-placement screening (CDCR Form 7219), and One hundred percent of the screenings were conducted in a confidential setting. Custody documented thirty minute welfare checks One hundred percent) of the time. Nursing documented daily LPT rounds One hundred percent of the time.
During the reporting period, four hundred and nine I/Ps entered ASU-Non-MHSDS program. Of those, One hundred percent received a timely nursing pre-placement screening (CDCR Form 7219), and One hundred percent of the screenings were conducted in a confidential setting. Custody documented thirty minute welfare checks One hundred percent of the time. Nursing documented daily LPT rounds One hundred percent of the time.

SHU CCCMS

During the reporting period, eight hundred and fifty seven I/Ps were admitted to the SHU-CCCMS. sixty two percent of the I/Ps had an initial IDTTs within fourteen calendar days. Subsequent IDTTs took place at least every ninety days, ninety five percent of the time. One hundred percent of IDTTs were attended by the primary clinician; seventy nine percent were attended by a psychiatrist, seventy nine percent were attended by the CC; One hundred percent were attended by the LPT; and fourty two percent of IDTTs were attended by the I/P. The only reason for non-participation included was I/P refusals. Ninety-three percent of I/Ps subsequently received contacts with their primary clinician at least once every thirty days, and ninety seven percent of I/Ps prescribed psychotropic medications were seen by a psychiatrist at least every

ninety days. Weekly LPT rounds were documented on the CDCR Form 7230-MH ninety three percent of the time.

SUICIDE PREVENTION

The institution has an active SPR-FIT. The SPR-FIT has continued to meet on a monthly basis. While the formal SPR-FIT Committee meets regularly on the fourth Tuesday of the month, the committee members, as well as all mental health clinicians and designated nursing and administrative staff, are encouraged to attend the SPR-FIT videoconference on the second Wednesday of each month.

Of the six SPR-FIT monthly meetings required during the reporting period, six monthly meetings occurred and were documented by minutes of the meeting. The SPC coordinates the monthly SPR-FIT. During these meetings, any completed suicides, serious suicide attempts, and the status of those I/Ps on the High-Risk Watch List are discussed, as well as any audits related to suicide prevention. The minutes and agendas during the reporting period are included in the Proof of Practice Binders-Tab I.

Completed Suicides

During the reporting period, there were no completed inmate suicides in the institution.

During the last two years there were no completed suicides in the institution.

Attempted Suicides during the Reporting Period

There were seven serious suicide/self harm attempts during the reporting period: one was by hanging; three were by lacerations; one was by overdose; one was by asphyxia; and one by swallowing a foreign body. Five required outside hospitalization and two were referred to the MHCB for acute mental health care services, with one ultimately referred to a DMH facility. Five continue on the High-Risk Watch List. All serious suicide attempts are discussed during the Emergency Medical Response Review Committee (EMRRC). These minutes are included in the Proof of Practice Binders – Tab T. These attempts are also listed in the Suicide Attempt Log.

On return to regular housing from a MHCB, five-day follow-ups were documented ninety five percent of the time. There were 304 MHCB discharges during this reporting period. Seventy were re-admitted or transferred and two were paroled. For the remaining two hundred and thirt two discharges, Ninety five percent of the five-day follow-ups were completed consecutively. The non-compliant five percent was restricted to weekend tracking errors.

Custody wellness checks were completed as required Eighty Six percent of the time, on average. An audit was completed during this reporting period to ascertain the percent completion of the three-day custody suicide prevention follow-up. This was determined by the presence of the Suicide Prevention Folder, which is completed by both custody and clinical staff. The percent completed, overall, is Eighty Six percent percent

Four of the five facilities ranged between eighty four percent and ninety eight percent. These results are available in the Proof of Practice Binders – Tab T.

RVR PROTOCOLS

During the reporting period, three thousand two hundred and nine I/Ps at the institution received RVRs: eight hundred and seventy one for GP, five hundred and thirty one for CCCMS, ninety for EOP, twenty six for MHCB, and two hundred and eleven for ASU. One hundred percent of the EOP and MHCB RVRs received a mental health assessment. In addition, two hundred and sixty eight of the CCCMS I/Ps and fourteen of the GP I/Ps received mental health assessments. Of the CCCMS inmates, seventy eight received A, B or C SHU-able offenses and four hundred and fifty three D, E, F offenses. Documentation is in the Proof of Practice Binder.

USE OF FORCE

A table of all the Use of Force and Non-Use of Force incidents during the reporting period can be found in Tab M. Of the Use of Force Incidents, sixty eight percent occurred with MHSDS I/Ps. For Non-Use of Force Incidents, sixty six occurred with MHSDS I/Ps.

MENTAL HEALTH REFERRALS

- Emergent: Immediately
- Urgent: Within twenty four hours
- Routine: Within five working days

During the reporting period, three thousand two hundred and seventy nine referrals were received and on the final day of the period, ninety eight percent were closed. Referral statistics (See Tab R) indicate that eighty nine percent of emergent referrals were seen the same day, fifty five percent of urgent referrals were seen within twenty four hours, and sixty eight percent of routine referrals were completed within five business days (MHTS.net's calculation uses calendar days rather than business days). This issue is being addressed through staff training.

MHTS.NET AGREEMENT AUDITS

The Agreement Audit determines the degree of agreement between the MHTS.net tracking and documents relating to that contact in the UHR or eUHR. Most recently we have been using the eUHR exclusively for these audits. Each contact has to agree on the date, the provider type, the name of the provider, and the type of contact. A total of six audits were conducted during the reporting period on all of the different programs. A summary table is available in the Proof of Practice Binders – Tab B.

Exhibit 21

Glossary of Terms

Acronym	Term
AIMS	Abnormal Involuntary Movement Scale
APP	Acute Psychiatric Program
ASU	Administrative Segregation Unit
CAP	Corrective Action Plan
CC	Correctional Counselor
CCCMS	Correctional Clinical Case Management System
CDCR	California Department of Corrections and Rehabilitation
CHSA	Correctional Health Services Administrator
DMH	Department of Mental Health
DOT	Direct Observation Therapy
EOP	Enhanced Outpatient Program
GP	General Population
HC-POP	Health Care Population Oversight Program
HS	Hour of Sleep
I/P	Inmate-patient
ICC	Institutional Classification Committee
ICF	Intermediate Care Facility
IDTT	Inter Disciplinary Treatment Team
LGB	Local Governing Body
LOC	Level of Care
LOP	Local Operating Procedure
LOS	Length of Stay
LPT	Licensed Psychiatric Technician
MAR	Medication Administration Record
MHCB	Mental Health Crisis Bed
MH-OHU	Mental Health-Outpatient Housing Unit
MHQM	Mental Health Quality Management Subcommittee
MHSDS	Mental Health Services Delivery System
MHTS	Mental Health Tracking System
OHU	Outpatient Housing Unit
PC	Primary Clinician
PSU	Psychiatric Services Unit
QIT	Quality Improvement Team
QM	Quality Management
QMC	Quality Management Committee
R&R	Receiving and Release
RVR	Rules Violation Report
SHU	Security Housing Unit
SPC	Suicide Prevention Coordinator
SPR-FIT	Suicide Prevention and Response-Focused Improvement Team
SRE	Suicide Risk Evaluation
UHR	Unit Health Record

Coleman Site Visit, Round XXV

MENTAL HEALTH MANAGEMENT REPORT

Monitoring Period: December 1, 2011 thru May 31, 2012

Date of site visit: July 30th thru August 1st, 2012

CALIFORNIA CORRECTIONAL INSTITUTION

Institutional Program Summary

Overview of all the mental health programs: CCI recently realigned to be an all SHU on yard A with a small Administrative Segregation component (HU6-8) and no General Population inmates. Yard B is completely SHU. Currently we house minimum and medium SNY inmates on levels C, D, and E. Yard C, no longer a reception center, houses security Level II inmates and is designated a SNY. Our RC program was discontinued 12/1/11. As of 4//5/12 we were designated a transgender cluster facility with selected mental staff, psychiatrist and psychologists, being sent to HQ for subject matter expert (SME) training in transgender issues.

New Construction/Remodeling: There is no construction or remodeling activity.

New or Anticipated Mission Changes: The small Reception Center ran on Yard III for many years has been closed and has been replaced with a SNY level III.

Major Population Moves: The realignment involved a major population move to transfer current inmates from our former reception yard to make room for the incoming medium (level II) security SNY population.

New or Overflow Administrative Segregation or any other Specialized Housing Units: Facility C (medium security 270 design yard) has been realigned to become an SNY facility. All other facilities remain as before. Level II Administrative Segregation is no longer active and inmates are no longer housed there.

Obstacles to Providing Mental Health Services and Adherence to Program Guide Requirements:

1. Labs continue to be challenging in two ways:
   Obtaining timely draws. The main fail point has been identified as getting the lab order to phlebotomists for scheduling. A new LOP was recently developed and implemented to resolve this problem. Ongoing MAPIP lab audits will prove whether or not the new LOP brings us up to threshold. Once the lab draw is scheduled the completion rate is well above 99%.
   Doing labs on required psychiatric medications. At this time labs are ordered on Lithium, Depakote, and Tegratol.
2. Timely psychiatric response to clinical referrals continue to be exigent, however; more recent innovations appear to have finally solved the problem and while we are encouraged we must remain guardedly optimistic until a larger pool of data can be analyzed.

3. CCI MH AB109 realignment staffing losses amount to over 60% of clinical line staff and 70% of supervisory staff. CCI's CEO and Chief of MH services have launched discussions as to how to arrange clinical priorities in the face of diminishing staff. We expect that the next six months will give the MH program the full reading of realignment impact.
4. Shortage of medical escort staff have slowed the pace of clinical contacts and IDTT's on celled yards. Steps have been taken to remedy this. We have centralized our service delivery efforts on the ASU and SHU yards which has reduced some of the bottlenecks caused by escort shortage and this has helped immensely.
5. Privacy has been a problem on Level 3 (Facility C) due to no confidential treatment space but this has most recently has been solved by the CEO with some minor construction and the authorization of laptops.

Mental Health Roster

Institutional Mental Health Staffing and Telemedicine

December 1, 2011 thru May 31, 2012

(Note: Throughout the reporting period, AB109 resulted in incremental MH staff losses as described in #6 above. The below figures represent staffing at the conclusion of the reporting period.)

Position	Positions Established	Positions Filled	Vacancies	Vacancy Rate	Full-Time Equivalent	Functional Vacancies	Functional Vacancy Rate
Chief Psychiatrist	0	0	0	0	0	0	0
Senior Psychiatrist	1	0	1	100%	0	0	100%
Chief Psychologist	1	1	0	0			
Senior **** Psychologist	2	2	0	0			
Staff Psychiatrist	6.5	4	2.5	38%	1.5	1.0	15%
Staff Psychologist	15	15	0	0		0	0
Supervising Social Worker	1	1	0	0			
Social Worker	6	3	3	50%	1.0	2	33%
Registered Nurse	1.0	1.0	0				
Senior Psych Tech	2.0	2.0	0	0			
Psych Tech	16	16	0	0	0	0	0
Recreation** Therapist	2.5	1.0	1.5	40%	0	1.5	40%

Other (specify)							

Telemedicine

Psychiatry telemedicine used?	Number of Hours Per Week
NO	N/A

Quality Management (Cross-reference Binder Tab B)

Local Governing Body (LGB)

CCI does not have a LGB. The CEO and Warden act in this capacity.

Quality Management Committee (QMC)

The purpose of the QMC is to monitor, assess, and improve the quality of health care. During the reporting period the QMC met six times with quorum requirements met. Agendas and minutes are available in the Proof of Practice binders in the Health Care Administrative Office. The QMC is chaired by the Chief Executive Officer designee and regularly attended by the Warden (or designee), Associate Warden for Health Care, the CHSA II, the Chief Physician Executive or designee, Chief of Mental Health or designee, Director of Nursing, and Chief Pharmacist. The QMC regularly collects reports from each service delivery area (e.g., pharmacy, nursing, and MHSDS). Presentations by each of the departments / subcommittees are data focused, and general communication/coordination issues are discussed.

Mental Health Quality Management Subcommittee (MHQM)

The purpose of the MHQMC is to oversee mental health services, review program performance, and monitor, create and implement improvement efforts. The Chief of Mental Health or designee serves as Chair. MHQMC is scheduled to meet monthly. During the reporting period the MHQMC met six times. A quorum was attained in 100% of the meetings during the reporting period.

Peer Review

A newly restructured Case Manager Peer Review Program for psychologists and LCSW's met twice during the reporting period. Peer Review at CCI consists of a quarterly evaluation of clinical documentation by the clinical staff, including psychologists, social workers and psychiatry. Each quarter, three to four clinicians of equal licensure, is confidentially assigned a peer to review by the chair of the Peer Review Committee. The clinician is requested to evaluate the quality of the documentation for up to three inmates, dating back several months depending on the inmate's current housing. The criteria for evaluation is provided on Peer Review Scoring Sheet that reviews items such as legibility, diagnosis, treatment plan, clinician summary, etc. The reviewing clinician is to evaluate if the quality of the evaluation is emerging, attains or exceeds CDCR minimum standards of documentation. The clinician is to review a variety of CDCR documentation including but not limited to 7230's, 7388 A and B, and 7386

forms. If a clinician is found to score below 65% in meeting the minimum standards of required documentation, the Peer Review Chair will counsel the clinician regarding needed areas of improvement. CCI has undergone a significant number of staffing changes over the past several months and as a result a new Peer Review Chair has volunteered to head the program. The Peer Review Program for Psychologists and Social Workers has met twice over the past two quarters. A total of six Psychologists have reviewed six peers and two Social Workers have reviewed two peers.

QIT Activities

There were a total of seven Mental Health QITs active at some point during this reporting period. Four new QITs were chartered during the review period. Four QIT were resolved with final summaries (or verbal reports) presented to the QMC during the review period. Input to the QMC may be found in QMC minutes.

QIT /CAP's initiated:

1. Three-day custody suicide prevention follow-up: Formed and retired during review period. New LOP was created. Training was given to affected staff.
2. LPT rounding documentation in CDC114 and 114A, and in MH CDCR 7230's: Nursing QIT formed and resolved during reporting period. Nursing audits report the problem has been resolved.
3. Privacy on Facility B (4B): (custody task force comprised of CEO, CMH, Captain and AW for HCA). Formed and resolved during reporting period. Privacy issues on IV B have been achieved for IP's consenting to come out of cell for clinical contacts. Refusals occur and are seen cell-front.
4. 21-day 30-minute ASU welfare checks: QIT formed by custody and retired during reporting period. .

QIT Unresolved:

1. Medication Management:
    a. Med continuity nursing CAP will be retired as resolved during next reporting because we have not gathered enough data at this juncture over a long enough date range.
    b. Med noncompliance notification CAP will be retired as resolved.
        i. Notification to PP is timely
        ii. Response by PC is timely
2. Parole Medications: Nursing QIT will be retired as resolved during next reporting period.
3. MH Labs: Newly developed LOP has been implemented. Problems continue yet improved.
4. Timely psychiatric response to clinical referrals: The solution appears at hand yet we do not have 6 month of good data yet so it must await final resolution.

QIT resolved/retired during monitoring period:

1. RVR write-ups were audited and found to meet the requirements of discussing:
    a. The IP's MH status
    b. How that status affected RVR case disposition.

2. Three-day custody suicide prevention follow-up: Formed and retired during review period. Custody was resolved this issue due to the resolution of their piece of the problem (a newly developed LOP).
3. LPT rounding documentation in CDC114 and 114A, and in MH CDCR 7230's: Formed and retired during reporting period as is determined not to be a problem any longer.
4. 21-day 30-minute ASU welfare checks (custody task force): Formed and retired by custody during reporting period.

Medication Management, Psychotropic Medications (Cross-reference Binder Tab C)

Total number of Caseload IP's on psychiatric medications

Data for this section was pulled from MHTS.net (Rx Grid). The total number of inmates in the MHSDS receiving psychotropic medications at the end of the reporting period was 594.

Medication Continuity for New Arrivals (Inter-Institutional CDCR Transfers)

91% of the sampled 80 new arrivals received medications by the next calendar day. The reporting is on all medications of which psychotropics are a subset. MAPIP protocols were followed by nurse auditors as to methodology and sample size. An ongoing nursing Medication Management QIT continues to monitor conformity and reports to MHQSC regularly.

Medication Continuity for Transfers (Intra-Institutional Transfers)

Based on a random sample of 80 charts, during the reporting period, 91% of I/Ps transferring within the institutions received their prescribed psychotropic medications without interruption. 100% of I/Ps discharged from the MHCB continued to receive their psychotropic medications without interruption. An ongoing nursing Medication Management QIT continues to monitor adherence to our guidelines.

Medication Continuity for Renewal of Orders/Bridge Orders

During the reporting period, 100% of inmate-patients received timely renewals of their psychiatric medications. No inmate-patients had a lapse in medication based on no written medication orders.

Lab Tests/Results for MHSDS Inmates

In accordance with MAPIP protocols, psychiatrists were the sole designated auditors of the lab function. CCI is below half-staffed with psychiatrists and to pull one off line to do lab audits would have pushed psychiatry farther and farther behind in terms of swelling clinical contact backlogs.

Direct Observation Therapy (DOT) Medication Administration

At the end of the reporting period, 934 psychotropic medications were prescribed DOT to 594 IP's. Nursing audits report that during pill lines, DOT medication administration procedures were followed 95% of the time.

HS Medications (After 2000 Hours)

There were 146 MHSDS inmate-patients receiving HS medications as of the end of the reporting period. HS medications are delivered after 2000 hours. During the reporting period HS medications were administered after 2000 hours 100% of the time.

Medication Non-Compliance Policies and Procedures

During the reporting period, there was an average of 20 to 30 notifications of non-compliance per week, and 40% of non-compliance cases had documented follow-up appointments with a psychiatrist within 7 days of the referral. MAPIP protocols were followed by nurse auditors as to methodology and sample size (n=20). During the reporting period a psychologist stood in for the psychiatry followup contact resulting in full compliance with the 7 day contact requirement. Nursing MAPIP audits do not allow for a psychologist stand-in, thus the 40% followup rate. At the writing of this report a new procedure is being developed to bring the 7-day psychiatrist contact requirement into compliance. This procedure is currently in effect but we have no data as of yet.

The Medication Administration Record (MAR)

The audited UHRs contained the previous month's MARS 96% of the time, and 100% of UHRs contained MARs that were complete and legible.

Timely Processing of Medication Orders

To verify timely processing, a random sample of 30 orders for DOT medications (MHSDS patients only) was selected. Guardian records the date orders were written and the manifest date (the date the pharmacy sent the medications to the pill window). 100% of changes and newly prescribed medications were received within 24 hours of the date the order was written.

Informed Consent Forms

For inmate-patients on psychiatric medications, the three most recent monthly audits of the current UHRs contained up-to-date consent forms 96%, 81%, 91% of the time respectively. UHR audits for medication consents are conducted during IDTT's which results in every UHR being audited at least annually. Consent forms expire annually.

Pill Lines

In open movement yards, medications are typically distributed via pill line. During the reporting period, the average pill line wait was 2-10 minutes on yards D and E.

Hoarding/Cheeking Medications

During the reporting period, there were 6 CDCR-115 Rules Violation Reports (RVRs) written explicitly for hoarding or cheeking medication.

Parole medication process

Currently, the Classification and Parole Representative notifies pharmacy of all paroling inmates at least 14 days in advance of release dates. During the reporting period, 60 I/Ps paroled with active prescriptions for psychotropic medications. 100% of existing orders were renewed for 30-days. Paroling inmates are required to sign for receipt for their parole medications. During the reporting period 100% signed manifests acknowledging receipt of their prescription medications.

Mainline CCCMS

Timeliness of PC and Psychiatrist Contacts

During the reporting period 1040 I/Ps entered the CCCMS mental health program. Of these, 88% received an initial contact with their PC within 10 days during which time the Clinical Intake Assessment was completed. In addition 91% had their initial IDTT within 14 days of arrival or transfer into the program. Thereafter 99% received PC contacts at least once every 90 days (or more often if indicated), and 100% had a scheduled IDTTs at least annually (or more often if indicated). PC was present 100% of the time, Psychiatrist 91.2% of the time, and I/P 51.6% of the time on celled units, and 86.6% of the time on open movement units. The reason the I/P failed to attend the IDTT: 100% inmate refusal. (Ongoing discussion is addressing the high refusal rate on the celled units and it appears that the high refusal rate on celled units had been driven by: 1) Ducats not going out the night before an appointment per guidelines. IP's were not given a heads-up for their appointments and were not prepared or ready for them when escorts showed up unannounced for their escort. This has been recently addressed and ducats are now going out per guidelines the night before a ducated appt; and 2) HU shot-callers putting out the word that IP's are not to meet with clinicians privately.)

During the reporting period, 98% of inmates with prescriptions for psychotropic medications received timely psychiatry appointments. Reason that inmates did not have timely psychiatry contacts: 100% inmate refusal.

Prerelease and Discharge Planning

During the reporting period, 332 I/Ps in the CCCMS level of care paroled from the institution. Of these, 90% received parole planning.

Mainline Enhanced Outpatient Program (EOP)

N/A

Prerelease and Discharge Planning

During the reporting period 5 I/Ps in the EOP level of care paroled from the institution. Of these 60% received parole planning. The clinicians responsible for EOP parole release planning have received re-training on parole release planning policies and procedures.

Department of Mental Health (DMH) Referrals (Cross-reference Binder Tab D)

During this period, 28 I/Ps met one or multiple criteria for a higher LOC. Of the identified I/Ps, 18% were referred to DMH, 82% of I/Ps were not referred. At each institution, 25 I/Ps listed on the DMH non-referral log (or all I/Ps on the list if less than 25) were randomly audited. Of those audited, 100% had a reason for non referral documented on the 7388B, and 89% had documented interventions to improve the I/P's level of functioning.

During the reporting period, 5 referrals to DMH were completed: 5 ICF and 0 APP. 80% of ICF referrals were completed within five working days. During this time period no DMH referral was denied or rescinded. During the reporting period 2 I/Ps returned to the institution from DMH.
Five day follow-ups were completed 100% of the time for returning I/Ps.

Mental Health Crisis Bed (MHCB)

CCI has no MHCB program.

Outpatient Housing Unit (OHU (Cross-reference Binder Tab F)

The institution has 8 MH designated OHU beds. During the reporting period there were 164 referrals to OHU and 125 admissions. A total of 54 I/Ps housed in the OHU were referred to a MHCB and 54 were admitted. The average length of stay was 5.34 days, ranging from 1 to 10 days. For those I/Ps with stays longer than 72 hours 100% were awaiting a bed in an MHCB.

OHU reports show 98% of I/Ps received daily contact with a licensed psychologist or psychiatrist seven days a week. MHTS.net reports indicate that 55% of I/Ps received daily contact from a licensed psychologist or psychiatrist. During the reporting period 71 I/Ps were placed in the OHU due to suicidality. Of those, the MHTS reports 64% were administered a SRE at the time of placement, 0% received and SRE upon release from OHU, and 62% received a five day follow-up upon their release. CCI's internal logs reflect 100% of admits received an SRE, 100% of discharging I/Ps received a SRE's, and 100% received 5-day follow-ups. CCI is looking into why there is such a large discrepancy between tracking system v. manual log figures. A contributing problem appears to be the unauthorized continued reliance on internal audit tools. In this case the reliance upon OHU tracking logs, which had been used to report data to the MHSCQM. Had this log use stopped the discrepancies would have been detected and rectified much earlier. Now only data from the .net system will be used to report data to MH subcommittee. We are studying the issue but it is not easy. Sometimes for example, a patient stays one day in the OHU; say Friday and is gone Saturday and has not even been seen by a Psychologist. Another contributing factor is loss of mh staff assigned to the OHU which has not been replaced.

Alternative Housing

During the reporting period there was only one I/P placed in alternative housing for 1.9 days while waiting for an available appropriate placement. He was administered an SRE prior to placement. He was placed on suicide watch in IVB holding cell which has a body length bench, sink and toilet.

Administrative Segregation Unit (ASU) (Cross-reference Binder Tab H)

During the reporting period there were 1035 I/Ps housed in ASU programs: 284 at CCCMS level of care (LOC), 46 at EOP LOC and 705 non-MHSDS I/Ps. All patients entering ASU are to receive a nursing pre-placement screening. During the reporting period 82% of the I/Ps received pre-placement screening prior to placement in the ASU setting, and 100% of the screenings were conducted in a confidential setting. Incoming I/Ps were placed in identified safety cells 100% of the time. 100% of I/P placed in ASU were reviewed for current MHSDS status within one working day following their placement in ASU, and prior to the 114D hearing. 100% of I/Ps received a mental health screening (31-item questionnaire) within 72 hours of placement. Custody documented 30-minute welfare checks during the reporting period 99.99% of the time.

ASU-CCCMS

During the reporting cycle, 101 I/Ps entered the ASU CCCMS program. 89% of the I/Ps were assessed by a clinician within 10 working days. 87% of initial IDTTs were completed within 14 calendar days or prior to ICC, whichever occurred first. Subsequent IDTTs took place at least every 90 days, 98% of the time. 100% of IDTTs were attended by the primary clinician; 92% of IDTTs were attended by a psychiatrist, 100% of IDTTs were attended by the CC; and 51% of IDTTs were attended by the I/P. In terms of patient non-participation it was due to I/P refusal 100 % of the time.

During the reporting period, 91% of I/Ps received at least weekly individual PC contacts, 59% of the time they were seen in a confidential setting; and 40% of the time they were seen cell-front. IP refusal was the reason for non-confidential contacts. Lack of ducats the night before and shot callers warning IP's against private contacts are viewed as significant regulators controlling the high number of refusals. 99% of I/Ps prescribed psychotropic medications were seen by a psychiatrist at least every 90 days. Daily LPT rounds were documented on the CDCR Form 7230-MH 100% of the time. Daily ASU morning meetings between custody and clinical staff occurred 5 days per week M-F and were documented 100% of the time.

ASU-EOP HUB

CCI is not an EOP ASU Hub.

ASU-Non-MHSDS

During the reporting period, 841 I/Ps entered ASU-Non-MHSDS program. Of those, 100% received a timely nursing pre-placement screening, and 100% of the screenings were conducted in a confidential setting. Custody documented 30-minute welfare checks 99.99% of the time. Nursing documented daily LPT rounds 99.7% of the time.

Psychiatric Services Unit (PSU)

CCI is not a designated PSU institution.

CCCMS SHU

During the reporting period, 311 I/Ps were admitted to the CCCMS-SHU. 84% of the I/Ps had an initial IDTTs within 14 calendar days or prior to the ICC whichever occurred first. Subsequent IDTTs took place at least every 90 days, 98% of the time. 100% of IDTTs were attended by the primary clinician; 92% were attended by a psychiatrist, 100% were attended by the CC; 87.5% were attended by the LPT; and 51% of IDTTs were attended by the I/P. IP refusal was the reason for I/P non-participation. (As contemplated above, high refusal rates on celled units are driven by ducats not going out the night before an appointment.) 96% of I/Ps subsequently received contacts with their primary clinician at least once every 30 days, and 96% of I/Ps prescribed psychotropic medications were seen by a psychiatrist at least every 90 days. Weekly LPT rounds were documented on the CDCR Form 7230-MH 100% of the time.

RECEPTION CENTER

CCI was not a reception center during the reporting period.

Suicide Prevention (Cross-reference Binder Tab I)

The institution has an active Suicide Prevention and Response Focused Improvement Team (SPR-FIT). See Tab I, Section 1 to review SPR-FIT meeting minutes.
Of the six SPR-FIT monthly meetings required during the reporting period, six monthly meetings were documented to have occurred. The SPC coordinates the monthly SPR-FIT. During the reporting period the agendas included: (See binder for more details)

- Proctor Mentoring program
- Managing significant staff reductions (66% loss of line staff; 70% supervisory staff) w/o sacrificing quality of SRE's and support of at risk IP's,
- New LOP re: Clinical/Custody communication
- Monitoring QIP items created after suicides
- Discussions of new employee orientation
- Discussions of the deleterious effects of AB109 inmate reductions and single celling risks

During the reporting period, ongoing suicide prevention training consisted of: monthly suicide prevention videoconferences; IST block and new employee training; Proctor Mentoring Program.

Completed Suicides

During the reporting period, there was one inmate suicide in the institution for a total 4 over a period of two years.

Attempted Suicides during the Reporting Period Other than the one completed suicide there were no serious suicide attempts during the monitoring period. There were 2 self injurious behaviors with suicidal ideation; however the cuts were superficial. Neither of the I/Ps wounds required sutures and both were sent to a MHCB for further evaluation and stabilization.

On return to regular housing from a MHCB, 5-day follow-up was documented 100% of the time. Custody wellness checks were completed as required 79% of the time. Custody has gotten more training and under the guidance of our new HCAW there appears to be a renewed vigor towards total resolution of this problem. Five of the 6 required SPR-FIT meetings took place during this reporting period and

minutes are available for review on request. The meeting is called to order and coordinated by the SPC. During this reporting period Suicide Prevention training consisted of monthly suicide prevention videoconferences for professional staff and block training for new employee orientation ongoingly.

Inmate Profile Procedure

Under the legacy MHTS for outgoing IP's two (2) Suicide Profiles were pulled by MHTS staff and sent to the respective receiving clinics for inclusion in the IP's transfer envelope. Arriving IP's were found to consistently have no profiles in their transfer envelope at CCI for distribution to the UHR and the Supervising Psychologist with a copy to the receiving clinician. Under MHTS.net profiles are available for pulling by any clinician receiving a new intake. Accordingly, the former clerical practice of pulling profiles for transfer ceased as an unnecessary step in the transfer process particularly in light of our recent staff losses.

RVR Protocols (Cross-reference Binder Tab J)

During the reporting period, 661 inmates at the institution received RVRs: 449 for GP Inmates, 205 CCCMS, 7 EOP, 3 MHCB, and 71 ASU. 30% of the EOP and MHCB RVRs received a mental health assessment (MHA). 100% RVR's received by the MH program for a MH assessment were timely assessed and returned to custody for processing. The above noted 30% MHA rate was due to the MH program not receiving a referral for the MHA. We'll be taking this issue up at MHQMC for discussion.

Use of Force (Cross-reference Binder Tab K)

A table of all the Use of Force and Non-Use of Force incidents during the reporting period can be found in Tab M. Of the Use of Force Incidents, 49.5% occurred with MHSDS inmate-patients. For Non-Use of Force Incidents, 39.1% occurred with MHSDS inmate-patients.

Mental Health Referrals (Cross-reference Binder Tab P)

Emergent: Immediately Urgent: Within 24 hours Routine: Within five working days
During the reporting period, 4043 referrals were received and on the final day of the period, 3950 (98%) were closed. Referral statistics (See Tab P) indicate that 100% of emergent referrals were seen the same day, 79% of urgent referrals were seen within 24 hours, and 82% of routine referrals were completed in within 5 business days (MHTS.net's calculation uses calendar days rather than business days). Please see earlier report sections that address timely referral contact problems.

Agreement Audits

Agreement rates are measured monthly via a methodology developed at HQ and averaged 90.33% for the reporting period.

Exhibit 22

Article

Journal of Correctional Health Care
00(0) 1-8
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sagepub.com/journalsPermissions.nav
DOI: 10.1177/1078345812474638
jcx.sagepub.com
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Suicide Prevention in Administrative Segregation Units: What Is Missing?

Heriberto G. Sánchez, PhD[1]

Abstract

Suicide remains a problem in prison administrative segregation units. Preventing suicide requires more than following policies and procedures and making structural changes to these units. The primary reason for placement in administrative segregation units is for an alleged rule violation, which in some cases could also be a crime. Prisoners could also be placed there for protection from other prisoners or pending an investigation of their allegations of staff misconduct. From the moment a prisoner is handcuffed for placement in administrative segregation, clinical and custody staff must work together in a manner that communicates genuine concern for the prisoner's well-being. This requires developing empathic relationships, understanding the prisoner's unique circumstances, and recognizing changing dynamics that could lead to hopelessness and suicide. Staff must be able to view the situation, including short- and long-term consequences, from the inmate's perspective. The author offers 10 recommendations to help reduce suicide on these units.

Keywords

prison, suicide, administrative segregation unit, risk assessment

Studies consistently show that administrative segregation units are high-risk settings for inmate suicide (Haney 2006; Hayes, 1995; Patterson & Hughes, 2008). Administrative segregation units are the jails within prisons where prisoners are isolated from the general population and housed alone, both of which can lead to feelings of loneliness and give genesis to suicidal thoughts (Van Ordern et al., 2010). If a prisoner's presence in the general inmate population poses an immediate threat to the safety of other inmates or staff, endangers prison security, or threatens the investigation of alleged serious misconduct or criminal activity, correctional staff will place the inmate in the administrative segregation unit. At the time of placement, the inmate is alleged to have violated a prison rule or committed a crime and is entitled to a due process hearing to determine his guilt or innocence. There are two other reasons for placement in the administrative segregation unit. If an inmate reports being threatened by other inmates or staff have information from other sources of a threat, they will

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place the inmate in the administrative segregation unit for his safety. Another reason is when an inmate makes allegations of misconduct against a staff member. In both of these cases, staff will retain the inmate pending an investigation and resolution of the issues.

A review of the literature failed to identify any articles that discuss suicide prevention in administrative segregation units. However, some states have addressed this problem. For example, in the California Department of Corrections and Rehabilitation, nursing staff conduct a prescreening of inmates prior to their placement in the administrative segregation unit, and mental health staff complete a mental health screen once they are placed into the unit (California Department of Corrections and Rehabilitation, 2009). A prisoner who does not pass these screens is referred for a comprehensive assessment, including a suicide risk evaluation with a mental health professional. Prisoners who are identified as at risk for suicide are referred to an inpatient setting where they receive mental health treatment. Once stabilized, they are placed back into the administrative segregation unit, where mental health staff continue to assess and treat them.

If the inmate passes the initial screening process, he will be housed in an intake cell within the administrative segregation unit. These cells are typically located near the custody staff office for ease of observation. These cells have been retrofitted to lessen the opportunities for suicide (e.g., removing towel racks that could be used for hanging). The prisoner remains in this cell for the first 72 hours. If the prisoner does not have safety concerns (enemies or history of in-cell violence), efforts are made to house him with a compatible cellmate since having a cellmate serves as a significant protective factor against suicide (Fazel, Cartwright, Norman-Nott, & Hawton, 2008; Patterson & Hughes, 2008).

Once a prisoner is placed in the cell, correctional staff give him a pamphlet that describes potential difficulties in adjusting to the administrative segregation unit, how this could affect his mental functioning, and how to ask for help. These pamphlets are available in both English and Spanish. Staff also provide reading assistance to inmates who score below a fourth-grade reading level. The education department provides a weekly list of inmates who score below this grade level. Officers conduct checks every 30 minutes for the first 21 days and document these checks in a log. Licensed vocational nurses or licensed psychiatric technicians with specialized training in recognizing mental health symptoms conduct daily rounds to identify prisoners having difficulties adjusting to the administrative segregation unit and will refer them to mental health clinicians for further evaluation. In addition, custody and mental health staff meet every morning to discuss new arrivals and identify inmates who are in need of mental health services.

Inmates are typically kept in their cells for 23 hours a day, coming out only for showers, exercise in fenced areas, and health care appointments. They also attend institutional classification committee reviews, which are held within 10 days of placement and at intervals of no more than 90 days afterward. The initial hearing addresses the segregation order to determine the need to retain the inmate in the administrative segregation unit for the reasons stated in the order. Subsequent reviews address the need for continued placement in this unit. Those inmates who are in the mental health program participate in psychological and recreational activities with mental health staff. Most prisoners find ways to cope with the isolation by exercising, writing, reading, or drawing. However, the typical prisoner has poor reading and writing skills, so this option is limited to a minority of the prisoners. Many prisoners engage in loud chatter as a way to deal with boredom. They spend time talking with other prisoners in adjacent cells through common air vents, or by yelling through the side of the cell door to other prisoners on the tier. For some prisoners, the loud noise level can add to the stress of being housed in this restrictive environment.

In response to the high number of suicides on these units, various changes were made to decrease stress in the administrative segregation unit (California Department of Corrections and Rehabilitation, 2009). In an effort to help prisoners cope with the boredom and isolation that can lead to sensory deprivation (Haney, 2006), prisons with electrical outlets in these units have allowed prisoners

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to bring their radios and televisions with them when they are placed in the unit. Recreation therapists offer crossword puzzles and newspapers clippings on a daily basis. Other interventions include providing more out-of-cell time for newly admitted prisoners, and reducing the length of stay for all prisoners in administrative segregation unit, but especially for those with mental illness.

These efforts incorporate custody and mental health approaches to address the problem of suicides in administrative segregation units. However, these efforts appear insufficient to prevent suicides in these locked units. Addressing this problem requires an understanding of the prisoner's state of mind at the time of placement in the locked unit. The prisoner knows he is being placed in the administrative segregation unit because he is accused of violating a prison rule, which, in some cases, may also be a crime. Depending on the alleged rule violation, the consequences could be minor or severe. Once this is determined, the main concern is the long-term suicide risk associated with the length of time on the unit and the prisoner's ability to cope and function for the duration of the placement. Prisoners placed in the administrative segregation unit for their safety face similar stressors related to being isolated. They also may experience anxiety, fear, and paranoia associated with the initial safety concerns that led to their placement on this unit.

If the consequences for the alleged rule violation are potentially serious, then concern for suicide is more immediate. To assess the impact on the prisoner, staff must be able to anticipate the future from his perspective. The short-term consequences are clear. The prisoner will be housed in the administrative segregation unit pending a hearing on his alleged rule violation. However, the long-term consequences can be more serious and affect the prisoner in many ways. Often, the alleged violation will seriously impact the prisoner's program and personal life. He may lose special privileges, such as single-cell housing; have his job terminated; be transferred to a higher security prison; have his parole date changed; or even lose the opportunity to be released from prison. Each of these possible losses has to be analyzed in depth. For example, if the prisoner's family lives nearby, being transferred to a higher security prison may translate into fewer visits for the prisoner and greater expense to his family. A transfer could put his support system in jeopardy. The prisoner could also feel guilt and shame due to the extra burden he has placed on his family. By fully exploring the consequences of the alleged rule violation from the prisoner's perspective, staff can better understand the potential risk for suicide.

Ironically, the prisoner may not immediately realize the consequences of the alleged rule violation all at once, or if he does, it might take some time for him to fully understand the implications. Initially, the prisoner may believe he can "beat" the charges, or not think of the potential impact on his life if found guilty. The initial mental health screening may not identify any concerns upon admission and this would be a correct assessment. However, as the prisoner sits in his cell thinking, he may eventually come to understand his predicament. Since the situation is not static but is constantly changing, the initial assessment may not be correct on the following day. As the prisoner begins to analyze how the alleged transgression will impact many aspects of his life, his thoughts and emotions will begin to change. Thus, the "life span" and reliability of these mental health screens and suicide risk evaluations are very short in these types of fluid situations. This might explain why suicides still occur despite prisoners passing these screens and all of the efforts by mental health and custody staff. So on the first day in the administrative segregation unit, the prisoner appears fine and denies any suicidal thoughts, but on Day 4, he commits suicide. During the 4 days, he has had the opportunity to think of the long-term consequences of his behavior and reached a state of hopelessness that led to his decision to take his life. Understanding this constant mental fluidity of prisoners in the administrative segregation units is critical to preventing suicides, since recent studies show most suicides occur with in the first 3 weeks of placement (Patterson & Hughes, 2008).

Hayes (2007) wrote about suicide risk despite denial of suicidal ideation. He emphasized looking at the totality of the initial jail experience and how the various stressors can contribute to psychological symptoms and eventual suicide. Placement in the administrative segregation unit is similar

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if viewed from the perspective that the incident leading to placement will change the prisoner's life. This is why suicide prevention should start at the time staff discovers the alleged rule violation. Every staff member involved in this initial process leading to placement in the administrative segregation unit should pay attention to the prisoner's behavior and statements, and report any concerns to the mental health staff who conduct the mental health screens. Suicide risk assessments should be completed for prisoners who screen positive for mental health problems. In addition, mental health staff should complete an assessment of the inmate's stressors and coping skills. This emphasis on the totality of the initial placement applies equally to prisoners who request protective custody. One of the biggest fears in correctional settings is being labeled a "snitch." This label becomes permanent throughout the prisoner's confinement and carries with it the fear of being assaulted.

Once staff can see this entire process from the prisoner's perspective, the focus should be on providing mental health counseling and support to help the prisoner deal with the serious implications of his alleged rule violation. Staff may need to be more involved in initiating this process since there continues to be the perception among newly committed prisoners that only the weak and "crazy" prisoners seek mental health services (Morgan, Rozycki, & Wilson, 2004). In addition, issues of confidentiality, particularly concerns about information being used against them, may be a deterrent to seeking help when prisoners face disciplinary charges. Understanding the fluid situation from the prisoner's perspective and considering possible beliefs about correctional mental health services will go a long way in preventing suicides in administrative segregation units. This will give staff the advantage of anticipating mental health problems and suicide risk, despite denials by the prisoner on initial and subsequent assessments. Staff can then intervene despite reluctance to ask for help.

By demonstrating sincere interest in the administrative segregation unit inmate, staff communicate empathy. For example, daily checks are more beneficial if staff demonstrate they know something about the prisoner's unique predicament and are able to ask questions about his situation. It is also through these interactions that staff will get a better assessment of how the prisoner is truly coping with his situation and identify prisoners at risk for suicide. Staff can use these opportunities to communicate a communal concern and communal effort among the prisoners that encourages them to report fellow prisoners who are having difficulties. All of these efforts will help combat the sense of isolation that is common in these units and that research has shown to be one of the strongest and reliable predictors of suicides (Van Ordern et al., 2010).

Prisoners will feel more comfortable asking for help when there is a history of positive staff–inmate interactions. Through the efforts discussed in this article, prison staff communicate understanding, empathy, and compassion at a time when the prisoner does not expect this type of response. These consistent positive encounters with various staff throughout the day may also increase a sense of connectedness that is important in preventing suicide (Van Ordern et al., 2010). Studies have demonstrated the importance of having a strong therapeutic alliance for successful therapy (Horvath & Symonds, 1991; Lambert & Barley, 2001; Orlinksy, Grave, & Parks, 1994). Research may eventually demonstrate a similar importance in the staff–prisoner relationship in preventing suicides, particularly in administrative segregation units.

Studies show that suicide is the most commonly encountered emergency for mental health professionals and creates more stress among clinicians than any other clinical situation (Jobes, 1995). In correctional settings, suicide assessment is more challenging because of the high numbers of self-injurious behaviors committed by prisoners and the difficulty in labeling these behaviors (Fagan, Cox, Helfand, & Aufderheide, 2010). Clinicians must distinguish between prisoners who have an intent to die and those who have no intent to die but still have mental health problems. In addition, there is the challenge of identifying prisoners who have ulterior reasons for self-harm behaviors, such as improving their situation (e.g., better housing) or escaping stressful situations (e.g., being threatened). Mental health professionals must develop intervention strategies that do not reward the prisoners' maladaptive behaviors while preventing actual stressful situations from becoming mental

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health crises. This is particularly relevant in administrative segregation units, where prisoners may try to use mental health problems, including self-harm behaviors, to avoid responsibility for their antisocial behavior, but also where stress can lead to real mental health problems.

Knoll (2010) provided recommendations for reducing the risk of suicide-related lawsuits for clinicians working in correctional settings. He noted that while clinicians are not expected to predict suicide, they are expected to use "reasonable professional judgment." He noted that clinicians can be sued for professional negligence for failure to perform an adequate suicide risk assessment, take appropriate precautions based on the risk, monitor someone identified as at risk for suicide on an adequate time interval, medicate properly, obtain an adequate history, and remove items that can be used for self-harm while under supervision for suicide risk. Clinicians can also be sued for allegations of civil rights violations based on the U.S. Constitution. The concept of deliberate indifference is based on the Eighth Amendment prohibition against cruel and unusual punishment (Hanser, 2002; Hayes, 1995). The assumption is that the violator was aware of the individual's need for mental health care and intentionally denied or delayed access to care. In the case of suicide, prison staff would have to know about the inmate's risk for suicide and do nothing to protect the inmate.

While there is little information on the number of individual lawsuits in correctional settings related to suicide, most class-action lawsuits regarding inadequate mental health care include suicide under the deliberate indifference standard (Hanser, 2002; Hayes, 1995). Regardless of the legal liabilities, suicides in prison create stress for staff and prisoners. First responders have to deal with a death scene that can be traumatizing, and there are numerous "survivors"—individuals who are affected by the suicide death (Bailly, Kral, & Dunham, 1999). Staff who knew the inmate are left to deal with the loss and ask themselves if there was anything they missed or could have done to prevent the suicide. If the inmate was a mental health patient, clinicians also have to deal with losing a patient, which sometimes involves self-doubt about the adequacy of their clinical interventions and fears of lawsuits (Farberow, 2005). Administrators are forced to reassess suicide prevention policies and procedures (Hayes, 1995). Prisoners who were friends or knew the deceased inmate mourn the loss of a fellow prisoner. Family and friends also go through the grieving process, which might include questions and doubts about whether their loved one committed suicide or was killed. The fact that one suicide can affect many is another reason why suicide prevention in prisons is important.

An understanding of the precipitants to suicidal behavior in the administrative segregation units will help in the development of prevention strategies. The psychological autopsy has been used to study suicides in correctional settings (Sanchez, 1999) and to make recommendations for improving suicide prevention policies, procedures, and mental health programs. These reviews attempt to identify presuicide risk factors, including stressors that contributed to the suicide. In addition, the importance of identifying the loss of protective factors has been noted in the literature (Sanchez, 2001). The loss of protective factors can be particularly detrimental to prisoners in administrative segregation units. Sanchez (1999) recommended using the psychological autopsy method to study attempted suicides, as well, since suicide attempts provide valuable information not available in a postmortem study. At the minimum, staff should inquire about what the prison system and staff could have done to prevent the suicide attempt. More importantly, this type of inquiry would give prison staff an opportunity to see the evolving dynamics that led to the suicide attempt from the prisoner's perspective. Case reviews for administrative segregation unit suicide attempts would be particularly beneficial in understanding how the high-stress environment contributes to these desperate behaviors.

Recommendations

1. As part of the preadministrative segregation unit placement, assess the potential consequences for the prisoner due to his rule violation (e.g., shame, possible transfer, disruption of outside

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support system due to transfer, negative impact on board hearing) from the prisoner's perspective. Then assess the prisoner's level of stress associated with placement on this unit and his ability to cope. Ask questions such as, "How will this rule violation impact you, your prison program, your safety, your board hearing, etc.?" "How will you handle this?" By placing oneself in the prisoner's shoes and asking these questions, potential problems can be identified. Include information received from staff involved in the pre-placement process. Identify salient events related to the administrative segregation placement process (e.g., outcome of disciplinary hearing) and assess the impact of these events on the prisoner's mental status and functioning. This process should also be followed for inmates placed in administrative segregation units for their safety or while pending an investigation into their allegations of staff misconduct.

2. Designate an administrative segregation new arrival officer whose responsibilities include serving as a support system for new inmates and inmate-patients. This officer introduces himself and informs the inmate he will be checking with him throughout the day to see how he is doing. The officer can also "inoculate" the prisoner to seek help by stating it is not uncommon for prisoners to find this unit difficult—mentally and physically -and the prisoner should let him know if he is having problems coping on this unit. Ideally, there would be a new arrival officer during each shift who is available to new arrivals during the first week on this unit. Housing new arrival prisoners in designated cells would make it easier for the new arrival officer to track these prisoners.
3. Conduct daily mental health assessments and suicide risk evaluations during the first 5 days and at critical decision points that could have significant impact on the prisoner's life, such as the outcome of a serious rule violation. Initially, the focus should be on establishing baselines for psychiatric symptoms, such as frequency, duration, and severity; daily functioning in areas such as sleeping, eating, and use of time; and the presence or absence of suicidal thoughts. Once these baselines are established, follow-up evaluations can assess changes that warrant further attention. In addition, protective factors should be identified and assessed for their continued presence. In some situations, the support systems are conditional. For example, a prisoner's wife may promise to stay with the prisoner as long as he remains out of trouble in prison and committed to changing his life. In other situations, the prisoner sets the conditions, such as when he states he would not commit suicide while his parents are alive. Discussing protective factors with the prisoner also communicates interest for those individuals who are important to him and helps build and maintain a strong therapeutic alliance.
4. Incorporate mental health counseling and supportive therapy during the first 21 days for prisoners identified as facing major changes in their lives due to the alleged rule violation and for prisoners who are having problems with placement on this unit. Inmates placed in administrative segregation units for their safety or for making allegations of staff misconduct may be under considerable stress and also require counseling. The frequency and duration of this intervention should be determined by the mental health professional.
5. Use staff–prisoner contacts to communicate genuine concern. For example, the distribution of the administrative segregation orientation pamphlets should be a process involving a discussion of the pamphlet. When the new arrival officers distribute these pamphlets, they should reinforce concern for the prisoner's welfare and commitment to his safety. The officer can explain the purpose of the pamphlet and tell the prisoner he will come back later (after he has had a chance to read the pamphlet) to ask if he has any questions. If the prisoner cannot read, the officer can explain what is in the pamphlet. Staff should use other staff–prisoner contacts to communicate genuine concern for the prisoner (e.g., during classification meetings and disciplinary hearings).

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6. Train custody staff to be vigilant for unusual behavior, such as a prisoner being awake in the middle of the night or signs a prisoner is making a hanging apparatus (e.g., torn bedding or clothes) and any other behavior that is out of the ordinary for that inmate (e.g., asking for writing materials when he has never done this before). The basic response to these situations is to engage the prisoner in conversation and ask about the unusual behavior.
7. Train administrative segregation staff to pay attention to how the prisoner is functioning (What does the prisoner do to occupy himself for 23 hours?). Officers should ask themselves whether the prisoner demonstrates the abilities and skills to occupy himself mentally and physically, and whether he can sustain administrative segregation unit placement for a prolonged time. They should be alert to changes in the prisoner's attitudes, mood, and behavior. For example, is the prisoner becoming hostile and angry, does he appear depressed and tired, has he been refusing meals or showers? If they are concerned about the prisoner's functioning, they should make a referral to mental health.
8. Imprint permanent signs on the cell walls that reinforce the value of each prisoner's life and provide instructions on how to get help if he is thinking about suicide.
9. Take extra precaution for high-risk prisoners, which include the mentally ill, prisoners with long sentences whose chances for parole could be jeopardized due to a serious rule violation, and prisoners who have safety concerns who may conclude they will eventually be attacked or killed by other prisoners. Prisoners who have a recent history of drug use, particularly those who are active alcohol and drug users in prison, should be considered high risk since they may undergo drug withdrawal shortly after being placed in the administrative segregation unit.
10. Encourage prisoners to help each other and to report prisoners who are having difficulty coping.

Summary

Preventing suicides in administrative segregation units requires clinical and custody staff working together to implement policies and procedures in a manner that communicates genuine concern for the prisoners' well-being. Staff can communicate compassion and empathy by demonstrating an understanding of the prisoner's unique circumstances and viewing the prisoner's predicament from his perspective. Verbalizing this understanding, anticipating the fluidity of the administrative segregation unit experience, and providing supportive interventions communicates empathy and encourages help-seeking behavior. In addition, by paying close attention to unusual behavior and overall functioning, staff can identify prisoners who are having problems and intervene accordingly. Staff should make efforts to express their concern directly to the prisoner each time there is an intervention, so the prisoner makes the connection between staff's caring for his well-being and the actions taken to help him. Staff should take advantage of other interactions to reinforce a commitment to providing help. In the end, it is these empathic staff–prisoner relationships that demonstrate genuine concern that will help prevent suicides in administrative segregation units. Holding prisoners accountable for rule violations in a respectful and compassionate manner will also help staff–prisoner relationships and make for a safer prison environment.

Declaration of Conflicting Interests

The author disclosed no conflicts of interest with respect to the authorship and/or publication of this article. For information about *JCHC*'s disclosure policy, please see the Self-Study Exam.

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Funding

The author received no financial support for the research, authorship, and/or publication of this article.

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Exhibit 23

DIVISION OF CORRECTIONAL HEALTH CARE SERVICES
STATEWIDE MENTAL HEALTH PROGRAM
P.O. Box 942883
Sacramento, CA94283-0001

March 1, 2013

Matthew A. Lopes, Jr. Esquire
Office of the Special Master
Pannone Lopes & Devereaux LLC
317 Iron Horse Point Way, Suite 301
Providence, RI 02908

via: Debbie J. Vorous, Esquire
Deputy Attorney General
Department of Justice
1300 "I" Street, Suite 125
P. O. Box 944255
Sacramento, CA 94244-2550

RE: COLEMAN MONTHLY REPORT OF INFORMATION REQUESTED AND RESPONSE TO JANUARY 19, 1999, COURT ORDER REGARDING STAFF VACANCIES

Dear Mr. Lopes:

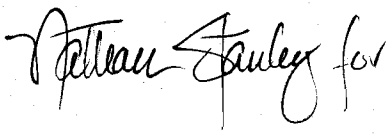
Enclosed is the Coleman Monthly Report reflective of January, 2013 data (or as otherwise noted). The following is the list of enclosures:

1. Mental Health Services Delivery System (MHSDS) Staffing Allocation and Vacancy History**.**
2. MHSDS Hiring Activity Report**.**
3. Health Care Placement Oversight Program (HCPOP) Information Report, Summary and Administrative Segregation Greater than 60 Days.
4. Mental Health Contract Services including Summary and Telemedicine Monthly Report for all disciplines.
5. California Department of Corrections and Rehabilitation (CDCR) Reception Center (RC) Monthly Report.
6. Monthly Summary of Mental Health Crisis Bed use by Institution Titles Inpatient Psychiatric Aging Report.
7. Referrals for Transfer to the Department of State Hospitals (DSH) (including admissions).
8. Atascadero State Hospital (ASH) Discharges.
9. Weekly Enhanced Outpatient Program (EOP)/Outpatient Psychiatric Program.
10. The Department of State Hospitals (DSH) Monthly Report of CDCR Patients in DSH Hospitals -- Summary and Penal Code 2684.
11. Suicide Report.
12. Statistics on Contracted Registered Nurse (RN). **(No Longer Available)**
13. RC Processing for MHSDS Inmate Patients.
14. Medical Technical Assistant (MTA) Vacancy Report. **(No Longer Available)**

16. EOP Inmates Waiting Transfer to a Psychiatric Services Unit (PSU).
17. Audit reports on Psychiatric Technician Rounds in Administrative Segregation at California State Prison, San Quentin (SQ), California State Prison-Corcoran (COR), and Salinas Valley State Prison (SVSP).
18. Mental Health Crisis Beds Wait List.
19. Correctional Treatment Centers and CDCR General Acute Care Hospital Care Placement Issues. **(No longer available)**
20. Transferred and Rescinded Mental Health Crisis Bed Referrals by Institution and Level of Care.

If you have any questions, please contact me at (916) 691-0296.

Sincerely,



TIMOTHY G. BELAVICH, Ph.D., MSHCA, CCHP
Deputy Director (A)
Statewide Mental Health Program
Division of Correctional Health Care Services

Enclosures

cc: Diana Toche, DDS, Director (A), Division of Correctional Health Care Services (DCHCS)
Mohamedu F., Jones, Esq., *Coleman* Deputy Special Master
Linda Holden, Esq., *Coleman* Deputy Special Master
Jeffrey L. Metzner, M.D., *Coleman* Expert
Kerry C. Hughes, M.D., *Coleman* Expert
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Nathan Stanley, Chief, Operational Program Oversight, Statewide Mental Health Program DCHCS
Teresa Owens, Associate Governmental Program Analyst, Operational Program Oversight, DCHCS

Mental Health Population By Institution

Download Date: January 18, 2013

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SUMMARY OF OUTPATIENT POPULATION

(ASU, GP, RC and SHU Detail on pages 2-4)

Institution	CCCMS (1)			EOP (2)			PSU (2)			Inst Total Outpatient Pop
	Capacity	Current Pop	% of Capacity	Capacity	Current Pop	% of Capacity	Capacity	Current Pop	% of Capacity	
ASP	1099	1352	123%		8					1360
CAL		22								22
CCC		7								7
CCI	1349	1043	77%		3					1046
CCWF	899	1286	143%	64	38	59%				1324
CEN		19								19
CIM	1299	1391	107%		57					1448
CIW	499	733	147%	85	60	71%	20	15	75%	808
CMC	1099	962	88%	634	621	98%				1583
CMF	599	492	82%	391	407	104%				899
COR	949	1226	129%	249	243	98%				1469
CRC-M	848	986	116%		1					987
CTF	845	1093	129%		8					1101
CVSP		6								6
DVI	649	396	61%		13					409
FOL	599	398	66%		1					399
HDSP	699	844	121%		5					849
ISP		16								16
KVSP	1000	1228	123%	96	95	99%				1323
LAC	1149	1297	113%	374	392	105%				1689
MCSP	1149	1060	92%	546	542	99%				1602
NKSP	799	840	105%		75					915
PBSP	349	219	63%	66	59	89%	128	119	93%	397
PVSP	1499	1731	115%		2					1733
RJD	1199	1460	122%	543	527	97%				1987
SAC	849	683	80%	458	376	82%	256	243	95%	1302
SATF	1199	1552	129%	352	370	105%				1922
SCC	499	566	113%		3					569
SOL	1199	1090	91%		9					1099
SQ	899	1032	115%	36	45	125%				1077
SVSP	999	1270	127%	264	226	86%				1496
VSP	849	480	57%		3					483
WSP	1049	873	83%		81					954
TOTAL	**26118**	**27653**	**106%**	**4158**	**4270**	**103%**	**404**	**377**	**93%**	**32300**

Group	CCCMS			EOP			Subtotal	Comments
Institution (3)	Capacity	Current Pop	% of Capacity	Capacity	Current Pop	% of Capacity	MH Pop	
Administrative Segregation Unit (ASU)								
ASP ASU		40			1		**41**	
CAL ASU		6					**6**	
CCC ASU		1					**1**	
CCI ASU		107					**107**	
CCWF ASU		49		10	3	30%	**52**	
CEN ASU		8					**8**	
CIM ASU		90			2		**92**	
CIW ASU		34		10	3	30%	**37**	
CMC ASU		31		54	62	115%	**93**	
CMF ASU		19		58	44	76%	**63**	
COR ASU		125		99	70	71%	**195**	
CTF ASU		27			2		**29**	
DVI ASU		45			2		**47**	
FOL ASU		13			1		**14**	
HDSP ASU		35			3		**38**	
ISP ASU		2					**2**	
KVSP ASU		70			3		**73**	
LAC ASU		150		74	64	86%	**214**	
MCSP ASU		52		36	36	100%	**88**	
NKSP ASU		39			6		**45**	
PBSP ASU		90			4		**94**	
PVSP ASU		152					**152**	
RJD ASU		105		63	56	89%	**161**	
SAC ASU		74		74	39	53%	**113**	
SATF ASU		104			1		**105**	
SCC ASU		15					**15**	
SOL ASU		79			4		**83**	
SQ ASU		69		36	10	28%	**79**	
SVSP ASU		160		72	48	67%	**208**	
WSP ASU		39			2		**41**	

Group	CCCMS			EOP			Subtotal MH Pop	Comments
Institution (3)	Capacity	Current Pop	% of Capacity	Capacity	Current Pop	% of Capacity		
Administrative Segregation Unit (ASU)								
Group Total for ASU		1,830		586	466	80%	2,296	

Group / Institution [3]			CCCMS Capacity	CCCMS Current Pop	CCCMS % of Capacity	EOP Capacity	EOP Current Pop	EOP % of Capacity	Subtotal MH Pop	Comments
General Population (GP)										
ASP	II		1,099	1,312	119%		7		**1,319**	
CAL	I,IV	+		16					**16**	
CCC	I,II,III			6					**6**	
CCI	I,II,III,IV	*	1,219	743	61%		2		**745**	
CCWF			745	1,067	143%	54	4	7%	**1,071**	
CEN	III			11					**11**	
CIM	I		666	1,200	180%		40		**1,240**	
CIW			499	613	123%	75	54	72%	**667**	
CMC	I,II,III		1,099	931	85%	580	559	96%	**1,490**	
CMF	I,II,III		599	473	79%	333	363	109%	**836**	
COR	I,III,IV	+ *	499	686	137%	150	172	115%	**858**	*SNY EOP=150 beds*
CRC-M	II		848	986	116%		1		**987**	
CTF	I,II		845	1,066	126%		6		**1,072**	
CVSP	I,II			6					**6**	
DVI	I,II		85	101	119%		2		**103**	
FOL	III		599	385	64%				**385**	
HDSP	I,III,IV	*	699	809	116%		2		**811**	
ISP	I,III			14					**14**	
KVSP	I,IV		1,000	1,158	116%	96	92	96%	**1,250**	*SNY EOP*
LAC	I,III,IV	+	1,149	1,147	100%	300	328	109%	**1,475**	
MCSP	I,II,III,IV	+	1,149	1,008	88%	510	506	99%	**1,514**	*SNY EOP*
NKSP	I,III		80	108	135%		3		**111**	
PBSP	I,IV	*	349	127	36%	66	55	83%	**182**	
PVSP	I,III		1,499	1,579	105%		2		**1,581**	
RJD	I,III		1,199	1,355	113%	480	471	98%	**1,826**	*SNY EOP=150 beds*
SAC	I,IV	*	849	594	70%	384	337	88%	**931**	
SATF	II,III,IV	*	1,199	1,448	121%	352	369	105%	**1,817**	*SNY EOP=264 beds*
SCC	I,II,III		499	551	110%		3		**554**	
SOL	II,III		1,199	1,011	84%		5		**1,016**	
SQ	I,II		350	803	229%		28		**831**	

Group / Institution (3)	CCCMS Capacity	CCCMS Current Pop	CCCMS % of Capacity	EOP Capacity	EOP Current Pop	EOP % of Capacity	Subtotal MH Pop	Comments
General Population (GP)								
SVSP I,IV *	999	1,110	111%	192	178	93%	**1,288**	
VSP	849	480	57%		3		**483**	
WSP I,III	105	105	100%				**105**	
Group Total for GP	**21,975**	**23,009**	**105%**	**3,572**	**3,592**	**101%**	**26,601**	
Reception Center (RC)								
CCWF-RC	154	170	110%		31		**201**	
CIM-RC	633	101	16%		15		**116**	
DVI-RC	564	250	44%		9		**259**	
NKSP-RC	719	693	96%		66		**759**	
SQ-RC	549	160	29%		7		**167**	
WSP-RC	944	729	77%		79		**808**	
Group Total for RC	**3,563**	**2,103**	**59%**		**207**		**2,310**	
Security Housing Unit (SHU)								
CCI-SHU	130	193	148%		1		**194**	
CIW SHU		86			3		**89**	
COR-SHU	450	415	92%		1		**416**	
PBSP SHU		2					**2**	
SAC SHU		15					**15**	
Group Total for SHU	**580**	**711**	**123%**		**5**		**716**	

Report Footnotes

(1) CCCMS capacities have not been adjusted to reflect realignment.

(2) EOP, ASU-EOP, and PSU may not reflect actual program vacancies because beds can be held vacant for inmate-patients temporarily housed in MHCB and OHU.

(3) " + " is a 270 Design Facility. " * " is a 180 Design Facility.

Exhibit 24

Data Analysis Unit
Estimates and Statistical Analysis Section
Offender Information Services Branch

Department of Corrections and Rehabilitation
State of California
April 23, 2012

WEEKLY REPORT OF POPULATION
AS OF MIDNIGHT April 18, 2012

TOTAL CDCR POPULATION

	FELON/ OTHER #1	CIVIL ADDICT	TOTAL	CHANGE SINCE 04/20/11 NO.	CHANGE SINCE 04/20/11 PCT.	DESIGN CAPACITY	PERCENT OCCUPIED	STAFFED CAPACITY
A. TOTAL IN-CUSTODY	137,916	367	138,283	-24,487	-15.0			
I. IN-STATE	128,383	367	128,750	-23,868	-15.6			
(MEN, Subtotal)	121,628	260	121,888	-21,189	-14.8			
(WOMEN, Subtotal)	6,755	107	6,862	-2,679	-28.0			
1. INSTITUTIONS/CAMPS	127,488	367	127,855	-19,114	-13.0	84,130	152.0	130,837
INSTITUTIONS	123,463	367	123,830	-19,212	-13.4	79,650	155.5	126,478
CAMPS(CCC, CIW & SCC)*	4,025		4,025	+98	+2.4	4,480	89.8	4,359
2. IN-STATE CONTRACT BEDS	663	0	663	-4,768	-87.7	2,784	23.8	
CCF PRIVATE	609		609	-1,515	-71.3	2,557	23.8	
PRISONER MOTHER PGM	12		12	-31	-72.0	47	25.5	
FAMILY FOUNDATION PGM	18		18	-42	-70.0	105	17.1	
FRCCC(BAKERSFIELD)	12		12	-62	-83.7	75	16.0	
SRITA(SANTA RITA)	12		12	-582	-97.9			
3. DMH STATE HOSPITALS	232		232	+14	+6.4			
II. OUT OF STATE(COCF)	9,533	0	9,533	-619	-6.0			
ARIZONA	4,568		4,568	-722	-13.6			
MISSISSIPPI	2,579		2,579	+23	+0.8			
OKLAHOMA	2,386		2,386	+80	+3.4			
B. PAROLE	85,442	829	86,271	-19,932	-18.7			
COMMUNITY SUP(Active)	77,907	829	78,736	-11,118	-12.3			
COOP CASES (Active) #3	1,510		1,510	+22	+1.4			
MNRP & NRP (Inactive)	6,025		6,025	-8,836	-59.4			
C. NON-CDC JURISDICTION #4	1,358	0	1,358	-132	-8.8			
OTHER STATE/FED. INST.	515		515	+53	+11.4			
OUT OF STATE PAROLE	643		643	-148	-18.7			
OUT OF STATE PAL	37		37	-3	-7.5			
CYA-W&IC 1731.5(c) INSTITUTIONS #5	163		163	-34	-17.2			
D. OTHER POPULATIONS #6	12,938	103	13,041	-1,102	-7.7			
INMATES OUT-TO-COURT, etc.	1,315	13	1,328	-561	-29.6			
ESCAPED	216		216	-2	-0.9			
PAROLEES (PAL/RAL)	11,407	90	11,497	-539	-4.4			
TOTAL CDCR POPULATION	237,654	1,299	238,953	-45,653	-16.0			

CHANGE FROM LAST WEEK			
A. TOTAL IN-CUSTODY	-317	-8	-325
(MEN, Subtotal)	-251	-10	-261
(WOMEN, Subtotal)	-45	+2	-43
B. PAROLE	-2,167	+2	-2,165
D. PAROLEES (PAL/RAL)	+16	-1	+15

This report contains the latest available reliable population figures from OBIS. They have been carefully audited, but are preliminary, and therefore subject to revision.

*Figure excludes institution based camps. Total persons in camps, including base camps, are 4,075. Base camp at CMC is included in institution counts.

Report # TPOP-1W. Questions: (916) 323-3639.

INSTITUTIONS/CAMPS	FELON/ OTHER	CIVIL ADDICT	TOTAL	DESIGN CAPACITY	PERCENT OCCUPIED	STAFFED CAPACITY
MALE						
ASP (AVENAL SP)	5,096		5,096	2,920	174.5	5,306
CCC (CAL CORRECTL CTR)	4,846		4,846	3,883	124.8	4,713
CCI (CAL CORRECTL INSTITN)	4,645		4,645	2,783	166.9	5,083
CIM (CAL INSTITN FOR MEN)	5,135	11	5,146	2,976	172.9	6,311
CMF (CAL MEDICAL FACIL)	2,397		2,397	2,297	104.4	2,340
CMC (CAL MEN'S COLONY)	5,574		5,574	3,838	145.2	5,586
CRC (CAL REHAB CTR, MEN)	3,646	224	3,870	2,491	155.4	4,022
CAL (CAL SP, CALIPATRIA)	3,972		3,972	2,308	172.1	3,810
CEN (CAL SP, CENTINELA)	3,689		3,689	2,308	159.8	3,758
COR (CAL SP, CORCORAN)	4,537		4,537	3,116	145.6	4,619
LAC (CAL SP, LOS ANGELES CO)	3,916		3,916	2,300	170.3	3,990
SAC (CAL SP, SACRAMENTO)	2,746		2,746	1,828	150.2	2,743
SQ (CAL SP, SAN QUENTIN)	3,789	3	3,792	3,082	123.0	3,932
SOL (CAL SP, SOLANO)	4,300		4,300	2,610	164.8	4,593
SATF (CAL SATF AND SP - COR)	5,722	10	5,732	3,424	167.4	5,483
CVSP (CHUCKAWALLA VALLEY SP)	2,592		2,592	1,738	149.1	2,811
CTF (CORRL TRAING FAC)	5,697		5,697	3,312	172.0	5,320
DVI (DEUEL VOCATL INSTITN)	2,560	8	2,568	1,681	152.8	2,685
FOL (FOLSOM SP)	2,948	1	2,949	2,469	119.4	2,937
HDP (HIGH DESERT SP)	3,768		3,768	2,324	162.1	3,746
IRON (IRONWOOD SP)	3,507		3,507	2,200	159.4	3,485
KVSP (KERN VALLEY SP)	4,153		4,153	2,448	169.6	4,344
MCSP (MULE CREEK SP)	3,055		3,055	1,700	179.7	3,036
NKSP (NORTH KERN SP)	4,672	1	4,673	2,694	173.5	4,770
PBSP (PELICAN BAY SP)	3,082		3,082	2,380	129.5	3,143
PVSP (PLEASANT VALLEY SP)	3,738		3,738	2,308	162.0	3,758
RJD (RJ DONOVAN CORR FACIL)	3,631		3,631	2,200	165.0	3,820
SVSP (SALINAS VAL SP)	3,503		3,503	2,452	142.9	3,459
SCC (SIERRA CONSERV CTR)	4,675		4,675	3,736	125.1	4,811
WSP (WASCO SP)	5,193	2	5,195	2,984	174.1	5,135
MALE TOTAL:	120,784	260	121,044	78,790	153.6	123,549
FEMALE						
CIW (CAL INST FOR WOMEN)	1,596	54	1,650	1,356	121.7	1,775
CCWF (CENT CAL WOMEN'S FACIL)	2,757	53	2,810	2,004	140.2	3,016
VSP (VALLEY SP)	2,351		2,351	1,980	118.7	2,497
FEMALE TOTAL:	6,704	107	6,811	5,340	127.5	7,288
TOTAL:	127,488	367	127,855	84,130	152.0	130,837

Exhibit 25

DIVISION OF CORRECTIONAL HEALTH CARE SERVICES
MENTAL HEALTH PROGRAM
P.O. Box 942883
Sacramento, CA 94283-0001

September 30, 2008

Matthew A. Lopes, Jr., Esq.
Office of the Special Master
Pannone Lopes & Devereaux LLC
317 Iron Horse Way, Suite 301
Providence, RI 02908

Via: Lisa Tillman
Deputy Attorney General
Department of Justice
1300 "I" Street, Suite 125
P. O. Box 944255
Sacramento, CA 94244-2550

RE: COLEMAN MONTHLY REPORT OF INFORMATION REQUESTED AND RESPONSE TO JANUARY 19, 1999, COURT ORDER REGARDING STAFF VACANCIES

Dear Mr. Lopes:

Enclosed is the Coleman Monthly Report reflective of August 2008 data (or as otherwise noted). The following is the list of enclosures:

1. Mental Health Services Delivery System (MHSDS) Staffing Allocation and Vacancy History. **(Not Available)**
2. MHSDS Hiring Activity Report. **(Not Available)**
3. Health Care Placement Oversight Program (HCPOP) Information Report, Summary and Administrative Segregation Greater than 60 Days.
4. Mental Health Contract Services including Summary and Telemedicine Monthly Report for all disciplines. **(Telemedicine Only)**
5. California Department of Corrections and Rehabilitation (CDCR) Reception Center (RC) Monthly Report.
6. Monthly Summary of Mental Health Crisis Bed use by Institution Titles Inpatient Psychiatric Aging Report. **(Not Available)**
7. Referrals for Transfer to the Department of Mental Health (including admissions).
8. Atascadero State Hospital (ASH) Discharges.
9. Weekly Enhanced Outpatient Program (EOP)/Outpatient Psychiatric Program.
10. The DMH Monthly Report of CDCR Patients in DMH Hospitals--Summary and Penal Code 2684.
11. Suicide Report.
12. Statistics on Contracted Registered Nurse (RN). **(No Longer Available)**
13. RC Processing for MHSDS Inmate Patients.
14. Medical Technical Assistant (MTA) Vacancy Report.
15. Allocated Case Manager Positions and Vacancies for the EOP Administrative Segregated Hub institutions.
16. EOP Inmates Waiting Transfer to a Psychiatric Services Unit (PSU).

17. Audit reports on Psychiatric Technician Rounds in Administrative Segregation at California State Prison-San Quentin (SQ), California State Prison-Corcoran (COR), and Salinas Valley State Prison (SVSP).
18. Mental Health Crisis Beds Wait List.
19. Correctional Treatment Centers and CDCR General Acute Care Hospital Care Placement Issues. **(No longer available)**
20. Transferred and Rescinded Mental Health Crisis Bed Referrals by Institution and Level of Care.

If you have any questions, please contact me at (916) 928-4705.

Sincerely,

DENNIS BEATY
Deputy Director, Program Services
Mental Health Program
Division of Correctional Health Care Services

Enclosures

cc: Robin Dezember, Director, Division of Correctional Health Care Services (DCHCS)
Karen Wong, Deputy Director (A), DCHCS
Brenda Epperly-Ellis, Director, Statewide Mental Health Program, DCHCS
Jeffrey L. Metzner, M.D., *Coleman* Expert
Dennis F. Koson, M.D., *Coleman* Expert
Kerry C. Hughes, M.D., *Coleman* Expert
Melissa G. Warren, Ph.D., *Coleman* Expert
Raymond F. Patterson, M.D, *Coleman* Expert
Pal Nicoll, MPA, *Coleman* Monitor
Ted Ruggles, Ph.D., *Coleman* Expert
Mary Perrien, Ph.D., *Coleman* Expert
Mary-Joy Spencer, Esq., *Coleman* Monitor
Yong Joo Erwin, LCSW, *Coleman* Expert
Kathryn A. Burns, M.D., MPH, *Coleman* Expert
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Kerry F. Walsh, Esq., *Coleman* Monitor
Angela Shannon, M.D., *Coleman* Expert
Lisa Tillman, Esq., Office of the Attorney General
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Michael Bien, Esq., Rosen, Bien and Galvan
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Andrew Swanson, M.D., Deputy Director, Psychiatry Services, DCHCS
Marion Chiurazzi, Psy.D., Deputy Director, Mental Health Clinical Services, DCHCS
Judy Burleson, Coleman Compliance Manager, DCHCS
Mary Neade, Correctional Counselor II, Division of Adult Institutions
Sharon Riegel, HPS II, DCHCS

CONFIDENTIAL

Combined Mental Health Population Per Institution

Includes Ad-Seg, SHU, Reception Center and GP Mental Health Populations Combined

Download Date August 8, 2008

	CCCMS			EOP			MHCB	Total Mental Health Pop
	Capacity	Current Pop	% of Capacity	Capacity	Current Pop	% of Capacity	Capacity	
ASP	1099	1277	116%		24			**1301**
CAL		13						**13**
CCC		3						**3**
CCI	1349	1379	102%		97			**1476**
CCWF	849	1076	127%	54	48	89%	12	**1124**
CEN		14			2			**16**
CIM	999	1297	130%		185		34	**1482**
CIW	449	661	147%	75	121	161%	10	**782**
CMC	1049	1154	110%	634	591	93%	36	**1745**
CMF	599	714	119%	591	630	107%	50	**1344**
COR	949	1240	131%	204	204	100%	23	**1444**
CRC-M	848	829	98%					**829**
CTF	699	869	124%		7			**876**
CVSP		21						**21**
DVI	649	768	118%		76			**844**
FOL	599	713	119%		5			**718**
HDSP	699	865	124%		18		10	**883**
ISP		15						**15**
KVSP	1000	859	86%		15		12	**874**
LAC	1149	833	72%	345	505	146%	12	**1338**
MCSP	999	1202	120%	546	526	96%	8	**1728**
NKSP	799	867	109%		63		10	**930**
PBSP	349	355	102%	66	67	102%	10	**422**
PVSP	1299	1671	129%		13		6	**1684**
RJD	1199	1224	102%	393	449	114%	14	**1673**
SAC	849	854	101%	458	466	102%	24	**1320**
SATF	1049	1381	132%		23		20	**1404**
SCC	499	618	124%		15			**633**
SOL	1199	1489	124%		16		9	**1505**
SQ	899	1025	114%	36	94	261%		**1119**
SVSP	999	1150	115%	237	228	96%	10	**1378**
VSPW	749	1161	155%	9	12	133%		**1173**
WSP	1049	1147	109%		105		6	**1252**
Totals	**24922**	**28744**	**115%**	**3648**	**4605**	**126%**	**316**	**33349**

**This population includes inmates in Hospice and S3, as well as HIV inmates in Unit IV and Y dorm at CMF. These inmates are not counted against the capacity identified in the Gates -Coleman Court

Mental Health numbers are as accurate as the information provided by the DDPS identifier system.

CRC-M does not include the SNY population.

Exhibit 26

CENTRAL CALIFORNIA WOMEN'S FACILITY
MENTAL HEALTH SERVICES DELIVERY SYSTEM
MANAGEMENT REPORT

COLEMAN ROUND XXV
MAY 16, 2012

DEBORAH JOHNSON
WARDEN (A)

TIM NEAL
CHIEF EXECUTIVE OFFICER

LORI WILLIAMS, PH.D.
CHIEF OF MENTAL HEALTH

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GLOSSARY OF TERMS

Acronym	Term
AIMs	Abnormal Involuntary Movement Scale
APP	Acute Psychiatric Program
ASU	Administrative Segregation Unit
CAP	Corrective Action Plan
CC	Correctional Counselor
CCCMS	Correctional Clinical Case Management System
CDCR	California Department of Corrections and Rehabilitation
CHSA	Correctional Health Services Administrator
DMH	Department of Mental Health
DOT	Direct Observation Therapy
EOP	Enhanced Outpatient Program
GP	General Population
HC-POP	Health Care Population Oversight Program
HS	Hour of Sleep
P/I	Patient/inmate
ICC	Institutional Classification Committee
ICF	Intermediate Care Facility
IDTT	Inter Disciplinary Treatment Team
LGB	Local Governing Body
LOC	Level of Care
LOP	Local Operating Procedure
LOS	Length of Stay
LPT	Licensed Psychiatric Technician
MAPIP	Medication Administration Performance Improvement Project
MAR	Medication Administration Record
MHCB	Mental Health Crisis Bed
MHPB	Mental Health Program Bed

MH-OHU	Mental Health-Outpatient Housing Unit
MHQM	Mental Health Quality Management Subcommittee
MHSDS	Mental Health Services Delivery System
MHTS	Mental Health Tracking System
OHU	Outpatient Housing Unit
PC	Primary Clinician
PSU	Psychiatric Services Unit
QIT	Quality Improvement Team
QM	Quality Management
QMC	Quality Management Committee
R&R	Receiving and Release
RVR	Rules Violation Report
SHU	Security Housing Unit
SPC	Suicide Prevention Coordinator
SPR-FIT	Suicide Prevention and Response-Focused Improvement Team
SRE	Suicide Risk Evaluation
UHR	Unit Health Record

Coleman: Round XXV
MENTAL HEALTH MANAGEMENT REPORT

October 1, 2011 – March 31, 2012
Central California Women's Facility (CCWF)

INSTITUTIONAL PROGRAM SUMMARY

OVERVIEW OF ALL THE MENTAL HEALTH PROGRAMS AT INSTITUTION

The Mental Health Service Delivery System at the Central California Women's Facility is comprised of six treatment programs: Administrative Segregation Unit Correctional Clinical Case Management System (ASU CCCMS), Mainline Correctional Clinical Case Management System (ML CCCMS), Reception Center Correctional Clinical Case Management System (RC CCCMS), Mainline Enhanced Outpatient Program (ML EOP), Reception Center Enhanced Outpatient Program (RC EOP), and Mental Health Program Beds (MHPB).

The ASU CCCMS program provides primary clinician and psychiatric services to approximately 24 ASU CCCMS inmate-patients (P/Is) and 20 Condemned Row (CR) P/Is through a quarter-position Psychiatrist, and two Psychologists under the direction of a quarter-time Senior Psychologist-Supervisor. In addition, services are readily available to General Population (GP) inmates who may require placement in MHSDS.

Under the direction of one Senior Psychiatrist-Supervisor, the ML CCCMS program offers mental health treatment to approximately 750 female P/Is housed in Facility B, C, and D, and the Skilled Nursing Facility. Services are also available to about 1,600 mainline general population inmates. In addition, a clinician is dedicated to each mainline facility. The assignment of clinicians to each yard successfully facilitates immediate inmate (CCCMS and GP) access to care within the larger CCCMS program. After-hours (1600-1900 hours) Triage and Treatment Area (TTA) coverage continues. The availability of one psychologist during these hours has markedly reduced the number of after-hour MHPB admissions. Overall, clinical services are provided by four psychiatrists, 4 psychologists, 7.5 licensed clinical social workers, and two recreation therapists (RTs). Individual and group therapy services are primarily centralized in Buildings 812 and 813.

The RC CCCMS program is located on Facility A, offering services to approximately 155 CCCMS P/Is. RC inmates classified as General Population (GP) and CCCMS are housed in Buildings 501, 502, and 503. Buildings 501 and 502 accommodate inmates in 8-person rooms (32 rooms per building). Building 503 is comprised of 2-person rooms (50 rooms per tier). Building 504 is designated for inmates at the EOP LOC and those placed in the ASU/CR. At present, staffing in the RC is as follows: one quarter senior psychologist-supervisor, two psychiatrists, and five and a half psychologists.

The ML EOP provides mental health evaluations, individual and group therapy, and psychiatric services to approximately 54 inmate-patients. The program is staffed with one

half senior psychologist-supervisor, a half-time psychiatrist, four psychologists, one social worker, and two RTs.

Reception Center patient/inmates who are designated EOP LOC are housed in Building 504. In most instances, these individuals are immediately transferred to this unit. If immediate transfer to EOP is delayed, arrangements with custody staff will be made to house the inmate(s) in RC Building 503 for up to 60 days. Services provided to these P/Is are identical to those provided to ML EOP P/Is. Additionally, if an inmate-patient who previously paroled at the EOP LOC returns to custody, upon arrival to R&R, she is automatically designated EOP LOC and housed in 504.

The Mental Health Program Beds (MHPB) program is a 12-bed acute psychiatric care unit located in the Paris-Lamb Skilled Nursing Facility (SNF) at CCWF. This program is defined as a Specialty Program within a SNF and governed by Title 22 regulations. The maximum length of stay (LOS) is designated as ten days. Lower levels of care (e.g. GP, CCCMS or EOP) P/Is are received from CCWF and Valley State Prison for Women (VSPW). Patients returning from the California Institution for Women (CIW), after stays in the longer-term intermediate care unit at Patton State Hospital (DMH LOC), are also admitted to the MHPB when clinically indicated. MHPB offers psychiatric evaluation and treatment services, crisis intervention and brief individual psychotherapy, psychological testing, psychiatric nursing services, recreation therapy, and discharge planning. Services are provided by a treatment team comprised of one quarter time senior psychiatrist-supervisor, one psychiatrist, two psychologists, and one RT.

NEW CONSTRUCTION/REMODELING

None.

NEW OR ANTICIPATED MISSION CHANGES

Presently, no specific mission changes are known.

MAJOR POPULATION MOVES

None.

NEW OR OVERFLOW ADMINISTRATIVE SEGREGATION OR ANY OTHER SPECIALIZED HOUSING UNITS

Building 504 is divided by a secure wall providing housing for EOP on one side and ASU and CR on the other. EOP is also utilized as an overflow for ASU and, on occasion, RC-status inmates.

OBSTACLES TO PROVIDING MENTAL HEALTH SERVICES AND ADHERENCE TO PROGRAM GUIDE REQUIREMENTS

Using EOP housing for ASU overflow continues to be of concern. ASU inmates are often loud and consequently disrupt EOP groups completed in the dayroom. Use of EOP housing for ASU also undermines confidentiality.

The lack of ASU treatment modules for MHPB P/Is on ASU or SHU status is problematic. Given the custody status of these inmates, the provision of clinical services in a confidential setting is minimal.

The EOP and ASU programs lack adequate group treatment space. There is no group treatment space for the ASU program and the EOP program must borrow space from the Reception Yard and the EOP housing unit common area. The ASU program has only one confidential room for clinical encounters by the psychiatrist and two psychologists.

MENTAL HEALTH ROSTER

October 1, 2011 – March 31, 2012
Central California Women's Facility (CCWF)
As of April 2012

Position	Positions Established	Positions Filled	Vacancies	Vacancy Rate	Full-Time Equivalent Contractors and Dual Appts.	Functional Vacancies	Functional Vacancy Rate
Chief Psychiatrist	0	0	0	0%	0	0	0
Senior Psychiatrist	1.0	1	0	0%	0	0	0
Chief Psychologist	1.0	0	1	100%	0	1	100%
Senior Psychologist	1.69	1	.69	41%	0	0	0
Staff Psychiatrist	8.26	8.5 (.5 temporarily separated)	0	0%	1 Intermittent	.5(1)	6%
Staff Psychologist	17.79	17.5	.29	2%	4 Intermittent()		0
Supervising Social Worker	.91	0	.91	100%	0	.91	100%
Social Worker	7.83	8	0	0%	0	0	0
SRN II	2	2	0	0%	0	0	0
Registered Nurse	9	9	0	0%	0	0	0
Senior Psych Tech	1	1	0	0%	0	0	0
Psych Tech	8	7	1	13%	0	1	13%
Recreation Therapist	3.93	4	0	0%	0	0	0
HPSI	1	1	0	0%	0	0	0
Medical Secretary	0	0	0	0%	0	0	0
Office Technician (T)	8.5	10.5 (2.5 temporarily separated)	0	0%	2 Intermittent	.5(2)	6%
Office Assistant (T)	0	0	0	0%	0	0	0

Telemedicine

Psychiatry telemedicine used?	Number of hours per week
No	N/A

Functional Vacancy Footnotes:

1. Although there is a dual position appointed as an hourly intermittent staff psychiatrist, they are currently not working any hours. The Personnel Department considers the remaining 26 position established above the eight established staff psychiatrist positions as a .5 position. Functional vacancy rate is based on long-term temporary separation of half time employee.
2. Functional vacancy rate is based on difference between long-term separation of 2.5 employees and two temporary intermittent employees on loan from medical.

QUALITY MANAGEMENT

Local Governing Body (LGB)

The Local Governing Body is responsible for oversight of health care services and is the ultimate authority for all health care matters. During the monitoring period, the LGB met on December 14, 2011, and again on March 14, 2012. Minutes reflect a quorum was achieved for both meetings. A systems overview of the Dental, Medical, and Mental Health Programs was completed, providing a high-level review of current status.

Refer to Tab B minutes and additional information.

Quality Management Committee (QMC)

The primary goal of the QMC is to monitor the overall quality of health care. The QMC is chaired by the Chief Executive Officer. During the reporting period, the QMC met six times. A quorum was attained in 100% of these meetings.

Mental Health Quality Management Subcommittee (MHQM)

The goals of the Mental Health Quality Management Subcommittee include oversight of mental health services, review program performance, and monitor, create and implement improvement efforts. The Chief of Mental Health, or designee, serves as the Chairperson. MHQM is scheduled to meet bimonthly. During the reporting period, the MHQM met 11 times. All programs were reviewed monthly during the reporting period. A quorum was attained in 100% of these meetings.

Refer to Tab B minutes and additional information.

Peer Review

Peer review activities during the monitoring period included the evaluation of clinical documentation by psychiatrists, psychologists, and social workers. Psychiatrists were also part of the Medication Administration Performance Improvement Project (MAPIP) audit. Internal and external peer review is in place for psychiatrists, psychologists and social workers.

With respect to external peer review, this committee was established as part of the ACA Accreditation Process. In coordination with VSPW, the external peer review committee began review of clinical activities on August 1, 2011.

The Quality Analytical Unit (QAU) serves to keep CCWF's peer review process current with the implementation of standardized statewide changes in peer review processes. As modifications in peer review, clinical review, and concordance procedures occur, the QAU will make needed adjustments to ensure that local practices are consistent with statewide practices.

For additional information, refer to Tab B.

Quality Improvement Team (QIT) Activities

Two Mental Health Quality Improvement teams were active during the reporting period. Two new QIT was chartered during this time and one QIT was resolved with final recommendations sent to the QMC. One QIT was resolved since the last management report.

QITs initiated:	Gender Identity Disorder LOP Mass Hunger Strike LOP
QITs resolved:	Concordance UHR and MHTS.net

MEDICATION MANAGEMENT, PSYCHOTROPIC MEDICATIONS

On February 15, 2012, 851 or 82% of P/Is in the MHSDS were prescribed psychotropic medications. This section utilizes the MAPIP audit results to demonstrate proof of practice. It should be noted the MAPIP audit team consultants concluded that a sample of 20 UHRs would create a 95% confidence level and 5% margin of error. Their method utilized a binomial probability distribution to assess sample requirements. Nursing data presented below is reflects the MAPIP audit from October 2011 through March 2012. The psychiatry data is from the first quarter of 2012. Psychiatry data is compiled on a quarterly basis.

Medication Continuity for New Arrivals (Inter-institutional CDCR Transfers)

The MAPIP audit of 120 new P/Is' prescribed psychotropic medications revealed that 100% received these medications within 24 hours (See Tab C).

Medication Continuity for Transfers (Intra-institutional Transfers)

On March 15, 2011, custody personnel began tracking and auditing all intra-institutional transfers utilizing Form 5839. A recent audit of the 5839 forms for the period from 11/1/11-3/31/12 demonstrated that of the 197 inmates transferred with medications all arrived at their new yard with those medications. An Addendum to Policy and Procedure M-032 explained the intra-institutional transfer process (See Tab C). The MAPIP audit of this procedure revealed 100% (120/120) of transferring P/Is received their medications in a timely manner.

Upon review of thirty-two randomly-selected MHPB discharges, 100% of these P/Is received their psychotropic medications without interruption.

Medication Continuity for Renewal of Orders/Bridge Orders

Bridge orders for psychotropic medications are documented in the monthly Nursing Mental Health Report submitted to the MHQM. A review of these reports indicated that ten bridge orders were written during the reporting period. All other psychiatric prescriptions were provided in a timely manner.

Lab Tests/Results for MHSDS Inmates

Between January 1, 2012 and March 31, 2012, approximately 100 randomly-selected UHRs of P/Is receiving psychotropic medications were reviewed through the MAPIP audit. Laboratory results for specific classes of psychotropic medications were present 80% to 100% of the time depending on the class of medication, and 60% to 100% had laboratory tests reviewed/signed/dated by an MD. Seventy-eight percent of Abnormal Involuntary Movement Scale (AIMS) measures were completed within established timeframes.

Direct Observation Therapy (DOT) Medication Administration

As of March 31, 2012, 673 (88%) P/Is were prescribed psychotropic DOT medication. According to the MAPIP, a review of 44 randomly-selected P/Is revealed that DOT medication administration procedures were followed 98% of the time.

HS Medications (After 2000 Hours)

Two hundred and Fifty-one MHSDS P/Is were receiving HS medications at the end of the reporting period (4/2/12, MHTS). The MAPIP audit reviewed 54 randomly-selected P/Is and revealed that HS medications were administered after 2000 hours on every occasion.

Medication Non-Compliance Policies and Procedures

During the reporting period, an average of 6 Medication Non-compliance referrals were completed by psychiatrists weekly. A random selection of 20 UHRs during this time demonstrated the following:

- A review of 120 charts demonstrated that nursing personnel noted the non-compliance on the MAR and generated a non-compliance referral (128-C) 98% of the time (MAPIP);
- A review of 120 charts demonstrated that a psychiatrist evaluated the P/I within seven days of the referral 92% of the time (MAPIP).

The Medication Administration Record (MAR)

Of 120 audited UHRs, 98% contained the previous month's MARs (MAPIP). The review of MARs demonstrated that if a medication was missed 98% were documented appropriately on the MAR. Per the MAPIP protocol, any incomplete or illegible MAR is considered deficient.

Timely Processing of Medication Orders

To ensure timely processing, all psychiatry medication orders are noted by a Licensed Psychiatric Technician (LPT) assigned to the Mental Health Department. These orders are promptly noted and faxed to the pharmacy. The following day, an LPT verifies their appropriate processing in the Guardian program (Maxor Pharmacy). In the event that an order is not correctly processed, the LPT re-faxes the order. Psychiatric orders written late in the afternoon are placed in pre-designated folders and are processed the following day. Any urgent or emergent medication orders are immediately processed by TTA nursing staff seven days a week.

Of the 120 charts audited (MAPIP), 98% of medication changes and newly prescribed medications were received by the yard medication clinics.

Informed Consent Forms

For P/Is on psychiatric medications, a random sample of the current UHR contained up-to-date consent forms 86% (37/43) of the time (Psychiatry Peer Audit 1/1/12-3/31/12). Consent forms are to be completed on initiation of any new psychotropic medication and annually.

Pill Lines

Medications are typically distributed via Nurse Administered (NA) or DOT. A random audit of thirty eight pill lines revealed all pill lines were completed in less than two hours (MAPIP). All pill line waiting areas were shaded and sheltered. A follow up audit on 4/16/12 revealed the noon time Pill Line on A yard required 3.25 minutes to get an inmate her medications while in a three person line and B yard required 6.5 minutes to process an inmate in an eight inmate line.

Hoarding/Cheeking Medications

During the reporting period, there were no CDCR-115 Rules Violation Reports (RVRs) written explicitly for hoarding or cheeking medication (See Tab J).

Parole Medications Process

Currently, the Classification and Parole Representative notifies pharmacy of all paroling inmates at least two days in advance of release dates. The Pharmacy Department was not able to provide a report focused solely on the total number of P/Is who paroled with active prescriptions for psychiatric medications. A random-sample audit of 120 parolees found that 100% of existing orders were renewed for 30 days (MAPIP). Paroling inmates were required to sign a receipt for their parole medications. This audit also revealed that all parolees signed manifests acknowledging receipt of their prescribed medications.

MAINLINE CCCMS

During the reporting period, 269 P/Is entered the CCCMS mental health program. Eighty-eight percent received an initial PC contact and clinical intake assessment within ten working days. In addition, 91% of initial IDTTs were completed within 14 workings days (18 calendar days) of arrival or transfer into the program. 98% of PC-routine contact measures (contact at least every 90 days) and 97% of IDTT contact measures (annual IDTT) were completed within established timeframes. Clinical staff participation in the IDTTs included:

- PC, or designee, 100%
- Primary Psychiatrist (PP), or designee, 99%.

P/Is attended 523/599 or 87% of the time. Specific reasons for P/I non-attendance are unknown.

During the reporting period, 97% of P/Is received timely initial psychiatric appointments. Ninety-eighty percent of PSY-routine contact measures (i.e., contact at least every 90 days) were completed within defined timelines.

Prerelease and Discharge Planning

There is one clinician assigned to provide prerelease planning for the CCCMS population, in addition to her other duties. During the audit period, seventy-two pre-release-specific appointments were completed for CCCMS P/Is. These appointments were in addition to pre-release tasks completed by PCs during routine visits. During the audit period, one-thousand one-hundred and sixty-four inmates were release. The C&PR was unable to provide data specific to CCCMS inmates paroling.

MAINLINE ENHANCED OUTPATIENT PROGRAM (EOP)

During the reporting period, 98% of all new EOP admits were assessed and presented to the IDTT within 14 days of placement, at which point their initial treatment plan was completed and signed by the IDTT attendees. More than 98% of PC-routine contact measures (i.e., weekly contact) and 98% of IDTT Contact measures (i.e., IDTT at least quarterly) completed were within defined timelines. Data reflected consistent clinical staff participation in IDTTs:

- PC, or designee, 100%
- PP, or designee, 100%.

Ninety-five percent of initial psychiatric appointments were completed within established timeframes. Ninety-seven percent of PSY-routine contact measures (i.e., contact at least every 90 days) were completed within defined timelines.

Clinical groups and recreation therapy services were consistently provided to EOP P/Is, with no significant schedule interruptions. Group topics included: AA, Addiction, AM Exercise, Anger Management, Art Therapy, Beginner Yoga, Coping Skills, Creative Healing, Current Events, Dealing with Anxiety, Dealing with Depression, Easy Listening, EOP Orientation, EOP Unit Library, Gardening, Healthy Living, Karaoke, Life Skills, Logic and Reasoning, Low Impact Aerobics, Main Yard Library, Meditation, Movie and Discussion, New Perspectives, Pre-Release, Problem Solving, Seeking Safety, Self-Esteem, Start Now, Table Games, Thinking Errors, Therapeutic Community Meeting, Wellness and Nutrition, Wind Down, and Yard Prep. On average, P/Is were offered 19.8 hours of structured therapeutic activity per week (a decrement in group hours offered was observed in Dec/Jan due to AB109 staffing realignment, this has been rectified). No P/Is were identified as requiring a modified treatment plan.

Prerelease and Discharge Planning

Forty-six pre-release-specific appointments were completed for EOP P/Is. Thirty-five EOP P/Is were scheduled to parole during the reporting period. Of these, all received parole planning.

DEPARTMENT OF MENTAL HEALTH (DMH) REFERRALS

From October 1, 2011, to March 31, 2012, 95 P/Is met one or more of the considerations for a higher LOC. Of the identified P/Is, 11% were referred to DMH and 89% were not referred. On a monthly basis, twenty-five P/Is listed on the DMH non-referral log were audited. In the event twenty-five P/Is were not identified in a given month, all P/Is were audited. Of those audited, 94% had a reason for non-referral documented on the 7388B, and 77% had documented interventions to improve the P/I's level of functioning. Due to realignment the complete EOP team was replaced by new clinicians, psychiatrist and senior psychologist. All clinicians were trained on the EOP program guide. The department continues to provide training on the new DMH referral and non-referral process.

DRPD 1 00072

Ten referrals to DMH ICF were completed during the reporting period. All required referral documents are uploaded by the DMH Coordinator to SharePoint for UM review. Upon completion of this preliminary review, DMH is contacted by UM HQ. One hundred percent of ICF referrals were completed within five working days and posted on SharePoint. Zero percent of ICF referrals were rejected by DMH. No referrals were rescinded.

Seventeen P/Is returned to the institution from DMH. DMH discharge summaries were uploaded to SharePoint 100% of the time. Subsequently, a DMH representative contacted CIW and CCWF personnel of the pending discharge. It should be noted that upon discharge from DMH, P/Is were first transferred to CIW before returning to CCWF. The P/I undergoes a psychological contact and return protocol at CIW (e.g., Five-Day Follow-Up). CIW staff contact the DMH coordinator regarding the patient. The percentage of clinician-to-clinician contacts taking place within five working days of the P/I's return to the institution was unknown as P/Is were initially transferred to CIW. All P/I's are seen by mental health clinical staff within 24 hours of arrival at CCWF. Upon arrival, the DMH Coordinator provides the discharge summary to the P/I's new treatment team.

MENTAL HEALTH PROGRAM BEDS (MHPB)

The institution has a 12-bed Mental Health Program Beds (MHPB) unit. As previously indicated, this program is defined as a Specialty Program within a SNF and governed by Title 22 regulations. P/Is are received from internal referrals as well as from other institutions. During the reporting period, 60 referrals were received from within the institution and 12 referrals were received from other institutions.

The total number of admissions to the MHPB unit was 72. The average length of stay (LOS) was 12 days. The range was from 1 to 62 days. The number of P/Is with a LOS of ten days or longer was 32. Reasons included: 28% referred to DMH, 69% clinically indicated due to continued acute psychosis or continued suicidal ideation, and 3% clozapine treatment initiation. Therefore, the percent retained for clinical reasons was 100. When P/Is on the DMH waiting list were removed from the calculation, the average LOS in the MHPB was 8.73 days.

Of those P/Is admitted during regular working hours, 100% were administered a pre-admission screening. Eighty two percent of initial IDTTs were completed within 72 hours of admission. P/Is were offered at least weekly IDTTs 92% of the time. Data reflected consistent staff participation in IDTTs:

- PC, or designee, 100%
- PP, or designee, 100%
- CCI 100%
- Nursing staff 100%.

Daily contacts by a licensed psychologist or psychiatrist occurred 90% of the time. Of those P/Is that were admitted due to suicidal threats or behavior, 100% were administered a Suicide Risk Evaluation (SRE) at the time of placement and 96% received a SRE upon release from the

MHPB. All P/Is irrespective of the reason for admission received a five-day follow-up after their release from the MHPB.

ALTERNATIVE HOUSING

Not applicable.

ADMINISTRATIVE SEGREGATION UNIT (ASU)

During the reporting period, 180 inmates were placed in ASU and the average daily census was 46.8. Note that this amount does not represent 180 different individuals; rather, it includes multiple placements by several inmates. Upon arrival, inmate levels of care were: 77 CCCMS, 21 EOP, and 82 GP. Over ninety-nine percent of inmates received a nursing Pre-Placement screening (CDCR 128-MH7) prior to placement in ASU. All inmates were reviewed for current MHSDS status within one working day following their placement in ASU. Ninety-eight percent (113/115) of GP inmates placed in ASU during the reporting period received a mental health screening (31-item questionnaire) within 72 hours of placement. Custody documented 30-minute welfare checks during the reporting period 100% of the time.

ASU CCCMS

During the reporting period, 107 P/Is entered the ASU CCCMS program, 27 of whom stayed less than seven days and 18 of whom stayed 7 to 14 days before release from ASU. Twenty-three P/Is were in ASU longer than 90 days, and seven stayed in ASU over 180 days. Contact Interval reports indicated that 96% of P/Is were assessed by a clinician within one week. Seventy-three percent of initial IDTTs were completed within 14 calendar days and 87% received a subsequent IDTT within timeframes. Data reflected consistent staff participation in IDTTs:

- PC, or designee, 100%
- PP, or designee, 100%
- CCI 93%.

Eighty-seven percent of IDTTs were attended by P/Is. Typically, P/I non-attendance at IDTT was due to her refusal or a conflicting medical appointment.

Approximately 83% of PC contacts and 99% of PSY contacts were completed in a confidential setting (about 17% cell-front). The primary reason for cell-front appointments was P/I refusal to leave the cell.

One hundred percent of P/Is prescribed psychotropic medications were seen by a psychiatrist at least every 90 days. Daily LPT rounds for MHSDS P/Is were documented on the CDCR Form 7230-MH 91% of the time. Daily ASU morning meetings between custody and clinical staff were documented 100% of the time.

ASU EOP (Hub)

EOP P/Is are transferred to VSPW typically within 30 days of ASU placement. Reasons for transfer delays include: pending adjudication of an RVR, Out-to-Court (OTC) status, MHPB admission, or pending Keyhea certification. If a P/I's LOC is changed to EOP after ASU placement, she will be transferred to VSPW within 30 days of this designation. During the reporting period, 17 different P/Is were EOP level of care. They received clinical visits equivalent to EOP level of care. The average length of stay in ASU was 36.7 days. Nine P/Is were transferred to VSPW.

ASU Non-MHSDS

During the reporting period, 82 GP inmates were placed in ASU. Of those, 100% received a CDCR 128-MH7 screening by trained nursing staff prior to placement in ASU. Custody documented 30-minute welfare checks 100% of the time. Nursing documented daily LPT rounds 100% of the time in the ASU log.

SUICIDE PREVENTION

CCWF maintains an active Suicide Prevention and Response Focused Improvement Team (SPR-FIT). See Tab I, Section 1 to review SPR-FIT meeting minutes.

Completed Suicides

During the reporting period, there were no successful inmate suicides in the institution.

The last successful inmate suicide at CCWF was January 14, 2010.

Attempted Suicides during the Reporting Period

Four suicide attempts occurred during the reporting period. Three attempts were made by attempting to overdose and one by laceration. One P/I required outside hospitalization and all were referred/admitted to MHPB for acute mental health care services.

Provision of a five-day follow-up upon discharge from MHPB occurred 100% of the time. Custody wellness checks were completed 100% of the time as required.

Six SPR-FIT monthly meetings were required during the reporting period and all were documented to have occurred and a quorum was achieved. The Suicide Prevention Coordinator facilitates the monthly SPR-FIT. During the reporting period, the agendas included: review of P/I demographic and clinical data related to MHPB admissions, case-by-case reviews of self-injury, ongoing review of 128-MH7 screenings for ASU in which 99% were completed and a review of medication-related 115s.

Ongoing suicide prevention training consisted of monthly suicide videoconferences, general meetings focused on five-day procedures emerging from the QIT, morning meetings reviewing cases involving self-injury, and Suicide Prevention training conducted during Block Training and New Employee Orientation.

The Emergency Medical Response Review Committee (EMRRC) remained operational throughout the reporting period. In addition to other medical-case reviews, this committee discussed all incidents of serious self-injury. Such cases typically result in transfer to a community-based hospital and/or MHPB admission.

Inmate Profile Procedure

Historical data related to a P/I's self-injurious behavior is readily available through MHTS.net. PCs and LPTs assigned to ASU have access to MHTS.net and can research this information as necessary. Registered Nurses assigned to inter-institutional transfers also have access to MHTS.net. Inmate Profiles from MHTS.net are generated prior to inmates' transfers to other institutions. Mental health clerical staff can also produce these documents and route them for inclusion in the Transfer Packet.

RVR PROTOCOLS

Data from the institution's 115 Tracking System show that 902 RVRs were given during the reporting period: 483 GP inmates, 382 (42%) CCCMS, 36 (4%) EOP, 1 (<1%) MHPB. A total of 173 115-MH evaluations were completed during this period. For additional information, refer to Tab J.

USE OF FORCE

Data tables were created showing all Use of Force and Non-Use of Force incidents during the reporting period. These tables can be found in Tab K. Of the 81 Use of Force Incidents, 58 (72%) involved MHSDS P/Is. Approximately 27 (69%) of the 39 Non-Use of Force Incidents occurred with MHSDS P/Is.

RECEPTION CENTER

Initial Health Screenings were conducted on 100% of incoming inmates by nursing staff within 24 hours of arrival. P/Is arriving in the RC with prescriptions for psychotropic medications were written a 14-day continuation order which was observed during the intake process. Initial Mental Health screenings were completed with 87% of incoming inmates within seven days of arrival. Those inmates that answer positively to specific clusters of questions, present with mental health symptoms, and/or were previously in the MHSDS are referred for a mental health intake evaluation (CDCR Form7386). These mental health evaluations were completed within 18 calendar days of the inmate's arrival 100% of the time. Initial mental health screenings were

completed in a confidential setting 100% of the time. Comprehensive mental health evaluations were conducted in a confidential setting 100% of the time.

Issues related to untimely assessments in this area included staff layoffs and reassignments. Since the reassignments, the timeframes are returning to the high levels (95-100%) observed prior to AB109 realignment.

RC CCCMS

RC inmates classified as General Population and CCCMS are housed in Buildings 501, 502, and 503. The RC CCCMS P/I population comprised about 15% of the entire MHSDS population. Valid average and range LOS data were not available for this reporting period. The census on March 31, 2012, reported 10 GP/CCCMS inmates (6% of the census reported on 3/31/12 for the CCCMS RC population) had a current LOS in excess of 90 days according to correctional counselor personnel. The primary reasons for these LOS were pending adjudication of an RVR(s)/ASU placement and inmates on OTC status.

Ninety-six percent of P/Is had initial Primary Clinician contacts within 30 days of placement in CCCMS. Ninety-eight percent of PC-routine contact measures (contact at least every 90 days) were completed within established timelines. All PSY-routine contact measures (psychiatry contact at least every 90 days) were also within defined parameters.

All RC mental health appointments were completed in a confidential setting.

RC EOP

This population is housed in Building 504 and comprises less than one percent of the P/Is in the MHSDS. RC EOP inmates are immediately transferred to this unit and receive identical services rendered to ML EOP P/Is. Data specific to RC EOP P/Is are not collected; rather, these data are incorporated in the ML EOP section.

MENTAL HEALTH REFERRALS

- Emergent: Immediately (four hours)
- Urgent: Within 24 hours
- Routine: Within five working days

During the reporting period 1,560 referrals were received: 51 emergent (3%), 109 urgent (7%), and 1,400 routine (90%). Ninety-six percent of emergent referrals were completed within four hours, 91% of urgent referrals were completed within 24 hours, and 97% of routine referrals were completed within five working days (See Tab P).

MHTS-UHR AGREEMENT AUDIT

The MHTS-UHR Agreement review process has been fully functional at CCWF to date. CCWF utilizes the statewide-standardized agreement methodology. QAU's Quality Improvement Auditor performs this audit on a monthly basis. The agreement between MHTS and the UHR has ranged from 90% to 93% during the reporting period. Although a QIT meets intermittently to look at outliers to suggest management interventions for ongoing quality improvement purposes, there were no CAPs established. Management interventions focus on working with clinical and clerical staff on a case-by-case basis as training issues present, based on lessons learned. For additional information, refer to Tab B.

Exhibit 27

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, ET AL., Plaintiffs, vs. EDMUND G. BROWN, JR., ET AL., Defendants.	CASE NO.: S 90-0520 LKK-JFM

DEPOSITION OF

JACQUELINE MOORE, RN, PH.D.

THURSDAY, FEBRUARY 21, 2013, 8:50 A.M.

SAN FRANCISCO, CALIFORNIA

REPORTED BY: MEGAN F. ALVAREZ, RPR, CSR NO. 12470

THORSNES LITIGATION SERVICES, LLC

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, ET AL., Plaintiffs, vs. EDMUND G. BROWN, JR., ET AL., Defendants.	CASE NO.: S 90-0520 LKK-JFM

The Deposition of JACQUELINE MOORE, RN, PH.D., taken on behalf of the Plaintiffs, before Megan F. Alvarez, Certified Shorthand Reporter No. 12470, Registered Professional Reporter, for the State of California, commencing at 8:50 a.m., Thursday, February 21, 2013, at the Rosen, Bien, Galvan & Grunfeld, LLP, 315 Montgomery Street, 10th Floor, San Francisco, California.

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discharge planning at the institution?

MS. VOROUS: Objection. Misstates her testimony.

THE WITNESS: Yes.

BY MR. FISCHER:

Q. Okay. And one last thing on CIM I wanted ask you about in your notes on the final page, 102633.

Most of the way down next to No. 5, it says: "Nurse UNFAM, SE, psy meds."

What does that note refer to?

A. Nurses were unfamiliar with the side effects of psychiatric meds.

Q. I imagine that's on your radar because you're a nurse?

A. I asked them.

Q. Why did you ask this question?

A. I asked all the institutions. That was one of the criteria on my audit tool.

Q. And here -- SE is side effects?

A. Side effects.

Q. And is this particular CIM of concern to you in your analysis?

A. Yes.

Q. Why is that?

A. Because it's a common practice that nurses

know the side effects of the medication that they're giving because very often you are the one that might observe lithium toxicity in an inmate.

Q. So it's important to be aware of the side effects of the psych medications in order to ensure the safety and well-being of those patients?

A. Yes, sir.

Q. Did you observe this problem at any other institutions? Do you remember?

A. Yes.

Q. Do you remember which institutions?

A. All of them except San Quentin.

Q. San Quentin?

A. Knew the side effects.

Q. They were good?

A. They were good.

Q. Did you raise this with -- at the exit interviews?

A. Each and every time.

Q. Did this make it into your report?

Direct you to page 26 of your report, Exhibit 4.

Tell me if I'm looking at the right -- bottom, "Nursing Medication Management." Just a short section.

Is that an issue you think could have been put

CERTIFICATE OF REPORTER

I, MEGAN F. ALVAREZ, a Certified Shorthand Reporter, hereby certify that the witness in the foregoing deposition was by me duly sworn to tell the truth, the whole truth and nothing but the truth in the within-entitled cause;

That said deposition was taken down in shorthand by me, a disinterested person, at the time and place therein stated, and that the testimony of the said witness was thereafter reduced to typewriting, by computer, under my direction and supervision;

I further certify that I am not of counsel or attorney for either or any of the parties to the said deposition, nor in any way interested in the events of this cause, and that I am not related to any of the parties hereto.

DATED: February 25, 2013

_____

MEGAN F. ALVAREZ

RPR, CSR 12470

Exhibit 28

RE: F/U question to your consulation to CDCR

Canning, Robert@CDCR (Robert.Canning@cdcr.ca.gov)
Thu 7/05/12 7:34 PM
Lindsay Hayes (lhayesta@msn.com)

I haven't forgotten just swamped. Hope you had a good Fourth.

Robert D. Canning, Ph.D. Desk: (916) 691-0276
Senior Psychologist Specialist Cell: (530) 400-8965
Statewide Mental Health Program Fax: (916) 691-0534
mail:

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HEALTH CARE SERVICES

From: Lindsay Hayes [mailto:lhayesta@msn.com]
Sent: Sunday, June 24, 2012 5:05 PM
To: Canning, Robert@CDCR
Subject: RE: F/U question to your consulation to CDCR

Robert:

I haven't heard back from you. Did by diatribe completely piss you off? I hope not, it was only friendly fire.

Lindsay M. Hayes, Project Director
National Center on Institutions and Alternatives
40 Lantern Lane Mansfield, MA 02048
(508)337-8806
www.ncianet.org/services/suicide-prevention-in-custody/

From: lhayesta@msn.com
To: robert.canning@cdcr.ca.gov; kathleen.o'meara@cdcr.ca.gov
Subject: RE: F/U question to your consulation to CDCR
Date: Tue, 19 Jun 2012 12:08:02 -0400

Robert:

Do I have any thoughts? This has become a very frustrating subject for me. I agreed to be a CDCR consultant only after Sharon Aungst (as well as the plaintiff attorneys) convinced me that my services could be more beneficial to CDCR then to the plaintiff and special master. In my opinion, the report I wrote was intended to serve as a rough blueprint on how the agency could work its way out of the suicide prevention provisions of *Coleman*. I believe the "end-product" was helpful to that end. From the manner in which the report was received, however, it now appears obvious to me that Sharon agreed to hire me only in an effort to support her suicide prevention philosophy, including expanded use of the OHU and administrative segregation units. If my end product did not mirror this philosophy, then it would be buried as it was.

In my report, I clearly made the argument that OHUs might be appropriate for inmates at risk of suicide that did not require MHCB level of care. However, as I hope you and Kathy would agree, the three OHUs that we visited at Mule Creek, Sac., and DVI were grossly inadequate and did not exemplify out-patient mental health housing units. My report strongly recommended that the agency upgrade OHUs and then present them as a viable option for suicidal inmates to both the plaintiff and special master.

I also believe that the threshold for placement on suicide observation status at CDCR is much too high and requires either *high risk* of self-injurious behavior and/or being in *immediate* danger of self-injurious behavior. You know much better than I whether clinical staff are literally interpreting levels of observation based upon the specific definitions of "suicide precaution" and "suicide watch," but it appears that these definitions are excluding other concerning suicidal behavior (e.g, moderate risk). I also believe that some of these inmates are the ones that Ray Patterson ultimately speaks to as "preventable suicides," a term of his that we have collectively been concerned about. I believe that lowering the threshold and redefining the behavior that necessitates the observation levels would ultimately result in more inmates on suicide precaution status, and thus necessitating increased use of OHUs for these inmates. This could strengthen the agency's argument to the plaintiff and special master that OHUs were necessary and viable. But, they needed to be upgraded.

Ironically, CDCR agreed to give the special master and plaintiff counsel a sanitized version of my report that only contained the section on the OHUs. CDCR also agreed to allow Jeff Metzner to speak with me about it. Jeff and I spoke last week. He was in overall agreement with my findings and recommendations, although we slightly disagreed in the comparison I made between California and New York State (where we both consulted together). From our conversation, it appears that the special master might be willing to revisit the issue of utilizing OHUs for certain suicidal inmates that did not require MHCB level of care. Jeff said the OHU argument had never been presented that way before.

It would appear that this issue could be discussed during another suicide prevention summit, but I, of course, have not been invited to any such meetings as a CDCR consultant. Having written my three-year contract, you know as well as I that my consultation could have extended beyond the lone on-site visit and report, but it has stopped dead in the water. Thus, the main source of my frustration with the agency. Thanks for allowing me to vent.

Lindsay M. Hayes, Project Director
National Center on Institutions and Alternatives
40 Lantern Lane Mansfield, MA 02048
(508)337-8806
www.ncianet.org/services/suicide-prevention-in-custody/

From: Robert.Canning@cdcr.ca.gov
To: lhayesta@msn.com
Date: Mon, 18 Jun 2012 12:53:36 -0700
Subject: F/U question to your consulation to CDCR

So, since I've got your attention, let me ask you how, the next time we hire you (or someone else for a similar task) we could improve. Obviously when your report landed it was not roundly applauded and in fact was buried. Part of the problem could have been our ability to frame the consultation in a way that would have made the end-product more helpful. For instance, was the scope of work we outlined concrete enough for you to produce a useable product, or was it too vague? Of course there is always the situation that by the time you delivered the situation on the ground had deteriorated and circumstances had changed. Any thoughts you might have about this?

Thanks.

Robert D. Canning, Ph.D. Desk: **(916) 691-0276**

Senior Psychologist Specialist Cell: **(530) 400-8965**

Statewide Mental Health Program Fax: **(916) 691-0534**

mail:

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Exhibit 29

CALIFORNIA DEPARTMENT OF CORRECTIONS

Mental Health Service Delivery System Study

FINAL REPORT

February 16, 1993

The Western Consortium for Public Health
In association with
Scarlett Carp and Associates, Inc.

EXECUTIVE SUMMARY

CALIFORNIA DEPARTMENT OF CORRECTIONS
Mental Health Service Delivery System Study

EXECUTIVE SUMMARY

In 1991, the California Department of Corrections (CDC) commissioned the Western Consortium for Public Health, in association with Scarlett Carp and Associates, Inc., to develop a service delivery and facilities plan for the treatment of seriously mentally disordered inmates.

The study was designed to provide information to enable the CDC to fulfill its mission of protecting the public and meeting basic inmate needs (including the need for mental health care and, where appropriate, specialized treatment). Furthermore, the CDC believes the provision of treatment for mentally ill inmates and parolees reduces the likelihood that these individuals will continue to pose a threat to the public.

Problems presented by severe mental disorders create some urgency within the prison environment. The behaviors symptomatic of such disorders can be profoundly disruptive and stressful to other inmates and, particularly, to staff who are not trained to handle them. Afflicted inmates should be legitimately able to expect help from qualified staff in the reduction of the severe distress that accompanies mental illness; moreover, access to treatment has been formally established by the courts as a right of these offenders. While this study was not initiated in response to any particular litigation, the mental health service delivery system proposed herein was developed with the goal that it be constitutionally adequate.

As the prison population of California grows, the number of inmates who are seriously mentally disordered also increases. The CDC inmate population grew from 101,995 inmates in 1991 (when this study began) to over 109,000 by December 1992. The projected inmate population for 1998 is expected to be 140,939. The number of commitments of mentally ill offenders to the CDC system may also be influenced by current and future cut-backs in community mental health resources.

Scope of the Study

The primary objective of this study is to produce information to enable the CDC to plan, obtain approval for, and implement a full mix of inpatient and outpatient mental health services to meet the needs of its inmate population through Fiscal Year (FY) 1996-97. The primary result of this study is a mental health service delivery system plan for use by the CDC. This plan is to detail the level and cost of resources required to implement the proposed mental health delivery system, including professional and support staffing, and construction/renovation requirements. It includes:

1. Evaluation of the adequacy, efficiency, and cost effectiveness of existing mental health services operated by CDC and by the Department of Mental Health (DMH) for CDC inmates. This evaluation is based on interviews, site visits, and analyses of existing data; it does not entail data collection or formal program reviews.

These services include psychotropic medication, various types of individual and group psychotherapy, and case management (advocacy, information, support, advice, etc.) In addition, certain inmates require services that deal with specific characteristics of their prison experience, mental illness, or life experience.

Inmates housed in Security Housing Units (SHUs) for long periods of time bear special mention. No dilemma in prison is more difficult than the management of the mentally ill inmate who, out of anger (and not because of mental illness), assaults staff or other inmates. Good correctional management requires that there be clear and public consequences for such acts. The lack of such consequences can gravely affect staff and inmate morale, in addition to threatening the safety of the prison. It may also be counter-therapeutic to convey to inmates that being mentally ill excuses violence, rule infractions, and subsequent disciplinary actions. On the other hand, some mentally ill inmates find segregation so unpleasant and anxiety provoking that they go to extreme lengths to force the system to move them out of segregation. Further, segregation may severely exacerbate pre-existing mental illness. While there is no easy answer to this dilemma, at the very least on-site regular mental health coverage must be provided to such units for ongoing assessment and support for inmates who legitimately have trouble tolerating segregation.

Pre-Release/Transition Services. This component of service focuses on preparing the seriously mentally ill inmate for parole to the community. Its objective is to maximize the individual's potential for successful linkage and transition to the parolee outpatient clinic or, if required, to inpatient services in the community. Pre-release/transition services include assessment, determination of the type of living situation required in the community, life skills training, medication management, and transition planning with the parole outpatient clinician from the region where the inmate will be paroled. This service will occur at all levels of care.

Parolee Clinic Services. Parolee clinic services provide short-term and limited sustained mental health interventions to parolees experiencing acute or chronic psychiatric problems. The outpatient clinician develops the inmate's transition plan with mental health staff in the institution, provides outpatient mental health care, and facilitates the parolee's linkage to community outpatient and, when needed, inpatient mental health care.

Management Consultation and Staff Training. Mental health staff may provide consultation to the prison management team about particularly stressful practices that exacerbate mental disturbance as well as about changes in prison routine that could improve morale or reduce stress for both staff and inmates. Mental health staff should actively participate in pre-service and in-service training of correctional officers and program staff regarding early recognition of the signs and symptoms of mental illness and suicide; the nature and effects of various psychotropic medications; the mental health services available at the prison; and when and how to make referrals to those services.

Although the above services are presented as a continuum of care, it should not be construed that a mentally ill inmate will necessarily need sequentially to access all components. For example, an inmate could be transferred directly from outpatient to residential care, or from a crisis bed to outpatient status. Each component of care should be accessed according to the assessed needs of the individual. The only exception is a transfer to inpatient hospital care. In

interventions, as identified here, is in place, inpatient hospital care can be limited and of generally short (approximately 45 to 60 days) duration. It is recognized that a small percentage may require longer periods of hospitalization.

Treatment modalities associated with this component of care include:

- Assessment & Diagnosis
- Forced Medication
- Medical Evaluation
- Psychotherapy
- 24 Hour Nursing Care
- Community/Group Meetings
- Triage & Referral
- Medication Monitoring
- Activities Therapy - Recreation/Occupation
- Physical Restraint/Management of Physical Violence
- Discharge Planning

Residential Care. Residential care is a sheltered living environment within the prison where seriously mentally disordered inmates will receive a full day of therapeutic programming. While there, those who are able will be mainstreamed into general population programs and activities appropriate to their custody requirements. Providing this level of care within the prison environment is cost-effective. Inmates with severe mental illness often have difficulty with the stresses of prison and are especially vulnerable to victimization while in the general population. Creating a psychologically (and perhaps physically) safer environment can reduce psychiatric distress and crisis, disciplinary violations, and suicide attempts. As a consequence, more expensive hospital transfers for seriously mentally ill inmates will be minimized.

Three different kinds of inmates may find their way into such a program. First, there is the "halfway in" inmate, who is responding reasonably well to a prescribed treatment regimen and for a time may need to be removed from the stresses of general population. With residential care he or she may avoid inpatient commitment. Second, is the "halfway out" inmate who, after an inpatient hospital stay, will use this option as a "decompression chamber" prior to returning to general population/housing according to their custody needs. For these two groups, the program will be transitional and should have a widely varied length of stay, often more than six months. Finally, there is the "chronic" patient, whose placement in this program essentially will be the best he or she is ever likely to experience. It is important to try moving inmates who might potentially fall into this "chronic" category into less intensive treatment settings several times prior to "giving up" on their chances of ever leaving the residential program.

Cognitive behavior therapies may be the treatment of choice aimed at understanding mental illness, how to manage it, and how to cope with the stresses of the prison environment more effectively. Inmates become members of a therapeutic community where they are encouraged to participate in as many therapeutic activities as are deemed appropriate by staff. Some will participate in general population work and education programs during the day. Inmates in this program should be involved in a full day of programming to discourage malingerers; that is, inmates who feign mental illness in order to "kick back".

Treatment modalities associated with this component of care include:

- Comprehensive Evaluation
- Therapeutic Milieu
- Community Meetings
- Medical Services Liaison
- Psychoeducational Modules/Skill Training
- Activities Therapy - Recreation/Occupation

Exhibit 30

SALINAS VALLEY
31625 Highway 101 - P.O. Box 1080
Soledad, CA 93960

Wednesday, January 23, 2013

Name Charles DaSilva,
Executive Director, Salinas Valley Psychiatric Program
Address 31625 Highway 101,
Soledad, CA 93960

Executive Director DaSilva,

As staff psychiatrists, we are writing you collectively to express our serious concern about the level of staffing at SVPP. At the end of January, we will have lost our 3rd psychiatrist in the past (6) weeks.

This will leave us only (7) full-time psychiatrists, including a senior, plus 1 part-time psychiatrist, covering (6) Units that average about 60 beds each. Other disciplines such as social work, psychology, and rehab therapy have 15 to 16 staff covering the same number of patients. The SVPP census issued today shows that there are 351 patients in the program. Across the (6) Units we have also been averaging about (2) to (3) admissions and discharges per Unit per week.

The DSH standard for Stockton and elsewhere is a (15) patient caseload for a team that does admissions, with about (2) admissions per week. When administration visited our facility recently to present the Stockton program, we were told that a 15 patient caseload would also be the standard at SVPP as well as Stockton. At present we have been averaging a caseload of about (40) with (2) admissions per week, and all psychiatrists are taking admissions. Some psychiatrists are already covering (60) patients daily, (4) times the accepted standard. We find a caseload of (40) to be unsafe, and a caseload of (60) is even more perilous.

As psychiatrists, we are united in our belief that the level of staffing currently present is not safe or appropriate for an ICF level of patient care. We believe that it potentially creates an unsafe situation for both staff and patients. When patient safety is at stake, we cannot in good conscience continue to take on a higher and higher caseload without making you aware of our concerns. In November, 2012 SVPP had its first completed suicide. Current staffing levels will create an unacceptable level of risk as far as patient safety.

We will continue to do our best for every patient, under every

John Brim
March 1, 2013
Exhibit No. 1
Megan F. Alvarez
RPR, CSR No. 12470

circumstance. ***But we need to inform you that we will be working in a state of protest regarding our caseload and the rate of admissions.*** We are also extremely concerned about further attrition of psychiatrists, which seems very likely considering the present workload and conditions.

We understand that since SVPP is being downsized that it may be difficult to attract new psychiatrists. However, in the past, staff from other facilities have been brought in on a temporary basis. This would be a tremendous help. We also believe the situation could be made significantly better through a reduction in admissions as we scale back and prepare to close C and D yards.

Thank you for listening to our concerns.

Sincerely,

Joel Badeaux, MD

John Brim, MD

Gayle Gaines, MD

Minhas Kapadia, MD

Muhammad Saleem, MD

Mary Stoller, MD

Ariel Troncoso, MD

Lei Wei, DO

Indu Aramandla, MD

Position Staff and Senior Psychiatrists
Division DSH SVPP

cc: Katherine Warburton, DO, Chief Psychiatrist, DSH
Nereyda Rivera, UAPD

SALINAS VALLEY
31625 Highway 101 – P.O. Box 1080
Soledad, CA 93960

Tuesday, February 12, 2013

Name Charles DaSilva,
Executive Director, Salinas Valley Psychiatric Program
Address 31625 Highway 101,
Soledad, CA 93960

Dear Executive Director DaSilva,

This letter will confirm our verbal communication to you during the psychiatry meeting today. We alerted you to the severe psychiatry staffing shortage in our letter of three weeks ago. Now, as you know, our psychiatry staffing shortage has devolved from serious to crisis level. With three more psychiatrists leaving in the near future we must take urgent action. After extensive discussion and consideration, the psychiatry staff at SVPP have unanimously determined that we cannot safely manage more than 40 patients per psychiatrist. We will not abandon additional patients beyond this limit, but can provide only emergency psychiatry services for such additional patients.

Thank you.

Sincerely,

Joel Badeaux, MD — Ariel Troncoso, MD

John Brim, MD — Lei Wei, DO

Minhas Kapadia, MD — Indu Aramandla, MD

Muhammad Saleem, MD — Mary Stoller, MD

cc: Katherine Warburton, DO, Chief Psychiatrist, DSH
Nereyda Rivera, UAPD

John Brim
March 1, 2013
Exhibit No. 2
Megan F. Alvarez
RPR, CSR No. 12470

Exhibit 31

From: Michael W. Bien <MBien@rbgg.com>
Sent: Friday, February 15, 2013 2:02 PM
To: Coleman Team - RBG Only
Subject: FW: CDCR/DSH Monthly Reports
Attachments: Coleman Status Report 01-31-13 (2).pdf.pdf; Licensure Report - CL.pdf.pdf; CSVR Signed CL 1-13 .pdf.pdf; Coleman Staff Vacancy Report - January 1, 2013.pdf.pdf; Coleman PIP Staffing Classifications and Vacancy Rate Report. Jan. 25, 2....xlsx; PIP Census 01-25-13.xls.xls

---

From: Debbie Vorous[SMTP:DEBBIE.VOROUS@DOJ.CA.GOV]
Sent: Friday, February 15, 2013 2:00:46 PM
To: Kerry Courtney Hughes, MD; Patricia M. Williams; Haunani Henry; Mary Perrien; Henry D. Dlugacz; Raymond F. Patterson, MD; Kathryn Burns, MD, MPH; Paul Nicoll; Linda Holden; Jeff Metzner; kwalsh@pldw.com; Matt Lopes; Mohamedu Jones; Steve Raffa; Kristina Hector
Cc: Debbie Vorous; Donald Specter; Jane E. Kahn; Michael W. Bien; Debbie Vorous; Steve Fama; William Downer
Subject: CDCR/DSH Monthly Reports
Auto forwarded by a Rule

February 15, 2013

Coleman v. Brown

Dear Special Master Lopes:

Attached are the following reports:

1. DSH cover letter and licensure report for the time period of January 1, 2013 to January 31, 2013;
2. DSH cover letter and monthly staffing and staffing vacancies report as of January 1, 2013; and
3. CDCR census and staffing report for CIW.

Thank you,

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DIVISION OF ADMINISTRATION
1600 Ninth Street, Room 140
Sacramento, CA 95814

January 23, 2013

Matthew A. Lopes, Jr., Esq.
Office of the Special Master
Pannone, Lopes & Devereaux, LLC
317 Iron Horse Way, Suite 301
Providence, RI 02908

via: Debbie J. Vorous
Deputy Attorney General
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550

RE: MONTHLY STAFFING AND STAFFING VACANCIES REPORT FOR ALL DSH FACILITIES

In accordance with the February 6, 2007 *Coleman* Court Order on the issue of pay parity for California Department of State Hospitals' (DSH) clinicians, DSH is providing the following information on Staffing and Staffing Vacancies for all DSH facilities.

The enclosed report contains the following data for 26 *Coleman* related clinical positions: total number of budgeted positions; positions filled; positions currently vacant; contracted full-time equivalents; and the overall percentage of vacancies for each facility as of January 1, 2013. Please note that DSH has included additional information that identifies the number of contracted staff employed at DSH facilities.

If you have any questions or concerns, please feel free to contact Candius Burgess, Coordination and Logistics Unit, at (916) 654-0090.

Sincerely,

ROB COOK
Staff Services Manager III
Administrative Services Division
Department of State Hospitals

Enclosures

DEPARTMENT OF STATE HOSPITALS
Coleman Related Clinical Positions
Monthly Staffing and Staffing Vacancies Report
as of January 1, 2013

Class Code	*COLEMAN* RELATED CLASSES	Facility Totals						
		Budgeted	Filled	Vacant	Contracted Full-Time Equivalents	Functional Vacancy	Vacancy Rate (Authorized Positions Vacant)	Functional Vacancy Rate (Contractor Offset to Vacancies)
7594/9660 9690/9693	Medical Director	6.00	3.00	3.00	0.00	3.00	50%	50%
8236	Psychiatric Technician Assistant (Safety)	302.00	269.00	33.00	0.00	33.00	11%	11%
8238	Psychiatric Technician Trainee (Safety)	30.50	29.00	1.50	0.00	1.50	5%	5%
8253	Psychiatric Technician (Safety)	2,332.30	2,057.00	275.30	62.00	213.30	12%	9%
8254	Pre-Licensed Psychiatric Technician (Safety)	7.00	7.00	0.00	0.00	0.00	0%	0%
8252	Senior Psychiatric Technician (Safety)	346.00	313.00	33.00	0.00	33.00	10%	10%
9873	Psychologist, Health Facility (Clinical-Safety)	263.60	239.25	24.35	12.00	12.35	9%	5%
9839	Senior Psychologist, Health Facility (Specialist)	29.00	28.00	1.00	0.00	1.00	3%	3%
9831	Senior Psychologist, Health Facility (Supervisor)	41.20	39.40	1.80	0.00	1.80	4%	4%
7619	Staff Psychiatrist (Safety)	188.00	173.30	14.70	28.00	-13.30	8%	-7%
9758	Staff Psychiatrist, Correctional and Rehabilitative Services (Safety)	32.50	22.50	10.00	8.00	2.00	31%	6%
7616	Senior Psychiatrist (Specialist)	3.60	3.00	0.60	0.00	0.60	17%	17%
9759	Senior Psychiatrist (Specialist), Correctional and Rehab Services (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
7609	Senior Psychiatrist (Supervisor)	35.10	27.00	8.10	0.00	8.10	23%	23%
9761	Senior Psychiatrist (Supervisor), Correctional and Rehab Services (Safety)	5.00	3.00	2.00	0.00	2.00	40%	40%
9271	Senior Psychiatrist, Correctional Facility (Supervisor)	0.00	0.00	0.00	0.00	0.00	0%	0%
8321	Rehabilitation Therapist, State Facilities (Music-Safety)	75.00	67.50	7.50	0.00	7.50	10%	10%
8323	Rehabilitation Therapist, State Facilities (Occupational-Safety)	11.20	10.00	1.20	0.00	1.20	11%	11%
8324	Rehabilitation Therapist, State Facilities (Recreation-Safety)	157.00	134.85	22.15	0.00	22.15	14%	14%
8420	Rehabilitation Therapist, State Facilities (Art-Safety)	52.00	47.50	4.50	0.00	4.50	9%	9%
8422	Rehabilitation Therapist, State Facilities (Dance-Safety)	7.00	7.00	0.00	0.00	0.00	0%	0%
9872	Clinical Social Worker (Health/Correctional Facility) – (Safety)	294.40	263.75	30.65	3.00	27.65	10%	9%
8104	Unit Supervisor (Safety)	139.00	132.00	7.00	0.00	7.00	5%	5%
9859	Chief Psychologist	6.00	3.00	3.00	0.00	3.00	50%	50%
9867	Supervising Psychiatric Social Worker	20.00	17.00	3.00	0.00	3.00	15%	15%
	***COLEMAN* GRAND TOTALS**	**4,383.40**	**3,896.05**	**487.35**	**113.00**	**374.35**	**11%**	**9%**

DEPARTMENT OF STATE HOSPITALS
Coleman Related Clinical Positions
Monthly Staffing and Staffing Vacancies Report
as of January 1, 2013

DSH Psychiatric Technician Classifications								
Class Code	*COLEMAN* RELATED POSITION	Budgeted	Filled	Vacant	Contracted Full-Time Equivalents	Functional Vacancy	Vacancy Rate (Authorized Positions Vacant)	Functional Vacancy Rate (Contractor Offset to Vacancies)
	Department of State Hospitals - Atascadero							
8236	Psychiatric Technician Assistant (Safety)	3.00	2.00	1.00	0.00	1.00	33%	33%
8238	Psychiatric Technician Trainee (Safety)	26.50	26.00	0.50	0.00	0.50	2%	2%
8253	Psychiatric Technician (Safety)	600.50	525.00	75.50	0.00	75.50	13%	13%
8254	Pre-Licensed Psychiatric Technician (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
8252	Senior Psychiatric Technician (Safety)	84.00	75.00	9.00	0.00	9.00	11%	11%
	DSH-Atascadero SUB-TOTAL	**714.00**	**628.00**	**86.00**	**0.00**	**86.00**	**12%**	**12%**
	Department of State Hospitals - Coalinga							
8236	Psychiatric Technician Assistant (Safety)	36.00	25.00	11.00	0.00	11.00	31%	31%
8238	Psychiatric Technician Trainee (Safety)	4.00	3.00	1.00	0.00	1.00	25%	25%
8253	Staff Psychiatrist (Safety)	426.80	361.00	65.80	62.00	3.80	15%	1%
8254	Pre-Licensed Psychiatric Technician (Safety)	7.00	7.00	0.00	0.00	0.00	0%	0%
8252	Senior Psychiatric Technician (Safety)	76.00	68.00	8.00	0.00	8.00	11%	11%
	DSH-Coalinga SUB-TOTAL	**549.80**	**464.00**	**85.80**	**62.00**	**23.80**	**0%**	**4%**
	Department of State Hospitals - Metropolitan							
8236	Psychiatric Technician Assistant (Safety)	39.00	35.00	4.00	0.00	4.00	10%	10%
8238	Psychiatric Technician Trainee (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
8253	Psychiatric Technician (Safety)	233.00	221.00	12.00	0.00	12.00	5%	5%
8254	Pre-Licensed Psychiatric Technician (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
8252	Senior Psychiatric Technician (Safety)	38.00	31.00	7.00	0.00	7.00	18%	18%
	DSH-Metropolitan SUB-TOTAL	**310.00**	**287.00**	**23.00**	**0.00**	**23.00**	**7%**	**7%**
	Department of State Hospitals - Napa							
8236	Psychiatric Technician Assistant (Safety)	184.00	177.00	7.00	0.00	7.00	4%	4%
8238	Psychiatric Technician Trainee (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
8253	Psychiatric Technician (Safety)	352.00	303.00	49.00	0.00	49.00	14%	14%
8254	Pre-Licensed Psychiatric Technician (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
8252	Senior Psychiatric Technician (Safety)	72.00	63.00	9.00	0.00	9.00	13%	13%
	DSH-NapaSUB-TOTAL	**608.00**	**543.00**	**65.00**	**0.00**	**65.00**	**11%**	**11%**

DEPARTMENT OF STATE HOSPITALS
Coleman Related Clinical Positions
Monthly Staffing and Staffing Vacancies Report
as of January 1, 2013

DSH Psychiatric Technician Classifications								
Class Code	*COLEMAN* RELATED POSITION	Budgeted	Filled	Vacant	Contracted Full-Time Equivalents	Functional Vacancy	Vacancy Rate (Authorized Positions Vacant)	Functional Vacancy Rate (Contractor Offset to Vacancies)
	Department of State Hospitals - Patton							
8236	Psychiatric Technician Assistant (Safety)	34.00	30.00	4.00	0.00	4.00	12%	12%
8238	Psychiatric Technician Trainee (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
8253	Psychiatric Technician (Safety)	673.00	642.00	31.00	0.00	31.00	5%	5%
8254	Pre-Licensed Psychiatric Technician (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
8252	Senior Psychiatric Technician (Safety)	76.00	76.00	0.00	0.00	0.00	0%	0%
	DSH-Patton SUB-TOTAL	**783.00**	**748.00**	**35.00**	**0.00**	**35.00**	**4%**	**4%**
	Department of State Hospitals - Vacaville							
8236	Psychiatric Technician Assistant (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
8238	Psychiatric Technician Trainee (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
8253	Psychiatric Technician (Safety)	27.00	0.00	27.00	0.00	27.00	100%	100%
8254	Pre-Licensed Psychiatric Technician (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
8252	Senior Psychiatric Technician (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
	DSH-Vacaville SUB-TOTAL	**27.00**	**0.00**	**27.00**	**0.00**	**27.00**	**100%**	**100%**
	Department of State Hospitals - Salinas Valley							
8236	Psychiatric Technician Assistant (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
8238	Psychiatric Technician Trainee (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
8253	Psychiatric Technician (Safety)	20.00	5.00	15.00	0.00	15.00	75%	75%
8254	Pre-Licensed Psychiatric Technician (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
8252	Senior Psychiatric Technician (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
	DSH-Salinas Valley SUB-TOTAL	**20.00**	**5.00**	**15.00**	**0.00**	**15.00**	**75%**	**75%**
	Department of State Hospitals - Stockton							
8236	Psychiatric Technician Assistant (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
8238	Psychiatric Technician Trainee (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
8253	Psychiatric Technician (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
8254	Pre-Licensed Psychiatric Technician (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
8252	Senior Psychiatric Technician (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
	DSH-Salinas Valley SUB-TOTAL	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0%**	**0%**
	TOTAL VACANCY RATE	**3,011.80**	**2,675.00**	**336.80**	**62.00**	**274.80**	**11%**	**9%**

DEPARTMENT OF STATE HOSPITALS
Coleman Related Clinical Positions
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as of January 1, 2013

Department of State Hospitals - Atascadero								
Class Code	***Coleman* Related Classifications**	**Budgeted**	**Filled**	**Vacant**	**Contracted Full-Time Equivalents**	**Functional Vacancy**	**Vacancy Rate (Authorized Positions Vacant)**	**Functional Vacancy Rate (Contractor Offset to Vacancies)**
7594	Medical Director	1.00	1.00	0.00	0.00	0.00	0%	0%
8236	Psychiatric Technician Assistant (Safety)	3.00	2.00	1.00	0.00	1.00	33%	33%
8238	Psychiatric Technician Trainee (Safety)	26.50	26.00	0.50	0.00	0.50	2%	2%
8253	Psychiatric Technician (Safety)	600.50	525.00	75.50	0.00	75.50	13%	13%
8254	Pre-Licensed Psychiatric Technician (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
8252	Senior Psychiatric Technician (Safety)	84.00	75.00	9.00	0.00	9.00	11%	11%
9873	Psychologist, Health Facility (Clinical-Safety)	51.40	42.70	8.70	0.00	8.70	17%	17%
9839	Senior Psychologist, Health Facility (Specialist)	2.00	2.00	0.00	0.00	0.00	0%	0%
9831	Senior Psychologist, Health Facility (Supervisor)	9.00	9.00	0.00	0.00	0.00	0%	0%
7619	Staff Psychiatrist (Safety)	25.90	22.00	3.90	12.00	-8.10	15%	-31%
9758	Staff Psychiatrist, Correctional and Rehabilitative Services (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
7616	Senior Psychiatrist (Specialist)	2.00	2.00	0.00	0.00	0.00	0%	0%
9759	Senior Psychiatrist (Specialist), Correctional and Rehab Services (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
7609	Senior Psychiatrist (Supervisor)	7.00	2.00	5.00	0.00	5.00	71%	71%
9761	Senior Psychiatrist (Supervisor), Correctional and Rehab Services (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
9271	Senior Psychiatrist, Correctional Facility (Supervisor)	0.00	0.00	0.00	0.00	0.00	0%	0%
8321	Rehabilitation Therapist, State Facilities (Music-Safety)	13.00	13.00	0.00	0.00	0.00	0%	0%
8323	Rehabilitation Therapist, State Facilities (Occupational-Safety)	2.00	2.00	0.00	0.00	0.00	0%	0%
8324	Rehabilitation Therapist, State Facilities (Recreation-Safety)	33.70	31.00	2.70	0.00	2.70	8%	8%
8420	Rehabilitation Therapist, State Facilities (Art-Safety)	3.00	3.00	0.00	0.00	0.00	0%	0%
8422	Rehabilitation Therapist, State Facilities (Dance-Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
9872	Clinical Social Worker, Health/Correctional Facility (Safety)	43.70	41.00	2.70	0.00	2.70	6%	6%
8104	Unit Supervisor (Safety)	31.00	30.00	1.00	0.00	1.00	3%	3%
9859	Chief Psychologist	1.00	1.00	0.00	0.00	0.00	0%	0%
9867	Supervising Psychiatric Social Worker	3.00	2.00	1.00	0.00	1.00	33%	33%
	***COLEMAN* TOTAL**	**942.70**	**831.70**	**111.00**	**12.00**	**99.00**	**12%**	**11%**

DEPARTMENT OF STATE HOSPITALS
Coleman Related Clinical Positions
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Department of State Hospitals - Coalinga								
Class Code	***Coleman* Related Classifications**	**Budgeted**	**Filled**	**Vacant**	**Contracted Full-Time Equivalents**	**Functional Vacancy**	**Vacancy Rate (Authorized Positions Vacant)**	**Functional Vacancy Rate (Contractor Offset to Vacancies)**
9693	Medical Director	1.00	0.00	1.00	0.00	1.00	100%	100%
8236	Psychiatric Technician Assistant (Safety)	36.00	25.00	11.00	0.00	11.00	31%	31%
8238	Psychiatric Technician Trainee (Safety)	4.00	3.00	1.00	0.00	1.00	25%	25%
8253	Psychiatric Technician (Safety)	426.80	361.00	65.80	62.00	3.80	15%	1%
8254	Pre-Licensed Psychiatric Technician (Safety)	7.00	7.00	0.00	0.00	0.00	0%	0%
8252	Senior Psychiatric Technician (Safety)	76.00	68.00	8.00	0.00	8.00	11%	11%
9873	Psychologist, Health Facility (Clinical-Safety)	45.90	39.25	6.65	12.00	-5.35	14%	-12%
9839	Senior Psychologist, Health Facility (Specialist)	9.00	8.00	1.00	0.00	1.00	11%	11%
9831	Senior Psychologist, Health Facility (Supervisor)	6.20	6.00	0.20	0.00	0.20	3%	3%
7619	Staff Psychiatrist (Safety)	11.80	4.00	7.80	16.00	-8.20	66%	-69%
9758	Staff Psychiatrist, Correctional and Rehabilitative Services (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
7616	Senior Psychiatrist (Specialist)	0.60	0.00	0.60	0.00	0.60	100%	100%
9759	Senior Psychiatrist (Specialist), Correctional and Rehab Services (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
7609	Senior Psychiatrist (Supervisor)	7.10	4.00	3.10	0.00	3.10	44%	44%
9761	Senior Psychiatrist (Supervisor), Correctional and Rehab Services (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
9271	Senior Psychiatrist, Correctional Facility (Supervisor)	0.00	0.00	0.00	0.00	0.00	0%	0%
8321	Rehabilitation Therapist, State Facilities (Music-Safety)	12.00	10.00	2.00	0.00	2.00	17%	17%
8323	Rehabilitation Therapist, State Facilities (Occupational-Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
8324	Rehabilitation Therapist, State Facilities (Recreation-Safety)	14.20	12.00	2.20	0.00	2.20	15%	15%
8420	Rehabilitation Therapist, State Facilities (Art-Safety)	14.00	11.50	2.50	0.00	2.50	18%	18%
8422	Rehabilitation Therapist, State Facilities (Dance-Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
9872	Clinical Social Worker, Health/Correctional Facility (Safety)	42.90	37.00	5.90	3.00	2.90	14%	7%
8104	Unit Supervisor (Safety)	23.00	21.00	2.00	0.00	2.00	9%	9%
9859	Chief Psychologist	1.00	0.00	1.00	0.00	1.00	100%	100%
9867	Supervising Psychiatric Social Worker	4.00	4.00	0.00	0.00	0.00	0%	0%
	***COLEMAN* TOTAL**	**742.50**	**620.75**	**121.75**	**93.00**	**28.75**	**16%**	**4%**

DEPARTMENT OF STATE HOSPITALS
Coleman Related Clinical Positions
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Department of State Hospitals - Metropolitan								
Class Code	***Coleman* Related Classifications**	**Budgeted**	**Filled**	**Vacant**	**Contracted Full-Time Equivalents**	**Functional Vacancy**	**Vacancy Rate (Authorized Positions Vacant)**	**Functional Vacancy Rate (Contractor Offset to Vacancies)**
9690	Medical Director	1.00	1.00	0.00	0.00	0.00	0%	0%
8236	Psychiatric Technician Assistant (Safety)	39.00	35.00	4.00	0.00	4.00	10%	10%
8238	Psychiatric Technician Trainee (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
8253	Psychiatric Technician (Safety)	233.00	221.00	12.00	0.00	12.00	5%	5%
8254	Pre-Licensed Psychiatric Technician (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
8252	Senior Psychiatric Technician (Safety)	38.00	31.00	7.00	0.00	7.00	18%	18%
9873	Psychologist, Health Facility (Clinical-Safety)	20.00	19.00	1.00	0.00	1.00	5%	5%
9839	Senior Psychologist, Health Facility (Specialist)	0.00	0.00	0.00	0.00	0.00	0%	0%
9831	Senior Psychologist, Health Facility (Supervisor)	4.00	4.00	0.00	0.00	0.00	0%	0%
7619	Staff Psychiatrist (Safety)	30.00	30.00	0.00	0.00	0.00	0%	0%
9758	Staff Psychiatrist, Correctional and Rehabilitative Services (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
7616	Senior Psychiatrist (Specialist)	0.00	0.00	0.00	0.00	0.00	0%	0%
9759	Senior Psychiatrist (Specialist), Correctional and Rehab Services (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
7609	Senior Psychiatrist (Supervisor)	6.00	6.00	0.00	0.00	0.00	0%	0%
9761	Senior Psychiatrist (Supervisor), Correctional and Rehab Services (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
9271	Senior Psychiatrist, Correctional Facility (Supervisor)	0.00	0.00	0.00	0.00	0.00	0%	0%
8321	Rehabilitation Therapist, State Facilities (Music-Safety)	7.10	5.50	1.60	0.00	1.60	23%	23%
8323	Rehabilitation Therapist, State Facilities (Occupational-Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
8324	Rehabilitation Therapist, State Facilities (Recreation-Safety)	21.70	21.60	0.10	0.00	0.10	0%	0%
8420	Rehabilitation Therapist, State Facilities (Art-Safety)	4.00	4.00	0.00	0.00	0.00	0%	0%
8422	Rehabilitation Therapist, State Facilities (Dance-Safety)	1.00	1.00	0.00	0.00	0.00	0%	0%
9872	Clinical Social Worker, Health/Correctional Facility (Safety)	36.00	34.00	2.00	0.00	2.00	6%	6%
8104	Unit Supervisor (Safety)	13.00	13.00	0.00	0.00	0.00	0%	0%
9859	Chief Psychologist	1.00	0.00	1.00	0.00	1.00	100%	100%
9867	Supervising Psychiatric Social Worker	2.00	2.00	0.00	0.00	0.00	0%	0%
	***COLEMAN* TOTAL**	**456.80**	**428.10**	**28.70**	**0.00**	**28.70**	**6%**	**6%**

DEPARTMENT OF STATE HOSPITALS
Coleman Related Clinical Positions
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	Department of State Hospitals - Napa							
Class Code	***Coleman* Related Classifications**	**Budgeted**	**Filled**	**Vacant**	**Contracted Full-Time Equivalents**	**Functional Vacancy**	**Vacancy Rate (Authorized Positions Vacant)**	**Functional Vacancy Rate (Contractor Offset to Vacancies)**
7594	Medical Director	0.00	0.00	0.00	0.00	0.00	0%	0%
8236	Psychiatric Technician Assistant (Safety)	184.00	177.00	7.00	0.00	7.00	4%	4%
8238	Psychiatric Technician Trainee (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
8253	Psychiatric Technician (Safety)	352.00	303.00	49.00	0.00	49.00	14%	14%
8254	Pre-Licensed Psychiatric Technician (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
8252	Senior Psychiatric Technician (Safety)	72.00	63.00	9.00	0.00	9.00	13%	13%
9873	Psychologist, Health Facility (Clinical-Safety)	46.80	45.80	1.00	0.00	1.00	2%	2%
9839	Senior Psychologist, Health Facility (Specialist)	8.50	8.50	0.00	0.00	0.00	0%	0%
9831	Senior Psychologist, Correctional Facility (Supervisor)	6.00	6.00	0.00	0.00	0.00	0%	0%
7619	Staff Psychiatrist (Safety)	49.80	47.80	2.00	0.00	2.00	4%	4%
9758	Staff Psychiatrist, Correctional and Rehabilitative Services (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
7616	Senior Psychiatrist (Specialist)	1.00	1.00	0.00	0.00	0.00	0%	0%
9759	Senior Psychiatrist (Specialist), Correctional and Rehab Services (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
7609	Senior Psychiatrist (Supervisor)	7.00	7.00	0.00	0.00	0.00	0%	0%
9761	Senior Psychiatrist (Supervisor), Correctional and Rehab Services (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
9271	Senior Psychiatrist, Correctional Facility (Supervisor)	0.00	0.00	0.00	0.00	0.00	0%	0%
8321	Rehabilitation Therapist, State Facilities (Music-Safety)	10.80	9.00	1.80	0.00	1.80	17%	17%
8323	Rehabilitation Therapist, State Facilities (Occupational-Safety)	3.20	2.00	1.20	0.00	1.20	38%	38%
8324	Rehabilitation Therapist, State Facilities (Recreation-Safety)	20.90	16.00	4.90	0.00	4.90	23%	23%
8420	Rehabilitation Therapist, State Facilities (Art-Safety)	13.00	13.00	0.00	0.00	0.00	0%	0%
8422	Rehabilitation Therapist, State Facilities (Dance-Safety)	3.00	3.00	0.00	0.00	0.00	0%	0%
9872	Clinical Social Worker, Health/Correctional Facility (Safety)	46.60	42.75	3.85	0.00	3.85	8%	8%
8104	Unit Supervisor (Safety)	39.00	35.00	4.00	0.00	4.00	10%	10%
9859	Chief Psychologist	1.00	0.00	1.00	0.00	1.00	100%	100%
9867	Supervising Psychiatric Social Worker	5.00	4.00	1.00	0.00	1.00	20%	20%
	***COLEMAN* TOTAL**	**869.60**	**783.85**	**85.75**	**0.00**	**85.75**	**10%**	**10%**

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	Department of State Hospitals - Patton							
Class Code	***Coleman* Related Classifications**	**Budgeted**	**Filled**	**Vacant**	**Contracted Full-Time Equivalents**	**Functional Vacancy**	**Vacancy Rate (Authorized Positions Vacant)**	**Functional Vacancy Rate (Contractor Offset to Vacancies)**
9660	Medical Director	1.00	1.00	0.00	0.00	0.00	0%	0%
8236	Psychiatric Technician Assistant (Safety)	34.00	30.00	4.00	0.00	4.00	12%	12%
8238	Psychiatric Technician Trainee (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
8253	Psychiatric Technician (Safety)	673.00	642.00	31.00	0.00	31.00	5%	5%
8254	Pre-Licensed Psychiatric Technician (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
8252	Senior Psychiatric Technician (Safety)	76.00	76.00	0.00	0.00	0.00	0%	0%
9873	Psychologist, Health Facility (Clinical-Safety)	64.50	62.50	2.00	0.00	2.00	3%	3%
9839	Senior Psychologist, Health Facility (Specialist)	5.50	5.50	0.00	0.00	0.00	0%	0%
9831	Senior Psychologist, Correctional Facility (Supervisor)	13.00	12.40	0.60	0.00	0.60	5%	5%
7619	Staff Psychiatrist (Safety)	70.50	69.50	1.00	0.00	1.00	1%	1%
9758	Staff Psychiatrist, Correctional and Rehabilitative Services (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
7616	Senior Psychiatrist (Specialist)	0.00	0.00	0.00	0.00	0.00	0%	0%
9759	Senior Psychiatrist (Specialist), Correctional and Rehab Services (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
7609	Senior Psychiatrist (Supervisor)	8.00	8.00	0.00	0.00	0.00	0%	0%
9761	Senior Psychiatrist (Supervisor), Correctional and Rehab Services (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
9271	Senior Psychiatrist, Correctional Facility (Supervisor)	0.00	0.00	0.00	0.00	0.00	0%	0%
8321	Rehabilitation Therapist, State Facilities (Music-Safety)	21.10	20.00	1.10	0.00	1.10	5%	5%
8323	Rehabilitation Therapist, State Facilities (Occupational-Safety)	5.00	5.00	0.00	0.00	0.00	0%	0%
8324	Rehabilitation Therapist, State Facilities (Recreation-Safety)	33.00	32.75	0.25	0.00	0.25	1%	1%
8420	Rehabilitation Therapist, State Facilities (Art-Safety)	9.00	9.00	0.00	0.00	0.00	0%	0%
8422	Rehabilitation Therapist, State Facilities (Dance-Safety)	2.00	2.00	0.00	0.00	0.00	0%	0%
9872	Clinical Social Worker, Health/Correctional Facility (Safety)	71.00	71.00	0.00	0.00	0.00	0%	0%
8104	Unit Supervisor (Safety)	33.00	33.00	0.00	0.00	0.00	0%	0%
9859	Chief Psychologist	1.00	1.00	0.00	0.00	0.00	0%	0%
9867	Supervising Psychiatric Social Worker	4.00	4.00	0.00	0.00	0.00	0%	0%
	***COLEMAN* TOTAL**	**1124.60**	**1084.65**	**39.95**	**0.00**	**39.95**	**4%**	**4%**

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Department of State Hospitals - Salinas Valley								
Class Code	***Coleman* Related Classifications**	**Budgeted**	**Filled**	**Vacant**	**Contracted Full-Time Equivalents**	**Functional Vacancy**	**Vacancy Rate (Authorized Positions Vacant)**	**Functional Vacancy Rate (Contractor Offset to Vacancies)**
7594	Medical Director	1.00	0.00	1.00	0.00	1.00	100%	100%
8236	Psychiatric Technician Assistant (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
8238	Psychiatric Technician Trainee (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
8253	Psychiatric Technician (Safety)	20.00	5.00	15.00	0.00	15.00	75%	75%
8254	Pre-Licensed Psychiatric Technician (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
8252	Senior Psychiatric Technician (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
9873	Psychologist, Health Facility (Clinical-Safety)	12.00	11.00	1.00	0.00	1.00	8%	8%
9839	Senior Psychologist, Health Facility (Specialist)	0.00	0.00	0.00	0.00	0.00	0%	0%
9831	Senior Psychologist, Health Facility (Supervisor)	2.00	1.00	1.00	0.00	1.00	50%	50%
7619	Staff Psychiatrist (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
9758	Staff Psychiatrist, Correctional and Rehabilitative Services (Safety)	5.00	3.00	2.00	3.00	-1.00	40%	-20%
7616	Senior Psychiatrist (Specialist)	0.00	0.00	0.00	0.00	0.00	0%	0%
9759	Senior Psychiatrist (Specialist), Correctional and Rehab Services (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
7609	Senior Psychiatrist (Supervisor)	0.00	0.00	0.00	0.00	0.00	0%	0%
9761	Senior Psychiatrist (Supervisor), Correctional and Rehab Services (Safety)	2.00	1.00	1.00	0.00	1.00	50%	50%
9271	Senior Psychiatrist, Correctional Facility (Supervisor)	0.00	0.00	0.00	0.00	0.00	0%	0%
8321	Rehabilitation Therapist, State Facilities (Music-Safety)	3.00	2.00	1.00	0.00	1.00	33%	33%
8323	Rehabilitation Therapist, State Facilities (Occupational-Safety)	1.00	1.00	0.00	0.00	0.00	0%	0%
8324	Rehabilitation Therapist, State Facilities (Recreation-Safety)	13.00	11.00	2.00	0.00	2.00	15%	15%
8420	Rehabilitation Therapist, State Facilities (Art-Safety)	6.00	4.00	2.00	0.00	2.00	33%	33%
8422	Rehabilitation Therapist, State Facilities (Dance-Safety)	1.00	1.00	0.00	0.00	0.00	0%	0%
9872	Clinical Social Worker, Health/Correctional Facility (Safety)	23.00	14.00	9.00	0.00	9.00	39%	39%
8104	Unit Supervisor (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
9859	Chief Psychologist	0.00	0.00	0.00	0.00	0.00	0%	0%
9867	Supervising Psychiatric Social Worker	1.00	1.00	0.00	0.00	0.00	0%	0%
	***COLEMAN* TOTAL**	**90.00**	**55.00**	**35.00**	**3.00**	**32.00**	**39%**	**36%**

DEPARTMENT OF STATE HOSPITALS
Coleman Related Clinical Positions
Monthly Staffing and Staffing Vacancies Report
as of January 1, 2013

	Department of State Hospitals - Stockton							
Class Code	*Coleman* Related Classifications	Budgeted	Filled	Vacant	Contracted Full-Time Equivalents	Functional Vacancy	Vacancy Rate (Authorized Positions Vacant)	Functional Vacancy Rate (Contractor Offset to Vacancies)
7594	Medical Director	0.00	0.00	0.00	0.00	0.00	0%	0%
8236	Psychiatric Technician Assistant (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
8238	Psychiatric Technician Trainee (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
8253	Psychiatric Technician (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
8254	Pre-Licensed Psychiatric Technician (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
8252	Senior Psychiatric Technician (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
9873	Psychologist, Health Facility (Clinical-Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
9839	Senior Psychologist, Health Facility (Specialist)	0.00	0.00	0.00	0.00	0.00	0%	0%
9831	Senior Psychologist, Health Facility (Supervisor)	0.00	0.00	0.00	0.00	0.00	0%	0%
7619	Staff Psychiatrist (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
9758	Staff Psychiatrist, Correctional and Rehabilitative Services (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
7616	Senior Psychiatrist (Specialist)	0.00	0.00	0.00	0.00	0.00	0%	0%
9759	Senior Psychiatrist (Specialist), Correctional and Rehab Services (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
7609	Senior Psychiatrist (Supervisor)	0.00	0.00	0.00	0.00	0.00	0%	0%
9761	Senior Psychiatrist (Supervisor), Correctional and Rehab Services (Safety)	1.00	1.00	0.00	0.00	0.00	0%	0%
9271	Senior Psychiatrist, Correctional Facility (Supervisor)	0.00	0.00	0.00	0.00	0.00	0%	0%
8321	Rehabilitation Therapist, State Facilities (Music-Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
8323	Rehabilitation Therapist, State Facilities (Occupational-Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
8324	Rehabilitation Therapist, State Facilities (Recreation-Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
8420	Rehabilitation Therapist, State Facilities (Art-Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
8422	Rehabilitation Therapist, State Facilities (Dance-Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
9872	Clinical Social Worker, Health/Correctional Facility (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
8104	Unit Supervisor (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
9859	Chief Psychologist	1.00	1.00	0.00	0.00	0.00	0%	0%
9867	Supervising Psychiatric Social Worker	0.00	0.00	0.00	0.00	0.00	0%	0%
	***COLEMAN* TOTAL**	**2.00**	**2.00**	**0.00**	**0.00**	**0.00**	**0%**	**0%**

DEPARTMENT OF STATE HOSPITALS
Coleman Related Clinical Positions
Monthly Staffing and Staffing Vacancies Report
as of January 1, 2013

	Department of State Hospitals - Vacaville							
Class Code	*Coleman* Related Classifications	Budgeted	Filled	Vacant	Contracted Full-Time Equivalents	Functional Vacancy	Vacancy Rate (Authorized Positions Vacant)	Functional Vacancy Rate (Contractor Offset to Vacancies)
7594	Medical Director	1.00	0.00	1.00	0.00	1.00	100%	100%
8236	Psychiatric Technician Assistant (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
8238	Psychiatric Technician Trainee (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
8253	Psychiatric Technician (Safety)	27.00	0.00	27.00	0.00	27.00	100%	100%
8254	Pre-Licensed Psychiatric Technician (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
8252	Senior Psychiatric Technician (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
9873	Psychologist, Health Facility (Clinical-Safety)	23.00	19.00	4.00	0.00	4.00	17%	17%
9839	Senior Psychologist, Health Facility (Specialist)	4.00	4.00	0.00	0.00	0.00	0%	0%
9831	Senior Psychologist, Health Facility (Supervisor)	1.00	1.00	0.00	0.00	0.00	0%	0%
7619	Staff Psychiatrist (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
9758	Staff Psychiatrist, Correctional and Rehabilitative Services (Safety)	27.50	19.50	8.00	5.00	3.00	29%	11%
7616	Senior Psychiatrist (Specialist)	0.00	0.00	0.00	0.00	0.00	0%	0%
9759	Senior Psychiatrist (Specialist), Correctional and Rehab Services (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
7609	Senior Psychiatrist (Supervisor)	0.00	0.00	0.00	0.00	0.00	0%	0%
9761	Senior Psychiatrist (Supervisor), Correctional and Rehab Services (Safety)	2.00	1.00	1.00	0.00	1.00	50%	50%
9271	Senior Psychiatrist, Correctional Facility (Supervisor)	0.00	0.00	0.00	0.00	0.00	0%	0%
8321	Rehabilitation Therapist, State Facilities (Music-Safety)	8.00	8.00	0.00	0.00	0.00	0%	0%
8323	Rehabilitation Therapist, State Facilities (Occupational-Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
8324	Rehabilitation Therapist, State Facilities (Recreation-Safety)	20.50	10.50	10.00	0.00	10.00	49%	49%
8420	Rehabilitation Therapist, State Facilities (Art-Safety)	3.00	3.00	0.00	0.00	0.00	0%	0%
8422	Rehabilitation Therapist, State Facilities (Dance-Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
9872	Clinical Social Worker, Health/Correctional Facility (Safety)	31.20	24.00	7.20	0.00	7.20	23%	23%
8104	Unit Supervisor (Safety)	0.00	0.00	0.00	0.00	0.00	0%	0%
9859	Chief Psychologist	0.00	0.00	0.00	0.00	0.00	0%	0%
9867	Supervising Psychiatric Social Worker	1.00	0.00	1.00	0.00	1.00	100%	100%
	***COLEMAN* TOTAL**	**149.20**	**90.00**	**59.20**	**5.00**	**54.20**	**40%**	**36%**

Exhibit 32

DIVISION OF CORRECTIONAL HEALTH CARE SERVICES
STATEWIDE MENTAL HEALTH PROGRAM
P.O. Box 942883
Sacramento, CA94283-0001

March 1, 2013

Matthew A. Lopes, Jr. Esquire
Office of the Special Master
Pannone Lopes & Devereaux LLC
317 Iron Horse Point Way, Suite 301
Providence, RI 02908

via: Debbie J. Vorous, Esquire
Deputy Attorney General
Department of Justice
1300 "I" Street, Suite 125
P. O. Box 944255
Sacramento, CA 94244-2550

RE: COLEMAN MONTHLY REPORT OF INFORMATION REQUESTED AND RESPONSE TO JANUARY 19, 1999, COURT ORDER REGARDING STAFF VACANCIES

Dear Mr. Lopes:

Enclosed is the Coleman Monthly Report reflective of January, 2013 data (or as otherwise noted). The following is the list of enclosures:

1. Mental Health Services Delivery System (MHSDS) Staffing Allocation and Vacancy History.
2. MHSDS Hiring Activity Report.
3. Health Care Placement Oversight Program (HCPOP) Information Report, Summary and Administrative Segregation Greater than 60 Days.
4. Mental Health Contract Services including Summary and Telemedicine Monthly Report for all disciplines.
5. California Department of Corrections and Rehabilitation (CDCR) Reception Center (RC) Monthly Report.
6. Monthly Summary of Mental Health Crisis Bed use by Institution Titles Inpatient Psychiatric Aging Report.
7. Referrals for Transfer to the Department of State Hospitals (DSH) (including admissions).
8. Atascadero State Hospital (ASH) Discharges.
9. Weekly Enhanced Outpatient Program (EOP)/Outpatient Psychiatric Program.
10. The Department of State Hospitals (DSH) Monthly Report of CDCR Patients in DSH Hospitals -- Summary and Penal Code 2684.
11. Suicide Report.
12. Statistics on Contracted Registered Nurse (RN). **(No Longer Available)**
13. RC Processing for MHSDS Inmate Patients.
14. Medical Technical Assistant (MTA) Vacancy Report. **(No Longer Available)**

16. EOP Inmates Waiting Transfer to a Psychiatric Services Unit (PSU).
17. Audit reports on Psychiatric Technician Rounds in Administrative Segregation at California State Prison, San Quentin (SQ), California State Prison-Corcoran (COR), and Salinas Valley State Prison (SVSP).
18. Mental Health Crisis Beds Wait List.
19. Correctional Treatment Centers and CDCR General Acute Care Hospital Care Placement Issues. **(No longer available)**
20. Transferred and Rescinded Mental Health Crisis Bed Referrals by Institution and Level of Care.

If you have any questions, please contact me at (916) 691-0296.

Sincerely,

TIMOTHY G. BELAVICH, Ph.D., MSHCA, CCHP
Deputy Director (A)
Statewide Mental Health Program
Division of Correctional Health Care Services

Enclosures

cc: Diana Toche, DDS, Director (A), Division of Correctional Health Care Services (DCHCS)
Mohamedu F., Jones, Esq., *Coleman* Deputy Special Master
Linda Holden, Esq., *Coleman* Deputy Special Master
Jeffrey L. Metzner, M.D., *Coleman* Expert
Kerry C. Hughes, M.D., *Coleman* Expert
Raymond F. Patterson, M.D, *Coleman* Expert
Paul Nicoll, MPA, *Coleman* Monitor
Mary Perrien, Ph.D., *Coleman* Expert
Kathryn A. Burns, M.D., MPH, *Coleman* Expert
Henry A. Dlugacz, Esq., *Coleman* Expert
Kerry F. Walsh, Esq., *Coleman* Monitor
Patricia Williams, Esq., *Coleman* Monitor
Haunani Henry, *Coleman* Monitor
Debbie Vorous, Esq., Office of the Attorney General
Heather McCray Esq., Office of Legal Affairs, CDCR
Michael Stone, Esq., Office of Legal Affairs, CDCR
Michael Bien, Esq., Rosen, Bien and Galvan

Donald Specter, Esq., Prison Law Office
Judy Burleson, Associate Director, Statewide Mental Health Program, DCHCS
Nathan Stanley, Chief, Operational Program Oversight, Statewide Mental Health Program DCHCS
Teresa Owens, Associate Governmental Program Analyst, Operational Program Oversight, DCHCS

Correctional Health Care Services
Mental Health Institution Vacancies

SUMMARY BY INSTITUTION BY CLASSIFICATION
As Of January - 2013

ASP		FY 12/13	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
CHIEF PSYCHOLOGIST/CF	9859	2.00	2.00	1.00	1.00	0.00	0.00	0.00	0.00	1.00	50.00%
CLINICAL SOCIAL WORKER (HEALTH/CF)-SAFETY	9872	10.50	10.50	1.00	9.50	0.00	0.00	1.44	0.00	8.06	76.76%
CORRECTIONAL HEALTH SERVICES ADMINSTRATOR II, CORRECTIONAL FACILITY	4912	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
HEALTH PROGRAM SP I	8338	2.50	2.50	2.00	0.50	0.00	0.00	0.00	0.00	0.50	20.00%
OFFICE SERVICES SUP II (G)	1150	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
OFFICE TECH (T)	1139	8.50	8.50	8.00	0.50	0.00	0.00	0.00	0.00	0.50	5.88%
PSYCH-CLINIC CF	9283	9.50	11.00	8.00	3.00	0.00	0.00	6.34	0.00	-4.84	-50.95%
REC THERAPIST CF	9286	2.00	1.15	1.00	0.15	0.00	0.00	0.00	0.00	1.00	50.00%
SENIOR PSYCHIATRIST (SUPERVISOR), CORRECTIONAL AND REHABILITATIVE	9761	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
SR PSYCH CF/SP	9287	2.00	2.00	1.00	1.00	0.00	0.00	0.00	0.00	1.00	50.00%
SR PSYCH CF/SUP	9288	1.50	1.50	1.00	0.50	0.00	0.00	0.00	0.00	0.50	33.33%
STAFF PSYCHIATRIST, CORRECTIONAL AND REHABILITATIVE SERVICES (SAFETY)	9758	4.00	6.00	0.00	6.00	0.00	0.00	4.84	0.00	-0.84	-21.00%
SUP PSYCH S WK I CF	9291	0.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	NC
	Totals	**45.50**	**49.15**	**25.00**	**24.15**	**0.00**	**0.00**	**12.62**	**0.00**	**7.88**	**17.32%**

Source: FY 12/13 7A; SCO Reports; MIRS reports; Hire Tracking System
Report Generated By:
Program Support

SUMMARY BY INSTITUTION BY CLASSIFICATION
As Of January - 2013

CAL		FY 12/13	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
CHIEF PSYCHOLOGIST/CF	9859	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
CLINICAL SOCIAL WORKER (HEALTH/CF)-SAFETY	9872	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
HEALTH PROGRAM SP I	8338	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
OFFICE TECH (T)	1139	3.50	3.50	3.00	0.50	0.00	0.00	0.00	0.00	0.50	14.29%
PSYCH-CLINIC CF	9283	6.00	6.00	5.00	1.00	0.00	0.00	0.00	0.00	1.00	16.67%
STAFF PSYCHIATRIST, CORRECTIONAL AND REHABILITATIVE SERVICES (SAFETY)	9758	0.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	NC
	Totals	**12.50**	**13.50**	**10.00**	**3.50**	**0.00**	**0.00**	**0.00**	**0.00**	**2.50**	**20.00%**

CCC		FY 12/13	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
CHIEF PSYCHOLOGIST/CF	9859	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
CLINICAL SOCIAL WORKER (HEALTH/CF)-SAFETY	9872	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
HEALTH PROGRAM SP I	8338	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
OFFICE TECH (T)	1139	3.00	3.00	0.00	3.00	0.00	0.00	0.00	0.00	3.00	100.00%
PSYCH-CLINIC CF	9283	4.00	4.00	0.00	4.00	0.00	0.00	0.00	0.00	4.00	100.00%
STAFF PSYCHIATRIST, CORRECTIONAL AND REHABILITATIVE SERVICES (SAFETY)	9758	0.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	NC
	Totals	**10.00**	**11.00**	**1.00**	**10.00**	**0.00**	**0.00**	**0.00**	**0.00**	**9.00**	**90.00%**

SUMMARY BY INSTITUTION BY CLASSIFICATION
As Of January - 2013

CCI		FY 12/13	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
CHIEF PSYCHOLOGIST/CF	9859	2.00	2.00	1.00	1.00	0.00	0.00	0.00	0.00	1.00	50.00%
CLINICAL SOCIAL WORKER (HEALTH/CF)-SAFETY	9872	12.00	12.00	4.00	8.00	0.00	0.00	0.00	0.00	8.00	66.67%
CORRECTIONAL HEALTH SERVICES ADMINSTRATOR II, CORRECTIONAL FACILITY	4912	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
HEALTH PROGRAM SP I	8338	2.00	2.50	0.00	2.50	0.00	0.00	0.00	0.00	2.00	100.00%
HEALTH REC T II SUP	1887	0.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	-1.00	NC
OFFICE SERVICES SUP II (G)	1150	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
OFFICE TECH (T)	1139	9.00	9.00	7.50	1.50	0.00	0.00	0.00	0.00	1.50	16.67%
PSYCH-CLINIC CF	9283	13.50	14.50	14.00	0.50	0.00	0.00	3.14	0.00	-3.64	-26.96%
REC THERAPIST CF	9286	3.00	3.00	1.00	2.00	0.00	0.00	0.00	0.00	2.00	66.67%
SENIOR PSYCHIATRIST (SUPERVISOR), CORRECTIONAL AND REHABILITATIVE	9761	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
SR PSYCH CF/SP	9287	2.00	2.00	1.00	1.00	0.00	0.00	0.00	0.00	1.00	50.00%
SR PSYCH CF/SUP	9288	2.00	2.00	2.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
STAFF PSYCHIATRIST, CORRECTIONAL AND REHABILITATIVE SERVICES (SAFETY)	9758	6.50	6.50	3.00	3.50	0.00	0.00	1.62	0.00	1.88	28.92%
SUP PSYCH S WK I CF	9291	1.00	0.50	1.00	-0.50	0.00	0.00	0.00	0.00	0.00	0.00%
	Totals	**56.00**	**58.00**	**35.50**	**22.50**	**0.00**	**0.00**	**4.76**	**0.00**	**15.74**	**28.11%**

Correctional Health Care Services
Mental Health Institution Vacancies

SUMMARY BY INSTITUTION BY CLASSIFICATION
As Of January - 2013

CCWF		FY 12/13	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
CHIEF PSYCHOLOGIST/CF	9859	2.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	1.00	50.00%
CLINICAL SOCIAL WORKER (HEALTH/CF)-SAFETY	9872	11.00	8.00	8.00	0.00	0.00	0.00	0.00	0.00	3.00	27.27%
CORRECTIONAL HEALTH SERVICES ADMINSTRATOR II, CORRECTIONAL FACILITY	4912	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.00	100.00%
HEALTH PROGRAM SP I	8338	2.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	1.00	50.00%
MEDICAL SECRETARY/CI	9551	0.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	NC
OFFICE ASST (T)	1379	0.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	NC
OFFICE SERVICES SUP I (T)	1148	0.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	NC
OFFICE SERVICES SUP II (G)	1150	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
OFFICE TECH (T)	1139	11.50	8.50	7.00	1.50	0.00	0.00	0.00	0.00	4.50	39.13%
PSYCH-CLINIC CF	9283	21.00	19.61	17.00	2.61	0.00	0.00	0.00	0.00	4.00	19.05%
REC THERAPIST CF	9286	4.00	4.00	4.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
SENIOR PSYCHIATRIST (SUPERVISOR), CORRECTIONAL AND REHABILITATIVE	9761	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
SR PSYCH CF/SP	9287	2.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.00	100.00%
SR PSYCH CF/SUP	9288	2.00	3.50	1.00	2.50	0.00	0.00	0.00	0.00	1.00	50.00%
STAFF PSYCHIATRIST, CORRECTIONAL AND REHABILITATIVE SERVICES (SAFETY)	9758	8.50	8.50	6.50	2.00	0.00	0.00	0.00	0.00	2.00	23.53%
SUP PSYCH S WK I CF	9291	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
	Totals	**68.00**	**60.11**	**47.50**	**12.61**	**0.00**	**0.00**	**0.00**	**0.00**	**20.50**	**30.15%**

SUMMARY BY INSTITUTION BY CLASSIFICATION
As Of January - 2013

CEN		FY 12/13	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
ASSOC GOVRL PROGRAM ANALYST	5393	0.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	-1.00	NC
CHIEF PSYCHOLOGIST/CF	9859	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
CLINICAL SOCIAL WORKER (HEALTH/CF)-SAFETY	9872	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
HEALTH PROGRAM SP I	8338	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.00	100.00%
OFFICE TECH (T)	1139	3.50	3.50	1.50	2.00	0.00	0.00	0.00	0.00	2.00	57.14%
PSYCH-CLINIC CF	9283	5.00	5.00	4.00	1.00	0.00	0.00	0.00	0.00	1.00	20.00%
STAFF PSYCHIATRIST, CORRECTIONAL AND REHABILITATIVE SERVICES (SAFETY)	9758	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
	Totals	**12.50**	**12.50**	**9.50**	**3.00**	**0.00**	**0.00**	**0.00**	**0.00**	**3.00**	**24.00%**

CHCF		FY 12/13	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
CHIEF PSYCHIATRIST, CORRECTIONAL AND REHABILITITATIVE SERVICES (SAFETY)	9774	0.00	2.00	1.00	1.00	0.00	0.00	0.00	0.00	-1.00	NC
CHIEF PSYCHOLOGIST/CF	9859	0.00	0.00	0.00	0.00	1.00	0.00	0.00	0.00	-1.00	NC
OFFICE TECH (T)	1139	0.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	-1.00	NC
SR PSYCH CF/SUP	9288	0.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	-1.00	NC
	Totals	**0.00**	**4.00**	**3.00**	**1.00**	**1.00**	**0.00**	**0.00**	**0.00**	**-4.00**	**-Infinity**

SUMMARY BY INSTITUTION BY CLASSIFICATION
As Of January - 2013

CIM		FY 12/13	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
ASSOC HEALTH PROGRAM ADV	8337	0.00	0.00	0.00	0.00	0.18	0.00	0.00	0.00	-0.18	NC
CHIEF PSYCHIATRIST, CORRECTIONAL AND REHABILITITATIVE SERVICES (SAFETY)	9774	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
CHIEF PSYCHOLOGIST/CF	9859	2.00	2.00	1.00	1.00	0.00	0.00	0.00	0.00	1.00	50.00%
CLINICAL SOCIAL WORKER (HEALTH/CF)-SAFETY	9872	12.50	13.60	12.00	1.60	0.00	0.00	0.00	0.00	0.50	4.00%
CORRECTIONAL HEALTH SERVICES ADMINSTRATOR II, CORRECTIONAL FACILITY	4912	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
HEALTH PROGRAM SP I	8338	2.50	2.50	1.00	1.50	0.00	0.00	0.00	0.00	1.50	60.00%
OFFICE ASST (T)	1379	0.00	0.00	0.00	0.00	1.00	0.00	0.00	0.00	-1.00	NC
OFFICE SERVICES SUP II (G)	1150	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
OFFICE TECH (T)	1139	16.00	17.00	11.00	6.00	0.00	0.00	0.00	0.00	5.00	31.25%
PSYCH-CLINIC CF	9283	29.50	29.50	23.50	6.00	0.00	0.00	0.00	0.00	6.00	20.34%
REC THERAPIST CF	9286	6.00	6.00	4.00	2.00	0.00	0.00	0.00	0.00	2.00	33.33%
SENIOR PSYCHIATRIST (SUPERVISOR), CORRECTIONAL AND REHABILITATIVE	9761	0.50	0.50	0.00	0.50	0.00	0.00	0.00	0.00	0.50	100.00%
SR PSYCH CF/SP	9287	2.00	2.50	2.00	0.50	0.00	0.00	0.00	0.00	0.00	0.00%
SR PSYCH CF/SUP	9288	3.00	3.00	3.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
STAFF PSYCHIATRIST, CORRECTIONAL AND REHABILITATIVE SERVICES (SAFETY)	9758	12.50	15.00	10.00	5.00	0.00	0.00	0.00	0.00	2.50	20.00%
SUP PSYCH S WK I CF	9291	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
	Totals	**90.50**	**95.60**	**70.50**	**25.10**	**1.18**	**0.00**	**0.00**	**0.00**	**18.82**	**20.79%**

CIW		FY 12/13	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
ADMINISTRATIVE ASSISTANT I	5361	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%

Source: FY 12/13 7A; SCO Reports; MIRS reports; Hire Tracking System
Report Generated By:
Program Support

SUMMARY BY INSTITUTION BY CLASSIFICATION
As Of January - 2013

CIW		FY 12/13	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
ASSOC INFORMATION SYS ANALYST/SP	1470	0.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	-1.00	NC
BLDG MAINT WRKR CF	6216	0.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	-1.00	NC
C.E.A. (CIVIL SERVICE)	7500	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
CHIEF PSYCHIATRIST, CORRECTIONAL AND REHABILITITATIVE SERVICES (SAFETY)	9774	0.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	NC
CHIEF PSYCHOLOGIST/CF	9859	2.00	2.00	1.00	1.00	0.00	0.00	0.00	0.00	1.00	50.00%
CLINICAL SOCIAL WORKER (HEALTH/CF)-SAFETY	9872	11.00	10.00	8.00	2.00	0.00	0.00	0.00	0.00	3.00	27.27%
CORRECTIONAL HEALTH SERVICES ADMINSTRATOR II, CORRECTIONAL FACILITY	4912	2.00	2.00	1.00	1.00	0.00	0.00	0.00	0.00	1.00	50.00%
CORRECTIONAL SUPERVISING COOK, CF	2183	0.00	3.20	3.00	0.20	0.00	0.00	0.00	0.00	-3.00	NC
FOOD ADMIN I CORR F	2153	0.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	-1.00	NC
HEALTH PROGRAM SP I	8338	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
HEALTH REC TECH I	1869	0.00	4.00	3.00	1.00	0.00	0.00	0.00	0.00	-3.00	NC
JANITOR CORR FAC	2006	0.00	7.00	6.00	1.00	0.00	0.00	0.00	0.00	-6.00	NC
JANITOR SUP II CF	2004	0.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	-1.00	NC
MATERIAL & STORES SUP I CF	1508	0.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	-1.00	NC
OFFICE SERVICES SUP II (G)	1150	1.00	0.50	0.00	0.50	0.00	0.00	0.00	0.00	1.00	100.00%
OFFICE TECH (G)	1138	2.00	2.00	0.00	2.00	0.00	0.00	0.00	0.00	2.00	100.00%
OFFICE TECH (T)	1139	8.00	7.00	7.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00%
PHARMACY TECH	7979	0.00	2.00	2.00	0.00	0.00	0.00	0.00	0.00	-2.00	NC
PROGRAM ASST (MENTAL DISABILITIES-SAFETY)	8102	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
PROGRAM DIRECTOR (MENTAL DISABILITIES-SAFETY)	8103	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
PSYCH-CLINIC CF	9283	16.50	14.50	14.50	0.00	1.00	0.00	0.00	0.00	1.00	6.06%
REC THERAPIST CF	9286	7.50	7.50	7.00	0.50	0.00	0.00	0.00	0.00	0.50	6.67%

Source: FY 12/13 7A; SCO Reports; MIRS reports; Hire Tracking System
Report Generated By:
Program Support

SUMMARY BY INSTITUTION BY CLASSIFICATION
As Of January - 2013

CIW		FY 12/13	SCO DATA					ADJUSTMENTS			
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
SENIOR PSYCHIATRIST (SUPERVISOR), CORRECTIONAL AND REHABILITATIVE	9761	2.00	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00%
SR PSYCH CF/SP	9287	2.50	2.50	2.00	0.50	0.00	0.00	0.00	0.00	0.50	20.00%
SR PSYCH CF/SUP	9288	1.50	1.50	2.00	-0.50	0.00	0.00	0.00	0.00	-0.50	-33.33%
STAFF PSYCHIATRIST, CORRECTIONAL AND REHABILITATIVE SERVICES (SAFETY)	9758	7.50	7.50	3.00	4.50	0.00	0.00	0.14	0.00	4.36	58.13%
SUP PSYCH S WK I CF	9291	1.00	0.50	1.00	-0.50	0.00	0.00	0.00	0.00	0.00	0.00%
TRAINING OFFICER I	5197	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
	Totals	**70.50**	**86.70**	**72.50**	**14.20**	**3.00**	**0.00**	**0.14**	**0.00**	**-5.14**	**-7.29%**

CMC		FY 12/13	SCO DATA					ADJUSTMENTS			
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
ASSOC GOVRL PROGRAM ANALYST	5393	2.00	2.00	1.00	1.00	0.00	0.00	0.00	0.00	1.00	50.00%
CHIEF PSYCHIATRIST, CORRECTIONAL AND REHABILITITATIVE SERVICES (SAFETY)	9774	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
CHIEF PSYCHOLOGIST/CF	9859	2.00	2.00	1.00	1.00	0.00	0.00	0.00	0.00	1.00	50.00%
CLINICAL SOCIAL WORKER (HEALTH/CF)-SAFETY	9872	21.50	20.50	16.00	4.50	0.00	0.00	0.00	0.00	5.50	25.58%
CORRECTIONAL HEALTH SERVICES ADMINSTRATOR II, CORRECTIONAL FACILITY	4912	2.00	2.00	0.00	2.00	0.00	0.00	0.00	0.00	2.00	100.00%
CORRECTIONAL SUPERVISING COOK, CF	2183	3.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	3.00	100.00%
HEALTH PROGRAM SP I	8338	3.00	3.00	2.00	1.00	0.00	0.00	0.00	0.00	1.00	33.33%
HEALTH REC T II SUP	1887	0.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	-1.00	NC
HEALTH REC TECH I	1869	2.50	1.00	0.00	1.00	0.00	0.00	0.00	0.00	2.50	100.00%
JANITOR CORR FAC	2006	6.00	2.00	0.00	2.00	0.00	0.00	0.00	0.00	6.00	100.00%
JANITOR SUP II CF	2004	0.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	NC

SUMMARY BY INSTITUTION BY CLASSIFICATION
As Of January - 2013

CMC		FY 12/13	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
LABORATORY ASSISTANT, CORRECTIONAL FACILITY	9265	0.70	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.70	100.00%
LEAP CANDIDATE/I C	4687	0.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	-1.00	NC
MAINT MECH CORR F	6941	1.30	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.30	100.00%
MATERIAL & STORES SUP I CF	1508	0.00	2.00	1.00	1.00	0.00	0.00	0.00	0.00	-1.00	NC
MEDICAL TRANSCRIBER	1177	3.70	0.00	0.00	0.00	0.00	0.00	0.00	0.00	3.70	100.00%
OFFICE SERVICES SUP II (G)	1150	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
OFFICE TECH (T)	1139	23.50	21.50	15.00	6.50	0.00	0.00	0.00	0.00	8.50	36.17%
PHARMACIST I	7982	0.70	1.00	1.00	0.00	0.00	0.00	0.00	0.00	-0.30	-42.86%
PHARMACY TECH	7979	1.80	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.80	44.44%
PHYSICIAN AND SURGEON, CF (INTERNAL MEDICINE/FA	9263	0.00	0.60	0.60	0.00	0.00	0.00	0.00	0.00	-0.60	NC
PSYCH-CLINIC CF	9283	43.50	41.50	40.00	1.50	0.00	0.00	0.00	0.00	3.50	8.05%
REC THERAPIST CF	9286	21.50	21.50	10.00	11.50	0.00	0.00	0.00	0.00	11.50	53.49%
SENIOR PSYCHIATRIST (SUPERVISOR), CORRECTIONAL AND REHABILITATIVE	9761	1.00	2.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00%
SR PSYCH CF/SP	9287	5.50	5.50	3.75	1.75	0.00	0.00	0.00	0.00	1.75	31.82%
SR PSYCH CF/SUP	9288	6.00	6.00	6.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
STAFF PSYCHIATRIST, CORRECTIONAL AND REHABILITATIVE SERVICES (SAFETY)	9758	18.50	18.00	16.50	1.50	0.00	0.00	0.00	0.00	2.00	10.81%
STDS COMP COORD	8328	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
SUP CL LAB TECH CF	9349	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.00	100.00%
SUP PSYCH S WK I CF	9291	1.00	0.50	0.00	0.50	1.00	0.00	0.00	0.00	0.00	0.00%
	Totals	**174.70**	**159.60**	**120.85**	**38.75**	**1.00**	**0.00**	**0.00**	**0.00**	**52.85**	**30.25%**

SUMMARY BY INSTITUTION BY CLASSIFICATION
As Of January - 2013

CMF		FY 12/13	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
ASSOC GOVRL PROGRAM ANALYST	5393	1.50	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.50	33.33%
BLDG MAINT WRKR CF	6216	0.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	NC
CHIEF PSYCHIATRIST, CORRECTIONAL AND REHABILITITATIVE SERVICES (SAFETY)	9774	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
CHIEF PSYCHOLOGIST/CF	9859	2.00	2.00	1.00	1.00	0.00	0.00	0.00	0.00	1.00	50.00%
CLINICAL LAB TECH CF	9293	0.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	NC
CLINICAL SOCIAL WORKER (HEALTH/CF)-SAFETY	9872	19.50	19.50	10.00	9.50	0.00	0.00	0.42	0.00	9.08	46.56%
CORRECTIONAL HEALTH SERVICES ADMINSTRATOR II, CORRECTIONAL FACILITY	4912	2.00	2.00	1.00	1.00	0.00	0.00	0.00	0.00	1.00	50.00%
CORRECTIONAL SUPERVISING COOK, CF	2183	0.00	3.50	2.00	1.50	0.00	0.00	0.00	0.00	-2.00	NC
FOOD ADMIN I CORR F	2153	0.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	NC
HEALTH PROGRAM SP I	8338	3.00	2.00	2.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00%
HEALTH REC T II SUP	1887	0.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	-1.00	NC
HEALTH REC TECH I	1869	1.50	2.00	1.00	1.00	2.00	0.00	0.00	0.00	-1.50	-100.00%
JANITOR CORR FAC	2006	0.00	4.00	1.00	3.00	0.00	0.00	0.00	0.00	-1.00	NC
JANITOR SUP II CF	2004	0.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	-1.00	NC
LABORATORY ASSISTANT, CORRECTIONAL FACILITY	9265	0.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	NC
MATERIAL & STORES SUP II CF	1505	0.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	NC
OFFICE SERVICES SUP II (G)	1150	0.50	0.50	0.00	0.50	0.00	0.00	0.00	0.00	0.50	100.00%
OFFICE TECH (T)	1139	18.00	18.00	11.00	7.00	0.00	0.00	0.00	0.00	7.00	38.89%
PHARMACIST I	7982	0.00	1.50	1.00	0.50	0.00	0.00	0.00	0.00	-1.00	NC
PHARMACY TECH	7979	0.00	2.00	2.00	0.00	0.00	0.00	0.00	0.00	-2.00	NC
PSYCH-CLINIC CF	9283	37.50	37.50	33.00	4.50	0.00	0.00	0.52	0.00	3.98	10.61%
REC THERAPIST CF	9286	18.00	18.00	11.00	7.00	0.00	0.00	0.00	0.00	7.00	38.89%

SUMMARY BY INSTITUTION BY CLASSIFICATION
As Of January - 2013

CMF		FY 12/13	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
SENIOR PSYCHIATRIST (SUPERVISOR), CORRECTIONAL AND REHABILITATIVE	9761	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
SR PSYCH CF/SP	9287	4.50	4.50	3.00	1.50	0.00	0.00	0.00	0.00	1.50	33.33%
SR PSYCH CF/SUP	9288	4.50	4.50	5.00	-0.50	0.00	0.00	0.00	0.00	-0.50	-11.11%
STAFF PSYCHIATRIST, CORRECTIONAL AND REHABILITATIVE SERVICES (SAFETY)	9758	14.00	16.00	13.00	3.00	0.00	0.00	0.00	0.00	1.00	7.14%
STDS COMP COORD	8328	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
SUP CL LAB TECH CF	9349	0.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	NC
SUP PSYCH S WK I CF	9291	1.00	0.50	0.00	0.50	0.00	0.00	0.00	0.00	1.00	100.00%
	Totals	**130.50**	**150.00**	**102.00**	**48.00**	**3.00**	**0.00**	**0.94**	**0.00**	**24.56**	**18.82%**

Source: FY 12/13 7A; SCO Reports; MIRS reports; Hire Tracking System
Report Generated By:
Program Support

Correctional Health Care Services
Mental Health Institution Vacancies

SUMMARY BY INSTITUTION BY CLASSIFICATION
As Of January - 2013

COR		FY 12/13	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
ASSOC GOVRL PROGRAM ANALYST	5393	0.50	0.50	0.00	0.50	0.00	0.00	0.00	0.00	0.50	100.00%
CHIEF PSYCHIATRIST, CORRECTIONAL AND REHABILITITATIVE SERVICES (SAFETY)	9774	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
CHIEF PSYCHOLOGIST/CF	9859	2.00	2.00	1.00	1.00	0.00	0.00	0.00	0.00	1.00	50.00%
CLINICAL SOCIAL WORKER (HEALTH/CF)-SAFETY	9872	20.50	17.40	10.00	7.40	0.00	0.00	1.94	0.00	8.56	41.76%
CORRECTIONAL HEALTH SERVICES ADMINSTRATOR II, CORRECTIONAL FACILITY	4912	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
CORRECTIONAL SUPERVISING COOK, CF	2183	0.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	NC
HEALTH PROGRAM SP I	8338	2.00	2.50	2.00	0.50	0.00	0.00	0.00	0.00	0.00	0.00%
JANITOR CORR FAC	2006	0.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	NC
OFFICE SERVICES SUP II (G)	1150	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
OFFICE TECH (T)	1139	16.00	14.00	11.50	2.50	0.00	0.00	0.00	0.00	4.50	28.13%
PHARMACIST I	7982	0.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	-1.00	NC
PHARMACY TECH	7979	0.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	-1.00	NC
PSYCH-CLINIC CF	9283	30.00	29.00	27.75	1.25	2.00	0.00	0.73	0.00	-0.48	-1.60%
REC THERAPIST CF	9286	11.50	11.50	10.00	1.50	0.00	0.00	0.00	0.00	1.50	13.04%
SENIOR PSYCHIATRIST (SUPERVISOR), CORRECTIONAL AND REHABILITATIVE	9761	0.00	0.50	0.00	0.50	0.00	0.00	0.00	0.00	0.00	NC
SR PSYCH CF/SP	9287	3.00	3.00	0.00	3.00	0.00	0.00	0.00	0.00	3.00	100.00%
SR PSYCH CF/SUP	9288	5.00	4.50	3.00	1.50	0.00	0.00	0.00	0.00	2.00	40.00%
STAFF PSYCHIATRIST, CORRECTIONAL AND REHABILITATIVE SERVICES (SAFETY)	9758	10.00	11.50	3.50	8.00	0.00	0.00	4.98	0.00	1.52	15.20%
SUP PSYCH S WK I CF	9291	1.00	0.50	0.00	0.50	1.00	0.00	0.00	0.00	0.00	0.00%
	Totals	**104.50**	**103.90**	**72.75**	**31.15**	**3.00**	**0.00**	**7.65**	**0.00**	**21.10**	**20.19%**

Source: FY 12/13 7A; SCO Reports; MIRS reports; Hire Tracking System
Report Generated By:
Program Support

SUMMARY BY INSTITUTION BY CLASSIFICATION
As Of January - 2013

CRC		FY 12/13	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
CHIEF PSYCHOLOGIST/CF	9859	2.00	2.00	1.00	1.00	0.00	0.00	0.00	0.00	1.00	50.00%
CLINICAL SOCIAL WORKER (HEALTH/CF)-SAFETY	9872	7.50	7.50	3.00	4.50	0.00	0.00	0.00	0.00	4.50	60.00%
CORRECTIONAL HEALTH SERVICES ADMINSTRATOR II, CORRECTIONAL FACILITY	4912	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
HEALTH PROGRAM SP I	8338	2.00	2.00	1.00	1.00	0.00	0.00	0.00	0.00	1.00	50.00%
OFFICE SERVICES SUP II (G)	1150	0.00	0.50	0.00	0.50	0.00	0.00	0.00	0.00	0.00	NC
OFFICE TECH (T)	1139	6.50	6.50	3.50	3.00	0.00	0.00	0.00	0.00	3.00	46.15%
PSYCH-CLINIC CF	9283	7.00	9.00	9.00	0.00	0.00	0.00	0.00	0.00	-2.00	-28.57%
REC THERAPIST CF	9286	1.00	1.50	1.00	0.50	0.00	0.00	0.00	0.00	0.00	0.00%
SENIOR PSYCHIATRIST (SUPERVISOR), CORRECTIONAL AND REHABILITATIVE	9761	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
SR PSYCH CF/SP	9287	1.50	2.00	0.00	2.00	0.00	0.00	0.00	0.00	1.50	100.00%
SR PSYCH CF/SUP	9288	1.00	0.50	1.00	-0.50	0.00	0.00	0.00	0.00	0.00	0.00%
STAFF PSYCHIATRIST, CORRECTIONAL AND REHABILITATIVE SERVICES (SAFETY)	9758	4.50	4.50	3.00	1.50	0.00	0.00	0.00	0.00	1.50	33.33%
SUP PSYCH S WK I CF	9291	0.00	0.50	0.00	0.50	0.00	0.00	0.00	0.00	0.00	NC
	Totals	**35.00**	**38.50**	**23.50**	**15.00**	**0.00**	**0.00**	**0.00**	**0.00**	**11.50**	**32.86%**

Source: FY 12/13 7A; SCO Reports; MIRS reports; Hire Tracking System
Report Generated By:
Program Support

SUMMARY BY INSTITUTION BY CLASSIFICATION
As Of January - 2013

CTF		FY 12/13	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
CHIEF PSYCHOLOGIST/CF	9859	2.00	2.00	1.00	1.00	0.00	0.00	0.00	0.00	1.00	50.00%
CLINICAL SOCIAL WORKER (HEALTH/CF)-SAFETY	9872	8.00	8.00	1.50	6.50	0.00	0.00	1.10	0.00	5.40	67.50%
CORRECTIONAL HEALTH SERVICES ADMINSTRATOR II, CORRECTIONAL FACILITY	4912	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
HEALTH PROGRAM SP I	8338	2.00	2.00	2.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
OFFICE SERVICES SUP II (G)	1150	0.00	0.50	0.00	0.50	0.00	0.00	0.00	0.00	0.00	NC
OFFICE TECH (T)	1139	7.00	7.00	7.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
PSYCH-CLINIC CF	9283	9.50	9.50	9.50	0.00	0.00	0.00	0.46	0.00	-0.46	-4.84%
REC THERAPIST CF	9286	0.50	0.50	0.00	0.50	0.00	0.00	0.00	0.00	0.50	100.00%
SENIOR PSYCHIATRIST (SUPERVISOR), CORRECTIONAL AND REHABILITATIVE	9761	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
SR PSYCH CF/SP	9287	2.00	2.00	2.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
SR PSYCH CF/SUP	9288	1.00	1.00	1.00	0.00	1.00	0.00	0.00	0.00	-1.00	-100.00%
STAFF PSYCHIATRIST, CORRECTIONAL AND REHABILITATIVE SERVICES (SAFETY)	9758	4.00	5.00	3.00	2.00	0.00	0.00	0.17	0.00	0.83	20.75%
SUP PSYCH S WK I CF	9291	0.00	0.50	0.50	0.00	0.00	0.00	0.00	0.00	-0.50	NC
	Totals	**38.00**	**40.00**	**28.50**	**11.50**	**1.00**	**0.00**	**1.73**	**0.00**	**6.77**	**17.82%**

SUMMARY BY INSTITUTION BY CLASSIFICATION
As Of January - 2013

CVSP		FY 12/13	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
CHIEF PSYCHOLOGIST/CF	9859	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
CLINICAL SOCIAL WORKER (HEALTH/CF)-SAFETY	9872	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
HEALTH PROGRAM SP I	8338	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
OFFICE TECH (T)	1139	3.00	3.00	2.00	1.00	0.00	0.00	0.00	0.00	1.00	33.33%
PSYCH-CLINIC CF	9283	4.00	4.00	2.50	1.50	0.00	0.00	0.40	0.00	1.10	27.50%
STAFF PSYCHIATRIST, CORRECTIONAL AND REHABILITATIVE SERVICES (SAFETY)	9758	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
	Totals	**11.00**	**11.00**	**4.50**	**6.50**	**0.00**	**0.00**	**0.40**	**0.00**	**6.10**	**55.45%**

SUMMARY BY INSTITUTION BY CLASSIFICATION
As Of January - 2013

DVI		FY 12/13	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
CHIEF PSYCHIATRIST, CORRECTIONAL AND REHABILITITATIVE SERVICES (SAFETY)	9774	0.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	-1.00	NC
CHIEF PSYCHOLOGIST/CF	9859	2.00	2.00	1.00	1.00	0.00	0.00	0.00	0.00	1.00	50.00%
CLINICAL SOCIAL WORKER (HEALTH/CF)-SAFETY	9872	4.50	5.50	2.00	3.50	0.00	0.00	0.88	0.00	1.62	36.00%
CORRECTIONAL HEALTH SERVICES ADMINSTRATOR II, CORRECTIONAL FACILITY	4912	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
HEALTH PROGRAM SP I	8338	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
OFFICE SERVICES SUP II (G)	1150	0.00	0.50	0.00	0.50	0.00	0.00	0.00	0.00	0.00	NC
OFFICE TECH (T)	1139	6.00	6.00	3.00	3.00	0.00	0.00	0.00	0.00	3.00	50.00%
PSYCH-CLINIC CF	9283	14.50	15.50	14.50	1.00	0.00	0.00	0.34	0.00	-0.34	-2.34%
REC THERAPIST CF	9286	0.65	0.65	0.65	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
SENIOR PSYCHIATRIST (SUPERVISOR), CORRECTIONAL AND REHABILITATIVE	9761	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
SR PSYCH CF/SP	9287	2.00	2.00	2.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
SR PSYCH CF/SUP	9288	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
STAFF PSYCHIATRIST, CORRECTIONAL AND REHABILITATIVE SERVICES (SAFETY)	9758	3.50	4.50	5.00	-0.50	0.00	0.00	0.00	0.00	-1.50	-42.86%
SUP PSYCH S WK I CF	9291	0.00	0.50	0.00	0.50	0.00	0.00	0.00	0.00	0.00	NC
	Totals	**37.15**	**42.15**	**31.15**	**11.00**	**0.00**	**0.00**	**1.22**	**0.00**	**4.78**	**12.87%**

Source: FY 12/13 7A; SCO Reports; MIRS reports; Hire Tracking System
Report Generated By:
Program Support

SUMMARY BY INSTITUTION BY CLASSIFICATION
As Of January - 2013

FSP		FY 12/13	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
CHIEF PSYCHOLOGIST/CF	9859	2.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.00	100.00%
CLINICAL SOCIAL WORKER (HEALTH/CF)-SAFETY	9872	5.00	3.00	3.00	0.00	0.00	0.00	0.00	0.00	2.00	40.00%
CORRECTIONAL HEALTH SERVICES ADMINSTRATOR II, CORRECTIONAL FACILITY	4912	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.00	100.00%
HEALTH PROGRAM SP I	8338	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
OFFICE TECH (T)	1139	4.00	4.50	4.00	0.50	0.00	0.00	0.00	0.00	0.00	0.00%
PSYCH-CLINIC CF	9283	6.00	6.50	6.00	0.50	0.00	0.00	0.00	0.00	0.00	0.00%
REC THERAPIST CF	9286	0.50	0.75	0.00	0.75	0.00	0.00	0.00	0.00	0.50	100.00%
SENIOR PSYCHIATRIST (SUPERVISOR), CORRECTIONAL AND REHABILITATIVE	9761	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
SR PSYCH CF/SP	9287	2.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.00	100.00%
SR PSYCH CF/SUP	9288	0.50	2.00	1.00	1.00	0.00	0.00	0.00	0.00	-0.50	-100.00%
STAFF PSYCHIATRIST, CORRECTIONAL AND REHABILITATIVE SERVICES (SAFETY)	9758	3.00	3.00	2.00	1.00	0.00	0.00	0.00	0.00	1.00	33.33%
	Totals	**26.00**	**21.75**	**18.00**	**3.75**	**0.00**	**0.00**	**0.00**	**0.00**	**8.00**	**30.77%**

Source: FY 12/13 7A; SCO Reports; MIRS reports; Hire Tracking System
Report Generated By:
Program Support

SUMMARY BY INSTITUTION BY CLASSIFICATION
As Of January - 2013

HDSP		FY 12/13	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
ASSOC GOVRL PROGRAM ANALYST	5393	0.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	NC
CHIEF PSYCHOLOGIST/CF	9859	2.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	1.00	50.00%
CLINICAL SOCIAL WORKER (HEALTH/CF)-SAFETY	9872	7.00	7.00	5.00	2.00	0.00	0.00	0.00	0.00	2.00	28.57%
CORRECTIONAL HEALTH SERVICES ADMINSTRATOR II, CORRECTIONAL FACILITY	4912	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.00	100.00%
HEALTH PROGRAM SP I	8338	1.50	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.50	33.33%
HEALTH REC T II SUP	1887	0.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	NC
OFFICE ASST (T)	1379	0.00	1.50	0.00	1.50	0.00	0.00	0.00	0.00	0.00	NC
OFFICE SERVICES SUP II (G)	1150	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.00	100.00%
OFFICE TECH (T)	1139	6.00	8.00	6.00	2.00	0.00	0.00	0.00	0.00	0.00	0.00%
PHARMACY TECH	7979	0.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	-1.00	NC
PSYCH-CLINIC CF	9283	11.50	15.12	9.00	6.12	0.00	0.00	1.07	0.00	1.43	12.43%
REC THERAPIST CF	9286	1.50	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.50	33.33%
SENIOR PSYCHIATRIST (SUPERVISOR), CORRECTIONAL AND REHABILITATIVE	9761	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
SR PSYCH CF/SP	9287	2.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.00	100.00%
SR PSYCH CF/SUP	9288	1.00	2.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00%
STAFF PSYCHIATRIST, CORRECTIONAL AND REHABILITATIVE SERVICES (SAFETY)	9758	4.00	5.00	0.00	5.00	0.00	0.00	0.93	0.00	3.07	76.75%
SUP PSYCH S WK I CF	9291	0.00	0.50	0.00	0.50	0.00	0.00	0.00	0.00	0.00	NC
	Totals	**39.50**	**46.12**	**25.00**	**21.12**	**1.00**	**0.00**	**2.00**	**0.00**	**11.50**	**29.11%**

Correctional Health Care Services
Mental Health Institution Vacancies

SUMMARY BY INSTITUTION BY CLASSIFICATION
As Of January - 2013

ISP		FY 12/13	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
CHIEF PSYCHOLOGIST/CF	9859	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
CLINICAL SOCIAL WORKER (HEALTH/CF)-SAFETY	9872	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
HEALTH PROGRAM SP I	8338	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
OFFICE TECH (T)	1139	3.00	3.00	2.00	1.00	0.00	0.00	0.00	0.00	1.00	33.33%
PSYCH-CLINIC CF	9283	4.00	4.00	3.00	1.00	0.00	0.00	0.00	0.00	1.00	25.00%
STAFF PSYCHIATRIST, CORRECTIONAL AND REHABILITATIVE SERVICES (SAFETY)	9758	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
	Totals	**11.00**	**11.00**	**7.00**	**4.00**	**0.00**	**0.00**	**0.00**	**0.00**	**4.00**	**36.36%**

Source: FY 12/13 7A; SCO Reports; MIRS reports; Hire Tracking System
Report Generated By:
Program Support

SUMMARY BY INSTITUTION BY CLASSIFICATION
As Of January - 2013

KVSP		FY 12/13	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
CHIEF PSYCHIATRIST, CORRECTIONAL AND REHABILITITATIVE SERVICES (SAFETY)	9774	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
CHIEF PSYCHOLOGIST/CF	9859	2.00	2.00	0.00	2.00	0.00	0.00	0.00	0.00	2.00	100.00%
CLINICAL SOCIAL WORKER (HEALTH/CF)-SAFETY	9872	11.50	11.50	7.00	4.50	0.00	0.00	3.06	0.00	1.44	12.52%
CORRECTIONAL HEALTH SERVICES ADMINSTRATOR II, CORRECTIONAL FACILITY	4912	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
HEALTH PROGRAM SP I	8338	2.50	1.50	1.00	0.50	0.00	0.00	0.00	0.00	1.50	60.00%
LABOR REL ANALYST	9529	0.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	NC
OFFICE SERVICES SUP II (G)	1150	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
OFFICE TECH (T)	1139	11.00	11.00	10.00	1.00	0.00	0.00	0.00	0.00	1.00	9.09%
PSYCH-CLINIC CF	9283	18.00	18.00	15.00	3.00	0.00	0.00	3.29	0.00	-0.29	-1.61%
REC THERAPIST CF	9286	4.00	4.00	1.00	3.00	0.00	0.00	0.00	0.00	3.00	75.00%
SR PSYCH CF/SP	9287	2.50	2.50	2.00	0.50	0.00	0.00	0.00	0.00	0.50	20.00%
SR PSYCH CF/SUP	9288	2.00	2.00	2.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
STAFF PSYCHIATRIST, CORRECTIONAL AND REHABILITATIVE SERVICES (SAFETY)	9758	8.00	8.00	2.00	6.00	0.00	0.00	5.79	0.00	0.21	2.63%
SUP PSYCH S WK I CF	9291	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
	Totals	**65.50**	**65.50**	**43.00**	**22.50**	**0.00**	**0.00**	**12.14**	**0.00**	**10.36**	**15.82%**

Source: FY 12/13 7A; SCO Reports; MIRS reports; Hire Tracking System
Report Generated By:
Program Support

SUMMARY BY INSTITUTION BY CLASSIFICATION
As Of January - 2013

LAC		FY 12/13	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
ASSOC GOVRL PROGRAM ANALYST	5393	0.10	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.10	100.00%
CHIEF PSYCHIATRIST, CORRECTIONAL AND REHABILITITATIVE SERVICES (SAFETY)	9774	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
CHIEF PSYCHOLOGIST/CF	9859	2.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	1.00	50.00%
CLINICAL SOCIAL WORKER (HEALTH/CF)-SAFETY	9872	17.00	10.00	9.00	1.00	0.00	0.00	0.00	0.00	8.00	47.06%
CORRECTIONAL HEALTH SERVICES ADMINSTRATOR II, CORRECTIONAL FACILITY	4912	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.00	100.00%
HEALTH PROGRAM SP I	8338	3.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	2.00	66.67%
MEDICAL SECRETARY/CI	9551	0.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	NC
OFFICE ASST (T)	1379	0.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	NC
OFFICE SERVICES SUP I (T)	1148	0.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	NC
OFFICE SERVICES SUP II (G)	1150	1.50	2.00	2.00	0.00	0.00	0.00	0.00	0.00	-0.50	-33.33%
OFFICE TECH (T)	1139	17.50	12.50	9.50	3.00	0.00	0.00	0.00	0.00	8.00	45.71%
PSYCH-CLINIC CF	9283	32.00	36.00	26.50	9.50	0.00	0.00	2.72	0.00	2.78	8.69%
REC THERAPIST CF	9286	12.00	7.15	4.00	3.15	0.00	0.00	0.00	0.00	8.00	66.67%
SR PSYCH CF/SP	9287	4.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	4.00	100.00%
SR PSYCH CF/SUP	9288	4.50	6.00	3.00	3.00	0.00	0.00	0.00	0.00	1.50	33.33%
STAFF PSYCHIATRIST, CORRECTIONAL AND REHABILITATIVE SERVICES (SAFETY)	9758	12.00	12.00	8.50	3.50	0.00	0.00	3.95	0.00	-0.45	-3.75%
SUP PSYCH S WK I CF	9291	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
	Totals	**108.60**	**92.65**	**64.50**	**28.15**	**0.00**	**0.00**	**6.67**	**0.00**	**37.43**	**34.47%**

SUMMARY BY INSTITUTION BY CLASSIFICATION
As Of January - 2013

MCSP		FY 12/13	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
ASSOC GOVRL PROGRAM ANALYST	5393	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
CHIEF PSYCHIATRIST, CORRECTIONAL AND REHABILITITATIVE SERVICES (SAFETY)	9774	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
CHIEF PSYCHOLOGIST/CF	9859	2.00	2.00	1.00	1.00	0.00	0.00	0.00	0.00	1.00	50.00%
CLINICAL SOCIAL WORKER (HEALTH/CF)-SAFETY	9872	18.00	18.00	6.00	12.00	0.00	0.00	2.55	0.00	9.45	52.50%
CORRECTIONAL HEALTH SERVICES ADMINSTRATOR II, CORRECTIONAL FACILITY	4912	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
HEALTH PROGRAM SP I	8338	3.00	3.00	0.00	3.00	0.00	0.00	0.00	0.00	3.00	100.00%
OFFICE SERVICES SUP II (G)	1150	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
OFFICE TECH (T)	1139	17.50	17.50	12.00	5.50	0.00	0.00	0.00	0.00	5.50	31.43%
PSYCH-CLINIC CF	9283	32.50	32.50	20.50	12.00	0.00	0.00	1.04	0.00	10.96	33.72%
REC THERAPIST CF	9286	15.00	15.30	8.00	7.30	0.00	0.00	0.00	0.00	7.00	46.67%
SR PSYCH CF/SP	9287	5.00	5.00	5.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
SR PSYCH CF/SUP	9288	5.00	5.00	3.00	2.00	0.00	0.00	0.00	0.00	2.00	40.00%
STAFF PSYCHIATRIST, CORRECTIONAL AND REHABILITATIVE SERVICES (SAFETY)	9758	11.00	12.00	7.50	4.50	0.00	0.00	1.58	0.00	1.92	17.45%
SUP PSYCH S WK I CF	9291	1.00	0.50	0.00	0.50	0.00	0.00	0.00	0.00	1.00	100.00%
	Totals	**114.00**	**114.80**	**65.00**	**49.80**	**0.00**	**0.00**	**5.17**	**0.00**	**43.83**	**38.45%**

Source: FY 12/13 7A; SCO Reports; MIRS reports; Hire Tracking System
Report Generated By:
Program Support

SUMMARY BY INSTITUTION BY CLASSIFICATION
As Of January - 2013

NKSP		FY 12/13	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
CHIEF PSYCHOLOGIST/CF	9859	2.00	2.00	1.00	1.00	0.00	0.00	0.00	0.00	1.00	50.00%
CLINICAL SOCIAL WORKER (HEALTH/CF)-SAFETY	9872	9.50	10.50	6.00	4.50	0.00	0.00	0.00	0.00	3.50	36.84%
CORRECTIONAL HEALTH SERVICES ADMINSTRATOR II, CORRECTIONAL FACILITY	4912	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
HEALTH PROGRAM SP I	8338	2.00	2.00	1.00	1.00	0.00	0.00	0.00	0.00	1.00	50.00%
OFFICE ASST (G)	1441	0.00	0.00	0.00	0.00	0.06	0.00	0.00	0.00	-0.06	NC
OFFICE ASST (T)	1379	0.00	0.00	0.00	0.00	1.82	0.00	0.00	0.00	-1.82	NC
OFFICE SERVICES SUP II (G)	1150	1.00	0.50	0.00	0.50	0.00	0.00	0.00	0.00	1.00	100.00%
OFFICE TECH (T)	1139	12.00	12.00	10.00	2.00	0.00	0.00	0.00	0.00	2.00	16.67%
PSYCH-CLINIC CF	9283	28.47	30.50	19.00	11.50	0.00	0.00	1.03	0.00	8.44	29.65%
REC THERAPIST CF	9286	2.00	3.00	1.00	2.00	0.00	0.00	0.00	0.00	1.00	50.00%
SENIOR PSYCHIATRIST (SUPERVISOR), CORRECTIONAL AND REHABILITATIVE	9761	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
SR PSYCH CF/SP	9287	2.00	2.00	0.00	2.00	0.00	0.00	0.00	0.00	2.00	100.00%
SR PSYCH CF/SUP	9288	2.00	2.00	2.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
STAFF PSYCHIATRIST, CORRECTIONAL AND REHABILITATIVE SERVICES (SAFETY)	9758	9.00	10.00	7.00	3.00	0.00	0.00	0.46	0.00	1.54	17.11%
SUP PSYCH S WK I CF	9291	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
	Totals	**72.97**	**77.50**	**48.00**	**29.50**	**1.88**	**0.00**	**1.49**	**0.00**	**21.60**	**29.60%**

Source: FY 12/13 7A; SCO Reports; MIRS reports; Hire Tracking System
Report Generated By:
Program Support

SUMMARY BY INSTITUTION BY CLASSIFICATION
As Of January - 2013

PBSP		FY 12/13	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
ASSOC GOVRL PROGRAM ANALYST	5393	0.50	1.00	1.00	0.00	0.00	0.00	0.00	0.00	-0.50	-100.00%
CHIEF PSYCHIATRIST, CORRECTIONAL AND REHABILITITATIVE SERVICES (SAFETY)	9774	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
CHIEF PSYCHOLOGIST/CF	9859	2.00	2.00	2.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
CLINICAL SOCIAL WORKER (HEALTH/CF)-SAFETY	9872	8.00	9.00	8.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00%
CORR COUNSELOR II SP	9901	0.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	-1.00	NC
CORRECTIONAL HEALTH SERVICES ADMINSTRATOR II, CORRECTIONAL FACILITY	4912	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
HEALTH PROGRAM SP I	8338	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
OFFICE ASST (G)	1441	0.00	6.00	1.00	5.00	0.00	0.00	0.00	0.00	-1.00	NC
OFFICE SERVICES SUP I (T)	1148	0.00	7.00	3.00	4.00	0.00	0.00	0.00	0.00	-3.00	NC
OFFICE SERVICES SUP II (G)	1150	1.00	0.50	1.00	-0.50	0.00	0.00	0.00	0.00	0.00	0.00%
OFFICE TECH (T)	1139	8.00	4.00	4.00	0.00	0.00	0.00	0.00	0.00	4.00	50.00%
PSYCH-CLINIC CF	9283	24.00	26.00	15.50	10.50	0.00	0.00	3.52	0.00	4.98	20.75%
REC THERAPIST CF	9286	7.65	8.50	3.00	5.50	0.00	0.00	0.00	0.00	4.65	60.78%
SR PSYCH CF/SP	9287	3.50	3.50	0.00	3.50	0.00	0.00	0.00	0.00	3.50	100.00%
SR PSYCH CF/SUP	9288	4.00	4.50	3.00	1.50	0.00	0.00	0.00	0.00	1.00	25.00%
STAFF PSYCHIATRIST, CORRECTIONAL AND REHABILITATIVE SERVICES (SAFETY)	9758	5.00	7.50	3.00	4.50	0.00	0.00	0.14	0.00	1.86	37.20%
	Totals	**66.65**	**83.50**	**45.50**	**38.00**	**0.00**	**0.00**	**3.66**	**0.00**	**17.49**	**26.24%**

SUMMARY BY INSTITUTION BY CLASSIFICATION
As Of January - 2013

PVSP		FY 12/13	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
CHIEF PSYCHIATRIST, CORRECTIONAL AND REHABILITITATIVE SERVICES (SAFETY)	9774	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
CHIEF PSYCHOLOGIST/CF	9859	2.00	2.00	1.00	1.00	0.00	0.00	0.00	0.00	1.00	50.00%
CLINICAL SOCIAL WORKER (HEALTH/CF)-SAFETY	9872	14.00	14.50	3.00	11.50	0.00	0.00	1.50	0.00	9.50	67.86%
CORRECTIONAL HEALTH SERVICES ADMINSTRATOR II, CORRECTIONAL FACILITY	4912	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
HEALTH PROGRAM SP I	8338	3.00	3.00	2.00	1.00	0.00	0.00	0.00	0.00	1.00	33.33%
OFFICE SERVICES SUP II (G)	1150	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
OFFICE TECH (T)	1139	11.00	11.50	4.00	7.50	0.00	0.00	0.00	0.00	7.00	63.64%
PSYCH-CLINIC CF	9283	16.49	16.00	13.00	3.00	0.00	0.00	1.59	0.00	1.90	11.52%
REC THERAPIST CF	9286	1.50	2.00	0.00	2.00	0.00	0.00	0.00	0.00	1.50	100.00%
SR PSYCH CF/SP	9287	2.00	2.00	1.00	1.00	0.00	0.00	0.00	0.00	1.00	50.00%
SR PSYCH CF/SUP	9288	2.00	2.00	1.50	0.50	0.00	0.00	0.00	0.00	0.50	25.00%
STAFF PSYCHIATRIST, CORRECTIONAL AND REHABILITATIVE SERVICES (SAFETY)	9758	7.00	9.00	5.00	4.00	0.00	0.00	0.29	0.00	1.71	24.43%
SUP PSYCH S WK I CF	9291	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
	Totals	**62.99**	**66.00**	**31.50**	**34.50**	**0.00**	**0.00**	**3.38**	**0.00**	**28.11**	**44.63%**

SUMMARY BY INSTITUTION BY CLASSIFICATION
As Of January - 2013

RJD		FY 12/13	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
ASSOC GOVRL PROGRAM ANALYST	5393	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
CHIEF PSYCHIATRIST, CORRECTIONAL AND REHABILITITATIVE SERVICES (SAFETY)	9774	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
CHIEF PSYCHOLOGIST/CF	9859	2.00	2.00	1.00	1.00	0.00	0.00	0.00	0.00	1.00	50.00%
CLINICAL SOCIAL WORKER (HEALTH/CF)-SAFETY	9872	20.50	20.50	17.00	3.50	0.00	0.00	0.00	0.00	3.50	17.07%
CORR COUNSELOR II SP	9901	0.00	0.10	0.00	0.10	0.00	0.00	0.00	0.00	0.00	NC
CORRECTIONAL HEALTH SERVICES ADMINSTRATOR II, CORRECTIONAL FACILITY	4912	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
HEALTH PROGRAM SP I	8338	2.60	2.60	2.00	0.60	0.00	0.00	0.00	0.00	0.60	23.08%
HEALTH REC TECH I	1869	0.00	2.00	2.00	0.00	0.00	0.00	0.00	0.00	-2.00	NC
OFFICE SERVICES SUP II (G)	1150	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
OFFICE TECH (T)	1139	21.00	22.00	10.00	12.00	0.00	0.00	0.00	0.00	11.00	52.38%
PHARMACIST I	7982	0.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	-1.00	NC
PSYCH-CLINIC CF	9283	39.50	42.50	41.50	1.00	0.00	0.00	3.02	0.00	-5.02	-12.71%
REC THERAPIST CF	9286	15.50	16.50	11.00	5.50	0.00	0.00	0.00	0.00	4.50	29.03%
SR PSYCH CF/SP	9287	6.00	5.00	5.00	0.00	0.00	0.00	0.00	0.00	1.00	16.67%
SR PSYCH CF/SUP	9288	5.00	6.00	5.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00%
STAFF PSYCHIATRIST, CORRECTIONAL AND REHABILITATIVE SERVICES (SAFETY)	9758	13.00	15.00	7.00	8.00	0.00	0.00	3.73	0.00	2.27	17.46%
SUP PSYCH S WK I CF	9291	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
	Totals	**130.10**	**140.20**	**104.50**	**35.70**	**0.00**	**0.00**	**6.75**	**0.00**	**18.85**	**14.49%**

SUMMARY BY INSTITUTION BY CLASSIFICATION
As Of January - 2013

SAC		FY 12/13	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
ASSOC GOVRL PROGRAM ANALYST	5393	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.00	100.00%
CHIEF PSYCHIATRIST, CORRECTIONAL AND REHABILITITATIVE SERVICES (SAFETY)	9774	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
CHIEF PSYCHOLOGIST/CF	9859	2.00	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00%
CLINICAL SOCIAL WORKER (HEALTH/CF)-SAFETY	9872	23.50	25.33	21.00	4.33	0.00	0.00	1.00	0.00	1.50	6.38%
CORR COUNSELOR II SP	9901	0.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	-1.00	NC
CORRECTIONAL HEALTH SERVICES ADMINSTRATOR II, CORRECTIONAL FACILITY	4912	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.00	100.00%
HEALTH PROGRAM SP I	8338	3.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	2.00	66.67%
HEALTH REC TECH I	1869	0.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	NC
MANAGEMENT SVCS TECH	5278	0.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	NC
OFFICE ASST (T)	1379	0.00	2.00	0.00	2.00	0.00	0.00	0.00	0.00	0.00	NC
OFFICE SERVICES SUP II (G)	1150	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
OFFICE TECH (T)	1139	23.50	23.00	13.00	10.00	0.00	0.00	0.00	0.00	10.50	44.68%
PSYCH-CLINIC CF	9283	54.50	52.50	36.38	16.12	1.00	0.00	11.56	0.00	5.56	10.20%
REC THERAPIST CF	9286	24.50	13.54	12.80	0.74	1.00	0.00	0.00	0.00	10.70	43.67%
SENIOR PSYCHIATRIST (SUPERVISOR), CORRECTIONAL AND REHABILITATIVE	9761	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
SR PSYCH CF/SP	9287	6.00	1.00	1.00	0.00	1.00	0.00	0.00	0.00	4.00	66.67%
SR PSYCH CF/SUP	9288	8.50	8.00	8.00	0.00	0.00	0.00	0.00	0.00	0.50	5.88%
STAFF PSYCHIATRIST, CORRECTIONAL AND REHABILITATIVE SERVICES (SAFETY)	9758	19.00	20.50	13.25	7.25	0.00	0.00	4.11	0.00	1.64	8.63%
SUP PSYCH S WK I CF	9291	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
	Totals	**170.50**	**154.87**	**111.43**	**43.44**	**4.00**	**0.00**	**16.67**	**0.00**	**38.40**	**22.52%**

Correctional Health Care Services
Mental Health Institution Vacancies

SUMMARY BY INSTITUTION BY CLASSIFICATION
As Of January - 2013

SATF		FY 12/13	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
ASSOC GOVRL PROGRAM ANALYST	5393	0.50	0.50	0.00	0.50	0.00	0.00	0.00	0.00	0.50	100.00%
CHIEF PSYCHIATRIST, CORRECTIONAL AND REHABILITITATIVE SERVICES (SAFETY)	9774	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
CHIEF PSYCHOLOGIST/CF	9859	2.00	2.00	1.00	1.00	0.00	0.00	0.00	0.00	1.00	50.00%
CLINICAL SOCIAL WORKER (HEALTH/CF)-SAFETY	9872	17.50	17.50	15.50	2.00	0.00	0.00	0.00	0.00	2.00	11.43%
CORRECTIONAL HEALTH SERVICES ADMINSTRATOR II, CORRECTIONAL FACILITY	4912	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
HEALTH PROGRAM SP I	8338	3.00	3.00	1.00	2.00	0.00	0.00	0.00	0.00	2.00	66.67%
OFFICE SERVICES SUP II (G)	1150	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
OFFICE TECH (T)	1139	17.00	17.00	13.50	3.50	0.00	0.00	0.00	0.00	3.50	20.59%
PSYCH-CLINIC CF	9283	31.50	31.50	25.75	5.75	0.00	0.00	0.00	0.00	5.75	18.25%
REC THERAPIST CF	9286	13.00	13.00	6.00	7.00	0.00	0.00	0.00	0.00	7.00	53.85%
SENIOR PSYCHIATRIST (SUPERVISOR), CORRECTIONAL AND REHABILITATIVE	9761	0.00	0.50	0.00	0.50	0.00	0.00	0.00	0.00	0.00	NC
SR PSYCH CF/SP	9287	3.50	3.50	2.00	1.50	0.00	0.00	0.00	0.00	1.50	42.86%
SR PSYCH CF/SUP	9288	4.00	4.00	4.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
STAFF PSYCHIATRIST, CORRECTIONAL AND REHABILITATIVE SERVICES (SAFETY)	9758	7.00	12.00	2.25	9.75	0.00	0.00	2.06	0.00	2.69	38.43%
STAFF PSYCHIATRST CF	9272	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.00	100.00%
SUP PSYCH S WK I CF	9291	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
	Totals	**104.00**	**108.50**	**72.00**	**36.50**	**0.00**	**0.00**	**2.06**	**0.00**	**29.94**	**28.79%**

Source: FY 12/13 7A; SCO Reports; MIRS reports; Hire Tracking System
Report Generated By:
Program Support

Correctional Health Care Services
Mental Health Institution Vacancies

SUMMARY BY INSTITUTION BY CLASSIFICATION
As Of January - 2013

SCC		FY 12/13	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
CHIEF PSYCHOLOGIST/CF	9859	2.00	2.00	0.00	2.00	0.00	0.00	0.00	0.00	2.00	100.00%
CLINICAL SOCIAL WORKER (HEALTH/CF)-SAFETY	9872	4.00	4.00	0.00	4.00	0.00	0.00	0.00	0.00	4.00	100.00%
CORRECTIONAL HEALTH SERVICES ADMINSTRATOR II, CORRECTIONAL FACILITY	4912	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
HEALTH PROGRAM SP I	8338	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
OFFICE SERVICES SUP I (T)	1148	0.00	3.00	0.00	3.00	0.00	0.00	0.00	0.00	0.00	NC
OFFICE SERVICES SUP II (G)	1150	0.00	0.50	0.00	0.50	0.00	0.00	0.00	0.00	0.00	NC
OFFICE TECH (T)	1139	3.00	3.00	2.00	1.00	0.00	0.00	0.00	0.00	1.00	33.33%
PSYCH-CLINIC CF	9283	5.50	5.75	6.00	-0.25	0.00	0.00	0.87	0.00	-1.37	-24.91%
REC THERAPIST CF	9286	0.50	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.50	100.00%
SENIOR PSYCHIATRIST (SUPERVISOR), CORRECTIONAL AND REHABILITATIVE	9761	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
SR PSYCH CF/SP	9287	2.00	2.00	0.00	2.00	0.00	0.00	0.00	0.00	2.00	100.00%
SR PSYCH CF/SUP	9288	0.50	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.50	100.00%
STAFF PSYCHIATRIST, CORRECTIONAL AND REHABILITATIVE SERVICES (SAFETY)	9758	2.50	2.50	1.00	1.50	1.00	0.00	0.00	0.00	0.50	20.00%
SUP PSYCH S WK I CF	9291	0.00	0.50	1.00	-0.50	0.00	0.00	0.00	0.00	-1.00	NC
	Totals	**23.00**	**28.25**	**12.00**	**16.25**	**1.00**	**0.00**	**0.87**	**0.00**	**9.13**	**39.70%**

Source: FY 12/13 7A; SCO Reports; MIRS reports; Hire Tracking System
Report Generated By:
Program Support

SUMMARY BY INSTITUTION BY CLASSIFICATION
As Of January - 2013

SOL		FY 12/13	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
CHIEF PSYCHIATRIST, CORRECTIONAL AND REHABILITITATIVE SERVICES (SAFETY)	9774	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
CHIEF PSYCHOLOGIST/CF	9859	2.00	2.00	1.00	1.00	0.00	0.00	0.00	0.00	1.00	50.00%
CLINICAL SOCIAL WORKER (HEALTH/CF)-SAFETY	9872	10.00	10.00	5.00	5.00	0.00	0.00	0.85	0.00	4.15	41.50%
CORRECTIONAL HEALTH SERVICES ADMINSTRATOR II, CORRECTIONAL FACILITY	4912	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
HEALTH PROGRAM SP I	8338	2.00	2.00	2.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
OFFICE SERVICES SUP II (G)	1150	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
OFFICE TECH (T)	1139	8.50	8.50	7.50	1.00	0.00	0.00	0.00	0.00	1.00	11.76%
PSYCH-CLINIC CF	9283	13.50	13.50	13.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
REC THERAPIST CF	9286	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
SR PSYCH CF/SP	9287	2.00	2.00	2.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
SR PSYCH CF/SUP	9288	1.50	1.50	1.00	0.50	0.00	0.00	0.00	0.00	0.50	33.33%
STAFF PSYCHIATRIST, CORRECTIONAL AND REHABILITATIVE SERVICES (SAFETY)	9758	5.00	6.50	3.00	3.50	0.00	0.00	1.02	0.00	0.98	19.60%
SUP PSYCH S WK I CF	9291	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
	Totals	**49.50**	**51.00**	**39.00**	**12.00**	**0.00**	**0.00**	**1.87**	**0.00**	**8.63**	**17.43%**

SQ		FY 12/13	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
BLDG MAINT WRKR CF	6216	0.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	-1.00	NC
CHIEF PSYCHIATRIST, CORRECTIONAL AND REHABILITITATIVE SERVICES (SAFETY)	9774	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
CHIEF PSYCHOLOGIST/CF	9859	2.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	1.00	50.00%
CLINICAL PSYCHOLOGY INTERN	9851	0.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	-1.00	NC

Source: FY 12/13 7A; SCO Reports; MIRS reports; Hire Tracking System
Report Generated By:
Program Support

Correctional Health Care Services
Mental Health Institution Vacancies

SUMMARY BY INSTITUTION BY CLASSIFICATION
As Of January - 2013

SQ		FY 12/13	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
CLINICAL SOCIAL WORKER (HEALTH/CF)-SAFETY	9872	12.50	14.50	12.00	2.50	0.00	0.00	0.00	0.00	0.50	4.00%
CORR COUNSELOR I	9904	0.00	1.50	0.00	1.50	0.00	0.00	0.00	0.00	0.00	NC
CORR COUNSELOR II SP	9901	0.00	1.10	0.00	1.10	0.00	0.00	0.00	0.00	0.00	NC
CORRECTIONAL HEALTH SERVICES ADMINSTRATOR II, CORRECTIONAL FACILITY	4912	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
CORRECTIONAL SUPERVISING COOK, CF	2183	0.00	2.00	2.00	0.00	0.00	0.00	0.00	0.00	-2.00	NC
HEALTH PROGRAM SP I	8338	2.50	2.50	1.00	1.50	0.00	0.00	0.00	0.00	1.50	60.00%
JANITOR CORR FAC	2006	0.00	2.00	0.00	2.00	0.00	0.00	0.00	0.00	0.00	NC
LABORATORY ASSISTANT, CORRECTIONAL FACILITY	9265	0.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	NC
OFFICE ASST (T)	1379	0.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	NC
OFFICE SERVICES SUP II (G)	1150	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
OFFICE TECH (T)	1139	12.40	13.40	6.00	7.40	0.00	0.00	0.00	0.00	6.40	51.61%
PHARMACIST I	7982	0.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	NC
PHARMACY TECH	7979	0.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	NC
PSYCH-CLINIC CF	9283	29.50	32.50	31.05	1.45	1.00	0.00	0.52	0.00	-3.07	-10.41%
REC THERAPIST CF	9286	8.00	6.00	4.00	2.00	0.00	0.00	0.97	0.00	3.03	37.88%
SENIOR PSYCHIATRIST (SUPERVISOR), CORRECTIONAL AND REHABILITATIVE	9761	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.00	100.00%
SR PSYCH CF/SP	9287	3.00	3.00	0.00	3.00	0.00	0.00	0.00	0.00	3.00	100.00%
SR PSYCH CF/SUP	9288	3.00	4.00	4.00	0.00	0.00	0.00	0.00	0.00	-1.00	-33.33%
STAFF PSYCHIATRIST, CORRECTIONAL AND REHABILITATIVE SERVICES (SAFETY)	9758	41.00	12.25	11.55	0.70	0.00	0.00	0.00	0.00	29.45	71.83%
STAT ENG-CF	6713	0.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	NC
SUP PSYCH S WK I CF	9291	1.50	0.50	0.00	0.50	0.00	0.00	0.00	0.00	1.50	100.00%
	Totals	**119.40**	**106.25**	**75.60**	**30.65**	**1.00**	**0.00**	**1.49**	**0.00**	**41.31**	**34.60%**

Source: FY 12/13 7A; SCO Reports; MIRS reports; Hire Tracking System

Report Generated By:
Program Support

SUMMARY BY INSTITUTION BY CLASSIFICATION
As Of January - 2013

SVSP		FY 12/13	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
ASSOC GOVRL PROGRAM ANALYST	5393	0.50	0.50	1.00	-0.50	0.00	0.00	0.00	0.00	-0.50	-100.00%
BLDG MAINT WRKR CF	6216	0.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	NC
CHIEF PSYCHIATRIST, CORRECTIONAL AND REHABILITITATIVE SERVICES (SAFETY)	9774	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
CHIEF PSYCHOLOGIST/CF	9859	2.00	2.00	1.00	1.00	0.00	0.00	0.00	0.00	1.00	50.00%
CLINICAL SOCIAL WORKER (HEALTH/CF)-SAFETY	9872	14.50	13.50	7.00	6.50	0.00	0.00	2.59	0.00	4.91	33.86%
CORRECTIONAL HEALTH SERVICES ADMINSTRATOR II, CORRECTIONAL FACILITY	4912	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
CORRECTIONAL SUPERVISING COOK, CF	2183	0.00	3.00	2.00	1.00	0.00	0.00	0.00	0.00	-2.00	NC
HEALTH PROGRAM SP I	8338	2.50	2.50	2.00	0.50	0.00	0.00	0.00	0.00	0.50	20.00%
HEALTH REC TECH I	1869	0.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	-1.00	NC
MATERIAL & STORES SUP I CF	1508	0.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	-1.00	NC
OFFICE SERVICES SUP II (G)	1150	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
OFFICE TECH (T)	1139	13.50	12.50	11.00	1.50	0.00	0.00	0.00	0.00	2.50	18.52%
PSYCH-CLINIC CF	9283	25.50	23.50	22.50	1.00	1.14	0.00	3.14	0.00	-1.28	-5.01%
REC THERAPIST CF	9286	6.50	7.00	3.00	4.00	0.00	0.00	0.00	0.00	3.50	53.85%
SR PSYCH CF/SP	9287	3.50	3.50	4.00	-0.50	0.00	0.00	0.00	0.00	-0.50	-14.29%
SR PSYCH CF/SUP	9288	3.50	3.50	3.00	0.50	0.00	0.00	0.00	0.00	0.50	14.29%
STAFF PSYCHIATRIST, CORRECTIONAL AND REHABILITATIVE SERVICES (SAFETY)	9758	8.00	9.00	5.00	4.00	0.00	0.00	2.50	0.00	0.50	6.25%
STAT ENG-CF	6713	0.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	NC
SUP PSYCH S WK I CF	9291	0.50	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.50	100.00%
	Totals	**83.50**	**88.50**	**63.50**	**25.00**	**1.14**	**0.00**	**8.23**	**0.00**	**10.63**	**12.73%**

Source: FY 12/13 7A; SCO Reports; MIRS reports; Hire Tracking System
Report Generated By:
Program Support

SUMMARY BY INSTITUTION BY CLASSIFICATION
As Of January - 2013

VSP		FY 12/13	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
CHIEF PSYCHOLOGIST/CF	9859	2.00	2.00	1.00	1.00	0.00	0.00	0.00	0.00	1.00	50.00%
CLINICAL SOCIAL WORKER (HEALTH/CF)-SAFETY	9872	4.50	7.90	4.75	3.15	0.00	0.00	0.00	0.00	-0.25	-5.56%
CORRECTIONAL HEALTH SERVICES ADMINSTRATOR II, CORRECTIONAL FACILITY	4912	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
HEALTH PROGRAM SP I	8338	2.00	2.00	2.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
OFFICE SERVICES SUP II (G)	1150	0.00	0.50	0.00	0.50	0.00	0.00	0.00	0.00	0.00	NC
OFFICE TECH (T)	1139	6.00	7.00	6.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00%
PSYCH-CLINIC CF	9283	5.50	9.50	9.00	0.50	2.00	0.00	0.00	0.00	-5.50	-100.00%
REC THERAPIST CF	9286	0.50	0.50	0.00	0.50	1.00	0.00	0.00	0.00	-0.50	-100.00%
SENIOR PSYCHIATRIST (SUPERVISOR), CORRECTIONAL AND REHABILITATIVE	9761	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
SR PSYCH CF/SP	9287	2.00	2.00	2.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
SR PSYCH CF/SUP	9288	1.00	1.00	1.00	0.00	1.00	0.00	0.00	0.00	-1.00	-100.00%
STAFF PSYCHIATRIST, CORRECTIONAL AND REHABILITATIVE SERVICES (SAFETY)	9758	4.00	5.50	5.00	0.50	1.00	0.00	0.00	0.00	-2.00	-50.00%
SUP PSYCH S WK I CF	9291	0.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	-1.00	NC
	Totals	**29.50**	**40.90**	**31.75**	**9.15**	**5.00**	**0.00**	**0.00**	**0.00**	**-7.25**	**-24.58%**

SUMMARY BY INSTITUTION BY CLASSIFICATION
As Of January - 2013

WSP		FY 12/13	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
CHIEF PSYCHIATRIST, CORRECTIONAL AND REHABILITITATIVE SERVICES (SAFETY)	9774	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
CHIEF PSYCHOLOGIST/CF	9859	2.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	2.00	100.00%
CLINICAL SOCIAL WORKER (HEALTH/CF)-SAFETY	9872	9.00	10.00	8.00	2.00	0.00	0.00	0.00	0.00	1.00	11.11%
CORRECTIONAL HEALTH SERVICES ADMINSTRATOR II, CORRECTIONAL FACILITY	4912	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.00	100.00%
HEALTH PROGRAM SP I	8338	2.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	1.00	50.00%
OFFICE ASST (T)	1379	0.00	0.00	0.00	0.00	2.00	0.00	0.00	0.00	-2.00	NC
OFFICE SERVICES SUP II (G)	1150	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.00	100.00%
OFFICE TECH (T)	1139	10.50	5.50	5.00	0.50	0.00	0.00	0.00	0.00	5.50	52.38%
PSYCH-CLINIC CF	9283	24.50	25.50	22.00	3.50	0.00	0.00	0.00	0.00	2.50	10.20%
REC THERAPIST CF	9286	2.00	1.50	0.00	1.50	0.00	0.00	0.00	0.00	2.00	100.00%
SENIOR PSYCHIATRIST (SUPERVISOR), CORRECTIONAL AND REHABILITATIVE	9761	0.00	0.00	0.00	0.00	1.00	0.00	0.00	0.00	-1.00	NC
SR PSYCH CF/SP	9287	2.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.00	100.00%
SR PSYCH CF/SUP	9288	2.00	2.00	2.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
STAFF PSYCHIATRIST, CORRECTIONAL AND REHABILITATIVE SERVICES (SAFETY)	9758	7.00	7.05	1.50	5.55	0.00	0.00	4.55	0.00	0.95	13.57%
SUP PSYCH S WK I CF	9291	1.00	0.50	0.00	0.50	0.00	0.00	0.00	0.00	1.00	100.00%
	Totals	**65.00**	**55.05**	**40.50**	**14.55**	**3.00**	**0.00**	**4.55**	**0.00**	**16.95**	**26.08%**

Source: FY 12/13 7A; SCO Reports; MIRS reports; Hire Tracking System
Report Generated By:
Program Support

Correctional Health Care Services
Mental Health Institution Vacancies

SUMMARY BY INSTITUTION BY CLASSIFICATION
As Of January - 2013

State Wide		FY 12/13	SCO DATA			Adjustments					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918[7]	920[8]	Registry	Hires	Adjusted Vacancy	Percent Vacant
State Wide Totals		**2238.06**	**2288.05**	**1555.53**	**732.52**	**31.20**	**0.00**	**106.46**	**0.00**	**544.87**	**24.35%**

Footnotes:
1. Data reflected in the Hire column is based on an actual hire with a start date occurring within the last 30 days.
2. Adjusted vacancy figures are calculated as factor of "Auth per 7A."
3. SCO = State Controller's Office (Payroll) Report; NC = Not Calculated
4. Data reflected in the Registry Column is a conversion of hours to PY. The formula is based on 173.33 hours per PY.
5. Positions Filled above the authorized PY are reflected as a negative number in the Adjusted Vacancy Column.
6. Establishment of positions in the SCO data is based on the 607 process, therefore the established amount may reflect a lag.
7. 918 = Salary and Wages Other Positions, Blanket Report. Pending hires and hires of staff being paid without an authorized position are sometimes placed in a blanket.
8. 920 = Long Term Sick Position Blanket Report.
9. Classifications can have more than one Class Code.
10. SCO data is approximately 45 days in arrears and does not include employees hired through various registry services or positions paid from the temporary help blanket (9999), unallocated positions.
11. Occasionally, additional new and certain existing employees are paid using 918 blanket numbers. This is an accounting issue, not a reduction in positions.

Exhibit 33

DIVISION OF CORRECTIONAL HEALTH CARE SERVICES
STATEWIDE MENTAL HEALTH PROGRAM
P.O. Box 942883
Sacramento, CA94283-0001

July 3, 2012

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Office of the Special Master
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P. O. Box 944255
Sacramento, CA 94244-2550

RE: COLEMAN MONTHLY REPORT OF INFORMATION REQUESTED AND RESPONSE TO JANUARY 19, 1999, COURT ORDER REGARDING STAFF VACANCIES

Dear Mr. Lopes:

Enclosed is the Coleman Monthly Report reflective of May, 2012 data (or as otherwise noted). The following is the list of enclosures:

1. Mental Health Services Delivery System (MHSDS) Staffing Allocation and Vacancy History.
2. MHSDS Hiring Activity Report.
3. Health Care Placement Oversight Program (HCPOP) Information Report, Summary and Administrative Segregation Greater than 60 Days. **Due to a server migration issue that occurred during the move to Elk Grove, the following reports are unavailable for the month of May:**
   - R-01: Mental Health Population by Institution
   - R-02: Mental Health ASU/SHU/PSU
     (The "MHSDS Management Information Summary" report has been provided, in lieu of these reports).
   - R-08: EOP and CCCMS in ASU/SHU/PSU - Placements greater than 21 less than 60 days
   - R-09: EOP and CCCMS in ASU/SHU/PSU - Placements greater than 60 less than 90 days
   - R-10: EOP and CCCMS in ASU/SHU/PSU - Placements greater than 90 days
     (Reports not included. Will be provided under separate cover).
4. Mental Health Contract Services including Summary and Telemedicine Monthly Report for all disciplines.
5. California Department of Corrections and Rehabilitation (CDCR) Reception Center (RC) Monthly Report.

[redacted]

6. Monthly Summary of Mental Health Crisis Bed use by Institution Titles Inpatient Psychiatric Aging Report. **(Not included. Will be provided under separate cover)**
7. Referrals for Transfer to the Department of Mental Health (including admissions).
8. Atascadero State Hospital (ASH) Discharges.
9. Weekly Enhanced Outpatient Program (EOP)/Outpatient Psychiatric Program.
10. The Department of Mental Health (DMH) Monthly Report of CDCR Patients in DMH Hospitals -- Summary and Penal Code 2684.
11. Suicide Report.
12. Statistics on Contracted Registered Nurse (RN). **(No Longer Available)**
13. RC Processing for MHSDS Inmate Patients.
14. Medical Technical Assistant (MTA) Vacancy Report. **(No Longer Available)**
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16. EOP Inmates Waiting Transfer to a Psychiatric Services Unit (PSU).
17. Audit reports on Psychiatric Technician Rounds in Administrative Segregation at California State Prison, San Quentin (SQ), California State Prison-Corcoran (COR), and Salinas Valley State Prison (SVSP).
18. Mental Health Crisis Beds Wait List.
19. Correctional Treatment Centers and CDCR General Acute Care Hospital Care Placement Issues. **(No longer available)**
20. Transferred and Rescinded Mental Health Crisis Bed Referrals by Institution and Level of Care.

If you have any questions, please contact me at (916) 691-0296.

Sincerely,

T. BELAVICH, Ph.D., MSHCA, CCHP
Deputy Director (A)
Statewide Mental Health Program
Division of Correctional Health Care Services

Enclosures

cc: Diana Toche, DDS, Director (A), Division of Correctional Health Care Services (DCHCS)
Mohamedu F., Jones, Esq., *Coleman* Deputy Special Master
Linda Holden, Esq., *Coleman* Deputy Special Master
Jeffrey L. Metzner, M.D., *Coleman* Expert
Kerry C. Hughes, M.D., *Coleman* Expert
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Judy Burleson, Associate Director, Statewide Mental Health Program, DCHCS
Nathan Stanley, Chief, Operational Program Oversight, Statewide Mental Health Program DCHCS
Karen Higgins, M.D., Chief of Behavioral Medicine, Statewide Mental Health Program, DCHCS
Teresa Owens, Associate Governmental Program Analyst, Operational Program Oversight, DCHCS

[redacted]

SUMMARY BY INSTITUTION BY CLASSIFICATION
As Of May - 2012

SVSP		FY 11/12	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
ASSOC GOVRL PROGRAM ANALYST	5393	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
BLDG MAINT WRKR CF	6216	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
CHIEF PSYCHIATRIST, CORRECTIONAL AND REHABILITITATIVE SERVICES (SAFETY)	9774	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
CHIEF PSYCHOLOGIST/CF	9859	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
CLINICAL SOCIAL WORKER (HEALTH/CF)-SAFETY	9872	8.00	8.00	6.00	2.00	0.00	0.00	0.98	0.00	1.02	12.75%
CORRECTIONAL SUPERVISING COOK, CF	2183	3.00	3.00	2.00	1.00	0.00	0.00	0.00	0.00	1.00	33.33%
HEALTH PROGRAM SP I	8338	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
HEALTH REC TECH I	1869	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
MATERIAL & STORES SUP I CF	1508	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
OFFICE SERVICES SUP I (T)	1148	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
OFFICE TECH (T)	1139	11.00	11.00	10.00	1.00	0.00	0.00	0.00	0.00	1.00	9.09%
PSYCH-CLINIC CF	9283	29.00	29.02	27.50	1.52	1.00	0.00	4.83	0.00	-4.33	-14.93%
REC THERAPIST CF	9286	5.30	6.00	3.00	3.00	0.00	0.00	1.44	0.00	0.86	16.23%
SR PSYCH CF/SUP	9288	4.00	4.00	3.00	1.00	0.00	0.00	0.00	0.00	1.00	25.00%
STAFF PSYCHIATRIST, CORRECTIONAL AND REHABILITATIVE SERVICES (SAFETY)	9758	9.50	9.50	5.50	4.00	0.00	0.00	0.64	0.00	3.36	35.37%
STAT ENG-CF	6713	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
	Totals	**78.80**	**79.52**	**63.00**	**16.52**	**1.00**	**0.00**	**7.89**	**0.00**	**6.91**	**8.77%**

Exhibit 34

DIVISION OF CORRECTIONAL HEALTH CARE SERVICES
STATEWIDE MENTAL HEALTH PROGRAM
P.O. Box 942883
Sacramento, CA94283-0001

APR 2 2012

Matthew A. Lopes, Jr. Esquire
Office of the Special Master
Pannone Lopes & Devereaux LLC
317 Iron Horse Point Way, Suite 301
Providence, RI 02908

via: Debbie J. Vorous, Esquire
Deputy Attorney General
Department of Justice
1300 "I" Street, Suite 125
P. O. Box 944255
Sacramento, CA 94244-2550

RE: COLEMAN MONTHLY REPORT OF INFORMATION REQUESTED AND RESPONSE TO JANUARY 19, 1999, COURT ORDER REGARDING STAFF VACANCIES

Dear Mr. Lopes:

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2. MHSDS Hiring Activity Report.
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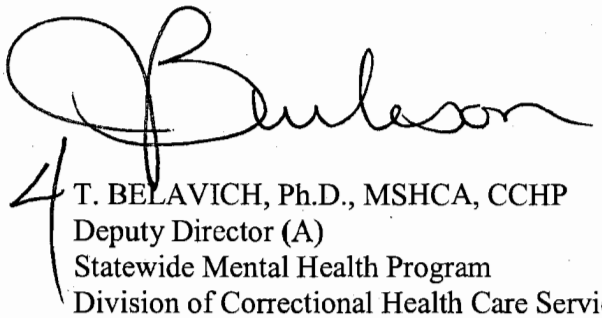
20. Transferred and Rescinded Mental Health Crisis Bed Referrals by Institution and Level of Care.

If you have any questions, please contact me at (916) 324-2933.

Sincerely,



T. BELAVICH, Ph.D., MSHCA, CCHP
Deputy Director (A)
Statewide Mental Health Program
Division of Correctional Health Care Services

Enclosures

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Teresa Owens, Associate Governmental Program Analyst, Operational Program Oversight, DCHCS

Correctional Health Care Services
Mental Health Institution Vacancies

SUMMARY BY INSTITUTION BY CLASSIFICATION
As Of February - 2012

SAC		FY 11/12	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
CHIEF PSYCHIATRIST, CORRECTIONAL AND REHABILITITATIVE SERVICES (SAFETY)	9774	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
CHIEF PSYCHOLOGIST/CF	9859	1.00	1.00	1.00	0.00	1.00	0.00	0.00	0.00	-1.00	-100.00%
CLINICAL SOCIAL WORKER (HEALTH/CF)-SAFETY	9872	25.30	25.33	21.00	4.33	0.00	0.00	2.02	0.00	2.28	9.01%
CORR COUNSELOR II SP	9901	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
HEALTH PROGRAM SP I	8338	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
HEALTH REC TECH I	1869	1.00	1.00	0.00	1.00	0.05	0.00	0.00	0.00	0.95	95.24%
MANAGEMENT SVCS TECH	5278	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
OFFICE ASST (T)	1379	2.00	2.00	0.00	2.00	0.00	0.00	0.00	0.00	2.00	100.00%
OFFICE SERVICES SUP II (G)	1150	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
OFFICE TECH (T)	1139	21.30	22.00	16.00	6.00	0.00	0.00	0.00	0.00	5.30	24.88%
PSYCH-CLINIC CF	9283	50.00	46.00	35.75	10.25	1.00	0.00	8.68	0.00	4.57	9.14%
REC THERAPIST CF	9286	13.50	13.54	12.80	0.74	1.00	0.00	0.00	0.00	-0.30	-2.22%
SENIOR PSYCHIATRIST (SUPERVISOR), CORRECTIONAL AND REHABILITATIVE	9761	2.00	2.00	1.00	1.00	0.00	0.00	0.00	0.00	1.00	50.00%
SR PSYCH CF/SP	9287	1.00	1.00	1.00	0.00	1.00	0.00	0.00	0.00	-1.00	-100.00%
SR PSYCH CF/SUP	9288	8.00	8.00	6.00	2.00	0.00	0.00	0.00	0.00	2.00	25.00%
STAFF PSYCHIATRIST, CORRECTIONAL AND REHABILITATIVE SERVICES (SAFETY)	9758	20.50	20.50	12.75	7.75	0.00	0.00	6.07	0.00	1.68	8.20%
SUP PSYCH S WK I CF	9291	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
	Totals	**151.60**	**148.37**	**111.30**	**37.07**	**4.05**	**0.00**	**16.77**	**0.00**	**19.48**	**12.85%**

Source: FY 11/12 7A; SCO Reports; MIRS reports; Hire Tracking System
Report Generated By:
Resource Management

Exhibit 35

DIVISION OF CORRECTIONAL HEALTH CARE SERVICES
STATEWIDE MENTAL HEALTH PROGRAM
P.O. Box 942883
Sacramento, CA94283-0001

July 3, 2012

Matthew A. Lopes, Jr. Esquire
Office of the Special Master
Pannone Lopes & Devereaux LLC
317 Iron Horse Point Way, Suite 301
Providence, RI 02908

via: Debbie J. Vorous, Esquire
Deputy Attorney General
Department of Justice
1300 "I" Street, Suite 125
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If you have any questions, please contact me at (916) 691-0296.

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T. BELAVICH, Ph.D., MSHCA, CCHP
Deputy Director (A)
Statewide Mental Health Program
Division of Correctional Health Care Services

Enclosures

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As Of May - 2012

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CHIEF PSYCHOLOGIST/CF	9859	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
CLINICAL SOCIAL WORKER (HEALTH/CF)-SAFETY	9872	10.00	10.00	8.00	2.00	0.00	0.00	0.98	0.00	1.02	10.20%
HEALTH PROGRAM SP I	8338	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
MEDICAL SECRETARY/CI	9551	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
OFFICE ASST (T)	1379	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
OFFICE SERVICES SUP I (T)	1148	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.00	100.00%
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PSYCH-CLINIC CF	9283	34.80	35.00	34.00	1.00	0.00	0.00	2.00	0.00	-1.20	-3.45%
REC THERAPIST CF	9286	7.20	6.15	4.00	2.15	0.00	0.00	0.00	0.00	3.20	44.44%
SR PSYCH CF/SUP	9288	6.00	6.00	5.00	1.00	0.00	0.00	0.00	0.00	1.00	16.67%
STAFF PSYCHIATRIST, CORRECTIONAL AND REHABILITATIVE SERVICES (SAFETY)	9758	11.50	11.00	5.50	5.50	0.00	0.00	5.12	0.00	0.88	7.65%
	Totals	**90.00**	**88.65**	**71.00**	**17.65**	**0.00**	**0.00**	**8.10**	**0.00**	**10.90**	**12.11%**

Source: FY 11/12 7A; SCO Reports; MIRS reports; Hire Tracking System
Report Generated By:
Resource Management

Exhibit 36

DIVISION OF CORRECTIONAL HEALTH CARE SERVICES
STATEWIDE MENTAL HEALTH PROGRAM
P.O. Box 942883
Sacramento, CA94283-0001

May 2, 2012

Matthew A. Lopes, Jr. Esquire
Office of the Special Master
Pannone Lopes & Devereaux LLC
317 Iron Horse Point Way, Suite 301
Providence, RI 02908

via: Debbie J. Vorous, Esquire
Deputy Attorney General
Department of Justice
1300 "I" Street, Suite 125
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Division of Correctional Health Care Services

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Kathryn A. Burns, M.D., MPH, *Coleman* Expert
Henry A. Dlugacz, Esq., *Coleman* Expert
Kerry F. Walsh, Esq., *Coleman* Monitor
Patricia Williams, Esq., *Coleman* Monitor

[redacted]

Haunani Henry, *Coleman* Monitor
Debbie Vorous, Esq., Office of the Attorney General
Heather McCray Esq., Office of Legal Affairs, CDCR
Michael Stone, Esq., Office of Legal Affairs, CDCR
Michael Bien, Esq., Rosen, Bien and Galvan
Donald Specter, Esq., Prison Law Office
Judy Burleson, Associate Director, Statewide Mental Health Program, DCHCS
Nathan Stanley, Chief, Operational Program Oversight, Statewide Mental Health Program DCHCS
Karen Higgins, M.D., Chief of Behavioral Medicine, Statewide Mental Health Program, DCHCS
Teresa Owens, Associate Governmental Program Analyst, Operational Program Oversight, DCHCS

SUMMARY BY INSTITUTION BY CLASSIFICATION
As Of March - 2012

RJD		FY 11/12	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
ASSOC GOVRL PROGRAM ANALYST	5393	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
ASSOC HEALTH PROGRAM ADV	8337	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
CHIEF PSYCHIATRIST, CORRECTIONAL AND REHABILITITATIVE SERVICES (SAFETY)	9774	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
CHIEF PSYCHOLOGIST/CF	9859	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
CLINICAL SOCIAL WORKER (HEALTH/CF)-SAFETY	9872	10.00	10.00	9.00	1.00	0.00	0.00	2.50	0.00	-1.50	-15.00%
CORR COUNSELOR II SP	9901	0.10	0.10	0.00	0.10	0.00	0.00	0.00	0.00	0.10	100.00%
CORRECTIONAL HEALTH SERVICES ADMINSTRATOR II, CORRECTIONAL FACILITY	4912	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
HEALTH REC TECH I	1869	2.00	2.00	2.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
OFFICE ASST (T)	1379	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
OFFICE SERVICES SUP II (G)	1150	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
OFFICE TECH (T)	1139	14.70	14.70	8.70	6.00	0.00	0.00	0.00	0.00	6.00	40.82%
PHARMACIST I	7982	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
PSYCH-CLINIC CF	9283	46.50	46.50	46.50	0.00	0.00	0.00	11.27	0.00	-11.27	-24.24%
REC THERAPIST CF	9286	7.70	7.65	7.00	0.65	1.00	0.00	0.00	0.00	-0.30	-3.90%
SENIOR PSYCHIATRIST (SUPERVISOR), CORRECTIONAL AND REHABILITATIVE	9761	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
SR PSYCH CF/SUP	9288	9.20	9.20	6.00	3.20	0.00	0.00	0.00	0.00	3.20	34.78%
STAFF PSYCHIATRIST, CORRECTIONAL AND REHABILITATIVE SERVICES (SAFETY)	9758	14.50	14.50	12.00	2.50	0.51	0.00	5.22	0.00	-3.23	-22.29%
SUP PROGRAM TECH III	9926	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
	Totals	**114.70**	**114.65**	**93.20**	**21.45**	**1.51**	**0.00**	**18.99**	**0.00**	**1.00**	**0.87%**

Exhibit 37

DIVISION OF CORRECTIONAL HEALTH CARE SERVICES
STATEWIDE MENTAL HEALTH PROGRAM
P.O. Box 942883
Sacramento, CA94283-0001

July 3, 2012

Matthew A. Lopes, Jr. Esquire
Office of the Special Master
Pannone Lopes & Devereaux LLC
317 Iron Horse Point Way, Suite 301
Providence, RI 02908

via: Debbie J. Vorous, Esquire
Deputy Attorney General
Department of Justice
1300 "I" Street, Suite 125
P. O. Box 944255
Sacramento, CA 94244-2550

RE: COLEMAN MONTHLY REPORT OF INFORMATION REQUESTED AND RESPONSE TO JANUARY 19, 1999, COURT ORDER REGARDING STAFF VACANCIES

Dear Mr. Lopes:

Enclosed is the Coleman Monthly Report reflective of May, 2012 data (or as otherwise noted). The following is the list of enclosures:

1. Mental Health Services Delivery System (MHSDS) Staffing Allocation and Vacancy History.
2. MHSDS Hiring Activity Report.
3. Health Care Placement Oversight Program (HCPOP) Information Report, Summary and Administrative Segregation Greater than 60 Days. **Due to a server migration issue that occurred during the move to Elk Grove, the following reports are unavailable for the month of May:**
   - R-01: Mental Health Population by Institution
   - R-02: Mental Health ASU/SHU/PSU
     (The "MHSDS Management Information Summary" report has been provided, in lieu of these reports).
   - R-08: EOP and CCCMS in ASU/SHU/PSU - Placements greater than 21 less than 60 days
   - R-09: EOP and CCCMS in ASU/SHU/PSU - Placements greater than 60 less than 90 days
   - R-10: EOP and CCCMS in ASU/SHU/PSU - Placements greater than 90 days
     (Reports not included. Will be provided under separate cover).
4. Mental Health Contract Services including Summary and Telemedicine Monthly Report for all disciplines.
5. California Department of Corrections and Rehabilitation (CDCR) Reception Center (RC) Monthly Report.

[redacted]

6. Monthly Summary of Mental Health Crisis Bed use by Institution Titles Inpatient Psychiatric Aging Report. **(Not included. Will be provided under separate cover)**
7. Referrals for Transfer to the Department of Mental Health (including admissions).
8. Atascadero State Hospital (ASH) Discharges.
9. Weekly Enhanced Outpatient Program (EOP)/Outpatient Psychiatric Program.
10. The Department of Mental Health (DMH) Monthly Report of CDCR Patients in DMH Hospitals -- Summary and Penal Code 2684.
11. Suicide Report.
12. Statistics on Contracted Registered Nurse (RN). **(No Longer Available)**
13. RC Processing for MHSDS Inmate Patients.
14. Medical Technical Assistant (MTA) Vacancy Report. **(No Longer Available)**
15. Allocated Case Manager Positions and Vacancies for the EOP Administrative Segregated Hub institutions.
16. EOP Inmates Waiting Transfer to a Psychiatric Services Unit (PSU).
17. Audit reports on Psychiatric Technician Rounds in Administrative Segregation at California State Prison, San Quentin (SQ), California State Prison-Corcoran (COR), and Salinas Valley State Prison (SVSP).
18. Mental Health Crisis Beds Wait List.
19. Correctional Treatment Centers and CDCR General Acute Care Hospital Care Placement Issues. **(No longer available)**
20. Transferred and Rescinded Mental Health Crisis Bed Referrals by Institution and Level of Care.

If you have any questions, please contact me at (916) 691-0296.

Sincerely,

T. BELAVICH, Ph.D., MSHCA, CCHP
Deputy Director (A)
Statewide Mental Health Program
Division of Correctional Health Care Services

Enclosures

cc: Diana Toche, DDS, Director (A), Division of Correctional Health Care Services (DCHCS)
Mohamedu F., Jones, Esq., *Coleman* Deputy Special Master
Linda Holden, Esq., *Coleman* Deputy Special Master
Jeffrey L. Metzner, M.D., *Coleman* Expert
Kerry C. Hughes, M.D., *Coleman* Expert
Raymond F. Patterson, M.D, *Coleman* Expert

[redacted]

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Henry A. Dlugacz, Esq., *Coleman* Expert
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Teresa Owens, Associate Governmental Program Analyst, Operational Program Oversight, DCHCS

[redacted]

Correctional Health Care Services
Mental Health Institution Vacancies

SUMMARY BY INSTITUTION BY CLASSIFICATION
As Of May - 2012

SOL		FY 11/12	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
CHIEF PSYCHIATRIST, CORRECTIONAL AND REHABILITITATIVE SERVICES (SAFETY)	9774	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
CHIEF PSYCHOLOGIST/CF	9859	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
CLINICAL SOCIAL WORKER (HEALTH/CF)-SAFETY	9872	6.00	6.00	5.00	1.00	0.00	0.00	1.83	0.00	-0.83	-13.83%
HEALTH PROGRAM SP I	8338	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
OFFICE ASST (T)	1379	0.50	0.50	0.00	0.50	0.00	0.00	0.00	0.00	0.50	100.00%
OFFICE SERVICES SUP II (G)	1150	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
OFFICE TECH (T)	1139	9.50	9.50	8.00	1.50	0.00	0.00	0.00	0.00	1.50	15.79%
PSYCH-CLINIC CF	9283	14.50	14.52	14.50	0.02	0.00	0.00	0.00	0.00	0.00	0.00%
REC THERAPIST CF	9286	2.20	2.15	1.00	1.15	0.00	0.00	0.00	0.00	1.20	54.55%
SR PSYCH CF/SUP	9288	2.00	2.00	2.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
STAFF PSYCHIATRIST, CORRECTIONAL AND REHABILITATIVE SERVICES (SAFETY)	9758	6.00	6.00	5.00	1.00	0.00	0.00	2.67	0.00	-1.67	-27.83%
	Totals	**44.70**	**44.67**	**38.50**	**6.17**	**0.00**	**0.00**	**4.50**	**0.00**	**1.70**	**3.80%**

SQ		FY 11/12	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
BLDG MAINT WRKR CF	6216	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
CHIEF PSYCHIATRIST, CORRECTIONAL AND REHABILITITATIVE SERVICES (SAFETY)	9774	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
CHIEF PSYCHOLOGIST/CF	9859	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
CLINICAL PSYCHOLOGY INTERN	9851	0.00	2.00	2.00	0.00	0.00	0.00	0.00	0.00	-2.00	NC
CLINICAL SOCIAL WORKER (HEALTH/CF)-SAFETY	9872	10.40	10.20	10.00	0.20	0.00	0.00	0.00	0.00	0.40	3.85%
CORR COUNSELOR I	9904	1.50	1.50	0.00	1.50	0.00	0.00	0.00	0.00	1.50	100.00%
CORR COUNSELOR II SP	9901	1.10	1.10	1.00	0.10	0.00	0.00	0.00	0.00	0.10	9.09%

Source: FY 11/12 7A; SCO Reports; MIRS reports; Hire Tracking System

Report Generated By:
Resource Management

SUMMARY BY INSTITUTION BY CLASSIFICATION
As Of May - 2012

SQ		FY 11/12	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
CORRECTIONAL HEALTH SERVICES ADMINSTRATOR II, CORRECTIONAL FACILITY	4912	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
CORRECTIONAL SUPERVISING COOK, CF	2183	2.00	2.00	2.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
HEALTH PROGRAM SP I	8338	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
JANITOR CORR FAC	2006	2.00	2.00	0.00	2.00	0.00	0.00	0.00	0.00	2.00	100.00%
LABORATORY ASSISTANT, CORRECTIONAL FACILITY	9265	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
OFFICE ASST (T)	1379	2.00	2.00	0.00	2.00	0.00	0.00	0.00	0.00	2.00	100.00%
OFFICE SERVICES SUP I (T)	1148	3.00	3.00	2.00	1.00	0.00	0.00	0.00	0.00	1.00	33.33%
OFFICE SERVICES SUP II (G)	1150	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
OFFICE TECH (T)	1139	11.30	11.25	6.00	5.25	0.00	0.00	0.00	0.00	5.30	46.90%
PHARMACIST I	7982	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
PHARMACY TECH	7979	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
PSYCH-CLINIC CF	9283	38.00	35.50	30.80	4.70	0.00	0.00	0.54	0.00	6.66	17.53%
PSYCHOMETRIST CF	9285	0.50	0.50	0.00	0.50	0.00	0.00	0.00	0.00	0.50	100.00%
REC THERAPIST CF	9286	5.40	5.30	3.75	1.55	0.00	0.00	0.51	0.00	1.14	21.11%
SENIOR PSYCHIATRIST (SUPERVISOR), CORRECTIONAL AND REHABILITATIVE	9761	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
SR PSYCH CF/SP	9287	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
SR PSYCH CF/SUP	9288	5.50	5.50	5.00	0.50	0.00	0.00	0.00	0.00	0.50	9.09%
STAFF PSYCHIATRIST, CORRECTIONAL AND REHABILITATIVE SERVICES (SAFETY)	9758	12.40	12.25	11.65	0.60	0.00	0.00	0.00	0.00	0.75	6.05%
STAT ENG-CF	6713	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
	Totals	**107.10**	**106.10**	**80.20**	**25.90**	**0.00**	**0.00**	**1.05**	**0.00**	**25.85**	**24.14%**

Source: FY 11/12 7A; SCO Reports; MIRS reports; Hire Tracking System
Report Generated By:
Resource Management

Exhibit 38

DIVISION OF CORRECTIONAL HEALTH CARE SERVICES
STATEWIDE MENTAL HEALTH PROGRAM
P.O. Box 942883
Sacramento, CA94283-0001

August 3, 2012

Matthew A. Lopes, Jr. Esquire
Office of the Special Master
Pannone Lopes & Devereaux LLC
317 Iron Horse Point Way, Suite 301
Providence, RI 02908

via: Debbie J. Vorous, Esquire
Deputy Attorney General
Department of Justice
1300 "I" Street, Suite 125
P. O. Box 944255
Sacramento, CA 94244-2550

RE: COLEMAN MONTHLY REPORT OF INFORMATION REQUESTED AND RESPONSE TO JANUARY 19, 1999, COURT ORDER REGARDING STAFF VACANCIES

Dear Mr. Lopes:

Enclosed is the Coleman Monthly Report reflective of June, 2012 data (or as otherwise noted). The following is the list of enclosures:

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5. California Department of Corrections and Rehabilitation (CDCR) Reception Center (RC) Monthly Report.
6. Monthly Summary of Mental Health Crisis Bed use by Institution Titles Inpatient Psychiatric Aging Report.
7. Referrals for Transfer to the Department of Mental Health (including admissions).
8. Atascadero State Hospital (ASH) Discharges.
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10. The Department of Mental Health (DMH) Monthly Report of CDCR Patients in DMH Hospitals -- Summary and Penal Code 2684.
11. Suicide Report.
12. Statistics on Contracted Registered Nurse (RN). **(No Longer Available)**
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14. Medical Technical Assistant (MTA) Vacancy Report. **(No Longer Available)**
15. Allocated Case Manager Positions and Vacancies for the EOP Administrative Segregated Hub institutions.

16. EOP Inmates Waiting Transfer to a Psychiatric Services Unit (PSU).
17. Audit reports on Psychiatric Technician Rounds in Administrative Segregation at California State Prison, San Quentin (SQ), California State Prison-Corcoran (COR), and Salinas Valley State Prison (SVSP).
18. Mental Health Crisis Beds Wait List.
19. Correctional Treatment Centers and CDCR General Acute Care Hospital Care Placement Issues. **(No longer available)**
20. Transferred and Rescinded Mental Health Crisis Bed Referrals by Institution and Level of Care.

If you have any questions, please contact me at (916) 691-0209.

Sincerely,

T. BELAVICH, Ph.D., MSHCA, CCHP
Deputy Director (A)
Statewide Mental Health Program
Division of Correctional Health Care Services

Enclosures

cc: Diana Toche, DDS, Director (A), Division of Correctional Health Care Services (DCHCS)
Mohamedu F., Jones, Esq., *Coleman* Deputy Special Master
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Teresa Owens, Associate Governmental Program Analyst, Operational Program Oversight, DCHCS

SUMMARY BY INSTITUTION BY CLASSIFICATION
As Of June - 2012

SVSP		FY 11/12	SCO DATA			ADJUSTMENTS					
Abbrev Class Title	Class Code	Authorized Per 7A	Established	Filled	Vacant	918	920	Registry (PY)	Hires	Adjusted Vacancy	Percent Vacant
ASSOC GOVRL PROGRAM ANALYST	5393	0.50	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.50	100.00%
BLDG MAINT WRKR CF	6216	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
CHIEF PSYCHIATRIST, CORRECTIONAL AND REHABILITITATIVE SERVICES (SAFETY)	9774	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
CHIEF PSYCHOLOGIST/CF	9859	2.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	1.00	50.00%
CLINICAL SOCIAL WORKER (HEALTH/CF)-SAFETY	9872	13.50	8.00	6.00	2.00	0.00	0.00	0.70	0.00	6.80	50.37%
CORRECTIONAL HEALTH SERVICES ADMINSTRATOR II, CORRECTIONAL FACILITY	4912	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.00	100.00%
CORRECTIONAL SUPERVISING COOK, CF	2183	3.00	3.00	2.00	1.00	0.00	0.00	0.00	0.00	1.00	33.33%
HEALTH PROGRAM SP I	8338	2.50	1.00	1.00	0.00	0.00	0.00	0.00	0.00	1.50	60.00%
HEALTH REC TECH I	1869	0.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	-1.00	NC
MATERIAL & STORES SUP I CF	1508	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00%
OFFICE SERVICES SUP I (T)	1148	0.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	NC
OFFICE SERVICES SUP II (G)	1150	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.00	100.00%
OFFICE TECH (T)	1139	12.50	12.00	10.00	2.00	0.00	0.00	0.00	0.00	2.50	20.00%
PSYCH-CLINIC CF	9283	23.50	29.02	27.50	1.52	1.00	0.00	3.67	0.00	-8.67	-36.89%
REC THERAPIST CF	9286	7.70	7.00	3.00	4.00	0.00	0.00	0.00	0.00	4.70	61.04%
SR PSYCH CF/SP	9287	3.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	3.50	100.00%
SR PSYCH CF/SUP	9288	3.50	4.00	3.00	1.00	0.00	0.00	0.00	0.00	0.50	14.29%
STAFF PSYCHIATRIST, CORRECTIONAL AND REHABILITATIVE SERVICES (SAFETY)	9758	9.00	9.50	5.50	4.00	0.00	0.00	0.60	0.00	2.90	32.22%
STAT ENG-CF	6713	1.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	100.00%
SUP PSYCH S WK I CF	9291	0.50	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.50	100.00%
	Totals	**87.70**	**82.52**	**62.00**	**20.52**	**1.00**	**0.00**	**4.97**	**0.00**	**19.73**	**22.50%**

Source: FY 11/12 7A; SCO Reports; MIRS reports; Hire Tracking System
Report Generated By:
Resource Management

Exhibit 39

Institutional Mental Health Staffing and Telemedicine

California State Prison, Sacramento

Point in Time Date: January 21, 2013

Position	Positions Established	Positions Filled	Vacancies	Vacancy Rate %	Full Time Equivalent	Functional Vacancies	Functional Vacancy Rate
Chief Psychiatrist	1	0	0	100%	0	0	100%
Senior Psychiatrist Supervisor	1	1	0	0%	0	0	0%
Chief Psychologist	2	2	0	0%	0	0	0%
Senior Psychologist Supervisor	9.5	9	0	5%	0	0	5%
Staff Psychiatrist	21	12.25	8.75	42%	4.0	4.75	23%
Staff Psychologist	58	38	20	34%	11	9	16%
Sr. Psychologist Specialist	6	4	2	33%	0	0	33%
Supervising Social Worker	.5	1	0	0%	0	0	0% (Overfilled)
Clinical Social Workers	24.5	19	5.5	22.5%	3.75	1.75	5%
Recreational Therapist	25.5	16	8.5	33%	0	8.5	33%
MHSDS Admin Support	24.5	13	11.5	47%	.75	10.75	44%
Office Services Supervisor	1.0	1.0	0	0%	0	0	0%

Telemedicine

Psychiatry Telemedicine Used?	Number of Hours Per Week
NO	N/A

Exhibit 40

Coleman Review, Round XXV

MENTAL HEALTH MANAGEMENT REPORT

California State Prison, Sacramento

Review Period: December 1, 2011 – May 31, 2012

California State Prison, Sacramento

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

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GLOSSARY OF TERMS

Acronym	Term
AIMS	Abnormal Involuntary Movement Scale
APP	Acute Psychiatric Program
ASU	Administrative Segregation Unit
CAP	Corrective Action Plan
CC	Correctional Counselor
CCCMS	Correctional Clinical Case Management System
CDCR	California Department of Corrections and Rehabilitation
CHSA	Correctional Health Services Administrator
DMH	Department of Mental Health
DOT	Direct Observation Therapy
EOP	Enhanced Outpatient Program
FIT	Focused Improvement Team
GP	General Population
HC-POP	Health Care Population Oversight Program
HS	Hour of Sleep
I/P	Inmate-patient
ICC	Institutional Classification Committee
ICF	Intermediate Care Facility
IDTT	Inter Disciplinary Treatment Team
LGB	Local Governing Body
LOC	Level of Care
LOP	Local Operating Procedure
LOS	Length of Stay
LPT	Licensed Psychiatric Technician
MAR	Medication Administration Record
MHCB	Mental Health Crisis Bed
MHCBU	Temporary Unlicensed Mental Health Crisis Bed Unit at SAC

MH-OHU	Mental Health-Outpatient Housing Unit
MHQM	Mental Health Quality Management Subcommittee
MHSDS	Mental Health Services Delivery System
MHTS	Mental Health Tracking System
ML	Mainline (General Population)
OHU	Outpatient Housing Unit
PC	Primary Clinician
PPEC	Professional Practice Executive Committee
PSU	Psychiatric Services Unit
QIT	Quality Improvement Team
QM	Quality Management
QMC	Quality Management Committee
R&R	Receiving and Release
RVR	Rules Violation Report
SAC	California State Prison, Sacramento
SHU	Security Housing Unit
SPC	Suicide Prevention Coordinator
SPR-FIT	Suicide Prevention and Response-Focused Improvement Team
SRE	Suicide Risk Evaluation
UHR	Unit Health Record

Coleman Review, Round XXV
MENTAL HEALTH MANAGEMENT REPORT
December 1, 2011 – May 31, 2012
California State Prison, Sacramento

I. Institutional Program Summary

A. Overview of all the mental health programs at institution

California State Prison, Sacramento (SAC) provides mental health treatment at the following locations and levels of care: ML CCCMS, ASU CCCMS, SHU CCCMS, ML EOP, ASU EOP, PSU, and MHCB levels of care.

B. New Construction/Remodeling

Construction of permanent treatment and office space in B-Work Center for the EOP program (approx. 16,000 square feet) was completed and activated on March 19, 2012. Treatment space includes 8 group rooms, 2 classrooms, 3 non-contact interview rooms and 5 contact interview rooms. Joint custody and clinical staff orientation training was conducted to familiarize staff with inmate-patient processing, ducating procedures, and emergency response within the treatment center. Groups and individual clinician contacts were quickly transitioned from the housing blocks to the treatment center space with minimal disruption in services. Assigned EOP-II psychiatrists report improved quality of care as a result of easy access to electronic data (labs, eUHR) during individual psychiatry sessions.

Installation of suicide resistant beds in the MHCB units in CTCI, CTCII, and the temporary unlicensed MHCB Unit is scheduled for July 6 – July 23, 2012.

Construction of a new treatment and administrative area for an additional PSU population of 152 I/Ps on B Facility is scheduled to be completed March 26, 2013.

C. New or Anticipated Mission Changes

There were no new mission changes during the review period. The PSU population is expected to expand by 152 beds in 2013.

D. Major Population Moves

Dormitory housing in C Facility (approximately 130 inmates) was deactivated in February 2012. Inmates from the minimum facility are now housed in a C Facility housing block for orientation.

E. New or Overflow Administrative Segregation or any other Specialized Housing Units

There were no new or overflow administrative segregation units, or any other specialized housing units activated during the review period. Inmates on ASU overflow are generally housed temporarily in PSU.

F. Obstacles to Providing Mental Health Services and Adherence to Program Guide Requirements

Access to treatment is regularly impacted in all programs by staff absences. Absences for vacation and sick leave (including long-term sick) were not covered with registry staff during the review period. In addition, staff who retired were not replaced until funds were available based on retirement payout. See Tab V.2 for a full description of the impact of staffing shortages on mental health treatment.

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II. Mental Health Roster

Institutional Mental Health Staffing and Telemedicine

Monitoring Period: December 1, 2011 – May 31, 2012
Point in Time Date: May 31, 2012

Position	Positions Established	Positions Filled	Vacancies	Vacancy Rate %	Full Time Equivalent	Functional Vacancies	Functional Vacancy Rate
Chief Psychiatrist	1	1	0	0%	0	0	0%
Senior Psychiatrist Supervisor	1	0	1	100%	0	1	100%
Chief Psychologist*	1	2	0	0%	0	0	0% (Overfilled)
Senior Psychologist Supervisor *	8	6	2	25%	1	1	17%
Staff Psychiatrist*	20.5	14	6.5	32%	5.76	.74	4%
Staff Psychologist	52.5	35	17.5	33%	8.19	9.31	27%
Sr. Psychologist Specialist*	1	2	0	0%	0	0	0% (Overfilled)
Supervising Social Worker	1	1	0	0%	0	0	0%
Clinical Social Workers*	25.33	21	4.33	17%	2.38	1.95	8%
Supervising RN II*	3	3	0	0%	.14	0	0% (Overfilled)
Registered Nurse*	34.01	34	.01	0%	5.64	0	0% (Overfilled)
Unit Supervisor*	1	3	0	0%	0	0	0% (Overfilled)
Psychiatric Technicians	80.4	77	1.39	2%	4.74	0	0% (Overfilled)
Recreational Therapist*	13.54	13	.54	4%	0	0	4%
MHSDS Admin Support*	25.3	16	9.3	37%	1	8.3	33%

Telemedicine

Psychiatry Telemedicine Used?	Number of Hours Per Week
NO	N/A

*Explanation of figures in Mental Health Roster:

- Chief Psychologist – Overfilled by 100%. 1 PY established in 918 Blanket (no funding attached at this time)
- Senior Psychologist Supervisor – 1 Supervisor on loan from FSP
- Staff Psychiatrist – 1 Employee Redirected due to PPEC/Disciplinary, 1 Employee acting in Sr. Psychiatrist position
- Sr. Psychologist Specialist – Overfilled by 100%. 1 PY established in 918 Blanket (no funding attached at this time)
- Clinical Social Worker – 1 Additional Employee 920 Blanket Long Term Sick pending possible non-punitive termination due to inability to become licensed
- Supervising RN II – Overfilled by 5%. (.14) PY in overtime used
- RN – Overfilled by 16%. 5.64 PY in overtime used
- Unit Supervisor – Overfilled by 200%. Funding for 2 Unit Supervisor positions in process of personnel research
- Recreational Therapists – 1 PY established in 918 Blanket (no funding attached at this time)
- MHSDS Admin Support – Total PY include 22.3 Office Technicians (13 Filled), OSS II - 1 PY Filled, HPS I – 1 PY Filled, CHSA II – 1 PY Filled in 918 Blanket (no funding attached at this time)

III. Quality Management

A. Local Governing Body (LGB)

The LGB at SAC is responsible for the oversight of the delivery of health care services. It meets at least quarterly and required attendance includes the Chief Executive Officer, Chief Physician Executive, Warden, the Chief Nursing Executive, the Chief of Mental Health and the Chief Supervising Dentist and/or the Correctional Health Services Administrator II. The Associate Warden of Healthcare also attends. Agendas and minutes for these meetings are maintained in Tab B.1.

The LGB is chaired by the CEO and requires a quorum be present for voting and recommendation purposes. The presence of 75% of the voting (required) members shall constitute a quorum. Optional attendees may be invited to the LGB meetings to provide additional information on agenda items but are not required and are not included in the 75% quorum. Meetings were held in February, March, and April, 2012. A quorum was not present at any meeting during the review period.

The LGB makes recommendations to the Quality Management Committee (QMC) from subcommittee reports presented by the Subcommittee Chairperson in each of the LGB meetings as a standing agenda item. The LGB also reviews and makes recommendations on any outstanding action item lists, adding new items if warranted. The LGB regularly reviews and approves operational policies, Title 22 regulatory and licensing standards, and individual practitioner privileges. No formal recommendations were made due to not having a quorum present at meetings.

B. Quality Management Committee (QMC)

The California Correctional Health Care Services (CCHCS) division at CSP - Sacramento strives to exceed effective, timely, competent care in its delivery of comprehensive healthcare services to its inmate-patients. The Quality Management Committee is the venue that sets this practice forth by facilitating continuous quality improvement processes in the delivery of health care services. CSP – Sacramento's QMC mission is to be a leader in the delivery of clinically sound and constitutionally adequate custodial health care in keeping with adopted standards and scope of services within the custodial environment.

The purpose of the AMC is to monitor, assess, and improve the quality of health care. During the reporting period, the QMC met 6 times. Minutes are available in Tab B.2. The QMC is chaired by the CEO and is comprised of department heads and clinical departments responsible for forwarding reports to the QMC from the following applicable committees: Pharmacy and Therapeutics Committee, Dental Program Subcommittee, Mental Health Program Subcommittee, Emergency Medical Response Review Committee, Licensed Inpatient Program, and Medical Program Subcommittee. Health Care Access custody officers also attend QMC meetings. Presentations by each of the departments/subcommittees are data focused and general communication/coordination issues are discussed. Of the six meetings, a quorum was present in five (83%).

C. Mental Health Quality Management Subcommittee (MHQM)

The purpose of the MHQM is to oversee mental health services, review program performance, and monitor, create and implement improvement efforts. The Chief of Mental Health or designee serves as Chair. The Chief Psychologist, Sr. Psychologists, Nursing Supervisor representative, and Health Care Access Captain are mandatory members. The MHQM is well attended by custody Sergeants and Lieutenants who work in the MH program. MHQM is scheduled to meet weekly. During the reporting period the MHQM met 24 times. A quorum was attained in 100% of the meetings during the reporting period.

The MHQM regularly reviews data related to adherence with MHSDS Program Guide requirements; identifies and resolves problems, or charters QITs to resolve problems; and receives input from QITs, FITs and QMC for consideration. The MHQM also plans interdisciplinary training as needed. See section E. for a description of QIT and FIT activities.

The MHQM functioned to prioritize clinical tasks in areas with high workload and/or functional vacancies. In order to prioritize supervisor time to critical tasks, and due to consistently high scores on UHR audits, in November 2011, the UHR audit schedule was revised from monthly to every-other month, and then to quarterly beginning in March 2012.

D. Peer Review

SAC has three peer reviews: one for primary clinicians (psychologists and social workers), one for psychiatrists working in inpatient settings, and one for psychiatrists working in outpatient settings.

Primary Clinicians

The primary clinician (PC) peer reviews are conducted semi-annually. PCs are reviewed at least once every two years. A team of two PCs comprises a review team. Quality and thoroughness of

documentation are evaluated across six areas: Documentation, Assessment, Diagnosis, Treatment Planning, Treatment Delivery, and Consultation and Referral. The review team rates each area on a 9-point scale and provides a rationale for the numeric score. A summary of results is sent to the clinician being reviewed. This process is confidential with only the Peer Review Committee and the review team being aware of the identity of the clinician reviewed. If an overall unsatisfactory review is received, that clinician is scheduled for inclusion in the following quarter's review round. Two consecutive unsatisfactory reviews result in the reviews being referred to the local SAC Professional Practice Executive Committee (PPEC) for a corrective action plan.

During the monitoring period, 23 clinicians were reviewed. Two physicians received unsatisfactory reviews. Those two clinicians will re-reviewed during the next review cycle. There were two additional reviews of other clinicians scheduled but had to be cancelled because there was insufficient documentation in eUHR to allow these two reviews. .

Inpatient Psychiatrist

The Inpatient Psychiatrist peer review committee reviews psychiatrists who work in MHCB. The committee is composed of all staff and contract psychiatrists. One staff psychiatrist serves as Committee Chairperson. Between December 1, 2011 and May 31, 2012, the committee met twice: January 12, 2012 and May 10, 2012. Each quarter approximately 5% of all cases are reviewed, and the review includes cases from all three MHCB units. Criteria reviewed include use of appropriate medications, addressing side effects, polypharmacy, informed consent, appropriate laboratory studies, medication compliance, consideration of involuntary medication, documentation of rationale for medication changes, AIMS, and use of effective communication. For each committee meeting MHCB charts were randomly selected and assigned to the psychiatrists for review. During the committee meeting results of the chart reviews are discussed. If a deficiency is found, the Committee Chairperson provides feedback to the psychiatrist confidentially at a later time. Six primary psychiatrists and several providing daily back-up coverage were reviewed during the noted time period. All but one chart was found to meet the standard of care without needing further follow-up. Lack of documentation was the most common deficiency. Specifically noted was lack of documentation for polypharmacy.

Outpatient Psychiatrist

The Outpatient Psychiatrist peer review committee consists of all staff and contract psychiatrists. The committee also meets quarterly. There are two Committee Chairpersons, both staff psychiatrists. This committee met on December 15, 2011 and March 15, 2012. Criteria reviewed included effective communication documentation, medication choices and documentation, polypharmacy, appropriate laboratory studies, AIMS, addressing danger to self/others/grave disability, legibility, inclusion of date and time on notes, documentation for missed appointments, and timely follow-up for medication changes. Forty-five charts were randomly selected from various programs for review at the committee meetings. Two psychiatrists are assigned a chart to review separately. Afterward they compare findings and report to the Committee Chairpersons. Any deficiencies are sent to the treating psychiatrist by email and he/she is asked to correct the chart. In two to three months, the Committee Chairpersons review the same chart to assure standard of care was met with corrections. If standard of care is still not met or continued deficiencies are found with a specific psychiatrist, a focused peer review occurs. This involves the Committee Chairpersons reviewing several charts from the psychiatrist being evaluated. All psychiatrists' notes were

evaluated at some point during the review period. No pattern of practice deficiencies was found. The most common omission was lack of a 5-Axis diagnosis and the "E" of a SOAPE note.

E. QIT and FIT Activities

Seventeen Mental Health QITs and FITs were active at some point during this reporting period. Seven new QITs were chartered since the last management report, and four new QITs were chartered during the review period. Eight QITs were resolved during the review period.

QITs initiated during the review period:

- Clozapine (Clozaril) Quality Assurance
    - This QIT was formed on 12/13/2011 to evaluate and create a process to monitor and manage Clozaril patients more closely. Systems were developed to ensure laboratory tests were ordered within required timeframes, and that responses to lab values were appropriate. The QIT continues to work on systems to ensure continuity of care when inmate-patients are transferred or released.
- Psychiatrist IP Access in EOPI
    - This QIT was formed on 3/6/12 to decrease barriers to providing psychiatric services in EOPI, including decreasing wait times to see inmate-patients and assess feasibility of holding a psychiatric clinic in the A Facility Clinic area, with longer hours than are available in the treatment center. The psychiatry clinic was established in April 2012, which significantly improved access. Once minor logistics issues related to ducating are resolved, this QIT will be closed.
- Disease Mgmt Guidelines (DMG) & Implementation for Psychiatry
    - This QIT was formed on 4/19/12 in order to review the DMG and implement a process to ensure that follow-up and ongoing assessments for patients treated with psychotropic medications follow the DMG.

QITs and FITs ongoing during the review period:

- Group Therapy Documentation – Revisited
    - This QIT was formed on March 18, 2011 to assess the possibility of initiating group therapy documentation if the implementation of the eUHR removed barriers related to filing an additional 2000 documents per month. eUHR was implemented in July 2011, and the QIT developed a pilot system for PSU to create group therapy notes beginning in November 2011. The pilot system includes group therapy communication notes from group facilitators, which are available for summary by the primary clinician at each IDTT. It is recognized that this does not always meet the requirement for group therapy summaries to be written every 30 days, but is an improvement over having no group therapy summary notes at SAC. The pilot was initially unsuccessful because group therapy communication notes from facilitators included large amounts of information that was not clinically meaningful. When facilitators were trained to include only clinically meaningful information, there were very few notes written at all. At the end of February 2012, group facilitators were re-trained on the meaning of "clinically meaningful" documentation, and supervisors used the progressive disciplinary system in March 2012 to ensure that notes were being written. In May 2012, the pilot was

expanded to ASU EOP and PSUII. If this expansion is successful, the GP EOP programs will implement the first week of July.

- Job Satisfaction
  - This QIT was formed on May 13, 2011 after a Job Satisfaction Advisory Committee recommended an ongoing QIT related to Job Satisfaction and employee retention. The QIT met approximately once a month during the review period to discuss ways to increase job satisfaction.
- Coping with Psychiatrist Shortages
  - This QIT was formed on July 7, 2011 when the psychiatrist vacancy rate reached 47%. This QIT developed and implemented strategies to recruit and retain psychiatrists. The current functional vacancy rate is 0%. However, psychiatry workload remains high due to two psychiatrists being redirected (one into a supervisor position, and one due to Professional Practice Executive Committee).
- DMH Clinical Review Panel
  - This QIT was formed on July 8, 2011 in order to review treatment provided to I/Ps who met criteria for consideration for referral to DMH, but were not referred. The final recommendation was approved by QMC on March 8, 2012. The recommendation was that the Chief of Mental Health continue a review process to ensure inmate-patients are referred to DMH as appropriate, and receive appropriate treatment if they are not referred. A binder documenting treatment plan reviews and feedback to primary clinicians is available upon request.
- 5/8 Day Follow-Up Procedures
  - This QIT was formed on August 4, 2011 due to inconsistent adherence to 5/8 day follow-up requirements. The QIT identified reasons for the deficiencies and developed corrective action. The final recommendation was approved by QMC on January 5, 2012. 5/8 Day Follow-Up audits have consistently demonstrated over 90% adherence to this requirement during this review period.
- Management of Inmate Misconduct and Abuse of Housing in Alternative Safe Housing
  - This QIT was formed on August 9, 2011 to discuss I/Ps who use alternative safe housing for secondary gain including indecent exposure and sexual misconduct. Final Recommendations of the QIT were submitted to the MHQM on May 11, 2012 and to QMC on June 7, 2012.
- MHTS.net
  - This QIT has been ongoing since August 13, 2010, to ensure that data is accurately entered into MHTS.net, used appropriately for quality management purposes, and is in agreement with documentation in the Unit Health Records. This QIT is required by MH Program Headquarters on an ongoing basis.
- Improving PSU Evening Group Activities
  - This QIT has been ongoing since December 10, 2010. The QIT formed because of lack of I/P participation in PSU evening group activities, and excessive staff absences for evening groups. This QIT created standby lists to ensure that groups are filled, and has developed a schedule for staff to work late hours in order to provide group therapy on a consistent basis beginning September 5, 2011. The QIT continued in order to ensure adequate coverage of late-hours groups and adequate standby lists. Final Recommendations from this QIT were sent to QMC on June 7, 2011.

- Flow of Documents from Nursing to Mental Health
    - This QIT was formed on November 4, 2011 in order to evaluate and monitor the flow of documents from nursing to MH in EOP and CCCMS, and to determine whether standardization of procedures across programs was needed. Final Recommendations for this QIT were sent to MHQM on April 20, 2012 and to QMC on May 3, 2012.
- File Server Maintenance
    - This QIT was formed on September 27, 2011 in order to examine which files on the shared server should be deleted, combined, or re-sorted based on an agreed-upon standards. Final Recommendations from this QIT were sent to QMC on May 3, 2012.
- Clinician Backup Systems
    - This QIT was formed on September 27, 2011 in order to ensure systems were in place for backup coverage when a primary clinician was not available. Final recommendations of this QIT were approved by QMC on January 5, 2012.
- ASU EOP Treatment Improvement FIT
    - This FIT focuses on improving participation in treatment and improving the quality of treatment in ASU EOP. The FIT has developed a Behavioral Incentive Program that will be implemented once incentive items are purchased. SAC continues to work with HQ staff to purchase items.
- PSU Group Therapy Coordination
    - This QIT was recommended by MHQM on May 18, 2012 in order to streamline communication regarding specific inmate-patient group attendance issues and to coordinate standby lists for some groups. The charter was not written until after the end of this review period, and the QIT did not meet during the review period.
- SPR-FIT
    - During the review period, SPR-FIT was held 11 times. There were six regular meetings and five additional meetings to review incidents of self-harm. See section XIV of this report for details of the agenda and actions taken to prevent suicides at SAC.

QITs resolved during monitoring period (see descriptions above):

- Improving Evening Groups
- Management of Inmate Misconduct and Abuse of System in Alternative Safe Housing
- Flow of Documents from Nursing to Mental Health
- File Server Maintenance
- 5/8 Day Follow Up
- Clinician Backup Systems
- Coping with Psychiatrist Shortages
- DMH Clinical Review Panel

IV. Medication Management, Psychotropic Medications

Some medication management audits for May 2012 were not yet completed at the time data for this report was compiled. In these cases, the data is provided for December 1, 2011 – April 30, 2012. Data for May 2012 will be available upon request at the time of the Coleman monitoring visit on July 10-11, 2012.

A. Total Inmate-Patients Receiving Psychotropic Medications

The total number of I/Ps in the MHSDS receiving psychotropic medications at the end of the reporting period was 1073.

B. Medication Continuity for New Arrivals (Inter-Institutional CDCR Transfers)

Based on Nursing Audit 2B, 97% of new arrivals received NA/DOT medications within 24 hours of arrival to the facility between December 1, 2011 and April 30, 2012. Audit 2B reviews records from every new arrival to SAC.

C. Medication Continuity for Transfers (Intra-Institutional Transfers)

Nursing Audit 6 monitors the percentage of I/Ps that transfer within the institution who received their prescribed psychotropic medications without interruption. Based on a random sample of 290 charts, from December 2011 through April 2012, 99% of I/Ps transferring within the institution received their prescribed psychotropic medications without interruption. At least ten records per housing unit are reviewed each month. The random sample is obtained by reviewing the MARS to collect all applicable I/Ps. Then, starting with the letter "L," every other name is selected until at least ten are identified. Each month a different letter is used as a starting point. SAC does not monitor/audit the percentage of I/Ps discharged from the MHCB who received their psychotropic medications without interruption separately from the audit noted above.

D. Medication Continuity for Renewal of Orders/Bridge Orders

Based on the Medication Continuity Audit, 88% of I/Ps received timely renewals of their psychiatric medications between December 1, 2011 and May 31, 2012. The Chief or Senior Psychiatrist completes this monthly audit using a sample of ten I/Ps obtained randomly from a pharmacy list. In order to provide consistent adherence to the policy, a number of steps have been taken. Psychiatrists are reminded to document the date they received the request for renewal of medications in their notes, and use pharmacy-generated lists of medications that are expiring on their unit. In units where there was no regularly designated psychiatrist due to functional vacancies (e.g. due to long term leave or suspended privileges), nursing staff have been trained to forward any expiring medications to the Chief or Senior Psychiatrist for renewal. Lapses in medication based on having no written medication orders are not tracked or audited separately from the audit described above.

E. Lab Tests/Results for MHSDS Inmate-Patients

SAC conducts audits on lab tests for two types of medications; Clozaril and Mood Stabilizers.

During the reporting period, all UHRs of I/Ps receiving Clozaril were reviewed by the Senior Psychiatrist. There were a total of 144 charts reviewed. 96% of the I/Ps had laboratory tests ordered and drawn as clinically indicated.

Based on the Mood Stabilizer Audit, 71% of I/Ps had laboratory tests ordered when clinically indicated between December 1, 2011 and May 31, 2012. To complete this audit ten inmate-patients are randomly selected using a list from the pharmacy of inmate-patients prescribed psychotropic medications on different units. There were 60 charts audited during the review period. Psychiatrists reviewed laboratory study results and documented clinical action in 50% of the cases. A Quality Improvement Team (Disease Management Guidelines and Implementation for Psychiatry)

was chartered on April 19, 2012 to address issues related to ordering laboratory tests and documenting appropriate review and clinical action. Standardized laboratory protocols based on disease management guidelines (DMG) have been forwarded to all psychiatrists, and training has been provided. Psychiatrists have been informed they are to follow the CDCR blood monitoring guidelines even if these medications are prescribed at low doses or as adjunctive therapy. SAC has been working with headquarters on development of a registry that can be used to monitor upcoming laboratory tests required, and provides notification of delinquent laboratory tests. The psychiatrists have been trained on use of the site and are encouraged to use it as an adjunctive monitoring tool. A meeting has been scheduled to address issues including refusal of medications and monitoring with ancillary staff to develop mechanisms to notify the physician, using the successful Clozaril protocol as a guide.

An Abnormal Involuntary Movement Scale (AIMS) must be completed every 6 months for each I/P prescribed psychotropic medications. Based on the AIMS/Consents Audit, an AIMS was completed within the last 6 months in 95% of applicable cases between December 1, 2011 and May 31, 2012. For this monthly audit the Chief or Senior Psychiatrist selects ten random I/Ps from all housing units within SAC.

F. Direct Observation Therapy (DOT) Medication Administration

Based on point-in-time data from the pharmacy, 176 I/Ps were prescribed psychotropic DOT medication on May 31, 2012. Based on Nursing Audit 9, DOT medication administration procedures were followed 100% of the time between December 1, 2011 and April 30, 2012. For this audit, nursing supervisors observe two random pill lines per housing unit each month. At least one of the two random pill lines is during 2nd watch and one during 3rd watch.

G. HS Medications (After 2000 Hours)

Based on point-in-time data obtained from the pharmacy, there were 200 MHSDS I/Ps receiving HS medications on May 31, 2012. HS medications are delivered after 2000 hours. Supervisors routinely make rounds to audit this process, however, no data is collected regarding percentage of adherence to the requirement.

H. Medication Non-Compliance Policies and Procedures

Medication Management Audit 5A reviews if nursing staff completed proper documentation (encircle initials in red and write comment) for an inmate-patient that is a "no show" or refuses his medications. Nursing staff completes this monthly audit by reviewing the MARS and identifying all applicable inmate-patients. Starting with a different letter each month, every other inmate-patient is audited until ten are completed in each housing unit. Audit results averaged 95%, with a range from 86% to 99% (see Tab E.7 (5A-attachment)).

Medication Management Audit 5B reviews if an inmate-patient was referred on an urgent basis to the prescriber and Public Health Nurse for refusal or "no show" of 1 dose of court-ordered medication or 2 consecutive doses of insulin, TB, or HIV meds. Nursing staff completes this monthly audit by reviewing the MARS, identifying all applicable inmate-patients, and selecting a different letter to begin audits with each month. Every other inmate-patient is audited until ten are completed in each housing unit. Audit results averaged 52%, with a range of 33% to 75% (see Tab

E.7 (5B-attachment)). All nursing staff have been retrained and nursing supervisors will continue to audit this process to achieve and maintain a 95% or greater adherence.

Medication Management Audit 5C reviews if there is a follow up appointment for medication counseling with the provider documented for inmate-patients who refuse or "no show" for 3 consecutive days or refuse 50% of medication over a 7-day period. During the review period, there were 60 charts audited. Four of the monthly audits included data regarding the total number of refusals in the unit. In these four months, there were a total of 62 inmate-patients who refused medications warranting a 128C chrono to be generated. This audit is completed by a staff psychiatrist and is rotated to a different housing unit each month. Ten names are randomly selected from the log of medication refusals. The psychiatrist reviews charts to verify that inmate-patient contact was made within 7 days of referral and that a treatment decision was documented. Audit results averaged 75%, with a range of 30% to 100% (see Tab E.7 (5C-attachment)).

I. The Medication Administration Record (MAR)

Based on Audits 7A and 7B, eUHRs contained the previous month's MARS 91% of the time between December 1, 2011 and April 30, 2011. 91% of the eUHRs contained MARs that were complete and legible.

Audits 7A and 7b are completed by identifying all I/Ps who meet the audit criteria in each healthcare program. Starting with a letter of the alphabet (I/P's last name, starting with a different letter each month), every third I/P's eUHR is selected and reviewed. A minimum of 10 I/Ps (or 100% if fewer than 10 I/Ps) per healthcare program are audited each month.

J. Timely Processing of Medication Orders

Based on Nursing Audits 3A and 3B, newly prescribed or changed medications were processed and provided to the I/P within 24 hours after the order was written 98% of the time between December 1, 2011 and April 30, 2012.

This audit is completed by identifying all I/Ps who meet the audit criteria in a selected healthcare program. Then starting with a letter of the alphabet (I/P's last name), every other I/P's MAR is selected and reviewed. A minimum of 10 records (or 100% if fewer than 10 I/Ps) per healthcare program are reviewed for the timely processing of medication orders.

K. Informed Consent Forms

Based on the AIMS/Consent Audit, up to date informed consents were present in 97% of the charts of I/Ps prescribed psychiatric medications between December 1, 2011 and May 31, 2012. This audit is completed monthly by the Chief or Senior Psychiatrist using a random sample of ten I/Ps from all housing units. Consent forms expire annually.

L. Pill Lines

There are currently 16 areas of medication administration. These are:

- Facility A: GP, GP EOP, ASU EOP, PSUI, PSUII, CTCI, CTCII, OHU, Stand Alone ASU
- Facility B: GP, GP EOP, ASU, SHU, Temporary Unlicensed MHCB
- Facility C: GP

- Minimum Support Facility: Dorms

Pill lines at SAC occur in Facility B and C, GP settings, and Facility A GP (8 Block sections A and C). Medication is delivered cell side in EOP level of care and lock up units. The pill lines in Facilities B and C have been sporadic due to frequent lock-downs in those yards. In C Facility, it takes approximately three minutes for each I/P to receive his medication from the medication cart. At that time, staff complete any needed checks for compliance before the I/P is released back to his housing or to yard as scheduled.

M. Hoarding/Cheeking Medications

During the reporting period, there were three CDCR-115 Rules Violation Reports (RVRs) written explicitly for hoarding or cheeking medication (see Tab P.7).

N. Parole medications process

The parole desk staff notifies pharmacy of all paroling inmates at least 30 days in advance of release dates. Because parole dates frequently change, daily updates are sent from the parole desk to the pharmacy. Based on Nursing Audit 8, there were 44 I/Ps who paroled and were taking psychotropic medications during the review period. Ninety-five percent of I/Ps with active prescriptions received a 30-day supply of psychiatric medication upon parole (between December 1, 2011 and May 31, 2012). This audit reviews every I/P who paroles from SAC. Paroling inmates are required to sign for receipt for their parole medications. There is no audit of the signatures conducted at SAC.

V. Mainline CCCMS

A. Timeliness of PC and Psychiatrist Contacts

At the end of the reporting period there were 5 primary clinicians providing services in the ML CCCMS program with an average caseload of 144 I/Ps. During the reporting period 338 I/Ps entered the CCCMS mental health program. Of these, 60% received an initial contact with their PC within 10 days during which time the Clinical Intake Assessment was completed. During the review period, 76% of inmate-patients in mainline CCCMS had their initial IDTT within 14 days of arrival or transfer into the program. Thereafter, 93% received PC contacts at least once every 90 days (or more often if indicated), and 98% had a scheduled IDTT at least annually (or more often if indicated). Twenty-three percent of individual PC contacts took place more frequently than 90 days for clinical reasons. Individual PC contacts took place in a confidential setting 46% of the time. Reasons for non-confidential contacts included; 67% of cell-front interviews were due to the lock downs, 32% were due to urgent/crisis evaluations and 5-day follow-ups. There were very few IP refusals or other reasons for cell-front contacts. Institutional staff participated in the IDTT with the PC being present 100% of the time, psychiatrist 69% of the time, and I/P 84% of the time. During the audit period there was a shortage of psychiatric staff, and individual inmate-patient care was prioritized over IDTT attendance for psychiatrists. Reasons why the I/P failed to attend the IDTT were generally contributed to the lockdown on C-facility and the lack of escort officers available at times.

During the reporting period, 94% of inmates with prescriptions for psychotropic medications received timely psychiatry appointments.

The main reason for the reduced adherence with initial contacts and IDTTs is that a decision was made through the quality management system (due to workload) that inmate-patients who return to CCCMS ML from ASU are not seen for a new intake and initial IDTT, unless clinically indicated. In addition, C-Facility houses approximately 65% of the SAC ML CCCMS population and has been on lockdown since December 2011. The unpredictable access to IPs during the lockdown has impacted the clinicians' ability to maintain the timelines for Initial Contacts and IDTT while attempting to offer confidential interviews and treatment. IDTT adherence improved after a dedicated escort officer was assigned to ensure that inmate-patients could be brought to IDTT. A sample review of MHTS.net shows that most of the Initial Contacts were seen within one week of being due.

B. Prerelease and Discharge Planning

During the reporting period, 21 I/Ps in the CCCMS level of care paroled from the institution. Of these, each was offered prerelease planning by their PC. On the mainline yard with the largest CCCMS population, a Pre-Release Group is typically offered as well. This audit period, however, the group has not been offered due to the lockdown on that yard. A normal group schedule will resume at the conclusion of the lockdown.

VI. Mainline Enhanced Outpatient Program (EOP)

A. Timeliness of PC and Psychiatrist Contacts

At the end of the reporting period there were two ML EOP programs, each with 8 PCs, with an average caseload of 24 I/Ps. During the reporting period, 87% of all new EOP admits were assessed and presented to the IDTT within 14 days of admission, at which point their initial treatment plan was completed and signed by the IDTT attendees. The reduced percentage for Initial IDTTs is due to administrative error in scheduling Initial IDTTs for new arrivals to GP EOP. Training has since been provided to clerical staff and the issue has now been corrected. Once I/Ps were admitted to the program, weekly PC contacts (individual or group activity) took place 96% of the time, IDTTs took place at least every 90 days 99 % of the time, and treatment plans were updated at least every 90 days 100% of the time. Individual PC contacts took place in a confidential setting 71% of the time. Reasons for non-confidential contacts occurring 29% of the time, included: 0% lack of confidential treatment space; 28% inmate refusal; 0% custody lock downs; 1% lack of escort officers; 9% modified program; 23% staff decision; and 40% unspecified. IDTTs were attended by their PC 100% of the time, by the psychiatrist 92% of the time, and by the I/P 84% of the time. Reasons why the I/P failed to attend the IDTT included; 71% inmate refusal, and 29% lock downs.

During the reporting period, group therapy was provided for I/Ps in the ML EOP program. Group topics included: Cultural Awareness, Spanish-language Group (assorted topics), Men's Health, Interpersonal Skills, Anger Management, Problem Solving, Communication Skills, Self-Esteem, Finding Happiness, Substance Abuse, and Pre-Release. On average, I/Ps were scheduled for at least 13 hours of structured therapeutic activity per week. During the reporting period, no ML EOP I/Ps were provided a modified treatment plan. Across the reporting period, there were 3 "down weeks" when all structured yard and groups were suspended in order to re-assign I/Ps to new treatment groups. When excluding "down week" data, the MHTS.net report for the review period indicates 9.5

hours as the average number of weekly structured therapeutic activities offered to ML EOP inmate-patients. On average_38% of the offered structured therapeutic activity was refused by I/Ps. Reasons for refusal are not systematically tracked but include mental health symptoms such as paranoia and lack of insight about need for treatment, avoidance of social interactions with other inmates, and dislike of specific groups or facilitators. The MHTS.net report for the entire review period, including "down weeks" reflects that 8.5 hours of structured therapeutic activities were offered on average to ML EOP I/Ps.

B. Prerelease and Discharge Planning

During the reporting period 54 I/Ps in the EOP level of care paroled from the institution. Of these 100% received parole planning. SAC offers pre-release groups to all ML EOP I/Ps. I/Ps are offered this group up to six months before their scheduled release. This group focuses on preparing I/Ps for transition to the community by identifying needs for mental health follow up, housing, transportation, and connection with county services. ML EOP I/Ps also are interviewed by contract Transitional Case Management Program (Federal Benefits Workers), who complete a needs assessment and may apply for benefits on behalf of the inmate-patient.

VII. Department of Mental Health (DMH) Referrals

During this period, 1151 I/Ps met one or more of the indicators for consideration of referral to a higher LOC. Of the identified I/Ps, 8 % were referred to DMH, and 92% of I/Ps were not referred. At each institution, 25 I/Ps listed on the DMH non-referral log (or all I/Ps on the list if fewer than 25) were randomly audited. Of those audited for SAC, 100% had a reason for non-referral documented on the 7388B, and 83% had documented interventions to improve the I/P's level of functioning.

During the reporting period, 87 referrals to DMH were completed: 42 ICF and 45 APP. Seventy-four percent of ICF referrals were completed within five working days, and 62% of APP referrals were completed within two working days and posted on SharePoint.

During this time period, 0% of ICF referrals and 0% of APP referrals were rejected by DMH, and 12% of ICF referrals and 22% of APP referrals were rescinded.

During the reporting period 99 I/Ps returned to the institution from DMH. DMH discharge summaries were received when the I/P returned to the institutions 100% of the time. Clinician-to-clinician contact took place within five working days of the I/P's return to the institution 97% of the time. Five-day follow-ups were completed 95% of the time for returning I/Ps.

VIII. Mental Health Crisis Bed (MHCB)

Data in MHTS.net regarding MHCB admissions has improved since the last Coleman reporting period. Headquarters MHTS development staff is actively working to improve the system and institution staff is encouraged to attend weekly Management Reporting Webinars. In addition, SAC has a MHTS.net QIT that refers issues to the MHTS development staff when indicated. Data for this report is obtained from MHTS.net, and in cases where this data is still not completely accurate, from MHCB local tracking logs, and manual eUHR audits.

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The institution has two licensed MHCB units (comprising 26 mental health crisis beds) and one unlicensed unit (comprising 20 mental health crisis beds) for a total of 46 mental health crisis beds. I/Ps are received from internal referrals as well as from other institutions. During the reporting period, 473 referrals were received from within the institution and 3 referrals were received from other institutions.

During the reporting period, the total number of admissions to the MHCB units, based on MHTS.net, totaled 476 (see Tab I.1). However, 44 of these were transferred to outside MHCBs. This total also does not include the inmate-patients that are currently at DMH, those who have since paroled, those that were referred from the unlicensed MHCBU to a licensed MHCB, and readmissions from outside hospitals. Including these additional admissions, the actual total number of admissions to MHCB units during the reporting period was 503, with 459 local SAC MHCB admissions. Of these 503 admissions, 256 were admitted through Crisis Triage.

The MHTS.net historical LOS Grid indicated the average LOS in MHCB was 15.2 days, and the range was from 0 to 112 days. The number of I/Ps with a LOS longer than 10 days was 262 (55%). Reasons for LOS longer than 10 days are indicated by a column inserted into the MHTS.net Historical LOS Grid filtered for LOS greater than 10 days (see Tab I.10 MHCB Historical LOS Grid with LOS Reasons Added). Primary reasons for LOS longer than 10 days are as follows: approximately 89 (34%) (Med Adj) were for medication adjustments and response monitoring; 56 (21%) (DMH Ref) were due to a DMH referral in progress or awaiting a bed; 44 (17%) (OCS) were to ensure continued stability to permit discharge; 21 (8%) (Weekend) were retained 1-3 extra days to ensure continuity of care and stability over a weekend; 16 (6%) (Sx Validity) were retained in MHCB to ensure safety of IP's expressing SI/HI who had questionable symptom validity; 12 (5%)(Medical) were for medical-psychiatric reasons; 8 (3%) (Cond SI) were to facilitate I/P negotiation of/coping with custody and safety concerns that would not be resolved by DMH transfer; 7(3%) (PBST) were for Positive Behavioral Support initiation/intervention; 5 (2%) (New Keyhea) were for Keyhea initiation (without DMH referral or other major reasons); 3 (1%) were retained in MHCB without DMH transfer due to impending parole, with parole planning as a critical component of treatment; 1 (<1%) was retained primarily to ensure the continued safety of an IP returned from DMH with polydipsia; 0% were clinically discharged awaiting bed, 0% were clinically discharged awaiting transfer back to home institutions. The percent retained for clinical reason was 100%. When I/Ps on the DMH waiting list were removed from the calculation, the average LOS in the MHCB was 12.2 days.

Once admitted to the MHCB unit, I/Ps received their initial IDTT within 72 hours of admission 97% percent of the time according to the MHTS.net contact interval reports (see Tab I.8). Thereafter, I/Ps were offered at least weekly IDTTs 100% of the time. IDTTs were attended by the PC 100% of the time, psychiatrist >99% % of the time; CCI 98% of the time; and nursing 98% of the time, according to eUHR audits (see Tab I.8a). Daily contacts by a licensed psychologist or psychiatrist occurred 99% of the time. Of those I/Ps that were admitted due to suicidal threats or behavior, adherence rates for Admission SREs was 99% and Discharge SRE's was 100%, according to SAC UHR audits (See Tab I.11 Compliance MHCB Admission and DC SRE-Background Data.) According to local SAC tracking, which audits 100% of required five day follow-up, the overall (average) adherence rate for 5/8 Day Follow-Up Contacts for the Correctional Treatment Centers (CTC) and Mental Health Crisis Bed Unit (MHCBU) from December 1 – May 31* was: 97.33% (See Tab I.8). Audits show that

more than 99% of IP's being admitted to MHCB receive a Mental Health Assessment/Update (7386/7386 Update).

IX. Outpatient Housing Unit (OHU)/Mental Health Outpatient Housing Unit (MH-OHU)

The institution has 20 OHU beds and no MH-OHU beds. At SAC, the OHU is used as the first option for alternative housing pending MHCB admission. There is no additional mental health staff assigned to OHU, and I/Ps are not placed in OHU for evaluation of need for a MHCB. Because the MHTS.net system does not include tracking of alternative housing placements, local spreadsheets are used to track alternative housing placements, including those in OHU.

The following data was derived primarily from the local alternative housing spreadsheet, which tracks placement location daily, sorted for I/Ps housed in OHU while placed in alternative housing pending crisis bed admission (See Tab J). During the reporting period, there were 0 referrals (all referrals are to alternative housing in general, not to OHU specifically) and 207 placements in OHU (See Tab J.3 OHU Contact Referrals). A total of 207 I/Ps were housed in the OHU pending transfer to a MHCB, and 98 were admitted to a MHCB. The average length of stay was 1.88 days, ranging from .5 to 4.5 days. There were 23 I/Ps with stays longer than 72 hours. 100% of I/Ps with a LOS beyond 72 hours were awaiting a bed in the MHCB.

Contact logs for Crisis Triage clinicians are cross-checked against the census daily by the Crisis Triage supervisor or designee to create a 100% selection audit. While residing in OHU, 100% of I/Ps received daily contact from a licensed psychologist, social worker or psychiatrist. Of those I/Ps placed in OHU pending MHCB admission, 100% were administered an SRE within 24 hours of placement, and 100% received an SRE upon release from OHU to regular housing (see Tab J.7). At least 99% received an SRE upon entry to a MHCB (See Tab I-11) Each SRE is annotated on the tracking sheets and reconciled by the Crisis Triage clinicians and OT daily. One hundred percent of inmate-patients released from OHU back to regular housing were ordered a five-day follow-up. Of those, 98% of I/P's received a completed or a substantial portion of a 5 day follow up or were returned to observation after their release.

X. Alternative Housing

The data that follows is tracked through local spreadsheets, accounting for all I/Ps spending time in alternative housing. During the reporting period there were 515 I/Ps were placed in alternative housing while waiting for a MHCB bed. All were placed on suicide observations with constant direct visual observation. During the audit period, 515 I/Ps were placed in alternative housing (outside of OHU) while waiting for a MHCB. Of the total placed in alternative housing, 172 were transferred to a MHCB. The average LOS was 1.9 days, ranging from .0 thru 3.24 days. The reasons for lengths of stay longer than 72 hours (23) was pending MHCB admission (100%). Of those I/Ps that were placed in alternative housing due to suicidal or serious self-injurious behaviors, 100% were administered a SRE prior to placement or by the next day (Those I/Ps entering after hours when a clinician is not available receive a SRE by the next day). One hundred percent of I/Ps were ordered a five-day

follow-up and 96% received a completed five-day follow-up upon their release, based on data from December – April 2012 (See Tab C.5 - May 2012 data was not available at the time of this report).

XI. Administrative Segregation Unit (ASU)

At the end of the reporting period (May 31, 2012) there were 286 I/Ps housed in ASU programs: 130 at CCCMS level of care (LOC), 49 at EOP LOC and 107 non-MHSDS I/Ps. Data in this section is based on audits using a 100% selection sample (see detailed audit information in Tab O.4, O.6, and O.8). All patients entering ASU are to receive a nursing pre-placement screening (CDCR Form 128-MH7). During the reporting period 97.6% of the I/Ps received pre-placement screening prior to placement in the ASU setting. Information describing the percentage of pre-placement screenings conducted in a confidential setting is not available. Based on a tally from the ASU Daily Movement Report, incoming I/Ps were placed in identified safety cells 32% of the time. All I/Ps placed in ASU were reviewed for current MHSDS status within one working day following their placement in ASU, and prior to the 114D hearing. One hundred percent of I/Ps received a mental health screening (31-item questionnaire) within 72 hours of placement. Custody documented 30-minute welfare checks 100% of the time, based on audits conducted by the custody supervisor on each shift.

A. ASU-CCCMS

During the reporting period, 233 I/Ps entered the ASU CCCMS program. Ninety-six percent of the I/Ps were assessed by a clinician within 10 working days. Ninety-three percent of initial IDTTs were completed within 14 work days or prior to ICC, whichever occurred first. Subsequent IDTTs took place at least every 90 days 99% of the time. One hundred percent of IDTTs were attended by the primary clinician; 7% of IDTTs were attended by a psychiatrist; 95% of IDTTs were attended by the CCII; and 36% of IDTTs were attended by the I/P. During the audit period there was a shortage of psychiatric staff, and individual inmate-patient care was prioritized over IDTT attendance for psychiatrists. The reason for the IP not attending his IDTT is generally due to IP refusal. There is a high rate of IP refusal to attend mental health services in ASU in general, and when IPs are housed in overflow housing units, the custody staff there have conflicting responsibilities and sometimes cannot be available for escorts.

During the reporting period, 95% of I/Ps received at least weekly individual PC contacts, 37% of the time they were seen in a confidential setting and 63% of the time they were seen cell-front. Reasons for non-confidential contacts included: 73% I/P refusals; 1% Modified Program; 1.5% No Escort; 19% Staff Decision; 5% Unspecified. Ninety-six percent of I/Ps prescribed psychotropic medications were seen by a psychiatrist at least every 90 days. Daily LPT rounds were documented on the CDCR Form 7230-MH 100% of the time. Daily ASU morning meetings between custody and clinical staff were documented 69% of the time. During this audit period, the staff psychologist who attends the daily ASU morning meeting changed work facilities. There was a lag in documentation while she moved and adjusted to the shift in her work. The morning meetings and documentation have been re-instituted.

B. ASU-EOP (HUB)

During the reporting period, according to the COMPSTAT ASU Tracking System, 191 I/Ps entered the ASU EOP. Based on data gathered from the ASU EOP Unit Health Record (UHR) audit, 80% of I/Ps received a comprehensive assessment (7386) prior to the initial IDTT or within 14 calendar days of

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referral/identification. Based on MHTS.net Contact Intervals Report, 81% of initial IDTTs were completed within 14 calendar days or prior to ICC, whichever occurred first. The available data underestimates adherence partially because of false triggers in MHTS.net for initial IDTTs.

Subsequent IDTTs took place at least every 90 days 91% of the time. One hundred percent of IDTTs were attended by the primary clinician; 100% of IDTTs were attended by the psychiatrist; 100% of IDTTs were attended by the CC; and 75% of IDTTs were attended by the I/P. Reasons for I/P non-participation included: 87% I/P refusals, 4% conflicted with group therapy ducat, 7% outside medical appointment, and 2% confined to quarters (CTQ) due to a norovirus outbreak.

During the reporting period, I/Ps with LOS (length of stay) longer than 60 days or 90 days fluctuated monthly, therefore the following data were calculated based on the data available through the COMPSTAT ASU Tracking System. An average of 50% of inmate-patients had a LOS greater than 60 days, and an average of 35% of inmate-patients had a LOS greater than 90 days (as measured on the first day of each month). Reasons for LOS longer than 90 days included: 5% awaiting release to GP, 3% pending investigation, 6% waiting transfer to SHU/PSU, 33% awaiting transfer to another GP, 35% pending CSR review, 18% awaiting disciplinary to be completed.

Of the I/Ps in the program during the reporting period, 97% received at least weekly individual PC contacts. Fifty-six percent of contacts took place in a confidential setting; 15% were out of cell, non-confidential contacts, and 29% of contacts were cell-front (MHTS.net Appointments Closed Report). Reasons for non-confidential cell-front contacts included, 23% I/P refusals; 1% lack of custody escorts; 3% modified program; 17% staff decision; 56% unspecified.

According to the Contact Intervals Report, 95% of I/Ps prescribed psychotropic medications were seen by a psychiatrist at least every 30 days. UHR audits determine the adherence level of documentation of the Weekly Summary of LPT Clinical Rounds. Utilizing these data averaged over the six month reporting period, daily LPT rounds were documented on the CDCR Form 7230-MH Progress Note 95% of the time.

An average of 8.66 weekly hours of structured therapeutic activity was offered for I/Ps in ASU EOP during the review period (See Tab O.16 for details). During the reporting period, excluding down weeks, I/Ps were scheduled for an average of 11.13 hours per week of group therapy, offered 8.66 hours per week, refused 4.29 hours per week, attended 4.37 hours per week, and had an average of 2.47 hours of group treatment cancelled per week. Some of the reasons for group cancellations included holidays, staff absence/vacancies, staff redirection and training, institutional lockdown (e.g. due to escape, TB testing, norovirus outbreak, etc.), staff participating in peer review and staff deaths.

During the reporting period, the average number of I/Ps who refused more than 5 hours of offered treatment during a given week was 32% (see Tab O.16). I/Ps refusing more than 50% of offered treatment services received daily contacts with a Primary Clinician during the workweek 100% of the time. The data indicate no I/Ps were on a modified treatment plan during the reporting period (See Tab S.7). Daily ASU morning meetings between custody and clinical staff were documented 100% of the time.

C. ASU-Non-MHSDS

All data reported in this section are from audits that use a 100% selection sample (see Tab O.4, O.6, and O.8 for details). During the reporting period, 676 I/Ps entered ASU. SAC does not maintain tracking that differentiates between MHSDS and Non-MHSDS inmate-patients entering ASU. Of those 676, 97.6% received a timely nursing pre-placement screening (CDCR Form 128-MH7). The percentage of screenings conducted in a confidential setting is not available. Custody documented 30-minute welfare checks 100% of the time, based on audits conducted by the custody supervisor on each shift. Nursing documented daily LPT rounds 100% of the time on unit Isolation Logs and 114 forms for each I/P.

XII. Psychiatric Services Unit (PSU)

At the end of the reporting period there were 16 primary clinicians providing services in the PSU program with an average caseload of 15 I/Ps (See Tab V.3). Four psychiatrists are assigned to PSU with one psychiatrist for each housing unit (with caseloads up to 64 inmate-patients).

During the reporting period, 215 I/Ps were transferred to the PSU; 158 were new arrivals and 57 were DMH returns (See Tab L.1). Eighty-eight percent of I/Ps who were new arrivals were seen for an evaluation by a clinician within 5 calendar days. From 12/1/11 through 5/31/12, 83% of I/Ps received a comprehensive assessment prior to the initial IDTT (which is to occur within 14 days). This data under-represent adherence to requirements because MHTS.net triggers a requirement for an initial evaluation every time an inmate-patient returns from alternative housing or out to court. Based on a quality management team decision regarding managing workload, Initial IDTTs for I/Ps returning from crisis bed admissions were scheduled only as deemed clinically necessary by the Treatment Team after 3/5/12.

Based on the MHTS.net On Demand Contact Intervals management report, subsequent IDTTs took place in a timely manner 97% of the time (Data does not differentiate 60 day versus 90 day reviews). One hundred percent of the IDTTs were attended by the senior psychologist (or designee); 100% were attended by the primary clinician or designee; 81% were attended by the psychiatrist (psychiatrists prioritized individual inmate-patient care over IDTT participation when necessary); 100% were attended by a CC-II; 88% were attended by the PSU facility captain (reduced adherence is due to institutional priorities such as Code 3, cell extractions or other safety and security matters that supersede IDTT); and 89% were either attended by the I/P or a reason was documented for the refusal (Primary clinicians failed to report reason for non-attendance on the 7230 in 11% of reviewed cases). If an IP refuses, the primary clinician provides a wellness check cell-side to ascertain his reason for refusal. The UHR audit does not capture the actual reasons for I/P non-participation, only that there was a reason included on the 7230 form. In general, the IP either refused the IDTT or the IDTT was done in absentia (e.g., when the IP is housed in alternative safe housing pending crisis bed, due to an incident involving the safety and security of the institution, Code 3, etc.). It is rarely, if ever, the case that there is an access to care issue with no available custody officers or conflicting ducats.

Based on the MHTS.net On Demand Contact Intervals management report, 89% of inmate-patients in PSU received at least weekly individual PC contacts. Due to several factors including

unpredictable workload for crisis/emergency treatment, vacancies, and inability to cover behind staff that are off on long-term leave, clinicians have sometimes been unable to provide weekly individual therapy for every inmate-patient in PSU. The mental health subcommittee determined that in order to manage workload, the treatment team may determine that specific inmate-patients (such as those who are pending level of care change to CCCMS or who are stable at EOP LOC) may receive individual therapy every-other week instead of weekly. Forty-eight percent of contacts took place in a confidential setting; 19% were out of cell non-confidential contacts, and 33% of contacts were cell-side. Reasons for non-confidential contacts included: 6% I/P refusals; 0% lack of clinical space; 1% custody lockdowns; 1% lack of custody escorts; 13% staff decision; 79% unspecified. Aside from inmate-patient refusals, cell front sessions are often utilized due to lack of provider time to complete all of their duties in a 40-hour workweek. Eighty-eight percent of I/Ps were seen by a psychiatrist at least every 30 days. 28.5% of I/Ps were offered at least ten hours of structured therapeutic activity per week (See Tab S.9).

The inmate-patients were scheduled, on average over the reporting period excluding down weeks, for 9.94 hours per week of group treatment, offered 7.91 hours per week, and refused 2.66 hours per week. 2.03 hours per week were cancelled, and 5.25 hours per week were attended by inmate-patients. Some of the reasons for group cancellations were: holidays, staff absence/vacancies, staff redirection and training, institutional lockdown, TB testing, staff participation in peer reviews and staff deaths. LPT rounds are not provided to PSU inmate-patients, only to ASU overflow inmate-patients housed in PSU.

On average, 34% of the offered structured therapeutic activity was refused by I/Ps. Reasons for refusal reported by inmate-patients included mental health symptoms, attempt to avoid incidents that could prevent parole, perceived safety concerns, or feeling tired of participating after being in PSU for a long period of time (See Tab S.10 for details). During the reporting period, 24 I/Ps were provided with a modified treatment plan that included fewer than 10 hours of structured therapeutic activity each week (See Tab S.7). From the beginning of the audit period until the first week in March 2012, 96% of those I/Ps with modified treatment plans were scheduled IDTTs on a monthly basis. Due to a quality management team decision regarding managing workload, since March 5, 2012, the modified treatment plan reviews have been combined with other regularly scheduled IDTTs (e.g., First 60 day, Second 60 day, or 90-day reviews).

Using a combination of paper records from both PSU and Custody staff, it was determined that, during the reporting period, 95 I/Ps' cases were reviewed to determine if their SHU term could be suspended and the I/P could be transferred to an EOP Mainline program. All 95 were released to ML EOP upon review by ICC/IDTT. In addition, during the reporting period, 25 PSU inmates were made CCCMS LOC; of these, eight were transferred to a non-PSU SHU.

XIII. CCCMS SHU

At the end of the reporting period there was one primary clinician providing services in the CCCMS-SHU with an average caseload of 12 I/Ps. During the reporting period, 8 I/Ps entered the CCCMS-SHU. One hundred percent of the I/Ps had an initial IDTT within 14 calendar days or prior to the ICC whichever occurred first. Subsequent IDTTs took place at least every 90 days, 100% of the time.

One hundred percent of IDTTs were attended by the primary clinician; 75% were attended by a psychiatrist; 100% were attended by the CCII; and 51% of IDTTs were attended by the I/P. During the audit period, there was a shortage of psychiatric staff, and individual inmate-patient care was prioritized over IDTT attendance for psychiatrists. Attendance at IDTT by the LPT has just recently been added to MHTS.net and therefore accurate numbers are not yet available. Reasons for I/P non-participation are generally due to IP refusal. Inmate-Patients mostly attend their initial IDTTs, but not necessarily their follow-up IDTTs. One hundred percent of I/Ps subsequently received contacts with their primary clinician at least once every 30 days, and 94% of I/Ps prescribed psychotropic medications were seen by a psychiatrist at least every 90 days. Weekly LPT rounds were documented on the CDCR Form 7230-MH 95% of the time.

XIV. Suicide Prevention

The institution has an active Suicide Prevention and Response Focused Improvement Team (SPR-FIT) that met 11 times during the review period. See Tab C.1 to review SPR-FIT meeting minutes.

Six regular monthly SPR-FIT meetings were held during the reporting period. In addition, SAC held five SPR-FIT meetings to discuss incidents of self-harm and self-harm reviews (December, January, February, April, and May). The Suicide Prevention Coordinator (SPC) coordinates the SPR-FIT. During the reporting period, ongoing suicide prevention efforts included (See Tab C.1 for more details):

- Action to construct vent covers in cells that are used for Alternative Safe Housing for Suicide Observations, which will not allow an Inmate-Patient to affix an item to attempt suicide by hanging.
- Per recommendation from local Indecent Exposure (IEX) Committee, SPR-FIT recommended to Mental Health Subcommittee to purchase longer suicide prevention smocks. The ordering of these smocks is currently in process.
- SPR-FIT inquired to Mental Health Headquarters staff regarding clarification around emergency medical treatment for Inmate-Patients who have an Advanced Directive that includes a Do Not Resuscitate (DNR) Order. According to Mental Health Headquarters staff, a DNR order does not apply to a violent death, including suicide. Training was provided to nursing staff regarding this issue.
- Policy was clarified regarding the treatment and assessment for Suicide Risk of Inmate-Patients who return from an outside hospital after a forensic medical examination following a reported sexual assault.
- Through recommendations from SPR-FIT to Mental Health Subcommittee and Quality Management, a Quality Improvement Team (QIT) was formed for the treatment of Inmate-Patients who overdose on medication or substances at CSP-SAC. The QIT is currently in process.
- The SPR-FIT committee identified a need for an additional staff alert to avoid administration of "Keep on Person" medication if an Inmate-Patient treated in CCCMS LOC had a history of cheeking, hoarding or overdosing on medication. In coordination with the Pharmacist and Pharmacy staff, there is now direction in the prescription instructions line for the medication indicating that precautions be taken for those Inmate-Patients needing supervision with medication administration.

During the reporting period, ongoing suicide prevention training consisted of: Weekly Block IST Suicide Prevention Training, Suicide Risk Assessment training, SRE Mentor Proctoring Program, Enhanced Safety Planning for I/Ps identified as needing written safety plans, and clinician consultation with Suicide Prevention Coordinator for at-risk I/Ps.

The self-harm review process remains active. Thirteen reviews have been completed and presented to the treatment teams and SPR-FIT for discussion during the reporting period.

On return to regular housing from a MHCB, OHU, or alternative housing 5-day follow-up was documented 97% of the time. Custody wellness checks were completed as required _100% of the time.

A. Completed Suicides

During the reporting period, there were no suicides in the institution. Therefore, no Suicide Report Final Executive Summaries are included in Tab C.9.

During the last two years there were four suicides in the institution.

B. Attempted Suicides during the Reporting Period

SAC maintains a log of all incidents of self-harm, and the following data were extrapolated from the self-harm log. Of the 21 serious suicide attempts during the reporting period, 5 of them were by hanging, 7 were by lacerations, 10 were by overdose, and 2 by other methods (1 by refusing insulin treatment and 1 by lighting items in his cell on fire). Note that three Inmate-Patients who engaged in serious suicide attempts used more than one method at a time (e.g., laceration and overdose). Therefore, there were 21 serious suicide attempts; however the total number of incidents in the above breakdown will equal 24. Four inmate-patients required outside hospitalization and 21 were referred to a MHCB for acute mental health care services, with 29% ultimately referred to a DMH facility.

C. Inmate Profile Procedure

Based on a local audit of 100% of transfers, inmate profiles were printed and sent with 100% of I/Ps transferring out of SAC during the review period. ASU units follow procedures to review inmate-patient profiles for new arrivals each morning.

XV. RVR Protocols

During the reporting period, 1490 RVRs were issued for inmates at SAC: Four hundred nineteen for GP inmates, 462 for CCCMS, 549 for EOP, 60 for MHCB, and 11 for ASU GP. Of RVRs issued during the review period to inmates assigned to the CCCMS, EOP and MHCB levels of care, nearly 800 were accompanied by 115-MH RVR Mental Assessment Requests. Over 95% of those 115-MH requests were answered, including all RVRs issued to EOP and MHCB levels of care; all Division A, B, and C RVRs; or any other RVR that could potentially result in assessment of a SHU-term issued to inmates assigned to the CCCMS level of care. Sixteen of these requests were not completed at SAC due to

inmates transferring to other institutions. Twenty-two of the requests are pending assessment. Two (2) RVR mental health assessment referrals were received concerning GP inmates, but in both cases referral criteria were not met, i.e. no bizarre or unusual behavior was exhibited.

XVI. Use of Force

A table of all the Use of Force and Non-Use of Force incidents during the reporting period can be found in Tab Q. Of the 178 Use of Force Incidents, 94% occurred with MHSDS I/Ps. For Non-Use of Force Incidents, 73% occurred with MHSDS I/Ps.

XVII. Mental Health Referrals

Statewide policy requires mental health referrals to be processed within the following time frames:

- Emergent: Immediately
- Urgent: Within 24 hours
- Routine: Within five working days

During the reporting period, 1134 referrals were received, and on the final day of the period, 96% were closed. Referral statistics (See Tab U.2) indicate that 98% of emergent referrals were seen the same day, 100% of urgent referrals were seen within 24 hours, and 75% of routine referrals were completed within 5 days (MHTS.net's calculation under-estimates adherence because it uses calendar days rather than reflecting the requirement, which is 5 business days).

XVIII. MHTS.net Agreement Audits

The Agreement Audit was completed regularly during the reporting period. This audit examines agreement between MHTS.net entries and eUHR documentation of those contacts. Specifically, the audit examines the eUHR to ensure that each selected clinician contact in MHTS had a corresponding entry in the eUHR.

Audits were conducted using the methodology and tool provided by HQ. Per this protocol, clinical contacts were randomly selected each month. The table below presents the data for each month.

Month	Number of Contacts Audited	Number of MHTS contacts with corresponding documentation	Agreement Rate
December 2011	100	90	90%
January 2012	100	92	92%
February 2012	99	97	98%
March 2012	100	96	96%
April 2012	100	95	95%
May 2012	100	93	93%

The mean agreement rate for the reporting period was 94%.

EUREKA C. DAYE
Chief Executive Officer

TIM V. VIRGA
Warden

Exhibit 41

Mean EOP Treatment Hours Summary 10/1/12 - 12/31/12*

Program	Scheduled	Offered	Attended
ASU	11.6	9.9	5.4
ML	12.3	9.1	5.2
PSU	10.2	7.7	5.4

*Does not include Down Weeks of 11/19 or 12/24, nor the first day of the following group cycle, 12/31/12

Exhibit 42

California State Prison – Los Angeles County

California Department
Of
Corrections and Rehabilitation

MENTAL HEALTH SERVICES DELIVERY SYSTEM MANAGEMENT REPORT ROUND 25 June 4-7, 2012

Auditing Period October 1, 2011 to March 31, 2012

L.S. McEwen
Warden (A)

T. Belavich, Ph.D., MSHCA
Chief Executive Officer

Richard Kendall, Psy.D.
Chief of Mental Health (A)

DRPD 1 00338

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GLOSSARY OF TERMS

Acronym	Term
AIMs	Abnormal Involuntary Movement Scale
APP	Acute Psychiatric Program
ASU	Administrative Segregation Unit
CAP	Corrective Action Plan
CC	Correctional Counselor
CCCMS	Correctional Clinical Case Management System
CDCR	California Department of Corrections and Rehabilitation
CHSA	Correctional Health Services Administrator
DMH	Department of Mental Health
DOT	Direct Observation Therapy
EOP	Enhanced Outpatient Program
GP	General Population
HC-POP	Health Care Population Oversight Program
HS	Hour of Sleep
I/P	Inmate-patient
ICC	Institutional Classification Committee
ICF	Intermediate Care Facility
IDTT	Inter Disciplinary Treatment Team
LGB	Local Governing Body
LOC	Level of Care
LOP	Local Operating Procedure
LOS	Length of Stay
LPT	Licensed Psychiatric Technician
MAR	Medication Administration Record
MHCB	Mental Health Crisis Bed
MH-OHU	Mental Health-Outpatient Housing Unit
MHQM	Mental Health Quality Management Subcommittee
MHSDS	Mental Health Services Delivery System

DRPD 1 00340

MHTS	Mental Health Tracking System
OHU	Outpatient Housing Unit
PC	Primary Clinician
PSU	Psychiatric Services Unit
QIT	Quality Improvement Team
QM	Quality Management
QMC	Quality Management Committee
R&R	Receiving and Release
RVR	Rules Violation Report
SHU	Security Housing Unit
SPC	Suicide Prevention Coordinator
SPR-FIT	Suicide Prevention and Response-Focused Improvement Team
SRE	Suicide Risk Evaluation
UHR	Unit Health Record

Coleman Site Visit, Round XXV
MENTAL HEALTH MANAGEMENT REPORT
October 2011-March 2012
CSP-LAC

INSTITUTIONAL PROGRAM SUMMARY

Introduction

The California State Prison-Los Angeles County (CSP-LAC) Mental Health Management Report focuses on the audit period of October 1, 2011 through March 31, 2012. Institutional staff representing various departments contributed the information contained in this report. The report has been organized so that relevant areas of the Mental Health Program are grouped together, providing a comprehensive account of mental health services. During the review period CSP-LAC provided the following mental health programs: Reception Center (RC)-Screening, RC-Enhanced Outpatient Program (EOP), General Population/ Sensitive Needs Yard (GP/SNY) Correctional Clinical Case Management System (CCCMS), GP-EOP, Administrative Segregation Unit-Correctional Clinical Case Management (ASU-CCCMS), ASU-EOP Hub and Mental Health Crisis Bed (MHCB).

Reception Center-Screening

During the review period the Reception Center Screening program at CSP-LAC continued to meet Program Guide requirements. CSP-LAC closed its reception mission in January of 2012. Beginning in February of 2012 no reception center inmates have been received. After arriving to the institution, inmate-patients are given a mental health screen within 24 hours. The RC-Screening program evaluated all inmate-patients who paroled/discharged at EOP level of care within seven days of arrival. Inmate-patients, who are new to the system or have no prior EOP history while previously incarcerated, may be determined to need EOP level of care. These I/Ps are evaluated within 18 calendar days of arrival and placed in the RC-EOP program. Mental Health staff utilizes information from MHTS.net and Developmental Disabilities Programs (DDPS) to identify these inmates, and in turn, compares this information with the inmates' self-reports. Other resources routinely used by MH staff in RC-Screening are the MAXOR pharmacy database and the Parole Outpatient Clinic (POC) database. Inmates who screened positively for mental health factors are given a Mental Health Evaluation (MH form 7386) within 18 days of arrival. All inmates who screen positive for mental health issues or who have paroled from the Mental Health Service Delivery System (MHSDS) are given a Suicide Risk Evaluation (SRE), irrespective of suicide history or reported symptoms indicating threat of self-injury.

Reception Center- Enhanced Outpatient Program

Treatment statistics for the RC-EOP program demonstrate continued adherence with Program Guide requirements. Interdisciplinary Treatment Teams (IDTT's) are being scheduled within the first 14 days of the inmates' arrival and a minimum of every thirty days thereafter until the inmate/patient is transferred to an EOP program or paroles. All RC-EOP inmates are scheduled for structured therapeutic activities and one confidential case management contact weekly. Over the course of this review period the Reception mission at CSP-LAC ended. This decreased the number of RC-EOP inmates significantly. As our GP-EOP population began to increase the RC-EOP inmates were moved from D-yard to B-yard. All treatment activities for the RC-EOP inmates occur in B-yard.

Correctional Clinical Case Management System
The CCCMS program continues to meet Program Guide requirements. Since January 2012 CSP-LAC has been receiving more CCCMS inmates. Our CCCMS numbers are projected to increase substantially as a function of the change in mission. We currently treat CCCMS inmate/patients on Yards A, B, C and D.

General Population-Enhanced Outpatient Program
The GP-EOP inmate-patients are housed in building D1 and D2. The GP-EOP program schedules a minimum of 14.75 hours of group treatment and one individual treatment session weekly. Treatment is provided daily (Mon-Fri).

Administrative Segregation-Correctional Clinical Case Management System
The ASU-CCCMS inmate-patients continue to be housed in building A5 and part of building A4.The ASU-CCCMS program continues to meet Program Guide requirements. ASU-CCCMS inmate-patients are provided with weekly individual primary clinician (PC) contacts, Initial and 90 day IDTTs, psychiatry contacts at least once every 90 days, and daily psychiatric technician (PT) contacts.

Administrative Segregation-Enhanced Outpatient Program
The ASU-EOP inmate-patients continue to be housed in building A4. Group therapy is offered a minimum of 6 days per week. ASU-EOP inmate/patients are provided with weekly individual primary clinician (PC) contacts, Initial and 90 day IDTTs, psychiatry contacts at least once every 30 days, and daily LPT contacts. Daily individual contacts are made by PCs or designee with each ASU-EOP inmate/patient who refuses 50% or more of the offered treatment.

Mental Health Crisis Bed
The MHCB continues to meet Program Guide requirements. MHCB treatment consists of daily PC contacts, daily psychiatry contacts, at least two weekly IDTTs, daily recreation therapy contacts; and five-day follow-ups are initiated on every inmate/patient discharged from the
MHCB. Additionally, the mental health, medical, and nursing staff all work together in an effort to address the inmates/ patients overall health care needs.

New Construction/Remodeling
CSP-LAC is also part of the Long-Term bed expansion project. A new treatment building is currently under construction. The treatment building is intended for the GP-EOP population. The new space will greatly enhance our ability to provide quality treatment services to I/Ps at CSP-LAC. Construction began on March 22, 2011, and is scheduled to be completed in June 2012. The building is located adjacent to the D5 housing unit in the Vocational Annex area.
The Chief of Mental Health and Chief Executive Officer-Health Care (CEO-HC) attend a bi-weekly teleconference with other stakeholders (custody staff, construction staff, and Head Quarters (HQ) staff) regarding the progress of the project.

New or Anticipated Mission Changes

Removal of the RC program:

As a part of the CDCR realignment plan, CSP-LAC has ended its reception center mission. As a result the MH department will lose both its RC-screening and RC-EOP programs.

Obstacles to the Provision of Mental Health Services and Adherence to Program Guide Requirements

AB 109:
AB 109 impact began in the latter portion of 2011. Due to this CSP-LAC lost several staff members who were replaced with staff from the Department of Juvenile Justice (DJJ). Almost all of the staff that were impacted worked in the ASU-EOP program. For this reason, our ability to adhere to Program Guide requirements in ASU-EOP suffered during the months of December and January.

MENTAL HEALTH ROSTER

Institutional Mental Health Staffing and Telemedicine

Position	Positions Established	Positions Filled	Vacancies	Vacancy Rate	Full-Time Equivalent Contractor	Functional Vacancies	Functional Vacancy Rate
Chief Psychiatrist	1	0	1	100%	0	1	100%
Senior Psychiatrist	0	0	0	0%	0	0	0%
Chief Psychologist	1	1	0	0%	0	0	0%
Senior Psychologist	5	5	0	0%	0	0	0%
Staff Psychiatrist	11	5.5	5.5	50%	5.5	0	0%
Staff Psychologist	35	35	0	0%	0	0	0%
Supervising Social Worker	0	0	0	0%	0	0	0%
Social Worker	10	9	1	10%	1	0	0%
HPS-I	1	1	0	100%	0	0	0%
Senior Psych Tech	2	2	0	0%	0	0	0%
Psych Tech	26.25	24	2.25	8.6%	0	2.25	8.6%
Recreation Therapist	6	4	2	33%	0	2	33%
Other (OSSII)	1	0	1	100%	0	1	100%

Telemedicine

Psychiatry telemedicine used?	Number of Hours Per Week
NO	N/A

QUALITY MANAGEMENT

Local Governing Body (LGB)

The LGB is responsible for oversight of health care services and is the ultimate authority for all health care matters. The LGB was met 6 times during the monitoring period and achieved a quorum during each meeting.

Quality Management Committee (QMC)

The purpose of the QMC is to monitor, assess, and improve the quality of health care. During the reporting period the QMC met 12 times. Agendas and minutes are available in the Proof of Practice binders in the Health Care Administrative Office. The QMC is chaired by the Chief Executive Officer and regularly attended by the Warden (or designee), Associate Warden for Health Care, the CHSA II, the Chief Physician Executive, Chief of Mental Health, Director of Nursing, and Chief Pharmacist. The QMC regularly collects reports from each service delivery area (e.g., pharmacy, nursing, and MHSDS). Presentations by each of the departments/subcommittees are data-focused, and general communication and coordination issues are discussed.

Mental Health Quality Management Subcommittee (MHQM)

The purpose of the MHQM is to oversee mental health services, review program performance, and monitor, create and implement improvement efforts. The Chief of Mental Health or designee serves as Chair. MHQM is scheduled to meet weekly, on Tuesdays at 10:00 am. During the reporting period the MHQM met twenty times. A quorum was attained in 100% of the meetings during the reporting period.

Peer Review

Psychologist and Social Worker Peer Review

Peer reviews are typically held quarterly, with the 4th quarter peer review being held in January of each year. This is to give all clinicians an opportunity to review completed chart notes and clinical documentation for the final three months of the year in their entirety.

The 4th quarter peer review at CSP-LAC was held on January 18th, 2012. Charts for the months of October, November and December of 2011 were reviewed. There were 26 clinicians scheduled to review 4 charts each and share constructive feedback with a peer. The revised peer review form allows for more dialogue and more opportunity for subjective as well of objective

review of the quality of the documentation. The prior form was primarily a checklist of documents present.

Overall, clinicians indicated the peer review process provided them with excellent feedback about their quality of their clinical interactions with I/Ps as well as their clinical observations and diagnostic consistency.

On January 18th, 2012 there were 22 clinicians in attendance, including social workers and psychologists. Because this is a mandatory requirement covered under job expectations for clinical case management, those not in attendance were either absent from the institution on the day of the peer review or taking emergency call.

There were a total of 88 charts reviewed. Feed-back from the monthly peer review QIT included suggestions to operationally define the questions in the narrative form, in an effort to clarify specific guidelines by which to adequately establish the quality of the documentation of each clinician.

The chair of the QIT stated an interest in investigating other institutions, and facilitating discussion of what guidelines are being utilized by which to measure an overall standard of quality for clinical documentation. The goal is to ensure that the clinical process between clinician and patient is being adequately encapsulated and incorporated in the clinical documentation with consistency and accuracy. Due to the sustained absence of both chairs (social worker and psychologist) of the QIT and the peer review process, follow-up was temporarily interrupted. New chairs have been appointed and are picking up this goal.

The first quarter peer review for the months of January, February and March of 2012 is scheduled for May 2nd, 2012. The expressed agenda for the on-going monthly Peer Review QIT, is to make this process more interesting and beneficial for the staff.

Overall, the general comments regarding the peer review process, from clinicians at CSP-LAC have been positive. The clinicians themselves are looking at this auditing process as an opportunity for genuine peer support to improve and enhance their documentation and clinical experience.

Psychiatry Peer Review

Psychiatry Peer Review is held on a monthly basis. During the monitoring period there were 6 psychiatry peer reviews held. The psychiatry peer review methodology consists of each psychiatrist reviewing four charts prepared by a psychiatrist other than him/her self. The completed 15-item questionnaire is turned in to the chairperson of the peer review and the chairperson tabulates the results. The results are then discussed with the psychiatry staff.

QIT Activities

There were a total of 5 Mental Health QITs active during this reporting period. No new QITs were chartered during the review period. There were no QITs resolved with final recommendations sent to the QMC during the review period. There were no QITs resolved since the last management report.

QITs initiated: None

QITs ongoing: Peer Review, ASU-EOP Treatment Improvement Plan, Alternative Housing, MH Referrals, MHTS.net-eUHR Agreement

QITs resolved during monitoring period: None

MEDICATION MANAGEMENT, PSYCHOTROPIC MEDICATIONS

The total number of inmates in the MHSDS receiving psychotropic medications at the end of the reporting period was 937.

Medication Continuity for New Arrivals (Inter-Institutional CDCR Transfers)

52% of the 180 new arrivals received medications by the next calendar day (psychotropic only).

Medication Continuity for Transfers (Intra-Institutional Transfers)

Based on a random sample of 60 charts, during the reporting period, 94% of I/Ps transferring within the institutions received their prescribed psychotropic medications without interruption. 99% of I/Ps discharged from the MHCB continued to receive their psychotropic medications without interruption.

Medication Continuity for Renewal of Orders/Bridge Orders

During the reporting period, 80% of inmate-patients received timely renewals of their psychiatric medications. 20% of inmate-patients had a lapse in medication, based on no written medication orders.

Lab Tests/Results for MHSDS Inmates

During the reporting period, 110 randomly selected UHRs of inmates receiving psychotropic medications were reviewed. Of 30 applicable cases, 73% had laboratory tests ordered when clinically indicated. Psychiatrists reviewed results and documented clinical action in 100% of the 5 cases with significant laboratory results. An Abnormal Involuntary Movement Scale (AIMS) must be completed every 6 months for each inmate prescribed antipsychotic medications. During the reporting period, an AIMS was completed within the last 6 months in 35% of the 57 applicable cases. A QIT has been formed to address the low percentage of completion.

Direct Observation Therapy (DOT) Medication Administration

At the end of the reporting period, 497 inmate-patients were prescribed psychotropic DOT medication. During pill lines, DOT medication administration procedures were followed 100% of the time.

HS Medications (After 2000 Hours)

There are 497 MHSDS inmate-patients receiving HS medications as of the end of the reporting period. HS medications are delivered after 2000 hours. During the reporting period HS medications were administered after 2000 hours 100% of the time.

Medication Non-Compliance Policies and Procedures

During the reporting period, there was an average of 26 notifications of non-compliance per week, and 87% of non-compliance cases had documented follow-up appointments with a psychiatrist within 7 days of the referral.

The Medication Administration Record (MAR)

The audited UHRs contained the previous month's MARS 98% of the time, and 83% of UHRs contained MARs that were complete and legible.

Timely Processing of Medication Orders

To verify timely processing, a random sample of 90 orders for DOT medications (MHSDS patients only) was selected. Guardian records the date orders were written and the manifest date (the date the pharmacy sent the medications to the pill window). 88% of changes and newly prescribed medications were received within 24 hours of the date the order was written. (January, February, March 2012)

Informed Consent Forms

For inmate-patients on psychiatric medications, a random sample of the current UHR contained up-to-date consent forms 46% of the time. Consent forms expire annually. A QIT was formed to address this.

Pill Lines

Medications are typically distributed via pill line window. During the reporting period, the average pill line wait was 1-5 minutes on D-Yard (EOP yard).

Hoarding/Cheeking Medications

During the reporting period, there was 1 CDCR-115 Rules Violation Reports (RVRs) written explicitly for hoarding or cheeking medication.

Parole medications process

Currently, the Classification and Parole Representative notifies pharmacy of all paroling inmates at least 5 days in advance of release dates. During the reporting period, 180 I/Ps paroled with active prescriptions for psychotropic medications. 100% of existing orders were renewed for 30-days. Paroling inmates are required to sign for receipt for their parole medications. During the reporting period 100% signed manifests acknowledging receipt of their prescription medications.

MAINLINE CCCMS

Timeliness of PC and Psychiatrist Contacts

During the reporting period 538 I/P's entered the CCCMS mental health program at CSP-LAC. Of these, 79.25% had initial contacts within the first 10 days. In addition, 70.5% had their initial IDTT within 14 days of arrival or transfer into the program. This low completion rate was due to a mix up between clinical and custody staff after the yard changed from being RC to GP in January, 2012. This was soon rectified, and thereafter 97.6% received PC contacts at least once every 90 days (or more often if indicated), and 98.5% had a scheduled IDTT at least annually (or more often if indicated). Institutional staff participated in the IDTT with the PC or an alternate clinician being present 100% of the time, psychiatrist 100% of the time, and I/P 80.4% of the time. Reasons why the I/P failed to attend the IDTT included: 20% inmate refusal and 80% lockdowns.

During the reporting period, 96% of inmates with prescriptions for psychotropic medications received timely psychiatry appointments. The main reason that inmates did not have timely psychiatry contacts was due to clinician unavailability.

Prerelease and Discharge Planning

During the reporting period, 135 I/Ps in the CCCMS level of care paroled from the institution. Of these, 13.5% received parole planning. This number appears low because the clinicians are not designating the sessions as prelease planning since this is encompassed within the PC 1:1 contact. MH staff has received training regarding the proper manner in which to code the prerelease contact.

MAINLINE ENHANCED OUTPATIENT PROGRAM (EOP)

During the reporting period, 86% of all new EOP admits were assessed and presented to the IDTT within 14 days of admission, at which point their initial treatment plan was completed and signed by the IDTT attendees. Once admitted to the program, weekly PC contacts (individual or group activity) took place 99% of the time, IDTTs took place at least every 90 days 99% of the

time, and treatment plans were updated at least every 90 days 99% of the time. IDTTs were attended by a clinician 100% of the time, by the psychiatrist 100% of the time, and the I/P 68% of the time. Reasons why the I/P failed to attend the IDTT included: 27% inmate refusal, 0.4% scheduling issues (sick/furlough), 1% lockdowns, 1% clinician unavailability, and 1.6% for other reasons (i.e. paroled).

During the reporting period, group therapy was provided for the I/Ps in the EOP LOC. Group topics provided include (see list of groups in binder). On average I/Ps were offered 11 hours of structured therapeutic activity per week. During this period no I/Ps required a modified treatment plan.

Prerelease and Discharge Planning

During the reporting period 56 EOP inmates are reported to have paroled between March 3, 2011 and April 1 2012. Of these, 80% received Pre-Release Planning services.

DEPARTMENT OF MENTAL HEALTH (DMH) REFERRALS

During this period, 420 I/Ps met one or more of the considerations for a higher LOC. Of the identified I/Ps, 17% were referred to DMH, and 83% were not. At each institution, 25 I/Ps listed on the DMH non-referral log (or all I/Ps on the list if less than 25) were randomly audited. Of those audited, 72% had a reason for non-referral documented on the 7388B, and 68% had documented interventions to improve the I/P's level of functioning.

During the reporting period, 71 referrals to DMH were completed: 46 ICF and 25 APP. 78% of ICF referrals were completed within five working days (or ten working days if Vitek was required), 72% of APP referrals were completed within two working days (or seven days if a Vitek was required) and posted on SharePoint.

During this time period there were no ICF referrals and no APP referrals rejected by DMH. 4% of ICF referrals were rescinded. No APP referrals were rescinded.

During the reporting period 42 I/Ps returned to the institution from DMH. DMH discharge summaries were received when the I/P returned to the institutions 100% of the time. Clinician-to-clinician contact took place within five working days of the I/P's return to the institution 35% of the time. Five day follow-ups were completed 100% of the time for returning I/Ps.

MENTAL HEALTH CRISIS BED (MHCB)

The institution has a 13 bed, Mental Health Crisis Bed (MHCB) unit. Inmate-patients are received from internal referrals as well as from other institutions. During the reporting period, 355 referrals were received from within the institution and 2 referrals were received from other institutions.

During the reporting period, the total number of admission to the MHCB unit was 237. Where 127 were admitted to the LAC MHCB unit and 110 were admitted to MHCB units at other

institutions by HCPOP. The average length of stay (LOS) was 15.7 days. The range was from 2 to 124 days. The number of I/Ps with a LOS longer than 10 days was 72. Reasons for LOS longer than 10 days included; 33% DMH referral awaiting a bed, 3% Keyhea in process, 15% clinically discharged awaiting bed, 0% clinically discharged awaiting transfer back to home institutions, 0% starting a trial of new psychotropic medication, and the percentage retained for clinical reason was 49%. When I/Ps on the DMH waiting list were removed from the calculation, the average LOS in the MHCB was 10.6 days.

Prior to being admitted to the MHCB unit, 100% of I/Ps admitted during regular working hours were administered a pre-admission screening. Once admitted to the MHCB unit they received their initial IDTT within 72 hours 92% of the time. Thereafter I/Ps were offered at least weekly IDTTs 100% of the time. IDTTs were attended by the PC 100% of the time, psychiatry 100%, CC-I 100% and nursing attends most of time, as of May 1st 2012 nursing attendance of IDTT meetings will be reported to the MHSC on a monthly basis. Daily contacts by a licensed psychologist or psychiatrist occurred 100% of the time. Of those I/Ps that were admitted due to suicidal threats or behavior, 100% were administered an SRE at the time of placement and 99% received a SRE upon release from the MHCB. 100% received a five day follow-up after their release from the MHCB.

OUTPATIENT HOUSING UNIT (OHU)/MENTAL HEALTH OUTPATIENT HOUSING UNIT (MH-OHU)

CSP-LAC does not have an OHU/MHOHU

ALTERNATIVE HOUSING

During the reporting period there were 330 I/Ps placed in alternative housing while waiting for a MHCB bed. 100% were placed on suicide watch. 65% were eventually transferred to a MHCB. The average LOS was 1.9 days, ranging from 1 to 6 days. There were 20 I/Ps with LOS longer than 72 hours. Nineteen were placed with HCPOP. Delays in transfer were mainly due to lack of appropriate beds on weekends or holidays. One I/P stabilized before transfer and was released back to the yard. Of those I/Ps that were placed in alternative housing due to suicidal or serious self-injurious behaviors, 100% were administered a SRE prior to placement (those I/Ps entering after hours when a clinician is not available received a SRE by the next day). 100% of I/Ps who were housed in alternative housing pending admission to a Mental Health Crisis Bed but whose referral to the Mental Health Crisis Bed is rescinded received a five day follow-up upon their release.

ADMINISTRATIVE SEGREGATION UNIT (ASU)

During the reporting period there were 1971 I/Ps housed in ASU programs: 704 at CCCMS level of care (LOC), 479 at EOP LOC and 788 non-MHSDS I/Ps. All patients entering ASU are to receive a nursing pre-placement screening (CDCR Form 7219). During the reporting period 100% of the I/Ps received pre-placement screening prior to placement in the ASU setting, and 100% of the screenings were conducted in a confidential setting. Incoming I/Ps were placed in identified safety cells 100% of the time. 100% of I/P placed in ASU were reviewed for current

MHSDS status within one working day following their placement in ASU, and prior to the 114D hearing. 100% of I/Ps received a mental health screening (31-item questionnaire) within 72 hours of placement. Custody documented 30-minute welfare checks during the reporting period approximately 99% of the time.

ASU-CCCMS

During the reporting period, 704 I/P's entered the ASU CCCMS program. 98% of the I/P's were assessed by a clinician within 10 working days. 92% of initial IDTT's were completed within 14 calendar days or prior to ICC, whichever occurred first. Subsequent IDTT's took place at least every 90 days 100% of the time. 100% of the IDTT's were attended by the primary clinician or an alternate member/clinician on the Treatment Team. 100% of IDTT's were attended by a psychiatrist, 100% were attended by a CCI and 42 % were attended by the I/P. Reason for I/P non-participation were 100% due to I/P refusal.

During the reporting period 99% of I/P's received at least weekly individual PC contacts. 18% of the time they were seen in a confidential setting, 43% were seen in an out of cell non-confidential setting and 39% of the time they were seen cell front. Reasons for non-confidential cell front contacts, 70% were due to I/P refusals and 30% were due to program modification e.g. lockdowns, emergency count, TB testing etc. 100% of I/P's prescribed psychotropic medication were seen by a psychiatrist at least every 90 days. Daily LPT rounds were documented on the CDCR Form 7230-MH 100% of the time. Daily ASU morning meetings between custody and clinical staff were documented 93% of the time.

ASU-EOP (HUB)

During the reporting period, 479 I/Ps entered the ASU EOP. 99.6% of I/Ps received a comprehensive assessment (7386) prior to the initial IDTT or within 14 calendar days of referral/identification. 95.5% of initial IDTTs were completed within 14 calendar days or prior to ICC, whichever occurred first. Subsequent IDTTs took place at least every 90 days, 99.5% of the time. 100% of IDTTs were attended by the primary clinician; 100% of IDTTs were attended by the psychiatrist; 98% of IDTTs were attended by a CC; and 58% of IDTTs were attended by I/P. Data tracking the reason the I/P did not attend IDTT was not routinely collected. We have corrected this and now keep statistics on these variables.

During the reporting period 9% of I/Ps had LOS longer than 60 days. 7% had LOS longer than 90 days, of those 100% were reviewed every 30 days by the Facility Captain and CC-II. Reasons for LOS longer than 90 days included: I/P endorsed awaiting transfer, I/P pending investigation, I/P pending DA referral, I/P awaiting bed placement.

Of the I/Ps in the program during the reporting period, 98.5% received at least weekly individual PC contacts. 49% of contacts took place in a confidential setting and 51% took place in a non confidential setting. Of the non-confidential contacts; 27% were out of cell non-confidential contacts and 71% were cell-front contacts. Reasons for non-confidential contacts included, 19.5% I/P refusals; 0% lack of confidential clinical space; 0.1% custody lockdowns; 1.2% lack of custody escorts; other (Staff Decision/Unspecified) 79.1% (79.1% of non-confidential

contacts were recorded as "staff decision/unspecified" because of an error in the way the tracking forms were completed. This error has been corrected.) 99% of I/Ps prescribed psychotropic medications were seen by a psychiatrist at least every 30 days. Daily LPT rounds were documented on the CDCR Form Progress Note 7230-MH 100% of the time. 57% of I/Ps were offered at least ten hours of structured therapeutic activities per week.

During the reporting period, the average number of I/Ps who refused more than 50% of offered treatment during a given week was 26%. I/Ps refusing more than 50% of offered treatment services received daily PC contacts during the work week 34% of the time, and 0% of I/Ps were given a modified treatment plan. Daily ASU morning meetings between custody and clinical staff were documented 97% of the time.

ASU-Non-MHSDS

During the reporting period, 788 I/Ps entered ASU-Non-MHSDS program. Of those, 100% received a timely nursing pre-placement screening (CDCR Form 7219), and 100% of the screenings were conducted in a confidential setting. Custody documented 30-minute welfare checks 100% of the time. Nursing documented daily LPT rounds 100% of the time.

PSYCHIATRIC SERVICES UNIT (PSU)

CSP – LAC does not have a Psychiatric Services Unit (PSU).

CCCMS SHU

CSP – LAC does not have a CCCMS SHU.

SUICIDE PREVENTION

The institution has an active Suicide Prevention and Response Focused Improvement Team (SPR-FIT). See Tab I, Section 1 to review SPR-FIT meeting minutes.

Completed Suicides

During the reporting period, there were NO completed inmate suicides in the institution.

During the last two years there were 6 completed suicides in the institution.

Attempted Suicides during the Reporting Period

Of the 5 serious suicide attempts during the reporting period 3 of them were by hanging and 2 were by overdose. All 5 required outside hospitalization and 5 were referred to an MHCB for acute mental health care services, with 1 of 5 inmates, or 20%, ultimately referred to a DMH facility. 1 was also placed in EOP from CCCMS.

On return to regular housing from a MHCB or MHOHU, 5-day follow-up was documented 100% of the time, (however, one 5-day follow-up missed Day 1 &2 and was extended to Day 7, one 5-day step-down missed day 3 and was extended to Day 6). Custody wellness checks were completed as required 100% of the time.

Of the six SPR-FIT monthly meetings required during the reporting period, 6 monthly meetings were documented to have occurred. The Suicide Prevention Coordinator (SPC) coordinates the monthly SPR-FIT. During the reporting period the agendas included: (1) review of high risk inmates and updates on high risk inmates in the areas of EOP, EOP RC, ASU, CCCMS, and MHCB; (2) report on completed suicides (3) report on suicide attempts and self-injurious behavior; (4) MHCB statistical reviews; (5) review of TTA suicide gestures/attempts data/statistics; (6) five-day step-downs; (7) audits by custody and mental health staff; and (8) 30-day inmate welfare checks and alternative housing Logs audit results. (See binder for more details).

During the reporting period, ongoing suicide prevention training consisted of: (1) suicide prevention training and restraints review in October 2011 with all nursing staff including LVN's, RN's, SRN II's, DON and PT's; (2) training for all mental health clinicians on November 23, 2011, regarding appropriate eUHR review for suicide prevention; (3) training for all mental health clinicians on December 7, 2011 on clinical documentation relating to suicide prevention; and (4) training with all psychiatrists on December 5, 2011 regarding clinical documentation guidelines for suicide prevention.

The self-harm review process remains active. Since October 2011, the SPR-FIT coordinator has reviewed (on a daily basis) the TTA Log, the 5 day step-down log, the PC Crisis Call log, and the MHCB log in order to compile a list of "high risk inmates". This list is reviewed at least weekly with the Chief of Mental Health in order to ascertain that individuals are receiving adequate follow up. This high risk list is distributed to senior psychologists and the Chief Psychiatrist and MHCB staff prior to each monthly SPR-Fit meeting in order to obtain updates on each inmate from the PC. These updates are presented by the senior psychologist from each area at each monthly SPR-FIT meeting or emailed to the SPR-FIT coordinator.

Inmate Profile Procedure

The R&R clerical staff faxes a list to the MH Department of inmates who are scheduled to transfer. The list is sent at least once a week and a new list is sent within the week if new inmates are added to the transfer list. The OT staff prints out the inmate profiles for the inmates on the list and delivers the profiles to R&R on the same day of the request.

RVR PROTOCOLS

During the reporting period, 1290 inmates at the institution received RVRs: 192 for GP Inmates, 680 CCCMS, 395 EOP, 15 MHCB, and 16 ASU. 95% of the EOP and MHCB RVRs (and CCCMS RVRs after June 1, 2011) received a mental health assessment. In addition, 0 of the CCCMS (prior to June 1, 2011) and 1 of the GP inmates also received mental health assessments.

USE OF FORCE

A table of all the Use of Force and Non-Use of Force incidents during the reporting period can be found in Tab M. Of the Use of Force Incidents, 65% occurred with MHSDS inmate-patients. For Non-Use of Force Incidents, 61% occurred with MHSDS inmate-patients.

RECEPTION CENTER

Initial Health Screenings were conducted on 100% of incoming inmates by nursing staff within 24 hours of arrival. I/Ps arriving in the RC with prescriptions for psychotropic medications were evaluated by the psychiatrist within 24 hours 52% of the time. Initial Mental Health screenings were completed with 99.62% of incoming inmates within seven days of arrival. Those inmates that answer positively to specific clusters of questions, present with mental health symptoms, and/or were previously in the MHSDS are referred for a mental health intake evaluation (7386). These mental health evaluations were completed within 18 calendar days of the inmate's arrival 99.75 % of the time. Initial mental health screenings were completed in a confidential setting 100% of the time. Comprehensive mental health evaluations were conducted in a confidential setting 100% of the time.

Throughout the entire monitoring period, completion rates of initial screenings and in follow-up 7386 assessments was below 100% during only one month, December 2011. During that month, two buses arrived late in the evening with 3 inmates on 12/13/11, and with 1 inmate on 12/23/11. The screening staff was not notified of the arrival of these buses, and did not receive a bus manifest at the time of arrival. Consequently, the inmates on these buses were not identified as requiring screening, and were screened and assessed outside of program guide timelines. In December 2011 completion rates for initial Mental Health Screening was 98.5%, and for 7388 being completed within 18 days of arrival was 99% for the month. This was an atypical situation throughout the years of the screening program, and was most likely, a product of the erratic and unpredictable arrival of busses which characterized the weaning back of new arrivals at CSP-LAC, and eventual elimination of the screening program in January 2012.

RC CCCMS

This population is housed primarily in B and D Yards and comprises 25% of the I/Ps in the MHDS. Only accurate data from October 2011 to December 2011 can be presented. Starting in January 2012 the RC was realigned to Mainline and RC inmates started leaving. This process is not yet completed, but as of today we have 85 inmates housed on B yard. The average LOS was 85 days and ranged from 1 to 355 days. 25% of I/Ps had LOS longer than 90 days. The reason for lengths of stay longer than 90 days included is that the facility keeps them in the RC until they parole.

Clinical contacts for the reporting period are contained in the RC CCCMS Case Manager Contacts audit (Tab N). 90.5% of the I/Ps had initial contacts with their PC within 30 days of arrival. Subsequently, 98% had routine contacts with their PC at least every 90 days.

Those I/Ps that had prescribed psychotropic medications received psychiatry contacts at least every 90 days 99.9% of the time. Confidential contacts with the PC took place 100% of the time.

RC EOP

This population is housed primarily in B & D yards and comprises .6% of the I/Ps in the MHSDS. The average LOS was 59.7 days and ranged from 1 to 302 days. 40% of I/Ps had LOS longer than 60 days. Reasons for lengths of stay longer than 60 days included: medical holds, custody failure to complete intake audits in a timely manner, CCI caseload changes, CSR deferrals, missing documentation for processing. RC EOP I/Ps were seen weekly by their PC 99.8% of the time, and monthly by their psychiatrist 94% of the time. Confidential contacts with the PC took place 39% of the time. Confidential contacts were not possible for all RC EOP TPU inmates due to a lack of space availability in their housing unit. All other non-confidential contacts for RC EOP inmates should be considered due exclusively to inmate refusal and program lock-downs/Modified Program Orders. Subsequent to the initial contact I/Ps had IDTTs scheduled monthly 99% of the time. I/Ps were offered at least five hours per week of structured therapeutic activity 68% of the time.

MENTAL HEALTH REFERRALS

- Emergent: Immediately
- Urgent: Within 24 hours
- Routine: Within five working days

During the reporting period, 3948 referrals were received and on the final day of the period, 99% were closed. Referral statistics indicate that 98% of emergent referrals were seen the same day, 91% of urgent referrals were seen within 24 hours, and 87% of routine referrals were completed in within 5 business days (MHTS.net's calculation uses calendar days rather than business days).

MHTS.NET AGREEMENT AUDITS

Month	**Agreement**	**PT groups**	**PC groups**	**Contacts**		
October	63/100 63%	15/37 41%	9/37 24%	13/37 35%	Groups included in audit	
On Nov 2011 audit methodology changed						
		No note	**No MHTS entry**	**Clinician in MHTS not match to note**	**Date do not match**	

DRPD 1 00356

November 2011	83/100 83%	9/17	5/17	2/17	1/17	
December 2011	89/100 89%	10/11	1/11	0	0	
January 2012	91/100 91%	5/9	4/9	0	0	
February 2012	76/100 76%	17/24	5/24	1/24	1/24	
March 2012	86/100 86%	9/14	1/14	0	4/14	

Exhibit 43

Data from November 2012 - January 2013			
LAC EOP ML			
LAC	9.86	6.93	3.82
LAC EOP ASU			
Institution	Scheduled	Offered	Attended
LAC	11.30	10.00	6.35

Exhibit 44

GLOSSARY OF TERMS

Acronym	Term
AIMS	Abnormal Involuntary Movement Scale
APP	Acute Psychiatric Program
ASU	Administrative Segregation Unit
CAP	Corrective Action Plan
CC	Correctional Counselor
CCCMS	Correctional Clinical Case Management System
CDCR	California Department of Corrections and Rehabilitation
CHSA	Correctional Health Services Administrator
DMH	Department of Mental Health
DOT	Direct Observation Therapy
EOP	Enhanced Outpatient Program
GP	General Population
HC-POP	Health Care Population Oversight Program
HS	Hour of Sleep
I/P	Inmate-patient
ICC	Institutional Classification Committee
ICF	Intermediate Care Facility
IDTT	Inter Disciplinary Treatment Team
LGB	Local Governing Body
LOC	Level of Care
LOP	Local Operating Procedure
LOS	Length of Stay
LPT	Licensed Psychiatric Technician
MAR	Medication Administration Record
MH	Mental Health
MHCB	Mental Health Crisis Bed
MH-OHU	Mental Health-Outpatient Housing Unit
MHQM	Mental Health Quality Management Subcommittee
MHSDS	Mental Health Services Delivery System

MHTS	Mental Health Tracking System
OHU	Outpatient Housing Unit
PC	Primary Clinician
PSU	Psychiatric Services Unit
QIT	Quality Improvement Team
QM	Quality Management
QMC	Quality Management Committee
R&R	Receiving and Release
RVR	Rules Violation Report
SHU	Security Housing Unit
SPC	Suicide Prevention Coordinator
SPR-FIT	Suicide Prevention and Response-Focused Improvement Team
SRE	Suicide Risk Evaluation
UHR	Unit Health Record

Coleman Site Visit, Round XXV
MENTAL HEALTH MANAGEMENT REPORT
(December 1, 2011 – May 31, 2012)
(Salinas Valley State Prison)

INSTITUTIONAL PROGRAM SUMMARY

a. Overview of all mental health programs at institution

Salinas Valley State Prison (SVSP) is a Level IV prison and provides the following mental health programs: ML CCCMS/SNY, ML EOP, ASU CCCMS, ASU EOP (Hub), and MHCB. In addition, the Department of Mental Health's Salinas Valley Psychiatric Program is located within the perimeter of SVSP.

While the overall SVSP population has decreased, the percentage of inmates with mental illness has increased. We are currently developing reliable metrics to determine what, if any, change in mental health treatment requirements emerge as a result of titrating into a higher concentration.

ML CCCMS:

The ML CCCMS program is located on all four yards. A Yard houses Level 4 SNY inmates. B, C and D yards house Level 4 non-SNY inmates. The A yard population experienced the greatest decrease starting at 605 I/Ps and dropping to 537. The end of May showed 260 patients on B yard, 160 patients on C yard and D yard with 27 patients.

ML EOP:

ML EOP inmates are housed in two buildings, D3 and D4. The ML EOP population has held steady beginning the reporting period at 178 inmates and ending at 175. At the time of this report, 6 ML EOP SNY inmates are housed on A yard and await transfer to other institutions.

ASU CCCMS:

ASU CCCMS inmates are housed in D1, D2 and D8 with the main concentration of patients in D8. The ASU CCCMS population has dropped from 205 to 172 inmates.

ASU EOP (Hub):

ASU EOP inmates are housed in D1 and D2. The ASU EOP population began the reporting period at 54 and has oscillated with a low of 32 and ended the reporting period at 36.

MHCB:

Beds 1-8, 11 and 12 are designated as MH Crisis Beds.

b. New Construction/Remodeling

Ground was broken on 03/05/2012 for the new ML EOP treatment building on A yard. The project is scheduled for completion by 08/05/2013.

c. New or Anticipated Mission Changes

Transgender Program

SVSP was identified as an institution to house transgendered inmates. To that end, training for one psychiatrist and one clinical psychologist was provided on 4/5/2012 in Sacramento.

DDP

SVSP has been chosen as a site for a Developmental Disability Program (DDP). The start date for the program is tentatively set for February of 2013 and will include all categories of DDP inmates, including DD3.

Planned DDP Housing Clusters are as follows:

Facility A, Building 5: Level IV (SNY)
Facility B, Building 1: Level IV (GP)
Facility D, Building 3: Level IV (GP EOP)

d. Major Population Moves

There were no major population moves during the reporting period. The overall population decreased 16% going from 3594 to 3003. In contrast, the population of mentally ill inmates decreased by half that number at 8%, dropping from 1499 to 1376. The institutional population continues to titrate toward a higher concentration of mentally ill inmates, increasing from 42% to 46% of the inmate population as a whole.

With little variance (except A yard) over the past 6 months, the percentage of mentally ill inmates against the whole, breaks down as follows: A yard increased from 62% in December to 70% in April and settled at 69% in May, B yard is at 31%, C yard is at 22% and D yard is at 78%.

e. New or Overflow Administrative Segregation or any other Specialized Housing Units

ASU expanded into several yards for discrete periods of time during four months of the reporting period. In January, 26 inmates were in ASU Overflow in buildings B1 and C8. In February, 62 ASU Overflow inmates were located in buildings A4, A5, B1, and C8. In March, 6

ASU Overflow inmates were located in buildings B1 and C8. April saw two ASU Overflow inmates in C8.

f. Obstacles to Providing Mental Health Services and Adherence to Program Guide Requirements

Modified programs remain an obstacle to providing mental health services on B and C yards. Both yards were locked down for the majority of the reporting period.

Lack of treatment space impacts the ASU and ML EOP programs. A plan has been presented for using the D Yard gym for mental health recreational activities with a potential start date of late summer 2012. The lack of treatment space problem should be alleviated if not eliminated with the completion of the new A Yard ML EOP building.

Staffing issues, both clinical and non-clinical, greatly affected the delivery of mental health services. A hiring freeze prohibited filling vacancies for psychologists and office technicians (OTs). Staff Services Analyst (SSA) and Office Services Supervisor I (OSSI) support staff positions were eliminated. Limited-term appointments for one OT and one psychologist end this July. LCSW and psychiatry positions remain difficult to fill despite attempts to hire. Budgetary constraints prohibited the hiring of contractors to fill all positions. Extended illness affecting 4 OTs in addition to an unfilled vacancy contributed to OT shortages during the reporting period.

Institutional Mental Health Staffing and Telemedicine

December 1, 2011 – May 31, 2012
SVSP

Position	Positions Established	Positions Filled	Vacancies	Vacancy Rate	Full-Time Equivalent	Functional Vacancies	Functional Vacancy Rate
Chief Psychiatrist	1	1	0	0	0	0	0%
Senior Psychiatrist	0	0	0	0	0	0	0%
Chief Psychologist	1	1	0	0	0	0	0%
Senior Psychologist	4	3	1	25%	0	0	0%
Staff Psychiatrist	9.5	5.5	4	42%	1	3	32%
Staff Psychologist	29.02	27.52	1.5	5%	1.5	0	0%
Supervising Social Worker	1	0	1	100%	0	1	100%
Social Worker	8	6	2	25%	1	1	13%
Registered Nurse	10.73	10	.73	7%	0	.73	7%
Senior Psych Tech	2	2	0	0	0	0	0%
Psych Tech	22	19	3	14%	3	0	0%
Recreation Therapist	6.50	3	3.50	54%	0	3.50	54%
Clerical	12	10	2	17%	0	2	17%
HPS I	1	1	0	0	0	0	0%
SSA/AGPA	1	0	1	100%	0	1	100%
SRN II	1	1	0	0	0	0	0%
SRN III	1	1	0	0	0	0	0%

Telemedicine

Psychiatry telemedicine used?	Number of Hours Per Week
NO	0

QUALITY MANAGEMENT

Local Governing Body (LGB)

The LGB is responsible for oversight of health care services and is the ultimate authority for all health care matters. The LGB met three times during the monitoring period. Approval of CTC policies was the focus of each meeting. None of the meetings' minutes documented whether a quorum was obtained. A recent policy decision in June 2012 limited the quorum requirements to include the Warden, CEO and Chief Services Executive. Quorum will be documented at each meeting in the future.

Quality Management Committee (QMC)

The purpose of the QMC is to monitor, assess, and improve the quality of health care. During the reporting period the QMC met 10 times reaching a quorum 100% of the time. Agendas and minutes are available in the Proof of Practice binders in the Health Care Administrative Office. The QMC is chaired by the Chief Executive Officer and regularly attended by the Warden (or designee), Associate Warden for Health Care, the CHSA II, the Chief Physician Executive, Chief of Mental Health, Director of Nursing, and Chief Pharmacist. The QMC regularly collects reports from each service delivery area (e.g., pharmacy, nursing, and MHSDS). Presentations by each of the departments / subcommittees are data focused, and general communication/coordination issues are discussed.

Mental Health Quality Management Subcommittee (MHQM)

The purpose of the MHQM is to oversee mental health services, review program performance, and monitor, create and implement improvement efforts. The Chief of Mental Health or designee serves as Chair. MHQM is scheduled to meet the first and third Wednesdays of every month. During the reporting period the MHQM met 9 times. A quorum was attained in 56% of the meetings during the reporting period. A collaborative, interdepartmental meeting will be held to address the low quorum percentage in August 2012.

Peer Review

The psychiatry peer review committee only meets when requested by the Chief Psychiatrist to address a specific clinical issue or institutional need. Since the introduction of the MAPIP program earlier this year, all psychiatrists review MAPIP data and conduct random chart reviews assigned by the OT which consists of 5 UHRs per month.

Four quality measures have been identified as key indicators in psychiatric medication management. Preliminary MAPIP audit data shows adherence rates of 82.6% in mood stabilizer laboratory monitoring, 96% in prescriptions written during face-to-face encounters, 93% of required informed consents were in the eUHR, and rationale for medication changes were documented 100% of the time.

During the reporting period the psychology peer review committee met two times, October and January. Fifteen UHRs plus two additional LOC-change charts (one EOP → CCCMS chart, one CCCMS → GP chart) were reviewed at each meeting, and confidential feedback was provided in written form to each clinician reviewed.

One part of the peer review process, which involved a study of the circumstances surrounding a peer review summary of an inmate suicide, was conducted by the Chair of the committee. Volumes I, II, and III of the IM's UHR were examined. Findings were discussed by the committee with a focus on types of training the incident has shown a greater need for, which included: a more thorough review of the eUHR when completing RVR assessments, and greater competence in addressing 7388-B criteria.

The social worker peer review committee did not meet in January due to illnesses. Meetings were held February 18th, March 22nd, April 19th, and May 17th. As of this year, all chart audits were conducted electronically (eUHR) by individual social workers. The social workers come together and present their chart audit findings. The feedback has been beneficial to the social workers. Discussions ensued regarding ways to maintain clinical connection between the assessment, recommendation and interventions indicated in the treatment plan. Another such discussion concerned the role of Mental Status Exam and when it should be completed.

During the meeting with the licensed clinicians, it was decided that conducting mini in-service trainings would allow for training opportunities directly related to enhancing each clinician's social work skills.

QIT Activities

There were no Mental Health QITs active during this reporting period. None were chartered and none were resolved with final recommendations sent to the QMC during the review period. No QITs were resolved since the last management report.

MEDICATION MANAGEMENT, PSYCHOTROPIC MEDICATIONS

The total number of inmates in the MHSDS receiving psychotropic medications as of 6/5/2012 was 992 according to Maxor. However, this number is inflated as Maxor considers more than five drugs as psychotropic when they are prescribed only for medical and not psychiatric reasons.

Medication Continuity for New Arrivals (Inter-Institutional CDCR Transfers)

93% of the 121 new arrivals received their prescribed psychotropic medications by the next calendar day.

Medication Continuity for Transfers (Intra-Institutional Transfers)

Based on a random sample of 583 charts during the reporting period, 99% of I/Ps transferring within the institutions received their prescribed psychotropic medications without interruption. 100% of I/Ps discharged from the MHCB continued to receive their psychotropic medications without interruption.

Medication Continuity for Renewal of Orders/Bridge Orders

During the reporting period, 80% of I/Ps received timely renewals of their psychiatric medications. 20% of I/Ps had a lapse in medication, based on no written medication orders.

Lab Tests/Results for MHSDS Inmates

During the reporting period, 108 randomly selected UHRs of inmates receiving psychotropic medications were reviewed. Of 23 applicable cases, 60% had laboratory tests ordered when clinically indicated. Psychiatrists reviewed results and documented clinical action in 100% with significant laboratory results. During the reporting period, an AIMs was completed in 81% of the 75 applicable cases.

Direct Observation Therapy (DOT) Medication Administration

At the end of the reporting period, 489 inmate-patients were prescribed psychotropic DOT medication. During pill lines, DOT medication administration procedures were followed 100% of the time.

HS Medications (After 2000 Hours)

There are 612 MHSDS inmate-patients receiving HS medications as of the end of the reporting period. HS medications are delivered after 2000 hours. During the reporting period HS medications were administered after 2000 hours 100% of the time.

Medication Non-Compliance Policies and Procedures

During the reporting period, there was an average of .70 notifications of non-compliance per week, and 65% of non-compliance cases had documented follow-up appointments with a psychiatrist within 7 days of the referral.

The Medication Administration Record (MAR)

The audited UHRs contained the previous month's MARS 93% of the time, and 87% of UHRs contained MARs that were complete and legible.

Timely Processing of Medication Orders

To verify timely processing, a random sample of 180 orders for DOT medications (MHSDS patients only) was selected. Guardian records the date orders were written and the manifest date

(the date the pharmacy sent the medications to the pill window). 92% of changes and newly prescribed medications were received within 24 hours of the date the order was written.

Informed Consent Forms

For inmate-patients on psychiatric medications, a random sample of the current UHR contained up-to-date consent forms 75% of the time. Consent forms expire annually.

Pill Lines

Medications are typically distributed via pill window. During the reporting period, the average pill line wait was 5 minutes on all yards.

Hoarding/Cheeking Medications

During the reporting period, there were zero CDCR-115 Rules Violation Reports (RVRs) written explicitly for hoarding or cheeking medication.

Parole Medications Process

Currently, the Classification and Parole Representative notifies pharmacy of all paroling inmates at least 30 days in advance of release dates. During the reporting period, 53 I/Ps paroled with active prescriptions for psychotropic medications. Paroling inmates are required to sign for receipt for their parole medications. During the reporting period 74% signed manifests acknowledging receipt of their prescription medications.

MAINLINE CCCMS

Timeliness of PC and Psychiatrist Contacts

During the reporting period 427 I/Ps entered the CCCMS mental health program. Of these, 71% received an initial contact with their PC within 10 days during which time the Clinical Intake Assessment was completed. In addition 82% had their initial IDTT within 14 days of arrival or transfer into the program. Thereafter 95% received PC contacts at least once every 90 days (or more often if indicated), and 95% had a scheduled IDTTs at least annually (or more often if indicated). Institutional staff participated in the IDTT with the PC being present 99% of the time, psychiatrist 98% of the time, and I/P 84% of the time. IP refusal is the most typical reason IDTTs are held in absentia. Other reasons are infrequent and not currently tracked.

During the reporting period, 93% of inmates with prescriptions for psychotropic medications received timely psychiatry appointments. Reasons that inmates did not have timely psychiatry contacts included: 59% refusal, 3% competing appointments, 10% due to lock downs, 0% lack of escort officers, and 28% clinician unavailability.

Prerelease and Discharge Planning

During the reporting period, 35 I/Ps in the CCCMS level of care paroled from the institution. Of these, 70% received parole planning.

MAINLINE ENHANCED OUTPATIENT PROGRAM (EOP)

During the reporting period, 94% of all new EOP admits were assessed and presented to the IDTT within 14 days of admission, at which point their initial treatment plan was completed and signed by the IDTT attendees. Once admitted to the program, weekly PC contacts (individual or group activity) took place 89% of the time, IDTTs took place at least every 90 days, 93% of the time, and treatment plans were updated at least every 90 days, 100% of the time. IDTTs were attended by their PC 95% of the time, by the psychiatrist 92% of the time, and by the IP 68% of the time. IP refusals were typically the reason IDTTs were held in absentia. Other reasons are infrequent and not currently tracked.

During the reporting period, group therapy was provided for the I/Ps in the EOP LOC. Group topics provided include: basic anger management, advanced anger management, symptom management, medication management, stress management, relaxation, thinking styles, lifer issues, diabetes education, fitness, art therapy, music therapy and health issues. On average, I/Ps were offered 9 hours of structured therapeutic activity per week. During the reporting period, up to one I/P a month were provided a modified treatment plan. 100% of those who received a modified treatment plan also received a monthly IDTT.

Prerelease and Discharge Planning

During the reporting period 8 I/Ps in the EOP level of care paroled from the institution. All but two were provided with parole planning assistance, either individually, in group, or both. One of the IPs who did not participate in parole planning appeared to be experiencing psychiatric symptoms too severe to allow for this kind of intervention. He spent the last week prior to his parole in MHCB. The remaining IP was transferred from the on-site DMH facility two days prior to parole, which did not allow sufficient time for intervention.

DEPARTMENT OF MENTAL HEALTH (DMH) REFERRALS

During this period, 212 I/Ps met one or more of the considerations for a higher LOC. Of the identified I/Ps, 11% were referred to DMH, 89% of I/Ps were not referred. During the reporting period, 25 I/Ps listed on the monthly DMH non-referral log (or all I/Ps on the list if less than 25) were randomly audited. Of those audited, 88% had a reason for non referral documented on the 7388-B, and 63% had documented interventions to improve the I/P's level of functioning.

During the reporting period, 24 referrals to DMH were completed: 16 ICF and 8 APP. 56% (9) of ICF referrals were completed within five working days, 75% (6) of APP referrals were completed within two working days and posted on SharePoint.

During this time period none of the ICF or APP referrals were rejected by DMH and 19% (3) of ICF referrals and 13% (1) of APP referrals were rescinded.

During the reporting period 50 I/Ps returned to the institution from DMH. DMH discharge summaries were received when the I/P returned to the institutions 88% of the time. Five day follow-ups were completed 94% of the time for returning I/Ps. Clinicians were provided clinician contact information when receiving an inmate from DMH 100% of the time. It is currently left to their discretion to contact the sending clinician as needed.

MENTAL HEALTH CRISIS BED (MHCB)

SVSP has a 10-psychiatric bed capacity Mental Health Crisis Bed (MHCB) unit. The following data was gathered using MHTS.Net, internal data compilation, and chart audits. Inmate-patients are received from internal referrals as well as from other institutions. During the reporting period, 252 referrals were received from within the institution and 38 referrals were received from other institutions.

During the reporting period, the total number of admissions to the MHCB unit totaled 90. The average clinical length of stay (LOS) was 9.4 days. The average physical LOS was 12.3 days. The range was from 1-day to 29-days. The number of I/Ps with a LOS longer than 10 days was 47. Reasons for LOS longer than 10 days included; 13% DMH referral awaiting a bed, 4% Keyhea in process, 30% clinically discharged awaiting bed, 17% clinically discharged awaiting transfer back to home institutions, 0% starting a trial of new psychotropic medication. The percent retained for clinical reasons was 36%. When I/Ps on the DMH waiting list were removed from the calculation, the average LOS in the MHCB was 11.7 days.

Prior to being admitted to the MHCB unit, 100% of the I/Ps admitted during regular working hours were administered a pre-admission screening. Once admitted to the MHCB unit they received their initial IDTT within 72 hours 85% of the time. Thereafter I/Ps were offered at least weekly IDTTs 100% of the time. IDTTs were attended by the PC 100% of the time, psychiatry 100%, CC-I 100% and nursing 100% of the time. Daily contacts by a licensed psychologist or psychiatrist occurred 99% of the time. Of those I/Ps that were admitted due to suicidal threats or behavior, 100% were administered an SRE at the time of placement and 99% received a SRE upon release from the MHCB. 100% received a five day follow-up after their release from the MHCB.

ALTERNATIVE HOUSING

During the reporting period there were 214 I/Ps placed in alternative housing while waiting for a MHCB bed. 100% were placed on suicide precaution. 24% were transferred to a MHCB. The average LOS was .33 days, ranging from a few hours to 2.5 days. None had lengths of stay longer than 72 hours. Of those I/Ps that were placed in alternative housing due to suicidal or serious self-injurious behaviors, 100% were administered a SRE prior to placement (those I/Ps entering after hours when a clinician is not available will receive a SRE by the next day). 100% of I/Ps received a five-day follow-up upon their release.

ADMINISTRATIVE SEGREGATION UNIT (ASU)

At the end of the reporting period there are 213 I/Ps housed in ASU programs: 183 CCCMS LOC, 41 EOP LOC and 211 non-MHSDS I/Ps. All I/Ps entering ASU are to receive a nursing pre-placement screening. During the reporting period 73.2% of the I/Ps received pre-placement screening prior to placement in the ASU setting, and 100% of the screenings were conducted in a confidential setting. Incoming I/Ps were placed in identified safety cells (intake cells) whenever open, otherwise, in the next closest cell. New arrivals are given the priority for intake cells. 100% of I/Ps placed in ASU were reviewed for current MHSDS status within one working day following their placement in ASU, and prior to the 114D hearing. 100% of I/Ps were offered a mental health screening and 76.2% of I/Ps received/participated with a mental health screening (31-item questionnaire) within 72 hours of placement. The ASU custody officers documented 30-minute welfare checks during the reporting period 100% of the time.

ASU-CCCMS

During the reporting period, 216 I/Ps entered the ASU CCCMS program. 87% of the I/Ps were assessed by a clinician within 5 calendar days. 83% of initial IDTTs were completed within 14 calendar days or prior to ICC, whichever occurred first. Subsequent IDTTs took place at least every 90 days, 93% of the time. 98% of IDTT's were attended by the primary clinician; 98% were attended by psychiatry, 98% were attended by the CC, and 67% were attended by the IP. IP refusal is the most typical reason IDTT's are held in absentia. All other reasons are infrequent and are not currently tracked.

During the reporting period, 90% of I/Ps received at least weekly individual PC contacts, and these contacts were confidential 43% of the time. The primary obstacle identified during this reporting period is the on-going lack of confidential treatment space. Mental health management is working with executive staff to identify options for more workable treatment space in the ASU setting. 80% of I/Ps prescribed psychotropic medications were seen by a psychiatrist at least every 90 days. Daily LPT rounds were documented on the CDCR Form 7230-MH 100% of the time. Daily ASU morning meetings between custody and clinical staff were documented 50% of the time. A system has been put in place to document these meetings daily.

ASU-EOP (HUB)

During the reporting period, 93 I/Ps entered the ASU EOP. 98% of initial IDTTs were completed within 14 calendar days or prior to ICC, whichever occurred first. Subsequent IDTTs took place at least every 90 days, 99% of the time. 99% of IDTT's were attended by the primary clinician; 92% were attended by psychiatry; 81% were attended by CC; and 68% were attended by the IP. IP refusals were typically the only reason IDTTs were held in absentia. All other reasons were infrequent and are not currently tracked.

During the reporting period 14% of I/Ps had a LOS longer than 60 days. 43% had a LOS longer than 90 days, all of whom are reviewed weekly by the Facility Captain and CC-II during the Focus Improvement Team meeting. Reasons for LOS longer than 90 days included: 43% endorsed awaiting transfer, 35% pending investigation, 13% pending DA referral, 9% awaiting bed placement.

Of the I/Ps in the program during the reporting period, 95% received at least weekly individual PC contacts, 42% of contacts took place in a confidential setting. Reasons for non-confidential contacts included: limited confidential treatment space, understaffing, and MH program shut down for one week in February for staff development. Additionally, multiple staff members were on vacation requiring non-confidential (cell front) contact. 71-92% of I/Ps prescribed psychotropic medications were seen by a psychiatrist at least every 30 days. Daily LPT rounds were documented on the CDCR Form Progress Note 7230-MH 100% of the time. On average, all I/Ps were scheduled for 11 hours of weekly structured therapeutic activity. Of those scheduled, an average of 10 hours of treatment were offered to all I/Ps in the program. An average of 59% of I/Ps were offered at least ten hours of structured therapeutic activities per week.

I/Ps in the modified program typically attended 4 activity hours per week. Holidays and a single week of program development impacted treatment offered and attended. Very few I/Ps are identified as Modified Treatment each month, with none identified during the month of February. During the reporting period, the average number of I/Ps who refused more than 50% of offered treatment during a given week period was 40%. I/Ps refusing more than 50% of offered treatment services received daily PC contacts during the work week 22% of the time, and 22% of I/Ps were given a modified treatment plan. Daily ASU morning meetings between custody and clinical staff were documented 50% of the time. A system has been put in place to document these meetings daily

ASU-Non-MHSDS

Since there is currently no tracking system to obtain historical data on admissions and discharges for all ASU units, a sampling was conducted for one of SVSP's ASU units, Z. The second week of each month from December 2011 through May 2012 was sampled and totaled. The number of I/Ps who entered Z, ASU-Non-MHSDS program, was 66. Of those, 72.3% received a timely nursing pre-placement screening (CDCR Form 7219), and 100% of the screenings were conducted in a confidential setting. Custody documented 30-minute welfare checks 100% of the time. Nursing documented daily LPT rounds 100% of the time.

SUICIDE PREVENTION

The institution has an active Suicide Prevention and Response Focused Improvement Team (SPR-FIT). See Tab I, Section 1 to review SPR-FIT meeting minutes.

Completed Suicides

During the reporting period, there were 3 completed inmate suicides in the institution.

During the last two years there were 7 completed suicides in the institution.

Attempted Suicides during the Reporting Period

Of the 10 serious suicide attempts during the reporting period, 1 was by laceration and 9 were by overdose. Outside hospitalization was not required. Ten were referred to a MHCB for mental health care services. No one out of this population was referred to a DMH facility.
On return to regular housing from a MHCB, 5-day follow-up was documented, on average, 84.5% of the time. Custody Wellness Checks were completed as required, on average, 93.5% of the time.

Of the six SPR-FIT monthly meetings required during the reporting period, 6 monthly meetings were documented to have occurred. The SPC coordinates the monthly SPR-FIT. During the reporting period the agendas included details of the Pre-ASU screening audit, 31 Item Questionnaire audit, 21-Day Observation, ASU audit, review of suicide attempts from the previous month, review of Custody Wellness Checks and 5-day clinical follow-up audits of the previous month, review of completed suicides, DOT Medication compliance audit and training needs. Attendance is indicated in the SPR FIT minutes. (See binder for more details).

Problematic areas still under review by SPR-FIT include the completion and distribution of the ASU Pre-placement chrono, issues related to the 21-Day Observation and the completion and return of the Custody Wellness Checks. Training specific to these topics is occurring in addition to the new employee 8-hour Suicide Prevention Training. Also, the new Suicide Risk Evaluation and Proctoring/Mentoring Program have been introduced to the staff with a plan to continue training in areas identified through the program as problematic.

The self-harm review process remains active. Clinicians are notified via telephone when an inmate who attempted self-harm is to return from the CTC. In addition, a Custody Wellness Check and a 5- day follow-up follow the inmate. The clinician presents the inmate and revision of the treatment plan to IDTT as appropriate. The Suicide Prevention Coordinator may continue to attend the Emergency Medical Response Review Committee and have access to all self harm incidents. The clinical director of the CTC will bring the data and present incidents of self harm to SPR-FIT.

Inmate Profile Procedure

SVSP does not have an LOP addressing data entry, transfer, and receipt of Inmate Profiles. With the launch of MHTS.Net, inmate profiles from other institutions are no longer used in the screening process in ASU housing units and SVSP does not send out inmate profiles. LPTs use the Daily Movement Sheets as well as reports from MHTS.Net to identify new ASU inmates. Each new ASU inmate's MHTS.Net data is then checked real time to review past MH treatment data including suicide history.

RVR PROTOCOLS

During the reporting period, 1982 inmates at the institution received RVRs: 1042 for GP Inmates, 750 CCCMS, 184 EOP, and 6 MHCB. ASU RVRs are not tracked separately but will

be beginning in August 2012. 93% of the EOP and MHCB RVRs,28% of the CCCMS, and 0% of the GP inmates also received mental health assessments

USE OF FORCE

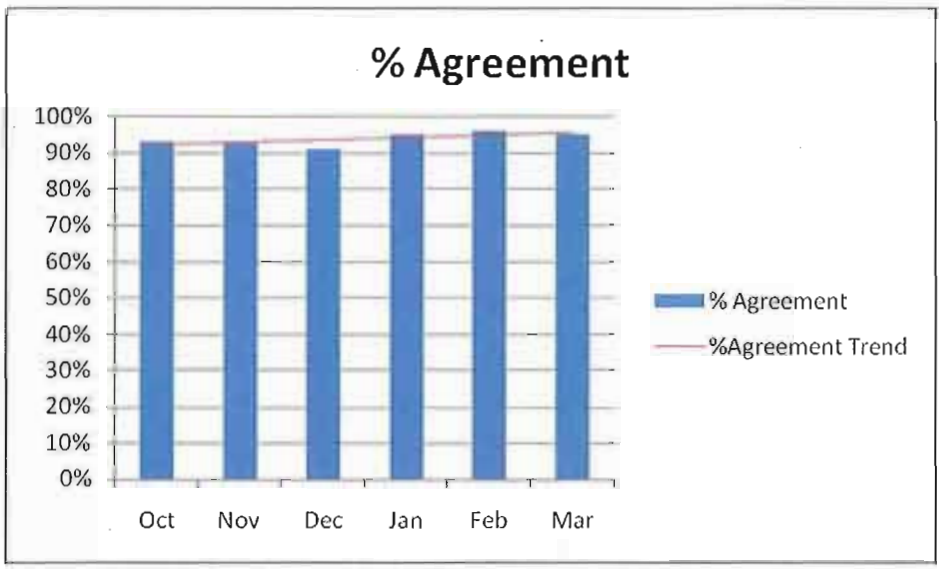
A table of all the Use of Force and Non-Use of Force incidents during the reporting period can be found in Tab M. Of the Use of Force Incidents, 45% occurred with MHSDS inmate-patients. For Non-Use of Force Incidents, 55% occurred with MHSDS inmate-patients.

MENTAL HEALTH REFERRALS

- Emergent: Immediately
- Urgent: Within 24 hours
- Routine: Within five working days

During the reporting period, 1818 referrals were received and on the final day of the period, 97% were closed. Referral statistics (See Tab R) indicate that 97% of emergent referrals were seen the same day, 90% of urgent referrals were seen within 24 hours, and 86% of routine referrals were completed in within 5 business days (MHTS.Net's calculation uses calendar days rather than business days).

MHTS.NET AGREEMENT AUDITS



Audits were run in December through May, with the actual months audited shown in the graph above.

Exhibit 45

Coleman Site Visit, Round XXV
MENTAL HEALTH MANAGEMENT REPORT

December 1, 2011 – May 31, 2012
San Quentin State Prison

INSTITUTIONAL PROGRAM SUMMARY

Overview of all the mental health programs at institution

At San Quentin State Prison (SQ), the Mental Health Department provides services in the following programs: Reception Center (processing), RC CCCMS, RC EOP, Mainline CCCMS, Administrative Segregation (ASU) CCCMS and EOP, ASU EOP Hub, Mental Health Crisis Bed (MHCB) and Specialized Care for the Condemned. These services are provided in a manner that implements the continuity-of-care model which allows inmate-patients (I/Ps) to develop a constructive therapeutic relationship with the mental health providers. Providers continue to work with the I/Ps as they move throughout the institution, change level of care or even enter the inpatient unit (MHCB) on-site. The department has also integrated quality management into our model and demonstrated an ability to self-monitor, self-analyze, self-correct and proactively improve all aspects of our mental health service delivery.

The mental health staff is organized according to function. During the reporting period, there were eight functional teams: (1) Quality Management Team; (2) Individual Treatment Team; (3) Recidivism Reduction Team; (4) Crisis, Screening and Intervention Team; (5) Assessment and Training Team; (6) Psychiatric Nursing Team, (7) Psychiatric Medication Management Team; and (8) Specialized Care for the Condemned Team. Previously, a Custody Counselor Team functioned under the supervision of the Chief of Mental Health and the CCII-Specialist remains a member of the Management Team.

The MHSDS department has established itself as a multidisciplinary Continuing Education Provider and provides training in Fellowship, Post-doc, Internship and Practicum programs for psychiatry and doctoral level psychology students. The department is also analyzing data related to recidivism and working toward tailoring programs to effectively reduce recidivism.

New Construction/Remodeling

Not applicable during this reporting period.

New or Anticipated Mission Changes

As a part of the CDCR realignment plan, SQSP anticipates reducing the RC population by approximately 684 beds, reducing the volume of the reception center by approximately 50%, increasing the GP Level II population by approximately 684 beds and reducing the corresponding SQ MHSDS staff by approximately 16.42 positions. It is unclear how this realignment will impact the overall mental health EOP and CCCMS population. At this time, the realignment is currently in process.

DRPD 1 00533

Major Population Moves
Not applicable during this reporting period.

New or Overflow Administrative Segregation or any other Specialized Housing Units
The Condemned inmate population has expanded from North Segregation into East Block. Condemned has now outgrown East Block and we are overflowing into the Adjustment Center which houses the institution's Administrative Segregation inmate-patients. SQ has realigned several Reception Center Population housing units to accommodate the ASU inmate population. The AB 109 IAS identifies 91 Carson Unit Reception Center beds deactivating and 48 Condemned beds activating. Due to the condemned population housed in the Adjustment Center, Carson Unit houses single celled ASU inmate-patients. Treatment of the condemned population is provided through the Specialized Care for the Condemned.

Obstacles to Providing Mental Health Services and Adherence to Program Guide Requirements
During the reporting period, the department has adjusted to changes related to the implementation and modification of new data systems including MHTS, eUHR, and SOMS. This has resulted in ongoing adjustments to audits and reports in both methodology and content. We continue to attempt to provide the most accurate, consistent and complete information, though obtaining this has been challenging given the changes. Adjustments and changes to staffing, not only in mental health but also in the custody and medical departments, have also impacted provision of services at times. The department, working with custody, has begun expanded treatment hours which we anticipate will result in improved patient care. The planned population changes and uncertainty due to realignment have, at times, impacted department morale. The department management is continually assessing performance and attempting to maintain adherence to Program Guide requirements and professional standards of care. Consideration is being given to reorganization of the department based on likely changes in SQ's mission and population.

MENTAL HEALTH ROSTER

Institutional Mental Health Staffing and Telemedicine

December 1, 2011 - May 31, 2012
San Quentin

Position	Positions Established	Positions Filled	Vacancies	Vacancy Rate	Full-Time Equivalent	Functional Vacancies	Functional Vacancy Rate
Chief of Mental Health	1.00	1.00	0.00	0%	0.00	0.00	0%
Chief Psychiatrist	1.00	1.00	0.00	0%	0.00	0.00	0%
Senior Psychiatrist	0.00	0.00	0.00	0%	0.00	0.00	0%
Senior Psychologist	5.50	5.00	0.50	9%	0.00	0.50	9%
Staff Psychiatrist	12.25	11.65	0.60	5%	0.00	0.60	5%

Staff Psychologist	35.50	30.80	4.70	13%	0.54	4.16	12%
Supervising Social Worker	0.00	0.00	0.00	0%	0.00	0.00	0%
Social Worker	10.20	10.00	0.20	2%	0.00	0.20	2%
Registered Nurse	2.46	2.46	0.00	0%	0.00	0.00	0%
Senior Psych Tech	1.00	1.00	0.00	0%	0.00	0.00	0%
Psych Tech	25.60	24.60	1.00	4%	0.00	1.00	4%
Recreation Therapist	5.30	3.75	1.55	29%	0.51	1.04	21%
Other (specify)	0.00	0.00	0.00	0%	0.00	0.00	0%

Telemedicine

Psychiatry telemedicine used?	Number of Hours Per Week
NO	0

QUALITY MANAGEMENT

Local Governing Body (LGB)
The LGB is responsible for oversight of health care services and is the ultimate authority for all health care matters. The LGB was scheduled to meet once during the monitoring period. The scheduled meeting achieved a quorum. The meeting covered discussion, review and approval of CTC policies and procedures for the recreation therapy program, administration, food and nutrition services and mental health.

Quality Management Committee (QMC)
The purpose of the QMC is to monitor, assess, and improve the quality of health care. During the reporting period the QMC met with the required quorum 6 times. Agendas and minutes are available in the Proof of Practice binders in the Health Care Administrative Office. The QMC is chaired by the Chief Executive Officer and attendees include the Warden (or designee), Associate Warden for Health Care, the CHSA II, the Chief Physician Executive, Chief of Mental Health, Director of Nursing, and Chief Pharmacist. The QMC regularly collects reports from each service delivery area (e.g., pharmacy, nursing, and mental health). Presentations by each of the departments or subcommittees are data focused and general communication/coordination issues are discussed.

Mental Health Quality Management Subcommittee (MHQM)
The purpose of the MHQM is to oversee mental health services, review program performance, and monitor, create and implement improvement efforts. The Chief of Mental Health or designee serves as Chair. MHQM is scheduled to meet weekly. During the reporting period the MHQM met 25 times. A quorum was attained in 100% of the meetings during the reporting period.

Peer Review
Each of the three primary clinical disciplines (psychiatry, psychology and social work) has a peer review chairperson from that discipline to oversee the process. The SQ LOP describes how often staff are reviewed, how staff are selected to serve on the peer review committee, the procedures used to evaluate medication management, documentation, assessment, diagnosis, treatment and pre-release planning, treatment provision, consultation and referral. It also addresses the confidentiality of peer reviews (which are not seen by other staff or supervisors) and includes the actual forms used by the reviewers. During the review period, 14 psychologist, 2 social worker and 3 psychiatrist peer reviews were completed. Results showed consistently positive reviews.

QIT Activities
There were a total of 3 Mental Health QITs active during this reporting period. No new QITs were chartered during the review period. Two QITs were resolved with final recommendations sent to the QMC during the review period. Two QITs were resolved since the last management report. The ongoing QIT was the Clozapine Quality Assurance QIT. The QITs resolved during the monitoring period were the Specialized Treatment for the Condemned Evaluation QIT and the MHTS-UHR Concordance QIT (also known as the Agreement Audit QIT).

MEDICATION MANAGEMENT, PSYCHOTROPIC MEDICATIONS

The total number of inmates in the MHSDS receiving psychotropic medications at the end of the reporting period was 615.

Medication Continuity for New Arrivals (Inter-Institutional CDCR Transfers)
I/Ps arriving in the RC with prescriptions for psychotropic medications were evaluated face-to-face or through records review by the psychiatrist within 24 hours 100% of the time. All medication orders that were received in the pharmacy by 1300 were sent to the LVN on the same day. All orders written after 1500 hours were processed the next day or within 24 hours.

Medication Continuity for Transfers (Intra-Institutional Transfers)
During the reporting period, 97% of the 463 I/Ps transferring within the institution, including I/P's discharged from the MHCB, received their prescribed psychotropic medications without interruption. The Medication Continuity Audit conducted during the reporting period indicates that none of the 3% of I/Ps were transferring in or out of the MHCB at the time of interrupted services.

Medication Continuity for Renewal of Orders/Bridge Orders
During the previous reporting period, 99.5% of inmate-patients received timely renewals of their psychiatric medications. Less than 0.5% of inmate-patients had a lapse in medication, based on no written medication orders. Given that there has been no change in prescription, dispensing, administering or monitoring / safeguards, this indicator was not re-audited.

To reduce the likelihood of unintentional prescription expirations, SQ's Mental Health Department produces a weekly Psychiatrist Appointment Analyzer spreadsheet using MHTS data and a weekly report from pharmacy of all active prescriptions. This spreadsheet quickly and accurately alerts psychiatrists to appointment and prescription timeframes that may cause

Program Guide timelines to be missed or prescriptions to expire unintentionally before an appointment. In addition, psychiatrists are required to see any patients who do not come for scheduled appointments that same day, in part to prevent the need for "bridge" orders. If medication renewal is required on an urgent basis and the patient cannot be seen, this authorization is typically for no more than thirty (30) days, and the patient is seen as soon as clinically indicated. Finally, psychiatrists renew all medication orders for 90-days at every visit.

Lab Tests/Results for MHSDS Inmates

The schedule of audits completed at SQ addressing lab tests/results does not correspond with the reporting period, but are completed quarterly. The numbers in this section reflect October 2011 through March 2012. During those 2 quarters, 178 randomly selected UHRs of inmates receiving psychotropic medications were reviewed. Laboratory tests were indicated for 165 of the 178 I/P's. Laboratory tests were ordered as indicated 92% of the time. Psychiatrists reviewed lab results and documented clinical action 88% of the time tests were ordered. An Abnormal Involuntary Movement Scale (AIMS) must be completed every 6 months for each inmate prescribed antipsychotic medications. Forty UHRs were audited for AIMS. An AIMS was completed within the last 6 months in 70% of the 40 sampled cases.

Direct Observation Therapy (DOT) Medication Administration

During pill lines, DOT medication administration procedures were followed 100% of the time. As of June 29, 2012, there were 19 I/Ps prescribed psychotropic DOT medication by a psychiatrist.

HS Medications (After 2000 Hours)

There were 19 MHSDS I/Ps receiving HS medications prescribed by a psychiatrist as of June 29, 2012. During the reporting period, HS medications were administered after 2000 hours 100% of the time.

Medication Non-Compliance Policies and Procedures

During the reporting period, there was an average of 52 notifications of non-compliance per week, For the monitoring period, the average medication compliance for the institution was 91%.

Inmate/patients who were noncompliant with medications during the reporting period were referred to a physician 93% of the time and were seen within a week of referral 53% of the time. These appointments will now be scheduled directly by nursing on behalf of psychiatrists to improve performance on these indicators.

The Medication Administration Record (MAR)

Per an audit completed by the Health Records Department for this report, audited eUHRs contained the previous month's MARS 100% of the time, and 100% of UHRs contained MARs that were complete and legible. MARs are received from the clinics on a daily basis and scanned into the eUHR. In the course of completing monthly audits, the Mental Health RN regularly reviews the MARs and reports that they are complete and legible.

Timely Processing of Medication Orders
To verify timely processing, a random sample of 100 orders for DOT medications (MHSDS patients only) was selected. Guardian records the date orders were written and the manifest date (the date the pharmacy sent the medications to the pill window). 100% of changes and newly prescribed medications were received within 24 hours of the date the order was written.

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Informed Consent Forms
Per an audit completed by the Health Records Department for this report, a random sample of 16 current eUHRs of I/Ps on psychiatric medications contained up-to-date consent forms 88% of the time.

Pill Lines
Medications are typically distributed via pill line. Lengths of pill lines are monitored along with Direct Observation Treatment and Nurse Administered Therapy. Pill lines with a wait of longer than 7 to 10 minutes are considered unacceptable and corrective measures (additional pill lines and/or alternate staff) are instituted. Nursing is currently developing a mechanism to further track and capture this success.

Hoarding/Cheeking Medications
During the reporting period, there was 1 CDCR-115 Rules Violation Report (RVR) written explicitly for hoarding or cheeking medication.

Parole medications process
Currently, the Classification and Parole Representative notifies pharmacy of all paroling inmates at least 1 day in advance of release dates. During the reporting period, 137 I/Ps paroled with active prescriptions for psychotropic medications. Existing orders were renewed for 30-days in 100% of the cases. Paroling inmates are required to sign for receipt of their parole medications. During the reporting period 99% signed manifests acknowledging receipt of their prescription medications (1 of 137 paroling I/Ps refused medication).

MAINLINE CCCMS

Timeliness of PC and Psychiatrist Contacts
During the reporting period 290 I/Ps entered the CCCMS mental health program. Of these, 83% received an initial contact with their PC within 10 days during which time the Clinical Intake Assessment was completed. In addition, 73% had their initial IDTT within 14 days of arrival or transfer into the program. Thereafter 98% received PC contacts at least once every 90 days (or more often if indicated) and 97% had a scheduled IDTT at least annually (or more often if indicated). Data from MHTS indicates institutional staff participated in the IDTT with the PC being present 95% of the time and psychiatrist 53% of the time. The I/P was present at IDTT 98% of the time.

During the reporting period, 97% of inmates with prescriptions for psychotropic medications received timely psychiatry appointments. The 3% of missed psychiatry appointments were due to inmate refusal, competing appointments, lock downs and clinician unavailability.

Prerelease and Discharge Planning
During the reporting period, 98 I/Ps in the CCCMS level of care paroled from the institution. Of these, 68 received parole planning. In addition, Primary Clinicians regularly consult with the Pre-release team and provide parole planning in the context of individual patient contacts.

MAINLINE ENHANCED OUTPATIENT PROGRAM (EOP)

SQ does not have a Mainline Enhanced Outpatient Program. EOP I/Ps endorsed to this institution are limited to the Condemned population.

SPECIALIZED CARE FOR THE CONDEMNED

For participants in the program, PCs and psychiatrist contacts are provided on both a patient need and ability-to-participate basis, as clinically indicated. Additionally, participants are offered in excess of 10 hours of structured treatment (group activity, recreational therapy, therapeutic yard) weekly. Participants in this program are afforded increased access to mental health staff and therapeutic opportunities.

Group topics provided include: Process group, Dialectical Behavioral Therapy (DBT), Symptom Management, Psycho-spirituality, Stress Management, Relaxation Techniques, and Recreational Therapy. All EOP level of care (LOC) I/Ps were participants in Specialized Care for the Condemned which provides patient-centered treatment based on clinical need, appropriateness and symptom constellation. I/Ps were offered structured therapeutic activity consistent with their treatment plans.

DEPARTMENT OF MENTAL HEALTH (DMH) REFERRALS

During this period, 92 I/Ps met one or more of the considerations for a higher LOC. Of the identified I/Ps, 54% were referred to DMH, 46% of I/Ps were not referred. At each institution, 25 I/Ps listed on the DMH non-referral log (or all I/Ps on the list if less than 25) were randomly audited. Of those audited, 79% had a reason for non referral documented on the 7388B, and 77% had documented interventions to improve the I/P's level of functioning.

During the reporting period, 59 referrals to DMH were completed: 19 ICF and 40 APP. Of those referred, 95% of ICF referrals were completed within five working days, 100% of APP referrals were completed within two working days and posted on SharePoint.

During this time period no ICF referrals and 2.5% of APP referrals were rejected by DMH and 21% of ICF referrals and 20% of APP referrals were rescinded.

During the reporting period 16 I/Ps returned to the institution from DMH. DMH discharge summaries were received when the I/P returned to the institution 100% of the time. Clinician-to-

clinician contact took place within five working days of the I/P's return to the institution 69% of the time and an additional 19% took place later than five working days after return. Five day follow-ups were completed 100% of the time for returning I/Ps. This includes those who were returned to housing upon arrival back at SQ and those admitted to the CTC upon return from DMH and later discharged from the CTC with a five-day follow-up.

MENTAL HEALTH CRISIS BED (MHCB)

The institution has a 17 bed, Mental Health Crisis Bed (MHCB) unit. Inmate-patients are received from internal referrals as well as from other institutions. During the reporting period, 156 referrals were received from within the institution and 54 referrals were received from other institutions.

During the reporting period, the total number of admissions to the MHCB was 194. The average length of stay (LOS) was 9 days. The range of stay was from 1 to 50 days. The number of I/Ps with a LOS for 10 or more days was 59. Reasons for LOS longer than 10 days include: 49% of the I/P's were awaiting a DMH bed, 9% of the I/P's had a Keyhea in process, 3% were clinically discharged awaiting housing, 4% were clinically discharged awaiting transfer back to their home institution, and 35% were retained for clinical reasons. When I/Ps on the DMH waiting list were removed from the calculation, the average LOS in the MHCB was 8 days.

Prior to being admitted to the MHCB unit, 100% of the I/Ps admitted during regular working hours were administered a pre-admission screening. Once admitted to the MHCB unit they received their initial IDTT within 72 hours 99% of the time. Thereafter I/Ps were offered at least weekly IDTTs 92% of the time. IDTTs were attended by the PC 75% of the time, psychiatry 81%, CC-I 59% and nursing 99% of the time. Daily contacts by a licensed psychologist or psychiatrist occurred 92% of the time. Of those I/Ps that were admitted due to suicidal threats or behavior, 94% were administered an SRE at the time of placement and 88% received a SRE upon release from the MHCB. 92% received a five day follow-up after their release from the MHCB.

OUTPATIENT HOUSING UNIT (OHU)/MENTAL HEALTH OUTPATIENT HOUSING UNIT (MH-OHU)

San Quentin does not have a Mental Health OHU.

ALTERNATIVE HOUSING

San Quentin does not use alternative housing.

ADMINISTRATIVE SEGREGATION UNIT (ASU)

During the reporting period there was a monthly average of 292 I/Ps housed in ASU at the following levels of care: 90 at CCCMS level of care (LOC), 14 at EOP LOC, 3 at MHCB LOC (there is a lag time on LOC change for I/Ps discharged from MHCB) and 185 non-MHSDS inmates. Patients entering ASU are brought to the TTA and receive a 7219 and MH7 100% of

the time. Incoming I/Ps were placed in identified safety cells 100% of the time. Inmate-patients placed in ASU were reviewed for current MHSDS status within one working day following their placement in ASU 100% of the time and 100% of I/Ps received a mental health screening (31-item questionnaire) within 72 hours of placement. Custody documented 30-minute welfare checks 100% of the time during the reporting period.

ASU-CCCMS

During the reporting period, 212 I/Ps entered the ASU CCCMS program. Of those, 84% of the I/Ps were assessed by a clinician within 7 days of placement in ASU and 73% of initial IDTTs were completed within 14 calendar days. Subsequent IDTTs took place at least every 90 days 99% of the time. Reports indicate 97% of IDTTs were attended by the primary clinician, 62% of IDTTs were attended by a psychiatrist, and 51% of IDTTs were attended by the CCI. The I/P was present at IDTT 93% of the time.

During the reporting period, 92% of I/Ps received at least weekly individual PC contacts. 82% of the time they were seen in a confidential setting and 18% of the time they were seen cell-front. Cell-front contacts were due to 13% staff decision, 3% unspecified and 2% refusal, lock down or lack of escort. Additionally, 100% of I/Ps prescribed psychotropic medications were seen by a psychiatrist at least every 90 days. Daily LPT rounds were documented on the CDCR Form 7230-MH 100% of the time. Daily ASU morning meetings between custody and clinical staff were documented 73% of the time.

ASU-EOP (HUB)

During the reporting period, 66 I/Ps entered the ASU EOP program. Based on MHTS compliance rules, no ASU EOP I/Ps required a comprehensive assessment (7386) prior to the initial IDTT or within 14 calendar days of referral/identification. Initial IDTTs were completed within 14 calendar days 66% of the time. Subsequent IDTTs took place at least every 90 days 97% of the time. Attendance at IDTT was: 94% were attended by the primary clinician; 65% were attended by the psychiatrist; 55% were attended by CC. The I/P was present at IDTT 93% of the time.

During the reporting period 2% of I/Ps had an LOS longer than 60 days and 1% had LOS longer than 90 days. Of those, 100% were reviewed every 30 days by the Facility Captain or CC-II. Reasons for LOS longer than 90 days included: 100% endorsed awaiting transfer. Note: 1 inmate from SVSP was temporarily housed at SQ to facilitate court hearings in Marin County.

Of the I/Ps in the program during the reporting period, 92% received at least weekly individual PC contacts, 94% occurred in a confidential setting, 0% occurred out of cell but non-confidential, and 6% occurred cell front. Reasons for non-confidential contacts included: 2% I/P refusals; 3% staff decision; 2% lack of custody escorts; <1% unspecified. Ninety-three percent of I/Ps prescribed psychotropic medications were seen by a psychiatrist at least every 30 days. Daily LPT rounds were documented on the CDCR Form Progress Note 7230-MH 100% of the time. 36% of I/P's were offered at least ten hours of structured therapeutic activities per week. Due to a MHTS coding error, this rate miscalculates the individualized nature of the treatment planning. We have corrected this error so that appointments and documentation will

more accurately capture this parameter in future reviews. Inmate-patients on modified treatment plans were offered structured therapeutic activity consistent with their treatment plans.

Per MHTS, during the reporting period, there were no I/Ps who refused more than 50% of offered treatment during a given week period. A manual audit indicated 1 I/P who refused more than 50% of offered treatment during the reporting period. MHTS indicates this I/P received daily Psych Tech contacts in addition to 87% of the additional required contacts which were conducted by a psychologist, social worker, psychiatrist or recreational therapist. Daily ASU morning meetings between custody and clinical staff were documented 73% of the time.

ASU-Non-MHSDS

During the reporting period, 390 I/Ps entered ASU-Non-MHSDS program. All inmates entering ASU are brought to the TTA and receive a nursing pre-placement screening. Logs are not separately kept to track the pre-placement screenings that occur. Nursing documented daily LPT rounds 100% of the time. Custody documented 30-minute welfare checks during the reporting period 100% of the time.

PSYCHIATRIC SERVICES UNIT (PSU)

San Quentin does not have a Psychiatric Services Unit.

CCCMS SHU

San Quentin does not have a CCCMS SHU.

SUICIDE PREVENTION

The institution has an active Suicide Prevention and Response Focused Improvement Team (SPR-FIT). See Tab I.1 to review SPR-FIT meeting minutes.

Completed Suicides

During the reporting period, there were 2 completed inmate suicides in the institution. During the last two years, May 2010 through May 2012, there were 6 completed suicides in the institution.

Attempted Suicides during the Reporting Period

Of the 9 serious suicide attempts that occurred during the reporting period, 2 were by hanging, 2 were by lacerations, and 5 were by overdose. Of those, 7 required outside hospitalization and 9 were referred to an MHCB for acute mental health care services, with 4 I/P's ultimately referred to a DMH facility.

On return to regular housing from a MHCB, a 5-day follow-up was initiated 100% of the time and documented as having been completed 92% of the time. Custody wellness checks were completed as required 99% of the time.

There were six SPR-FIT monthly meetings during the reporting period. The SPC coordinates the monthly SPR-FIT. The meetings/trainings included: "Suicide - The Magic Word: Threats, Gestures, Plans and Culture" (May 2012); "Administrative Segregation and Suicide" (April 2012); "Deliberate Indifference and Suicide" (March 2012); "Self Mutilation in an Incarcerated Population" (February 2012); "Profiling the Mainline: Risk Factors vs. Protective Factors" (January 2012); and "Suicide Review: Case Presentation" (December 2011) (See binder for additional details). In addition, the SPC (or designee) participated in monthly HQ video/teleconferences and weekly IST trainings.

The self-harm review process remains active. Since the last management report 5 reviews have been completed and presented to the treatment teams and SPR-FIT for discussion. Zero reviews are in progress, and 0 are awaiting return of the I/P to the institution from DMH. The SPC maintains a database of inmates who are high risk, have histories of suicide attempts, suicidal gestures and self-injurious behaviors. These lists are distributed to the Mental Health Department on a regular basis to keep the department apprised of inmates who may be at risk. The SPC is also responsible for the On-Call Log, and keeps track of inmates who have presented to the TTA for mental health reasons. Related to this is an incident log of suicides, suicide attempts, suicidal gestures and self-injurious behavior, which is maintained by the SPC and supervisor of the SPC. If systemic issues are noted, they are brought to the SPR-FIT and Mental Health Program Subcommittee for discussion. Case-specific concerns are brought to the attention of the supervisors as needed.

Inmate Profile Procedure

An inmate's history of suicidal behavior, thinking, and history of self harm is available via the Mental Health Tracking System (MHTS) Inmate Profile. Within one business day of an inmate's placement into an Administrative Segregation Unit, a Licensed Psychiatric Technician (PT) will print a copy of the inmate's Inmate Profile from the MHTS database. This profile is reviewed no later than 72 hours after placement. Pertinent information is shared by the PT with custody staff during their morning check-in meeting, abiding by confidentiality expectations.

RVR PROTOCOLS

During the reporting period, 816 inmates at the institution received a total of 1,192 RVRs: 69% were GP inmates, 24% were CCCMS I/P's, 6% were EOP I/P's, 1% were MHCB. Of these, 161 inmates received 115X Mental Health RVR screenings: 10 for GP inmates, 87 CCCMS I/P's, 61 EOP I/P's, and 4 MHCB I/P's. The EOP and MHCB RVR 115X's that were requested by custody were completed 100% of the time.

USE OF FORCE

Of the Use of Force Incidents during the reporting period, 53% occurred with MHSDS I/Ps. For Non-Use of Force Incidents, 41% occurred with MHSDS I/Ps. A table of all the Use of Force and Non-Use of Force incidents during the reporting period can be found in Tab K.

RECEPTION CENTER

Initial Health Screenings were conducted on 100% of incoming inmates by nursing staff within 24 hours of arrival. Inmate-patients arriving in the RC with prescriptions for psychotropic medications were evaluated face-to-face or through records review by the psychiatrist within 24 hours 100% of the time. If not seen face-to-face, the I/P is scheduled for an appointment with an assigned psychiatrist to occur within 5 days. Per MHTS, Initial Mental Health screenings were completed with 98% of incoming inmates within seven days of arrival. Internal tracking indicates 100% of those arriving to SQ were screened within 24 hours. Those inmates that answer positively to specific clusters of questions, present with mental health symptoms, and/or were previously in the MHSDS are referred for a mental health intake evaluation (7386). These mental health evaluations were completed within 18 calendar days of the inmate's arrival 93% of the time. Initial mental health screenings were completed in a confidential setting 100% of the time. Comprehensive mental health evaluations were conducted in a confidential setting 100% of the time.

Issues related to untimely assessments in this area include accuracy of scheduling, data entry into MHTS, ducating, lockdown and escort problems. To rectify these issues, the department has implemented a plan to have all clinicians enter their own scheduling and closing of appointments in MHTS. Staff continue to receive feedback and training in accurate and timely data entry. QMT staff have also addressed SOMS/MHTS discrepancies with HQ and SOMS staff.

RC CCCMS

This population is housed primarily in South block/yard and currently comprises 17% of the I/Ps in the MHSDS. The average LOS was 166 days and ranged from 1 day to 1106 days. Of these, 56% of I/Ps had LOS longer than 90 days. Reasons for lengths of stay longer than 90 days included: unavailability of bus seats, disciplinary issues/process, safety concerns, Out to Court (OTC), and MHCB/DMH placement.

Clinical contacts for the reporting period are contained in the RC CCCMS Case Manager Contacts audit (Tab L). Results indicate 99% of I/Ps had initial contacts with their PC within 30 days of arrival. Subsequently, 99% had routine contacts with their PC at least every 90 days.

Those I/Ps that had prescribed psychotropic medications received psychiatry contacts at least every 90 days 98% of the time. Confidential contacts with the PC took place 99% of the time. The 1% of non-confidential contacts were due to I/P refusal, lock downs, lack of escort officers and competing ducats.

RC EOP

This population is housed primarily in South block and currently comprises 1% of the I/Ps in the MHSDS. The average LOS was 140 days and ranged from 2 to 619 days. Of these, 69 % of I/Ps had LOS longer than 60 days. Reasons for lengths of stay longer than 60 days included: lack of sufficient beds at institutions with EOP programs and for those inmates with complex case factors, stays extended due to RVRs and time in the ASU, delays in endorsement or delays in transport.

RC EOP I/Ps were seen weekly by their PC 93% of the time, and monthly by their psychiatrist 94% of the time. Confidential contacts with the PC took place 99% of the time. The 1% of non-confidential contacts were due to IP refusal, lock downs, lack of escort officers and competing ducats.

Subsequent to the initial contact, I/Ps had IDTTs scheduled monthly 97% of the time. I/Ps were offered at least five hours per week of structured therapeutic activity 69% of the time. I/Ps on modified treatment plans were offered structured therapeutic activity consist with their treatment plan.

MENTAL HEALTH REFERRALS

- Emergent: Within 4 hours
- Urgent: Within 24 hours
- Routine: Within five working days

During the reporting period, 2252 referrals were received and on the final day of the period, 100% were closed. Referral statistics (See Tab P) indicate that 83% of emergent referrals were seen within 4 hours, 95% of urgent referrals were seen within 24 hours, and 100% of routine referrals were completed within 5 business days.

MHTS.NET AGREEMENT AUDITS

The Agreement Audit was conducted monthly during the reporting period pursuant to the methodology endorsed by HQ. Results for the agreement between MHTS and the eUHR during the reporting period ranged from 91% - 98%. This is a significant improvement since the last reporting period and allowed the Agreement Audit QIT to be closed in April 2012, after 3 consecutive months of results over 90%.

DRPD 1 00545

Exhibit 46

GLOSSARY OF TERMS

Acronym	Term
AIMS	Abnormal Involuntary Movement Scale
APP	Acute Psychiatric Program
ASU	Administrative Segregation Unit
CAP	Corrective Action Plan
CC	Correctional Counselor
CCCMS	Correctional Clinical Case Management System
CDCR	California Department of Corrections and Rehabilitation
CHSA	Correctional Health Services Administrator
DMH	Department of Mental Health
DOT	Direct Observation Therapy
EOP	Enhanced Outpatient Program
GP	General Population
HC-POP	Health Care Population Oversight Program
HS	Hour of Sleep
I/P	Inmate-patient
ICC	Institutional Classification Committee
ICF	Intermediate Care Facility
IDTT	Inter Disciplinary Treatment Team
LGB	Local Governing Body
LOC	Level of Care
LOP	Local Operating Procedure
LOS	Length of Stay
LPT	Licensed Psychiatric Technician
MAR	Medication Administration Record
MHCB	Mental Health Crisis Bed
MH-OHU	Mental Health-Outpatient Housing Unit
MHQM	Mental Health Quality Management Subcommittee
MHSDS	Mental Health Services Delivery System
MHTS	Mental Health Tracking System

OHU	Outpatient Housing Unit
PC	Primary Clinician
PSU	Psychiatric Services Unit
QIT	Quality Improvement Team
QM	Quality Management
QMC	Quality Management Committee
R&R	Receiving and Release
RVR	Rules Violation Report
SHU	Security Housing Unit
SPC	Suicide Prevention Coordinator
SPR-FIT	Suicide Prevention and Response-Focused Improvement Team
SRE	Suicide Risk Evaluation
UHR	Unit Health Record

Acronym	RJD -Added Terms
eUHR	Electronic Unit Health Record
C&PR	Classification and Parole Representative
HPSI	Health Program Specialist
HU	Housing Unit
OT	Office Technician
MHMR	Mental Health Management Report
SIB	Self Injurious Behavior
SPT III	Supervising Program Technician III
THC	Temporary Housing Cell

Coleman Site Visit, Round XXV
MENTAL HEALTH MANAGEMENT REPORT
(January 1, 2012- June 30, 2012)
(Richard J. Donovan Correctional Facility)

INSTITUTIONAL PROGRAM SUMMARY

Overview of all the Mental Health Programs at Institution.
Population: At the time of the Mental Health Management Report (MHMR) writing, the Richard J. Donovan Correctional Facility (RJDCF) total population is 3,282. The total MHSDS population is 1,904 including a total EOP population of 548: ML EOP 325, SNY EOP 143, ASU EOP 57, RC EOP 23. Total CCCMS population is 1,334 including, ML CCCMS 270, ML SNY CCCMS 860, ASU CCCMS 113, RC CCCMS 91, and CTC medical patients including CCCMS and EOP I/Ps total 7, and CTC MHCB 15 I/Ps.

New Construction/Remodeling.
- Trailer acquired on Facility D for Mental Health individual, group and office space.
- Trailer acquired on Facility B for ASU medical treatment and office space.
- Wall installed to create telemedicine office in CTC.
- Removal of fence, Mental Health Building, Facility D. Completed on June 13, 2012.
- Facility D visiting room non-contact booths removal for ML conversion planned.

New or Anticipated Mission Changes.
- Designated as an intermediate medical care site.
- RC to ML conversion of Facility D. Deactivation of reception mission in process.
- ML Sensitive Needs Facility III CCCMS mission activation in process.

Major Population Moves.
- RC intakes continued in reporting period with all County intakes into the RC ceasing at the writing of the management report, July 2012.
- Conversion of Facility D, HUs 16-19 from a RC to a Level III SNY Program in process.
- Convert Facility D, HU 20 from a Level III GP to a Level III SNY Program in process.

New or Overflow Administrative Segregation or any other Specialized Housing Units.
- No ASU Overflow was utilized during this reporting period.

Obstacles to Providing Mental Health Services and Adherence to Program Guide Requirements

The ongoing hiring freeze has continued to affect the ability to hire clinical staff and senior clinical staff integral to the delivery of mental health services. The use of out of class assignments and contractors as full time equivalents behind established position vacancies and functional vacancies (such as staff out for Family Medical Leave Act, worker's compensation or in out-of-class assignments) has been essential to clinical service delivery.

The institution will focus the coming year on three goals: 1) maintaining quantitative demonstration of program guidelines 2) Demonstrating consideration of subjective factors in IDTT for higher LOC reviews and 3) Increasing the quality of clinical documentation throughout all programs. RJDCF will need to hire allocated staff to maintain gains and continue to achieve these planned goals.

MENTAL HEALTH ROSTER

Institutional Mental Health Staffing and Telemedicine

January 1, 2012 – June 30, 2012

Institution: RJDCF

Position	Positions Established	Positions Filled	Vacancies	Vacancy Rate	Full-Time Equivalent	Functional Vacancies	Functional Vacancy Rate
Chief Psychiatrist	1	1	0	0%	0	0	0%
Senior Psychiatrist	1	0	1	100%	0	1	100%
Chief Psychologist	1	1	0	0%	0	0	0%
Senior Psychologist	6	5	1	17%	0	0	17%
Staff Psychiatrist	16	8	8	50%	4.5	3.5	22%
Staff Psychologist	42.5	39.5	3	7%	7	0	0%
Supervising Social Worker	0.6	0	0.6	100%	0.6	0	0%
Social Worker	10	9	1	10%	0	1.6	16%
Registered Nurse	13.44	12	1.44	11%	0	1.44	11%
Senior Psych Tech	2	2	0	0%	0	0	0%
Psych Tech	22	21	1	5%	13	-12	-55%
Recreation Therapist	7.65	7	0.65	11%	0	0.65	8%

Other (specify)							
Total	123.19	105.5	17.69	14%	25.1	-3.81	-3%
Office Technician	14.7	7	7.7	52%	6	1.7	12%
Offices Services Supervisor II	1	0	1	100%	0	1	100%
Office Assistant (T)	1	0	1	100%	0	1	100%
Health Records Technician I	2	2	0	0%	0	0	0%
Correctional Health Administrator II	1	0	1	100%	1	0	0%
Associate Gov Program Analyst	1	1	0	0%	0	0	0%
Pharmacist I	1	1	0	0%	0	0	0%
Unit Supervisor Safety	1	1	0	0%	0	0	0%
Supervisor Registered Nurse II	3	3	0	0%	0	0	0%
Associate Health Program Advisor	0	0	0	0%	0	0	0%
Supervising Program Tech III	0	0	0	0%	0	0	0%
Total	25.7	15	10.7	42%	7	3.7	14%

Telemedicine

Psychiatry telemedicine used?	Number of Hours Per Week
No	0

QUALITY MANAGEMENT (QM)

Local Governing Body (LGB)

The LGB is responsible for oversight of health care services and is the ultimate authority for all health care matters. The LGB was scheduled to meet three times during the monitoring period: January 6, 2012, March 23, 2012, and June 26, 2012. One hundred percent (100%) of the three scheduled meetings achieved a quorum. LGB minutes are available in the QM Document Binder.

Quality Management Committee (QMC)

The purpose of the QMC is to monitor, assess, and improve the quality of health care. During the reporting period, the QMC met six times. The QMC is chaired by the Chief Quality Officer and regularly attended by, Associate Warden for Health Care, Captain for Access to Care, Medical Contracts Analyst, Chief Psychiatrist, Chief Psychologist, Budget Analyst, Chief Dentist, HPS-Is, CHSA II, CHSA I, Chief Physician Executive, Chief Nursing Executive/Director of Nursing, Health Care Appeals Coordinators and the Chief Pharmacist and the Chief Executive Officer (CEO) and Acting Chief of Mental Health. The QMC regularly collects reports from each service delivery area (Dental, Pharmacy, Nursing, Medical, and Mental Health). Presentations by each of the departments and subcommittees are data focused, and general communication/coordination issues are discussed. QMC minutes are available in the QM Document Binder.

Mental Health Quality Management Subcommittee (MHQM)

The MHQM reviews mental health services, program performance and monitors improvement efforts. The HPS-I (A) was designated and served as the Chair through the end of January 2012. The Chief of Psychology was designated as the Chair of the MHQM from February through the duration of the reporting period. MHQM is scheduled to meet monthly. During January through June, MHQM met six times. A quorum was attained in 100% of the meetings during the reporting period. Monthly reports from MHQM were made to the QMC. MHQM-Mental Health Program Subcommittee minutes are available in the QM Document Binder.

Peer Review

In this reporting period the peer review process, was continued and expanded. In April of 2012 a new peer review program began with a team of clinicians using the peer proctor mentor program developed by Headquarters. Quality chart reviews and reviews of cases of all I/Ps who engaged in a self-injurious behavior and/or a suicide attempt were also developed and implemented in this reporting period.

QIT Activities

There were a total of ten Mental Health QITs active during the reporting period. Two additional QITs were resolved with final recommendations since the last management report.

QITs initiated:

- Clinical Documentation Improvement
- Higher Level of Care Consideration and IDTT Process Improvement
- Clark Program Improvement and Preparation for site Designation
- eUHR Rejections Reduction Plan

QITs ongoing:

- MHTS - eUHR Agreement
- Five-Day Follow Up: Frequency, Form, Process, Training and Audit
- ASU Action Items
- MHCB Action Items
- ML EOP Recreational Therapy Redesign
- IDTT Attendance (CCI) and C-file availability in IDTT

QITs resolved during monitoring period:

- Mainline EOP Yard Time/ Facility A-Fence Proposal
- Mental Health, Emergent, Urgent, Referral Routing Tracking and Response

MEDICATION MANAGEMENT, PSYCHOTROPIC MEDICATIONS

The total number of inmates in the MHSDS receiving psychotropic medications at the end of the reporting period was 1,680.

Medication Continuity for New Arrivals (Inter-Institutional CDCR Transfers)

Eighty-seven percent of the audited sample for May 1, 2012-June 30, 2012 received medications by the next calendar day. Eighty-four percent of the audited sample for January 1, 2012-April 30, 2012 received medications by the next calendar day.

Medication Continuity for Transfers (Intra-Institutional Transfers)

Ninety-three percent of I/Ps audited for May 1, 2012-June 30, 2012 transferring within the institutions received their prescribed psychotropic medications without interruption.
Based on a sample of 111 charts, 95% of I/Ps audited for January 1, 2012-April 30, 2012 transferring within the institutions received their prescribed psychotropic medications without interruption. Ninety-three percent of I/Ps discharged from the MHCB continued to receive their psychotropic medications without interruption.

Medication Continuity for Renewal of Orders/Bridge Orders

During the reporting period January 2, 2012-July 1 2012, 95% of I/P received timely renewals of the psychiatric medications. Of 499 prescriptions audited, 475 prescriptions were either renewed by the expiration date or had a stop order to end therapy. Twenty-four prescriptions were found not renewed or/and without a stop order.

Lab Tests/Results for MHSDS Inmates

During the reporting period, ten eUHRs of inmates receiving psychotropic medications were reviewed. Of the ten applicable cases, 80% had laboratory tests ordered when clinically indicated. Psychiatrists reviewed results and documented clinical action in 0% of the 3 cases with significant laboratory results. An AIMS must be completed every six months for each inmate prescribed antipsychotic medications. During the reporting period, ten eUHRs of inmates receiving psychotropic medications were reviewed for presence of AIMS. The AIMS was completed within the last six months in 70% of the ten applicable cases.

Direct Observation Therapy (DOT) Medication Administration

At the end of six months reporting period (June 2012), 1,386 I/Ps were prescribed psychotropic DOT medications. During pill lines, DOT medication administration procedures were followed in 90% (1,519/1,694) of the time.

HS Medications (After 2000 Hours)

There are 816 MHSDS I/Ps receiving HS medications as of the end of the reporting period. During April 1, 2012-June 30, 2012, HS medications were administered after 2000 hours 100% of the time for the audited HS pill lines. During January 1, 2012-March 31, 2012, HS medications were administered after 2000 hours 95% of the time for the audited HS pill lines..

Medication Non-Compliance Policies and Procedures

During the reporting period there was an average of 81 medication non-compliance 128cs for a total of 2,101 incidents of non-compliance. During the month of June 2012, 53.9% of audited cases of non-compliance cases had documented follow-up appointments with a psychiatrist within seven days of the referral.

The Medication Administration Record (MAR)

The audited eUHRs contained the previous month's MARs 93% of the time for April 1, 2012-June 30, 2012. Eighty-six percent of the eUHRs reviewed contained MARs that were complete. The audited eUHRs contained the previous month's MARs 98% of the time for January 1, 2012-March 31, 2012. Seventy-four percent (74%) of the eUHRs reviewed contained MARs that were complete.

Timely Processing of Medication Orders

Eight hundred eighty-three of newly prescribed medications and medication changes were delivered to nursing within 24 hours of the date ordered. Fourteen prescriptions were dispensed beyond the "next business" day as required by IMSP&P, Volume 9, Pharmacy P&P Chapter 38, and Prescription Turnaround Time.

Informed Consent Forms

For I/Ps on psychiatric medications that were audited, current consent forms were present in the eUHR 100% of the time.

Pill Lines

Medications are typically distributed via pill lines inside the housing units with the exception of Facility A (Buildings 3, 4 and 5) and Facility B (Buildings 8, 9 and 10) in which medications are distributed from clinic pill lines. The average pill line wait time was 5.3 minutes.

Hoarding/Cheeking Medications

During the reporting period, there were six CDCR-115 RVRs written for hoarding or cheeking medication.

Parole Medication Process

The Classification and Parole Representative (C&PR) notifies pharmacy of all paroling inmates at least 14 days in advance of release dates. During the reporting period, 153 I/Ps paroled with 288 active prescriptions for psychiatric medication. Ninety-nine percent of existing orders were renewed for 30 days. Paroling inmates are required to sign for receipt of their parole medications. During the reporting period 95.4% signed manifests acknowledging receipt of their prescription medications.

MAINLINE CCCMS

Timeliness of PC and Psychiatrist Contacts

During the reporting period, 397 I/Ps entered the CCCMS Mental Health program. Of these I/Ps, 97% received an initial contact with their PC within 10 days during which time the clinical intake assessment was completed. MHTS indicated 94%, which was corrected, as explained in the Management Report Document Binder in greater detail. Ninety-six percent 96% had their initial IDTT within 14 days of arrival or transfer into the program. Thereafter, 97% received PC contacts at least once every 90 days (or more often if indicated), and 98% had a scheduled IDTT at least annually (or more often if indicated). Institutional staff participated in the IDTT with the PC present 100% of the time, psychiatrist 97% of the time, and I/P 95% of the time. During this period, a total of 806 I/Ps had IDTTs, of which, 39 were done in absentia. Reasons why the I/P failed to attend the IDTT included; 64% I/P refusal, and 36% competing appointments.

During the reporting period, 96% of inmates with prescriptions for psychotropic medications received timely initial psychiatry appointments, and 100% of inmates with prescriptions for psychotropic medications received timely ongoing appointments

Pre-release and Discharge Planning

During the reporting period, 61 I/Ps in the CCCMS level of care paroled from the institution and all 100% received parole planning

MAINLINE ENHANCED OUTPATIENT PROGRAM (ML SNY EOP)

During the reporting period, 97% of all new SNY EOP placements were assessed for an initial PC contact and presented to the IDTT within 14 days of placement at which point their initial treatment plan was completed and signed by all IDTT attendees. Ninety-one percent (91%) of new placements were presented to the IDTT within 14 days of arrival. During their initial team meeting the I/P's initial treatment plan was completed and signed by the IDTT attendees.

Once admitted to the program weekly PC contacts (Individual or Group Activity) took place, 94%. IDTTs took place at least every 90 days, 99% of the time, and treatment plans were updated. IDTTs were attended by the PC or a PC designee 100% of the time, by the psychiatrist 99% of the time, and attended by the inmate 99% of the time. The reason the I/Ps did not attend was due to inmate refusal.

During the reporting period, group therapy was provided for I/Ps in the EOP LOC. Group topics provided include: stress management, symptom management, criminal thinking, substance abuse, social skills, health issues, family issues, grief/loss, emotional regulation, anger management, coping skills, sleep strategies, creative writing, storytelling, physical movements, reading expression, art, lifer, father's group, theatrical expression, book club, cognitive behavior, poetry, and pain management. Tab M in the Documents Binders contains the group matrix and further detail on group offerings.

On average, I/Ps were offered 14.87 hours of structured therapeutic activity per week. On average, I/Ps attended 10.45 hours of structured therapeutic activity per week. Ninety-Four percent were scheduled more than ten hours on average, 100% more than five hours on average. On average 84 % of SNY EOPs were offered more than ten hours on average. Fifty-two percent of SNY EOPs attended more than ten hours on average, while 86% attended over five hours per week on average. During the reporting period, three I/Ps were provided a modified treatment plan.

MAINLINE ENHANCED OUTPATIENT PROGRAM (EOP)

During the reporting period, 88% of all new EOPs were assessed and presented to the IDTT within 14 days of admission, at which point their initial treatment plan was completed and signed by the IDTT attendees. MHTS yielded 88% and was corrected as summarized below and described in detail in monthly CAPs and in the MHMR Document Binder. Once admitted to the program, weekly PC contacts (individual or group activity) took place 87% of the time. IDTTs took place at least every 90 days, 98% of the time. Treatment plans were updated at least every 90 days, 82% of the time IDTTs were attended by their PC 100% of the time, by the psychiatrist 100% of the time, and the I/P 100% of the time.

During the reporting period, group therapy was provided for I/Ps in the EOP LOC. Group topics included: RT sports groups, weekly community meetings, current events, social skills, leisure

and wellness, creative expression, music or yoga group, anger management, commitment to change, advanced creative expression, Spanish-speaking, parenting, lifer, and pre-release. On average, I/Ps were offered 9.87 hours of structured therapeutic activity per week. During the reporting period, 21 I/Ps were provided a modified treatment plan.

Prerelease and Discharge Planning

During the reporting period 86 I/Ps in the ML EOP level of care paroled/community released from the institution and all received group parole planning services.

DEPARTMENT OF MENTAL HEALTH (DMH) REFERRALS

During this period, 429 I/Ps met one or more of the considerations for a higher LOC including DMH referred inmates. Of the identified I/Ps, 19% were referred to DMH. During the reporting period, 65 referrals to DMH were completed: 48 ICF and 17 APP. Fifty-four (54%) of ICF referrals were completed within five working days, 24% of APP referrals were completed within two working days and posted on SharePoint. There were no ICF or APP referrals rejected by DMH and six percent of ICF referrals and zero percent of APP referrals were rescinded. During the reporting period, 51 I/Ps returned to the institution from DMH. DMH discharge summaries were received when the I/P returned to the institution 100% of the time. Clinician-to-clinician contact took place within five working days of the I/P's return to the institution 73% of the time. Five day Follow ups were completed 94% of the time for returning I/Ps. At each institution, the internal 7388-B audit includes 25 HQ selected I/Ps. Of those audited, 85% had a reason for non-referral documented on the 7388B, and 76% had documented interventions to improve the I/P's level of functioning

MENTAL HEALTH CRISIS BED (MHCB)

The institution has 14 mental health beds, and two swing beds routinely used for MHCB, totaling 16 MHCBs. Inmate-patients are received from internal referrals as well as from other institutions.

Thirteen inmate admissions were received from other institutions and 38 referrals were sent to other institutions for MHCB admit in the reporting period through HC-POP transfers. During the reporting period, 294 referrals were made to the MHCB, and there were 289 admissions. The average clinical length of stay (LOS) was 7.96 days and average physical LOS was 9.11 days. Range in LOS was one day to 40 days. Of the 294 admissions, 63 I/Ps stays exceeded ten days. Reasons for LOS exceeding ten days include:

- New medication regimen 14% (9/63)
- Psychosis 8% (5/63)
- Suicidal ideation 5% (3/63)
- Secondary gains 3% (2/63)
- Suicidal ideation/secondary gains 13% (8/63)
- Awaiting DMH transfer 3% (2/63)

• DMH-ICF Referral	5% (3/63)
• DMH-APP Referral	19% (12/63)
• Medication side effects	3% (2/63)
• Treatment/Medication non-compliance	3% (2/63)
• Involuntary Medication initiated	3% (2/63)
• Other – depressed mood/chronic sleep problems	2% (1/63)
• Unknown	19% (12/63)
Total	**63***

*Two cases not included above : One I/P was transferred from APP DMH to RJD MHCB to attend court proceedings; second inmate was discharged from MHCB and was on administrative days and was readmitted while waiting for Yard housing due to decompensation totaling 13 days including administrative days.

MHTS data indicates once admitted to the MHCB unit, I/Ps received their initial IDTT within 72 hours for 95% of the admissions. Thereafter, 93% received at least weekly IDTTs as per program guidelines. IDTTs were attended by the PC 100% of the time, psychiatry 100%, CC1 85% and nursing 88% of the time.

Initial daily contacts with primary clinician or psychiatrist occurred 98% of the. Routine daily contacts with primary clinician or psychiatrist occurred 95% of the time. Audit results for SRE documentation indicate timely documentation was available for 91% of I/Ps admitted due to suicidal threats or behavior, for 85% at the time of MHCB discharge, and available for 89% for the fifth day of the 5-Day Follow Up. On return to regular housing from a MHCB, a 5-Day Follow Up was completed by PCs and weekend staff and was documented 98% (218/223) of the time. Custody observation records were completed as required 90% of the time.

OUTPATIENT HOUSING UNIT (OHU)

RJDCF does not have an Outpatient Housing Unit (OHU)

Alternative Housing –THC

During the six-month reporting period, there were 85 I/Ps placed in alternative housing while waiting for an MHCB bed with an average stay of one day. Fifty- five (65%) were subsequently admitted to an MHCB. Thirty (35%) I/Ps resolved their crisis before admission to MHCB. One hundred percent of inmates awaiting MHCB placement were placed on suicide watch while waiting admit.

The average LOS in THC was one day (1.33) including inmates ultimately not admitted to MHCB due to resolved crisis and 1.07 for inmates who were ultimately admitted to MHCB.
Of those I/Ps that were placed in alternative housing due to suicidal ideation or self-injurious behaviors, 89% were administered an SRE prior to placement in THC, including inmates placed after hours. Those I/Ps entering after hours when a clinician is not available receive the SRE by

the next day. Eighty percent (80%) of inmates released from alternative housing without an MHCB admit received a correctly completed, five consecutive days; follow up, upon their release from alternative housing.

ADMINISTRATIVE SEGREGATION UNIT (ASU)

At the writing of the management report, the population totals in ASU are 267 I/Ps housed in ASU programs: 113 CCCMS LOC, 56 EOP LOC and 98 non-MHSDS.

All patients entering ASU are to receive a nursing pre-placement screening (CDCR Form 128-MH7). During the reporting period, pre-placement screenings were present in the eUHR 79% (230/290) of the time for the sample audited. Forty-seven percent of the screenings were completed without the presence of other inmates in close proximity. Data on safety cell usage witt new ASU arrivals was not tracked during the audit period. One hundred percent (100%) of I/Ps placed in ASU were reviewed for current MHSDS status within one working day following their placement in ASU, and prior to the 114D hearing. Documentation in MHTS was available for 94% of GPs and GP (Ms) with completed MH1s from the 31 item screen within 72 hours of placement (117 IPs out of 125 IPs). Custody documented 30-minute welfare checks 92% of the time and 90% of the time for housing units 6 and 7 respectively during the reporting period.

ASU-CCCMS

Ninety-eight percent (98%) of the I/Ps were assessed by a clinician within ten working days of admission to ASU. Ninety-four percent (94%) of initial IDTTs were completed within 14 calendar days or prior to ICC, whichever occurred first. Subsequent IDTTs took place at least every 90 days, 97% of the time. One hundred percent of IDTTs were attended by the PC or designated PC, 100% of IDTTs were attended by a psychiatrist, 94% of IDTTs were attended by the CCI, and 78% of IDTTs were attended by the I/P.

During the reporting period, 95% of I/Ps received at least weekly individual PC contacts. IPs were seen in a confidential setting 0% of the time. RJD uses therapeutic modules on the day room floor of ASU arranged into crescents due to lack of a separate treatment building for ASU clinical contacts. Cell front contacts are primarily completed when an inmate refuses out-of-cell contact. Reasons for cell front contacts included, 63% I/P refusals; 4% custody lockdowns; 24% staff decision and 8% was unspecified.

One hundred percent (100%) of I/Ps who were prescribed psychotropic medications were seen by a psychiatrist at least every 90 days. Daily LPT rounds were documented on the CDCR Form 7230-MH Progress Note 98% (263/268) of the time for May 1, 2012-June 30, 2012. Daily LPT rounds were documented on the CDCR Form Progress Note 7230-MH 95% (683/718) of the time from January 1, 2012-April 30, 2012. Interdisciplinary ASU morning meetings continued to be held daily and were documented 98% of the time.

ASU-EOP (HUB)

Ninety-three percent incoming I/Ps had a comprehensive assessment completed and their initial IDTT within 14 calendar days. Subsequent IDTTs took place at least every 90 days 96% of the time. One hundred percent 100% of IDTTs were attended by the PC or PC designee; 100% by the psychiatrist; 92% by the CC-1; and 86% by I/P. The reason for I/P non-participation was I/P refusal 100% of the time.

During the reporting period 44% of I/Ps had LOS longer than 60 days. Thirty-two percent had LOS longer than 90 days. Of those, 100% were reviewed every 30 days by the Facility Captain or CCII. Reasons for LOS longer than 90 days included: 19% endorsed awaiting transfer, 4% pending investigation, 3% pending DA referral, 22% Pending CSR Review, 22% Pending RVR, 5% Pending 5% DA, Pending 5% Casework, and 5% Pending Parole. During the reporting period, 99% of I/Ps received at least weekly individual PC contacts. I/Ps were seen 0% of the time in a confidential setting. The ASU treatment space is within the housing unit on the dayroom floor. Consequently, no treatment space in ASU is considered confidential with the exception of the IDTT space in building 6, which is a separate room. Reasons for cell front contacts include: 16% I/P refusals; 2% custody lockdowns; 79% staff decision and 3% was unspecified. Cell front visits coded as "staff decision" are additional rounds completed for EOPs who refuse greater than 50% of treatment, or other inmates who may benefit from increased monitoring such as DMH referrals, High Risk List I/Ps.

Ninety-seven (97%) of I/Ps who are prescribed psychotropic medications were seen by a psychiatrist at least every 30 days. Daily LPT rounds were documented on the CDCR Form 7230-MH Progress Note, 97% (263/270) of the time for May 1, 2012-June 30,2012.
Daily LPT rounds were documented on the CDCR Form Progress Note 7230-MH 95% (683/718) of the time from January 1, 2012-April 30, 2012.

During the reporting period, the average weekly offering of structured treatment was 11.53 hours. On average, I/Ps attended 7.03 and refused 4.50 hours of the offered structured treatment. Ten or more hours were offered to 71% of all EOPs not on modified treatment plans including RC ASU and ML ASU. Forty-one percent of EOPs refused greater than five hours of structured treatment per week on average. Ninety-three percent of EOPs refused > 5 hours of structured treatment per week on average. During the reporting period, 11 inmate patients were provided a modified treatment plan. Interdisciplinary ASU morning meetings continued to be held daily and were documented 98% of the time.

ASU-Non-MHSDS

Ninety-five I/Ps entered ASU-Non-MHSDS program between May and June. Of those, 81% (69/85) of I/Ps' pre-placement screenings were present in the eUHR at the time of audit. Seventy-two percent of the screenings were completed without inmates in close proximity.
Seventy-eight I/Ps entered ASU-Non-MHSDS program January through April of 2012. Seventy-nine of I/Ps' pre-placement screenings were present in the eUHR at the time of audit. Forty-two percent (26/62) of the screenings were completed without inmates in close proximity.
Custody documented 30-minute welfare checks 92% of the time and 90% of the time for housing units 6 and 7 respectively during the reporting period. Nursing documented daily LPT rounds 100% of the time.

PSYCHIATRIC SERVICES UNIT (PSU)

RJDCF does not have a psychiatric services unit (PSU).

CCCMS SHU

RJD does not have a CCCMS SHU.

SUICIDE PREVENTION

Suicide Prevention Summary: The SPR-FIT met monthly during the reporting period. Minutes were maintained at all SPR-FIT meetings and the minutes indicated that quorums were present at all meetings. The Emergency Response Review Committee (EMRRC) met monthly during the reporting period with quorums and minutes for each meeting.

Of the 44 instances of Self-Injurious Behavior (SIB) reported during the monitoring period, 97% percent were referred for MHCB evaluation. One hundred percent (100%) of inmates referred for MHCB admit for SIB were admitted to MHCB. Forty SIB incidents were completed by 36 I/Ps, eight of which were referred for DMH. The institution conducted daily reviews of profiles for newly arriving inmates. The Senior Psychologist assigned a PC to see those inmates whose profile contained a suicide risk alert and a log was kept of all profiles received.

SPR-FIT and SIB Details: The institution has an active SPR-FIT. During the month of April 2012, a new Suicide Prevention Coordinator was appointed and chairs the monthly SPR-FIT meetings. The minutes format was changed this monitoring period to increase data tracking and clarify interdisciplinary issues. See Tab I, Section 1 to review SPR-FIT meeting minutes.

During the reporting period, ongoing suicide prevention training consisted of:

- Proctor-Mentor Program on Suicide Risk Evaluations (CDCR form 7447)
- 15 Suicide Prevention Trainings for Custody during Off-Post Training
- 6 Suicide Prevention Trainings for New Employee Training.
- 38 OJTs delivered 1:1 for each error in a five day follow up document.
- 42 OJTs delivered 1:1 for each error in a high risk progress note document.

Completed Suicides

During the reporting period, there were two completed inmate suicides in the institution both by asphyxiation (June 11 and June 23). One death review occurred during the month of June. The other death review was completed after the reporting period's conclusion. During the preceding two years there had been zero completed suicides. No final reports have been received as of the writing of this report.

Attempted Suicides and SIB during the Reporting Period

During the reporting period, there were 44 I/Ps identified as having reported or engaged in SIBs, including unsubstantiated reports, gestures and confirmed self injurious behaviors. Of those 44 inmate SIB reports, five incidents were deemed a possible suicide attempt. Nine I/Ps or 21% were transported for evaluation at an outside hospital. Of the transported inmates, seven had reported an ingestion of an unknown or known medication(s) or foreign object(s) (i.e., razors). Pursuant to claims of ingestion, inmates are routinely transported to a hospital in the community for medical attention and clearance. Community hospital transports include all inmates referred for toxicology and X-ray screening, both with positive and negative results. Of the seven inmates who were transported to an outside hospital, three were confirmed by toxicology and/or screening/x-ray as positive for the reported behavior.

Forty-four SIB incidents reported or observed listed by frequency of methodology:

- 27% (12/44) were by lacerations/cuts
- 23% (10/44) superficial scratches
- 2% (1/44) hanging/attempted hanging
- 2% (1/44) choke self
- 13% (8/44) overdose/ reported OD (includes negative and positive toxicology results)
- 5% (2/44) jump of bunk
- 9% (4/44) ingestion of foreign objects (i.e., razors)
- 9% (4/44) head banging
- 5% (2/44) suicide gesture (noose)

Inmate Profile Procedure

A total of 163 inmate profiles were received in the reporting period containing 14 alerts. Inmate Profiles arrive with the inmates and are received in R&R by nursing. Profiles are picked up daily. If there is an alert indicated on the profiles it is sent to the PC for immediate contact. The positive alerts were routed by the Lead OT and now are routed to the PC through the referral process as an urgent referral for same day contact with the inmate to be tracked as an MH5. All profiles and alerts are listed on a log in the Document Binder.

MONTH	PROFILES RECEIVED	PROFILES WITH ALERTS
January	11	1
February	32	2
March	23	3
April	28	1
May	37	3
June	32	4

RVR PROTOCOLS

During the reporting period, 1,020 RVRs issued: 440 for GP Inmates, 309 CCCMS, 188 EOP, 4 MHCB, and 79 ASU. One hundred percent of the EOP and MHCB RVRs received a mental health assessment. In addition, 50% of the CCCMS and 4% of the GP inmates also received

mental health assessments. Included in those percentages are the RVR MHs completed for all GPs and CCCMS with bizarre or uncharacteristic behavior and for Category A, B and C offenses.

USE OF FORCE

A table of all the Use of Force and Non-Use of Force incidents during the reporting period can be found in Tab M. Of the Use of Force Incidents 53% occurred with MHSDS I/Ps. For Non-Use of Force Incidents, 57% occurred with MHSDS I/Ps.

RECEPTION CENTER

Initial Health Screenings were conducted on 99% (917/927) of incoming inmates by nursing staff within the next calendar day. I/Ps arriving to the RC with prescriptions for psychotropic medications were evaluated by the psychiatrist within 24 hours 97% of the time. Initial Mental Health screenings were completed on 99% of incoming inmates within 72 hours of arrival. Those inmates that answer positively to specific symptom clusters of questions, present with mental health symptoms, and /or were previously in the MHSDS program were referred for a mental health intake evaluation (7386) within 18 calendar days of the inmate's arrival 96% (215/224) of the time. Initial mental health evaluations (7386) were completed for the RC EOP within seven calendar days of the inmate's arrival 92% (24/26) of the time.

RC CCCMS

RC CCCMS is housed on Facility D. The average LOS was 88 days for the reporting period (n=852) and ranged from one day to 850 days. Forty-percent of I/Ps had LOS longer than 90 days with an average of 150 days. Ninety-eight percent of I/Ps had initial contacts with their PC within 30 days of arrival. Ninety-eight percent had routine contacts with their PC at least every 90 days. Those I/Ps with prescribed psychotropic medications received psychiatry contacts at least every 90 days 99% of the time. RC standard confidential contacts with the PC took place 98% of the time during the reporting period. Non-confidential contacts with the PC took place 2% of the time during the reporting period. Reasons for non-confidential contacts included limited movement based on reduced RC populations combining GP, SNY, and ML inmates on the Yard.

RC EOP

The RC EOP population is housed on Facility D. The average LOS was 53 days (n=424) and ranged from one day to 525 days. Thirty-three percent (33%) of I/Ps had LOS longer than 60 days. RC EOP I/Ps were seen for initial contacts 98% of the time and weekly by their PC 90% of the time. The RC EOP inmates were seen monthly by their Psychiatrist 92% of the time. Standard confidential contacts with the PC took place 78% of the time. Non-confidential contacts with the PC took place 12% of the time. Non-confidential cell front contacts with the PC took place 10% of the time. Reasons for non-confidential cell front contacts included: unspecified 48%, staff decision 22%, lack of escort officers 16%, modified program 8% and I/P refusal less

than 5%. I/Ps initial IDTTs were timely 82% of the time. Routine IDTTs were completed on time 98% of the time. Eighty-five of the RC EOPs were offered five or more hours on average of structured therapeutic activity for the reporting period. Sixty-nine percent of RC EOP I/Ps attended five hours or more. On average 6.36 hours of structured therapeutic activity for the reporting period was offered. I/Ps on average received 5.5 hours of structure therapeutic activity for the reporting period. .

MENTAL HEALTH REFERRALS

- **EMERGENT: IMMEDIATELY**
- **URGENT: WITHIN 24 HOURS**
- **ROUTING: WITHIN FIVE WORKING DAYS**

During the reporting period 2,461 referrals were received and at the end of the period, one hundred percent of these referrals were closed. Overall timeliness of all referrals was 97%.

RJD Referral Timeliness – January through June 2012

	Emergency		Urgent		Routine	
January	44	100%	8	100%	420	96%
February	52	100%	13	100%	382	93%
March	45	100%	8	100%	374	93%
April	38	100%	12	100%	305	87%
May	25	100%	11	100%	359	93%
June	15	100%	11	91%	339	95%
Total	**219**	**100%**	**63**	**98%**	**2179**	**93%**

See Document Binder, Tab R. **Methodology:** Program Reports, MH Referrals, LOC All, Program All, Sub Program All.

eUHR-MHTS AGREEMENT AUDIT

The agreement audit compares the agreement between MHTS inmate appointment histories with eUHR documentation.

Training is provided specific to programs and providers when disagreements are found between MHTS and eUHR. A daily log audit is completed monthly to determine the cause of these disagreements. A QIT was initiated to monitor progress and implement solutions to increase agreement between eUHR and MHTS.

Year-to Date-Percentage of Agreement Between eUHR and MHTS Results

	January 2012 (November Data)	February 2012 (December Data)	March 2012 (January Data)
Program	**Percent Agreement**	**Percent Agreement**	**Percent Agreement**
ML EOP	92%	82%	71%
SNY EOP	89%	92%	85%
ASU EOP	88%	81%	79%
RC EOP	81%	88%	77%
ASU CCCMS	79%	76%	83%
RC CCCMS	90%	90%	50%
ML CCCMS	84%	76%	94%
Total:	**86%**	**85%**	**79%**
	April 2012 (February Data)	**May 2012 (March Data)**	**June 2012 (April Data)**
Program	**Percent Agreement**	**Percent Agreement**	**Percent Agreement**
ML EOP	73%	83%	90%
SNY EOP	84%	91%	84%
ASU EOP	86%	71%	82%
RC EOP/CCCMS	78%	76%	78%
ASU CCCMS	99%	87%	94%
ML CCCMS	88%	91%	87%
Total:	**85%**	**84%**	**86%**

Exhibit 47

RICHARD J. DONOVAN CORRECTIONAL FACILITY

MAPIP MEASURES

Measure 6 - Medication Non-Compliance for Psychiatrist Prescribed Medication
Part C – Physician's order or progress not Form 7230 presents documentation indicating the inmate was evaluated for noncompliance within 7 days of referral and the medication was renewed, discontinued or substituted.

Audit Results:

Report Month	Percentage
October 2012	65%
November 2012	90%
December 2012	30%
January 2013	30%

Measure 1A-1G Laboratory Studies
MAPIP Report (Audit Period October 2012 thru December 2012)
Reported January 2013

Measures	Category	Percentage
Measure 1A – Atypical Antipsychotics	Lab Results Documented	100%
	Glucose	95%
	Lipids	90%
	CBC	90%
	CMP	100%
	AIMS	80%
	EKG	55%
	Thyroid	75%
Measure 1B – Depakote	Lab Results Documented	90%
	CBC	85%
	CMP	85%
	Depakote Trough	70%
Measure 1C – Lithium	Lab Results Documented	100%
	CBC	85%
	EKG	75%
	Thyroid	100%
	Lithium Level	95%
	Renal Function	100%
Measure 1D – Carbamazepine	Lab Results Documented	100%
	CBC	100%
	CMP	100%
	Thyroid	50%
	Carbamezapine Level	63%

Measure 1E – Lamictal	Lab Results Documented	100%
	Glucose	60%
	Lipids	60%
	CBC	100%
	CMP	90%
	Thyroid	60%
Measure 1F – Clozapine – No patients on Clozapine at time of audit	N/A	N/A
Measure 1G – Antidepressants	Lab Results Documented	95%
	CBC	95%
	CMP	95%
	Thyroid	60%
	RPR	10%
	RBC Folate	10%
	EKG	65%

Exhibit 48

RICHARD J. DONOVAN CORRECTIONAL FACILITY

HEALTH CARE SERVICES

CTC MONTHLY MAR AUDIT

Audit Month	Total Number of MARs Reviewed	Number of Complete MARs	Number of Incomplete MARs	Percentage of Complete MARs
December-12	21	16	5	76%
November-12	23	20	3	87%
October-12	22	18	4	82%
4th Quarter Average	**66**	**54**	**12**	**82%**

Exhibit 49

ANNUAL REPORT OF QUALITY IMPROVEMENT PLANS IN SUICIDE REPORTS FOR 2010

QIP General Categories: The 17 categories listed below encompass all 112 QIPs generated by suicide reports in 2010. In some cases, a single QIP was assigned to several different individuals (e.g., Warden, Chief of Mental Health, and Director of Nursing), who shared responsibility for its completion. Areas that represent the greatest percentage of identified problems include documentation, emergency medical response procedures, staff misconduct, and custodial concerns. QIPs for missing or incomplete suicide risk assessments or evaluations were fewer in number, representing approximately eight percent of the QIPs for the year.

TABLE 1. QIP GENERAL CATEGORIES

IDENTIFIED AREA OF FOCUS	NUMBER OF QIPS	PERCENTAGE OF TOTAL QIPS
Documentation missing or incomplete	20	18
Emergency medical response	15	13
Misconduct by staff	11	10
Custodial concerns	11	10
SRAC/ SRE missing or incomplete*	9	8
Treatment plans	8	7
Program Guide requirements not met	7	6
Medication management	6	5
Access to UHR	5	4
Diagnosis	5	4
Miscellaneous	4	3.5
MHCB – no follow-up	3	3
Higher level of care	2	2
Monitoring	2	2
Psychiatrist or physician concerns	2	2
Mental health referral not considered	1	<1
Chart review	1	<1
Total	**112**	

* The Suicide Risk Assessment Checklist was revised and renamed as the Suicide Risk Evaluation as of April 2010.

Note: Tables 2 through 9, below, list QIPs assigned to specific disciplines and are presented in descending order, beginning with the discipline receiving the greatest number of QIPs. The table listing QIPs for SPR FIT at Headquarters, CCHCS is provided as the final table. While those QIPs comprise 17% of the total for the year, they are in a different category, one that seeks to provide support to institutions along with policy revision.

Mental Health: The QIPs listed in Table 2 represent 34% of the total number of QIPs generated by CDCR suicide reviews in 2010. It should be noted that the reports are considered psychological autopsies and, as such, maintain a primary focus on problems with mental health treatment of inmates. As a result, it can be expected that a large proportion of improvements in the delivery of mental health services have been required by suicide reviews. However, significant efforts have been made to provide comprehensive information concerning more than purely psychological factors that may have contributed to difficulties experienced by inmates who committed suicide. Various difficulties pertaining to the completion of suicide risk assessments represent the highest number of QIPs assigned to Chiefs of Mental Health during 2010, with documentation concerns as the next highest area requiring attention.

TABLE 2. MENTAL HEALTH

IDENTIFIED AREA OF FOCUS	NUMBER OF QIPS	PERCENTAGE OF TOTAL QIPS
Suicide Risk Assessment Checklist/ Suicide Risk Evaluation (SRAC/SRE) problems		
o Incomplete or inaccurate	3	
o No clinical rationale for judgment of risk	2	
o Not completed	1	
o Missing both before and after Mental Health Crisis Bed (MHCB) admission	1	
o Missing SRAC/ SRE	2	9
Documentation problems		
o Entered into record after death of inmate	1	
o Incomplete or inaccurate	3	
o Missing from Unit Health Record (UHR)	3	7
Diagnostic Problems		
o Clinical assessment – poor quality	2	
o Lack of proper diagnosis and treatment plan	2	4
Referrals to oversight committees		
o Lack of clinical care	1	
o Professional Practices Executive Committee (PPEC) referral based on staff misconduct	2	3
Access to UHR:		
o No access for clinicians	2	
o Not available during clinical contact	1	3
Treatment plan problems		
o Interdisciplinary Treatment Team (IDTT) decision not adequate	1	
o No interdisciplinary collaboration	1	
o No pain management options	1	3
Higher level of care issues		
o Inmate not referred to higher level of care	1	
o No Department of Mental Health (DMH) consideration after 10 days in MHCB	1	2

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TABLE 2. MENTAL HEALTH		
IDENTIFIED AREA OF FOCUS	**NUMBER OF QIPS**	**PERCENTAGE OF TOTAL QIPS**
MHCB – no follow-up		
o Five-day follow-up not completed	1	
o No clinical follow-up after MHCB discharge	1	2
Chart review inadequate	1	1
Mental health referral not considered despite inmate's increased instability	1	1
Medication non-compliance not addressed	1	1
Program Guide: requirements not met for clinical contact	1	1
Miscellaneous: did not use interpreters; inadequate awareness of cultural factors	1	1
Total	**38**	**38**

Custody: The QIPs listed in Table 3 represent 24% of the total number of QIPs generated by CDCR suicide reviews in 2010. The highest numbers of QIPs assigned to Wardens during 2010 include various difficulties with custody-specific issues such as the misuse of Administrative Segregation Unit (ASU) intake cells and incomplete hourly counts. Requests for referrals to the Office of Internal Affairs represent the highest number of QIPs for a single concern assigned to Wardens (see Misconduct, below).

TABLE 3. CUSTODY		
IDENTIFIED AREA OF FOCUS	**NUMBER OF QIPS**	**PERCENTAGE OF TOTAL QIPS**
Custody-specific issues		
o ASU intake cell not used on arrival	2	
o Bed chain too long (used in suicide) ←	1	
o Counts not completed	2	
o Delay in reception center processing of an endorsement to Sensitive Needs Yard (SNY)	1	
o Inmate's geographic request for location of institution not considered	1	
o Notification of next-of-kin not provided to family	1	
o Razor blade in ASU	2	10
Documentation problems		
o Documentation altered	1	
o Incident report timelines inconsistent with review data	1	
o Incident reports completed late	2	
o ASU wellness checks information inaccurate	1	

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TABLE 3. CUSTODY		
IDENTIFIED AREA OF FOCUS	**NUMBER OF QIPS**	**PERCENTAGE OF TOTAL QIPS**
o 30-minute welfare checks not adequate o 30-minute welfare checks not documented	1 1	7
Misconduct o Lack of care provided to inmate o Office of Internal Affairs (OIA) referral advised	1 3	4
Emergency medical response o Alarm not sounded immediately o Delay in transport to hospital	1 1	2
Monitoring: 30-minute welfare checks not done	1	1
Program Guide non-compliance o 30-minute welfare checks for inmate returning from crisis bed not completed o No clinical and ASU staff morning meetings to discuss new arrivals and mental health care	1 1	2
Treatment plan problems: No interdisciplinary collaboration	1	1
Total	**27**	**27**

Nursing: The QIPs listed in Table 4 represent slightly less than 10% of the total number of QIPs generated by CDCR suicide reviews in 2010. Various difficulties with the documentation, emergency response procedures and referrals to oversight committees are included in the category with the highest number of QIPs assigned to Directors of Nursing for issues related to tasks performed by nursing staff.

TABLE 4. NURSING		
IDENTIFIED AREA OF FOCUS	**NUMBER OF QIPS**	**PERCENTAGE OF TOTAL QIPS**
UHR not available during clinical contact	1	1
Documentation problems o Incomplete or inaccurate o Not available for review	1 1	2
Emergency response problems o Delay in transport to hospital o Inadequate use of automated external defibrillator (AED)	1 1	2
No interdisciplinary collaboration	1	1
Medication not administered	1	1
CDCR policy not followed	1	1

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TABLE 4. NURSING		
IDENTIFIED AREA OF FOCUS	NUMBER OF QIPS	PERCENTAGE OF TOTAL QIPS
Referrals to oversight committees		
o Referral to Medical Oversight Program	1	
o PPEC referral	1	2
No mental health referral despite inmate's increased instability	1	1
Total	**11**	**11**

Health Care Manager/ CEO: The QIPs listed in Table 5 represent approximately 6% of the total number of QIPs generated by CDCR suicide reviews in 2010.

TABLE 5. HEALTH CARE MANAGER/ CEO		
IDENTIFIED AREA OF FOCUS	NUMBER OF QIPS	NUMBER OF QIPS IN THIS CATEGORY
UHR – no access for clinicians	1	1
Emergency medical response problems		
o Delay in use of AED	1	
o Delay in opening cell door	1	
o Emergency medical response needs improvement	1	
o Primary Care Physician (PCP) delay in arrival to Triage and Treatment Area (TTA) during emergency response	1	
o Refer to Medical Oversight Program	1	5
Staff misconduct		
o Inmates make allegations	1	1
Total	7	7

Psychiatry: In some cases, the QIPs listed in Table 6 were also assigned to responsible parties other than the Chief Psychiatrist. The QIPs listed below represent approximately 3.5% of the total number of QIPs generated by CDCR suicide reviews in 2010.

TABLE 6. PSYCHIATRY		
IDENTIFIED AREA OF FOCUS	NUMBER OF QIPS	NUMBER OF QIPS IN THIS CATEGORY
Documentation problems		
o Incomplete or inaccurate	1	
o Missing from UHR	1	2

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Psychiatric appointment – no clinical follow-up	1	1
Psychiatric services not provided within time frame	1	1
Total	**4**	**4**

Records: The QIPs in Table 7 represent approximately 3.5% of the total number of QIPs generated by CDCR suicide reviews in 2010.

TABLE 7. RECORDS		
IDENTIFIED AREA OF FOCUS	**NUMBER OF QIPS**	**NUMBER OF QIPS IN THIS CATEGORY**
UHR – no access for clinicians	2	2
Documentation missing from UHR	2	2
Total	**4**	**4**

Pharmacy: The QIPs listed in Table 8 represent slightly less than 1% of the total number of QIPs generated by CDCR suicide reviews in 2010.

TABLE 8. PHARMACY		
IDENTIFIED AREA OF FOCUS	**NUMBER OF QIPS**	**NUMBER OF QIPS IN THIS CATEGORY**
Medication administration delayed due to lack of access to medication	1	1
Total	**1**	**1**

SPR FIT at Headquarters, CCHCS: The QIPs listed in Table 9 cover a number of categories and were assigned either to the CCHCS SPR FIT for discussion and recommendations or to the monthly suicide videoconference for training purposes. Many of them are duplicates of concerns assigned to specific individuals in the institutions and were assigned to Headquarters to obtain additional support for the institutions. These concerns represent nearly 17% of the QIPs generated by 2010 suicide reports.

TABLE 9. SPR FIT AT HEADQUARTERS, CCHCS	
IDENTIFIED AREA OF FOCUS	**NUMBER OF QIPS**
Lack of proper diagnosis or treatment plan	3
Treatment plan inadequate	1
Palliative care not considered in treatment plan	1
UHR – no access for clinicians	1
30-item questionnaire inadequate to assess suicide risk	1

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TABLE 9. SPR FIT AT HEADQUARTERS, CCHCS	
IDENTIFIED AREA OF FOCUS	**NUMBER OF QIPS**
Access to institutional staff for family members in crisis – inadequate	1
SRAC needs update	1
No 30-minute welfare checks after MHCB discharge	1
Policy development needed – discharge from MHCB in absentia	1
Difficulty establishing contact with the physician on call during emergency medical response	1
Inmate left unattended while bleeding	1
Need interdisciplinary pain management training	1
Delay in moving inmate to the CTC	1
Inmate discharged from Correctional Treatment Center (CTC) to general population with dietary problems	1
Attorneys may need education re inmate-clients' risk of self harm	1
Third level appeals response delayed	1
Total	**19**

Summary: Quality Improvements Initiated In Response to Inmate Suicides

Quality Improvement Plans (QIPs) generated by suicide reviews helped to initiate a number of improvements to the quality of care provided to CDCR inmates. In many cases, institutions began examining and improving their internal processes immediately following the inmate's death. These improvements included the following:

- more extensive audits of clinical contacts in order to ensure that inmates were receiving sufficient clinical care;
- revision of the ducating process so non-completed appointments are easily and quickly identified and rescheduled;
- establishment of policy requiring the scheduling of all psychiatric appointments in a confidential setting;
- a corrected filing system to alert clinicians to any acute or developing mental health concerns for inmates who are experiencing an increase in mental health symptoms;
- the development and scheduling of in-depth video-taped presentations for clinicians regarding diagnosis and treatment.

Although many improvements to the quality of care provided to CDCR inmates appear to have been driven by the suicide review and QIP process, in actuality, institutional staff routinely collaborated with staff from the Mental Health Program at CCHCS to determine the most effective method of improving the mental health treatment of inmates. The QIP process simply provided a formal setting to highlight and monitor those developments. Target areas improved as a result of this process included mental health treatment practices; psychiatric concerns; nursing practices; emergency response procedures;

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custody practices including the monitoring of inmates in segregated housing; access to medical records; and examination of various topics of concern by the SPR FIT at CCHCS. A detailed account of improvements in the quality of care provided to inmates is provided below.

Mental Health Treatment Practices: In addition to ensuring improvement in basic practices such as clinical documentation, developments in this area included numerous opportunities to examine clinical concerns such as quality interviewing, in-depth assessment of suicide risk, diagnostic complexity, pain management considerations, crisis bed follow-up procedures, and determination of higher level-of-care needs for inmates with complex presentations.

Custody Practices: Custody staff increased training efforts and improved practices in the area of emergency response, examined issues related to inmate versus custody safety when entering a cell to provide emergency life-saving measures, and assured quick access to emergency medical equipment. Improvements were made in the area of segregated housing, such as correct usage of intake cells and timely welfare checks for new arrivals to segregated housing. Other areas of focus involved a reduction of delays in reception center processing and increased collaboration with mental health regarding inmate continuity of care, the impact of mental illness on the disciplinary process, and pain management concerns.

Nursing Practices: Improvements were initiated for nursing staff in the provision of emergency medical response practices including access to and the timely employment of instruments and accurate documentation of emergency response timelines. In other areas, nursing staff made improvements in referral processes for inmates demonstrating symptoms of mental illness, medication administration practices, and referrals to mental health clinicians for inmates who were non-compliant with medication routines.

Psychiatric Concerns: Psychiatric services were improved in a number of ways including, but not limited to, medication management. Other areas of focus included increased interdisciplinary communication regarding an inmate's psychiatric presentation, improved documentation practices, responses to an inmate's refusal of medication, and assessment of suicide risk.

Medical Records: Medical records departments improved collaboration with mental health clinicians to provide timely access to inmates' records, improved access to archived records, and more rapid inclusion of clinical notes in the Unit Health Record.

SPR FIT at CCHCS: The SPR FIT at Headquarters examined a number of difficulties arising from suicide reviews and made improvements in suicide prevention strategies as a result. Those improvements included an increased focus on clinical training via the monthly videoconference especially in the areas of diagnostic complexity, treatment planning, and the use of thorough documentation to communicate relevant clinical information to staff involved in mental health treatment of inmates. Improvements in suicide prevention strategies involved the development of suicide risk information for

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attorneys and the manufacturing of pocket cards listing suicide risk factors to be disseminated to nursing, mental health, and dental staff.

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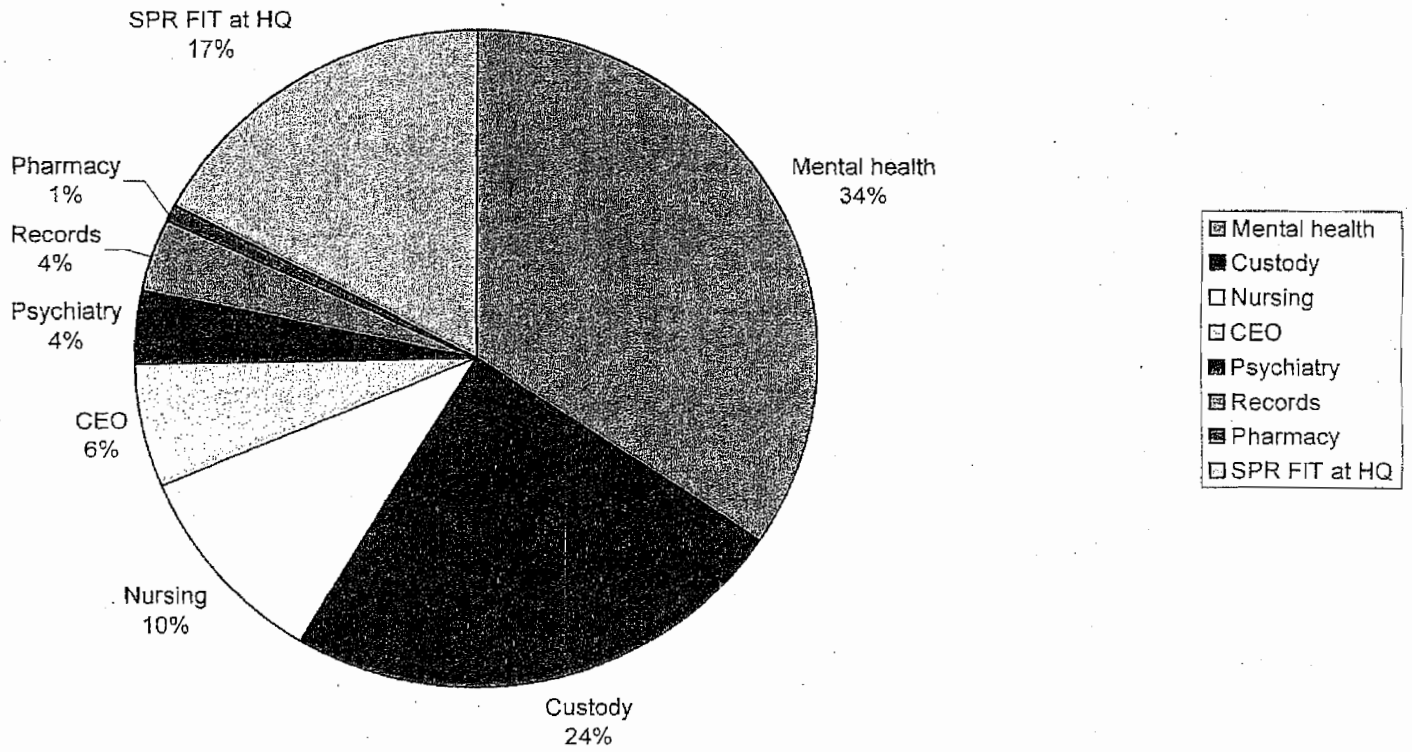
Quality Improvement Plan (QIP) Assignments for Suicides in 2010



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ANNUAL REPORT OF SUICIDES AND SUICIDE PREVENTION IN THE CDCR FOR YEAR 2010

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Suicide is the fifth leading cause of death in state prisons, after heart disease, cancer, liver disease, and HIV-related illnesses.[1] The California CDCR of Corrections and Rehabilitation (CDCR) established a Suicide Prevention and Response Program in 1996, as part of the implementation of a comprehensive mental health services delivery system, as required by the *Coleman v. Brown* class-action litigation. Since 1997, the Division of Correctional Health Care Services (now the California Correctional Health Care Services, CCHCS) has maintained databases to track all inmate deaths, including a separate database specifically for tracking inmate suicides. Various demographic and historical variables are included, such as criminal offenses, the inmate's incarceration history, and mental health history and treatment. CDCR's Suicide Reviews (a.k.a. psychological autopsies) generate data from review of Central Files, Unit Health Records, various tracking logs, and incident reports, as well as interviews with clinical and custody staff, other inmates, and sometimes family members.

Each year, the CCHCS Mental Health Program produces a report containing suicide statistics, as mandated by the federal court in *Coleman v. Brown*. These annual reports describe some of the findings from the data for the year. Each year, new variables are added to the database, and as the database develops over time, it is expected that information may emerge which can be used to improve CDCR's Suicide Prevention and Response Program. Meaningful data acquisition and analysis is a longitudinal process, and the reader is cautioned not to over-interpret the significance of apparent short-term trends based on data compiled for less than a five-year period.

[1] Mumola, C.J. (2005). *Suicide and homicide in state prisons and local jails.* Retrieved from the Bureau of Justice Statistics: http://www.ojp.usdoj.gov/bjs/abstract/shsplj.htm

Overview of 2010 Suicides

There were 35 verified suicides occurring in 18 of CDCR's 33 in-state institutions and one out-of-state facility. Table 1 lists the number of suicides at the institutions where they occurred.

Table 1. Frequency by Institution

Institution	Frequency
CCI	1
CCWF	1
CMC	6
CMF	1
COR	1
CTF	1
COCF – North Fork	1
DVI	1
FSP	2
KVSP	1
LAC	3
MCSP	2
NKSP	2
PBSP	1
SATF	2
SAC	1
SOL	1
SQ	3
SVSP	4
Total	35

Suicide attempts in institutions have been tracked by counting incident reports generated when an inmate requires medical attention for a self-inflicted injury. In 2007, the method of acquiring these reports changed and data has not been available since the first half of November of that year. Currently, the Statewide Mental Health Program is developing a program to systematically collect and aggregate suicide attempt data from all institutions. This data will aid the statewide suicide prevention program by allowing it to better recognize who among those inmates who self-harm are more likely to go on and attempt suicide.

CDCR also tracks and reports deaths of inmates in the Mental Health Services Delivery System that have occurred as a result of homicide, overdose of substances of abuse, or factors that may be identified as a mental health issue. In 2010, the Division of Correctional Health Care Services reported 15 such deaths. These were subject to a Medical Death Review (by the federally-overseen California Correctional Health Care Services), and vetted through the Suicide Case Review Focused Improvement Team suicide determination process. CDCR follows national and international standards for determining when a death is a result of suicide.

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Rate of Suicide

The overall (raw) rate of suicides for CDCR in 2010 was 21.1 suicides per 100,000 inmates. This was an increase in the overall rate from 2009, when the rate was 14.9 per 100,000. The average overall rate of suicides in CDCR for the decade 2001 through 2010 was 19.5 (ranging between 13.9 in 2002 to 24.9 in 2006).

Table 2 reports the rates of suicide among California state prison inmates for twenty years from 1991 through 2010. Reported rates are not age-adjusted.

Table 2. Annual Frequency and Rate (per 100,000) by Gender, 1990-2009*

Year	Male			Female			Total		
	Population	Freq	Rate	Population	Freq	Rate	Population	Freq	Rate
1991	95,340	13	13.6	6,655	0	0	101,995	13	12.7
1992	98,008	15	15.3	6,344	0	0	104,352	15	14.4
1993	108,302	29	26.8	7,232	0	0	115,534	29	25.1
1994	116,879	18	15.4	7,934	0	0	124,813	18	14.4
1995	122,514	22	18.0	8,828	0	0	131,342	22	16.8
1996	131,273	19	14.5	9,744	0	0	141,017	19	13.5
1997	141,669	18	12.7	10,837	0	0	152,506	18	11.8
1998	147,001	21	14.3	11,206	0	0	158,207	21	13.3
1999	150,581	24	15.9	11,483	0	0	162,064	24	14.8
2000	150,793	14	9.3	11,207	0	0	162,000	14	8.6
2001	150,785	26	17.2	10,712	1	9.3	161,497	27	16.7
2002	148,153	22	14.8	9,826	0	0.0	157,979	22	13.9
2003	150,851	35	23.2	10,080	0	0.0	160,931	35	21.7
2004	152,859	24	15.7	10,641	3	28.2	163,500	27	16.5
2005	153,323	39	25.4	10,856	0	0.0	164,179	39	23.8
2006	160,812	39	24.3	11,749	4	34.0	172,561	43	24.9
2007	161,424	33	20.4	11,888	1	8.4	173,312	34	19.6
2008	159,581	36	22.6	11,392	0	0.0	170,973	36	21.1
2009	156,805	25	15.9	11,027	0	0.0	167,832	25	14.9
2010	155,721	34	21.8	10,096	1	9.9	165,817	35	21.1
1991-2010	2,812,674	506	18.0	199,737	10	5.0	3,012,411	516	17.1
2001-2010	1,550,314	313	20.2	108,267	10	9.2	1,658,581	323	19.5

* Population figures are from Offender Information Services Branch Population Reports as of June 30 of each year, and include all inmates in institutions, camps, CDCR of Mental Health hospitals, out-of-state facilities, and Community Correctional Centers.

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For comparison, the average rate of suicide for state prisoners nationally for the period 2001 through 2007 was 16 per 100,000 inmates[2] while in CDCR it was 19 per 100,000. In the community during the same time period, the rate of suicide for men and women of all races and ages was 11.1 per 100,000.[3] Since state prisoners are limited to those ages 18 and above, limiting the comparisons to those 18 and above finds that in the community the rate was 14.3 per 100,000 for both sexes. Narrowing it further by limiting the sample to only males (the vast majority of suicides in CDCR) age 18 years of age and older, the rate was 23.5 per 100,000 while the rate for males in CDCR over the same period was 20.1 per 100,000.

Demographic Characteristics

Demographic factors play a role in suicide because suicide rates vary by gender, age, and race. Demographic characteristics can provide a starting point for understanding elevated risk, but are rarely, if ever, considered proximal causes of suicide.[4]

Gender: Historically, male inmates in CDCR have committed suicide at much higher rates than female inmates. In the last ten years, male CDCR inmate suicide rates have ranged from 14.8 per 100,000 in 2002 (22 suicide deaths) to 24.3 per 100,000 in 2006 (39 suicide deaths). In 2010 there were 34 suicides of male inmates for an unadjusted rate of 21.8 suicides per 100,000 inmates.

There was one suicide of a female inmate during 2010. From 2001 through 2010 nine female inmates have committed suicide while in CDCR custody. One female inmate committed suicide in 2001; three did so in 2004, four in 2006, and one in 2007. For the 10 years ending in 2010, the raw unadjusted rate of suicide among female inmates in CDCR was 9.2 per 100,000. (In the previous decade there were no suicides by female inmates.) Nationally, females commit suicide at much lower rates than males (both in prisons and in the community). The average national rate of female inmate suicide nationally during 2001-2007 was 11 per 100,000 inmates (compared to 16 per 100,000 for male inmates).[5] The 2001-2007 average community rate for females over the age of 18 was 5.7 per 100,000.[6]

Race/Ethnicity: Table 3 shows the frequencies and percentages of suicides of male inmates broken down by CDCR ethnic group. Historically, Caucasian inmates in California prisons have committed suicide at higher rates than inmates of other ethnicities. Over the ten-year period

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[2]Deaths in Custody Reporting Program, Bureau of Justice Statistics, U.S. Department of Justice. (accessed August 15, 2011). Table 11 Average annual mortality rate per 100,000 state prisoners, by cause of death and selected characteristics, 2001-2007. Retrieved from http://bjs.ojp.usdoj.gov/index.cfm?ty=pbdetail&iid=2093.

[3] National Center for Injury Prevention & Control, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services... (accessed August 15, 2011). Web-based Injury Statistics Query and Reporting System. Retrieved from http://www.cdc.gov/injury/wisqars/index.html.

[4] Mościcki, E.K. (2001). Epidemiology of completed and attempted suicide: toward a framework for prevention. *Clinical Neuroscience Research, 1*, 310-323.

[5] Deaths in Custody Reporting Program, Bureau of Justice Statistics, U.S. Department of Justice. (accessed August 15, 2011). Table 11 Average annual mortality rate per 100,000 state prisoners, by cause of death and selected characteristics, 2001-2007. Retrieved from http://bjs.ojp.usdoj.gov/index.cfm?ty=pbdetail&iid=2093

[6] National Center for Injury Prevention & Control, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services... (accessed August 15, 2011). Web-based Injury Statistics Query and Reporting System. Retrieved from http://www.cdc.gov/injury/wisqars/index.html.

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ending 2010, it was significantly more likely for Caucasian inmates to commit suicide than non-white inmates.

In 2010, 54 percent of all suicides were committed by Caucasian inmates; more than twice the proportion of Caucasian inmates in the total CDCR population (see Table 3 and Figure 1, below). This mirrors community rates for Caucasians (particularly males over the age of 18).

Hispanic inmates, who make up about 40 percent of all CDCR inmates, accounted for 29 percent (10) of the suicides in 2010. This percentage was the lowest proportion of Hispanic inmates committing suicide in the past ten years.

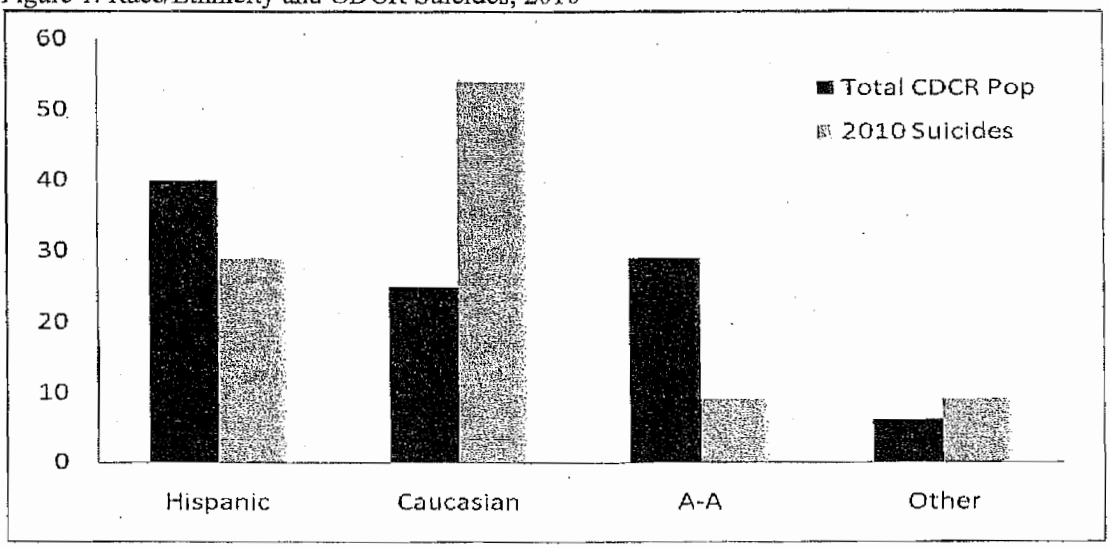
Table 3. Race/Ethnicity and CDCR Suicides, 2010

	Male		Female		Total		
Racial Group	Frequency	Percentage	Frequency	Percentage	Frequency	Percent	% in CDCR Population*
African-American	3	9	0	0	3	9	29
Caucasian	18	53	1	100	19	54	25
Hispanic	10	29	0	0	10	29	40
Other	3	9	0	0	3	9	6

** As of December 31, 2010*

The proportion of suicides among African-American inmates (9 percent) was lower than their corresponding proportion among the total inmate population (29 percent). African-American inmates historically have committed suicide at lower rates than Caucasian and Hispanic inmates. (The suicide rate among African-American males older than 18 years of age in the community – 12 percent – is also much lower than the rate for White males 18 years of age and older – 26.5 percent.)

Figure 1. Race/Ethnicity and CDCR Suicides, 2010



During 2010 the "Other" ethnicity group included one Asian, one Native American inmate and one Israeli inmate. They accounted for just nine percent of CDCR's 2010 suicides, a little more

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than their representation of 6.1 percent in the inmate population at large. Over the last ten years, suicides by ethnicities classified by CDCR as "Other" have comprised 7.8 percent of all suicides in CDCR.

All inmates who committed suicide in 2010 had English identified as their primary language. Three inmates had active Immigration and Customs Enforcement holds at the time of their suicide.

Age: In 2010, the youngest inmate to commit suicide was 23 years old, and the oldest was 67 years old. The age distribution of 2009 suicides was more similar to the overall age distribution of CDCR's population than in recent years (see Table 3 and Figure 2, below). The average age of inmates who committed suicide was 39 while the average age of CDCR inmates is 38.

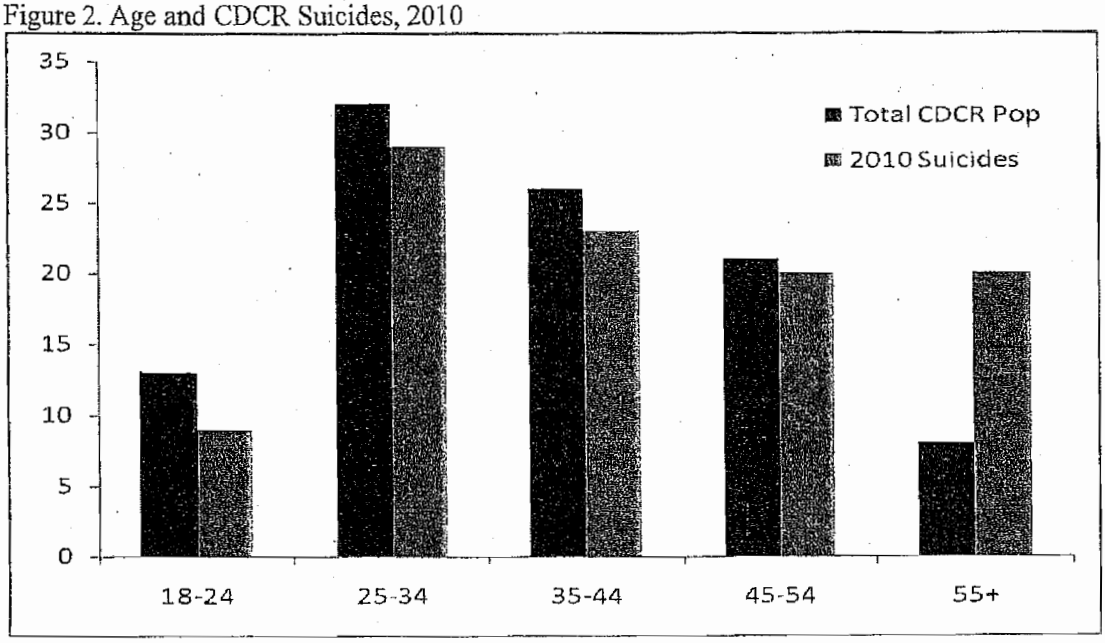
Table 3. Age

	Male	Female		Total	
Age Group	Frequency	Frequency	Frequency	Percent	Total CDCR*
18-24	3	0	3	9	13
25-34	9	1	10	29	32
35-44	8	0	8	23	26
45-54	7	0	7	20	21
55+	7	0	7	20	8

** As of December 31, 2010*

The figure (below) presents in graphic form, the distribution of suicides (males only) among five age groups compared to the overall proportion of CDCR inmates in each age group.

Figure 2. Age and CDCR Suicides, 2010



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Education, Employment, and Marital Status: In studies of community populations, education and employment factors have not been identified as significant risk factors for suicide. In prison populations, these variables may have different meaning. For instance, inmates with higher educational attainment may be able to cope better with complex and stressful circumstances, and thus gain a protective value from their education. Both in the community and in the prison setting, employment can be an important protective factor – a fact not always evident until the job is lost, sometimes with disastrous consequences.

During 2010, 97 percent (32) of the 33 inmates who committed suicide, and for whom the number of years of education was known, completed at least some high school education and 55 percent (18) had finished high school. Of these 18, six had General Education Diploma's. Additionally, three inmates had post-high school education. One of the inmates for whom education was unknown was illiterate and apparently could not even dial a telephone. The median number of years of education was twelve. (Estimates of educational attainment used for this report are derived from inmate self-reports contained in Unit Health Records and Central Files and should be thought of as rough estimates. Additionally, inmates are tested upon entry into CDCR using the Test of Adult Basic Education but these scores are not reported in this report.)

Among the inmates who committed suicide in 2010, and for whom data about employment was available (21 of 35), nine (43%) had five or more years of employment and seven (33%) had 10 or more. On the other hand, 79 percent had less than five years of employment or intermittent work histories. Two-thirds of the inmates for whom employment experience was known had five or less years of work experience, typically as unskilled labor. Seven inmates were assigned to prison jobs at the time of their suicide.

Married inmates may obtain positive social support from their relationship with a spouse; however, the psychological pain of separation from a spouse may increase an inmate's isolation and thus their vulnerability to self-harm.[7] Among the 35 suicides during 2010, only one inmate was married at the time of his death. Twenty-one (60%) were listed as "single," nine were listed as divorced, and two as widowed – thus over 90% were functionally single at the time of their deaths. These frequencies are in line with totals from the last decade, during which less than 15 percent of inmates who committed suicide were married at the time of their death.

Temporal Factors

Since 2001, on average, the frequency of suicides among CDCR inmates appeared to increase during the late spring and early summer, with approximately 50 percent of suicides annually occurring between March 1 and July 31. In 2010, the period March to July only totaled about one-quarter of the year's suicides, whereas almost half the suicides occurred in August through December. The monthly frequency of suicides in 2010 did not significantly vary by day of week, month, or quarter. That is, inmates were equally likely to commit suicide on any day of the week, during any month, or any quarter of the year. Additionally, there was no seasonal variation in the frequency of inmate suicides during 2010.

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[7] Fazel, S., Cartwright, J., Norman-Nott, A., & Hawton, K. (2008). Suicide in prisoners: A systematic review of risk factors. *Journal of Clinical Psychiatry, 69*, 1721.

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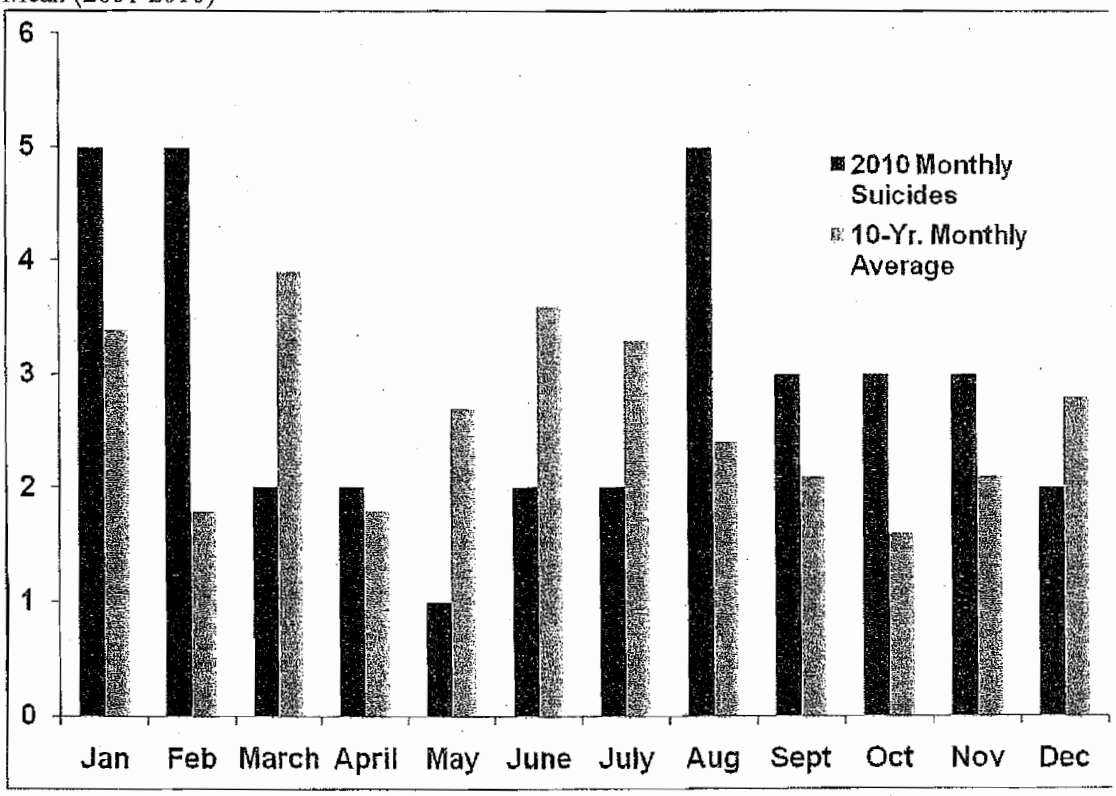
Figure 3. Monthly Distribution of CDCR Suicides, 2010 Compared to the 10-Year Monthly Mean (2001-2010)



The time of day suicides are discovered has not revealed any notable trends in past years, dispelling the common belief that inmate suicides are more likely to happen at night. In reports of this type, time is often examined by dividing the day into quarters. The first and last quarters of the day represent the night hours, and the second and third quarters represent the daylight hours. In 2010, 50 percent of the suicides were discovered during daylight hours, which is similar to 2009 when half of the suicides were discovered during daylight. It should be noted, however, that the correspondence between time of discovery and actual time of suicide is uncontrolled, because the exact time of the suicidal act is almost always unknown.

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Table 4. Time of Day

Time Period	Frequency
0000 – 0600	5
0600 – 1200	10
1200 – 1800	8
1800 – 2400	12

The watch or shift during which a suicide was discovered was examined separately; because inmates contemplating suicide might be expected to choose times when the fewest staff may be present (First Watch – 2200-0600 hours). As Table 5 shows, in 2010, 43 percent (15) of suicides were discovered during the second watch, when the majority of institutional staff is present.

Table 5. Time of Discovery

Watch	Number of Suicides
1st Watch (2200-0600)	9
2nd Watch (0600 – 1400)	15
3rd Watch (1400 – 2200)	11

Day-of-the-week has not been a significant temporal variable for suicide prevention planning. Unlike 2008 & 2009, when most suicides occurred on Tuesdays, in 2010 the higher number of suicides occurred on Fridays. Eleven suicides occurred on weekends, when staffing is reduced, which is similar to data over the last decade.

Sentencing and Term Issues

The actual years left to serve, or the time until the next opportunity for release by the Board of Parole Hearings, may interact with other risk factors to increase an inmate's vulnerability to suicidal thinking and behavior. For instance, among inmates imprisoned for many years, social networks may disappear and the prospect of parole may become more anxiety-provoking, leading to a loss of hope and meaning. On the other hand, inmates who are within the first few years of a long (or indeterminately long) sentence may lose hope and suffer demoralization leading to thoughts of death. Additionally, the age of an inmate and the amount of time left to serve may be a meaningful interaction. A ten year sentence for a 25 year-old inmate has vastly different meaning than the same sentence for an inmate in his late 50s.

In 2010, 54.3 percent (19) of the inmates who committed suicide had received life sentences, and of these, nine had had been given "indeterminate" life sentences. Four of the inmates had been sentenced to life-without-parole. One of these four committed suicide having served only six months in CDCR while another committed suicide after only 27 days in custody. One inmate had been condemned to death but the week before his death he had been resentenced to life-without-parole.[8] Inmates with life terms (54%) are overrepresented in the group of inmates who committed suicide in 2010, compared to the percentage of inmates with life or life-without-

[8] This inmate had been resentenced after a successful appeal of his death sentence based on *Atkins v. Virginia*, 536 U.S. 304 (2002).

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parole in the CDCR as a whole (18%). Overall, inmates with long (10+ years) or life-term sentences comprised almost three-quarters of the suicides in 2010.

Table 7. Length of Sentence

Sentence	Frequency	Percentage
< 1 year	1	3
1 – 5 years	6	17
6 – 10 years	2	6
11 – 20 years	4	11
20+ years	3	9
Indeterminate Life (may parole)	14	40
Life without possibility of parole	4	11
Condemned	1	3

In addition to length of sentence, the actual time left to serve may have a bearing on the inmate's vulnerability to suicidal thinking and behavior (see Table 7). Inmates with determinate sentences and who committed suicide in 2010 had a wide range of time remaining in their sentences. The median time remaining to serve was 3.7 years. Four inmates had greater than ten years remaining to serve at the time of their suicide. Two inmates had 12 months or less remaining in their prison term suggesting that for some, stress associated with parole may play a role in suicidal thinking.

Table 7. Time Remaining to Serve

Time to serve	Frequency	Percentage
12 months or less	2	6
1-5 years	7	20
6-10 years	3	9
11-15 years	3	9
More than 15 years (including Lifers)	20	57

Inmates serving their first term in CDCR have consistently been overrepresented among inmate suicides. In 2010, 54 percent (19) of the 25 inmates who committed suicide were serving their first term in a California prison, although the range of time served was days to more than two decades. Of these, 15 were also serving life terms. Only two inmates serving a "third strike" term committed suicide in 2010.

Another subgroup of inmates committing suicide had been in CDCR's custody for a short time, supporting the idea that poor adjustment to prison is a risk factor for suicide. In 2010, almost one-quarter (8) of inmates committing suicide had served a year or less and of these, six had served less than six months of their term at the time of their deaths. A little over 30 percent of inmates committing suicide in 2010 had served over ten years in CDCR custody at the time of their death.

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Table 9. Time Served at time of Death

Time	Frequency	Percentage
1 year or less	8	23
2 – 5 years	4	11
6 – 10 years	12	34
11 – 20 years	8	23
Greater than 20 years	3	9

Criminal History

Over time, there has been a strong association between violent criminal history and inmate suicides in CDCR. This is consistent with literature on suicide, which documents a clear association between violent behavior and risk for suicide. In 2010, as in the past, a majority of inmates (79 percent) who committed suicide had been sentenced for a violent crime, a much larger percentage than in the male inmate population as a whole (58 percent of whom have been sentenced for a crime against a person).

Inmates convicted of sex crimes are at higher risk of suicide than other inmates. In the decade ending 2008, more than a quarter of suicides were committed by inmates with a history of or conviction for a sex crime, compared to 17 percent of inmates in the total CDCR population who are required to register as sex offenders. In 2010, 18 percent (6) of the 35 inmates who committed suicide had sexual offense histories.

Forty-three percent (15) had some sort of gang affiliation – either in the past in prison, currently, or in the community. In addition, 40 percent (5) of the 15 had also been involved with youth gangs. While gang affiliation can be a protective factor in that the inmate has a social community within the prison environment, the demands of gang membership may also be stressful.

Over the past decade, the proportion of inmates with a juvenile criminal justice history has been rising. Over the past several years at least 40 percent of inmates who committed suicide had some history of juvenile crime. In 2010, just over 49 percent (17) of inmates who committed suicide had a documented history of juvenile crime.

Criminal history factors are summarized in Table 10. Where the information was available, comparisons were made with the total inmate population.

Table 10. Case Factors

Factor	Number of Suicides	Percent of Suicides	Percent of Total Male Population
Violent Crime*	27	79	58
Sex Offense History**	6	18	17
Gang Affiliation	15	43	N/A
Juvenile History	17	49	N/A

** Crimes against persons*

*** PC 290 registration required*

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Institutional Programming, Custodial Factors, & Classification

Historically, few inmates who commit suicide have had vocational assignments at the time of their death. In 2010 33% (7) of eligible inmates were assigned jobs at the time of their death. This includes two inmates who were working jobs within hours or several days of being re-housed in an Administrative Segregation unit.

In past years, a number of inmates with Immigration & Customs Enforcement "holds" committed suicide. In 2010 nine percent (3) of the 35 inmates who committed suicide had holds at the time of their death.

CDCR's inmate classification system reflects a variety of demographic, historical, and case factors, including the risk of violent behavior. (CDCR does not classify female inmates.) Inmates with higher violence potential are typically placed in higher security settings. Over the years, inmates who commit suicide have been consistently overrepresented at the highest classification level (Level IV) when compared to the male inmate population at large. In 2010, 50 percent (16) of classified inmates who committed suicide were classified at Level IV, in contrast to 21 percent of the total male population classified at Level IV. Ten inmates who committed suicide were Level III, five were Level II, and one was Level I. (The remaining three male inmates were Reception Center inmates at the time of their deaths.)

Table 11. Suicides and Classification Level*

Classification Level	Frequency	Percent of Total Suicides	Percent of Total Male Population
I	1	3.1	11.4
II	5	15.6	32.9
III	10	31.3	36.4
IV	16	50.0	21.1

* Includes only classified male inmates (N = 32)

Figure 4 graphically illustrates the association between classification level and suicide. It shows the disproportionate rate of suicide among Level IV inmates, compared to the lower percentage of the overall inmate population at that classification level. This result mirrors the analysis of data from the previous ten years, which found that there are significantly more suicides committed by Level IV inmates, than inmates at lower classifications.

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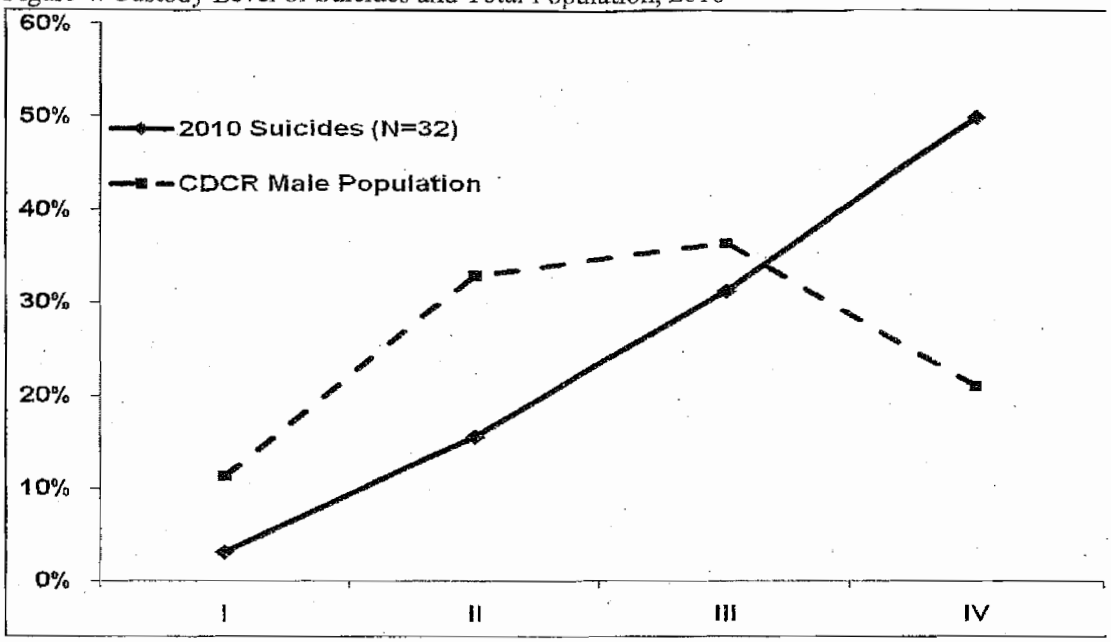
Figure 4. Custody Level of Suicides and Total Population, 2010



Housing

Housing issues, particularly whether an inmate is housed alone or is housed in more restrictive housing settings, have figured prominently in inmate suicides over the years. The percentage of total suicides occurring in Administrative Segregation Units from the beginning of 2001 to the end of 2010 (see Figure 5), has varied from a high of 69 percent in 2004, to a low of 24 percent in 2002. By contrast, an analysis of suicides of inmates in the Federal Bureau of Prisons in the 1980s and 1990s found that 63 percent occurred in segregated housing units (White, Schimmel, & Frickey, 2002).[9] Over this ten year timeframe, the average percentage in CDCR was 40 percent, and the trend in the past ten years has slightly down.[10]

In 2010, thirty-four percent (12) of total suicides were housed in CDCR's Administrative Segregation Units at the time of their death. On average, only five percent of the total inmate population is typically housed in Administrative Segregation Units at any given time. One additional inmate was housed in a Condemned housing unit, where inmates are housed alone and procedures are similar to other segregated housing units, and was waiting re-housing after resentencing to life-without-parole. One inmate attempted to kill himself while housed in a medical unit and succumbed to his injuries in an outside hospital. The remaining 21 inmates were housed in general population housing at the time of their death.

[9] White, T.W., Schimmel, D.J., & Frickey, R. (2002). A comprehensive analysis of suicides in federal prisons: A fifteen-year review. *Journal of Correctional Health Care 9*: 321-343.

[10] Administrative Segregation Units are not the only type of segregated housing CDCR maintains. Security Housing Units, Psychiatric Services Units, and units for condemned inmates are also operated as segregated housing. The total population of inmates housed in these units is approximately 4,400 inmates (male and female) – a little more than half the number of inmates housed in Administrative Segregation Units statewide.

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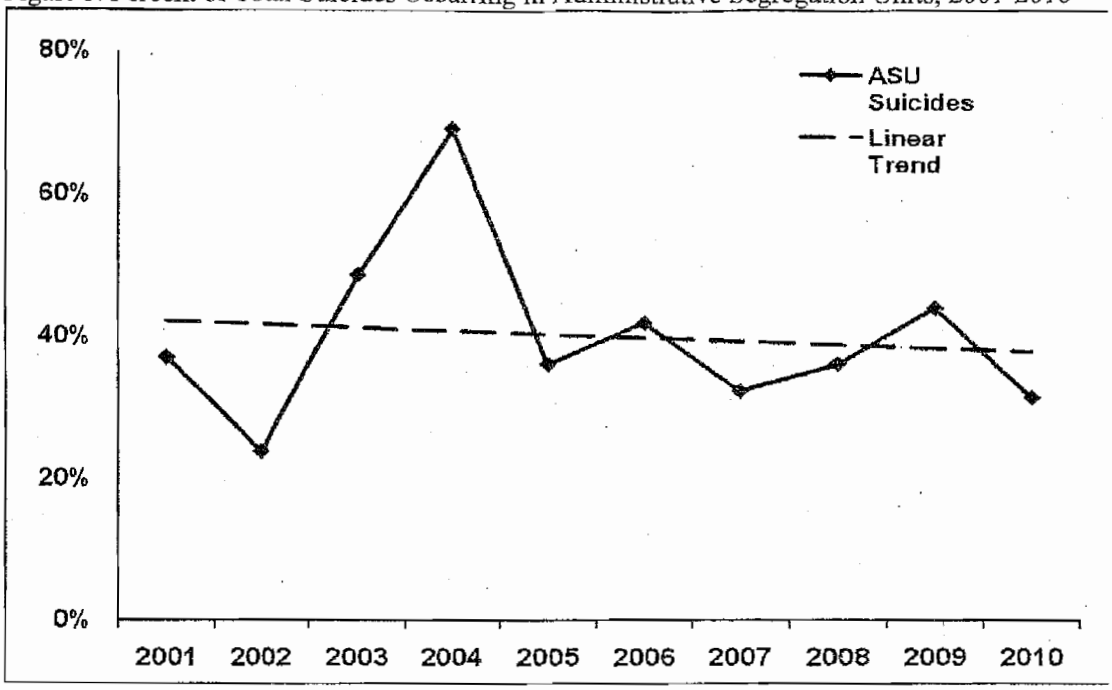
Figure 5. Percent of Total Suicides Occurring in Administrative Segregation Units, 2001-2010



Five of the twelve inmates housed in Administrative Segregation Units at the time of their death were originally placed there for safety reasons. (It is important to note, however, that in some cases the reasons for housing in Administrative Segregation actually involved inter-related factors of multiple issues of discipline, safety, ongoing court processes, gang affiliation, and so forth.) Additionally, of the 21 inmates who died while housed in general population units, three were identified as having "sensitive needs yard" status, which indicates that they had safety concerns and were placed in one of CDCR's "Special Needs Yards."

Table 12. Housing

Housing	Number	Percent
Administrative Segregation	12	34
General Population	21	60
Medical	1	3
Condemned	1	3

Over the years, the vast majority of suicides have occurred when inmates are alone in a cell (whether they have an assigned cellmate or not). This is true for inmates housed in Administrative Segregation units, where, typically, inmates are housed alone for the first ten days while awaiting their first Institutional Classification Committee meeting.

In 2010, all of the 19 inmates who committed suicide in mainline celled housing were on single-cell status or, although assigned cellmates, were alone in their cell at the time of their death. None of the 12 inmates housed in segregated housing units at the time of their deaths were assigned cellmates. Two inmates were assigned to dormitory housing. The lone female inmate died by overdose of prescription medications and the other dorm-housed inmate killed himself in his bunk via laceration. Obviously, an inmate alone in a cell has more opportunity to complete a

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suicide without interference from another inmate. A recent review of studies of prison and jail suicide found that housing inmates alone was a significant risk factor for suicide.[11]

Despite evidence that the percentage of suicides in Administrative Segregation Units statewide has consistently been less than the percentage committed in general population housing units (see Figure 5), CDCR believes that these units are high risk environments for vulnerable inmates, particularly during the ten days after placement. Administrative Segregation suicides continue to account for a disproportionate number of suicides compared to the proportion of inmates housed in these units. Data collected by the statewide Mental Health Program show that many suicides among Administrative Segregation Unit inmates have occurred within hours or a few days of placement. For this reason, CDCR has undertaken targeted initiatives to screen and monitor inmates during their first days in Administrative Segregation.

In 2010, one-third (4) of suicides in Administrative Segregation Units occurred within five days of placement in the housing units. The median length of stay in Administrative Segregation before suicide was three weeks. One inmate had been housed in segregated settings (Security Housing Unit or Administrative Segregation) for over a year, although he had also spent some of that time in inpatient mental health treatment.

Suicide Methods

By far, the most common method of suicide in California prisons (and among correctional systems worldwide) has been hanging. This tendency is associated with the easy access to the means for hanging, e.g. sheets, shoelaces, towels, articles of clothing, etc. From conversations with inmates it is a well-known fact that hanging is a simple and easy way to end one's life. (It should be noted that hanging in prison is often actually "self-strangulation," accomplished by simply leaning into a ligature until consciousness is lost.)

In 2010, 77 percent (27) suicides were completed by hanging with some type of ligature. (One suicide involved both hanging and laceration, and an autopsy was not performed, thus the actual cause of death remains undetermined.) Attachment sites included bunks (6), ventilation grills (7), or ladders (3). Other attachment sites included light fixtures, towel racks, windows, clothing pegs attached to wall of cell, locker, an overhead pipe, shelves, a faucet, and a chain attached to an upper bunk. Four additional inmates died by laceration (and subsequent exsanguination), one by asphyxiation, and two died by overdose. Twelve of 13 suicides completed in segregated housing were by hanging with various attachment sites: bunks (3), ladders (2), a ventilation grill, clothing pegs, a locker, a bunk chain, a sink faucet, a light fixture, and a shelf.

Mental Health Factors

As in the community at-large, a history of suicide attempts and current or past mental health treatment rank among the top risk factors for suicide for prison inmates. Other significant mental health-related risk factors include psychiatric diagnosis and substance disorders.[12]

[11] See Fazel, et al. (2008), Table 1, which shows single cell occupancy having the second highest odds ratio among risk factors reviewed.

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Record reviews and interviews suggested that prior to entering prison, 27 percent (9) inmates who committed suicide in 2010 had a history of suicidal behavior in the community (for one inmate there was no information about pre-CDCR suicidal behavior), ranging from talking about or threatening suicide to making multiple attempts. Twenty-seven percent (9) of the inmates completing suicide in 2010 had made one or more suicide attempts while in CDCR's custody, and of these, four were also among those with a suicide history before prison. Overall, forty-six percent (16) of inmates had some history of suicidal behavior and all but one (a reception center inmate) had received formal mental health treatment at some point while in CDCR custody.

From 2001 through 2010, 59 percent of suicides were committed by inmates who were participants in CDCR's mental health system at the time of their death. In 2010, 59 percent (20) of suicides were committed by inmates participating in CDCR's Mental Health Services Delivery System at the time of their deaths. Twelve of these inmates were at the Correctional Clinical Case Management level of care, and eight were being treated at the more intensive Enhanced Outpatient Program level. There were no suicides by inmates housed in CDCR's Mental Health Crisis Bed units or Department of Mental Health inpatient programs. Five inmates who committed suicide in 2010 had previously been participants in the Mental Health Services Delivery System, but were not in active treatment at the time of their deaths.

Information regarding mental health history of inmates prior to entering prison is often based on inmate self-report, documentation, or in court documents. Previous mental health treatment outside of CDCR was noted for 51 percent (18) of inmates completing suicide in 2010

Eighty-six percent (30) of the inmates committing suicide in 210 had a known history of illegal drug use or substance abuse, either by self-report, chart review, or criminal record. Substance abuse is a known risk factor for suicide among individuals in the community. However, because a high percentage of inmates in general have a drug history, its utility as a discriminating characteristic of suicide risk in correctional settings is limited.

Table 14. 2010 Inmate Suicides - Mental Health History

Factor	Number	Percent
Treatment History (including jail)	18	51
Suicide History before CDCR	9	27
Suicide Attempts in CDCR	9	27
Any Suicide History	16	46
Substance Abuse History	30	86

Inmates who committed suicide in 2009 and were participants in CDCR's mental health program were grouped by primary diagnosis. Many inmates had more than one diagnosis, but only the final primary diagnosis was used in this analysis. Diagnoses of inmates who had previously been participants in the Mental Health Services Delivery System (MHSDS), but were not participants at the time of their death, were also included in this analysis. Unlike many previous years, mood and psychotic disorder diagnoses occurred with equal frequency among inmates currently and previously participating in the MHSDS. Fifty-seven percent (20) of inmates committing suicide

[12] See Mościcki (2001), for a discussion of psychiatric risk factors in the community, and Fazel et al. (2008) for a discussion of risk factors among prison inmates.

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in 2010 suffered from either psychotic disorders (schizophrenia, schizoaffective, and other psychotic disorders) or mood disorders (Major Depressive Disorder, Bipolar Disorder, and others). Three inmates had diagnoses noted on Axis II – Personality Disorders.

Table 15. 2010 Inmate Suicides – Psychiatric Diagnosis

Primary Diagnosis	Frequency	Percent
Any DSM Disorder	23	66
Any Mood Disorder	10	29
Any Psychotic Disorder	10	29
Other Diagnoses incl. Adjustment disorder	3	9
No diagnosis (includes non-MHSDS inmates)	12	34

Twenty-nine percent (10) of inmates who completed suicide in 2010 had serious medical problems that were noted by reviewers. These ranged from paraplegia, diabetes, low back pain, to severe cardiomyopathy, hypertension, and gastroesophogeal reflux disease.

Thirty-one percent (11) of inmates who committed suicide left a suicide note or letter, with themes ranging from frustration to despair. In many cases there was no clear precipitant for the suicide, and staff were often surprised. Fear and/or loss characterized most of the suicides for which motives could be speculated.

Summary

In 2010 there were 35 verified suicides of inmates in CDCR custody. This was an increase from 2009 when only 25 inmates killed themselves in CDCR – the lowest total since 2004 when 24 inmates committed suicide. Since 2001, the average annual number of suicides among CDCR inmates has been 32. The suicide rate for 2010 was 21.1 deaths per 100,000 inmates, higher than the most recent estimate of the nationwide suicide rate for state prison inmates – 16 per 100,000 inmates. The rate of suicide in the United States as a whole for individuals 18 years of age and older (the age cut-off for prison inmates) was 15 per 100,000 individuals in 2008, and for males, 25 per 100,000 individuals.

Suicides occurred at 17 in-state CDCR institutions and one out-of-state contract facility. Eight institutions accounted for 71 percent (25) of the total suicides in 2010. One institution had six suicides; one four, three had three; three had two suicides; and the remaining nine all had one. In twenty years of suicide recordkeeping, no institution has had six suicides in one year.

One female inmate committed suicide in CDCR in 2010. Over the past ten years ten female inmates have committed suicide in CDCR custody. In the ten years between 1991 and 2000 no female inmates committed suicide in CDCR.

As in other years, in 2010 Caucasian inmates committed the majority of suicides (18), followed by Hispanic inmates, then African-American inmates, and then the heterogeneous group called "Other," which often includes Asian-American inmates as well as inmates of Native American heritage and other racial/ethnic groups.

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Over the past ten years, including 2010, neither season, day of week, or time of day has appeared to be associated with an increase in the frequency of suicides in CDCR. In contrast to most years in the last decade, a little over half of 2010's suicides occurred in the second half of the year.

Inmates with long or life terms comprised almost 75% of the suicides in 2010. More than half the suicides occurred among inmates with more than 15 years to serve (including life term inmates) and almost 25% of the inmates who committed suicide had a year or less to serve in their term.

In 2010 79 percent of suicides occurred among those who had committed a violent crime, 18 percent among those who had sex offenses, and 43 among present or former gang members. Almost half the suicides were by inmates with a history of juvenile crime.

Few of the inmates who committed suicide in 2010 had jobs, assignments, or immigration holds. As in past years, level IV inmates were over-represented among suicides, comprising 50% of suicides among classified inmates, compared to only 21% of the total CDCR population.

Thirty-four percent of suicides occurred among inmates in Administrative Segregation Units, a lower figure than 2009 and below the ten-year average of 40% of suicides.

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Exhibit 50

TO: Thomas L. Gilevich, Assistant Chief Counsel
Office of Legal Affairs
California Department of Corrections and Rehabilitation

FROM: Lindsay M. Hayes, Project Director
National Center on Institutions and Alternatives

DATE: August 16, 2011

RE: CDCR Suicide Prevention Consultation

Please accept this memorandum as my opinion regarding several suicide prevention issues within the California Department of Corrections and Rehabilitation (CDCR). This memorandum also includes a slight revision of my preliminary opinions previously offered on January 30, 2011. These opinions and recommendations are made with the explicit intent for CDCR to strategize ways to systemically reduce both the number and rate of inmate suicides, as well as remove the suicide prevention requirements from *Coleman v. Brown*.

As of August 15, 2011, the CDCR has sustained 19 suicides for the year (with an estimated 28-29 such deaths projected thru the end of the year). In 2010, CDCR had 35 suicides, resulting in a suicide rate of 21.1 deaths per 100,000 inmates. In 2009, CDCR had 25 suicides, resulting in a suicide rate of 14.9 deaths per 100,000 inmates. In 2008, CDCR had 37 suicides, resulting in a suicide rate of 22.3 deaths per 100,000 inmates.

1) Review of 2010 Inmate Suicides

I reviewed the Suicide Reports for 25 of the 35 inmate suicides during 2010. As a preface, it should be noted that these Suicide Reports, compiled by designated mental health suicide reviewers (MHSR), represent the strength of CDCR's Mental Health Services Delivery System. Per Program Guide requirements, the reviews are conducted by clinical psychologists with specific training and experience in this area. Each report contains an executive summary, review of circumstances leading to the suicide, medical autopsy/toxicology findings, background information, mental health history, medical history, institutional functioning, personality dynamics, precipitating events and pre-suicidal functioning, discussion/conclusions, and recommendations. The recommendations section includes identification of the problem area(s), quality improvement plan for each problem area, and required supporting documents for each problem area. Each preliminary Suicide Report is then reviewed and subsequently approved by the Division of Correctional Health Care Services (DCHCS)' Suicide Case Review Subcommittee.

The 25 reviewed Suicide Reports were extremely thorough and among the most comprehensive evaluations of inmate suicides that I have seen in correctional agencies throughout the country. The DCHCS and each MHSR should be strongly commended for their work.

However, the DCHCS's strength also reveals its greatest weakness in suicide prevention, i.e., documentation of a continuing and chronic problem in the identification and management of

inmates at risk for suicide. Following review of these 25 cases, I informally made the following calculations:

- 28% (7 of 25) of the cases involved problems with the emergency response to the incident, most of which were caused by either untimely responses in opening the cell door and initiating CPR and/or emergency equipment failure. However, it should also be noted, that a previous chronic problem of correctional officers failing to initiate CPR prior to the arrival of medical staff has perhaps been resolved, as few of the cases involved such an issue.

- 28% (7 of 25) of the cases involved inmates who committed suicide within hours or days following their discharge from suicide observation status,[1] or cases in which inmates either threatened suicide, expressed suicidal ideation, and/or had other suicide risk factors that did not result in their placement on suicide observation status. These cases were very troubling and will be discussed in more detail throughout this report.

- 16% (4 of 25) of the cases involved inmates who were found with either rigor mortis and/or the review determined that cell checks were not performed as required.

- 44% (11 of 25) of the cases involved inmates who were confined in Administrative Segregation Unit cells (ASU). This finding is not surprising and consistent with previous CDCR data indicating that there is a disproportionate number of inmate suicides occurring within ASU cells. However, as a result of this phenomenon, the CDCR instituted several corrective actions, including designating suicide-resistant intake cells in the ASU units, as well as requiring correctional officers to conduct cell checks at 30-minute intervals during the first 21 days of ASU confinement. However, my review of the suicide reports found that several inmates who committed suicide shortly after ASU placement were not placed in designated ASU intake cells and, as indicated above, several ASU inmates were not observed at 30-minute intervals as required.

- 68% (17 of 25) of the cases involved multiple problem areas, with recommendations for corrective action offered to mental health, medical, and correctional officials. In the remaining 32% (8 of 25) of the cases, either only minor deficiencies or no problem areas were found during the reviews.

[1]For purposes here, I am using the term "suicide observation" generally to include the CDCR terms "suicide precautions" and "suicide watch."

2) Threshold for Placement on Suicide Observation is Set Too High

According to *Chapter 10: Suicide Prevention and Response*, inmates identified at risk for suicide are placed on either of the following suicide observation levels:

- ***Suicide Precaution***, *"when the inmate is in an MHCB because of high risk of attempting self- injurious behavior, but is not in immediate danger";* and

- ***Suicide Watch***, *"when an inmate is in an MHCB because of suicide risk and is in immediate danger of self-injurious behavior."*

As written, a literal interpretation of these definitions requires the placement of an inmate on suicide observation status ***only*** if they are at high risk of attempting suicide and are in immediate danger.

The Suicide Risk Evaluation form (CDCR 744) is an excellent tool for the assessment of suicide risk and includes a listing of both chronic and acute risk factors, as well as protective factors. The evaluation form also includes a mental status exam, estimate of suicide risk, and treatment plan (if appropriate). Within the Estimate of Suicide Risk section, both Chronic Risk and Acute Risk are listed with corresponding boxes for risk level (Low, Moderate, and High). It could be argued that this matrix of risk level, while appropriate, is either not consistent with the definitions of risk behavior necessitating either Suicide Precaution or Suicide Watch, or potentially confusing to the clinician.

In fact, in comparing both the definitions of Suicide Precaution and Suicide Watch with the estimate of risk levels contained within the Suicide Risk Evaluation (SRE) form, a clinician could easily conclude that only an inmate scoring in the high category of acute risk would be placed on suicide observation status. The question then becomes, is this what DCHCS officials intended when developing the definitions of risk behavior necessitating either Suicide Precaution or Suicide Watch?

I would argue that the current definitions of risk behavior necessitating either Suicide Precaution or Suicide Watch are overly restrictive and exclude suicidal behavior that warrants placement under suicide observation status. For example, a clinician completing an SRE could conclude based upon acute risk factors, lack of protective factors, and troubling mental status exam that the inmate fell into the moderate acute risk for suicide category, yet because the inmate is not at high risk of attempting suicide nor in immediate danger according to the Program Guide, they will not be placed on suicide observation status. In fact, this is exactly what is happening within CDCR facilities. I reviewed various medical charts during tours of Mule Creek State Prison, Deuel Vocational Institution, and the California State Prison – Sacramento and found examples at each site in which inmates at moderate acute risk for suicide were discharged from suicide observation status in the MHCB. And, as stated above, 28% (7 of 25) of the reviewed Suicide Reports for 2010 involved inmates who committed suicide within hours or days following their discharge from suicide observation status.

In conclusion, it is my belief that the current threshold for placement of inmates on suicide observation status is set too high and unnecessarily and dangerously excludes a potentially suicidal inmate and/or inmate at moderate risk for self-injurious/suicidal behavior. As such, the definitions necessitating placement on both Suicide Precaution and Suicide Watch in *Chapter 10: Suicide Prevention and Response* should be revised to include this concerning behavior.

3) Recommended Changes to *Chapter 10: Suicide Prevention and Response*

I reviewed *Chapter 10: Suicide Prevention and Response* (2009 Revision) and offer the following changes:

- On page 11, under Peer Consultation: would recommend adding both "correctional staff" and "medical staff" as peers that need to be consulted.

- On page 11, bottom, and top of page 12: Why is this disclaimer necessary? Earlier in this section, it is stated peer consultation can be one of the most important clinical safeguards. In this paragraph, the statement reads that peer consultation is not always necessary. If peer consultation is one of the most clinical safeguards then it should always be necessary. I would recommend that this paragraph be deleted from the program guide.

- On page 12, under Suicide History Tracking: As offered on page 10 of this report, I strongly believe that the Mental Health Tracking System be expanded to include *all* inmates who have attempted suicide, engaged in self-injurious behavior, or otherwise been placed on suicide observation regardless of whether or not they are "high risk mental health inmate–patients' or current members of the MHSDS. This section should be revised accordingly.

- On page 12, third paragraph from the bottom reads "When an inmate–patient verbalizes suicidal ideation without other signs and symptoms of increased risk of suicide, the mental health clinician is responsible for evaluating any contributing environmental stressors and communicating with custody staff and supervisors regarding any potentially solvable custody issues." This paragraph is seemingly referring to inmates who are using the threat of suicide to gain cell relocation, i.e., are viewed as manipulative and/or malingering. My concern is that inmates who present as manipulative and/or malingering can still be suicidal and require placement on suicide observation status. I would recommend that this paragraph be reviewed again and clarified if necessary.

- On page 14, under Inmate and Cell Search, third paragraph from bottom of page: delete reference to "bed frames" being "removed" from the cell, as well as "on the floor." Insert narrative that all inmates on suicide observation status shall be provided with a suicide-resistant beds.

- On page 14, under Inmate and Cell Search: There is no narrative describing what other items or privileges (shower, out-of-cell time, telephone calls, visitation, etc.), if any, is permitted. In my tours of the visited facilities, I found very restrictive conditions for inmates that were on suicide observation status. All inmates were stripped of all clothing and possessions, and given only a safety smock. Except for being offered a shower every other day, they were confined to their cells at all other times, without consideration for out-of-cell time, telephone calls, visitation, etc. I was informed that these were correctional (not mental health) decisions.

  It would be my opinion that such a practice is overly restrictive and seemingly punitive. Confining a suicidal inmate to their cell for 24 hours a day only enhances isolation and is anti-therapeutic. Under these conditions, it is also difficult, if not impossible, to accurately gauge the source of an inmate's suicidal ideation. Take, for example, the daily scenario of a clinician interviewing an inmate on suicide observation status. The inmate has been in the cell for a few days, clothed only in a smock. He rarely has been out of the cell that has an incredibly foul odor because the inmate has not showered (even if it had been offered). The clinician then asks the inmate: "Are you suicidal?" Given the circumstances he finds himself in, the likelihood of an inmate answering affirmatively to that question, the result of which will be his continued placement under these conditions, is highly questionable.

  The management of inmates under suicide observation status can be a complex issue and would require further discussion within CDCR. However, I would argue that the decision to remove clothing and issue a safety smock to an inmate on suicide observation status should be determined on a case-by-case basis *by a mental health clinician*. In addition, unless contraindicated by a clinician following a suicide risk assessment, each inmate on suicide observation status should continue to receive regular privileges (e.g., showers, telephone, visiting, out-of-cell time, etc.) commensurate with their security level.

- On pages 15 and 16, revise definitions of both Suicide Precaution and Suicide Watch as discussed above.

- On page 16 and 17, within the boxes that indicates Guidelines for Clinician-Ordered Suicide Precaution and Suicide Watch: delete reference to "remove all furniture" and insert provision of suicide-resistant beds.

- On page 19, under Discharge or Return: I would argue that inmates sent to the OHU for suicide observation status should receive the same 5-day clinical follow-up as inmates placed in the MHCB for similar reasons. Therefore, delete the last sentence of the second paragraph that begins with "The inmate-patient may, depending on clinical determination, be placed on 5-day clinical follow-up...." and insert the following: "The inmate-patient shall be placed on the 5-day clinical

follow-up treatment plan and custody wellness check procedures as detailed below."

- On page 19, under both Discharge or Return and MHCB Discharge: I would recommend deleting the word "imminent" from the paragraphs. As previously detailed above, the lack of imminent or immediate danger of self harm should not be the only criteria for removal from suicide observation status.

- On page 20, at the bottom of the page, the sentence reads that "Custody shall conduct an hourly check of the inmate–patient's discharge from MHCB for the first 24 hours after discharge....If the custody checks are continued, the mental health clinician shall determine whether the checks are to be every hour, every two hours, or every four hours for the next 24–48 hours." I have several concerns regarding this paragraph. Its intent seems to suggest a transitioning from suicide observation status to general population, yet cell checks at 60-minute intervals does not seem like much of a transition. Utilizing the same rationale as the requirement to observe inmates at 30-minute intervals upon their placement into the ASU, the policy should be revised to require that inmates discharged from suicide observation status should be observed at 30-minute intervals upon return to their designated housing unit for a duration determined by the mental health clinician. (It is also concerning that there is program guide narrative regarding observation intervals of between two and four hours. Consistent with standard correctional practice throughout the country, an inmate should never be left unobserved for longer than 60 minutes.)

- On pages 21 and 22, under both the Custody Protocol and Hanging sections: There is reference to the term "if trained to do so" when referring to providing immediate life support by officers. It was my understanding that correctional officers within the CDCR were required to be trained in both first aid and CPR/AED and, if so, this term should be deleted from the program guide.

4) Use of Outpatient Housing Units (OHUs) for Suicide Precautions

According to *Chapter 5: Mental Health Crisis Bed* of the Mental Health Services Delivery System Program Guide, "*Not all crises require admission to the MHCB. Crisis episodes for some inmate–patients may be handled on an outpatient basis.*" The overall treatment criteria for a mental health crisis bed includes meeting one of the following two criteria: 1) Treatment and monitoring are provided to any inmate who has *current* symptoms and/or requires treatment for the current DSM diagnosed (may be provisional) Axis 1 serious mental disorders... or 2) Medical necessity: Mental health treatment shall be provided as needed, after review by the Interdisciplinary Treatment Team (IDTT)....

In addition to the overall treatment criteria cited above, an inmate must meet the following specific criteria to receive treatment at the MHCB level of care:

- Marked impairment and dysfunction in most areas (daily living activities, communication and self interaction) requiring 24-hour nursing care; and/or

- Dangerousness to Others as a consequence of a serious mental disorder/Dangerousness to Self.

- These conditions usually result in a Global Assessment of Functioning (GAF) score of less than 30.

In addition, although *Chapter 5* does not explicitly detail conditions upon which MHCB and/or alternative housing can be utilized for inmate-patients requiring suicide observation, *Chapter 10: Suicide Prevention and Response* allows for the use of out-patient housing units (OHUs) to house suicidal inmates. According to *Chapter 10*, "The preferred location to place an inmate on Suicide Precautions or Watch status is in the MHCB, or in the OHU pending transfer to the MHCB.... Inmate/patients that are placed in the OHU for *continued assessment of suicide risk* or, in an MHCB for *active suicidal ideation, threats, or attempt*, shall have a note regarding progress toward the treatment plan goals and objectives recorded daily by a treating clinician in the Interdisciplinary Progress Notes section of the UHR.

There appears to be several issues for discussion regarding placement of inmate-patients on suicide observation within CDCR facilities. First, the *Mental Health Services Delivery System Program Guide* does not either explicitly endorse or exclude the use OHUs for inmates on suicide observation. In addition, the clarifying language to set certain criteria appears misleading. For example, *Chapter 10* attempts to distinguish use of OHU versus MHCB by suggesting that OHUs are utilized as a location to place an inmate for *continued assessment of suicide risk*, whereas the MHCB is reserved for *active suicidal ideation, threats or attempt.* This distinction is not helpful because the assessment of suicide risk occurs in both units, and inmates that are actively suicidal, expressing ideation or demonstrating self-injurious behaviors could be found in either unit.

In my opinion, the real differences between the two housing locations should be: 1) whether the inmate-patient meets the MHCB admission criteria, which at a minimum includes serious mental illness, and 2) the level of care necessary to treat the inmate-patient's suicidal behavior. As detailed below, not all inmates that appear to be suicidal, as demonstrated by suicidal ideation, gesture, and/or attempt are seriously mentally ill and require an in-patient level of care.

The second issue concerns the standard of care for treating and managing inmates on suicide observation in correctional systems throughout the country. MHCBs within the CDCR are noteworthy for providing a *licensed* 24-hour continuous nursing level of care. It has been my experience in consulting with numerous state departments of corrections throughout the country that not all inmates who are in need of treatment and management under suicide observation require a licensed 24-hour continuous nursing level of care. In fact, few if any, agencies provide in-patient treatment to all inmate-patients placed on suicide observation within the prison system.

For example, the New York State Department of Correctional Services (DOCS) provides 12 out-patient mental health satellite units within selective maximum security DOCs facilities. Each

satellite unit contains a Residential Crisis Treatment Program (RCTP) comprised of both crisis observation cells and dormitory beds. The vast majority of inmates placed on suicide observation are housed in these crisis cells and dormitory beds. The RCTP is not licensed and does not provide a 24-hour continuous nursing level of care. Inmate-patients in DOCS that require extended mental health care are committed to the Central New York Psychiatric Center (CNYPC), a 226-bed maximum security forensic hospital.

It should be noted that the recent settlement agreement in *Disability Advocates, Inc. v. New York State Office of Mental Health et al* [02-Civ. 4002 (GEL] outlines the specific use of RCTP beds for inmate-patients requiring suicide observation:

> a. Length of Stay. The use of observation cells should be no longer in duration than necessary to deal with the mental health crisis which caused the inmate-patient to be placed in observation. Defendants' goal shall be to keep inmates in observation cells for no more than four (4) days and there shall be a presumption in favor of releasing inmates from observation cells within four (4) days. However, any decision on when to release an inmate from an observation cell after more or less than any particular number of days is a clinical judgment. All cases in which an inmate is held over seven days in observation shall be referred to the CNYPC Clinical Director or designee for consultation.
>
> b. Suicide Watch. Constant 24-hour observation will be provided for inmates on suicide watch.
>
> c. Amenities. No inmate should be left in an observation cell without clothing, smock or paper gown, and a paper gown should only be used where there is a specific safety and security need. The specific amenities provided to an inmate in an observation cell must be determined on the basis of clinical need and safety and security considerations relating to the particular crisis involved in each case.
>
> d. Clinical Contact and Treatment. All inmates in observation cells will be seen by clinical staff every day, five days a week, and by nursing staff on two shifts every day, seven days a week. In addition, every inmate in an observation cell will be offered a minimum daily out-of-cell individual session with a therapist and/or psychiatrist, five (5) days a week, Monday through Friday, when this can be done without unacceptable risk to safety and security. Determinations of such unacceptable risk shall be documented in the mental health treatment record.

The entire agreement can be found at:
www.disabilityadvocates.info/complaints/DAIvOMHSettlement.pdf

Having been a consultant to both the New York State Department of Correctional Services (DOCS) and California Department of Corrections and Rehabilitation, I can state with confidence that use of the New York State DOCS' non-licensed RCTP for treating and managing most inmates on suicide observation is comparable to CDCR's use of the OHU program.

Returning to the CDCR, it would appear from the description of the MHCB admission criteria in *Chapter 5*, that not all potentially suicidal inmates, including those that threatened suicide, express suicidal ideation, and/or engage in non-lethal self-injurious behaviors warrant treatment within a mental health crisis bed. There are numerous reasons why inmates engage in self-injurious behaviors, including: 1) To cope with their environment -- it temporarily relieves intense feelings, tension, pressure, anxiety, and anger; 2) As an act of self-punishment in response to feelings of guilt, sexual or violent impulses, low self-esteem; 3) As a way to control and manage pain (unlike the pain experienced through physical or sexual abuse); and 4) To manipulate their environment, e.g., to gain a desired housing unit or cell relocation due to conflicts with other staff or inmates, etc. It is important to realize that not all of these behaviors reflect a serious mental illness.

Not all inmates who become suicidal are seriously and persistently mentally ill and require an in-patient level of care. As former special master J. Michael Keating said in his Report on Defendants' Plan to Expedite Access to a Mental Health Crisis Bed (MHCB) Level of Care in November 2001, "inmates with no mental health involvement may manifest temporarily symptoms of a mental disorder in the correctional environment, especially during the reception process. A rigid requirement to transfer immediately every agitated inmate who enters and OHU makes no sense. As long as the OHU transfers an inmate as soon as it becomes clear that he or she needs, for example a MHCB level of stabilizing care, the 72-hour observation period is acceptable." I would agree.

It should also be noted that while on site and touring several facilities, I learned that due to the shortage of MHCB beds within the system, inmate-patients were being transported offsite to other prison facilities that had MHCB beds. In some cases, transporting an inmate-patient on suicide observation from an OHU level of care on-site to a MHCB level of care off-site, perhaps several hours away, is contraindicated, interrupts the continuity of care, and is not in the best interests of the inmate-patient.

With that said, while I would support the decision to utilize out-patient housing units for the management of certain inmates on suicide observation, the current structure and environment of the OHUs would need to be revised. As you are aware, I toured the Mule Creek State Prison, Deuel Vocational Institution, and the California State Prison – Sacramento. Each of these facilities has an OHU, and both Mule Creek State Prison and California State Prison – Sacramento have MHCBs. The Deuel Vocational Institution is the only reception center in the CDCR system that does not have any mental health crisis beds.

I was quite concerned about the current conditions observed in the OHUs at each facility. The Mule Creek State Prison has an unlicensed mental health outpatient housing unit (MHOHU). Cells utilized to house inmates on suicide observation generally had poor lighting, visibility, and sanitation conditions (i.e., dirty floors and walls, non-sanitized mattresses, etc.).

At the Deuel Vocational Institution, inmates on suicide observation were housed in either OHU or the OHU Overflow unit located alongside the administrative segregation unit on L–Unit. The conditions within the OHU were quite bad, with poor lighting, visibility, and sanitation problems. I had difficulty observing inmates through the cell windows. Many cells contained tile

floors, with pieces of tile previously removed that could easily be utilized for self-injurious behavior. Clinical staff space was quite limited, with a converted cell being utilized as a staff office, storage area, and interview room. Conditions in the OHU Overflow were worse and quite deplorable. All of the inmates in this unit were on constant 1:1 observation with one certified nursing assistant (CNA) assigned to each inmate at significant expense to the CDCR due to the hazardous conditions of each cell. The OHU Overflow is situated in the same area as the ASU. Upon my entrance into the unit, there was a foul odor apparently left from the recent use of pepper spray. Due to this foul odor, many of CNAs were wearing face masks as they were observing each inmate. Similar to the OHU, each cell in the OHU Overflow had poor lighting, visibility, and sanitation. Each inmate was on lockdown status and clothed in a safety smock. It is difficult to understand how this environment is conducive to alleviating the symptoms of suicidal behavior and/or mental illness. In addition, by routinely subjecting an inmate-patient to these conditions, CDCR runs the risk of some suicidal inmate-patients denying any suicidal ideation during clinical interviews in order to avoid continuation of such harsh conditions.

At the California State Prison – Sacramento, I toured both a mental health crisis bed unit (which although unlicensed had receive a waiver to be a MHCB) and a OHU. Within the OHU, the same conditions existed with poor visibility, lighting, and sanitation. Cells in the unit also had hazardous ventilation grates that were conducive to a suicide attempt by hanging. While on the unit, I observed two mental health staff conducting cell-side assessments of inmates that were on suicide observation. I observed these assessments to be very brief, and neither clinician was utilizing the required Suicide Risk Evaluation (Form No. CDCR-7447). When inquiring as to why assessments were not being conducted in a private interview room, one clinician told me that the designated room was not available (although a subsequent inquiry determined that it was, in fact, available).

In addition, as previously stated, basic amenities and privileges for inmate-patients in each facility, such as protective clothing, out-of-cell time, showers, visits, telephone calls, other possessions, etc. are controlled, not by mental health staff but, by custody personnel. This is not appropriate for an OHU and in contrast to how MHCBs are managed. Such decisions should be made by clinical staff based upon the inmate-patient's individual treatment plan.

In conclusion, it would be my opinion that although OHUs could effectively be utilized for the short-term treatment and management of certain inmate–patients on suicide observations not requiring an acute inpatient level of care, the CDCR would need to significantly upgrade the overall conditions of these units to provide an adequate level of care. For example, OHU cells should be suicide-resistant, contain adequate lighting, visibility into the cell interior, and sanitation (i.e., clean floors and walls, sanitized mattresses, etc.). Daily suicide risk assessments should be conducted with reasonable privacy and confidentiality in an interview room, with cell-side assessments avoided when possible. Nursing staff should also make twice daily rounds of the unit. Unless the inmate-patient has lost basic amenities/privileges as a result of a disciplinary sanction, all decisions regarding protective clothing out-of-cell time, showers, visits, telephone calls, other possessions, etc. should be made by mental health staff based upon the inmate-patient's individual treatment plan.

Finally, in an attempt to convince the Special Master, his experts, and the plaintiffs that OHUs could effectively be utilized for the short-term treatment and management of certain inmate–patients on suicide observation status not requiring an acute inpatient level of care, I would strongly recommend that the CDCR argue that it is proposing to lower the threshold for behavior that warrants placement on suicide observation status and, as such, will be in need of additional suicide-resistant cells to house these inmates. It is both impractical and unreasonable to expect that all these inmates will necessitate a MHCB-level of care and, therefore, would be more appropriately housed in an OHU.

5) Use of Suicide-Resistant Beds in the Correctional Treatment Centers' MHCBs

During my tour of prison facilities that contained correctional treatment centers with mental health crisis beds, I observed that *none* the inmate–patient rooms contained any beds. Upon inquiry, I was informed that hospital beds were automatically removed from the room when it was used as an MHCB for inmate–patients on suicide observation. The rationale for removing hospital beds was that they were hazardous for inmates who had a propensity for engaging in self-injurious behavior. While hospital beds may indeed be hazardous for suicidal individuals, the practice of withholding a bed from an inmate-patient is not an acceptable alternative and does not reflect the standard of care in correctional facilities throughout the country. The standard of care reflects that inmate–patients placed on suicide observation should be housed in a cell or room that is suicide-resistant and includes a bed that is suicide-resistant. Current CDCR policy allows for inmate-patients to be housed in a MHCB for up to 10 days, and forcing them to sleep on a mattress on the floor is, at a minimum, degrading and seemingly punitive, however unintentional it might be. As previously stated, it is difficult to understand how forcing an inmate to sleep on a mattress without a bed is conducive to alleviating the symptoms of suicidal behavior and/or mental illness.

Suicide-resistant beds are readily available to correctional facilities throughout the country, either through purchase from a private vendor or manufactured by the agency itself. While the plaintiffs have pointed to the use of ModuForm beds in several CDC facilities that house inmate-patients on suicide observation, I also observed suicide-resistant beds during my tour of non-MHCB areas that simply included bunk construction that was securely bolted to the floor and flush with the walls, with a metal skirt covering the entire bunk thus ensuring no anchoring points from which a ligature could be tied.

In conclusion, there is simply no security or therapeutic rationale for prohibiting inmates from having suicide-resistant bedding. Therefore, I would strongly encourage the CDCR to ensure that any inmate-patient placed on suicide observation is housed in a room or cell within a OHU or MHCB that contains a suicide-resistant bunk.

6) Use of "ZZ" Cells for Housing Inmate-Patients on Suicide Observation

While touring the CDCR facilities, and in particular the California State Prison–Sacramento, I observed the use of "ZZ" cells for the housing of inmate–patients on suicide observation. Three

(3) inmates were observed in these cells at California State Prison–Sacramento during my tour. These cells are normally located outside common areas and/or corridors of housing units and were originally intended for the temporary housing of inmates in transit. They appear to more resemble temporary holding cells. I was informed that these ZZ cells were being utilized to house inmate-patients on suicide observation who were awaiting placement into the MHCB. These cells appeared very small and I was also told that an inmate–patient can remain in these holding cells under lockdown status for several days while awaiting an appropriate housing assignment. During this time, inmates are on constant 1:1 observation with a CNA assigned at significant expense to the CDCR due to the hazardous conditions of each cell. There is no discussion about utilizing ZZ cells for inmate-patients on suicide observation status in the *Mental Health Services Delivery System Program Guide*. Once the CDCR significantly upgrades the overall conditions of OHUs to provide an adequate level of care, I would strongly encourage the agency to prohibit the use of these ZZ cells for suicide observation.

7) Expanded Use of the Mental Health Tracking System

CDCR currently has a Mental Health Tracking System i.e., a standardized automated system of record management and case tracking. During my on-site visit to CDCR headquarters, as well as various prison facilities, I was informed that the Mental Health Tracking System does not routinely collect data on *all* inmates who have attempted suicide, engaged in self-injurious behavior, or otherwise been placed on suicide observation.

It is extremely important for a clinician assessing suicide risk to not only gather self-reported information from the inmate–patient, but also any relevant information gathered from external sources, e.g., the Mental Health Tracking System. Although it is my understanding that the CDCR has expressed a willingness to collect historical data on previous suicidal behavior for inmate–patients who are *currently* in the Mental Health Services Delivery System (MHSDS), there has been a reluctance to collect such data for *all* inmates (i.e., non-MHSDS).

It is been my experience that a significant percentage of inmates who commit suicide in correctional facilities throughout the country are *not* on a mental health caseload at the time of their deaths. In fact, within the CDCR, it appeared that more than 42% of the inmate suicides during 2010 were non-MHSDS inmates. It has also been my experience that a number of prison suicide victims not only had a mental health history, but a history of suicidal and/or self-injurious behavior. In fact, CDCR's own data indicates that 48% of inmates who committed suicide during 2007 had a history of suicidal behavior.[2] This is a very significant finding.

I have recently been informed that the CDCR is committed to creating a new generated alert system for those inmates with a "High Acute Suicide Risk." This term was not defined and it was unclear how many current CDCR inmates would be classified under this status, nor whether it would include both MHSDS and non-MHSDS inmates. Nevertheless, it is strongly recommended that the CDCR begin utilizing the Mental Health Tracking System to collect data on *all* inmates (including non-MHSDS) who has been placed on suicide observation, to include

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[2]Canning, R.D. (2009), *Annual Report of Suicides and Suicide Prevention in the CDCR for Year 2009*, Sacramento, CA: California Department of Correction and Rehabilitation.

inmates attempting suicide and/or engaging in self-injurious behavior. The collection of such data will serve as an invaluable tool for a mental health clinician's suicide risk assessment.

Quite frankly, it is difficult to see any downside to expansion of the Mental Health Tracking System to include all inmates (including non-MHSDS) who has been placed on suicide observation. The inclusion of data of all inmates who were on suicide observation status will not necessarily increase the number of inmates placed on suicide observation. The data will simply provide clinicians with more tools in their toolbox to assess current suicide risk, as well as decreasing potential liability to the CDCR.[3]

8) Suicide Prevention Training Curricula

Several suicide prevention training curricula were reviewed, including the lesson plan entitled *Mental Health Services Delivery System* for the Basic Correctional Officer Academy. This lesson plan includes a 2.5-hour instruction on Crisis Intervention and Suicide Prevention. Although the lesson plan has very good content in these two subject areas, it was last revised in 2008 and is in need of revision. I would recommend adding the following sections: 1) self-injurious v. suicidal behavior and effectively dealing with manipulative inmates; 2) identifying inmates at risk for suicide despite their denial of risk; 3) updated research on CDCR suicides, and 4) identified problem areas and corrective actions from previous Suicide Review reports.

A 1-hour lesson plan for Health Care New Employee Orientation entitled *Suicide Prevention* was also reviewed. The content is adequate, but the 1-hour duration is not and wrongly suggests that health care employees need less suicide prevention training then correctional personnel. This workshop should be expanded to 2.5 hours and contain the same information as offered in the Basic Correctional Officer Academy lesson plan referenced above.

Finally, a 1-hour In-Service Training lesson plan entitled *Suicide Prevention* was reviewed. This lesson plan is designed for annual instruction to all CDCR employees. The content is very good, but the workshop should be expanded to 2 hours and include discussion of identified problem areas and corrective actions from previous Suicide Review reports.

It is my firm belief that the problem areas and corrective actions identified in individual Suicide Review reports are pertinent not only to the individual facilities that sustained the death, but to all CDCR facilities. Therefore, while ensuring confidentiality of inmate and facility names, all staff should have knowledge of these potential problem areas and recommended corrective actions. The most appropriate forums for presenting this knowledge are pre-service and annual training workshops.

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[3]An effective argument could be made that, if an inmate committed suicide and their previous placement on suicide observation status was unknown to a clinician during an assessment, the State could be held liable in a wrongful death case for having knowledge of the information but not allowing clinicians easier access to the data.

9) Local Suicide Prevention and Response Focused Improvement Team (SPR-FIT)

Chapter 10: Suicide Prevention and Response sets out various specific responsibilities for the local Suicide Prevention and Response Focused Improvement Team (SPR-FIT). The following review of the Suicide Reports from the 2010 inmate suicides, it would appear that many of the deficiencies cited in each case, as well as the responsible parties for corrective actions, fall within the responsibility of the local SPR-FIT. One of the inherent responsibilities of the SPR-FIT system should be to systemically strive for a decrease in both the rate and number of inmate suicides, but that has not occurred. The question is - Why? It would be my opinion that CDCR needs to determine if the local SPR-FITs are functioning effectively, including whether they are operating as reactionary committees following a bad outcome or trying to proactively prevent a bad outcome. For example, each local SPR-FIT is required to meet at least monthly, with various responsibilities that include, but are not limited to, ensuring compliance with all CDCR policies and procedures, suicide prevention procedures, 5-day clinical follow-up treatment plans, etc. However, when I toured each of the three facilities, I observed numerous poor practices in the area of suicide prevention that should have previously been identified by each of the local SPR-FITs.

For example, at Deuel Vocational Institution, clinicians were utilizing an assessment form entitled "Suicide Risk Assessment," a slightly different version of the CDCR-mandated Suicide Risk Evaluation form that did *not* contain the treatment planning section. At Mule Creek State Prison, clinicians were utilizing a "psychiatric observation" status that required observation at 15-minute intervals for inmates that were being transitioned from Suicide Precaution/Suicide Watch, were at risk to others, and/or assessed as gravely disabled. Although this observation status level might be an excellent idea, it appears to be a local practice and not authorized within *Chapter 10: Suicide Prevention and Response.* Of interest, clinicians at the facility could not even point me to any locally written policy or description of the practice. At the *California State Prison – Sacramento*, I observed two different certified nursing assistants (CNAs) in *both* correctional treatment centers falsifying observation logs of inmates on suicide observation status (i.e., making notations on the forms for time intervals that had not yet occurred). In another unit, CNAs were utilizing an observation form that had staggered time intervals already pre-printed on the form that had been developed by the facility's nursing department. Finally, following review of medical charts at all three facilities, I had concerns regarding the adequacy of documentation on the SREs to justify discharge from suicide observation status. In several of the reviewed charts, SREs required for discharge from suicide observation status and 5-day follow-up progress notes were missing or never written.

In conclusion, most, if not all, of these deficiencies were easily observable and should not have been identified for the *first* time by an outside consultant. The fact that I easily identified these issues speaks to the questionable effectiveness of the local SPR-FITS at these facilities, and perhaps systemwide.

10) Use of Administrative Segregation Units for Suicide Observation

Although CDCR officials have entertained the possibility of utilizing administrative segregation unit (ASU) cells as an option for the housing and management of inmates on suicide observation status, given the current inadequate and inconsistent practices of effectively managing such inmates in the OHUs, it would appear premature to discuss an ASU option until the State has demonstrated good practices in other areas. In fact, if the State can eventually demonstrate to the Special Master, his monitoring team, and the plaintiffs that the OHUs are a viable alternative to MHCB placement for selective inmates, the option for utilizing ASU cells might not be necessary.

Concluding Thoughts

Where does the CDCR go from here? It is my opinion that the State's ability to remove itself from the suicide prevention requirements of the *Coleman* case are predicated upon its ability to maintain a robust quality improvement program. The Suicide Review process of DCHCS's Suicide Case Review Subcommittee and mental health suicide reviewers is among its strengths, yet its inability to historically reduce the number of corrective actions in these cases and the corresponding questionable effectiveness of the local SPR-FITs is among the greatest weaknesses.

Exhibit 51

From: Jay Russell <Jay.Russell@doj.ca.gov>
Sent: Wednesday, February 20, 2013 5:02 PM
To: Aaron Fischer
Cc: Patrick McKinney; William Downer; Maneesh Sharma; Debbie Vorous; Coleman Team - RBG Only; Steve Fama; Katherine@CDCR Tebrock (katherine.tebrock@cdcr.ca.gov); Schwartz, Jennifer@CDCR (jennifer.schwartz@cdcr.ca.gov)
Subject: RE: Coleman discovery [IWOV-DMS.FID25914]
Attachments: AH DATA 1-28.xlsx; AH DATA 1-32.xlsx; AH summaries1-23.pdf; AH Summary 1-32.pdf; AH Summary May-Nov 2012.pdf

Aaron –

In response to your email message below, documents responsive to Plaintiffs' second request for production are being delivered to your office overnight for delivery tomorrow. As you are surely aware, William Downer, who has been coordinating document responses, is at Kern Valley today accompanying Plaintiffs' counsel and experts during their inspection. When Mr. Downer returns to the office, documents responsive to the third request will be reviewed, Bates stamped, and then delivered to your office on February 22.

During our telephone conference last Friday, Defendants agreed to use their best efforts to provide further responses to Plaintiffs' requests, but made no promises to provide documents by today. Indeed, during the telephone conference, you demanded that documents be provided by Thursday February 21, *not* today. Moreover, at no time during that call did you place any particular primacy in documents responsive to requests 76 through 78. For you to now ask for production of these document within hours of your email below, sent yesterday afternoon at 3:00 p.m., is simply unreasonable.

In any event, we are completing preparation of documents responsive to requests numbers 76 and 77, and they should be included in the delivery to your office on Friday. At this juncture, CDCR has determined there are no further documents responsive to request 78 that are not already in Plaintiffs' position. In addition, I am attaching to this email documents in native format documents that are responsive to request number 76. (A second email with remaining documents will immediately follow this transmission.) These have *not* been Bates stamped but, as stated above, will be included in the formal production provided to your office on Friday. To that end, if you intend to use any of these documents during Mr. Johnson's deposition on Monday, I ask that the Bates stamped version of these documents be introduced into the record, rather than the unmarked documents that accompany this email.

Should you have any questions, please contact me.

From: Aaron Fischer [mailto:AFischer@rbgg.com]
Sent: Tuesday, February 19, 2013 3:03 PM
To: Jay Russell
Cc: Patrick McKinney; William Downer; Maneesh Sharma; Debbie Vorous; Coleman Team - RBG Only; Steve Fama
Subject: RE: Coleman discovery [IWOV-DMS.FID25914]

Jay,

I am following up on Friday's meet and confer regarding *Coleman* discovery. I know that you and Maneesh are making further inquiries as to a number of Plaintiffs' requests for production for which Defendants had initially indicated in their written responses that they would not produce responsive documents (RFPs 28, 31, 33, 35, 38, 39, 40, 47, 53, 59, 60, 61, 64, 65, 83, 84, 90, 91, 92, 93, 94, 95, 96, 99). Please let me know the status of these follow-up inquiries as soon as

possible and no later than tomorrow, 2/20. Please also let me know when we can expect to receive the privilege log you agreed Defendants would produce for all RFPs, as appropriate.

As we agreed, Defendants will produce in *native format* all responsive charts and other documents that cannot be practically viewed in PDF or hard copy form. Plaintiffs agreed to this on the understanding that Defendants would promptly re-produce any other documents, upon Plaintiffs' request, in native format as appropriate.

We have yet to receive any production of documents responsive to Request Sets 2 and 3; we requested that we receive all or the bulk of the production by tomorrow, 2/20. As you know, the court-ordered discovery cut-off is 10 days from now, and production must move forward without delay. Depositions of Defendants' declarants begin *this week*. If we have not received a sufficient production in advance of these depositions, we may have to continue certain depositions over to a second day. For example, we must have produced, by Noon tomorrow (2/20), *all documents responsive to RFPs 76-78*.

In an effort to reduce the burden of discovery on Defendants, we agreed to provide search terms and custodians in order to narrow the search for documents responsive to RFPs 48, 81, and 85. We expect to provide that information shortly.

Thank you for your attention and ongoing efforts. Let me know if you have any questions about the above.

Many thanks,
Aaron

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From: Jay Russell [mailto:Jay.Russell@doj.ca.gov]
Sent: Friday, February 15, 2013 10:21 AM
To: Aaron Fischer
Cc: Patrick McKinney; William Downer; Maneesh Sharma
Subject: RE: Coleman discovery [IWOV-DMS.FID25914]

Aaron – Are you available for a telephone conference with Maneesh Sharma of our office and me at 11 am?

Also, responses to the third set of Requests for Production were served both via email and regular mail last night.

Jay C. Russell
Supervising Deputy Attorney General

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From: Aaron Fischer [mailto:AFischer@rbgg.com]
Sent: Thursday, February 14, 2013 5:39 PM
To: Debbie Vorous; William Downer
Cc: Lisa Ells; Coleman Team - RBG Only
Subject: Coleman discovery [IWOV-DMS.FID25914]

Debbie and Sonny,

We would like to meet and confer regarding Defendants' responses to Plaintiffs' Second Set of Requests for Production of Documents. Please let me know when you are available on Friday for a phone call.

Also, we have not yet received responses to Plaintiffs' Third Set of Requests for Production of Documents, which are due today pursuant to the Court's order. When can we expect those to arrive?

Thank you,
Aaron

Aaron J. Fischer, Esq.
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San Francisco, CA 94104
Tel: (415) 433-6830
Fax: (415) 433-7104
afischer@rbgg.com
www.rbgg.com

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SUMMARY OF CASES IN ALTERNATIVE HOUSING

May 18, 2012 - December 27, 2012

Week	Total in Alt Housing	Referred to HC-POP for MHCB	% Referred	Not Referred to HC-POP	% Not Referred	Hours in Alt Housing				Total in Alt Housing 24 hrs or less	% in Alt Housing 24 hrs or less
						High	Low	Median	Mean		
1 May 18 - May 24	81	48	59%	33	41%	170.00	0.58	20.87	32.39	47	58%
2 May 25 - May 31	92	43	47%	49	53%	170.00	1.50	20.25	31.25	61	66%
3 June 1 - June 8	71	42	59%	29	41%	70.00	0.00	22.60	28.09	41	58%
4 June 9 - June 14	81	47	58%	34	42%	78.75	0.00	15.71	17.55	62	77%
5 June 15 - June 21	68	44	65%	24	35%	84.25	0.67	18.79	21.03	50	74%
6 June 22 - June 28	71	51	72%	20	28%	63.42	0.00	19.25	22.51	48	68%
7 June 29 - July 5	82	64	78%	18	22%	63.42	0.32	19.43	22.09	59	72%
8 July 6 - July 12	77	65	84%	12	16%	82.15	0.20	19.33	25.33	49	64%
9 July 13 - July 19	76	62	82%	14	18%	57.75	0.50	20.25	21.15	52	68%
10 July 20 - July 26	104	85	82%	19	18%	96.17	1.23	21.18	27.94	66	63%
11 July 27 - Aug 2	79	63	80%	16	20%	84.25	0.08	21.00	25.87	47	59%
12 Aug 3 - Aug 9	75	58	77%	17	23%	49.50	0.03	16.67	20.32	54	72%
13 Aug 10 - Aug 16	117	108	92%	9	8%	106.00	0.03	18.83	23.71	78	67%
14 Aug 17 - Aug 23	81	72	89%	9	11%	50.65	0.25	20.13	22.03	59	73%
15 Aug 24 - Aug 30	116	113	97%	3	3%	90.22	1.48	19.80	24.46	79	68%
16 Aug 31 - Sep 6	94	87	93%	7	7%	105.55	0.92	23.37	29.90	51	54%
17 Sep 7 - Sep 13	99	91	92%	8	8%	106.58	1.50	20.67	25.91	57	58%

SUMMARY OF CASES IN ALTERNATIVE HOUSING

May 18, 2012 - December 27, 2012

Week	Total in Alt Housing	Referred to HC-POP for MHCB	% Referred	Not Referred to HC-POP	% Not Referred	Hours in Alt Housing				Total in Alt Housing 24 hrs or less	% in Alt Housing 24 hrs or less
						High	Low	Median	Mean		
18 Sep 14 - Sep 20	99	88	89%	11	11%	69.33	0.52	18.75	20.70	71	72%
19 Sep 21 - Sep 27	95	83	87%	12	13%	61.95	0.25	17.50	19.65	67	71%
20 Sep 28 - Oct 4	80	67	84%	13	16%	44.60	0.33	17.67	18.59	61	76%
21 Oct 5 - Oct 11	58	52	90%	6	10%	44.58	2.08	18.33	18.81	46	79%
22 Oct 12 - Oct 18	67	53	79%	14	21%	51.50	0.52	17.58	17.06	55	82%
23 Oct 19 - Oct 25	87	80	92%	7	8%	38.25	1.50	16.50	16.33	74	85%
24 Oct 26 - Nov 1	75	67	89%	8	11%	45.58	4.65	17.75	19.18	61	81%
25 Nov 2 - Nov 8	47	42	89%	5	11%	43.50	0.25	19.46	21.09	32	68%
26 Nov 9 - Nov 15	48	43	90%	5	10%	44.08	2.58	17.61	17.95	40	83%
27 Nov 16 - Nov 22	54	40	74%	14	26%	84.72	0.30	20.44	22.50	37	69%
28 Nov 23 - Nov 29	41	36	88%	5	12%	64.50	0.50	21.18	22.57	26	63%
29 Nov 30 - Dec 6	57	39	68%	18	32%	48.83	0.83	15.42	15.37	49	86%
30 Dec 7 - Dec 13	49	38	78%	11	22%	42.67	2.25	18.88	19.99	38	78%
31 Dec 14 - Dec 20	47	40	85%	7	15%	43.92	0.18	19.75	21.11	37	79%
32 Dec 21 - Dec 27	61	48	79%	13	21%	44.58	1.50	18.42	20.53	46	75%
TOTAL	2429	1959	81%	470	19%					1700	70%
AVG/WK	76	61	81%	15	19%	71.91	0.86	19.17	22.28	53	70%

SUMMARY OF CASES IN ALTERNATIVE HOUSING

May 18, 2012 - December 27, 2012

DISPOSITION OF CASES IN ALTERNATIVE HOUSING				
Week	MHCB Placement	No MHCB Placement	TOTAL CASES	% Placed
1 May 18 - May 24	49	32	81	60%
2 May 25 - May 31	39	53	92	42%
3 June 1 - June 7	36	35	71	51%
4 June 8 - June 14	43	38	81	53%
5 June 15 - June 21	35	33	68	51%
6 June 22 - June 28	40	31	71	56%
7 June 29 - July 5	42	40	82	51%
8 July 6 - July 12	43	34	77	56%
9 July 13 - July 19	38	38	76	50%
10 July 20 - July 26	55	49	104	53%
11 July 27 - Aug 2	47	32	79	59%
12 Aug 3 - Aug 9	35	40	75	47%
13 Aug 10 - Aug 16	78	39	117	67%
14 Aug 17 - Aug 23	44	37	81	54%
15 Aug 24 - Aug 30	58	58	116	50%
16 Aug 31 - Sep 6	64	30	94	68%
17 Sep 7 - Sep 13	55	44	99	56%
18 Sep 14 - Sep 20	57	42	99	58%
19 Sep 21 - Sep 27	53	42	95	56%
20 Sep 28 - Oct 4	36	44	80	45%
21 Oct 5 - Oct 11	32	26	58	55%
22 Oct 12 - Oct 18	32	35	67	48%
23 Oct 19 - Oct 25	41	46	87	47%
24 Oct 26 - Nov 1	37	38	75	49%
25 Nov 2 - Nov 8	24	23	47	51%
26 Nov 9 - Nov 15	22	26	48	46%
27 Nov 16 - Nov 22	26	28	54	48%
28 Nov 23 - Nov 29	26	15	41	63%
29 Nov 30 - Dec 6	28	29	57	49%
30 Dec 7 - Dec 13	32	17	49	65%
31 Dec 14 - Dec 20	27	20	47	57%
32 Dec 21 - Dec 27	27	34	61	44%
TOTAL	1301	1128	2429	54%
AVG/WK	41	35	76	54%

SUMMARY OF CASES IN ALTERNATIVE HOUSING

May 18, 2012 - December 27, 2012

DISPOSITION DETAIL OF CASES REFERRED TO HC-POP					DISPOSITION DETAIL OF CASES NOT REFERRED TO HC-POP				
Week	Transferred to MHCB	Intra-Inst MHCB Placement	Rescinded (Deemed no MHCB, Outpatient Placement)	TOTAL REFERRED	Intra-Inst MHCB Placement	Deemed no MHCB, Outpatient Placement	DNSH	Parole	TOTAL NOT REFERRED
1	22	14	12	48	13	19	0	1	33
2	13	8	22	43	18	31	0	0	49
3	14	11	17	42	11	18	0	0	29
4	13	21	13	47	9	25	0	0	34
5	19	9	16	44	7	17	0	0	24
6	23	8	20	51	9	11	0	0	20
7	25	10	29	64	7	11	0	0	18
8	14	25	26	65	4	8	0	0	12
9	29	6	27	62	3	11	0	0	14
10	25	26	34	85	4	15	0	0	19
11	29	15	19	63	3	13	0	0	16
12	12	18	28	58	5	12	0	0	17
13	39	35	34	108	4	5	0	0	9
14	12	29	31	72	3	6	0	0	9
15	33	24	56	113	1	2	0	0	3
16	30	32	25	87	2	5	0	0	7
17	23	28	40	91	4	4	0	0	8
18	24	28	36	88	5	6	0	0	11
19	22	27	34	83	4	8	0	0	12
20	13	19	35	67	4	9	0	0	13
21	23	5	24	52	4	2	0	0	6
22	11	17	25	53	4	10	0	0	14
23	17	23	40	80	1	6	0	0	7
24	20	15	32	67	2	5	1	0	8
25	14	9	19	42	1	4	0	0	5
26	15	7	21	43	0	5	0	0	5
27	12	8	20	40	6	8	0	0	14
28	12	11	13	36	3	2	0	0	5
29	9	9	21	39	10	8	0	0	18
30	13	13	12	38	6	5	0	0	11
31	13	10	17	40	4	3	0	0	7
32	17	6	25	48	4	9	0	0	13
TOTAL	610	526	823	1959	165	303	1	1	470
AVG/WK	19	16	26	61	5	9	0	0	15

Exhibit 52

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE 1-28-13 PRISON SVSP UNIT / SECTION D-2 C POD

CELL NUMBERS IN SECTION 121, 125, 126, 221

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
12: 00	12: 06	BEATTIE	
12: 30	12: 36	BEATTIE	
12:	12:		
13: 00	13: 05	BEATTIE	
13: 30	13: 36	BEATTIE	
13:	13:		
14:	14:		
14:	14:		
14:	14:		
15:	15:		
15:	15:		
15:	15:		
16:	16:		
16:	16:		
16:	16:		
17:	17:		
17:	17:		
17:	17:		
18:	18:		
18:	18:		
18:	18:		
19:	19:		
19:	19:		
19:	19:		
20:	20:		
20:	20:		
20:	20:		
21:	21:		
21:	21:		
21:	21:		
22: 31	22: 36	MCTJA	
22: 31	22: 36	MCTJA	
22:	22:		
23: 31	23: 36	MCTJA	
23: 31	23: 36	MCTJA	
23:	23:		

1st Watch Review - Supervisor Signature:	
2nd Watch Review - Supervisor Signature:	
3rd Watch Review - Supervisor Signature:	

Revised July 31, 2007

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE 1-28-13 PRISON SVSP UNIT / SECTION D-2 B POD

CELL NUMBERS IN SECTION 111, 115, 119, 120, 214, 215, 219, 220

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
12: 00	12: 06	FRANCO	
12: 31	12: 34	FRANCO	
12:	12:		
13: 03	13: 06	FRANCO	
13: 31	13: 35	FRANCO	
13:	13:		
14:	14:		
14:	14:		
14:	14:		
15:	15:		
15:	15:		
15:	15:		
16:	16:		
16:	16:		
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18:	18:		
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18:	18:		
19:	19:		
19:	19:		
19:	19:		
20:	20:		
20:	20:		
20:	20:		
21:	21:		
21:	21:		
21:	21:		
22: 02	22: 34	MEJIA	
22: 32	22: 34	MEJIA	
22:	22:		
23: 02	23: 04	MEJIA	
23: 32	23: 34	MEJIA	
23:	23:		

1st Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

Revised July 31, 2007

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE 1-28-13 PRISON SVSP UNIT / SECTION D-2 A POD

CELL NUMBERS IN SECTION 104

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
1202	12:04	MENDOZA	L-M-
12:32	12:34	MENDOZA	L-M-
12:	12:		
13:01	13:04	MENDOZA	L-M-
13:32	13:34	MENDOZA	L-M-
13:	13:		
14:	14:		
14:	14:		
14:	14:		
15:	15:		
15:	15:		
15:	15:		
16:	16:		
16:	16:		
16:	16:		
17:	17:		
17:	17:		
17:	17:		
18:	18:		
18:	18:		
18:	18:		
19:	19:		
19:	19:		
19:	19:		
20:	20:		
20:	20:		
20:	20:		
21:	21:		
21:	21:		
21:	21:		
22:00	22:02	MEJIA	
22:30	22:32	MEJIA	
22:	22:		
23:00	23:02	MEJIA	
23:30	23:32	MEJIA	
23:	23:		
1st Watch Review - Supervisor Signature:			
2nd Watch Review - Supervisor Signature:			
3rd Watch Review - Supervisor Signature:			

Revised July 31, 2007

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE 1-28-13 PRISON SVSP UNIT / SECTION D-2 A POD

CELL NUMBERS IN SECTION 104

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
00: 00	00: 02	MEJIA	
00: 30	00: 32	MEJIA	
00:	00:		
01: 00	01: 02	MEJIA	
01: 30	01: 32	MEJIA	
01:	01:		
02: 00	02: 02	MEJIA	
02: 30	02: 32	MEJIA	
02:	02:		
03: 00	03: 02	MEJIA	
03: 30	03: 32	MEJIA	
03:	03:		
04: 00	04: 02	MEJIA	
04: 30	04: 32	MEJIA	
04:	04:		
05: 00	05: 02	MEJIA	
05: 30	05: 32	MEJIA	
05:	05:		
06: 00	06: 02	BEATTIE	
06: 30	06: 32	MEJIA	
06:	06:		
07: 02	07: 04	MENDOZA	
07: 31	07: 33	MENDOZA	
07:	07:		
08: 03	08: 05	MENDOZA	
08: 32	08: 34	MENDOZA	
08:	08:		
09: 00	09: 02	MENDOZA	
09: 29	09: 29	MENDOZA	
09:	09:		
10: 01	10: 03	MENDOZA	
10: 32	10: 33	MENDOZA	
10:	10:		
11: 02	11: 04	MENDOZA	
11: 31	11: 33	MENDOZA	
11:	11:		
1st Watch Review - Supervisor Signature:			
2nd Watch Review - Supervisor Signature:			
3rd Watch Review - Supervisor Signature:			

Revised July 31, 2007

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE 1-28-13 PRISON SVSP UNIT / SECTION D2 CPOD

CELL NUMBERS IN SECTION 121, 125, 126, 221

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
00: 01	00: 06	MEJIA	
00: 31	00: 36	MEJIA	
00:	00:		
01: 31	01: 0[illegible]	MEJIA	
01: 31	01: 36	MEJIA	
01:	01:		
02: 01	02: 0[illegible]	MEJIA	
02: 31	02: 36	MEJIA	
02:	02:		
03: 01	03: 0[illegible]	MEJIA	
03: 31	03: 36	MEJIA	
03:	03:		
04: 31	04: 0[illegible]	MEJIA	
04: 31	04: 36	MEJIA	
04:	04:		
05: 31	05: 0[illegible]	MEJIA	
05: 31	05: 36	MEJIA	
05:	05:		
06: 01	06: 15	BEATTIE	
06: 30	06: 34	BEATTIE	
06:	06:		
07: 00	07: 04	BEATTIE	
07: 32	07: 36	BEATTIE	
07:	07:		
08: 00	08: 05	BEATTIE	
08:30	08: 34	BEATTIE	
08:	08:		
09: 00	09: 05	BEATTIE	
09: 32	09: 36	BEATTIE	
09:	09:		
10: 00	10: 06	BEATTIE	
10: 30	10: 36	BEATTIE	
10:	10:		
11: 00	11: 06	BEATTIE	
11: 30	11: 36	BEATTIE	
11:	11:		

1st Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

Revised July 31, 2007

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE 1-28-13 PRISON SUSP UNIT / SECTION D-2 B POD

CELL NUMBERS IN SECTION 111, 115, 119, 120, 214, 215, 219, 220

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
00: 02	00: 04	MCTJIA	
00: 32	00: 34	MCTJIA	
00:	00:		
01: 32	01: 34	MCTJIA	
01: 32	01: 34	MCTJIA	
01:	01:		
02: 02	02: 04	MCTJIA	
02: 32	02: 34	MCTJIA	
02:	02:		
03: 02	03: 04	MCTJIA	
03: 32	03: 34	MCTJIA	
03:	03:		
04: 02	04: 04	MCTJIA	
04: 32	04: 34	MCTJIA	
04:	04:		
05: 02	05: 04	MCTJIA	
05: 32	05: 34	MCTJIA	
05:	05:		
06: 02	06: 04	SEATTLE	
06: 30	06: 34	FRANCO	
06:	06:		
07: 02	07: 07	FRANCO	
07: 31	07: 35	FRANCO	
07:	07:		
08: 01	08: 06	FRANCO	
08: 30	08: 34	FRANCO	
08:	08:		
09: 02	09: 06	FRANCO	
09: 30	09: 34	FRANCO	
09:	09:		
10: 00	10: 05	FRANCO	
10: 32	10: 35	FRANCO	
10:	10:		
11: 02	11: 06	FRANCO	
11: 31	11: 35	FRANCO	
11:	11:		

1st Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

Revised July 31, 2007

Exhibit 53

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET			
DATE: 1/28/13 PRISON: SVSP UNIT/SECTION: Z9 C WING CELL NUMBERS IN SECTION: 130			
START TIME	FINISH TIME	PRINTED STAFF NAME	STAFF NAME
00: 03	00: 04	D. ANGUIANO	DA
00: 31	00: 32	D. ANGUIANO	DA
00:	00:		
01: 01	01: 02	D. ANGUIANO	DA
01: 34	01: 35	D. ANGUIANO	DA
01:	01:		
02: 02	02: 03	D. ANGUIANO	DA
02: 33	02: 34	D. ANGUIANO	DA
02:	02:		
03: 01	03: 02	D. ANGUIANO	DA
03: 29	03: 30	D. ANGUIANO	DA
03:	03:		
04: 05	04: 06	D. ANGUIANO	DA
04: 33	04: 35	D. ANGUIANO	DA
04:	04:		
05: 03	05: 05	D. ANGUIANO	DA
05: 31	05: 33	D. ANGUIANO	DA
05:	05:		
06: 03	06: 04	T. WARUMAN	
06: 27	06: 31	T. WARUMAN	
06:	06:		
07: 01	07: 02	T. WARUMAN	
07: 30	07: 33	T. WARUMAN	
07:	07:		
08: 01	08: 02	A. GARCIA	
08: 30	08: 32	T. WARUMAN	
08:	08:		
09: 01	09: 03	T. WARUMAN	
09: 32	09: 33	T. WARUMAN	
09:	09:		
10: 03	10: 05	T. WARUMAN	
10: 27	10: 31	T. WARUMAN	
10:	10:		
11: 00	11: 02	T. WARUMAN	
11: 29	11: 30	A. GARCIA	
11:	11:		
1st Watch Review-Supervisor Signature:			
2nd Watch Review-Supervisor Signature:			
3rd Watch Review-Supervisor Signature:			

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET			
DATE: 1/28/13 PRISON: SVSP UNIT/SECTION: Z9 C WING CELL NUMBERS IN SECTION: 130			
START TIME	FINISH TIME	PRINTED STAFF NAME	STAFF NAME
12: 01	12: 07	M. GARCIA	
12: 31	12: 04	W. Escoto	
12:	12:		
13: 02	13: 06	W. Escoto	
13: 30	13: 33	W. Escoto	
13:	13:		
14: 00	14: 02	A. RUIZ	T. S
14:	14:		
14: 30	14: 32	A. RUIZ	T. S
15 00	15: 02	A. RUIZ	T. S
15:	15:		
15: 30	15: 32	A. RUIZ	T. S
16:	16:		
16:	16:		
16:	16:		
17:	17:		
17:	17:		
17:	17:		
18	18:		
18:	18:		
18:	18:		
19:	19:		
19:	19:		
19:	19:		
20:	20:		
20:	20:		
20:	20:		
21:	21:		
21:	21:		
21:	21:		
22: 00	22: 04	D. ANGUIANO	D. A
22: 31	22: 33	D. ANGUIANO	D. A
22:	22:		
23: 04	23: 06	D. ANGUIANO	D. A
23: 32	23: 34	D. ANGUIANO	D. A
23:	23:		
1st Watch Review-Supervisor Signature:			
2nd Watch Review-Supervisor Signature:			
3rd Watch Review-Supervisor Signature:			

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET			
DATE: 1/28/13 PRISON: SVSP UNIT/SECTION: Z9 F WING CELL NUMBERS IN SECTION: 163, 168, 173			
START TIME	FINISH TIME	PRINTED STAFF NAME	STAFF NAME
00: 05	00: 06	D. ANGUIANO	DA
00: 32	00: 33	D. ANGUIANO	DA
00:	00:		
01: 03	01: 04	D. ANGUIANO	DA
01: 36	01: 37	D. ANGUIANO	DA
01:	01:		
02: 05	02: 07	D. ANGUIANO	DA
02: 37	02: 39	D. ANGUIANO	DA
02:	02:		
03: 05	03: 07	D. ANGUIANO	DA
03: 30	03: 32	D. ANGUIANO	DA
03:	03:		
04: 06	04: 08	D. ANGUIANO	DA
04: 35	04: 38	D. ANGUIANO	DA
04:	04:		
05: 05	05: 08	D. ANGUIANO	DA
05: 33	05: 36	D. ANGUIANO	DA
05:	05:		
06: 01	06: 02	T. UARTE DUMONT	
06: 31	06: 33	T. UARTE DUMONT	
06:	06:		
07: 01	07: 02	M. GARCIA	
07: 30	07: 31	M. GARCIA	
07:	07:		
08: 01	08: 02	M. GARCIA	
08: 29	08: 32	T. UARTE DUMONT	
08:	08:		
09: 07	09: 04	T. UARTE DUMONT	
09: 28	09: 31	T. UARTE DUMONT	
09:	09:		
10: 00	10: 03	T. UARTE DUMONT	
10: 32	10: 34	W. ESCOBAR	
10:	10:		
11: 02	11: 07	W. ESCOBAR	
11: 29	11: 30	M. GARCIA	
11:	11:		
1st Watch Review-Supervisor Signature:			
2nd Watch Review-Supervisor Signature:			
3rd Watch Review-Supervisor Signature:			

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET			
DATE: 1/28/13 PRISON: SVSP UNIT/SECTION: Z9 F WING CELL NUMBERS IN SECTION: 163, 168, 173			
START TIME	FINISH TIME	PRINTED STAFF NAME	STAFF NAME
12: 01	12: 02	M. GARCIA	
12: 31	12: 33	T. WARNAUMONT	
12:	12:		
13: 02	13: 04	T. WARNAUMONT	
13: 32	13: 35	T. WARNAUMONT	
13:	13:		
14:	14:		
14:	14:		
14:	14:		
15	15:		
15:	15:		
15:	15:		
16:	16:		
16:	16:		
16:	16:		
17:	17:		
17:	17:		
17:	17:		
18	18:		
18:	18:		
18:	18:		
19:	19:		
19:	19:		
19:	19:		
20:	20:		
20:	20:		
20:	20:		
21:	21:		
21:	21:		
21:	21:		
22: 05	22: 08	D. ANGUIANO	DA
22: 33	22: 35	D. ANGUIANO	DA
22:	22:		
23: 06	23: 08	D. ANGUIANO	DA
23: 34	23: 36	D. ANGUIANO	DA
23:	23:		
1st Watch Review-Supervisor Signature:			
2nd Watch Review-Supervisor Signature:			
3rd Watch Review-Supervisor Signature:			

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET			
DATE: 1/28/13 PRISON: SVSP UNIT/SECTION: Z9 G WING CELL NUMBERS IN SECTION: 178, 179			
START TIME	FINISH TIME	PRINTED STAFF NAME	STAFF NAME
00: 07	00: 08	D. ANGUIANO	DA
00: 34	00: 35	D. ANGUIANO	DA
00:	00:		
01: 05	01: 06	D. ANGUIANO	DA
01: 38	01: 39	D. ANGUIANO	DA
01:	01:		
02: 05	02: 07	D. ANGUIANO	DA
02: 37	02: 39	D. ANGUIANO	DA
02:	02:		
03: 05	03: 07	D. ANGUIANO	DA
03: 32	03: 34	D. ANGUIANO	DA
03:	03:		
04: 08	04: 10	D. ANGUIANO	DA
04: ~~05~~ 35	04: ~~08~~ 38	D. ANGUIANO	DA
04:	04:		
05: 05	05: 08	D. ANGUIANO	DA
05: 33	05: 36	D. ANGUIANO	DA
05:	05:		
06: 03	06: 04	T. URRUTIA	
06: 33	06: 35	T. URRUTIA	
06:	06:		
07: 03	07: 04	T. URRUTIA	
07: 29	07: 31	T. URRUTIA	
07:	07:		
08: 02	08: 03	M. GARCIA	
08: 32	08: 34	T. URRUTIA	
08:	08:		
09: 03	09: 05	T. URRUTIA	
09: 27	09: 31	T. URRUTIA	
09:	09:		
10: 00	10: 03	T. URRUTIA	
10: 29	10: 30	M. GARCIA	
10:	10:		
11: 01	11: 02	M. GARCIA	
11: 29	11: 30	M. GARCIA	
11:	11:		
1st Watch Review-Supervisor Signature:			
2nd Watch Review-Supervisor Signature:			
3rd Watch Review-Supervisor Signature:			

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET			
DATE: 1/28/13 PRISON: SVSP UNIT/SECTION: Z9 G WING CELL NUMBERS IN SECTION: 178, 179			
START TIME	FINISH TIME	PRINTED STAFF NAME	STAFF NAME
12: 01	12: 02	M. GARCIA	
12: 29	12: 30	M. GARCIA	
12:	12:		
13: 02	13: 01	M. GARCIA	
13: 30	13: 31	M. GARCIA	
13:	13:		
14: 00	14: 01	MARTINEZ	
14: 30	14: 31	MARTINEZ	
14:	14:		
15 00	15: 01	MARTINEZ	
15:	15:		
15:	15:		
16:	16:		
16:	16:		
16:	16:		
17:	17:		
17:	17:		
17:	17:		
18	18:		
18:	18:		
18:	18:		
19:	19:		
19:	19:		
19:	19:		
20:	20:		
20:	20:		
20:	20:		
21:	21:		
21:	21:		
21:	21:		
22: 05	22: 08	D. ANGUIANO	DA
22: 33	22: 35	D. ANGUIANO	DA
22:	22:		
23: 06	23: 08	D. ANGUIANO	DA
23: 34	23: 36	D. ANGUIANO	DA
23:	23:		
1st Watch Review-Supervisor Signature:			
2nd Watch Review-Supervisor Signature:			
3rd Watch Review-Supervisor Signature:			

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET			
DATE: 1/28/13 PRISON: SVSP UNIT/SECTION: Z9 B WING CELL NUMBERS IN SECTION: _____			
START TIME	FINISH TIME	PRINTED STAFF NAME	STAFF NAME
00:	00:		
00:	00:		
00:	00:		
01:	01:		
01:	01:		
01:	01:		
02:	02:		
02:	02:		
02:	02:		
03:	03:		
03:	03:		
03:	03:		
04:	04:		
04:	04:		
04:	04:		
05:	05:		
05:	05:		
05:	05:		
06:	06:		
06:	06:		
06:	06:		
07:	07:		
07:	07:		
07:	07:		
08:	08:		
08:	08:		
08:	08:		
09:	09:		
09:	09:		
09:	09:		
10:	10:		
10:	10:		
10:	10:		
11:	11:		
11:	11:		
11:	11:		
1st Watch Review-Supervisor Signature:			
2nd Watch Review-Supervisor Signature:			
3rd Watch Review-Supervisor Signature:			

No welfare checks

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET			
DATE: 1/28/13 PRISON: SVSP UNIT/SECTION: Z9 B WING CELL NUMBERS IN SECTION: _____			
START TIME	FINISH TIME	PRINTED STAFF NAME	STAFF NAME
12:	12:		
12:	12:		
12:	12:		
13:	13:		
13:	13:		
13:	13:		
14:	14:		
14:	14:		
14:	14:		
15	15:		
15:	15:		
15:	15:		
16:	16:		
16:	16:		
16:	16:		
17:	17:		
17:	17:		NO
17:	17:		
18	18:		
18:	18:		WELFARE
18:	18:		
19:	19:		
19:	19:		✓
19:	19:		
20:	20:		
20:	20:		
20:	20:	CELLS	
21:	21:		
21:	21:		
21:	21:		
22:	22:		
22:	22:		
22:	22:		NO checks
23:	23:		
23:	23:		
23:	23:		
1st Watch Review-Supervisor Signature:			
2nd Watch Review-Supervisor Signature:			
3rd Watch Review-Supervisor Signature:			

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET			
DATE: 1/28/13 PRISON: SVSP UNIT/SECTION: Z9 H WING CELL NUMBERS IN SECTION: 195			
START TIME	FINISH TIME	PRINTED STAFF NAME	STAFF NAME
00: 07	00: 08	D. ANGUIANO	DA
00: 34	00: 35	D. ANGUIANO	DA
00:	00:		
01: 05	01: 06	D. ANGUIANO	DA
01: 38	01: 39	D. ANGUIANO	DA
01:	01:		
02: 07	02: 07	D. ANGUIANO	DA
02: 39	02: 39	D. ANGUIANO	DA
02:	02:		
03: 07	03: 08	D. ANGUIANO	DA
03: 32	03: 34	D. ANGUIANO	DA
03:	03:		
04: 08	04: 10	D. ANGUIANO	DA
04: 35	04: 38	D. ANGUIANO	DA
04:	04:		
05: 05	05: 08	D. ANGUIANO	DA
05: 33	05: 37	D. ANGUIANO	DA
05:	05:		
06: 03	06: 05	T. UNRUH	
06: 27	06: 31	T. UNRUH	
06:	06:		
07: 01	07: 02	M. GARCIA	
07: 29	07: 30	M. GARCIA	
07:	07:		
08: 00	08: 01	M. GARCIA	
08: 31	08: 32	T. UNRUH	
08:	08:		
09: 01	09: 03	T. UNRUH	
09: 32	09: 34	T. UNRUH	
09:	09:		
10: 01	10: 02	M. GARCIA	
10: 29	10: 30	M. GARCIA	
10:	10:		
11: 00	11: 01	M. GARCIA	
11: 29	11: 30	M. GARCIA	
11:	11:		
1st Watch Review-Supervisor Signature:			
2nd Watch Review-Supervisor Signature:			
3rd Watch Review-Supervisor Signature:			

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET			
DATE: 1/28/13 PRISON: SVSP UNIT/SECTION: Z9 H WING CELL NUMBERS IN SECTION: 195			
START TIME	FINISH TIME	PRINTED STAFF NAME	STAFF NAME
12: 01	12: 02	M. GARCIA	
12: 29	12: 30	M. GARCIA	
12:	12:		
13: 00	13: 01	M. GARCIA	
13: 30	13: 31	M. GARCIA	
13:	13:		
14: 07	14: 05	GALINDO	
14: 29	14: 33	GALINDO	
14:	14:		
15 01	15: 04	GALINDO	
15: 32	15: 35	GALINDO	
15:	15:		
16:	16:		
16:	16:		
16:	16:		
17:	17:		
17:	17:		
17:	17:		
18	18:		
18:	18:		
18:	18:		
19:	19:		
19:	19:		
19:	19:		
20:	20:		
20:	20:		
20:	20:		
21:	21:		
21:	21:		
21:	21:		
22: 05	22: 08	D. ANGUIANO	DA
22: 33	22: 35	D. ANGUIANO	DA
22:	22:		
23: 06	23: 08	D. ANGUIANO	DA
23: 34	23: 36	D. ANGUIANO	DA
23:	23:		
1st Watch Review-Supervisor Signature:			
2nd Watch Review-Supervisor Signature:			
3rd Watch Review-Supervisor Signature:			

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET			
DATE: 1/28/13 PRISON: SVSP UNIT/SECTION: Z9 A WING CELL NUMBERS IN SECTION: 102, 103, 110			
START TIME	FINISH TIME	PRINTED STAFF NAME	STAFF NAME
00: 02	00: 03	D. ANGUIANO	DA
00: 30	00: 31	D. ANGUIANO	DA
00:	00:		
01: 00	01: 01	D. ANGUIANO	DA
01: 33	01: 34	D. ANGUIANO	DA
01:	01:		
02: 01	02: 02	D. ANGUIANO	DA
02: 32	02: 33	D. ANGUIANO	DA
02:	02:		
03: 00	03: 01	D. ANGUIANO	DA
03: 28	03: 29	D. ANGUIANO	DA
03:	03:		
04: 04	04: 05	D. ANGUIANO	DA
04: 33	04: 35	D. ANGUIANO	DA
04:	04:		
05: 03	05: 05	D. ANGUIANO	DA
05: 31	05: 33	D. ANGUIANO	DA
05:	05:		
06: 02	06: 03	J. LARIOS	
06: 29	06: 30	J. LARIOS	
06:	06:		
07: 00	07: 01	J. LARIOS	
07: 31	07: 32	J. LARIOS	
07:	07:		
08: 01	08: 02	M. GARCIA	
08: 30	08: 33	J. LARIOS	
08:	08:		
09: 02	09: 04	J. LARIOS	
09: 33	09: 35	J. LARIOS	
09:	09:		
10: 03	10: 35	W. Estrada	
10: 31	10: 36	W. Estrada	
10:	10:		
11: 05	11: 08	W. Estrada	
11: 29	11: 30	M. GARCIA	
11:	11:		
1st Watch Review-Supervisor Signature:			
2nd Watch Review-Supervisor Signature:			
3rd Watch Review-Supervisor Signature:			

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET			
DATE: 1/28/13 PRISON: SVSP UNIT/SECTION: Z9 A WING CELL NUMBERS IN SECTION: 102, 103, 110			
START TIME	FINISH TIME	PRINTED STAFF NAME	STAFF NAME
12: 00	12: 01	M. GARCIA	
12:30	12: 32	T. WAREHAM	
12:	12:		
13: 01	13: 03	T. WAREHAM	
13: 29	13: 31	T. WAREHAM	
13:	13:		
14: 00	14: 02	G. FLETES	
14: 31	14: 33	G. FLETES	
14:	14:		
15: 01	15: 03	G. FLETES	
15: 33	15: 35		
15:	15:		
16:	16:		
16:	16:		
16:	16:		
17:	17:		
17:	17:		
17:	17:		
18	18:		
18:	18:		
18:	18:		
19:	19:		
19:	19:		
19:	19:		
20:	20:		
20:	20:		
20:	20:		
21:	21:		
21:	21:		
21:	21:		
22: 00	22: 04	D. ANGUIANO	DA
22: 31	22: 33	D. ANGUIANO	DA
22:	22:		
23: 04	23: 06	D. ANGUIANO	DA
23: 32	23: 34	D. ANGUIANO	DA
23:	23:		
1st Watch Review-Supervisor Signature:			
2nd Watch Review-Supervisor Signature:			
3rd Watch Review-Supervisor Signature:			

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 1/28/13 PRISON: SVSP UNIT/SECTION: Z9 E WING
CELL NUMBERS IN SECTION: 149, 150, 159

START TIME	FINISH TIME	PRINTED STAFF NAME	STAFF NAME
00: 05	00: 06	D. ANGUIANO	DA
00: 32	00: 33	D. ANGUIANO	DA
00:	00:		
01: 03	01: 04	D. ANGUIANO	DA
01: 36	01: 37	D. ANGUIANO	DA
01:	01:		
02: 03	02: 05	D. ANGUIANO	DA
02: 35	02: 37	D. ANGUIANO	DA
02:	02:		
03: 03	03: 05	D. ANGUIANO	DA
03: 30	03: 32	D. ANGUIANO	DA
03:	03:		
04: 06	04: 08	D. ANGUIANO	DA
04: 35	04: 38	D. ANGUIANO	DA
04:	04:		
05: 05	05: 08	D. ANGUIANO	DA
05: 33	05: 36	D. ANGUIANO	DA
05:	05:		
06: 04	06: 05	T. VARELA	
06: 34	06: 36	T. VARELA	
06:	06:		
07: 05	07: 07	T. VARELA	
07: 34	07: 38	T. VARELA	
07:	07:		
08: 00	08: 01	M. GARCIA	
08: 31	08: 33	T. VARELA	
08:	08:		
09: 01	09: 02	T. VARELA	
09: 33	09: 35	T. VARELA	
09:	09:		
10: 02	10: 04	M. Escobar	
10: 33	10: 37	M. Escobar	
10:	10:		
11: 05	11: 10	M. Escobar	
11: 31	11: 33	M. Escobar	
11:	11:		

1st Watch Review-Supervisor Signature:

2nd Watch Review-Supervisor Signature:

3rd Watch Review-Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET			
DATE: 1/28/13 PRISON: SVSP UNIT/SECTION: Z9 E WING CELL NUMBERS IN SECTION: 149, 150, 159			
START TIME	FINISH TIME	PRINTED STAFF NAME	STAFF NAME
12: 00	12: 03	M Escobedo	
12: 32	12: 33	T. Urquhart	
12:	12:		
13: 02	13: 04	T. Urquhart	
13: 30	13: 35	T. Urquhart	
13:	13:		
14: 01	14: 03	GALINDO	
14: 28	14: 31	GALINDO	
14:	14:		
15: 05	15: 07	GALINDO	
15: 28	15: 30	GALINDO	
15:	15:		
16:	16:		
16:	16:		
16:	16:		
17:	17:		
17:	17:		
17:	17:		
18	18:		
18:	18:		
18:	18:		
19:	19:		
19:	19:		
19:	19:		
20:	20:		
20:	20:		
20:	20:		
21:	21:		
21:	21:		
21:	21:		
22: 00	22: 04	D. ANGUIANO	DA
22: 31	22: 33	D. ANGUIANO	DA
22:	22:		
23: 04	23: 06	D. ANGUIANO	DA
23: 32	23: 34	D. ANGUIANO	DA
23:	23:		
1st Watch Review-Supervisor Signature:			
2nd Watch Review-Supervisor Signature:			
3rd Watch Review-Supervisor Signature:			

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET			
DATE: 1/28/13 PRISON: SVSP UNIT/SECTION: Z9 D WING CELL NUMBERS IN SECTION: 136, 146			
START TIME	FINISH TIME	PRINTED STAFF NAME	STAFF NAME
00: 03	00: 04	D. ANGUIANO	DA
00: 31	00: 32	D. ANGUIANO	DA
00:	00:		
01: 01	01: 02	D. ANGUIANO	DA
01: 34	01: 35	D. ANGUIANO	DA
01:	01:		
02: 02	02: 03	D. ANGUIANO	DA
02: 33	02: 34	D. ANGUIANO	DA
02:	02:		
03: 01	03: 02	D. ANGUIANO	DA
03: 29	03: 30	D. ANGUIANO	DA
03:	03:		
04: 05	04: 06	D. ANGUIANO	DA
04: 33	04: 35	D. ANGUIANO	DA
04:	04:		
05: 03	05: 05	D. ANGUIANO	DA
05: 31	05: 33	D. ANGUIANO	DA
05:	05:		
06: 01	06: 05	M. Escobar	
06: 32	06: 36	M. Escobar	
06:	06:		
07: 02	07: 03	T. VARGAS	
07: 29	07: 31	T. VARGAS	
07:	07:		
08: 00	08: 01	M. GARCIA	
08: 31	08: 32	T. VARGAS	
08:	08:		
09: 02	09: 04	T. VARGAS	
09: 28	09: 31	T. VARGAS	
09:	09:		
10: 01	10: 03	T. VARGAS	
10: 31	10: 33	M. Escobar	
10:	10:		
11: 05	11: 10	M. Escobar	
11: 32	11: 35	M. Escobar	
11:	11:		
1st Watch Review-Supervisor Signature:			
2nd Watch Review-Supervisor Signature:			
3rd Watch Review-Supervisor Signature:			

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET			
DATE: 1/28/13 PRISON: SVSP UNIT/SECTION: Z9 D WING CELL NUMBERS IN SECTION: 136, 146			
START TIME	FINISH TIME	PRINTED STAFF NAME	STAFF NAME
12: 00	12: 04	M. Escobar	
12: 30	12: 32	M. Escobar	
12:	12:		
13: 01	13: 04	M. Escobar	
13: 30	13: 35	M. Escobar	
13:	13:		
14: 03	14: 03	GALINDO	
14: 27	14: 30	GALINDO	
14:	14:		
15: 03	15: 05	GALINDO	
15: 30	15: 32	FLETES	
15:	15:		
16:	16:		
16:	16:		
16:	16:		
17:	17:		
17:	17:		
17:	17:		
18	18:		
18:	18:		
18:	18:		
19:	19:		
19:	19:		
19:	19:		
20:	20:		
20:	20:		
20:	20:		
21:	21:		
21:	21:		
21:	21:		
22: 00	22: 04	D. ANGUIANO	DA
22: 31	22: 33	D. ANGUIANO	DA
22:	22:		
23: 04	23: 06	D. ANGUIANO	DA
23: 32	23: 34	D. ANGUIANO	DA
23:	23:		
1st Watch Review-Supervisor Signature:			
2nd Watch Review-Supervisor Signature:			
3rd Watch Review-Supervisor Signature:			

Exhibit 54

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: PRISON: UNIT/SECTION:

CELL NUMBERS IN SECTION:

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
00:	00:		
00:	00:		
01:	01:		
01:	01:		
02:	02:		
02:	02:		
03:	03:		
03:	03:		
04:	04:		
04:	04:		
05:	05:		
05:	05:		
06:	06:		
06:	06:		
07:	07:		
07:	07:		
08:	08:		
08:	08:		
09:	09:		
09:	09:		
10:	10:		
10:	10:		
11:	11:		
11:	11:		

1ST Watch Review – Supervisor Signature

2nd Watch Review – Supervisor Signature

Revised July 27, 2009

Exhibit 55

SAC AD-SEG

B-4

30 MINUTE WELFARE

-8-13 THRU 1-28-13

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 1-24-13 PRISON: CSP-Sac UNIT/SECTION: B & ASU

CELL NUMBERS IN SECTION: A B C

START TIME		END TIME		PRINTED STAFF NAME	STAFF SIGNATURE
00:	00	00:	03	Stocker	
00:	30	00:	33		
01:	00	01:	03	Stocker	
01:	30	01:	33		
02:	00	02:	03	Stocker	
02:	30	02:	33		
03:	00	03:	03	Stocker	
03:	30	03:	33		
04:	00	04:	03	Stocker	
04:	30	04:	33		
05:	00	05:	03	Stocker	
05:	30	05:	33		
06:	00	06:	03	Stocker	
06:	30	06:	33		
07:	00	07:	04	Ellis	
07:	31	07:	35		
08:	00	08:	03	Ellis	
08:	30	08:	33	Teller	
09:	00	09:	04	Teller	
09:	30	09:	34	Teller	
10:	00	10:	04	Teller	
10:	31	10:	35	Teller	
11:	01	11:	05	Teller	
11:	35	11:	40	Teller	

1ST WATCH REVIEW - SUPERVISOR SIGNATURE:

2ND WATCH REVIEW - SUPERVISOR SIGNATURE:

3RD WATCH REVIEW - SUPERVISOR SIGNATURE:

REV 8/23/2007

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 1-28-13 PRISON: CSP-Sac UNIT/SECTION: D & ASU

CELL NUMBERS IN SECTION: A B C

START TIME		END TIME		PRINTED STAFF NAME	STAFF SIGNATURE
12:	05	12:	05	T Tellez	
12:	38	12:	34	T Tellez	
13:	04	13:	04	T Tellez	
13:	30	13:	35	T Tellez	
14:	01	14:	06	B. WATTS	B. Watts
14:	32	14:	37		
15:	03	15:	08	B. WATTS	B. Watts
15:	34	15:	35		
16:	01	16:	07	B. WATTS	B. Watts
16:	34	16:	39		
17:	03	17:	08	B. WATTS	B. Watts
17:	32	17:	36		
18:	02	18:	07	B. WATTS	B. Watts
18:	33	18:	38		
19:	03	19:	07	B. WATTS	B. Watts
19:	32	19:	35		
20:	05	20:	12	B. WATTS	B. Watts
20:	34	20:	39		
21:	04	21:	09	B. WATTS	B. Watts
21:	32	21:	35	B. WATTS	B. Watts
22:		22:			
22:	20	22:	33	Stocker	
23:	00	23:	03	Stocker	
23:	30	23:	33		

1ST WATCH REVIEW - SUPERVISOR SIGNATURE:	
2ND WATCH REVIEW - SUPERVISOR SIGNATURE:	
3RD WATCH REVIEW - SUPERVISOR SIGNATURE:	

REV 8/23/2007

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 1/27/13 • PRISON: CSP-Sac UNIT/SECTION: • B4

CELL NUMBERS IN SECTION: A, B, C, Section

START TIME		END TIME		PRINTED STAFF NAME	STAFF SIGNATURE
00:	00	00:	06	Gomez	
00:	30	00:	34		
01:	00	01:	04	Gomez	
01:	30	01:	35		
02:	00	02:	06	Gomez	
02:	30	02:	36		
03:	00	03:	08	Gomez	
03:	30	03:	36		
04:	00	04:	06	Gomez	
04:	30	04:	38		
05:	00	05:	08	Gomez	
05:	30	05:	36		
06:	05	06:	10	Gomez	
06:	34	06:	38	Dunlap	
07:	02	07:	07	Dunlap	
07:	31	07:	36	Dunlap	
08:	04	08:	09	Dunlap	
08:	30	08:	35	Dunlap	
09:	00	09:	06	Dunlap	
09:	31	09:	36	Dunlap	
10:	01	10:	06	Dunlap	
10:	31	10:	37	Dunlap	
11:	00	11:	06	Dunlap	
11:	32	11:	37	Dunlap	

1ST WATCH REVIEW - SUPERVISOR SIGNATURE:

2ND WATCH REVIEW - SUPERVISOR SIGNATURE:

3RD WATCH REVIEW - SUPERVISOR SIGNATURE:

REV 8/23/2007

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: _____ PRISON: _____ UNIT/SECTION: _____

CELL NUMBERS IN SECTION: _____

START TIME		END TIME		PRINTED STAFF NAME	STAFF SIGNATURE
12:	04	12:	08	Dunlap	
12:	30	12:	35	Dunlap	
13:	04	13:	08	Dunlap	
13:	32	13:	37	Dunlap	
14:	02	14:	07	Callahan	
14:	34	14:	38		
15:	04	15:	08	Callahan	
15:	33	15:	39		
16:	06	16:	09	Calldwell	
16:	31	16:	34		
17:	01	17:	05	Calldwell	
17:	34	17:	39		
18:	05	18:	09	Calldwell	
18:	33	18:	36		
19:	00	19:	10	Calldwell	
19:	30	19:	35		
20:	01	20:	05	Calldwell	
20:	31	20:	36		
21:	05	21:	10	Calldwell	
21:	30	21:	34		
22:	03	22:	07	Calldwell	
22:		22:			
23:		23:		Calldwell	
23:		23:			

1ST WATCH REVIEW - SUPERVISOR SIGNATURE:	
2ND WATCH REVIEW - SUPERVISOR SIGNATURE:	
3RD WATCH REVIEW - SUPERVISOR SIGNATURE:	

REV 8/23/2007

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: JAN 26 2013 PRISON: SAC UNIT/SECTION: B4.

CELL NUMBERS IN SECTION:

START TIME		END TIME		PRINTED STAFF NAME	STAFF SIGNATURE
00:	02	00:	07	Stanley	
00:	31	00:	36	Stanley	
01:	00	01:	06	Stanley	
01:	33	01:	38	Stanley	
02:	02	02:	07	Stanley	
02:	31	02:	36	Stanley	
03:	00	03:	06	Stanley	
03:	32	03:	37	Stanley	
04:	02	04	07	Stanley	
04:	31	04:	36	Stanley	
05:	00	05:	05	Stanley	
05:	33	05:	38	Stanley	
06:	01	06:	05	Cisneros	Cisneros
06:	30	06:	33	Cisneros	Cisneros
07:	00	07:	04	Cisneros	Cisneros
07:	32	07:	35	Cisneros	Cisneros
08:	01	08:	04	Cisneros	Cisneros
08:	30	08:	33	Cisneros	Cisneros
09:	03	09:	06	Cisneros	Cisneros
09:	32	09:	35	Cisneros	Cisneros
10:	00	10:	03	Cisneros	Cisneros
10	31	10:	34	Cisneros	Cisneros
11:	02	11:	06	Cisneros	Cisneros
11	33	11:	36	Cisneros	Cisneros

1ST WATCH REVIEW - SUPERVISOR SIGNATURE:

2ND WATCH REVIEW - SUPERVISOR SIGNATURE:

3RD WATCH REVIEW - SUPERVISOR SIGNATURE:

E 1

REV 8/23/2007

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: JAN 26 PRISON: SAC UNIT/SECTION: B4

CELL NUMBERS IN SECTION:

START TIME		END TIME		PRINTED STAFF NAME	STAFF SIGNATURE
12:	00	12:	04	CISNEROS	Cisneros
12:	32	12:	35	CISNEROS	Cisneros
13:	01	13:	05	CISNEROS	Cisneros
13:	30	13:	34	CISNEROS	Cisneros
14:	03	14:	09	B. WATTS	B. Watts
14:	31	14:	33		
15:	04	15:	08	S CORONA	S Corona
15:	35	15:	38	S CORONA	S Corona
16:	00	16:	04	S CORONA	S Corona
16:	33	16:	37		
17:	03	17:	07	B. WATTS	B. Watts
17:	32	17:	35		
18:	02	18:	08	B. WATTS	B. Watts
18:	31	18:	36		
19:	01	19:	06	B. WATTS	B. Watts
19:	33	19:	39		
20:	03	20:	08	B. WATTS	B. Watts
20:	34	20:	38		
21:	02	21:	06	B. WATTS	B. Watts
21:	31	21:	36		
22:		22:			
22:	31	22:	36	SETHER	
23:	00	23:	05	SETHER	
23:	32	23:	37	SETHER	

1ST WATCH REVIEW - SUPERVISOR SIGNATURE:

2ND WATCH REVIEW - SUPERVISOR SIGNATURE:

3RD WATCH REVIEW - SUPERVISOR SIGNATURE:

E2

REV 8/23/2007

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 1-25-13 PRISON: SAC UNIT/SECTION: B4

CELL NUMBERS IN SECTION: A SEC, B SEC, C SEC

START TIME		END TIME		PRINTED STAFF NAME	STAFF SIGNATURE
12:	01	12:	04	CISNEROS	Cisneros
12:	30	12:	33	CISNEROS	Cisneros
13:	00	13:	03	CISNEROS	Cisneros
13:	31	13:	34	CISNEROS	Cisneros
14:	00	14.	04	BROWN	
14:	30	14:	36		
15:	00	15:	05	BROWN	
15:	30	15:	35		
16:	00	16:	08	BROWN	
16.	30	16:	38		
17:	00	17:	06	BROWN	
17:	35	17:	40		
18	03	18:	08	B. WATTS	B. Watts
18:	31	18:	36		
19.	03	19:	08	B WATTS	B. Watts
19.	33	19:	39		
20:	04	20:	09	B WATTS	B. Watts
20:	34	20:	38		
21:	04	21:	09	B. WATTS	B. Watts
21.	31	21:	36	B. WATTS	B. Watts
22:	03	22:	09	B. WATTS	B. Watts
22:	32	22:	37	S CORONA	S Corona
23:	04	23:	09	S CORONA	S Corona
23:	34	23:	39		

1ST WATCH REVIEW - SUPERVISOR SIGNATURE:

2ND WATCH REVIEW - SUPERVISOR SIGNATURE:

3RD WATCH REVIEW - SUPERVISOR SIGNATURE:

REV 8/23/2007

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 1/25/2013 PRISON: Sac UNIT/SECTION: B/4

CELL NUMBERS IN SECTION: A Sec, B Sec, C Sec

START TIME		END TIME		PRINTED STAFF NAME	STAFF SIGNATURE
00:	00	00:	02	Shepard	
00:	30	00:	32		
01:	00	01:	02	Shepard	
01:	30	01:	32		
02:	00	02:	02	Shepard	
02:	30	02:	32		
03:	00	03:	02	Shepard	
03:	30	03:	32		
04:	00	04:	02	Shepard	
04:	30	04:	32		
05:	00	05:	02	Shepard	
05:	30	05:	32		
06:	00	06:	02	Shepard	
06:	31	06:	33		
07:	00	07:	03	C Santos	
07:	32	07:	34	C Santos	
08:	01	08:	04	C Santos	
08:	30	08:	33	C Santos	
09:	02	09:	05	C Santos	
09:	31	09:	33	C Santos	
10:	00	10:	03	C Santos	
10:	31	10:	34	C Santos	
11:	02	11:	05	C Santos	
11:	30	11:	33	C Santos	

1ST WATCH REVIEW - SUPERVISOR SIGNATURE:

2ND WATCH REVIEW - SUPERVISOR SIGNATURE:

3RD WATCH REVIEW - SUPERVISOR SIGNATURE:

REV 8/23/2007

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 1/25/2013 PRISON: Sac UNIT/SECTION: B/4

CELL NUMBERS IN SECTION: B Sec

START TIME		END TIME		PRINTED STAFF NAME	STAFF SIGNATURE
00:	00	00:	02	Shepard	
00:	30	00:	32		
01:	00	01:	02	Shepard	
01:	30	01:	32		
02:	00	02:	02	Shepard	
02:	30	02:	32		
03	00	03:	02	Shepard	
03:	30	03:	32		
04:	00	04:	02	Shepard	
04:	30	04:	32		
05:	00	05:	02	Shepard	
05:	30	05:	32	Shepard	
06:	00	06:	02	Shepard	
06:		06:			
07:	05	07:	10	GOODRUM	
07:	40	07:	45	GOODRUM	
08	10	08:	15	GOODRUM	
08:	45	08:	50	GOODRUM	
09:	20	09:	25	GOODRUM	
09:	50	09:	55	GOODRUM	
10:	25	10:	30	GOODRUM	
10	55	10:	59	GOODRUM	
11:	27	11:	29	GOODRUM	
11:	56	11:	58	GOODRUM	

1ST WATCH REVIEW - SUPERVISOR SIGNATURE:

2ND WATCH REVIEW - SUPERVISOR SIGNATURE:

3RD WATCH REVIEW - SUPERVISOR SIGNATURE:

REV 8/23/2007

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 1/25/2013 PRISON: Sac UNIT/SECTION: B/4

CELL NUMBERS IN SECTION: C Sec

START TIME		END TIME		PRINTED STAFF NAME	STAFF SIGNATURE
00:	00	00:	02	Steward	
00:	30	00:	32		
01:	00	01:	02	Steward	
01:	30	01:	32		
02:	00	02:	02	Steward	
02:	30	02:	32		
03:	00	03:	02	Steward	
03:	30	03:	32		
04:	00	04:	02	Steward	
04:	30	04:	32		
05:	00	05:	02	Steward	
05:	30	05:	32		
06:	00	06:	02	Steward	
06:		06:			
07:	03	07:	06	Higgins	
07:	31	07:	35	Higgins	
08:	00	08:	04	Higgins	
08:	31	08:	35	Higgins	
09:	02	09:	05	Higgins	
09:	32	09:	39	Higgins	
10(0)	00	10	03	Higgins	
1033	33	10	38	Higgins	
11:	00	11:	04	Higgins	
11:	29	11:	34	Higgins	

1ST WATCH REVIEW - SUPERVISOR SIGNATURE:

2ND WATCH REVIEW - SUPERVISOR SIGNATURE:

3RD WATCH REVIEW - SUPERVISOR SIGNATURE:

REV 8/23/2007

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 1-Oct-13 PRISON: CSP-SAC UNIT/SECTION B-1

CELL NUMBERS IN SECTION: A B C

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
00: 00	00: 03	Hocker	
00: 30	00: 33		
01: 00	01: 03	Hocker	
01: 30	01: 33		
02: 00	02: 03	Hocker	
02: 30	02: 33		
03: 00	03: 03	Hocker	
03: 30	03: 33		
04: 00	04: 03	Hocker	
04: 30	04: 33		
05: 00	05: 03	Hocker	
05: 30	05: 33		
06: 00	06: 03	Hocker	
06: 30	06: 33		
07: 00	07: 04	Higgins	
07: 30	07: 34	Higgin	
08: 00	08: 05	Higgins	
08: 30	08: 35	Higgin	
09: 00	09: 06	Higgins	
09: 30	09: 36	Higgin	
10: 00	10: 07	Higgins	
10: 30	10: 37	Higgin	
11: 00	11: 08	Higgins	
11: 30	11: 38	Higgin	

1st Watch Review – Supervisor Signature:

2nd Watch Review – Supervisor Signature:

3rd Watch Review – Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 12-4-13 PRISON: CSP-Sac UNIT/SECTION: A

CELL NUMBERS IN SECTION: A

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
12: 00	12: 04	Higgins	
12: 30	12: 34	Higgins	
13: 00	13: 01	Higgins	
13: 30	13: 31	Higgins	
14: 00	14: 05	BROWN	
14: 30	14: 35		
15: 00	15: 05	BROWN	
15: 30	15: 35		
16: 00	16: 04	BROWN	
16: 30	16: 34		
17: 00	17: 05	BROWN	
17: 30	17: 35		
18: 00	18: 05	BROWN	
18: 30	18: 35		
19: 00	19: 06	BROWN	
19: 30	19: 30		
20: 00	20: 08	BROWN	
20: 30	20: 38		
21: 00	21: 06	BROWN	
21: 30	21: 34		
22: 00	22: 07	BROWN	
22: 30	22: 35	Stocker	
23: 00	23: 03	Stocker	
23: 30	23: 33		

1ST Watch Review – Supervisor Signature

2nd Watch Review – Supervisor Signature

3rd Watch Review – Supervisor Signature

Revised July 27, 2009

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 1-23-13 PRISON: CSP-Sac UNIT/SECTION: B4

CELL NUMBERS IN SECTION: 1 B 3

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
12: 00	12: 06	Higgin	
12: 30	12: 36	Higgin	
13: 00	13: 01	Higgin	
13: 30	13: 37	Higgin	
14: 00	14: 04	Higgin	
14: 30	14: 34	Higgin	
15: 00	15: 03	BROWN	
15: 30	15: 33		
16: 00	16: 03	BROWN	
16: 30	16: 32		
17: 00	17: 04	BROWN	
17: 30	17: 34		
18: 00	18: 05	BROWN	
18: 30	18: 35		
19: 00	19: 05	BROWN	
19: 30	19: 35		
20: 00	20: 06	BROWN	
20: 30	20: 36		
21: 00	21: 04	BROWN	
21: 30	21: 34		
22: 00	22: 05	BROWN	
22: 30	22: 33	Hocker	
23: 00	23: 03	Hocker	
23: 30	23: 33		

1ST Watch Review – Supervisor Signature

2nd Watch Review – Supervisor Signature

3rd Watch Review – Supervisor Signature

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 1-23-13 PRISON: CSP-Sac UNIT/SECTION: B 4

CELL NUMBERS IN SECTION: A B C

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
00: 00	00: 03	Stocker	
00: 33	00: 33		
01: 00	01: 03	Stocker	
01: 30	01: 33		
02: 00	02: 03	Stocker	
02: 30	02: 33		
03: 00	03: 03	Stocker	
03: 30	03: 33		
04: 00	04: 03	Stocker	
04: 30	04: 33		
05: 00	05: 03	Stocker	
05: 30	05: 33		
06: 00	06: 03	Stocker	
06: 30	06: 33		
07: 00	07: 01	Higgins	
07: 30	07: 31	Higgins	
08: 00	08: 02	Higgins	
08: 30	08: 32	Higgins	
09: 00	09: 03	Higgins	
09: 30	09: 33	Higgins	
10: 00	10: 04	Higgins	
10: 30	10: 34	Higgins	
11: 00	11: 05	Higgins	
11: 30	11: 35	Higgins	

1st Watch Review – Supervisor Signature:

2nd Watch Review – Supervisor Signature:

3rd Watch Review – Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 1-22-13 PRISON: CSP-SAC UNIT/SECTION: B 4

CELL NUMBERS IN SECTION: A B C

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
00: 00	00: 03	Hocker	
00: 30	00: 33		
01: 00	01: 03	Hocker	
01: 30	01: 33		
02: 00	02: 03	Hocker	
02: 30	02: 33		
03: 00	03: 03	Hocker	
03: 30	03: 33		
04: 00	04: 03	Hocker	
04: 30	04: 33		
05: 00	05: 03	Hocker	
05: 30	05: 33		
06: 00	06: 03	Hocker	
06: 30	06: 33		
07: 00	07: 01	Higgins	
07: 30	07: 31	Higgins	
08: 00	08: 02	Higgins	
08: 30	08: 32	Higgins	
09: 00	09: 33	Higgins	
09: 30	09: 33	Higgins	
10: 00	10: 04	Higgins	
10: 30	10: 34	Higgins	
11: 00	11: 05	Higgins	
11: 30	11: 35	Higgins	

1st Watch Review – Supervisor Signature:

2nd Watch Review – Supervisor Signature:

3rd Watch Review – Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 1.22.13 PRISON: CSP SAC UNIT/SECTION: B

CELL NUMBERS IN SECTION: A B C

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
12: 00	12: 06	Higgins	
12: 30	12: 36	Higgins	
13: 00	13: 07	Higgins	
13: 30	13: 37	Higgins	
14: 00	14: 07	Brown	
14: 30	14: 37		
15: 00	15: 07	Brown	
15: 30	15: 35		
16: 00	16: 07	Brown	
16: 30	16: 37		
17: 00	17: 07	Brown	
17: 30	17: 39		
18: 00	18: 07	Brown	
18: 30	18: 35		
19: 00	19: 06	Brown	
19: 30	19: 36		
20: 00	20: 04	Brown	
20: 30	20: 34		
21: 00	21: 03	Brown	
21: 30	21: 37		
22: 00	22: 04	Brown	
22: 30	22: 35	Hocker	
23: 00	23: 03	Hocker	
23: 30	23: 35		

1ST Watch Review – Supervisor Signature

2nd Watch Review – Supervisor Signature

3rd Watch Review – Supervisor Signature

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 1/21/13 PRISON: CSP-SAC UNIT/SECTION: B-4

CELL NUMBERS IN SECTION: A section

START TIME		END TIME		PRINTED STAFF NAME	STAFF SIGNATURE
00:	00	00:	05	McAnelly, J	
00:	30	00:	35	McAnelly, J	
01:	00	01:	05	McAnelly, J	
01:	30	01:	35	McAnelly, J	
02:	00	02:	05	McAnelly, J	
02:	30	02:	35	McAnelly, J	
03:	00	03:	05	McAnelly, J	
03:	30	03:	35	McAnelly, J	
04:	00	04:	05	McAnelly, J	
04:	30	04:	35	McAnelly, J	
05	00	05:	05	McAnelly, J	
05	30	05:	35	McAnelly, J	
06	00	06:	05	McAnelly, J	
06:	30	06:	33	D. VILLASENOR	
07:	00	07:	05	D. VILLASENOR	
07:	30	07:	35	D. VILLASENOR	
08:	00	08:	05	D. VILLASENOR	
08:	30	08:	35	D. VILLASENOR	
09:	00	09:	05	D. VILLASENOR	
09:	30	09:	35	D. VILLASENOR	
10:	00	10:	05	D. VILLASENOR	
10:	30	10:	33	D. VILLASENOR	
11:	00	11:	05	D. VILLASENOR	
11:	30	11:	33	D. VILLASENOR	

1ST WATCH REVIEW - SUPERVISOR SIGNATURE:

2ND WATCH REVIEW - SUPERVISOR SIGNATURE:

3RD WATCH REVIEW - SUPERVISOR SIGNATURE:

REV 8/23/2007

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 1/21/13 PRISON: CSP SAC UNIT/SECTION: B-4

CELL NUMBERS IN SECTION: A, B, C SECTIONS

START TIME		END TIME		PRINTED STAFF NAME	STAFF SIGNATURE
14	00	14	03	Callahan	
14	31	14	33		
15	03	15	06	Callahan	
15	31	15	35		
16	00	16	05	Callahan	
16	30	16	35		
17	01	17	06	Callahan	
17	30	17	35		
18	05	18	10	Callahan	
18	35	18	42		
19	06	19	10	Callahan	
19	31	19	36		
20	05	20	08	Callahan	
20	33	20	38		
21	00	21	04	Callahan	
21	30	21	34		
22	00	22	05	Callahan	
22	30	22	35		
23		23			
23		23			
00		00			
00		00			
01		01			
01		01			

1ST WATCH REVIEW - SUPERVISOR SIGNATURE:

2ND WATCH REVIEW - SUPERVISOR SIGNATURE:

3RD WATCH REVIEW - SUPERVISOR SIGNATURE:

REV 8/23/2007

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 1/21/13 PRISON: CSP-SAC UNIT/SECTION: B-4

CELL NUMBERS IN SECTION: B Section

START TIME		END TIME		PRINTED STAFF NAME	STAFF SIGNATURE
00:	00	00:	05	McAnelly, J	
00:	30	00:	35	McAnelly, J	
01:	00	01:	05	McAnelly, J	
01:	30	01:	35	McAnelly, J	
02:	00	02:	05	McAnelly, J	
02:	30	02:	35	McAnelly, J	
03:	00	03:	05	McAnelly, J	
03:	30	03:	35	McAnelly, J	
04:	00	04:	05	McAnelly, J	
04:	30	04:	35	McAnelly, J	
05:	00	05:	00	McAnelly, J	
05:	30	05:	35	McAnelly, J	
06:	00	06:	05	McAnelly, J	
06:	30	06:	35		
07:	60	07:	05	Teller	
07:	31	07:	36	Teller	
08:	01	08:	06	Teller	
08:	32	08:	37	Teller	
09:	00	09:	05	Teller	
09:	30	09:	35	Teller	
10:	60	10:	05	Teller	
10:	30	10:	35	Teller	
11:	01	11:	06	Teller	
11:	32	11:	38	Teller	

1ST WATCH REVIEW - SUPERVISOR SIGNATURE:	
2ND WATCH REVIEW - SUPERVISOR SIGNATURE:	
3RD WATCH REVIEW - SUPERVISOR SIGNATURE:	

REV 8/23/2007

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 1/21/13 PRISON: CSP-SAC UNIT/SECTION: B-4

CELL NUMBERS IN SECTION: C Section

START TIME		END TIME		PRINTED STAFF NAME	STAFF SIGNATURE
00:	00	00:	05	McAnelly J	
00:	30	00:	35	McAnelly J	
01:	00	01:	05	McAnelly J	
01:	30	01:	35	McAnelly J	
02:	00	02:	05	McAnelly, J	
02:	30	02:	35	McAnelly, J	
03:	00	03.	05	McAnelly, J	
03:	30	03:	35	McAnelly, J	
04:	00	04:	05	McAnelly, J	
04:	30	04:	35	McAnelly, J	
05:	00	05:	05	McAnelly, J	
05	30	05.	35	McAnelly, J	
06:	00	06:	05	McAnelly, J	
06:		06:			
07:	03	07:	05	GOODRICH	
07:	35	07:	38	GOODRICH	
08:	15	08:	18	Goodrich	
08:	32	08:	35	Goodrich	
09:	09	09:	13	GOODRICH	
09:	39	09:	43	GOODRICH	
10:	10	10:	13	GOODRICH	
10:	46	10.	49	GOODRICH	
11:	14	11:	17	GOODRICH	
11:	49	11:	52	GOODRICH	

ST WATCH REVIEW - SUPERVISOR SIGNATURE:	
2ND WATCH REVIEW - SUPERVISOR SIGNATURE:	
3RD WATCH REVIEW - SUPERVISOR SIGNATURE:	

REV 8/23/2007

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: JAN 2 0 2013 PRISON: ~~RJ~~ SAC UNIT/SECTION: B4

CELL NUMBERS IN SECTION:

START TIME		END TIME		PRINTED STAFF NAME	STAFF SIGNATURE
00:	02	00:	07	Stauer	
00:	31	00:	36	Stauer	
01:	00	01:	07	Stauer	
01:	33	01:	38	Stauer	
02:	01	02:	06	Stauer	
02:	34	02:	39	Stauer	
03:	00	03:	06	Stauer	
03:	31	03:	37	Stauer	
04:	02	04:	07	Stauer	
04:	33	04:	39	Stauer	
05:	60	05:	06	Stauer	
05:	31	05:	37	Stauer	
06:	00	06:	06	Jochim	
06	30	06:	37	Jochim	
07:	00	07:	07	Jochim	
07:	30	07:	38	Jochim	
08:	00	08:	06	Jochim	
08.	30	08:	36	Jochim	
09:	00	09:	09	Jochim	
09:	30	09:	38	Jochim	
10:	00	10:	07	Jochim	
10:	30	10:	36	Jochim	
11:	00	11:	09	Jochim	
11:	30	11:	36	Jochim	

1ST WATCH REVIEW - SUPERVISOR SIGNATURE:	
2ND WATCH REVIEW - SUPERVISOR SIGNATURE:	
3RD WATCH REVIEW - SUPERVISOR SIGNATURE:	

REV 8/23/2007

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE JAN 2 0 2013 PRISON: SAC UNIT/SECTION: B4

CELL NUMBERS IN SECTION:

START TIME		END TIME		PRINTED STAFF NAME	STAFF SIGNATURE
12:	00	12:	05	Jochow	
12:	30	12:	35	Toole	
13:	00	13:	05	Jochow	
13:	30	13:	35	Toole	
14:	00	14:	05	B. WATTS	B. Watts
14:	30	14:	35		
15:	00	15:	05	B. WATTS	B. Watts
15:	30	15:	35		
16:	00	16:	05	B. WATTS	B. Watts
16:	30	16:	35		
17:	00	17:	05	B. WATTS	B. Watts
17:	30	17:	35		
18:	00	18:	05	B. WATTS	B. Watts
18:	30	18:	35		
19:	00	19:	05	B. WATTS	B. Watts
19:	30	19:	35		
20:	00	20:	05	B. WATTS	B. Watts
20:	30	20:	35		
21:	00	21:	05	B. WATTS	B. Watts
21:	30	21:	35		
22:	00	22:	05	B. Watts	
22:	30	22:	35		
23:	01	23:	07		
23:	33	23:	38		

1ST WATCH REVIEW - SUPERVISOR SIGNATURE:	
2ND WATCH REVIEW - SUPERVISOR SIGNATURE:	
3RD WATCH REVIEW - SUPERVISOR SIGNATURE:	

\GE 2

REV 8/23/2007

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE JAN 19 2013 PRISON: SAC UNIT/SECTION: B4

CELL NUMBERS IN SECTION:

START TIME		END TIME		PRINTED STAFF NAME.	STAFF SIGNATURE
00:	02	00:	07		
00:	31	00:	36		
01:	00	01:	05		
01:	33	01:	38		
02:	01	02:	06		
02:	34	02:	39		
03:	00	03:	06		
03:	32	03:	37		
04:	01	04:	06		
04:	30	04:	35		
05:	00	05:	07		
05:	31	05:	36		
06:	00	06:	04		
06:	30	06:	39		
07:	00	07:	05		
07:	30	07:	38		
08:	00	08:	06		
08:	30	08:	34		
09:	00	09:	05		
09:	30	09:	39		
10:	00	10:	04		
10:	30	10:	34		
11:	00	11:	04		
11:	30	11:	34		

1ST WATCH REVIEW - SUPERVISOR SIGNATURE:	
2ND WATCH REVIEW - SUPERVISOR SIGNATURE:	
3RD WATCH REVIEW - SUPERVISOR SIGNATURE:	

F 1

REV 8/23/2007

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE JAN 19 2013 PRISON: Sac UNIT/SECTION: B4

CELL NUMBERS IN SECTION:

START TIME		END TIME		PRINTED STAFF NAME	STAFF SIGNATURE
12:	00	12:	05	Locke	
12:	30	12:	34	Locke	
13:	00	13:	07	Locke	
13:	30	13:	34	Locke	
14:	00	14:	05	B. WATTS	BLW
14.	30	14:	35		
15:	00	15:	05	B. WATTS	BLW
15:	30	15:	35		
16:	00	16:	05	B. WATTS	BLW
16:	30	16:	35		
17:	00	17:	05	B. WATTS	BLW
17.	30	17.	35		
18:	00	18:	05	B. WATTS	BLW
18	30	18:	35		
19:	00	19:	05	B. WATTS	BLW
19:	30	19:	35		
20:	00	20:	05	B. WATTS	BLW
20:	30	20:	35		
21:	00	21:	05	B. WATTS	BLW
21:	30	21:	35		
22:	00	22:	05	B. WATTS	BLW
22:	31	22:	36	Stuart	
23:	00	23:	07	Stuart	
23:	33	23:	38	Stuart	

1ST WATCH REVIEW - SUPERVISOR SIGNATURE:

2ND WATCH REVIEW - SUPERVISOR SIGNATURE:

3RD WATCH REVIEW - SUPERVISOR SIGNATURE:

REV 8/23/2007

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 11/18/12 PRISON: CSP-SAC UNIT/SECTION: B4

CELL NUMBERS IN SECTION:

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
00: 03	00: 08	K Quast	
00: 31	00: 36	K Quast	
01: 00	01: 05	K Quast	
01: 30	01: 35	K Quast	
02: 00	02: 05	K Quast	
02: 35	02: 40	K Quast	
03: 10	03: 15	K Quast	
03: 40	03: 45	K Quast	
04: 05	04: 10	K Quast	
04: 35	04: 40	K Quast	
05: 00	05: 05	K Quast	
05: 29	05: 34	K Quast	
06: 00	06: 05	K Voe	
06: 30	06: 30	Lochin	
07: 00	07: 07	Lochin	
07: 30	07: 38	Lochin	
08: 00	08: 06	Lochin	
08: 30	08: 38	Lochin	
09: 00	09: 09	Lochin	
09: 30	09: 35	Lochin	
10: 00	10: 04	Lochin	
10: 30	10: 34	Lochin	
11: 00	11: 08	Lochin	
11: 30	11: 35	Lochin	

1ST Watch Review – Supervisor Signature

2nd Watch Review – Supervisor Signature

PAGE 1 Revised July 27, 2009

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 7/18/13 PRISON: CSP-SAC UNIT/SECTION: B4

CELL NUMBERS IN SECTION:

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
12: 00	12: 05	Tocha	
12: 30	12: 35	Tocha	
13: 00	13: 05	Tocha	
13: 30	13: 35	Tocha	
14: 00	14: 05	B. WATTS	B. Watts
14: 30	14: 35		
15: 00	15: 05	B. WATTS	B. Watts
15: 30	15: 35		
16: 00	16: 05	B. WATTS	B. Watts
16: 30	16: 35		
17: 00	17: 05	B. WATTS	B. Watts
17: 30	17: 35		
18: 00	18: 05	B. WATTS	B. Watts
18: 30	18: 35		
19: 00	19: 05	B. WATTS	B. Watts
19: 30	19: 35		
20: 00	20: 05	B. WATTS	B. Watts
20: 30	20: 35		
21: 00	21: 05	B. WATTS	B. Watts
21: 30	21: 35		
22: 00	22: 05	K. Quash	
22: 30	22: 35		
23: 02	23: 07	K. Quash	
23: 32	23: 37	K. Quash	

1ST Watch Review – Supervisor Signature

2nd Watch Review – Supervisor Signature

3rd Watch Review – Supervisor Signature

Revised July 27, 2009

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 1-17-13 PRISON: CSP-SAC UNIT/SECTION B 4

CELL NUMBERS IN SECTION: A B C

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
00: 00	00: 03	Hocker	
00: 30	00: 33		
01: 00	01: 03	Hocker	
01: 30	01: 33		
02: 00	02: 03	Hocker	
02: 30	02: 33		
03: 00	03: 03	Hocker	
03: 30	03: 33		
04: 00	04: 03	Hocker	
04: 30	04: 33		
05: 00	05: 03	Hocker	
05: 30	05: 33		
06: 00	06: 03	Hocker	
06: 30	06: 33		
07: 01	07: 03	CISNEROS	
07: 30	07: 33	CISNEROS	
08: 00	08: 03	CISNEROS	
08: 30	08: 33	D. VILLASENOR	
09: 00	09: 04	D. VILLASENOR	
09: 30	09: 33	D. VILLASENOR	
10: 00	10: 03	D. VILLASENOR	
10: 30	10: 31	D. VILLASENOR	
11: 00	11: 03	D. VILLASENOR	
11: 30	11: 33	D. VILLASENOR	

1st Watch Review – Supervisor Signature:

2nd Watch Review – Supervisor Signature:

3rd Watch Review – Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 1.17.13 PRISON: SP-SAC UNIT/SECTION: B 4

CELL NUMBERS IN SECTION: A B C

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
12:00	12:03	D. VILLASENOR	
12:30	12:33	D. VILLASENOR	
13:00	13:03	D. VILLASENOR	
13:30	13:33	D. VILLASENOR	
14:00	14:06	Caldwell	
14:30	14:34		
15:01	15:05		
15:32	15:36		
16:00	16:04		
16:33	16:37		
17:04	17:08		
17:30	17:36		
18:00	18:06		
18:30	18:35		
19:01	19:05	Brown	
19:32	19:35		
20:03	20:05	Brown	
20:34	20:35		
21:00	21:	Brown	
21:30	21:		
22:01	22:		
22:30	22:	Stocker	
23:00	23:03	Stocker	
23:30	23:33		

1ST Watch Review – Supervisor Signature

2nd Watch Review – Supervisor Signature

3rd Watch Review – Supervisor Signature

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 1-16-13 PRISON CSP-Sac UNIT/SECTION B4 454

CELL NUMBERS IN SECTION:

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
00: 00	00: 03	Hocker	
00: 30	00: 33		
01: 00	01: 03	Hocker	
01: 30	01: 33		
02: 00	02: 03	Hocker	
02: 30	02: 33		
03: 00	03: 03	Hocker	
03: 30	03: 33		
04: 00	04: 03	Hocker	
04: 30	04: 33		
05: 00	05: 03	Hocker	
05: 30	05: 33		
06: 00	06: 03	Hocker	
06: 30	06: 33		
07: 00	07: 04	Tochin	
07: 30	07: 35	Tochin	
08: 00	08: 07	Tochin	
08: 30	08: 38	Tochin	
09: 00	09: 07	Tochin	
09: 30	09: 38	Tochin	
10: 00	10: 04	Tochin	
10: 30	10: 34	Tochin	
11: 00	11: 07	Tochin	
11: 30	11: 38	Tochin	

1st Watch Review – Supervisor Signature:

2nd Watch Review – Supervisor Signature:

3rd Watch Review – Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 1-16-13 PRISON: CSP-Sac UNIT/SECTION: B-4 ASU

CELL NUMBERS IN SECTION:

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
12:00	12:04	Tochin	
12:30	12:34	Tochin	
13:00	13:04	Tochin	
13:30	13:34	Tochin	
14:00	14:05		
14:30	14:35		
15:00	15:05	T. Brown	
15:30	15:35	T. Brown	
16:00	16:05	T. Brown	
16:30	16:35	T. Brown	
17:00	17:05	T. Brown	
17:30	17:35	T. Brown	
18:00	18:05	T. Brown	
18:30	18:34	T. Brown	
19:00	19:05	T. Brown	
19:30	19:35	T. Brown	
20:	20:		
20:	20:		
21:	21:		
21:	21:		
22:	22:		
22:30	22:33	Stocker	
23:00	23:03	Stocker	
23:30	23:33		

1ST Watch Review – Supervisor Signature

2nd Watch Review – Supervisor Signature

3rd Watch Review – Supervisor Signature

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 1013 PRISON: CSP Sac UNIT/SECTION: B 4 ASU

CELL NUMBERS IN SECTION: A B C

START TIME		END TIME		PRINTED STAFF NAME	STAFF SIGNATURE
12:	00	12:	01	[illegible]	[signature]
12:	30	12:	31	[illegible]	[signature]
13:	00	13:	02	[illegible]	[signature]
13:	30	13:	32	[illegible]	[signature]
14:	00	14:	03	[illegible]	[signature]
14:	30	14:	33	[illegible]	[signature]
15:	00	15:	04	[illegible] Brown	[signature]
15:	30	15:	34	[illegible] Brown	[signature]
16:	00	16:	04	[illegible] Brown	[signature]
16:	30	16:	34	[illegible]	[signature]
17:	00	17:	05	Slaughter	[signature]
17:	30	17:	35	Slaughter	[signature]
18:	00	18:	04	[illegible]	[signature]
18:	30	18:	34	[illegible]	[signature]
19:	00	19:	04	T Brown	[signature]
19:	30	19:	34	T Brown	[signature]
20:	00	20:	04	T Brown	[signature]
20:	30	20:	34	T Brown	[signature]
21:	00	21:	05	T Brown	[signature]
21:	30	21:	35	T Brown	[signature]
22:	00	22:	30	T Brown	[signature]
22:	30	22:	33	Stocker	[signature]
23:	00	23:	03	Stocker	[signature]
23:	30	23:	33	[illegible]	[signature]

1ST WATCH REVIEW - SUPERVISOR SIGNATURE:	[signature]
2ND WATCH REVIEW - SUPERVISOR SIGNATURE:	
3RD WATCH REVIEW - SUPERVISOR SIGNATURE:	

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 11-13-13 PRISON: SP-SAC UNIT/SECTION: B4 ASU

CELL NUMBERS IN SECTION: A B C

START TIME		END TIME		PRINTED STAFF NAME	STAFF SIGNATURE
00:	00	00:	03	Stocker	
00:	30	00:	33		
01:	00	01:	03	Stocker	
01:	30	01:	33		
02:	00	02:	03	Stocker	
02:	30	02:	33		
03:	00	03:	03	Stocker	
03:	30	03:	33		
04:	00	04:	03	Stocker	
04:	30	04:	33		
05:	00	05:	03	Stocker	
05:	30	05:	33		
06:	00	06:	03	Stocker	
06:	30	06:	33		
07:	00	07:	01	~~Higgins~~ Higgins	
07:	30	07:	31	~~Higgin~~ Higgin	
08:	00	08:	02	Higgins	
08:	30	08:	32	Higgin	
09:	00	09:	03	Higgin	
09:	30	09:	33	Higgin	
10:	00	10:	04	Higgin	
10:	30	10:	34	Higgin	
11:	00	11:	05	Higgins	
11:	30	11:	35	Higgin	

1ST WATCH REVIEW - SUPERVISOR SIGNATURE:	
2ND WATCH REVIEW - SUPERVISOR SIGNATURE:	
3RD WATCH REVIEW - SUPERVISOR SIGNATURE:	

REV 8/23/2007

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 4-13 PRISON: CSP Sac UNIT/SECTION: B-4 ASU

CELL NUMBERS IN SECTION: A B C

START TIME		END TIME		PRINTED STAFF NAME	STAFF SIGNATURE
00:	01	00:	03	Locker	
00:	30	00:	33		
01:	00	01:	03	Locker	
01:	30	01:	33		
02:	00	02:	03	Locker	
02:	30	02:	33		
03:	00	03:	03	Locker	
03:	30	03:	33		
04:	00	04:	03	Locker	
04:	30	04:	33		
05:	00	05:	03	Locker	
05:	30	05:	33		
06:	00	06:	03	Locker	
06:	30	06:	33		
07:	00	07:	03	D. Villasenor	
07:	30	07:	33	D. Villasenor	
08:	00	08:	03	D. Villasenor	
08:	30	08:	33	D. Villasenor	
09:	00	09:	03	D. Villasenor	
09:	30	09:	33	D. Villasenor	
10:	01	10:	04	C. Serros	
10:	30	10:	33	C. Serros	
11:	00	11:	03	C. Serros	
11:	31	11:	34	C. Serros	

1ST WATCH REVIEW - SUPERVISOR SIGNATURE:

2ND WATCH REVIEW - SUPERVISOR SIGNATURE:

3RD WATCH REVIEW - SUPERVISOR SIGNATURE:

REV 8/23/2007

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 1-4-13 PRISON: CSP-SAC UNIT/SECTION: B-4 ASU

CELL NUMBERS IN SECTION: A B C

START TIME		END TIME		PRINTED STAFF NAME	STAFF SIGNATURE
12:	00	12:	03	C. SANCHOS	
12:	31	12:	34	C. SANCHOS	
13:	07	13:	04	C. SANCHOS	
13:	31	13:	34	C. SANCHOS	
14:	00	14:	05	B. WATTS	BW
14:	35	14:	35		
15:	00	15:	05	B. WATTS	BW
15:	30	15:	35		
16:	00	16:	05	B. WATTS	BW
16:	30	16:	35		
17:	00	17:	05	B. WATTS	BW
17:	30	17:	35		
18:	00	18:	05	B. WATTS	BW
18:	30	18:	35		
19:	00	19:	05	B. WATTS	BW
19:	30	19:	35		
20:	00	20:	05	B. WATTS	BW
20:	30	20:	35		
21:	00	21:	05	B. WATTS	B. Watts
21:	30	21:	35		
22:		22:		B. WATTS	B. Watts
22:	30	22:	33	HOCKETT	
23:	00	23:	03	HOCKETT	
23:	30	23:	33		

1ST WATCH REVIEW - SUPERVISOR SIGNATURE:	
2ND WATCH REVIEW - SUPERVISOR SIGNATURE:	
3RD WATCH REVIEW - SUPERVISOR SIGNATURE:	

REV 8/23/2007

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: JAN 1 3 2012 PRISON: SAC UNIT/SECTION: B4

CELL NUMBERS IN SECTION:

START TIME		END TIME		PRINTED STAFF NAME	STAFF SIGNATURE
00:	02	00:	07	STAMUZA	
00:	31	00:	36	STAMUZA	
01:	00	01:	06	STAMUZA	
01:	33	01:	39	STAMUZA	
02:	02	02:	07	STAMUZA	
02:	31	02:	36	STAMUZA	
03:	00	03:	07	STAMUZA	
03:	32	03:	38	STAMUZA	
04:	03	04:	08	STAMUZA	
04:	31	04:	36	STAMUZA	
05:	00	05:	06	STAMUZA	
05:	32	05:	37	STAMUZA	
06:	00	06:	07	Tocher	
06:	30	06:	36	Tocher	
07:	00	07:	07	Tocher	
07:	30	07:	35	Tocher	
08:	00	08:	04	Tocher	
08:	30	08:	28	Tocher	
09:	00	09:	06	Tocher	
09:	30	09:	35	Tocher	
10:	00	10:	05	Tocher	
10:	30	10:	34	Tocher	
11:	00	11:	04	Tocher	
11:	30	11:	35	Tocher	

1ST WATCH REVIEW - SUPERVISOR SIGNATURE:	
2ND WATCH REVIEW - SUPERVISOR SIGNATURE:	
3RD WATCH REVIEW - SUPERVISOR SIGNATURE:	

REV 8/23/2007

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: JAN 13 2013 PRISON: SAC UNIT/SECTION: B4

CELL NUMBERS IN SECTION:

START TIME		END TIME		PRINTED STAFF NAME	STAFF SIGNATURE
12:	00	12:	05	Sachs	
12:	30	12:	34	Sachs	
13:	00	13:	04	Sachs	
13:	30	13:	34	Sachs	
14:	00	14:	04	Calderon	
14:	30	14:	34		
15:	00	15:	06		
15:	30	15:	35		
16:	00	16:	05		
16:	30	16:	37		
17:	00	17:	06		
17:	30	17:	35		
18:	00	18:	05	B. WATTS	SW
18:	30	18:	35		
19:	00	19:	05	B. WATTS	SW
19:	30	19:	35		
20:	00	20:	05	B. WATTS	SW
20:	30	20:	35		
21:	00	21:	05	B. Watts	S.W
21:	30	21:	35		
22:	00	22:	05	B. WATT	SW
22:	31	22:	36	Shuler	
23:	00	23:	07	Shuler	
23:	33	23:	38	Shuler	

1ST WATCH REVIEW - SUPERVISOR SIGNATURE:	
2ND WATCH REVIEW - SUPERVISOR SIGNATURE:	C. Jungo
3RD WATCH REVIEW - SUPERVISOR SIGNATURE:	

REV 8/23/2007

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 1/12/13 PRISON: SAC UNIT/SECTION: B4

CELL NUMBERS IN SECTION:

START TIME		END TIME		PRINTED STAFF NAME	STAFF SIGNATURE
00:	00	00:	07	Stuwe	
00:	31	00:	36	Stuwe	
01:	00	01:	05	Stuwe	
01:	33	01:	38	Stuwe	
02:	01	02:	06	Stuwe	
02:	34	02:	39	Stuwe	
03:	01	03:	07	Stuwe	
03:	33	03:	39	Stuwe	
04:	02	04:	06	Stuwe	
04:	30	04:	35	Stuwe	
05:	00	05:	04	Stuwe	
05:	32	05:	37	Stuwe	
06:	00	06:	06	Jochim	
06:	30	06:	29	Jochim	
07:	00	07:	07	Jochim	
07:	30	07:	36	Jochim	
08:	00	08:	06	Jochim	
08:	30	08:	35	Jochim	
09:	00	09:	06	Jochim	
09:	30	09:	36	Jochim	
10:	00	10:	06	Joch	
10:	30	10:	35	Joch	
11:	00	11:	05	Joch	
11:	30	11:	36	Joch	

1ST WATCH REVIEW - SUPERVISOR SIGNATURE:	
2ND WATCH REVIEW - SUPERVISOR SIGNATURE:	
3RD WATCH REVIEW - SUPERVISOR SIGNATURE:	

REV 8/23/2007

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 1/12/13 PRISON: SAC UNIT/SECTION: 3A

CELL NUMBERS IN SECTION:

START TIME		END TIME		PRINTED STAFF NAME	STAFF SIGNATURE
12:	00	12:	05	Tech	
12:	30	12:	35	Tech	
13:	00	13:	05	Tech	
13:	30	13:	35	Tech	
14:	00	14:	05	B. WATTS	B. Watts
14:	30	14:	35		
15:	00	15:	05	B. WATTS	B. Watts
15:	30	15:	35		
16:	00	16:	05	B. WATTS	B. Watts
16:	30	16:	35		
17:	00	17:	05	B. WATTS	B. WATTS
17:	30	17:	35		
18:	00	18:	05	B. WATTS	B. Watts
18:	30	18:	35		
19:	00	19:	05	B WATTS	B. Watts
19:	30	19:	35		
20:	00	20:	05	B. WATTS	B. Watts
20:	30	20:	35		
21:	00	21:	05	B. WATTS	B. Watts
21:	30	21:	35		
22:	00	22:	05	B. WATTS	B. Watts
22:	31	22:	36	Stuller	
23:	00	23:	07	Stuller	
23:	33	23:	38	Stuller	

1ST WATCH REVIEW - SUPERVISOR SIGNATURE:	
2ND WATCH REVIEW - SUPERVISOR SIGNATURE:	
3RD WATCH REVIEW - SUPERVISOR SIGNATURE:	

REV 8/23/2007

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 11-13 PRISON: CSP-SAC UNIT/SECTION: D4 ASU

CELL NUMBERS IN SECTION: A B C

START TIME		END TIME		PRINTED STAFF NAME	STAFF SIGNATURE
12:	00	12:	04	Coahran	
12:	30	12:	34	Coahran	
13:	00	13:	04	Coahran	
13:	30	13:	33	Coahran	
14:	00	14:	04		
14:	30	14:	34		
15:	00	15:	04		
15:	30	15:	34		
16:	00	16:	04		
16:	30	16:	34		
17:	00	17:	05		
17:	30	17:	35		
18:	00	18:	05		
18:	30	18:	35		
19:	00	19:	05		
19:	30	19:	35		
20:		20:			
20:		20:			
21:		21:			
21:		21:			
22:		22:			
22:	30	22:	33	Stocker	
23:	00	23:	03	Stocker	
23:	30	23:	33		

1ST WATCH REVIEW - SUPERVISOR SIGNATURE:	
2ND WATCH REVIEW - SUPERVISOR SIGNATURE:	
3RD WATCH REVIEW - SUPERVISOR SIGNATURE:	

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 1-11-13 PRISON: CSP-SAC UNIT/SECTION: B4 ASU

CELL NUMBERS IN SECTION: A B C

START TIME		END TIME		PRINTED STAFF NAME	STAFF SIGNATURE
00:	00	00:	03	Stocker	
00:	30	00:	33		
01:	00	01:	03	Stocker	
01:	30	01:	33		
02:	00	02:	03	Stocker	
02:	30	02:	33		
03:	00	03:	03	Stocker	
03:	30	03:	33		
04:	00	04:	03	Stocker	
04:	30	04:	33		
05:	00	05:	03	Stocker	
05:	30	05:	33		
06:	00	06:	03	Stocker	
06:	30	06:	33		
07:	00	07:	04	Jochim	
07:	30	07:	34	Jochim	
08:	00	08:	02	Jochim	
08:	30	08:	34	Jochim	
09:	00	09:	04	Jochim	
09:	30	09:	37	Jochim	
10:	00	10:	04	Jochim	
10:	30	10:	39	Jochim	
11:	00	11:	04	Jochim	
11:	30	11:	04	Jochim	

1ST WATCH REVIEW - SUPERVISOR SIGNATURE:	
2ND WATCH REVIEW - SUPERVISOR SIGNATURE:	C. Jungo
3RD WATCH REVIEW - SUPERVISOR SIGNATURE:	

REV 8/23/2007

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 1-10-13 PRISON: CSP-Sac UNIT/SECTION: B-4 ASU

CELL NUMBERS IN SECTION: A 3 C

START TIME		END TIME		PRINTED STAFF NAME	STAFF SIGNATURE
00:	00	00:	03	Stocker	
00:	30	00:	33		
01:	00	01:	03	Stocker	
01:	30	01:	33		
02:	00	02:	03	Stocker	
02:	30	02:	33		
03:	00	03:	03	Stocker	
03:	30	03:	33		
04:	00	04:	03	Stocker	
04:	30	04:	33		
05:	00	05:	03	Stocker	
05:	30	05:	33		
06:	00	06:	03	Stocker	
06:	30	06:	33		
07:	00	07:	04	Sochin	
07:	30	07:	34	Sochin	
08:	00	08:	04	Sochin	
08:	30	08:	34	Sochin	
09:	00	09:	04	Sochin	
09:	30	09:	34	Sochin	
10:	00	10:	04	Sochin	
10:	30	10:	34	Sochin	
11:	00	11:	05	Sochin	
11:	30	11:	00	Sochin	

1ST WATCH REVIEW - SUPERVISOR SIGNATURE:	
2ND WATCH REVIEW - SUPERVISOR SIGNATURE:	
3RD WATCH REVIEW - SUPERVISOR SIGNATURE:	

REV 8/23/2007

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 1·10·13 PRISON: CSP-SAC UNIT/SECTION: B4 ASU

CELL NUMBERS IN SECTION: A B C

START TIME		END TIME		PRINTED STAFF NAME	STAFF SIGNATURE
12:	00	12:	06	Stocker	
12:	30	12:	37	Stocker	
13:	00	13:	05	Stocker	
13:	30	13:	34	Stocker	
14:	00	14:	05	BROWN	
14:	30	14:	35		
15:	00	15:	05	BROWN	
15:	30	15:	35		
16:	00	16:	05	BROWN	
16:	30	16:	35		
17:	00	17:	05	BROWN	
17:	30	17:	35		
18:	00	18:	05	BROWN	
18:	30	18:	35		
19:	00	19:	05	BROWN	
19:	30	19:	35		
20:	00	20:	04	Slaughter	
20:	30	20:	35		
21:	00	21:	05	Slaughter	
21:	30	21:	35		
22:	00	22:	04	Slaughter	
22:	30	22:	33	Stocker	
23:	00	23:	03	Stocker	
23:	30	23:	33		

1ST WATCH REVIEW - SUPERVISOR SIGNATURE:	
2ND WATCH REVIEW - SUPERVISOR SIGNATURE:	
3RD WATCH REVIEW - SUPERVISOR SIGNATURE:	

REV 8/23/2007

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 1-9-13 PRISON: CSP SAC UNIT/SECTION: B4 ASU

CELL NUMBERS IN SECTION: A B C

START TIME		END TIME		PRINTED STAFF NAME	STAFF SIGNATURE
00:	00	00:	03	Stocker	
00:	30	00:	33		
01:	00	01:	03	Stocker	
01:	30	01:	33		
02:	00	02:	03	Stocker	
02:	30	02:	33		
03:	00	03:	03	Stocker	
03:	30	03:	33		
04:	00	04:	03	Stocker	
04:	30	04:	33		
05:	00	05:	03	Stocker	
05:	30	05:	33		
06:	00	06:	03	Stocker	
06:	30	06:	33		
07:	00	07:	04	Tochin	
07:	30	07:	34	Tochin	
08:	00	08:	04	Tochin	
08:	30	08:	34	Tochin	
09:	00	09:	04	Tochin	
09:	30	09:	34	Tochin	
10:	00	10:	04	Tochin	
10:	30	10:	34	Tochin	
11:	00	11:	04	Tochin	
11:	30	11:	34	Tochin	

1ST WATCH REVIEW - SUPERVISOR SIGNATURE:	
2ND WATCH REVIEW - SUPERVISOR SIGNATURE:	
3RD WATCH REVIEW - SUPERVISOR SIGNATURE:	

REV 8/23/2007

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 1.9.13 PRISON: SP-SAC UNIT/SECTION: 1B4 A&4

CELL NUMBERS IN SECTION: A - B C

START TIME		END TIME		PRINTED STAFF NAME	STAFF SIGNATURE
12:		12:			
12:		12:			
13:		13:			
13:		13:			
14:	00	14:	05	Slaughter	
14:	30	14:	36	Slaughter	
15:	00	15:	04	Slaughter	
15:	30	15:	35		
16:	00	16:	05	Slaughter	
16:	30	16:	35		
17:	00	17:	04	Slaughter	
17:	30	17:	34		
18:	00	18:	06	Slaughter	
18:	30	18:	35		
19:	00	19:	04	Slaughter	
19:	30	19:	35		
20:	00	20:	03	Slaughter	
20:	30	20:	34		
21:	00	21:	05	Slaughter	
21:	30	21:	34		
22:	00	22:	04	Slaughter	
22:	30	22:	33	Stocks	
23:	00	23:	03	Stocks	
23:	30	23:	33		

1ST WATCH REVIEW - SUPERVISOR SIGNATURE:	
2ND WATCH REVIEW - SUPERVISOR SIGNATURE:	
3RD WATCH REVIEW - SUPERVISOR SIGNATURE:	

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 1.8.13 PRISON: CSPSAC UNIT/SECTION: B-4

CELL NUMBERS IN SECTION:

START TIME		END TIME		PRINTED STAFF NAME	STAFF SIGNATURE
00:	00	00:	03	Stocker	
00:	30	00:	33		
01:	00	01:	03	Stocker	
01:	30	01:	33		
02:	00	02:	03	Stocker	
02:	30	02:	33		
03:	00	03:	03	Stocker	
03:	30	03:	33		
04:	00	04:	03	Stocker	
04:	30	04:	33		
05:	00	05:	03	Stocker	
05:	30	05:	33		
06:	00	06:	03	Stocker	
06:	30	06:	32		
07:		07:			
07:		07:			
08:		08:			
08:		08:			
09:		09:			
09:		09:			
10:		10:			
10:		10:			
11:		11:			
11:		11:			

1ST WATCH REVIEW - SUPERVISOR SIGNATURE:	
2ND WATCH REVIEW - SUPERVISOR SIGNATURE:	
3RD WATCH REVIEW - SUPERVISOR SIGNATURE:	

REV 8/23/2007

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 8-13 PRISON: CSP SAC UNIT/SECTION: B4 A54

CELL NUMBERS IN SECTION:

START TIME		END TIME		PRINTED STAFF NAME	STAFF SIGNATURE
12:		12:			
12:		12:			
13:		13:			
13:		13:			
14:	00	14:	04	[illegible]	[illegible]
14:	30	14:	34		
15:	00	15:	04	[illegible]	[illegible]
15:	30	15:	35		
16:	00	16:	01	[illegible]	[illegible]
16:	30	16:	34		
17:	00	17:	07	[illegible]	[illegible]
17:	30	17:	36		
18:	00	18:	03	[illegible]	[illegible]
18:	30	18:	37		
19:	00	19:	04	[illegible]	[illegible]
19:	30	19:	34		
20:	00	20:	04	[illegible]	[illegible]
20:	30	20:	34		
21:	00	21:	04	[illegible]	[illegible]
21:	30	21:	34		
22:	00	22:	05		
22:	30	22:	33	Stocker	[illegible]
23:	00	23:	03	Stocker	[illegible]
23:	30	23:	33		

1ST WATCH REVIEW - SUPERVISOR SIGNATURE:	[illegible]
2ND WATCH REVIEW - SUPERVISOR SIGNATURE:	
3RD WATCH REVIEW - SUPERVISOR SIGNATURE:	

REV 8/23/2007

Exhibit 56

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET — 1ST Watch

DATE: 2-1-13 PRISON: CSP LAC UNIT / SECTION: A - B - C

"A" SECTION	"B" SECTION	"C" SECTION
115, 206, 214, 111, 111	125, 126, 127, 224, 234	142, 145, 146, 149, 204
	220, 121	232, 242, 132, 143, 250
		235, 236, 140

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22: 00	22: 05	J. Martin	
22: 30	22: 35	J. Martin	
23: 00	23: 05	J. Martin	
23: 30	23: 35	J. Martin	
00: 00	00: 05	J. Martin	
00: 30	00: 35	J. Martin	
01: 00	01: 05	J. Martin	
01: 30	01: 35	J. Martin	
02: 00	02: 05	J. Martin	
02: 30	02: 35	J. Martin	
03: 00	03: 05	J. Martin	
03: 30	03: 35	J. Martin	
04: 00	04: 05	J. Martin	
04: 30	04: 35	J. Martin	
05: 00	05: 05	J. Martin	
05: 30	05: 35	J. Martin	

1ST Watch Review-Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET — 2ND Watch

DATE: 2-1-13 PRISON: CSP-LAC UNIT / SECTION: A-B-C

"A" SECTION	"B" SECTION	"C" SECTION
115, 203, 214, 111, 111	125, 126, 127, 224	142, 145, 146, 149, 204
	234, 120, 121	232, 242, 132, 143, 250
		235, 236, 140

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
06: 05	06: 10	MILLER	
06: 30	06: 35	MILLER	
07: 00	07: 05	MILLER	
07: 30	07: 35	MILLER	
08: 00	08: 07	CARTER F.	
08: 30	08: 36	GIBSON	
09: 00	09: 07	GIBSON	
09: 33	09: 39	GIBSON	
10:	10:		
10:	10:		
	11:		
	12:		

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

3RD Watch

DATE: _____ PRISON _____ UNIT: SECTION: _____

"A" SECTION "B" SECTION "C" SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
14:	14:		
14:	14:		
15:	15:		
15:	15:		
16:	16:		
16:	16:		
17:	17:		
17:	17:		
18:	18:		
18:	18:		
19:	19:		
19:	19:		
20:	20:		
20:	20:		
21:	21:		
21:	21:		

3RD Watch Review Supervisor Signature: _____

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ASU 30 MINUTE WELFARE CHECK TRACKING SHEET — 1ST Watch

DATE: 1-31-13 PRISON: LAC UNIT / SECTION: A B C

"A" SECTION	"B" SECTION	"C" SECTION
111, 111, 115, 206, 214	120, 121, 125, 126, 127	140, 142, 145, 146, 149
	224, 231	137, 143, 240, 235, 236

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22:00	22:05	J Martin	
22:30	22:35	J Mart	
23:00	23:05	J Mart	
23:30	23:35	J Mart	
00:00	00:05	J Mart	
00:30	00:35	J Mart	
01:00	01:05	J Mart	
01:30	01:35	J Mart	
02:00	02:05	J Mart	
02:30	02:35	J Mart	
03:00	03:05	J Mart	
03:30	03:35	J Mart	
04:00	04:05	J Mart	
04:30	04:35	J Mart	
05:00	05:05	J Mart	
05:30	05:35	J Mart	

1ST Watch Review-Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET — 2ND Watch

DATE: 1-31-13 PRISON: CSP - LAC UNIT / SECTION: A B C

"A" SECTION	"B" SECTION	"C" SECTION
111, 115, 206, 214, 112	120, 121, 125, 126, 127	140, 142, 145, 146, 149
	224, 231, 133	137, 143, 240, 235, 236
		246, 241, 242, 150

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
06:00	06:16	CARTER F.	
06:32	06:41	CARTER F.	
07:00	07:05	MILLER	
07:30	07:35	MILLER	
08:00	08:05	MILLER	
08:31	08:39	BELTRAN	
09:00	09:06	MILLER	
09:30	09:40	PAGE	
10:00	10:15	CARTER F.	
10:30	10:35	Miller	
11:00	11:05	MILLER	
11:33	11:40	BELTRAN	
12:00	12:11	BELTRAN	
12:24	12:37	[illegible]	

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

3RD Watch

DATE: 1-31-2013 PRISON: CSP LAC UNIT / SECTION: A4 A, B, C

"A" SECTION
111 112 115
206 214

"B" SECTION
120 121 125 126 127
133
224 231

"C" SECTION
140 142 145 146 149
127 143 150
235 236 242 246 247
250

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
14: 00	14: 06	C Fuentes	
14: 30	14: 37	R Rubio	
15: 00	15: 05	C Fuentes	
15: 30	15: 37	Garcia, L	
16: 00	16: 06	Garcia, L	
16: 30	16: 37	Garcia, L	
17: 00	17: 06	Fuentes, C.	
17: 30	17: 35	Fuentes, C.	
18: 00	18: 05	Fuentes, C	
18: 30	18: 30	Fuentes, C	
19: 0	19: 06	fors	
19: 32	19: 40	fors	
20: 00	20: 06	Fuentes, C.	
20: 30	20: 36	Garcia, L	
21: 00	21: 12	Moran	
21: 34	21: 42	Moran	

3RD Watch Review Supervisor Signature:

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LAC 49

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET — 1ST Watch

DATE: 1-30-13 PRISON: LAC UNIT / SECTION: A B C

"A" SECTION: 115, 206, 214, 111, 111

"B" SECTION: 125, 126, 122, 224, 231, 120, 121

"C" SECTION: 142, 145, 146, 149, 204, 232, 242, 137, 143, 150, 250

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22: 00	22: 05	J Mont	
22: 30	22: 35	J Mont	
23: 00	23: 05	J Mont	
23: 30	23: 35	J Mont	
00: 00	00: 05	J Mont	
00: 30	00: 35	J Mont	
01: 00	01: 05	J Mont	
01: 30	01: 35	J Mont	
[redacted]	02: 05	J Mont	
02: 30	02: 35	J Mont	
03: 00	03: 05	J Mont	
03: 30	03: 35	J Mont	
04: 00	04: 05	J Mont	
04: 30	04: 35	J Mont	
05: 00	05: 05	J Mont	
05: 30	05: 35	J Mont	

1ST Watch Review-Supervisor Signature: J_M

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET — 2ND Watch

DATE: PRISON: UNIT / SECTION:

"A" SECTION: 115, 206, 214, 111, 111

"B" SECTION: 125, 126, 122, 224, 231, 120, 121

"C" SECTION: 142, 145, 146, 149, 204, 232, 242, 137, 143, 150, 250

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
06: 05	06: 10	MILLER	
06: 30	06: 35	MILLER	
07: 00	07: 05	MILLER	
07: 30	07: 35	MILLER	
08: 02	08: 09	BALTRAN	MB
08: 31	08: 38	BELTRAN	MB
09: 05	09: 11	BELTRAN	MB
09: 35	09: 40	BELTRAN	MB
10: 01	10: 07	BELTRAN	MB
10: 31	10: 36	BELTRAN	MB
11: 00	11: 05	MILLER	
11: 30	11: 35	MILLER	
12: 00	12: 05	Miller	
		Miller	

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

5TH Watch

DATE: 1-30-07 PRISON: LAC UNIT / SECTION: A B C

"A" SECTION: 115 206 214 111 114

"B" SECTION: 125 126 127 224 231 / 120 121

"C" SECTION: 142 145 146 149 201 / 251 248 139 143 150 / 160

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
14:00	14:08	J CAMACHO	
14:30	14:36	J CAMACHO	
15:00	15:09	J CAMACHO	
15:30	15:35	J CAMACHO	
16:00	16:07	J CAMACHO	
16:30	16:35	J CAMACHO	
17:00	17:06	J CAMACHO	
17:30	17:38	D. ANDERSON	
18:00	18:07	D ANDERSON	
18:30	18:35	D ANDERSON	
19:00	19:05	Moran	
19:30	19:37	Moran	
20:00	20:05	Moran	
20:30	20:36	Moran	
21:00	21:06	Moran	
21:30	21:38	Moran	

3RD Watch Review Supervisor Signature:

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ASU 30 MINUTE WELFARE CHECK TRACKING SHEET — 1st Watch

DATE: 1/29/13 PRISON: CSP LAC UNIT / SECTION: ABC

"A" SECTION: 115, 201, 201, 206, 214

"B" SECTION: 120, 121, 125, 126, 127, 224, 231

"C" SECTION: 142, 143, 145, 146, 149, 150, 237, 242, 250

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22:00	22:05	J Martin	
22:30	22:35	J Martin	
23:00	23:05	J Martin	
23:30	23:35	J Martin	
00:00	00:05	J Martin	
00:30	00:35	J Martin	
01:00	01:05	J Martin	
01:30	01:35	J Martin	
02:00	02:05	J Martin	
02:30	02:35	J Martin	
03:00	03:05	J Martin	
03:30	03:35	J Martin	
04:00	04:05	J Martin	
04:30	04:35	J Martin	
05:00	05:05	J Martin	
05:30	05:35	J Martin	

1ST Watch Review-Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET — 2ND Watch

DATE: 1/29/13 PRISON: CSP LAC UNIT / SECTION: ABC

"A" SECTION: 115, 201, 201, 206, 214

"B" SECTION: 120, 121, 125, 126, 127, 224, 231

"C" SECTION: 142, 143, 145, 146, 149, 150, 232, 240, 250, 150

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
06:00	06:06	Morelli	
06:30	06:36	Morelli	
07:00	07:07	Morelli	
07:30	07:36	Morelli	
08:10	08:15	Sands	
08:25	08:32	Sands	
09:00	09:06	Morelli / Beltran	
09:40	09:40	Beltran	
10:05	10:11	Beltran	
10:28	10:32	Gonzalez	
11:00	11:03	Gonzalez	
11:30	11:36	Gonzalez	
12:03	12:08	Gonzalez	
12:32	12:37	Gonzalez / Jones	

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

3RD Watch

DATE 1/29/13 PRISON CSP-LAC UNIT / SECTION AJB4C

"A" SECTION: 115 111 206 214 204

"B" SECTION: 120 121 125 126 127 224 231

"C" SECTION: 137 142 143 141 142 145 146 149 233 243 150 250 150

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
14: 01	14: 04	Fowler	
14: 30	14: 34	Fowler	
15: 02	15: 06	Fowler	
15: 31	15: 35	Fowler	
16: 01	16: 06	Fowler	
16: 30	16: 34	Fowler	
17: 00	17: 05	Fowler	
~~17: 30~~	17: 34	Fowler	
18: 01	18: 05	Fowler	
18: 32	18: 37	Fowler	
19: 00	19: 04	Fowler	
19: 31	19: 36	Fowler	
20: 00	20: 05	Fowler	
20: 31	20: 36	Fowler	
21: 00	21: 04	Fowler	
21: 31	21: 37	Fowler	

3RD Watch Review Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET — 1ST Watch

DATE: 1/29/13 PRISON: CSP LAC UNIT / SECTION: ABC

"A" SECTION: 115 201 201 206 214

"B" SECTION: 120 121 125 126 127 224 231

"C" SECTION: 142 145 145 146 149 150 232 247 250

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22: 00	22: 05	J Martí	
22: 30	22: 35	J Martí	
23: 00	23: 05	J Martí	
23: 30	23: 35	J Martí	
00: 00	00: 05	J Martí	
00: 30	00: 35	J Martí	
01: 00	01: 05	J Martí	
01: 30	01: 35	J Martí	
02: 00	02: 05	J Martí	
02: 30	02: 35	J Martí	
03: 00	03: 05	J Martí	
03: 30	03: 35	J Martí	
04: 00	04: 05	J Martí	
04: 30	04: 35	J Martí	
05: 00	05: 05	J Martí	
05: 30	05: 35	J Martí	

1ST Watch Review-Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET — 2ND Watch

DATE: 1/29/13 PRISON: CSP LAC UNIT / SECTION: ABC

"A" SECTION: 115 201 201 206 214

"B" SECTION: 120 121 125 126 127 224 231

"C" SECTION: 142 145 145 146 149 150 232 247 250

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
06:00	06:05	Morelli	
06:30	06:35	Morelli	
07:00	07:05	Morelli	
07:30	07:35	Morelli	
08:00	08:05	Sais	
08:25	08:32	Sais	
09:00	09:05	Morelli	
09:30	09:40	Gelman	
10:05	10:11	Gelman	
10:28	10:32	Gonzalez	
11:00	11:05	Gonzalez	
11:30	11:36	Gonzalez	
12:03	12:09	Gonzalez	
12:32	12:37	Gonzalez & Sais	
13:05	13:11	Gonzalez & Sais	

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET — 3RD Watch

DATE: 1/29/13 PRISON: CSP-LAC UNIT / SECTION: AJB&C

"A" SECTION: 115 111 206 214 204

"B" SECTION: 120 121 125 126 129 224 231

"D" SECTION: 137 142 143 141 142 145 146 149 239 240 150 250 80

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
14: 01	14: 07	Fowler	
14: 30	14: 36	Fowler	
15: 02	15: 06	Fowler	
15: 31	15: 35	Fowler	
16: 01	16: 06	Fowler	
16: 30	16: 34	Fowler	
17: 00	17: 05	Fowler	
~~17: 30~~	17: 34	Fowler	
18: 01	18: 05	Fowler	
18: 32	18: 37	Fowler	
19: 00	19: 04	Fowler	
19: 31	19: 36	Fowler	
20: 00	20: 05	Fowler	
20: 31	20: 36	Fowler	
21: 00	21: 04	Fowler	
21: 31	21: 37	Fowler	

3RD Watch Review Supervisor Signature:

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ASU 30 MINUTE WELFARE CHECK TRACKING SHEET — 1ST Watch

DATE: 1/28/13 PRISON: LAC UNIT / SECTION: ASU

"A" SECTION: 115, 206, 214

"B" SECTION: 125, 126, 127, 224, 231

"C" SECTION: 142, 145, 146, 149, 150, 237, 247

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22:00	22:05	L. Marsh	
22:30	22:35	L. Marsh	
23:00	23:05	L. Marsh	
23:30	23:35	L. Marsh	
00:00	00:05	L. Marsh	
00:30	00:35	L. Marsh	
01:00	01:05	L. Marsh	
01:30	01:35	L. Marsh	
02:00	02:05	L. Marsh	
02:30	02:35	L. Marsh	
03:00	03:05	L. Marsh	
03:30	03:35	L. Marsh	
04:00	04:05	L. Marsh	
04:30	04:35	L. Marsh	
05:00	05:05	L. Marsh	
05:30	05:35	L. Marsh	

1ST Watch Review-Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET — 2ND Watch

DATE: 1/28/13 PRISON: LAC UNIT / SECTION: ASU

"A" SECTION: 115, 206, 214

"B" SECTION: 125, 126, 127, 224, 231

"C" SECTION: 142, 145, 146, 149, 150, 237, 247

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
06:00	06:05	MORELLI	
06:30	06:35	MORELLI	
07:00	07:05	MORELLI	
07:30	07:36	MORELLI	
08:00	08:06	MORELLI	
08:30	08:38	PAIGE	
09:00	09:06	MORELLI	
09:32	09:40	BD-TRAN	
10:00	10:06	MORELLI	
10:30	10:36	MORELLI	
11:00	11:06	MORELLI	
11:30	11:37	MORELLI	
12:00	12:06	MORELLI	
12:30	12:40	PAIGE	
13:00	13:10	PAIGE	
		PAIGE	

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

3RD Watch

DATE: 1-28-2013 PRISON CSP LAC UNIT / SECTION: A B C

"A" SECTION: 115 206 214

"B" SECTION: 125 126 87 224 231

"C" SECTION: 142 145 146 149 150 237 247

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
14:00	14:09	W Puckett JR	W Puckett
14:30	14:35	C Reyes	C Reyes
15:00	15:05	C Reyes	C Reyes
15:30	15:35	C Reyes	C Reyes
16:00	16:05	C Reyes	C Reyes
16:35	16:38	R Rubio	R Rubio
17:00	17:05	R Rubio	R Rubio
17:30	17:41	R Rubio	R Rubio
18:00	18:05	C Reyes	C Reyes
18:30	18:36	C Reyes	C Reyes
19:00	19:05	C Reyes	C Reyes
19:30	19:36	C Reyes	C Reyes
20:01	20:13	W Puckett JR	W Puckett
20:30	20:36	C Reyes	C Reyes
21:02	21:13	W Puckett JR	W Puckett
21:30	21:39	W Puckett JR	W Puckett

3RD Watch Review Supervisor Signature:

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ASU 30 MINUTE WELFARE CHECK TRACKING SHEET — 1ST Watch

DATE: 1-27-2013 PRISON: CAC UNIT / SECTION: A4

"A" SECTION: 103, 112, 115, 117, 201, 204, 206, 209, 214

"B" SECTION: 122, 125, 126, 127, 129, 133, 219, 224, 230, 131, 231, 232

"C" SECTION: 137, 140, 141, 142, 143, 144, 145, 146, 149, 150, 235, 236, 241, 243, 247, 249, 234, 237

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22:00	22:36	M. OSLING	
22:30	22:39	M. OSLING	
23:00	23:09	M. OSLING	
23:30	23:38	M. OSLING	
00:01	00:09	M. OSLING	
00:30	00:39	M. OSLING	
01:01	01:10	M. OSLING	
01:30	01:39	M. OSLING	
02:00	02:09	M. OSLING	
02:30	02:39	M. OSLING	
03:00	03:09	M. OSLING	
03:30	03:39	M. OSLING	
04:01	04:09	M. OSLING	
04:30	04:39	M. OSLING	
05:00	05:09	M. OSLING	
05:30	05:39	M. OSLING	

1ST Watch Review-Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET — 2ND Watch

DATE: 1/27/13 PRISON: LAC UNIT / SECTION: A-4

"A" SECTION: 103, 112, 115, 117, 201, 204, 206, 209, 214

"B" SECTION: 122, 125, 126, 127, 126, 133, 219, 224, 230, 131, 231, 232

"C" SECTION: 135, 140, 141, 142, 143, 144, 145, 146, 149, 150, 234, 235, 236, 241, 243, 247, 233, 249

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
06:00	06:05	Morelli	
06:30	06:36	Morelli	
07:00	07:06	Morelli	
07:30	07:36	R. HERNANDEZ	
08:02	08:08	R. HERNANDEZ	
08:30	08:80	Morelli	
09:03	09:10	Morelli	
09:30	09:36	Morelli	
10:00	10:06	Morelli	
10:30	10:36	Morelli	
11:00	11:08	KAGE	
11:30	11:40	KAGE	
12:00	12:12	KAGE	
12:30	12:36	Morelli	
13:00	13:06	Morelli	

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

3RD Watch

DATE 6-27-2013 PRISON CSP LAC UNIT/SECTION A B C

"A" SECTION

113 112 115 117 201
204 206 209 214

"B" SECTION

121 126 124 127 128
133 219 224 220 129
231 232

"C" SECTION

137 140 141 142 143
144 145 146 149 150
235 236 238 243 247
241 234 237

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
14:01	14:11	W Puckett JR	W Puckett
14:30	14:40	W Puckett JR	W Puckett
15:01	15:31	W Puckett JR	W Puckett
15:31	15:42	W Puckett JR	W Puckett
16:01	16:13	W Puckett JR	W Puckett
16:30	16:39	W Puckett JR	W Puckett
17:01	17:13	W Puckett JR	W Puckett
~~17:30~~	17:40	W Puckett JR	W Puckett
18:01	18:13	W Puckett JR	W Puckett
18:31	18:40	W Puckett JR	W Puckett
19:00	19:13	W Puckett JR	W Puckett
19:30	19:42	W Puckett JR	W Puckett
20:01	20:11	W Puckett JR	W Puckett
20:30	20:40	W Puckett JR	W Puckett
21:02	21:13	W Puckett JR	W Puckett
21:32	21:42	W Puckett JR	W Puckett

~~3RD Watch Review Supervisor Signature:~~

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET | 1ST Watch

DATE: 1-26-2013 PRISON: LAC UNIT / SECTION: A-4

"A" SECTION: 103, 112, 115, 117, 201, 204, 206, 209, 214

"B" SECTION: 122, 125, 126, 127, 128, 133, 219, 224, 230, 121, 231, 232, 119

"C" SECTION: 137, 140, 141, 142, 143, 144, 145, 146, 149, 150, 235, 236, 241, 243, 247, 249, 234, 237

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START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22:00	22:17	J. Acquilano	
22:30	22:40	J. Acquilano	
23:00	23:15	J. Acquilano	
23:36	23:42	J. Acquilano	
00:01	00:07	J. Acquilano	
00:30	00:38	J. Acquilano	
01:00	01:07	J. Acquilano	
01:32	01:39	J. Acquilano	
02:00	02:07	J. Acquilano	
02:39	02:49	J. Acquilano	
03:05	03:12	J. Acquilano	
03:30	03:39	J. Acquilano	
04:00	04:09	J. Acquilano	
04:31	04:40	J. Acquilano	
05:03	05:12	J. Acquilano	
05:33	05:47	J. Acquilano	

1ST Watch Review-Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET | 2ND Watch

DATE: 1/26/13 PRISON: CSP-LAC UNIT / SECTION: A-Y A,B,C

"A" SECTION: 103, 112, 115, 117, 201, 204, 206, 209, 214

"B" SECTION: 122, 125, 126, 127, 128, 133, 219, 224, 230, 121, 231, 232

"C" SECTION: 137, 140, 141, 142, 143, 144, 145, 146, 149, 150, 235, 236, 241, 243, 247, 241, 224, 237

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
06:00	06:07	ESPINOZA	
06:30	06:35	ESPINOZA	
07:00	07:10	Gray	
07:30	07:39	Gray	
08:00	08:12	Gray	
08:30	08:41	Gray	
09:00	09:09	Gray	
09:30	09:42	Gray	
10:00	10:10	Gray	
10:30	10:40	Gray	
11:00	11:07	Gray	
11:30	11:41	Gray	
12:00	12:12	Gray	
12:30	12:37	Gray	
13:00	13:09	Gray	

AS I 30-MINUTE WELFARE CHECK TRACKING SHEET

3RD Watch

DATE: 1/26/13 PRISON: CSP LAC UNIT / SECTION: A4 A, B, C

"A" SECTION: 103 112 115 117 201 204 206 209 214

"B" SECTION: 121 122 125 126 127 128 133 219 224 230 231 232

"C" SECTION: 139 140 141 142 143 144 145 146 149 150 234 235 236 241 242 248

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
14: 00	14: 05	C Evans	
14: 31	14: 36	C Evans	
15: 00	15: 05	C Evans	
15: 31	15: 36	C Evans	
16: 00	16: 05	C Evans	
16: 30	16: 31	C Evans	
17: 00	17: 01	C Evans	
~~17: 31~~	17: 36	Evans	
18: 01	18: 01	Evans	
18: 30	18: 36	C Evans	
19: 00	19: 05	Evans	
19: 30	19: 36	Garcia	
20: 00	20: 07	Garcia	
20: 30	20: 36	Garcia	
21: 00	21: 05	Evans	
21: 31	21: 36	Garcia	

3RD Watch Review Supervisor Signature: [signature]

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ASU 30 MINUTE WELFARE CHECK TRACKING SHEET — 1ST Watch

DATE: 1/25/13 PRISON: CSP/LAC UNIT/SECTION: A,B,C

"A" SECTION	"B" SECTION	"C" SECTION
117, 112, 209, 214	122, 130, 224	141, 141, 145, 242

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22:00	22:05	L Martin	
22:30	22:35	L Martin	
23:00	23:05	L Martin	
23:30	23:35	L Martin	
00:00	00:05	L Martin	
00:30	00:35	L Martin	
01:00	01:05	L Martin	
01:30	01:35	L Martin	
02:00	02:05	L Martin	
02:30	02:35	L Martin	
03:00	03:05	L Martin	
03:30	03:35	L Martin	
04:00	04:05	L Martin	
04:30	04:35	L Martin	
05:00	05:05	L Martin	
05:30	05:35	L Martin	

1ST Watch Review-Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET — 2ND Watch

DATE: 1/25/13 PRISON: CSP/LAC UNIT/SECTION: A,B,C

"A" SECTION	"B" SECTION	"C" SECTION
117, 209, 214, 117	122, 130, 224	141, 141, 145, 242

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
06:00	06:09	M Gray	
06:30	06:36	Ecmpoa	
07:00	07:10	M. Gray	
07:30	07:37	M. Gray	
08:00	08:05	MILLER	
08:30	08:35	MILLER	
09:00	09:05	MILLER	
09:30	09:35	MILLER	
10:00	10:05	MILLER	
10:35	10:40	MILLER	
11:00	11:05	MILLER	
11:30	11:35	MILLER	
12:00	12:05	MILLER	
12:30	12:35	MILLER	
13:00	13:05	MILLER	
[illegible]	[illegible]	MILLER	

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

1ST Watch

DATE _____ PRISON: _____ UNIT / SECTION _____

"A" SECTION "B" SECTION "C" SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22:	22:		
22:	22:		
23:	23:		
23:	23:		
00:	00:		
00:	00:		
01:	01:		
01:	01:		
02:	02:		
02:	02:		
03:	03:		
03:	03:		
04:	04:		
04:	04:		
05:	05:		
05:	05:		

1ST Watch Review-Supervisor Signature: _____

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

2ND Watch

DATE: _____ PRISON: _____ UNIT / SECTION: _____

"A" SECTION "B" SECTION "C" SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
06:	06:		
06:	06:		
07:	07:		
07:	07:		
08:	08:		
08:	08:		
09:	09:		
09:	09:		
10:	10:		
10:	10:		
11:	11:		
11:	11:		
12:	12:		
12:	12:		
13:	13:		

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

3RD Watch

DATE: 1-25-2013 PRISON: CSP/LAC UNIT / SECTION: A, B, C

"A" SECTION	"B" SECTION	"C" SECTION
112 205 214 162	122 130 224	141 141 145 242

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
14:00	14:05	KATRAVAS	
14:30	14:36	KATRAVAS	
15:00	15:08	KATRAVAS	
15:30	15:35	KATRAVAS	
16:01	16:07	KATRAVAS	
16:31	16:38	KATRAVAS	
17:01	17:07	KATRAVAS	
17:31	17:39	KATRAVAS	
18:02	18:07	KATRAVAS	
18:30	18:35	KATRAVAS	
19:01	19:08	KATRAVAS	
19:31	19:36	KATRAVAS	
20:00	20:06	KATRAVAS	
20:31	20:36	KATRAVAS	
21:01	21:07	Ferris	
21:30	21:35	Ferris	

3rd Watch Review Supervisor Signature: Sgt

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ASU 30 MINUTE WELFARE CHECK TRACKING SHEET | 1st Watch

DATE: 1/24/12 PRISON: CSP LAC UNIT / SECTION: A B C

"A" SECTION: 112 209 214

"B" SECTION: 122 130

"C" SECTION: 141 141 145 240

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22: 00	22: 05	d. Martin	
22: 30	22: 35	d. Martin	
23: 00	23: 05	d. Martin	
23: 30	23: 35	d. Martin	
00: 00	00: 05	d. Martin	
00: 30	00: 35	d. Martin	
01: 00	01: 05	d. Martin	
01: 30	01: 35	d. Martin	
02: 00	02: 05	d. Martin	
02: 30	02: 35	d. Martin	
03: 00	03: 05	d. Martin	
03: 30	03: 35	d. Martin	
04: 00	04: 05	d. Martin	
04: 30	04: 35	d. Martin	
05: 00	05: 05	d. Martin	
05: 30	05: 35	d. Martin	

1st Watch Review-Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET | 2nd Watch

DATE: 1/24/13 PRISON: CSP LAC UNIT / SECTION: A, B, C

"A" SECTION: 112 209 214 112

"B" SECTION: 122 130 224

"C" SECTION: 141 141 145 243 236 240

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
06: 05	06: 10	Miller	
06: 30	06: 35	Miller	
07: 00	07: 05	Miller	
07: 30	07: 35	Miller	
08: 05	08: 10	Miller	
08: 30	08: 35	Miller	
09: 00	09: 05	Miller	
09: 30	09: 36	Miller	
10: 00	10: 05	Miller	
10: 30	10: 35	Miller	
11: 00	11: 05	Miller	
11: 30	11: 35	Miller	
12: 00	12: 05	Miller	
12: 30	12: 40	F. Chavez	
13: 00	13: 05	Miller	
		Miller	

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

3RD Watch

DATE 1/24/13 PRISON CSP-LAC JOB / SECTION A/B&C

"A" SECTION 112. 209 214

"B" SECTION 122 130 224

"C" SECTION 141 145 236 247

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
14:00	14:06	Moran	
14:30	14:36	moran	
15:00	15:06	moran	
15:30	15:36	moran	
16:00	16:06	moran	
16:30	16:36	moran	
17:00	17:06	moran	
17:30	17:36	moran	
18:00	18:06	moran	
18:30	18:36	Garcia, L	
19:05	19:11	Garcia, L	
19:30	19:36	Garcia, L	
20:00	20:06	Garcia, L	
20:30	20:36	Mora	
21:00	21:06	Mora	
21:30	21:36	Mora	

3RD Watch Review Supervisor Signature:

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ASU 30 MINUTE WELFARE CHECK TRACKING SHEET — 1ST Watch

DATE: 1/23/13 PRISON: LAC UNIT / SECTION: A/B/C

"A" SECTION	"B" SECTION	"C" SECTION
103, 112, 209, 214	122, 130, 143	141, 161, 145, 242

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22: 00	22: 05	J. Mata	
22: 30	22: 35	J. Mata	
23: 00	23: 05	J. Mata	
23: 30	23: 35	J. Mata	
00: 00	00: 01	J. Mata	
00: 30	00: 35	J. Mata	
01: 00	01: 05	J. Mata	
01: 30	01: 35	J. Mata	
02: 00	02: 05	J. Mata	
02: 30	02: 35	J. Mata	
03: 00	03: 05	J. Mata	
03: 30	03: 35	J. Mata	
04: 00	04: 05	J. Mata	
04: 30	04: 35	J. Mata	
05: 00	05: 05	J. Mata	
05: 30	05: 35	J. Mata	

1ST Watch Review Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET — 2ND Watch

DATE: 1/23/13 PRISON: LAC UNIT / SECTION: A/B/C

"A" SECTION	"B" SECTION	"C" SECTION
103, 112, 209, 214	122, 130, 143	141, 161, 145, 242

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
06: 10	06: 15	MILLER	
06: 30	06: 35	MILLER	
07: 00	07: 05	MILLER	
07: 30	07: 35	MILLER	
08: 00	08: 05	MILLER	
08: 30	08: 35	MILLER	
09: 00	09: 05	MILLER	
09: 30	09: 35	MILLER	
10: 00	10: 05	PAIGE	
10: 30	10: 40	PAIGE	
11: 00	11: 05	MILLER	
11: 30	11: 35	MILLER	
12: 00	12: 10	PAIGE	
12: 30	12: 35	PAIGE	
13: 00	13: 05	PAIGE	

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

3RD Watch

DATE: 1/23/13 PRISON: CSP-LAC UNIT / SECTION: A1BAC

"A" SECTION	"B" SECTION	"C" SECTION
103 112 207 214	122 130 183	141 203 247

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
14:00	14:06	Moran	
14:30	14:36	Moran	
15:00	15:06	Moran	
15:30	15:36	Moran	
16:00	16:06	Moran	
16:31	16:35	Fars	
17:01	17:07	Fars	
17:35	17:40	Fars	
18:00	18:05	Fars	
18:30	18:37	Fars	
19:01	19:08	Fars	
19:36	19:42	Moran	
20:10	20:16	Moran	
20:31	20:41	Wilcutt	
21:01	21:10	Wilcutt	
21:30	21:40	Wilcutt	

3RD Watch Review Supervisor Signature:

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ASU 30 MINUTE WELFARE CHECK TRACKING SHEET — 1ST Watch

DATE: 1/22/13 PRISON: LAC UNIT / SECTION: A B C

"A" SECTION: 103, 209, 112, 214

"B" SECTION: 143, 122, 130

"C" SECTION: 141, 141, 243, 143

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22: 00	22: 05	J. Mart	
22: 00	22: 25	J. Mart	
23: 00	23: 05	J. Mart	
23: 30	23: 35	J. Mart	
00: 00	00: 05	J. Mart	
00: 30	00: 35	J. Mart	
01: 00	01: 05	J. Mart	
01: 30	01: 35	J. Mart	
02: 00	02: 05	J. Mart	
02: 30	02: 35	J. Mart	
03: 00	03: 05	J. Mart	
03: 30	03: 35	J. Mart	
04: 00	04: 05	J. Mart	
04: 30	04: 35	J. Mart	
05: 00	05: 05	J. Mart	
05: 30	05: 35	J. Mart	

1ST Watch Review-Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET — 2ND Watch

DATE: 1/22/13 PRISON: LAC UNIT / SECTION: ABC

"A" SECTION: 103, 209, 112, 214

"B" SECTION: 143, 122, 130

"C" SECTION: 141, 143, 243, 143

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
06: 00	06: 06	Moreno	
06: 30	06: 36	Moreno	
07: 00	07: 06	Moreno	
07: 32	07: 39	M. Tran	
08: 05	08: 17	Salas	
08: 43	08: 52	Salas	
09: 10	09: 20	Salas	
09: 35	09: 42	Salas	
10: 08	10: 14	W. Bowser	
10: 28	10: 34	W. Bowser	
11: 00	11: 05	Miller	
11: 30	11: 35	Miller	
12: 00	12: 12	Paige	
12: 30	12: 40	Paige	
13: 00	13: 08	Paige	

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ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

3rd Watch

DATE: 1-22-13 PRISON: SP-AC UNIT / SECTION: A/B & C

"A" SECTION: 103, 102, 209, 214

"B" SECTION: 122, 130

"C" SECTION: 143, 141, 243

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
14:00	14:06	Moore	
14:30	14:36	Moore	
15:00	15:06	Moore	
15:30	15:36	Moore	
16:00	16:06	Moore	
16:30	16:36	Moore	
17:00	17:06	Moore	
[illegible]	17:36	chambers	
18:00	18:06	chambers	
18:30	18:36	chambers	
19:00	19:06	chambers	
19:30	19:36	chambers	
20:00	20:06	Moore	
20:30	20:36	Moore	
21:00	21:04	Moore	
21:30	21:42	Moore	

3rd Watch Review Supervisor Signature: [signature]

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ASU 30 MINUTE WELFARE CHECK TRACKING SHEET | 1ST Watch

DATE: 1/21/13 PRISON: LAC UNIT / SECTION: A/B/C

"A" SECTION	"B" SECTION	"C" SECTION
112, 209, 214	143, 122, 130	141, 243, 145

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22: 00	22: 05	J. Martin	
22: 30	22: 35	J. Martin	
23: 00	23: 05	J. Martin	
23: 30	23: 35	J. Martin	
00: 00	00: 05	J. Martin	
00: 30	00: 35	J. Martin	
01: 00	01: 05	J. Martin	
01: 30	01: 35	J. Martin	
02: 00	02: 05	J. Martin	
02: 30	02: 35	J. Martin	
03: 00	03: 05	J. Martin	
03: 30	03: 05	J. Martin	
04: 00	04: 05	J. Martin	
04: 30	04: 35	J. Martin	
05: 00	05: 05	J. Martin	
05: 30	05: 35	J. Martin	

1ST Watch Review Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET | 2ND Watch

DATE: 1/21/13 PRISON: LAC UNIT / SECTION:

"A" SECTION	"B" SECTION	"C" SECTION
112, 209, 214	122, 130	143, 141, 243, 145

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
06: 00	06: 06	MORELLI	
06 30	06 36	MORELLI	
07 02	07: 07	M. BELTRAN	
07: 30	07: 30	MORELLI	
08: 00	08 06	MORELLI	
08: 30	08: 36	MORELLI	
09: 00	09: 06	MORELLI	
09: 32	09: 39	M. BELTRAN	
10: 03	10: 11	M. BELTRAN	
10: 34	10: 40	M. BELTRAN	
11: 00	11: 06	MORELLI	
11 30	11: 35	MORELLI	
12: 00	12: 25	[illegible]	
12: 30	12: 36	MORELLI	
13: 02	13: 06	MORELLI	

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

3RD Watch

DATE: 1/24/13 PRISON: CSP-LAC UNIT / SECTION: A, B & C

"A" SECTION: 112 209 214

"B" SECTION: 122 130

"C" SECTION: 141 143 243 145

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
14:00	14:04	Moore	
14:31	14:40	Puckett JR	WP
15:01	15:11	Puckett JR	WP
15:30	15:36	Crumbs	CF
16:00	16:06	Crumbs	CF
16:30	16:36	Crumbs	CF
17:00	17:04	Crumbs	CF
17:30	17:36	Crumbs	CF
18:00	18:06	Crumbs	CF
18:30	18:35	Crumbs	CF
19:01	19:11	Puckett JR	WP
19:30	19:34	Puckett JR	WP
20:00	20:11	Puckett JR	WP
20:30	20:36	Moore	MM
21:00	21:06	Moore	MM
21:30	21:38	Moore	MM

3RD Watch Review Supervisor Signature:

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ASU 30 MINUTE WELFARE CHECK TRACKING SHEET — 1ST Watch

DATE: 1-19-13 PRISON: CSP LAC UNIT / SECTION: A, B, C

"A" SECTION: 103, 201, 209, 212, 214

"B" SECTION: 122, 126, 130, 232

"C" SECTION: 143, 141, 150, 250, 141, 243

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22:00	22:30	Parano	
22:30	22:35	Parano	
23:00	23:05	Parano	
23:30	23:35	Parano	
00:00	00:05	Parano	
00:30	00:35	Parano	
01:00	01:05	Parano	
01:30	01:35	Parano	
02:00	02:05	Parano	
02:30	02:35	Parano	
03:00	03:05	Parano	
03:30	03:35	Parano	
04:00	04:05	Parano	
04:30	04:35	Parano	
05:00	05:05	Parano	
05:30	05:30	Parano	

1ST Watch Review-Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET — 2ND Watch

DATE: 1-19-13 PRISON: CSP LAC UNIT / SECTION: ABC

"A" SECTION: 103, 201, 209, 212, 214

"B" SECTION: 122, 126, 130, 232

"C" SECTION: 143, 141, 150, 250, 141, 243, 150, 145

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
06:00	06:06	Morelli	
06:30	06:36	Morelli	
07:00	07:06	Morelli	
07:30	07:36	Morelli	
08:00	08:06	Morelli	
08:30	08:36	Miller	
09:00	09:06	Miller	
09:30	09:36	Miller	
10:00	10:06	Miller	
10:30	10:36	Miller	
11:00	11:06	Morelli	
11:30	11:36	Morelli	
12:00	12:06	Morelli	
12:30	12:36	Morelli	
13:00	13:06	Morelli	

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

3RD Watch

DATE: _____ PRISON: _____ UNIT / SECTION _____

"A" SECTION	"B" SECTION	"C" SECTION
102 112	122 126 130	134 143 145 150
201 209 214	222	223 230

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
14:00	14:05	[illegible]	
14:30	14:36	[illegible]	
15:00	15:05	C Fuentes	
15:30	15:36	C Fuentes	
16:00	16:06	C Fuentes	
16:30	16:36	C Fuentes	
17:00	17:05	C Fuentes	
~~17:30~~	17:40	W PUCKETT JR	
18:01	18:09	W PUCKETT JR	
18:30	18:40	W PUCKETT JR	
19:01	19:13	W PUCKETT JR	
19:30	19:42	W PUCKETT JR	
20:02	20:11	W PUCKETT JR	
20:30	20:36	[illegible]	
21:00	21:05	C Fuentes	
21:30	21:36	C Fuentes	

3rd Watch Review Supervisor Signature: [illegible]

PA522

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

1st Watch

DATE: 1-20-13 PRISON: CSP LAC UNIT / SECTION: A, B, C

"A" SECTION: 103, 209, 112, 214

"B" SECTION: 122, 126, 130

"C" SECTION: 143, 141, 243, 145

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22:00	22:05	Paramo	
22:30	22:35	Paramo	
23:00	23:06	Paramo	
23:30	23:36	Paramo	
00:00	00:06	Paramo	
00:30	00:35	Paramo	
01:00	01:05	Paramo	
01:30	01:35	Paramo	
02:00	02:05	Paramo	
02:30	02:35	Paramo	
03:00	03:05	Paramo	
03:30	03:35	Paramo	
04:00	04:05	Paramo	
04:30	04:35	Paramo	
05:00	05:05	Paramo	
05:30	05:35	Paramo	

1st Watch Review-Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

2ND Watch

DATE: 1/20/13 PRISON: CSP LAC UNIT / SECTION: A BC

"A" SECTION: 103, 209, 112, 214

"B" SECTION: 122, 126, 130

"C" SECTION: 143, 141, 243, 145

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
06:00	06:06	Morelli	
06:30	06:36	Morelli	
07:00	07:06	Morelli	
07:30	07:36	Morelli	
08:00	08:06	Morelli	
08:30	08:36	Morelli	
09:00	09:07	Morelli	
09:30	09:40	Lopez	
10:00	10:10	Lopez	
10:30	10:36	Morelli	
11:00	11:07	Morelli	
11:30	11:40	PAIGE	
12:00	12:15	PAIGE	
12:30	12:36	Morelli	
13:01	13:07	Morelli	

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

3RD Watch

DATE: 1-20-13 PRISON: CSP LAC UNIT / SECTION: A, BC

"A" SECTION: 103 209 112 214

"B" SECTION: 122 126 00

"C" SECTION: 143 141 20 145

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
14:01	14:11	W Puckett JR	W Puckett
14:36	14:35	W Puckett JR	W Puckett
15:02	15:10	W Puckett JR	W Puckett
15:31	15:39	W Puckett JR	W Puckett
16:00	16:10	W Puckett JR	W Puckett
16:30	16:46	W Puckett JR	W Puckett
17:00	17:05	Fowler	
17:30	17:37	Fowler	
18:00	18:06	Fowler	
18:31	18:38	Fowler	
19:01	19:07	FOWLER	
19:30	19:35	Fowler	
20:00	20:00	Fowler	
20:30	20:38	Fowler	
21:00	21:07	Fowler	
21:30	21:37	Fowler	

3RD Watch Review Supervisor Signature:

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ASU 30 MINUTE WELFARE CHECK TRACKING SHEET — 1st Watch

DATE: 1/18/13 PRISON: CSP LAC UNIT / SECTION: A/B/C

"A" SECTION: 102 115 201 112 214 201

"B" SECTION: 143 110 126 100 DC

"C" SECTION: 141 143 150 252 141 203

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22:00	22:05	J. Martinez	
22:30	22:35	J. Martinez	
23:00	23:05	J. Martinez	
23:30	23:35	J. Martinez	
00:00	00:05	J. Martinez	
00:30	00:35	J. Martinez	
01:00	01:05	J. Martinez	
01:30	01:35	J. Martinez	
02:00	02:05	J. Martinez	
02:30	02:35	J. Martinez	
03:00	03:05	J. Martinez	
03:30	03:35	J. Martinez	
04:00	04:05	J. Martinez	
04:30	04:35	J. Martinez	
05:00	05:05	J. Martinez	
05:30	05:35	J. Martinez	

1ST Watch Review-Shpervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET — 2ND Watch

DATE: 1/18/13 PRISON: CSP LAC UNIT / SECTION: A/B/C

"A" SECTION: 102 115 201 112 214 201

"B" SECTION: 143 110 126 100 DC

"C" SECTION: 141 143 150 252 141 203

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
06:00	06:05	MILLER	
06:30	06:35	MILLER	
07:00	07:05	MILLER	
07:30	07:35	MILLER	
08:00	08:05	CARTER E.	
08:30	08:42	CARTER E.	
09:35	09:50	SALAS	
09:30	09:35	MILLER	
10:10	10:20	SALAS	
10:30	10:35	G. GONZALEZ	
11:00	11:05	SALAS	
11:30	11:35	GONZALEZ	
12:15	12:27	SALAS	
12:38	12:43	GONZALEZ	
13:05	13:10	GONZALEZ	

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ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

3RD Watch

DATE 1/18/13 PRISON CSP-LAC UNIT / SECTION A B C

"A" SECTION: 103 LCE 209 201 214

"B" SECTION: 122 126 130 143 232

"C" SECTION: 141 149 150 243 250

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
14: 00	14: 06	C Fuentes	
14: 30	14: 36	Moore	
15: 00	15: 06	Moore	
15: 30	15: 36	Moore	
16: 00	16: 06	Moore	
16: 30	16: 36	C Fuentes	
17: 00	17: 05	C Fuentes	
[illegible]	17: 36	C Fuentes	
18: 00	18: 07	C Fuentes	
18: 31	18: 36	C Fuentes	
19: 00	19: 05	C Fuentes	
19: 31	19: 37	C Fuentes	
20: 00	20: 06	C Fuentes	
20: 31	20: 36	Gomez, C	
21: 00	21: 06	Gomez, C	
21: 30	21: 35	Flores	

3RD Watch Review Supervisor Signature:

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LAC 79

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

1st Watch

DATE: 01-17-13 PRISON: CSP-LA Co UNIT / SECTION:

"A" SECTION: 102, 113, 201, 209, 112, 214

"B" SECTION: 103, 122, 126, 130, 232

"C" SECTION: 141, 149, 150, 250, 241, 243

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22:00	22:05	L Martinez	
22:30	22:35	L Martinez	
23:00	23:05	L Martinez	
23:30	23:35	L Martinez	
00:00	00:05	L Martinez	
00:30	00:35	L Martinez	
01:00	01:05	L Martinez	
01:30	01:35	L Martinez	
02:00	02:05	L Martinez	
02:30	02:35	L Martinez	
03:00	03:05	L Martinez	
03:30	03:35	L Martinez	
04:00	04:05	L Martinez	
04:30	04:35	L Martinez	
05:00	05:05	L Martinez	
05:30	05:35	L Martinez	

1ST Watch Review-Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

2ND Watch

DATE: 01-17-13 PRISON: CSP-LA Co. UNIT / SECTION:

"A" SECTION: 103, 115, 201, 209, 112, 214

"B" SECTION: 103, 122, 126, 130, 232

"C" SECTION: 141, 149, 150, 250, 241, 243

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
06:00	06:10	RUSH R	R Rush
06:30	06:40	RUSH R	R Rush
07:00	07:10	RUSH R	R Rush
07:35	07:45	RUSH R	R Rush
08:00	08:08	RUSH R.	R Rush
08:35	08:51	SALAS	
09:00	09:10	SALAS/CAPORUSSO	J Caporusso
09:23	09:33	SALAS	
10:20	10:32	SALAS	
10:35	10:56	F. CAPORUSSO	F Caporusso
11:00	11:05	MILLER	
11:30	11:35	MILLER	
12:00	12:05	MILLER	
12:30	12:35	MILLER	
13:00	13:05	MILLER	

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ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

3RD Watch

DATE: 01/17/13 PRISON: CSP-LAC UNIT / SECTION: A, B & C

"A" SECTION: 103 111 115 201 214 229

"B" SECTION: 122 126 130 232

"C" SECTION: 141 143 150 241 243 250

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
14:00	14:06	Moran	
14:30	14:36	Moran	
15:00	15:06	Moran	
15:30	15:36	Moran	
16:04	16:10	Moran	
16:40	16:44	Moran	
17:10	17:16	Moran	
~~17:40~~	17:42	Moran	
18:10	18:16	Moran	
18:38	18:45	Moran	
19:10	19:16	Moran	
19:40	19:46	Moran	
20:10	20:16	Garcia	
20:36	20:42	Garcia	
21:13	21:19	Moran	
21:46	21:52	Moran	

3RD Watch Review Supervisor Signature: M

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET — 1ST Watch

DATE: 1/16/13 PRISON: LAC UNIT / SECTION: ASC

"A" SECTION: 103, 115, 201, 209, 112, 204

"B" SECTION: 143, 122, 126, 130, 232

"C" SECTION: 141, 149, 130, 150, 250, 141, 213

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22:00	22:05	J Martinez	
22:30	22:35	J Martinez	
23:00	23:05	J. Martinez	
23:30	23:35	J. Mart	
00:00	00:05	J Martinez	
00:30	00:35	J Mart	
01:00	01:05	J Mart	
01:30	01:35	J Mar	
02:00	02:05	J Mart	
02:30	02:35	J Mart	
03:00	03:05	J Mar	
03:30	03:35	J Ma	
04:00	04:05	J Mart	
04:30	04:35	J Mart	
05:00	05:05	J Mart	
05:30	05:35	J Ma	

1ST Watch Review-Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET — 2ND Watch

DATE: 1/16/13 PRISON: LAC UNIT / SECTION: ASC

"A" SECTION: 103, 115, 201, 209, 112, 204

"B" SECTION: 143, 122, 126, 130, 232

"C" SECTION: 141, 149, 130, 150, 250, 141, 213

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
06:05	06:10	MILLER	
06:30	06:35	MILLER	
07:00	07:05	MILLER	
07:30	07:35	M PEDTRAN	
08:02	08:10	M PEDTRAN	
08:30	08:41	CARTER C.	
09:00	09:12	CARTER C.	
09:30	09:35	MILLER	
10:00	10:05	MILLER	
10:30	10:35	MILLER	
11:00	11:05	MILLER	
11:30	11:35	MILLER	
12:00	12:05	MILLER	
12:30	12:39	CARTER	
13:00	13:05	MILLER	

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

3RD Watch

DATE: 1/16/13 PRISON: CSP-LAC UNIT / SECTION: A/B & C

"A" SECTION: 103, 115, 112, 201, 209, 214

"B" SECTION: 122, 126, 130, 232, 128

"C" SECTION: 141, 143, 149, 243, 250

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
14:00	14:06	[illegible]	[illegible]
14:30	14:36	[illegible]	[illegible]
15:00	15:06	[illegible]	[illegible]
15:31	15:36	Fers	[illegible]
16:02	16:09	Fers	[illegible]
16:30	16:39	Puckett Jr	[illegible]
17:00	17:06	C Contreras	[illegible]
~~17:30~~	17:36	C Contreras	[illegible]
18:00	18:06	C Contreras	[illegible]
18:30	18:36	C. Contreras	[illegible]
19:01	19:11	Puckett JR.	[illegible]
19:30	19:41	Puckett JR	[illegible]
20:01	20:12	Puckett JR	[illegible]
20:31	20:40	Puckett JR	[illegible]
21:10	21:16	[illegible]	[illegible]
21:30	21:36	C. Contreras	[illegible]

3rd Watch Review Supervisor Signature: [illegible]

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ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

1ST Watch

DATE 11/15/13 PRISON LAC UNIT/SECTION ASU

"A" SECTION	"B" SECTION	"C" SECTION
103, 113, 204, 202, 213, 214	142, 122, 126, 129, 130, 23b, 232	141, 141, 150, 150, 250, 211, 216

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22:00	22:05	J. Martinez	
22:30	22:35	J. Martinez	
23:00	23:05	J. Martinez	
23:30	23:35	J. Martinez	
00:00	00:05	J. Martinez	
00:30	00:35	J. Martinez	
01:00	01:05	J. Martinez	
01:30	01:35	J. Martinez	
02:00	02:05	J. Martinez	
02:30	02:35	J. Martinez	
03:00	03:05	J. Martinez	
03:30	03:35	J. Martinez	
04:00	04:05	J. Martinez	
04:30	04:35	J. Martinez	
05:00	05:05	J. Martinez	
05:30	05:35	J. Martinez	

1ST Watch Review-Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

2ND Watch

DATE: 11/16/13 PRISON: LAC UNIT/SECTION: ASU

"A" SECTION	"B" SECTION	"C" SECTION
103, 113, 201, 209, 212, 244	122, 126, 127, 130, 23, 232	141, 142, 149, 150, 250, 211

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
06:00	06:05	Morelli	
06:30	06:35	Morelli	
07:00	07:05	Morelli	
07:30	07:35	Morelli	
08:00	08:05	Morelli	
08:30	08:35	Morelli	
09:00	09:05	Morelli	
09:30	09:35	Morelli	
10:00	10:05	Morelli	
10:30	10:40	Vance/Caporusso	
11:00	11:10	Vance/Caporusso	
11:30	11:40	Vance/Caporusso	
12:00	12:15	Vance/Caporusso	
12:30	12:35	Miller	
13:00	13:05	Miller	

2ND Watch Review-Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

3RD Watch

DATE: 7-15-13 PRISON: CSP LAC UNIT / SECTION: A4

"A" SECTION: 103 115 201 209 212 214

"B" SECTION: 143 122 126 127 130 220 232

"C" SECTION: 149 199 150 250 243

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
14:01	14:11	W Puckett JR	WPuckett
14:30	14:40	W Puckett JR	WPuckett
15:02	15:12	W Puckett JR	WPuckett
15:30	15:31	W Puckett JR	WPuckett
16:02	16:13	W Puckett JR	WPuckett
16:31	16:43	W Puckett JR	WPuckett
17:03	17:10	Moran	
~~17:38~~	17:44	Moran	
18:10	18:16	Moran	
18:30	18:38	Puckett JR	WPuckett
19:01	19:11	Puckett JR	WPuckett
19:31	19:41	Puckett JR	WPuckett
20:	20:		
20:	20:		
21:	21:		
21:	21:		

3RD Watch Review Supervisor Signature:

PAGE 1

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

1ST Watch

DATE: 1/14/13 PRISON: LAC UNIT / SECTION: A 13 C

"A" SECTION: 103, 115, 201, 209, 212, 214

"B" SECTION: 119, 121, 126, 127, 130, 230, 232

"C" SECTION: 141, 149, 150, 150, 250, 242, 243

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22:00	22:05	J Martin	
22:30	22:35	J Mart	
23:00	23:05	J Mart	
23:30	23:35	J Mart	
00:00	00:05	J Mart	
00:30	00:35	J Martin	
01:00	01:05	J Martin	
01:30	01:35	J Martin	
02:00	02:05	J Mart	
02:30	02:35	J Mart	
03:00	03:05	J Mart	
03:30	03:35	J Mart	
04:00	04:05	J Mart	
04:30	04:35	J Mart	
05:00	05:05	J Mart	
05:30	05:35	J Mart	

1ST Watch Review-Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

2ND Watch

DATE: 1/14/13 PRISON: CSP-LAC UNIT / SECTION: A, B, C A-4

"A" SECTION: 103, 115, 201, 209, 212, 214

"B" SECTION: 119, 121, 126, 127, 130, 230, 232

"C" SECTION: 141, 149, 150, 250, 243, [illegible]

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
06:00	06:07	ESTRADA	
06:30	06:35	ESTRADA	
07:00	07:07	ESTRADA	
07:30	07:36	MORELLI	
08:00	08:06	MORELLI	
08:30	08:40	PAIGE	
09:00	09:12	PAIGE	
09:30	09:38	PAIGE	
10:00	10:06	ESTRADA	
10:30	10:37	ESTRADA	
11:00	11:05	Lowther	
11:30	11:35	Lowther	
12:00	12:12	PAIGE	
12:30	12:40	PAIGE	
13:00	13:12	PAIGE	
13:30	13:40	PAIGE	

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

3RD Watch

DATE: 1/14/13 PRISON: CSP-AC UNIT / SECTION: A4 A, B, C

"A" SECTION: 103. 118

"B" SECTION: 122. 126. 127. 130. 143

"C" SECTION: 141. 148. 150

204. 209. 212. 214.

230. 232.

243. 250.

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
14: 00	14: 05	C Fuentes	
14: 30	14: 36	C Fuentes	
15: 00	15: 05	C Fuentes	
15: 27	15: 34	C Fuentes	
16: 00	16: 00	C Fuentes	
16: 32	16: 37	C Fuentes	
17: 00	17: 05	C Fuentes	
17: 30	17: 36	C Fuentes	
18: 00	18: 05	C Fuentes	
18: 30	18: 36	C Fuentes	
19: 00	19: 06	C Fuentes	
19: 30	19: 36	C Fuentes	
20: 00	20: 05	C Fuentes	
20: 30	20: 36	Moore	
21: 00	21: 11	Moore	
21: 30	21: 35	Fowler	

3RD Watch Review Supervisor Signature:

PAGE 2

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

1st Watch

DATE 01-12-13 PRISON CSP/LAC UNIT / SECTION A4 ABC

"A" SECTION: 103 115 112 / 201 209 214

"B" SECTION: 122 126 127 130 / 226 232

"C" SECTION: 141 143 149 150 / 245 250

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22:05	22:10	Maldonado	
22:40	22:45	Maldonado	
23:10	23:15	Maldonado	
23:40	23:45	Maldonado	
00:05	00:10	Maldonado	
00:40	00:45	[illegible]	
01:05	01:10	[illegible]	
01:40	01:45	[illegible]	
02:05	02:10	[illegible]	
02:40	02:45	[illegible]	
03:05	03:10	[illegible]	
03:40	03:45	[illegible]	
04:05	04:10	Maldonado	
04:40	04:45	Maldonado	
05:05	05:10	Maldonado	
05:40	05:45	Maldonado	

1st Watch Review-Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

2ND Watch

DATE: 1/13/13 PRISON: CSP/LAC UNIT / SECTION: A4 - ABC

"A" SECTION: 103 115 112 / 201 209 214

"B" SECTION: 122 126 127 130 / 226 232

"C" SECTION: 141 143 149 150 / 245 250

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
06:00	06:08	Morelli	
06:30	06:36	Morelli	
07:00	07:07	Morelli	
07:30	07:36	Morelli	
08:00	08:06	Morelli	
08:30	08:38	Morelli	
09:00	09:08	PAIGE	
09:30	09:39	PAIGE	
10:00	10:11	PAIGE	
10:30	10:40	PAIGE	
11:00	11:05	PAIGE	
11:30	11:06	Morelli	
12:00	12:00	Morelli	
12:30	12:39	Morelli	
13:00	13:06	Morelli	

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

3RD Watch

DATE: 1-13-2013 PRISON: CSP LAC UNIT / SECTION: A4

"A" SECTION: 108 112 116 201 209 214

"B" SECTION: 122 126 130 230 232

"C" SECTION: 141 143 149 150 243 250

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
14:01	14:11	W. Puckett JR	W. Puckett JR
14:30	14:40	W. Puckett JR	W. Puckett JR
15:02	15:13	W. Puckett JR	W. Puckett JR
15:30	15:41	W. Puckett JR	W. Puckett
16:00	16:06	E. Simon	
16:30	16:36	E. Simon	
17:00	17:05	E. Simon	
17:30	17:38	E. Simon	
18:00	18:05	E. Simon	
18:35	18:40	E. Simon	
19:00	19:04	E. Simon	
19:32	19:39	Puckett JR	W. Puckett JR
20:00	20:10	Puckett JR	W. Puckett JR
20:31	20:41	Puckett JR	W. Puckett JR
21:01	21:12	Puckett JR	W. Puckett JR
21:30	21:40	Puckett JR	W. Puckett JR

3RD Watch Review Supervisor Signature:

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LAC 89

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET — 1ST Watch

DATE: 1-12-13 PRISON: CSP LAC UNIT / SECTION: 4BC

"A" SECTION: 103, 115, 201, 209, 112, 214

"B" SECTION: 143, 122, 126, 127, 130, 230, 232

"C" SECTION: 141, 149, 150, 230, 141, 143, 243

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22:00	22:05	Paramo	
22:30	22:35	Paramo	
23:00	23:05	Paramo	
23:30	23:37	Paramo	
00:00	00:06	Paramo	
00:30	00:35	Paramo	
01:00	01:05	Paramo	
01:30	01:35	Paramo	
02:00	02:06	Paramo	
02:30	02:35	Paramo	
03:00	03:36	Paramo	
03:30	03:35	Paramo	
04:00	04:30	Paramo	
04:30	04:35	Paramo	
05:00	05:30	Paramo	
05:30	05:35	Paramo	

1ST Watch Review-Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET — 2ND Watch

DATE: 1/12/13 PRISON: CSP-LAC UNIT / SECTION: 4BC

"A" SECTION: 103, 115, 201, 209, 112, 214

"B" SECTION: 143, 122, 126, 127, 130, 230, 232

"C" SECTION: 141, 149, 150, 230, 141, 143, 243

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
06:00	06:05	Morelli	
06:30	06:36	Morelli	
07:00	07:07	Morelli	
07:30	07:35	Morelli	
08:00	08:06	Morelli	
08:30	08:36	Morelli	
09:00	09:06	Morelli	
09:30	09:35	Miller	
10:00	10:05	Miller	
10:30	10:35	Miller	
11:00	11:06	Morelli	
11:30	11:35	Miller	
12:00	12:05	Miller	
12:30	12:35	Miller	
13:00	13:05	Miller	

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

3RD Watch

DATE: 1-12-13 PRISON: CSP-LAC UNIT / SECTION: AM A, B, C

"A" SECTION: 103 115 122

"B" SECTION: 122 126 127 130

"C" SECTION: 141 143 149 150

201 209 214

218 222

240 252

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
14:00	14:05	C Flintt	
14:30	14:36	M. Gray	
15:00	15:09	M. Gray	
15:30	15:39	M. Gray	
16:00	16:12	M. Gray	
16:30	16:36	C Flintt	
17:00	17:10	M. Gray	
17:30	17:36	J Newman	
18:00	18:10	J Newman	
18:20	18:36	J Newman	
19:00	19:16	J Newman	
19:30	19:39	M. Gray	
20:00	20:10	M. Gray	
20:30	20:42	M. Gray	
21:00	21:10	M. Gray	
21:30	21:37	M. Gray	

3RD Watch Review Supervisor Signature:

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LAC 91

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

1ST Watch

DATE: 1/11/13 PRISON: LAC UNIT / SECTION: 4-3 C

"A" SECTION: 103, 112, 113, 201, 214, 201, 204

"B" SECTION: 123, 126, 127, 130, 232, 233

"C" SECTION: 130, 140, 146, 149, 150, 150, 152, 141, 154

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22:00	22:05		
22:30	22:35		
23:00	23:05		
23:30	23:35		
00:00	00:05		
00:30	00:35		
01:00	01:05		
01:30	01:35		
02:00	02:05		
02:30	02:35		
03:00	03:05		
03:30	03:35		
04:00	04:05		
04:30	04:35		
05:00	05:05		
05:30	05:35		

1ST Watch Review-Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

2ND Watch

DATE: 1/11/13 PRISON: LAC UNIT / SECTION:

"A" SECTION: 103, 112, 113, 201, 214, 201, 204

"B" SECTION: 123, 126, 127, 130, 230, 232

"C" SECTION: 130, 140, 146, 149, 150, 150, 152, 141, 142

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
06:00	06:09	MORELLI	
06:30	06:39	MORELLI	
07:00	07:05	MORELLI	
07:30	07:35		
08:00	08:05		
08:31	08:42		
09:00	09:05	MORELLI	
09:30	09:36	MORELLI	
10:00	10:05	MORELLI	
10:30	10:36	MORELLI	
11:00	11:05		
11:30	11:35		
12:00	12:05		
12:30	12:35		
13:00	13:06	MORELLI	

LAC 92

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

3RD Watch

DATE: 1/14/13 PRISON: CSP-LAC UNIT/SECTION: A B & C

"A" SECTION: 103 112 113 201 204 207 214

"B" SECTION: 120 122 127 130 230 232

"C" SECTION: 143 140 144 147 150 239

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
14:00	14:06	Moore	MD
14:30	14:36	Moore	MD
15:00	15:06	Moore	MD
15:30	15:36	Moore	MD
16:00	16:06	Moore	MD
16:30	16:36	Moore	MD
17:00	17:06	Moore	MD
17:30	17:36	Moore	MD
18:00	18:06	Moore	MD
18:30	18:36	Gracia	
19:00	19:06	Gracia	
19:30	19:36	Gracia	
20:00	20:06	Franco C.	
20:30	20:36	Moore	MD
21:00	21:06	Moore	MD
21:30	21:36	Moore	MD

Watch Review Supervisor Signature:

PAGE 2

LAC 93

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET — 1ST Watch

DATE: 1/10/12 PRISON: LAC UNIT / SECTION: ABC

"A" SECTION: 102, 112, 115, 209, 214, 201

"B" SECTION: 143, 122, 126, 127, 130, 220, 232

"C" SECTION: 134, 140, 141, 149, 150, 151, 150, 141

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
23: 00	22: 05	J. Martin	
22: 10	22: 15	J. Mata	
23: 00	23: 05	J. Mata	
23: 30	23: 35	J. Mata	
00: 00	00: 05	J. Mata	
00: 30	00: 35	J. Mata	
01: 00	01: 05	J. Mata	
01: 30	01: 35	J. Mata	
02: 00	02: 05	J. Mata	
02: 30	02: 35	J. Mata	
03: 00	03: 05	J. Mata	
03: 30	03: 35	J. Mata	
04: 00	04: 05	J. Mata	
04: 30	04: 35	J. Mata	
05: 00	05: 05	J. Mata	
05: 30	05: 37	J. Mata	

1ST Watch Review-Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET — 2ND Watch

DATE: 1/10/12 PRISON: LAC UNIT / SECTION: ABC

"A" SECTION: 102, 112, 115, 209, 214, 201

"B" SECTION: 143, 122, 126, 127, 130, 220, 232

"C" SECTION: 130, 140, 141, [redacted], 150, 220, 141

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
06: 05	06: 10	MILLER	
06: 30	06: 35	MILLER	
07: 00	07: 05	MILLER	
07: 30	07: 35	MILLER	
08: 00	08: 05	MILLER	
08: 30	08: 35	MILLER	
09: 00	09: 06	MILLER	
09: 30	09: 36	MILLER	
10: 00	10: 05	MILLER	
10: 30	10: 41	CARTER E.	
11: 01	11: 16	CARTER E.	
11: 30	11: 35	MILLER	
12: 00	12: 05	MILLER	
12: 30	12: 40	JUNIOR / CAPORUSSO	
13: 00	13: 05	MILLER	

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

3RD Watch

DATE: 1/10/13 PRISON: CSP-LAC UNIT / SECTION: A, B & C

"A" SECTION: 202 212 213 201 209 214

"B" SECTION: 143 122 124 127 130 230 232

"C" SECTION: 136 140 141 149 150 150 250

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
14:00	14:06	Nava	
14:30	14:36	Nava	
15:00	15:06	Garcia, L	
15:30	15:36	Garcia, L	
16:00	16:36	Garcia, L	
16:30	16:31	Garcia, L	
17:00	17:06	Garcia, L	
17:30	17:36	Garcia, L	
18:00	18:06	Garcia, L	
18:30	18:36	Garcia, L	
19:00	19:06	Garcia, L	
19:30	19:36	Garcia, L	
20:00	20:06	Garcia, L	
20:30	20:36	Frias	
21:00	21:06	Chavez	
21:30	21:36	Chavez	

3RD Watch Review Supervisor Signature:

PAGE 1

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET — 1ST Watch

DATE: 1/9/13 PRISON: LAC UNIT / SECTION: AAC

"A" SECTION: 103, 115, 201, 207, 112, 214

"B" SECTION: 118, 122, 126, 127, 130, 230, 232

"C" SECTION: 136, 140, 141, 145, 150, 150, 250, NL

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22: 00	22: 03	J. Martin	
22: 30	22: 35	J. Martin	
23: 00	23: 05	J. Martin	
23: 30	23: 35	J. Martin	
00: 00	00: 05	J. Martin	
00: 30	00: 35	J. Martin	
01: 00	01: 05	J. Martin	
01: 30	01: 35	J. Martin	
02: 00	02: 05	J. Martin	
02: 30	02: 35	J. Martin	
03: 00	03: 05	J. Martin	
03: 30	03: 30	J. Martin	
04: 00	04: 05	J. Martin	
04: 30	04: 35	J. Martin	
05: 00	05: 05	J. Martin	
05: 30	05: 35	J. Martin	

1ST Watch Review-Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET — 2ND Watch

DATE: 1/9/13 PRISON: LAC UNIT / SECTION: A, B, C

"A" SECTION: 103, 115, 201, 207, 112, 214

"B" SECTION: 118, 122, 126, 127, 130, 230, 232

"C" SECTION: 136, 140, 141, 149, 150, 250, 141

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
06: 05	06: 10	MILLER	
06: 30	06: 35	MILLER	
07: 00	07: 05	MILLER	
07: 30	07: 35	MILLER	
08: 00	08: 12	CARTER	
08: 30	08: 41	CARTER	
09: 00	09: 05	MILLER	
09: 30	09: 35	MILLER	
10: 00	10: 06	TAIGE	
10: 36	10: 44	TAIGE	
11: 01	11: 09	M BAUMANN	
11: 30	11: 35	MILLER	
12: 00	12: 15	TAIGE	
12: 30	12: 30	SALAS	
13: 00	13: 12	CARTER F.	

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

3RD Watch

DATE: 1-9-2013 PRISON: CSP LAC UNIT / SECTION: A4

"A" SECTION: 202 204 206 208 210 212 214

"B" SECTION: 125 127 126 127 130 228 232

"C" SECTION: 136 140 141 145 150 230 234

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
14:01	14:11	W Puckett JR	W Puckett
14:30	14:40	W Puckett JR	W Puckett
15:02	15:13	W Puckett JR	W Puckett
15:31	15:41	W Puckett JR	W Puckett
16:03	16:15	W Puckett JR	W Puckett
16:31	16:42	W Puckett JR	W Puckett
17:01	17:11	W Puckett JR	W Puckett
17:30	17:42	W Puckett JR	W Puckett
18:02	18:15	W Puckett JR	W Puckett
18:31	18:41	W Puckett JR	W Puckett
19:01	19:11	W Puckett JR	W Puckett
19:31	19:45	W Puckett JR	W Puckett
20:02	20:12	W Puckett JR	W Puckett
20:31	20:43	W Puckett JR	W Puckett
21:01	21:11	W Puckett JR	W Puckett
21:33	21:41	W Puckett JR	W Puckett

3RD Watch Review Supervisor Signature: M Nick

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Exhibit 57

DOCUMENTS COPIED FEBRUARY 1, 2013

A-5 logs

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET — 1ST Watch

DATE: 2/1/13 PRISON: CSP / LAC UNIT / SECTION: A5 / A, B, C

"A" SECTION: 101, 104, 110, 112, 113, 206, 214, 215

"B" SECTION: 125, 132, 225, 228

"C" SECTION: 136, 142, 150, 235, 237, 249, 250

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22: 00	22: 12	A. GRAHAM	A. Ghol
22: 30	22: 40	A. GRAHAM	A. Ghol
23: 01	23: 10	A. GRAHAM	A. Ghol
23: 32	23: 40	A. GRAHAM	A. Ghol
00: 05	00: 15	A. GRAHAM	A. Ghol
00: 30	00: 40	A. GRAHAM	A. Ghol
01: 01	01: 10	A. GRAHAM	A. Ghol
01: 35	01: 42	A. GRAHAM	A. Ghol
02: 05	02: 14	A. GRAHAM	A. Ghol
02: 30	02: 41	A. GRAHAM	A. Ghol
03: 00	03: 10	A. GRAHAM	A. Ghol
03: 35	03: 42	A. GRAHAM	A. Ghol
04: 01	04: 09	A. GRAHAM	A. Ghol
04: 31	04: 40	A. GRAHAM	A. Ghol
05: 03	05: 15	A. GRAHAM	A. Ghol
05: 30	05: 40	A. GRAHAM	A. Ghol

1ST Watch Review-Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET — 2ND Watch

DATE: 2/1/13 PRISON: CSP-LAC UNIT / SECTION: A-5 A/B/C

"A" SECTION: 101, 104, 105, 110, 112, 113, 214, 215

"B" SECTION: 125, 132, 225, 228

"C" SECTION: 136, 142, 150, 235, 237, 249, 250

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
06: 00	06: 13	A. Ramos	A. Ramos
06: 29	06: 42	Ramos	A. Ramos
07: 01	07: 10	Ramos	A. Ramos
07: 27	07: 38	Ramos	A. Ramos
08: 00	08: 05	A. LICON	C. Licon
08: 31	08: 37	A. LICON	C. Licon
09: 00	09: 06	A. LICON	C. Licon
09: 31	09: 40	Ramos	A. Ramos
10:	10:		
10:	10:		
11:	11:		
11:	11:		
12:	12:		
12:	12:		
13:	13:		
13:	13:		

2ND Watch Review-Supervisor Signature:

(Note: 3RD watch on back of sheet)

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

3RD Watch

DATE: _____ PRISON: _____ UNIT / SECTION: _____

"A" SECTION _____ "B" SECTION _____ "C" SECTION _____

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
14:	14:		
14:	14:		
15:	15:		
15:	15:		
16:	16:		
16:	16:		
17:	17:		
17:	17:		
18:	18:		
18:	18:		
19:	19:		
19:	19:		
20:	20:		
20:	20:		
21:	21:		
21:	21:		

3RD Watch Review-Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET — 1ST Watch

DATE: 1·31·13 PRISON: CSP. LAC UNIT / SECTION: FAB 5 ABC

"A" SECTION: 101, 104, 110, 110, 111, 113, 240

"B" SECTION: 125, 132, 225, 228

"C" SECTION: 136, 142, 150, 232, 240, 249, 249, 250, 250

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22:06	22:12	1·30·13 F. Magdaleno	
22:32	22:38	1·30·13 F. Magdaleno	
23:03	23:09	1·30·13 F. Magdaleno	
23:35	23:41	1·30·13 F. Magdaleno	
00:04	00:10	F. Magdaleno	
00:31	00:37	F. Magdaleno	
01:02	01:08	F. Magdaleno	
01:35	01:41	F. Magdaleno	
02:05	02:11	F. Magdaleno	
02:36	02:42	F. Magdaleno	
03:01	03:07	F. Magdaleno	
03:30	03:36	F. Magdaleno	
04:00	04:06	F. Magdaleno	
04:33	04:39	F. Magdaleno	
05:07	05:13	F. Magdaleno	
05:31	05:37	F. Magdaleno	

1ST Watch Review-Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET — 2ND Watch

DATE: 1/31/13 PRISON: CSP-LAC UNIT / SECTION: A5, A/B/C

"A" SECTION: 101, 104, 110, 112, 113, 106, 214, 245

"B" SECTION: 125, 132, 225, 228

"C" SECTION: 136, 142, 150, 235, 237, 249, 250

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
06:00	06:12	A Ramos	
06:29	06:43	Ramos	
07:01	07:10	Ramos	
07:30	07:42	Ramos	
08:01	08:10	Ramos	
08:29	08:36	Ramos	
09:00	09:08	Ramos	
09:33	09:41	Ramos	
10:02	10:12	Ramos	
10:30	10:43	Ramos	
11:05	11:13	Ramos	
11:30	11:36	A Ucan	
12:00	12:05	A Ucan	
12:30	12:36	A Ucan	
13:03	13:15	Ramos	
13:35	13:45	Ramos	

2ND Watch Review-Supervisor Signature:

(Note: 3RD watch on back of sheet)

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

3RD Watch

DATE: _____ PRISON: _____ UNIT / SECTION: _____

"A" SECTION _____, _____, _____, _____, _____
_____, _____, _____, _____, _____
_____, _____, _____, _____, _____
_____, _____, _____, _____, _____

"B" SECTION _____, _____, _____, _____, _____
_____, _____, _____, _____, _____
_____, _____, _____, _____, _____
_____, _____, _____, _____, _____

"C" SECTION _____, _____, _____, _____, _____
_____, _____, _____, _____, _____
_____, _____, _____, _____, _____
_____, _____, _____, _____, _____

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
14:00	14:15	R Jorgenson	
14:30	14:40	R Jorgenson	
15:03	15:11	R Jorgenson	
15:30	15:40	R Jorgenson	
16:02	16:13	R Jorgenson	
16:30	16:41	R Jorgenson	
17:01	17:12	R Jorgenson	
17:32	17:43	R Jorgenson	
18:00	18:10	R Jorgenson	
18:30	18:40	R Jorgenson	
19:02	19:11	R Jorgenson	
19:30	19:40	R Jorgenson	
20:00	20:10	B. CHANEY	
20:30	20:40	B. CHANEY	
21:00	21:10	B. CHANEY	
21:30	21:40	B. CHANEY	

3RD Watch Review-Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET — 1ST Watch

DATE: 1·30·13 PRISON: CSP·LAC UNIT / SECTION: FAB5ABC

"A" SECTION	"B" SECTION	"C" SECTION
101, 104, 110, 110, 112	125, 132, 225, 248	141, 150, 237, 240, 249
113, 205, 205, 240		249, 250, 250

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22:07	22:13	F.Magdaleno 1·29·13	
22:32	22:38	F.Magdaleno 1·29·13	
23:06	23:12	F.Magdaleno 1·29·13	
23:34	23:40	F.Magdaleno 1·29·13	
00:01	00:07	F.Magdaleno	
00:33	00:39	F.Magdaleno	
01:02	01:05	F.Magdaleno	
01:31	01:37	F.Magdaleno	
02:00	02:06	F.Magdaleno	
02:35	02:41	F.Magdaleno	
03:02	03:08	F.Magdaleno	
03:30	03:36	F.Magdaleno	
04:06	04:12	F.Magdaleno	
04:31	04:37	F.Magdaleno	
05:04	05:10	F.Magdaleno	
05:32	05:38	F.Magdaleno	

1ST Watch Review-Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET — 2ND Watch

DATE: 1·30·13 PRISON: CSPLAC UNIT / SECTION: A5

"A" SECTION	"B" SECTION	"C" SECTION
101, 104, 110, 110, 112	128, 132, 225, 248	141, 150, 137, 240, 249
113, 205, 205, 240		249, 250, 250

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
06:05	06:20	D.Washington	
06:29	06:50	D.Washington	
07:00	07:17	D.Washington	
07:29	07:51	D.Washington	
08:05	08:15	D.Washington	
08:25	08:45	D.Washington	
09:00	09:17	D.Washington	
09:30	09:53	D.Washington	
10:00	10:17	D.Washington	
10:30	10:47	D.Washington	
11:01	11:19	D.Washington	
11:33	11:54	D.Washington	
12:00	12:17	D.Washington	
12:31	12:50	D.Washington	
13:08	13:17	D.Washington	
13:25	13:45	D.Washington	

2ND Watch Review-Supervisor Signature:

(Note: 3RD watch on back of sheet)

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

3RD Watch

DATE: _____ PRISON: _____ UNIT / SECTION: _____

"A" SECTION	"B" SECTION	"C" SECTION
____, ____, ____, ____, ____	____, ____, ____, ____, ____	____, ____, ____, ____, ____
____, ____, ____, ____, ____	____, ____, ____, ____, ____	____, ____, ____, ____, ____
____, ____, ____, ____, ____	____, ____, ____, ____, ____	____, ____, ____, ____, ____
____, ____, ____, ____, ____	____, ____, ____, ____, ____	____, ____, ____, ____, ____

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
14:00	14:15	R Jorgenson	
14:30	14:40	R Jorgenson	
15:01	15:10	R Jorgenson	
15:33	15:45	R Jorgenson	
16:00	16:10	R Jorgenson	
16:30	16:40	R Jorgenson	
17:03	17:11	R Jorgenson	
17:32	17:43	R Jorgenson	
18:00	18:10	R Jorgenson	
18:33	18:43	R Jorgenson	
19:00	19:13	R Jorgenson	
19:32	19:40	R Jorgenson	
20:00	20:11	R Jorgenson	
20:31	20:40	R Jorgenson	
21:00	21:10	R Jorgenson	
21:	21:		

3RD Watch Review-Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET | 1ST Watch

DATE: 1.29.13 PRISON: ESP-LAC UNIT / SECTION: A5 / ABC

"A" SECTION	"B" SECTION	"C" SECTION
101, 104, 107, 108, 113	125, 132, 225, ___, ___	141, 150, 238, 241, 249
210, 212, 214, ___, ___	___, ___, ___, ___, ___	250 ___, ___, ___, ___
___, ___, ___, ___, ___	___, ___, ___, ___, ___	___, ___, ___, ___, ___
___, ___, ___, ___, ___	___, ___, ___, ___, ___	___, ___, ___, ___, ___

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22:00	22:15	M.OSCINO	
22:30	22:37	M.OSCINO	
23:00	23:07	M.OSCINO	
23:30	23:07	M.OSCINO	
00:00	00:07	M.OSCINO	
00:30	00:37	M.OSCINO	
01:00	01:07	M.OSCINO	
01:30	01:37	M.OSCINO	
02:00	02:08	M.OSCINO	
02:30	02:38	M.OSCINO	
03:00	03:07	M.OSCINO	
03:30	03:37	M.OSCINO	
04:00	04:07	M.OSCINO	
04:30	04:37	M.OSCINO	
05:00	05:07	M.OSCINO	
05:30	05:37	M.OSCINO	

1ST Watch Review-Supervisor Signature: Lt

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET | 2ND Watch

DATE: 1-29-13 PRISON: CSP-LAC UNIT / SECTION: A5 / ABC

"A" SECTION	"B" SECTION	"C" SECTION
101, 104, 110, 112, 113	125, 132, 225, 228, ___	142, 150, 237, 240, 249
209, 210, ___, ___, ___	___, ___, ___, ___, ___	250, ___, ___, ___, ___
___, ___, ___, ___, ___	___, ___, ___, ___, ___	___, ___, ___, ___, ___
___, ___, ___, ___, ___	___, ___, ___, ___, ___	___, ___, ___, ___, ___

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
06:00	06:20	D. Washington	
06:30	06:50	D. Washington	
07:05	07:20	D. Washington	
07:29	07:51	D. Washington	
08:00	08:20	D. Washington	
08:30	08:38	V. MORRIS	
09:00	09:07	V. MORRIS	
09:30	09:35	V. MORRIS	
10:00	10:05	V. MORRIS	
10:30	10:37	V. MORRIS	
11:00	11:20	D. Washington	
11:29	11:50	D. Washington	
12:00	12:20	D. Washington	
12:27	12:50	D. Washington	
13:00	13:17	D. Washington	
13:25	13:45	D. Washington	

2ND Watch Review-Supervisor Signature:

(Note: 3RD Watch on back of sheet)

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

3RD Watch

DATE: _____ PRISON: _____ UNIT / SECTION: _____

"A" SECTION

"B" SECTION

"C" SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
14:10	14:15	R Johanson	
14:30	14:40	R Johanson	
15:03	15:11	R Johanson	
15:31	15:41	R Johanson	
16:00	16:10	R Johanson	
16:30	16:40	R Johanson	
17:00	17:10	R Johanson	
17:35	17:46	R Johanson	
18:00	18:10	R Johanson	
18:31	18:42	R Johanson	
19:01	19:10	R Johanson	
19:30	19:40	R Johanson	
20:00	20:12	R Johanson	
20:30	20:40	R Johanson	
21:03	21:14	R Johanson	
21:30	21:40	R Johanson	

3RD Watch Review-Supervisor Signature:

Exhibit 58

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ASU1 30 MINUTE WELFARE CHECK TRACKING SHEET

3RD Watch

DATE: 1-19-13 PRISON: CSP-LAC UNIT / SECTION: A, B, C, D, E, F, G, H,

"A" SECTION	"B" SECTION	"C" SECTION	"D" SECTION	"E" SECTION	"F" SECTION	"G" SECTION	"H" SECTION
01, 107	14	130, 135		148, 149, 150	165, 170	178, 181, 187	189, 192, 197
							198

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
4: 00	14: 10	J. MELENDEZ	
4: 30	14: 40	J. MELENDEZ	
5: 08	15: 16	PDATY	
5: 30	15: 38	DOTY	
6: 00	16: 08	DOTY	
16: 30	16: 38	DOTY	
17: 03	17: 12	DOTY	
17: 32	17:40	DOTY	
18: 01	18: 10	DOTY	
18: 30	18:40	DOTY	
19: 05	19: 13	DOTY	
19: 32	19:40	DOTY	
20: 03	20: 12	DOTY	
20: 31	20:41	DOTY	
21: 00	21:08	DOTY	
21: 33	21:42	DOTY	

3RD Watch Review-Supervisor Signature:

ASU1 30 MINUTE WELFARE CHECK TRACKING SHEET | 1ST Watch

DATE: 4-19-13 PRISON: CSP-LAC UNIT / SECTION: A, B, C, D, E, F, G, H.

"A" SECTION	"B" SECTION	"C" SECTION	"D" SECTION	"E" SECTION	"F" SECTION	"G" SECTION	"H" SECTION
101, 103, 107, 109,	114,	130, 135,	148, 149, 150,	155,	165, 170,	178, 181,	189, 192, 197

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22:00	22:10	Newman	
22:30	22:40	Newman	
23:00	23:10	Newman	
23:30	23:40	Newman	
00:00	00:10	Newman	
00:30	00:40	Newman	
01:00	01:10	Newman	
01:30	01:40	Newman	
02:00	02:10	Newman	
02:30	02:40	Newman	
03:00	03:10	Newman	
03:30	03:40	Newman	
04:00	04:10	Newman	
04:30	04:40	Newman	
05:00	05:10	Newman	
05:30	05:40	Newman	

1ST Watch Review-Supervisor Signature:

ASU1 30 MINUTE WELFARE CHECK TRACKING SHEET | 2ND Watch

DATE: PRISON: CSP-LAC UNIT / SECTION: A, B, C, D, E, F, G, H.

"A" SECTION	"B" SECTION	"C" SECTION	"D" SECTION	"E" SECTION	"F" SECTION	"G" SECTION	"H" SECTION
101, 103,	114,	130, 135,		148, 149, 150,	165, 170,	178, 181, 187,	189, 192, 197, 198,

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
06:00	06:10	J. MELENDEZ	
06:30	06:40	J. MELENDEZ	
07:00	07:10	J. MELENDEZ	
07:30	07:40	J. MELENDEZ	
08:00	08:10	J. MELENDEZ	
08:30	08:40	J. MELENDEZ	
09:00	09:10	J. MELENDEZ	
09:30	09:40	J. MELENDEZ	
10:00	10:10	J. MELENDEZ	
10:30	10:40	J. MELENDEZ	
11:00	11:10	J. MELENDEZ	
11:30	11:40	J. MELENDEZ	
12:00	12:10	J. MELENDEZ	
12:30	12:40	J. MELENDEZ	
13:00	13:09	J. MELENDEZ	
13:30	13:40	J. MELENDEZ	

2ND Watch Review-Supervisor Signature:

(Note: 3RD watch on back of sheet)

ASU1 30 MINUTE WELFARE CHECK TRACKING SHEET

3RD Watch

DATE: 1-20-13 PRISON: CSP-LAC UNIT / SECTION: A, B, C, D, E, F, G, H.

"A" SECTION	"B" SECTION	"C" SECTION	"D" SECTION	"E" SECTION	"F" SECTION	"G" SECTION	"H" SECTION
1, 107,	114,	130, 135,		148, 149, 150,	165, 170,	175, 181, 187,	189, 192, 197
							198,

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
13: 00	14: 15	C Copland	
13: 30	14: 45	C Copland	
14: 00	15: 15	C Copland	
14: 30	15: 45	C Copland	
15: 00	16: 15	C Copland	
15: 30	16: 45	C Copland	
16: 00	17: 10	J. MELENDEZ	
16: 30	17: 40	J. MELENDEZ	
17: 00	18: 09	J. MELENDEZ	
17: 30	18: 40	J. MELENDEZ	
18: 00	19: 16	J. MELENDEZ	
18: 30	19: 38	J. MELENDEZ	
19: 00	20: 10	J. MELENDEZ	
19: 30	20: 40	J. MELENDEZ	
20: 00	21: 09	J. MELENDEZ	
20: 30	21: 38	J. MELENDEZ	

3RD Watch Review-Supervisor Signature:

PAGE 2

ASU1 30 MINUTE WELFARE CHECK TRACKING SHEET | 1st Watch

DATE: 1-20-13 PRISON: CSP-LAC UNIT / SECTION: A, B, C, D, E, F, G, H.

"A" SECTION	"B" SECTION	"C" SECTION	"D" SECTION	"E" SECTION	"F" SECTION	"G" SECTION	"H" SECTION
101, 107,	114,	130, 135,		148, 149, 150,	165, 170,	178, 181, 187,	189, 192, 197,
							195,

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22: 00	22: 10	Newman	
22: 30	22: 40	Newman	
23: 00	23: 10	Newman	
23: 30	23: 40	Newman	
00: 00	00: 10	Newman	
00: 30	00: 40	Newman	
01: 00	01: 10	Newman	
01: 30	01: 40	Newman	
02: 00	02: 10	Newman	
02: 30	02: 40	Newman	
03: 00	03: 10	Newman	
03: 30	03: 40	Newman	
04: 00	04: 10	Newman	
04: 30	04: 40	Newman	
05: 00	05: 10	Newman	
05: 30	05: 40	Newman	

1ST Watch Review-Supervisor Signature:

ASU1 30 MINUTE WELFARE CHECK TRACKING SHEET | 2ND Watch

DATE: 1/20/13 PRISON: CSP-LAC UNIT / SECTION: A, B, C, D, E, F, G, H.

"A" SECTION	"B" SECTION	"C" SECTION	"D" SECTION	"E" SECTION	"F" SECTION	"G" SECTION	"H" SECTION
101, 107,	114,	130, 135,		148, 149, 150,	165, 170,	178, 181, 187,	189, 192, 197,
							196,

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
06: 01	06: 14	C. GIORDANO	
06: 29	06: 38	C. GIORDANO	
07: 00	07: 11	C. GIORDANO	
07: 28	07: 37	C. GIORDANO	
08: 02	08: 13	C. GIORDANO	
08: 31	08: 42	C. GIORDANO	
09: 01	09: 14	C. GIORDANO	
09: 30	09: 40	C. GIORDANO	
10: 00	10: 12	C. GIORDANO	
10: 32	10: 41	GIORDANO	
11: 01	11: 14	GIORDANO	
11: 28	11: 39	GIORDANO	
12: 00	12: 10	GIORDANO	
12: 29	12: 38	GIORDANO	
13: 02	13: 15	GIORDANO	
13: 25	13: 37	GIORDANO	

2ND Watch Review-Supervisor Signature:

(Note: 3RD watch on back of sheet)

ASU1 30 MINUTE WELFARE CHECK TRACKING SHEET

3RD Watch

DATE: 1-21-13 PRISON: CSP-LAC UNIT / SECTION: A, B, C, D, E, F, G, H

"A" SECTION	"B" SECTION	"C" SECTION	"D" SECTION	"E" SECTION	"F" SECTION	"G" SECTION	"H" SECTION
107	114	130, 155		148, 149, 150	165, 170	178, 181, 187	189, 192, 197, 198

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
: 00	14: 15	C. Copland	
: 30	14: 45	C. Copland	
: 00	15: 15	C. Copland	
: 30	15: 45	C. Copland	
: 00	16: 15	C. Copland	
: 30	16: 45	C. Copland	
: 00	17: 15	C. Copland	
: 30	17: 45	C. Copland	
: 00	18: 45	C. Copland	
: 30	18: 45	C. Copland	
: 00	19: 15	C. Copland	
: 30	19: 45	C. Copland	
: 00	20: 15	C. Copland	
: 30	20: 45	C. Copland	
: 00	21: 15	C. Copland	
: 30	21: 45	C. Copland	

RD Watch Review-Supervisor Signature:

PAGE 2

ASU1 30 MINUTE WELFARE CHECK TRACKING SHEET | 1st Watch

DATE: 1-21-13 PRISON: CSP-LAC UNIT / SECTION: A, B, C, D, E, F, G, H,

"A" SECTION	"B" SECTION	"C" SECTION	"D" SECTION	"E" SECTION	"F" SECTION	"G" SECTION	"H" SECTION
101, 107,	114,	130, 135,		148, 149, 150,	165, 170,	178, 181, 187,	189, 192, 197,
							198,

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22: 00	22: 10	Newman	
22: 30	22: 40	Newman	
23: 00	23: 10	Newman	
23: 30	23: 40	Newman	
00: 00	00: 10	Newman	
00: 30	00: 40	Newman	
01: 00	01: 10	Newman	
01: 30	01: 40	Newman	
02: 00	02: 10	Newman	
02: 30	02: 40	Newman	
03: 00	03: 10	Newman	
03: 30	03: 40	Newman	
04: 00	04: 10	Newman	
04: 30	04: 40	Newman	
05: 00	05: 10	Newman	
05: 30	05: 40	Newman	

1ST Watch Review-Supervisor Signature:

ASU1 30 MINUTE WELFARE CHECK TRACKING SHEET | 2ND Watch

DATE: PRISON: CSP-LAC UNIT / SECTION: A, B, C, D, E, F, G, H.

"A" SECTION	"B" SECTION	"C" SECTION	"D" SECTION	"E" SECTION	"F" SECTION	"G" SECTION	"H" SECTION
101, 107,	114,	130, 135,		148, 149, 150,	165, 170,	178, 181, 187,	189, 192, 197,
							198,

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
06: 00	06: 07	S. Cornelius	
06: 31	06: 35	S. Cornelius	
07: 01	07: 06	S. Cornelius	S. Cornelius
07: 32	07: 35	S. Cornelius	
08: 00	08: 08	S. Cornelius	S. Cornelius
08: 32	08: 37	S. Cornelius	
09: 00	09: 05	S. Cornelius	
09: 32	09: 37	S. Cornelius	
10: 02	10: 06	S. Cornelius	
10: 30	10: 35	S. Cornelius	
11: 00	11: 05	S. Cornelius	
11: 33	11: 38	S. Cornelius	
12: 00	12: 07	S. Cornelius	
12: 32	12: 36	S. Cornelius	
13: 00	13: 08	S. Cornelius	
13: 30	13: 35	S. Cornelius	

2ND Watch Review-Supervisor Signature:

(Note: 3RD Watch on back of sheet)

ASU1 30 MINUTE WELFARE CHECK TRACKING SHEET

3RD Watch

DATE: 1-22-13 PRISON: CSP-LAC UNIT / SECTION: A, B, C, D, E, F, G, H,

"A" SECTION	"B" SECTION	"C" SECTION	"D" SECTION	"E" SECTION	"F" SECTION	"G" SECTION	"H" SECTION
107, 109,	114,	130, 135,		148, 149, 160	165, 170,	181, 181, 192,	185, 192, 197
							198

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
: 02	14:05	C Compland	
: 36	14: 45	C. Compland	
: 00	15: 15	C. Compland	
: 30	15:45	C. Compland	
: 00	16:,5	C Compland	
: 30	16:45	C. Compland	
: 00	17: 15	C. Compland	
:30	17:45	C. Compland	
:00	18: 15	C. Compland	
:30	18: 45	C. Compland	
: 00	19: 15	C. Compland	
:30	19: 40	D. Simpson	
: 00	20: 10	D. Simpson	
: 30	20: 40	D. Simpson	
: 00	21: 10	D. Simpson	
: 30	21: 40	D. Simp	

RD Watch Review-Supervisor Signature:

PAGE 2

ASU1 30 MINUTE WELFARE CHECK TRACKING SHEET

1ST Watch

DATE: 1-22-13 PRISON: CSP-LAC UNIT / SECTION: A, B, C, D, E, F, G, H.

"A" SECTION	"B" SECTION	"C" SECTION	"D" SECTION	"E" SECTION	"F" SECTION	"G" SECTION	"H" SECTION
101, 107	114, ,	130, 135,	, ,	148, 149, 150,	165, 170,	178, 181, 187,	189, 192, 197
, ,	, ,	, ,	, ,	, ,	, ,	, ,	198,
, ,	, ,	, ,	, ,	, ,	, ,	, ,	, ,
, ,	, ,	, ,	, ,	, ,	, ,	, ,	, ,

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22: 00	22: 10	Newman	
22: 30	22: 40	Newman	
23: 00	23: 10	Newman	
23: 30	23: 40	Newman	
00: 00	00: 10	Newman	
00: 30	00: 40	Newman	
01: 00	01: 10	Newman	
01: 30	01: 40	Newman	
02: 00	02: 10	Newman	
02: 30	02: 40	Newman	
03: 00	03: 10	Newman	
03: 30	03: 40	Newman	
04: 00	04: 10	Newman	
04: 30	04: 40	Newman	
05: 00	05: 10	Newman	
05: 30	05: 40	Newman	

1ST Watch Review-Supervisor Signature:

ASU1 30 MINUTE WELFARE CHECK TRACKING SHEET

2ND Watch

DATE: 1-22-13 PRISON: CSP-LAC UNIT / SECTION: A, B, C, D, E, F, G, H.

"A" SECTION	"B" SECTION	"C" SECTION	"D" SECTION	"E" SECTION	"F" SECTION	"G" SECTION	"H" SECTION
101, 107,	114, ,	130, 135,	, ,	148, 149, 150,	165, 170,	178, 181, 187,	189, 192, 197,
, ,	, ,	, ,	, ,	, ,	, ,	, ,	198,
, ,	, ,	, ,	, ,	, ,	, ,	, ,	, ,
, ,	, ,	, ,	, ,	, ,	, ,	, ,	, ,

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
06: 00	06: 10	A. MARTINEZ	
06: 30	06: 41	A. MARTINEZ	
07: 00	07: 09	A. MARTINEZ	
07: 31	07: 39	A. MARTINEZ	
08: 00	08: 10	A. MARTINEZ	
08: 30	08: 40	A. MARTINEZ	
09: 00	09: 10	A. MARTINEZ	
09: 32	09: 41	A. MARTINEZ	
10: 00	10: 11	A. MARTINEZ	
10: 30	10: 39	A. MARTINEZ	
11: 00	11: 11	A. MARTINEZ	
11: 30	11: 39	A. MARTINEZ	
: 00	12: 10	A. MARTINEZ	
: 30	12: 39	A. MARTINEZ	
13: 00	13: 11	A. MARTINEZ	
13: 30	13: 38	A. MARTINEZ	

2ND Watch Review-Supervisor Signature:

(Note: 3RD watch on back of sheet)

ASU1 30 MINUTE WELFARE CHECK TRACKING SHEET

3RD Watch

DATE: _____ PRISON: CSP-LAC UNIT / SECTION: A. B. C. D. E. F. G. H.

"A" SECTION	"B" SECTION	"C" SECTION	"D" SECTION	"E" SECTION	"F" SECTION	"G" SECTION	"H" SECTION
107	114	130, 135		148, 149, 150	165, 170	178, 191, 197	189, 192, 199, 199

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
: 00	14: 08	G VAZQUEZ	
: 31	14: 38	G VAZQUEZ	
: 00	15: 07	G VAZQUEZ	
: 31	15: 38	G VAZQUEZ	
: 00	16: 07	G VAZQUEZ	
: 31	16: 38	G VAZQUEZ	
: 00	17: 07	G VAZQUEZ	
: 31	17: 38	G VAZQUEZ	
: 00	18: 08	G VAZQUEZ	
: 31	18: 38	G VAZQUEZ	
: 00	19: 08	G VAZQUEZ	
: 31	19: 38	G VAZQUEZ	
: 00	20: 09	G VAZQUEZ	
: 31	20: 38	G VAZQUEZ	
: 00	21: 07	G VAZQUEZ	
: 31	21: 38	G VAZQUEZ	

RD Watch Review-Supervisor Signature:

PAGE 2

ASU1 30 MINUTE WELFARE CHECK TRACKING SHEET | 1st Watch

DATE: 1-23-13 PRISON: CSP-LAC UNIT / SECTION: A, B, C, D, E, F, G, H.

"A" SECTION	"B" SECTION	"C" SECTION	"D" SECTION	"E" SECTION	"F" SECTION	"G" SECTION	"H" SECTION
102, 107, 109	114	130, 135		148, 149, 150	~~165~~, 176	176, 181, 187	187, 192, 197, 198

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22:00	22:10	Newman	
22:30	22:40	Newman	
23:00	23:10	Newman	
23:30	23:40	Newman	
00:00	00:10	Newman	
00:30	00:40	Newman	
01:00	01:10	Newman	
01:30	01:40	Newman	
02:00	02:10	Newman	
02:30	02:40	Newman	
03:00	03:10	Newman	
03:30	03:40	Newman	
04:00	04:10	Newman	
04:30	04:40	Newman	
05:00	05:10	Newman	
05:30	05:40	Newman	

1ST Watch Review-Supervisor Signature: M

ASU1 30 MINUTE WELFARE CHECK TRACKING SHEET | 2ND Watch

DATE: _____ PRISON: CSP-LAC UNIT / SECTION: A, B, C, D, E, F, G, H.

"A" SECTION	"B" SECTION	"C" SECTION	"D" SECTION	"E" SECTION	"F" SECTION	"G" SECTION	"H" SECTION
101, 107, 109	114	130, 135		148, 149, 150	176	176, 181, 187	187, 192, 197, 198

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
06:00	06:10	Tucker	
06:30	06:40	Tucker	
07:00	07:10	Tucker	
07:30	07:40	Tucker	
08:00	08:10	Tucker	
08:30	08:35	Tucker	
09:00	09:10	Tucker	
09:30	09:40	Tucker	
10:00	10:10	Tucker	
10:30	10:40	Tucker	
11:00	11:10	Tucker	
11:30	11:40	Tucker	
12:00	12:10	Tucker	
12:30	12:40	Tucker	
13:00	13:10	Tucker	
13:30	13:35	~~Tucker~~	

2ND Watch Review-Supervisor Signature:

(Note: 3RD watch on back of sheet)

ASU1 30 MINUTE WELFARE CHECK TRACKING SHEET

3RD Watch

DATE: _____ PRISON: CSP-LAC UNIT / SECTION: A, B, C, D, E, F, G, H.

"A" SECTION	"B" SECTION	"C" SECTION	"D" SECTION	"E" SECTION	"F" SECTION	"G" SECTION	"H" SECTION
102, 109,	114,	130, 135,		148, 149, 150,	170,	176, 181, 187,	189, 192, 197
							A8,

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
:00	14:09	P.DOTY	
:30	14:38	G. VAZQUEZ	
:04	15:13	P.DOTY	
:31	15:40	P.DOTY	
:05	16:15	P.DOTY	
:30	1639	G VAZQUEZ	
:01	17:09	G VAZQUEZ	
:30	17:39	G VAZQUEZ	
:00	18:08	G VAZQUEZ	
:37	18:39	G VAZQUEZ	
:00	19:09	G VAZQUEZ	
:31	19:38	G VAZQUEZ	
:00	20:08	G VAZQUEZ	
:31	20:38	G VAZQUEZ	
:00	21:07	G VAZQUEZ	
:31	2138	G VAZQUEZ	

3RD Watch Review-Supervisor Signature: SGT R Sedam (SEDAM)

ASU1 30 MINUTE WELFARE CHECK TRACKING SHEET | 1ST Watch

DATE: 1/24/13 PRISON: CSP-LAC UNIT / SECTION: A, B, C, D, E, F, G, H.

"A" SECTION	"B" SECTION	"C" SECTION	"D" SECTION	"E" SECTION	"F" SECTION	"G" SECTION	"H" SECTION
102, 107, 109, ___, ___, ___	114, ___, ___, ___, ___, ___	130, 131, ___, ___, ___, ___	___, ___, ___, ___, ___, ___	148, 149, 150, ___, ___, ___	170, ___, ___, ___, ___, ___	176, 181, 187, ___, ___, ___	189, 192, 197, 198, ___, ___

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22: 05	22: 10	BOCANEGRA	
22: 30	22: 35	BOCANEGRA	
23: 05	23: 10	BOCANEGRA	
23: 30	23: 35	BOCANEGRA	
00: 05	00: 10	BOCANEGRA	
00: 30	00: 35	BOCANEGRA	
01: 05	01: 10	BOCANEGRA	
01: 30	01: 35	BOCANEGRA	
02: 05	02: 10	BOCANEGRA	
02: 30	02: 35	BOCANEGRA	
03: 05	03: 10	BOCANEGRA	
03: 30	03: 35	BOCANEGRA	
04: 05	04: 10	BOCANEGRA	
04: 30	04: 35	BOCANEGRA	
05: 05	05: 10	BOCANEGRA	
05: 30	05: 35	BOCANEGRA	

1ST Watch Review-Supervisor Signature: DC

ASU1 30 MINUTE WELFARE CHECK TRACKING SHEET | 2ND Watch

DATE: 1/24/13 PRISON: CSP-LAC UNIT / SECTION: A, B, C, D, E, F, G, H.

"A" SECTION	"B" SECTION	"C" SECTION	"D" SECTION	"E" SECTION	"F" SECTION	"G" SECTION	"H" SECTION
102, 107, 109, ___, ___, ___	114, ___, ___, ___, ___, ___	130, 131, ___, ___, ___, ___	___, ___, ___, ___, ___, ___	148, 149, 150, ___, ___, ___	170, ___, ___, ___, ___, ___	176, 181, 187, ___, ___, ___	189, 192, 197, 198, ___, ___

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
06: 00	06: 10	M. JAMERSON	
06: 31	06: 41	M. JAMERSON	
07: 01	07: 11	M. JAMERSON	
07: 32	07: 42	M. JAMERSON	
08: 00	08: 10	M. JAMERSON	
08: 30	08: 40	M. JAMERSON	
09: 00	09: 10	M. JAMERSON	
09: 31	09: 41	M. JAMERSON	
10: 02	10: 12	M. JAMERSON	
10: 32	10: 42	M. JAMERSON	
11: 02	11: 12	M. JAMERSON	
11: 33	11: 43	M. JAMERSON	
12: 01	12: 11	M. JAMERSON	
12: 32	12: 42	M. JAMERSON	
13: 00	13: 10	M. JAMERSON	
13:	13:		

2ND Watch Review-Supervisor Signature:

(Note: 3RD watch on back of sheet)

ASU1 30 MINUTE WELFARE CHECK TRACKING SHEET

3RD Watch

DATE: 1-25-13 PRISON: CSP-LAC UNIT / SECTION: A, B, C, D, E, F, G, H,

"A" SECTION	"B" SECTION	"C" SECTION	"D" SECTION	"E" SECTION	"F" SECTION	"G" SECTION	"H" SECTION
107 109	114	131 135		148 149 150	170	176 181 187	189 192 197
				158			198

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
: 00	14: 10	M. SAUNDERS	
: 30	14: 38	M. SAUNDERS	
: 00	15: 07	M. SAUNDERS	
: 32	15: 41	P. DAILY	
: 01	16: 11	P. DAILY	
: 30	16: 39	P. DAILY	
: 03	17: 12	P DAILY	
: 30	17: 39	P DAILY	
: 04	18: 12	P. DAILY	
: 30	18: 38	M. SAUNDERS	
: 01	19: 10	M. SAUNDERS	
: 30	19: 39	M. SAUNDERS	
: 00	20: 09	P DAILY	
:33	20: 41	P DAILY	
: 05	21: 13	P DAILY	
: 31	21: 40	P DAILY	

RD Watch Review-Supervisor Signature:

PAGE 2

ASU1 30 MINUTE WELFARE CHECK TRACKING SHEET | 1st Watch

DATE: 1/25/13 PRISON: CSP-LAC UNIT / SECTION: A, B, C, D, E, F, G, H.

"A" SECTION	"B" SECTION	"C" SECTION	"D" SECTION	"E" SECTION	"F" SECTION	"G" SECTION	"H" SECTION
101, 107, 109,	114,	130, 131,		146, 149, 150,	170,	176, 181, 187,	189, 192, 197, 198,

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22: 00	22: 05	BOCANEGRA	
22: 35	22: 40	BOCANEGRA	
23: 00	23: 05	BOCANEGRA	
23: 35	23: 40	BOCANEGRA	
00: 00	00: 05	BOCANEGRA	
00: 35	00: 40	BOCANEGRA	
01: 00	01: 05	BOCANEGRA	
01: 35	01: 40	BOCANEGRA	
02: 00	02: 05	BOCANEGRA	
02: 35	02: 40	BOCANEGRA	
03: 00	03: 05	BOCANEGRA	
03: 35	03: 40	BOCANEGRA	
04: 00	04: 05	BOCANEGRA	
04: 55	04: 40	BOCANEGRA	
05: 00	05: 05	BOCANEGRA	
05: 35	05: 40	BOCANEGRA	

1ST Watch Review-Supervisor Signature: DC

ASU1 30 MINUTE WELFARE CHECK TRACKING SHEET | 2ND Watch

DATE: 1-25-13 PRISON: CSP-LAC UNIT / SECTION: A, B, C, D, E, F, G, H.

"A" SECTION	"B" SECTION	"C" SECTION	"D" SECTION	"E" SECTION	"F" SECTION	"G" SECTION	"H" SECTION
101, 107, 109,	114,	130, 135,		148, 149, 150	170,	176, 181, 187,	189, 192, 197, 198,

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
06:05	06:10	L.E. Newman	
06:30	06:35	L.E. Newman	
07:05	07:10	L.E. Newman	
07:35	07:40	L.E. Newman	
08:05	08:10	L.E. Newman	
08:30	08:35	L.E. Newman	
09:00	09:05	L.E. Newman	
09:30	09:35	L.E. Newman	
10:00	10:05	L.E. Newman	
10:35	10:40	L.E. Newman	
11:05	11:10	L.E. Newman	
11:35	11:40	L.E. Newman	
:05	12:10	L.E. Newman	
:35	12:40	L.E. Newman	
13:00	13:05	L.E. Newman	
13:25	13:30	L.E. Newman	

2ND Watch Review-Supervisor Signature:

(Note: 3RD watch on back of sheet)

ASU1 30 MINUTE WELFARE CHECK TRACKING SHEET

3RD Watch

DATE: _____ PRISON: CSP-LAC UNIT / SECTION: A, B, C, D, E, F, G, H.

"A" SECTION	"B" SECTION	"C" SECTION	"D" SECTION	"E" SECTION	"F" SECTION	"G" SECTION	"H" SECTION
103	114	130, 131	~~DARK~~, ~~DARK~~	148, 149	176	176, 181, 187	189, 192
			~~DARK~~	158			197, 198

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
14:00	14:09	P. DATY	
14:31	14:41	P. DATY	
15:00	15:08	P. DATY	
15:30	15:39	P. DATY	
16:00	16:08	P. DATY	
16:33	16:42	P. DATY	
17:00	17:09	G. VAZQUEZ	
17:31	17:38	G. VAZQUEZ	
18:01	18:09	G. VAZQUEZ	
18:30	18:37	G. VAZQUEZ	
19:00	19:09	G. VAZQUEZ	
19:32	19:39	G. VAZQUEZ	
20:00	20:07	G. VAZQUEZ	
20:31	20:38	G. VAZQUEZ	
21:00	21:09	G. VAZQUEZ	
21:31	21:41	P. DATY	

3RD Watch Review-Supervisor Signature:

PAGE 2

ASU1 30 MINUTE WELFARE CHECK TRACKING SHEET | 1st Watch

DATE: 1-26-13 PRISON: CSP-LAC UNIT / SECTION: A, B, C, D, E, F, G, H,

"A" SECTION	"B" SECTION	"C" SECTION	"D" SECTION	"E" SECTION	"F" SECTION	"G" SECTION	"H" SECTION
101, 107, 109	114	131, 135		148, 149, 150, 158	170	178, 181, 187	189, 192, 197, 198

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22: 05	22: 10	Newman	
22: 36	22: 40	Newman	
23: 05	23: 10	Newman	
23: 30	23: 40	Newman	
00: 05	00: 10	Newman	
00: 30	00: 40	Newman	
01: 05	01: 10	Newman	
01: 30	01: 40	Newman	
02: 05	02: 10	Newman	
02: 30	02: 40	Newman	
03: 05	03: 10	Newman	
03: 30	03: 40	Newman	
04: 05	04: 10	Newman	
04: 30	04: 40	Newman	
05: 05	05: 10	Newman	
05: 30	05: 40	Newman	

1ST Watch Review-Supervisor Signature:

ASU1 30 MINUTE WELFARE CHECK TRACKING SHEET | 2ND Watch

DATE: 1-26-13 PRISON: CSP-LAC UNIT / SECTION: A, B, C, D, E, F, G, H,

"A" SECTION	"B" SECTION	"C" SECTION	"D" SECTION	"E" SECTION	"F" SECTION	"G" SECTION	"H" SECTION
109, 107		135		149, 150	170	178, 181, 187	189, 192, 197

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
06: 00	06: 10	J. MELENDEZ	
06: 30	06: 40	J. MELENDEZ	
07: 00	07: 10	J. MELENDEZ	
07: 30	07: 40	J. MELENDEZ	
08: 00	08: 09	J. MELENDEZ	
08: 31	08: 38	J. MELENDEZ	
09: 00	09: 10	J. MELENDEZ	
09: 31	09: 39	J. MELENDEZ	
10: 00	10: 10	J. MELENDEZ	
10: 30	10: 40	J. MELENDEZ	
11: 00	11: 10	J. MELENDEZ	
11: 30	11: 40	J. MELENDEZ	
12: 00	12: 10	J. MELENDEZ	
12: 30	12: 40	J. MELENDEZ	
13: 00	13: 10	J. MELENDEZ	
13: 30	13: 40	J. MELENDEZ	

2ND Watch Review-Supervisor Signature:

(Note: 3RD watch on back of sheet)

ASU1 30 MINUTE WELFARE CHECK TRACKING SHEET

3RD Watch

DATE: 1-27-13 PRISON: CSP-LAC UNIT / SECTION: A, B, C, D, E, F, G, H,

"A" SECTION	"B" SECTION	"C" SECTION	"D" SECTION	"E" SECTION	"F" SECTION	"G" SECTION	"H" SECTION
107, 109	114, ___, ___	130, 131, ___	148, 149, 153	170, ~~165~~ ___	176, 181, 187	___, ___, ___	189, 192, 197
___, ___, ___	___, ___, ___	___, ___, ___	~~152~~ ___, ___	___, ___, ___	___, ___, ___	___, ___, ___	198, ___, ___
___, ___, ___	___, ___, ___	___, ___, ___	___, ___, ___	___, ___, ___	___, ___, ___	___, ___, ___	___, ___, ___
___, ___, ___	___, ___, ___	___, ___, ___	___, ___, ___	___, ___, ___	___, ___, ___	___, ___, ___	___, ___, ___

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
:00	14:10	R. Lesher	
:30	14:40	R. Lesher	
:00	15:10	R. Lesher	
:30	15:40	R. Lesher	
:00	16:10	R. Lesher	
:30	16:40	R. Lesher	
:00	17:09	G Vazquez	
:31	17:39	G Vazquez	
:00	18:09	G Vazquez	
:31	18:39	G Vazquez	
:00	19:09	G Vazquez	
:30	19:30	R. Lesher	
:00	20:10	R. Lesher	
:31	20:39	G Vazquez	
:00	21:09	G Vazquez	
:31	21:39	G Vazquez	

3RD Watch Review-Supervisor Signature:

PAGE 2

ASU1 30 MINUTE WELFARE CHECK TRACKING SHEET | 1ST Watch

DATE: 1-27-13 PRISON: CSP-LAC UNIT / SECTION: A, B, C, D, E, F, G, H

"A" SECTION	"B" SECTION	"C" SECTION	"D" SECTION	"E" SECTION	"F" SECTION	"G" SECTION	"H" SECTION
101, 107, 109	114	130, 131		148, 149, 150	170	176, 181, 187	189, 192, 197, 198

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22:00	22:10	Newman	
22:30	22:40	Newman	
23:00	23:10	Newman	
23:30	23:40	Newman	
00:00	00:10	Newman	
00:30	00:40	Newman	
01:00	01:10	Newman	
01:30	01:40	Newman	
02:00	02:10	Newman	
02:30	02:40	Newman	
03:00	03:10	Newman	
03:30	03:40	Newman	
04:00	04:10	Newman	
04:30	04:40	Newman	
05:00	05:10	Newman	
05:30	05:40	Newman	

1ST Watch Review-Supervisor Signature:

ASU1 30 MINUTE WELFARE CHECK TRACKING SHEET | 2ND Watch

DATE: 1-27-13 PRISON: CSP-LAC UNIT / SECTION: A, B, C, D, E, F, G, H

"A" SECTION	"B" SECTION	"C" SECTION	"D" SECTION	"E" SECTION	"F" SECTION	"G" SECTION	"H" SECTION
101, 107, 109	114	130, 131	[illegible]	148, 149, 150	170	176, 181, 187	189, 192, 197, 198

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
06:00	06:05	V. MORRIS	
06:30	06:37	V. MORRIS	
07:00	07:05	V. MORRIS	
07:30	07:37	V. MORRIS	
08:00	08:05	V. MORRIS	
08:30	08:35	V. MORRIS	
09:00	09:05	V. MORRIS	
09:30	09:37	V. MORRIS	
10:00	10:07	V. MORRIS	
10:30	10:35	V. MORRIS	
11:00	11:07	V. MORRIS	
11:30	11:35	V. MORRIS	
12:00	12:05	V. MORRIS	
12:30	12:35	V. MORRIS	
13:00	13:05	V. MORRIS	
13:30	13:37	V. MORRIS	

2ND Watch Review-Supervisor Signature:

(Note: 3RD watch on back of sheet)

ASU1 30 MINUTE WELFARE CHECK TRACKING SHEET

3RD Watch

DATE: 1·28·13 PRISON: CSP-LAC UNIT / SECTION: A. B. C. D. E. F. G. H.

"A" SECTION	"B" SECTION	"C" SECTION	"D" SECTION	"E" SECTION	"F" SECTION	"G" SECTION	"H" SECTION
107, 109,	114,	130, 134,		145, 149, 150	170,	176, 181, 187	189, 192/197
							198

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
14:00	14:15	C. Compland	
14:30	14:45	C. Compland	
15:00	15:15	C Compland	
15:30	15:45	C. Compland	
16:00	16:15	C. Compland	
16:30	16:45	C. Compland	
17:00	17:15	C. Compland	
17:30	17:45	C. Compland	
18:00	18:15	C. Compland	
18:30	18:45	C. Compland	
19:00	19:15	C. Compland	
19:30	19:45	C. Compland	
20:00	20:15	C. Compland	
20:30	20:45	C. Compland	
21:00	21:15	C. Compland	
21:30	21:45	C Compland	

3RD Watch Review-Supervisor Signature:

ASU1 30 MINUTE WELFARE CHECK TRACKING SHEET | 1st Watch

DATE: 1-28-13 PRISON: CSP-LAC UNIT / SECTION: A, B, C, D, E, F, G, H.

"A" SECTION	"B" SECTION	"C" SECTION	"D" SECTION	"E" SECTION	"F" SECTION	"G" SECTION	"H" SECTION
101, 107, 161,	114,	130, 131,	148, 149, 150,	170,	176, 181, 187,		189, 192, 197, 198,

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22: 00	22: 10	Newman	
22: 30	22: 40	Newman	
23: 00	23: 10	Newman	
23: 30	23: 40	Newman	
00: 00	00: 10	Newman	
00: 30	00: 40	Newman	
01: 00	01: 10	Newman	
01: 30	01: 40	Newman	
02: 00	02: 10	Newman	
02: 30	02: 40	Newman	
03: 00	03: 10	Newman	
03: 30	03: 40	Newman	
04: 00	04: 10	Newman	
04: 30	04: 40	Newman	
05: 00	05: 10	Newman	
05: 30	05: 40	Newman	

1ST Watch Review-Supervisor Signature:

ASU1 30 MINUTE WELFARE CHECK TRACKING SHEET | 2ND Watch

DATE: 1-28-13 PRISON: CSP-LAC UNIT / SECTION: A, B, C, D, E, F, G, H.

"A" SECTION	"B" SECTION	"C" SECTION	"D" SECTION	"E" SECTION	"F" SECTION	"G" SECTION	"H" SECTION
101, 107, 161, 109,	114,	130, 131,	148, 149, 150,	170,	176, 181, 187,		189, 192, 197, 198,

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
06: 10	06: 20	K. Humphrey	
06: 40	06: 50	K. Humphrey	
07: 10	07: 20	K. Humphrey	
07: 30	07: 40	K. Humphrey	
08: 00	08: 10	K. Humphrey	
08: 30	08: 40	K. Humphrey	
09: 00	09: 10	K. Humphrey	
09: 30	09: 40	K. Humphrey	
10: 05	10: 15	A. GRANADOS	
10: 40	10: 55	A. GRANADOS	
11: 10	11: 17	A. GRANADOS	
11: 40	11: 51	A. GRANADOS	
12: 05	12: 15	A. GRANADOS	
12: 40	12: 48	A. GRANADOS	
13: 01	13: 10	A. GRANADOS	
13: 30	13: 40	A. GRANADOS	

2ND Watch Review-Supervisor Signature:

(Note: 3rd watch on back of sheet)

ASU1 30 MINUTE WELFARE CHECK TRACKING SHEET

3RD Watch

DATE: 1-29-17 PRISON: CSP-LAC UNIT / SECTION: A. B. C. D. E. F. G. H.

"A" SECTION	"B" SECTION	"C" SECTION	"D" SECTION	"E" SECTION	"F" SECTION	"G" SECTION	"H" SECTION
109		135		149	170	187	189
							191 197

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
14:00	14:05	P. DAY	
14:34	14:42	P. DAY	
15:00	15:10	P DAY	
15:31	15:40	P DAY	
16:00	16:10	P. DAY	
16:32	16:42	P. DAY	
17:04	17:15	C. Copeland	
17:30	17:46	C. Copeland	
18:00	18:09	P DAY	
18:30	18:39	P DAY	
19:02	19:10	P DAY	
19:31	19:40	P DAY	
20:00	20:09	P DAY	
20:34	20:42	P DAY	
21:01	21:09	P DAY	
21:33	21:42	P DAY	

3RD Watch Review-Supervisor Signature:

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ASU1 30 MINUTE WELFARE CHECK TRACKING SHEET

1ST Watch

DATE: 1-29-13 PRISON: CSP-LAC UNIT / SECTION: A, B, C, D, E, F, G, H.

"A" SECTION	"B" SECTION	"C" SECTION	"D" SECTION	"E" SECTION	"F" SECTION	"G" SECTION	"H" SECTION
101, 107, 109	114	130, 131		148, 149, 150	170	176, 181, 187	189, 192, 197, 198

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22: 00	22: 10	Newman	
22: 30	22: 40	Newman	
23: 00	23: 10	Newman	
23: 30	23: 40	Newman	
00: 00	00: 10	Newman	
00: 30	00: 40	Newman	
01: 00	01: 10	Newman	
01: 30	01: 40	Newman	
02: 00	02: 10	Newman	
02: 30	02: 40	Newman	
03: 00	03: 10	Newman	
03: 30	03: 40	Newman	
04: 00	04: 10	Newman	
04: 30	04: 40	Newman	
05: 00	05: 10	Newman	
05: 30	05: 40	Newman	

1ST Watch Review-Supervisor Signature:

ASU1 30 MINUTE WELFARE CHECK TRACKING SHEET

2ND Watch

DATE: 1-29-13 PRISON: CSP-LAC UNIT / SECTION: A, B, C, D, E, F, G, H.

"A" SECTION	"B" SECTION	"C" SECTION	"D" SECTION	"E" SECTION	"F" SECTION	"G" SECTION	"H" SECTION
107, 109		135		149	170	181, 187	189, 192, 197

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
06: 05	06: 17	GIANDOLA	
06: 40	06: 52	GIANDOLA	
07: 10	07: 17	GIANDOLA	
07: 45	07: 55	GIANDOLA	
08: 10	08: 17	GIANDOLA	
08: 50	08: 56	GIANDOLA	
09: 10	09: 17	GIANDOLA	
09: 40	09: 50	GIANDOLA	
10: 10	10: 17	GIANDOLA	
10: 40	10: 49	GIANDOLA	
11: 01	11: 09	GIANDOLA	
11: 42	11: 52	GIANDOLA	
12: 10	12: 15	GIANDOLA	
12: 30	12: 35	GIANDOLA	
13: 01	13: 06	GIANDOLA	
13: 30	13: 37	GIANDOLA	

2ND Watch Review-Supervisor Signature:

(Note: 3RD watch on back of sheet)

ASU1 30 MINUTE WELFARE CHECK TRACKING SHEET

3RD Watch

DATE: 1-30-13 PRISON: CSP-LAC UNIT / SECTION: A. B. C. D. E. F. G. H.

"A" SECTION	"B" SECTION	"C" SECTION	"D" SECTION	"E" SECTION	"F" SECTION	"G" SECTION	"H" SECTION
109		135				178, 181, 177,	179

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
:00	14: 10	D. SIMPSON	
: 30	14: 40	D. SIMPSON	
: 00	15: 10	D. SIMPSON	
: 30	15: 40	D. SIMPSON	
: 00	16: 10		
: 30	16: 40		
: 00	17: 10		
: 30	17: 40		
: 00	18: 10		
: 30	18: 40		
: 00	19: 10		
: 30	19: 40		
: 00	20: 10		
: 30	20: 40		
: 00	21: 10		
: 30	21: 40		

RD Watch Review-Supervisor Signature:

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ASU1 30 MINUTE WELFARE CHECK TRACKING SHEET | 1st Watch

DATE: 1-30-13 PRISON: CSP-LAC UNIT / SECTION: A, B, C, D, E, F, G, H.

"A" SECTION	"B" SECTION	"C" SECTION	"D" SECTION	"E" SECTION	"F" SECTION	"G" SECTION	"H" SECTION
107, 109		135		149	170	181, 187	189, 191, 197

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22: 00	22: 16	Newman	
22: 30	22: 40	Newman	
23: 00	23: 10	Newman	
23: 30	23: 40	Newman	
00: 00	00: 10	Newman	
00: 30	00: 40	Newman	
01: 00	01: 10	Newman	
01: 30	01: 40	Newman	
02: 00	02: 10	Newman	
02: 30	02: 40	Newman	
03: 00	03: 10	Newman	
03: 30	03: 40	Newman	
04: 00	04: 10	Newman	
04: 30	04: 40	Newman	
05: 00	05: 10	Newman	
05: 30	05: 40	Newman	
1ST Watch Review-Supervisor Signature:			

ASU1 30 MINUTE WELFARE CHECK TRACKING SHEET | 2ND Watch

DATE: 1-30-13 PRISON: CSP-LAC UNIT / SECTION: A, B, C, D, E, F, G, H.

"A" SECTION	"B" SECTION	"C" SECTION	"D" SECTION	"E" SECTION	"F" SECTION	"G" SECTION	"H" SECTION
109		135				178, 181, 187	189

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
06:00	06: 10	C. Tucker	
06:30	06: 40	C. Tucker	
07: 00	07: 10	C. Tucker	
07: 30	07: 40	C. Tucker	
08: 00	08: 07	C. Tucker	
08:30	08: 37	C. Tucker	
09: 00	09: 10	C. Tucker	
09: 30	09: 40	C. Tucker	
10: 00	10: 07	C. Tucker	
10: 30	10: 37	C. Tucker	
11: 00	11: 10	C. Tucker	
11: 30	11: 40	C. Tucker	
12: 00	12: 10	C. Tucker	
12: 30	12: 40	C. Tucker	
13: 00	13: 10	C. Tucker	
13: 30	13: 40	C. Tucker	
2ND Watch Review-Supervisor Signature:			

(Note: 3RD watch on back of sheet)

ASU1 30 MINUTE WELFARE CHECK TRACKING SHEET

3RD Watch

DATE: 1-31-12 PRISON: CSP-LAC UNIT / SECTION: A, B, C, D, E, F, G, H

"A" SECTION	"B" SECTION	"C" SECTION	"D" SECTION	"E" SECTION	"F" SECTION	"G" SECTION	"H" SECTION
7, 15		135	149	147	123	161, 163	189, 191, 193

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
13: 00	14: 10	M SAUNDERS	
13: 30	14: 36	M. SAUNDERS	
14: 00	15: 08	M. SAUNDERS	
14: 31	15: 29	M. SAUNDERS	
15: 02	16: 15	M. SAUNDERS	
15:	16:		
16:	17:		
16:	17:		
17:	18:		
17:	18:		
18:	19:		
18:	19:		
19:	20:		
19:	20:		
20:	21:		
20:	21:		

3RD Watch Review-Supervisor Signature:

ASU1 30 MINUTE WELFARE CHECK TRACKING SHEET | 1ST Watch

DATE: 1/31/13 PRISON: CSP-LAC UNIT / SECTION: A, B, C, D, E, F, G, H,

"A" SECTION	"B" SECTION	"C" SECTION	"D" SECTION	"E" SECTION	"F" SECTION	"G" SECTION	"H" SECTION
107, 109,		135,		149,	170,	181, 187,	189, 191, 197

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22: 05	22: 10	BOCANEGRA	
22: 30	22: 35	BOCANEGRA	
23: 05	23: 10	BOCANEGRA	
23: 30	23: 35	BOCANEGRA	
00: 05	00: 10	BOCANEGRA	
00: 30	00: 35	BOCANEGRA	
01: 05	01: 10	BOCANEGRA	
01: 30	01: 35	BOCANEGRA	
02: 05	02: 10	BOCANEGRA	
02: 30	02: 35	BOCANEGRA	
03: 05	03: 10	BOCANEGRA	
03: 30	03: 35	BOCANEGRA	
04: 05	04: 10	BOCANEGRA	
04: 30	04: 35	BOCANEGRA	
05: 05	05: 10	BOCANEGRA	
05: 30	05: 35	BOCANEGRA	

1ST Watch Review-Supervisor Signature:

ASU1 30 MINUTE WELFARE CHECK TRACKING SHEET | 2ND Watch

DATE: 1/31/13 PRISON: CSP-LAC UNIT / SECTION: A, B, C, D, E, F, G, H,

"A" SECTION	"B" SECTION	"C" SECTION	"D" SECTION	"E" SECTION	"F" SECTION	"G" SECTION	"H" SECTION
107 109		135		149	170	181, 187	189, 191, 197

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
06: 00	06: 10	M. JAMERSON	
06: 32	06: 42	M. JAMERSON	
07: 01	07: 11	M. JAMERSON	
07: 30	07: 40	M. JAMERSON	
08: 02	08: 12	M. JAMERSON	
08: 31	08: 41	M. JAMERSON	
09: 02	09: 12	M. JAMERSON	
09: 30	09: 40	M. JAMERSON	
10: 01	10: 11	M. JAMERSON	
10: 33	10: 43	M. JAMERSON	
11: 00	11: 10	M. JAMERSON	
11: 32	11: 42	M. JAMERSON	
12: 02	12: 12	M. JAMERSON	
12: 30	12: 40	M. JAMERSON	
13: 01	13: 11	M. JAMERSON	
13: 30	13: 40	M. JAMERSON	

2ND Watch Review-Supervisor Signature:

(Note: 3RD watch on back of sheet)

Exhibit 59

Overflow and Alternative Housing	
A-Yard	HU 1 cells 1-150
B-Yard	HU 6 cells 123-128 and 222-229
C-Yard	HU 15 cell 150

124 is DPW,
125 appears not in take

Total Inmates in Overflow and Alternative Housing as of 2/11/13: 0

Segregated Housing Units
Yard B: HU 6 houses ASU EOP & ASU CCCMS
Yard B: HU 7 houses ASU CCCMS and Non-MHSDS inmates

Exhibit 60

5th Tier

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2/17 2012 UNIT: CARSON SECTION

CELL NUMBERS IN SECTION CARSON

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10:00	10:03	Jones	
10:30	10:33	Jones	
11:00	11:05	Jones	
11:33	11:35	Jones	
12:00	12:03	Jones	
12:30	12:35	Jones	
13:00	13:05	Jones	
13:25	13:30	Jones	
14:00	14:03	VALUE	
14:28	14:35	VALUE	
15:01	15:04	VALUE	
15:30	15:32	VALUE	
16:00	16:02	VALUE	
16:30	16:32	VALUE	
17:01	17:04	VALUE	
17:30	17:32	VALUE	
18:01	18:02	VALUE	
18:30	18:33	VALUE	
19:00	19:04	VALUE	
19:31	19:35	VALUE	
20:00	20:02	VALUE	
20:30	20:33	VALUE	
21:00	21:02	VALUE	
21:25	21:30	VALUE	

1ST Watch Review - Supervisor Signature: DJP

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

5th Tier

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2012 2-17-13 UNIT: CARSON SECTION

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10: 00	10: 02	[illegible]	
10: 32	10: 35	[illegible]	
11: 00	11: 03	[illegible]	
11: 24	11: 26	[illegible]	
12: 02	12: 05	[illegible]	
12: 30	12: 34	[illegible]	
13: 00	13: 05	[illegible]	
13: 34	13: 38	[illegible]	
14: 01	14: 04	[illegible]	
14: 31	14: 36	[illegible]	
15: 00	15: 10	[illegible]	
15: 31	15: 35	[illegible]	
16: 02	16: 08	[illegible]	
16: 32	16: 36	[illegible]	
17: 00	17: 05	[illegible]	
17: 30	17: 34	[illegible]	
18: 02	18: 06	[illegible]	
18: 31	18: 34	[illegible]	
19: 02	19: 08	[illegible]	
19: 33	19: 36	[illegible]	
20: 01	20: 07	[illegible]	
20: 32	20: 34	[illegible]	
21: 02	21: 04	[illegible]	
21: 34	21: 36	[illegible]	

1ST Watch Review - Supervisor Signature: [illegible]

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

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ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: ~~2012~~ 2-17-2013 (3) UNIT: CARSON SECTION

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10: 04	10: 05	GUTIERREZ	
10: 34	10: 35	GUTIERREZ	
11: 05	11: 08	HERNANDEZ J	
11: 30	11: 33	HERNANDEZ J	
12: 03	12: 08	HERNANDEZ J	
12: 30	12: 33	HERNANDEZ J	
13: 03	13: 07	HERNANDEZ J	
13: 34	13: 38	HERNANDEZ J	
14: 00	14: 02	AWC	
14: 25	14: 27	AWC	
15: 02	15: 05	AWC	
15: 35	15: 37	AWC	
16: 00	16: 08	AWC	
16: 25	16: 32	AWC	
17: 00	17: 02	AWC	
17: 25	17: 27	AWC	
18: 03	18: 05	AWC	
18: 35	18: 37	AWC	
19: 05	19: 07	AWC	
19: 32	19: 35	AWC	
20: 05	20: 07	AWC	
20: 30	20: 32	AWC	
21: 00	21: 02	AWC	
21: 24	21: 26	AWC	

1ST Watch Review - Supervisor Signature: DJM

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2-17-2013 (2) UNIT: CARSON SECTION

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10:01	10:04	Phillips	
10:30	10:34	BALAND	
11:00	11:05	BALAND	
11:30	11:33	BALAND	
12:01	12:04	BALAND	
12:30	12:33	BALAND	
13:02	13:06	BALAND	
13:30	13:34	BALAND	
14:00	14:04	Hamwell	
14:30	14:35	Hamwell	
15:02	15:05	Hamwell	
15:33	15:37	Hamwell	
16:01	16:04	Hamwell	
16:32	16:36	Hamwell	
17:01	17:04	Hamwell	
17:31	17:35	Hamwell	
18:00	18:04	Hamwell	
18:30	18:34	Hamwell	
19:02	19:06	Hamwell	
19:31	19:35	Hamwell	
20:00	20:04	Hamwell	
20:31	20:35	Hamwell	
21:00	21:05	Hamwell	
21:30	21:35	Hamwell	

1ST Watch Review - Supervisor Signature: DSM

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

SQ 609

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2-17-13 2012 13 UNIT: CARSON SECTION

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10:02	10:04	SCOTT	KS.
10:30	10:32	SCOTT	KS
11:04	11:06	SCOTT	KS.
11:31	11:33	SCOTT	KS
12:06	12:08	SCOTT	KS
12:31	12:33	SCOTT	KS
13:00	13:02	SCOTT	KS
13:31	13:34	SCOTT	KS
14:01	14:05	SAECHAO	KFS
14:30	14:35	SAECHAO	KFS
15:~~01~~ 00	15:~~37~~ 04	SAECHAO	KFS.
15:30	15:35	SAECHAO	KFS.
16:01	16:03	SAECHAO	KFS
16:30	16:33	SAECHAO	KFS
17:01	17:04.	SAECHAO	KFS
17:25	17:30	SAECHAO	
18:04	18:08	GUIA	
18:31	18:35	GUIA	
19:05	19:08	GUIA	
19:32	19:36	GUIA	
20:01	20:04	GUIA	
20:30	20:34	GUIA	
21:01	21:04	GUIA	
21:26	21:32	GUIA	

1ST Watch Review - Supervisor Signature: DJT

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

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(1)

5th Tier

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2/18/ 2013 [redacted] UNIT: CARSON SECTION

CELL NUMBERS IN SECTION CARSON

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10:00	10:03	Dionne	
10:30	10:33	Dionne	
11:00	11:04	Dionne	
11:30	11:34	Dionne	
12:00	12:04	Dionne	
12:30	12:34	Dionne	
13:00	13:03	Jones	
13:25	13:30	Toner	
14:00	14:04	Acero	
14:32	14:36	Acero	
15:00	15:05	Acero	
15:32	15:36	Acero	
16:00	16:04	Acero	
16:31	16:36	Acero	
17:00	17:05	Acero	
17:31	17:36	Acero	
18:00	18:04	Acero	
18:33	18:36	Acero	
19:00	19:04	Acero	
19:31	19:35	Acero	
20:00	20:04	Acero	
20:32	20:35	Acero	
21:00	21:04	Acero	
21:33	21:37	Acero	

1ST Watch Review - Supervisor Signature: D-M

2nd Watch Review - Supervisor Signature: R T

3rd Watch Review - Supervisor Signature:

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5th Tier

SQ 611

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: [redacted]2013 2/18/13 4TH UNIT: CARSON SECTION

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10:00	10:02	[illegible]	[illegible]
10:30	10:32	[illegible]	[illegible]
11:00	11:02	[illegible]	[illegible]
11:30	11:32	[illegible]	[illegible]
12:00	12:02	[illegible]	[illegible]
12:30	12:32	[illegible]	[illegible]
13:00	13:02	[illegible]	[illegible]
13:30	13:32	[illegible]	[illegible]
14:05	14:10	[illegible]	[illegible]
14:29	14:35	[illegible]	[illegible]
15:04	15:08	[illegible]	[illegible]
15:27	15:31	[illegible]	[illegible]
16:01	16:05	[illegible]	[illegible]
16:31	16:35	[illegible]	[illegible]
17:04	17:08	[illegible]	[illegible]
17:31	17:36	[illegible]	[illegible]
18:01	18:05	[illegible]	[illegible]
18:29	18:33	[illegible]	[illegible]
19:04	19:07	[illegible]	[illegible]
19:26	19:30	[illegible]	[illegible]
20:00	20:04	[illegible]	[illegible]
20:29	20:33	[illegible]	[illegible]
21:01	21:05	[illegible]	[illegible]
21:27	21:30	[illegible]	[illegible]

1ST Watch Review - Supervisor Signature: [illegible]

2nd Watch Review - Supervisor Signature: [illegible]

3rd Watch Review - Supervisor Signature:

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4TH

SQ 612

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: [redacted]2013 3RP UNIT: CARSON SECTION

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10:01	10:05	CARROSIO	
10:32	10:36	CARROSIO	
11:00	11:04	CARROSIO	
11:31	11:35	CARROSIO	
12:03	12:07	CARROSIO	
12:00	12:05	CARROSO	
13:30	13:34	CARROSO	
13:	13:		
14:00	14:02	AWL	
14:32	14:35	AWL	
15:05	15:07	AWL	
15:25	15:35	AWL	
16:00	16:08	AWL	
16:24	16:26	AWL	
17:03	17:05	AWL	
17:25	17:27	AWL	
18:05	18:07	AWL	
18:29	18:30	AWL	
19:00	19:02	AWL	
19:25	19:27	AWL	
20:00	20:02	AWL	
20:30	20:32	AWL	
21:02	21:04	AWL	
21:24	21:26	AWL	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

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ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2013 [redacted] UNIT: CARSON SECTION

CELL NUMBERS IN SECTION 2ND TIER

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10:00	10:03	Phillips	SPh
10:31	10:34	Phillips	SPh
11:02	11:04	Phillips	SPh
11:31	11:33	Phillips	SPh
12:00	12:02	Phillips	SPh
12:31	12:33	Phillips	SPh
13:01	13:03	Phillips	SPh
13:23	13:24	Phillips	SPh
14:02	14:05	Jones	Jones
14:33	14:35	Jones	Jones
15:01	15:04	Jones	Jones
15:32	15:34	Jones	Jones
16:01	16:03	Jones	Jones
16:33	16:35	Jones	Jones
17:00	17:04	Jones	Jones
17:32	17:34	Jones	Jones
18:02	18:05	Jones	Jones
18:33	18:35	Jones	Jones
19:	19:		
19:	19:		
20:	20:		
20:	20:		
21:	21:		
21:	21:		

1ST Watch Review - Supervisor Signature: DJ

2nd Watch Review - Supervisor Signature: R

3rd Watch Review - Supervisor Signature:

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ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 02-18-[redacted] UNIT: CARSON SECTION

CELL NUMBERS IN SECTION 1ST TIER

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10:00	10:04	BARR	
10:31	10:35	HANNAH	
11:05	11:10	BARR	
11:31	11:34	HANNAH	
12:00	12:03	HANNAH	
12:33	12:35	BARR	
13:00	13:33	HANNAH	
13:30	13:33	HANNAH	
14:00	14:07		
14:31	14:38		
15:02	15:08		
15:31	15:37		
16:00	16:04		
16:31	16:36		
17:01	17:07		
17:32	17:38		
18:04	18:09		
18:33	18:4.		
19:00	19:09		
19:30	19:35		
20:00	20:05		
20:30	20:35		
21:00	21:07		
21:31	21:36		

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

SQ 615

4TH TIER

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2/22/13 PRISON SAN QUENTIN UNIT/SECTION CARSON SECTION

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
12:00	12:02	BLASCO	
12:20	12:23		
13:00	13:02		
13:20	13:23		
14:00	14:05	Spencer	
14:30	14:35	Spencer	
15:00	15:05	Spencer	
15:30	15:35	Spencer	
16:00	16:05	Spencer	
16:30	16:35	Spencer	
17:00	17:05	Spencer	
17:30	17:35	Spencer	
18:00	18:05	Spencer	
18:30	18:35	Spencer	
19:00	19:05	Spencer	
19:30	19:35	Spencer	
20:00	20:05	Spencer	
20:30	20:35	Spencer	
21:00	21:05	Spencer	
21:30	21:35	Spencer	
22:00	22:05	KOTRODE	
22:30	22:35	KOTRODE	
23:00	23:05	KOTRODE	
23:30	23:35	KOTRODE	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

3RD TIER

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2/22/13 PRISON SAN QUENTIN UNIT/SECTION CARSON SECTION

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
12: 00	12: 04	F/Hernandez	
12: 31	12:35	F/Hernandez	
13: 00	13: 04	F/Hernandez	
13: 27	13: 31	F/Hernandez	
14: 05	14: 10	H. deleon	H. de
14: 31	14: 38	H. deleon	H. de
15: 06	15: 12	H. deleon	H. de
15: 35	15: 40	H. deleon	H. de
16: 01	16: 08	H. deleon	H. de
16: 33	16: 41	H. deleon	H. de
17: 00	17: 05	H. deleon	H. de
17: 30	17: 35	H. deleon	H. de
18: 01	18: 09	H. deleon	H. de
18: 30	18: 32	Arce	
19: 02	19: 04	Arce	
19: 35	19: 37	Arce	
20: 05	20: 07	Arce	
20: 25	20: 27	Arce	
21: 04	21: 06	Arce	
21: 24	21: 26	Arce	
22: 00	22: 04	Ramirez	
22: 30	22: 35	Ramirez	
23: 00	23: 05	Ramirez	
23: 30	23: 35	Ramirez	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

2ND TIER

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2/22/13 PRISON SAN QUENTIN UNIT/SECTION CARSON SECTION

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
12:00	12:03	A. SULLIVAN	
12:30	12:32	A. SULLIVAN	
13:00	13:03	A. Sull	
13:30	13:37	A. Sull	
14:00	14:05	G. GALCZYNSKI	
14:28	14:33	G. GALCZYNSKI	
15:02	15:07	G. GALCZYNSKI	
15:34	15:39	G. GALCZYNSKI	
16:08	16:12	G. GALCZYNSKI	
16:31	16:36	G. GALCZYNSKI	
17:04	17:09	G. GALCZYNSKI	
17:27	17:32	G. GALCZYNSKI	
18:01	18:06	G. GALCZYNSKI	
18:33	18:38	G. GALCZYNSKI	
19:00	19:05	G. GALCZYNSKI	
19:32	19:37	G. GALCZYNSKI	
20:06	20:11	G. GALCZYNSKI	
20:37	20:42	G. GALCZYNSKI	
21:09	21:14	G. GALCZYNSKI	
21:30	21:35	G. GALCZYNSKI	
22:00	22:05	[illegible]	
22:30	22:35	[illegible]	
23:00	23:05	[illegible]	
23:30	23:35	[illegible]	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

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1ST TIER

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2/22/13 PRISON SAN QUENTIN UNIT/SECTION CARSON SECTION

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
12: 00	12: 03	I CONASIAK	
12: 30	12: 34	I CONASIAK	
13: 01	13: 05	I CONASIAK	
13: 30	13: 34	Valenzuela	
14: 00	14: 04		
14: 31	14: 38		
15: 02	15: 10		
15: 33	15: 39		
16: 01	16: 10		
16: 31	16: 38		
17: 03	17: 07		
17: 32	17: 40		
18: 01	18: 06		
18: 34	18: 40		
19: 00	19: 03		
19: 36	19: 42		
20: 02	20: 07		
20: 30	20: 35		
21: 01	21: 05		
21: 30	21: 35		
22: 00	22: 05	[illegible]	
22: 30	22: 35	[illegible]	
23: 00	23: 05	[illegible]	
23: 30	23: 35	[illegible]	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

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5TH TIER

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2/22/13 PRISON SAN QUENTIN UNIT/SECTION CARSON SECTION

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
12: 00	12: 03	JONES	Jones
12:30	12:33	JONES	Jones
13: 00	13: 05	JONES	Jones
13:25	13: 30	JONES	Jones
14: 00	14: 03	VALLE	
14: 30	14: 32	VALLE	
15: 00	15: 02	VALLE	
15:30	15: 32	VALLE	
16: 00	16:02	VALLE	
16: 30	16: 32	VALLE	
17: 02	17: 06	MARQUARDT	
17: 28	17: 34	MARQUARDT	
18: 01	18: 06	MARQUARDT	
18:30	18:32	VALLE	
19: 01	19:04	VALLE	
19: 32	19:32	VALLE	
20: 03	20:05	MARQUARDT	
20: 29	20: 34	MARQUARDT	
21: 06	21: 06	MARQUARDT	
21: 20	21: 25	MARQUARDT	
22: 00	22: 05	[illegible]	
22: 30	22: 35	[illegible]	
23: 00	23: 04	[illegible]	
23:30	23: 35	[illegible]	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2-21-13 2013 UNIT: CARSON SECTION

CELL NUMBERS IN SECTION 1ST

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10: 01	10: 07	SALDANA	
10: 32	10: 37	SALDANA	
11: 02	11: 07	SALDANA	
11: 30	11: 36	SALDANA	
12: 00	12: 03	Valenzuela	
12: 31	12: 35	Valenzuela	
13: 01	13: 06	SALDANA	
13: 31	13: 38	SALDANA	
14: 00	14: 04		
14: 32	14: 39		
15: 01	15: 07		
15: 33	15: 40		
16: 00	16: 08		
16: 31	16: 36		
17: 00	17: 07		
17: 31	17: 39		
18: 02	18: 05		
18: 31	18: 39		
19: 00	19: 07		
19: 31	19: 38		
20: 00	20: 06		
20: 30	20: 34	Sullivan	
21: 00	21: 07	Sullivan	
21:	21:		

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: : 2013 UNIT: CARSON SECTION

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10: 00	10: 03	[illegible]	
10: 30	10: 33	[illegible]	
11: 00	11: 05	[illegible]	
11: 30	11: 34	[illegible]	
12: 00	12: 06	[illegible]	
12: 30	12: 31	[illegible]	
13: 00	13: 02	[illegible]	
13: 30	13: 32	[illegible]	
14: 00	14: 15	Caballero	
14: 32	14: 37	Caballero	
15: 01	15: 01	Caballero	
15: 35	15: 41	Caballero	
16: 00	16: 08	Caballero	
16: 37	16: 43	Caballero	
17: 03	17: 09	Caballero	
17: 32	17: 36	Caballero	
18: 02	18: 06	Caballero	
18: 35	18: 38	Caballero	
19: 01	19: 07	Caballero	
19: 40	19: 45	Caballero	
20: 03	20: 08	Caballero	
20: 40	20: 45	Caballero	
21: 10	21: 15	Jones	Jones
21: 35	21: 40	Jones	Jones

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

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ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: : 2013 UNIT: CARSON SECTION

CELL NUMBERS IN SECTION 3RD TIER

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10: 02	10: 05	WILLIAMS	SW
10: 29	10: 33	FITZSIMMONS	
11: 00	11: 04	FITZSIMMONS	
11: 29	11: 33	FITZSIMMONS	
12: 02	12: 04	FITZSIMMONS	
12: 29	12: 33	FITZSIMMONS	
13: 01	13: 04	FITZSIMMONS	
13: 29	13: 31	FITZSIMMONS	
14: 05	14: 10	H. DELEE	HD
14: 30	14: 35	H. DELEE	HD
15: 02	15: 08	H. DELEE	HD
15: 31	15: 34	H. DELEE	HD
16: 00	16: 05	H. DELEE	HD
16: 30	16: 35	H. DELEE	HD
17: 04	17: 12	H. DELEE	HD
17: 31	17: 38	H. DELEE	HD
18: 05	18: 10	H. DELEE	HD
18: 35	18: 40	H. DELEE	HD
19: 00	19: 04	H. DELEE	HD
19: 30	19: 35	H. DELEE	HD
20: 01	20: 06	H. DELEE	HD
20: 31	20: 36	H. DELEE	HD
21: 05	21: 10	H. DELEE	HD
21: 30	21: 35	H. DELEE	HD

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: : 2013 UNIT: CARSON SECTION

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10:06	10:13	Phillips	SPL
10:30	10:32	Phillips	SPL
11:01	11:04	Phillips	SPL
11:30	11:33	Phillips	SPL
12:01	12:04	Phillips	SPL
12:31	12:37	Phillips	SPL
13:00	13:02	Phillips	SPL
13:20	13:21	Phillips	SPL
14:00	14:05	[illegible]	[illegible]
14:20	14:[illegible]	[illegible]	[illegible]
15:00	15:[illegible]	[illegible]	[illegible]
15:35	15:40	[illegible]	[illegible]
16:01	16:[illegible]	[illegible]	[illegible]
16:30	16:[illegible]	[illegible]	[illegible]
17:01	17:05	Robinson	[illegible]
17:31	17:35	Robinson	[illegible]
18:01	18:06	Robinson	[illegible]
18:31	18:36	Robinson	[illegible]
19:01	19:05	Robinson	[illegible]
19:31	19:35	Robinson	[illegible]
20:01	20:06	Robinson	[illegible]
20:31	20:36	Robinson	[illegible]
21:01	21:06	Robinson	[illegible]
21:31	21:36	Robinson	[illegible]

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2/21/ 2013 4TH UNIT: CARSON SECTION

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10:00	10:02	Flores	
10:30	10:32	Flores	
11:05	11:08	Flores	
11:40	11:42	Flores	
12:00	12:02	Flores	
12:35	12:38	Flores	
13:00	13:02	Flores	
13:25	13:28	Flores	
14:01	14:05	Thorell	
14:30	14:34	Thorell	
15:02	15:06	Thorell	
15:31	15:34	Thorell	
16:01	16:08	Azevedo	
16:30	16:35	Azevedo	
17:02	17:10	Azevedo	
17:30	17:35	Azevedo	
18:08	18:18	Azevedo	
18:36	18:44	Azevedo	
19:02	19:10	Azevedo	
19:30	19:36	Azevedo	
20:00	20:15	Azevedo	
20:30	20:38	Azevedo	
21:09	21:18	Azevedo	
21:30	21:35	Azevedo	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

4TH

SQ 625

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2013 UNIT: CARSON SECTION

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10:00	10:05	T. Unger	
10:31	10:34	T. Unger	
11:04	11:08	T. Unger	
11:32	11:37	T. Unger	
12:02	12:06	T. Unger	
12:30	12:35	T. Unger	
13:01	13:05	T. Unger	
13:35	13:38	T. Unger	
14:00	14:07	Carter	
14:27	14:32	Carter	
15:00	15:03	Carter	
15:29	15:32	Carter	
16:00	16:03	Carter	
16:30	16:33	Carter	
17:00	17:03	Carter	
17:29	17:32	Carter	
18:00	18:03	Carter	
18:29	18:32	Carter	
19:00	19:03	Carter	
19:30	19:37	Carter	
20:00	20:03	Carter	
20:29	20:32	Carter	
21:00	21:03	Carter	
21:20	21:33	Carter	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2/20/2013 4TH UNIT: CARSON SECTION

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10:07	10: 10		
10: 30	10: 32		
11: 00	11: 02		
11: 30	11:32		
12: 07	12:10		
12: 30	12: 32		
13: 00	13: 02		
13: 20	13:22		
14:01	14:08		
14: 30	14: 36		
15:02	15:10		
15: 33	15: 39		
16:02	16:10		
16: 36	16:38		
17: 02	17: 10		
17: 38	17: 35		
18: 02	18: 09		
18: 30	18: 36		
19:04	19: 12		
19: 33	19: 39		
20: 02	20: 10		
20: 30	20: 35		
21: 01	21: 08		
21: 30	21: 35		

1ST Watch Review - Supervisor Signature: C-Rle

2nd Watch Review - Supervisor Signature: C-Rle

3rd Watch Review - Supervisor Signature:

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4TH

SQ 627

3rd

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: : 2013 UNIT: **CARSON SECTION**

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10: 01	10: 03	WILLIAMS	
10: 31	10: 34	WILLIAMS	
11: 01	11: 04	WILLIAMS	
11: 30	11: 33	WILLIAMS	
12: 00	12: 04	WILLIAMS	
12: 30	12: 33	WILLIAMS	
13: 01	13: 04	WILLIAMS	
13: 30	13: 35	WILLIAMS	
14: 06	14: 12	H. DELA	H.D
14: 31	14: 38	H. DELA	H.D
15: 05	15: 10	H. DELA	H.D
15: 31	15: 39	H. DELA	H.D
16: 00	16: 05	H. DELA	H.D
16: 30	16: 35	H. DELA	H.D
17:00	17:04	DIX	[illegible]
17:30	17:34	DIX	[illegible]
18:02	18:06	DIX	[illegible]
18:30	18:36	DIX	[illegible]
19: 01	19: 07	DIX	[illegible]
19: 31	19:37	DIX	[illegible]
20:03	20: 08	DIX	[illegible]
20: 33	20: 38	DIX	[illegible]
21: 00	21: 03	DIX	[illegible]
21: 30	21: 33	DIX	[illegible]

1ST Watch Review - Supervisor Signature: G. Polanco

2nd Watch Review - Supervisor Signature: G. Polanco

3rd Watch Review - Supervisor Signature: Mendez

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2nd

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: : 2013. UNIT: **CARSON SECTION**

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10:00	10:02	Phillips	SPL
10:31	10:33	Phillips	SPL
11:01	11:04	Phillips	SPL
11:30	11:32	Phillips	SPL
12:00	12:03	Phillips	SPL
12:32	12:34	Phillips	SPL
13:00	13:02	Phillips	SPL
13:21	13:22	Phillips	SPL
14:00	14:05	K Wrace	K Wrace
14:30	14:35	K Wrace	K Wrace
15:00	15:05	K Wrace	K Wrace
15:30	15:35	K Wrace	K Wrace
16:00	16:05	K Wrace	K Wrace
16:30	16:35	K Wrace	K Wrace
17:00	17:05	K Wrace	K Wrace
17:32	17:37	Perrone	N
18:01	18:08	Perrone	N
18:30	18:37	Perrone	N
19:01	19:06	Perrone	N
19:30	19:37	Perrone	N
20:00	20:05	K Wrace	K Wrace
20:35	20:38	K Wrace	K Wrace
21:00	21:05	K Wrace	K Wrace
21:30	21:35	K Wrace	K Wrace

1ST Watch Review - Supervisor Signature: C. Palau

2nd Watch Review - Supervisor Signature: C. Palau

3rd Watch Review - Supervisor Signature:

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1ST

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: : 2013 UNIT: CARSON SECTION

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10: 00	10: 04	FITZSIMMONS	
10: 28	10: 32	FITZSIMMONS	
11: 03	11: 06	FITZSIMMONS	
11: 28	11: 32	FITZSIMMONS	
12: 00	12: 04	FITZSIMMONS	
12: 27	12: 31	FITZSIMMONS	
13: 01	13: 05	FITZSIMMONS	
13: 27	13: 31	FITZSIMMONS	
14: 00	14: 07		
14: 31	14: 39		
15: 02	15: 08		
15: 33	15: 37		
16: 01	16: 10		
16: 32	16: 39		
17: 03	17: 08		
17: 31	17: 40		
18: 04	18: 11		
18: 33	18: 39		
19: 00	19: 06		
19: 31	19: 37		
20: 00	20: 09		
20: 32	20: 38		
21: 01	21: 07		
21: 29	21: 30		

1ST Watch Review - Supervisor Signature: G. Polanco

2nd Watch Review - Supervisor Signature: G. Polanco

3rd Watch Review - Supervisor Signature:

SQ 630

5th Tier

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2-19-13 2013 UNIT: CARSON SECTION

CELL NUMBERS IN SECTION: CARSON

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10:00	10:03	Jones	
10:30	10:33	Jones	
11:00	11:05	Jones	
11:25	11:30	Jones	
12:00	12:03	Jones	
12:33	12:35	Jones	
13:00	13:05	Jones	
13:25	13:30	Jones	
14:00	14:03	Jones	
14:30	14:33	Jones	
15:01	15:05	Grimes	
15:29	15:32	Grimes	
16:00	16:03	Jones	
16:30	16:33	Jones	
17:00	17:05	Jones	
17:31	17:36	Grimes	
18:00	18:07	Grimes	
18:30	18:35	Grimes	
19:00	19:04	Grimes	
19:29	19:33	Grimes	
20:02	20:06	Grimes	
20:32	20:37	Grimes	
21:00	21:05	Jones	
21:25	21:30	Jones	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

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5th Tier

SQ 631

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2/19/2013 [redacted] 4TH UNIT CARSON SECTION

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10 00	10: 02	Flores	
10 35	10 38	Flores	
11 05	11 08	Flores	
11 30	11 32	Flores	
12 00	12 02	Flores	
12 30	12 32	Flores	
13: 00	13: 02	Flores	
13: 20	13: 22	Flores	
14: 00	14: 05	T Horell	
14: 30	14: 35	T Horell	
15: 00	15: 05	T Horell	
15: 30	15: 35	T Horell	
16: 02	16: 06	T Horell	
16: 31	16: 35	T Horell	
17: 02	17: 07	T Horell	
17: 31	17: 36	T Horell	
18: 02	18: 04	T Horell	
18: 30	18: 35	T Horell	
19: 00	19: 05	T Horell	
19: 30	19: 35	T Horell	
20: 00	20: 04	T Horell	
20: 30	20: 34	T Horell	
21: 00	21: 05	Thom	
21: 30	21: 35	Jhn	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

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ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2013 [redacted] 3RD TIER UNIT. CARSON SECTION

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10: 03	10: 06	WILLIAMS	
10: 30	10: 33	WILLIAMS	
11: 01	11: 03	WILLIAMS	
11: 32	11: 34	WILLIAMS	
12: 00	12: 04	WILLIAMS	
12: 30	12: 34	WILLIAMS	
13: 00	13: 03	WILLIAMS	
13: 30	13: 33	WILLIAMS	
14: 01	14: 09	H. dela	
14: 30	14: 31	H. dela	
15: 02	15: 08	H. dela	
15: 30	15: 35	H. dela	
16: 07	16: 14	H. dela	
16: 31	16: 37	H. dela	
17: 05	17: 10	H. dela	
17: 35	17: 40	H. dela	
18: 00	18: 05	H. dela	
18: 30	18: 35	H. dela	
19: 00	19: 12	H. dela	
19: 31	19: 38	H. dela	
20: 05	20: 10	H. dela	
20: 30	20: 35	H. dela	
21: 05	21: 10	H. dela	
21: 30	21: 35	H. dela	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

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SQ 633

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: [redacted]2013 2nd Tier UNIT: CARSON SECTION

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10:00	10:02	Phillips	SPh
10:31	10:33	Phillips	SPh
11:01	11:04	Phillips	SPh
11:31	11:33	Phillips	SPh
12:02	12:04	Phillips	SPh
12:30	12:33	Phillips	SPh
13:00	13:02	Phillips	SPh
13:21	13:22	Phillips	SPh
14:00	14:[illegible]	[illegible]	[illegible]
14:30	14:[illegible]	[illegible]	[illegible]
15:07	15:[illegible]	Winters	BW
15:03	15:05	Winters	BW
16:02	16:05	Winters	BW
16:29	16:32	Winters	BW
17:05	17:08	Winters	BW
17:~~30~~ 05	17:~~32~~ 08	Winters	BW
18:00	18:03	Winters	BW
18:03	18:~~29~~ 05	Winters	BW
19:00	19:[illegible]	[illegible]	[illegible]
19:30	19:[illegible]	[illegible]	[illegible]
20:04	20:07	Winters	BW
20:29	20:32	Winters	BW
21:00	21:04	Winters	BW
21:28	21:31	Winters	BW

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

SQ 634

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2013 [redacted] UNIT: CARSON SECTION

CELL NUMBERS IN SECTION: 1ST Tier

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10:00	10:05	Valenzuela	
10:31	10:35	Valenzuela	
11:00	11:03	Valenzuela	
11:30	11:34	Valenzuela	
12:00	12:04	Valenzuela	
12:31	12:35	Valenzuela	
13:00	13:35	Valenzuela	
13:30	13:34	Valenzuela	
14:00	14:06	[illegible]	
14:32	14:38	[illegible]	
15:03	15:09	[illegible]	
15:34	15:40	[illegible]	
16:01	16:08	[illegible]	
16:32	16:39	[illegible]	
17:00	17:10	[illegible]	
17:31	17:36	[illegible]	
18:02	18:07	[illegible]	
18:33	18:40	[illegible]	
19:02	19:06	[illegible]	
19:30	19:35	Compton	
20:00	20:05	Compton	
20:30	20:35	Compton	
21:00	21:05	Compton	
21:30	21:35	Compton	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

5th Tier

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2-23-13 PRISON SAN QUENTIN UNIT/SECTION CARSON SECTION

CELL NUMBERS IN SECTION TIER 5

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
12:00	12:03	Jones	Jones
12:33	12:35	Jones	Jones
13:00	13:05	Jones	Jones
13:25	13:30	Jones	Jones
14:02	14:07	Lovato	
14:31	14:36	Lovato	
15:00	15:05	Lovato	
15:33	15:37	Lovato	
16:04	16:09	Lovato	
16:32	16:37	Lovato	
17:02	17:06	Lovato	
17:35	17:40	Lovato	
18:04	18:08	Lovato	
18:31	18:36	Lovato	
19:00	19:05	Lovato	
19:33	19:37	Lovato	
20:02	20:06	Lovato	
20:31	20:35	Lovato	
21: 00	21: 05	Vathe	
21: 25	21:30	Vathe	
22: 28	22:30	R Cason	R Cason
22: 56	22: 59	R Cason	R Cason
23:23	23:27	R Cason	R Cason
23:55	23: 58	R Cason	R Cason

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

Revised November 31, 2007 PAGE 2 OF 2

5th Tier

4th

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2-23-13 PRISON SAN QUENTIN UNIT/SECTION CARSON SECTION

CELL NUMBERS IN SECTION Tier 4

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
12: 00	12: 04		
12: 20	12: 25		
13: 00	13: 08		
13: 20	13: 25		
14: 00	14: 05	Spencer	
14: 30	14: 35	Spencer	
15: 00	15: 05	Spencer	
15: 30	15: 35	Spencer	
16: 00	16: 05	Spencer	
16: 30	16: 35	Spencer	
17: 00	17: 05	Spencer	
17: 30	17: 35	Spencer	
18: 00	18: 05	Spencer	
18: 30	18: 35	Spencer	
19: 00	19: 05	Spencer	
19: 30	19: 35	Spencer	
20: 00	20: 05	Spencer	
20: 30	20: 35	Spencer	
21: 00	21: 05	Spencer	
21: 30	21: 35	Spencer	
22: 23	22: 27	R Cason	R Cason
22: 51	22: 55	R Cason	R Cason
23: 16	23: 21	R Cason	R Cason
23: 50	23: 53	R Cason	R Cason

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

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3rd

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2-23-13 PRISON SAN QUENTIN UNIT/SECTION CARSON SECTION

CELL NUMBERS IN SECTION TIER 3

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
12: 00	12: 06	Smith	
12: 31	12: 39	Smith	
13: 00	13: 07	Smith	
13: 30	13: 36	Smith	
14: 02	14: 10	H delao	H-d
14: 30	14: 34	H delao	H-d
15: 00	15: 02	ATWL	
15: 25	15: 27	ATWL	
16: 00	16: 08	ATWL	
16: 30	16: 32	ATWL	
17: 02	17: 05	ATWL	
17: 25	17: 27	ATWL	
18: 02	18: 05	ATWL	
18: 32	18: 35	ATWL	
19: 05	19: 07	ATWL	
19: 35	19: 37	ATWL	
20: 00	20: 02	ATWL	
20: 25	20: 27	ATWL	
21: 00	21: 02	ATWL	
21: 24	21: 26	ATWL	
22: 18	22: 22	R CASUN	R Cas
22: 45	22: 49	R CASUN	R Cas
23: 11	23: 14	R CASUN	R. Cas
23: 43	23: 48	R CASUN	R Cas

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

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2nd

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2-23-13 PRISON SAN QUENTIN UNIT/SECTION CARSON SECTION

CELL NUMBERS IN SECTION TIER 2

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
12:00	12:02	A Ashlock	
12:30	12:32	A Ashlock	
13:00	13:02	A Ashlock	
13:25	13:27	A Ashlock	
14:03	14:05	Ashlock	
14:31	14:33	Ashlock	
15:01	15:03	Ashlock	
15:30	15:32	Ashlock	
16:04	16:06	Ashlock	
16:31	16:33	Ashlock	
17:02	17:04	Ashlock	
17:31	17:33	Ashlock	
18:01	18:03	Ashlock	
18:30	18:32	Ashlock	
19:00	19:02	Ashlock	
19:33	19:35	Ashlock	
20:02	20:04	Ashlock	
20:31	20:33	Ashlock	
21:04	21:06	Ashlock	
21:30	21:37	Ashlock	
22:13	22:17	R. Cason	R Cas
22:40	22:43	R Cason	R Cas
23:05	23:09	R Cason	R Cas
23:37	23:40	R Cason	R Cas

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

1st

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 1-23-13 PRISON SAN QUENTIN UNIT/SECTION CARSON SECTION

CELL NUMBERS IN SECTION TIER 1

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
12:02	12:05	PONCE, A-J.	
12:31	12:34	PONCE, A-J.	
13:01	13:04	PONCE, A-J.	
13:30	13:33	PONCE, A-J.	
14:55	14:06	Asante	
14:30	14:33	Asante	
15:05	15:11	Asante	
15:32	15:40	Asante	
16:04	16:10	Asante	
16:33	16:42	Asante	
17:00	17:08	Asante	
17:32	17:39	Asante	
18:00	18:09	Asante	
18:31	18:38	Asante	
19:05	19:11	Asante	
19:32	19:37	Asante	
20:04	20:10	Asante	
20:38	20:43	Asante	
21:02	21:10	Asante	
21:25	21:31	Asante	
22:06	22:11	R. CASON	R Ca
22:34	22:39	R CASON	R Ca
23:00	23:03	R CASON	R Ca
23:31	23:35	R CASON	R Ca

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

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9
17

5th Tier

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE 2/24/2013 UNIT CARSON SECTION

HOUSING UNIT(S) CARSON

TIME	TIME	PRINTED NAME	STAFF SIGNATURE
10:00	10:03	Jones	Jones
10:30	10:33	Jones	Jones
11:00	11:05	Jones	Jones
11:25	11:30	Jones	Jones
12:00	12:03	Jones	
12:33	12:35	Jones	
13:00	13:05	Jones	
13:25	13:30	Jones	
14:00	14:03	VALLE	
14:31	14:32	VALLE	
15:01	15:04	VALLE	
15:30	15:33	VALLE	
16:00	16:02	VALLE	
16:30	16:32	VALLE	
17:00	17:02	VALLE	
17:30	17:33	VALLE	
18:01	18:05	VALLE	
18:31	18:36	VALLE	
19:00	19:02	VALLE	
19:30	19:32	VALLE	
20:00	20:02	VALLE	
20:30	20:32	VALLE	
21:00	21:04	VALLE	
21:25	21:27	VALLE	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature: T. Johnson

3rd Watch Review - Supervisor Signature:

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8AM 5C16, 5C12
12:30 5C20

5th Tier

SQ 641

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2/24/2013 4TH UNIT: CARSON SECTION

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10:00	10:02	[illegible]	
10:30	10:32	[illegible]	
11:03	11:05	[illegible]	
11:35	11:38	[illegible]	
12:00	12:02	[illegible]	
12:30	12:33	[illegible]	
13:00	13:02	[illegible]	
13:30	13:32	[illegible]	
14:01	14:05	THORN	
14:30	14:34	THORN	
15:02	15:06	THORN	
15:30	15:34	THORN	
16:05	16:10	THORN	
16:32	16:36	THORN	
17:01	17:04	THORN	
17:30	17:35	THORN	
18:00	18:06	THORN	
18:30	18:35	THORN	
19:00	19:04	THORN	
19:30	19:34	THORN	
20:00	20:03	THORN	
20:32	20:35	THORN	
21:00	21:04	THORN	
21:32	21:35	THORN	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

SQ 642

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2013 [redacted] UNIT: CARSON SECTION

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10: 01	10: 04	M Payne	
10 34	10:38	Payne	
11: 01	11: 15	Payne	
11: 40	11 46	Payne	
12: 05	12: 35	Payne	
12: 35	12: 40	Payne	
13: 05	13: 15	Payne	
13: 40	13: 45	Payne	
14: 00	14: 05	Alvarez	
14: 32	14: 35	Alvarez	
15: 02	15: 04	Alvarez	
15: 25	15: 27	Alvarez	
16: 02	16: 10	Alvarez	
16: 25	16: 32	Alvarez	
17: 02	17: 05	Alvarez	
17: 32	17: 35	Alvarez	
18: 04	18: 06	Alvarez	
18: 32	18:35	Alvarez	
19: 00	19:03	Alvarez	
19: 27	19:30	Alvarez	
20: 02	20: 04	Alvarez	
20: 32	20:35	Alvarez	
21: 00	21: 02	Alvarez	
21: 24	21: 26	Alvarez	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature: T C Bhasin

3rd Watch Review - Supervisor Signature:

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ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2013 [redacted] UNIT: CARSON SECTION

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10:01	10:03	Phillips	
10:30	10:33	Phillips	
11:02	11:04	Phillips	
11:30	11:32	Phillips	
12:00	12:04	BALAND	
12:30	12:33	BALAND	
13:00	13:03	BALAND	
13:30	13:33	BALAND	
14:00	14:04	Hammell	
14:30	14:34	Hammell	
15:01	15:05	Hammell	
15:32	15:36	Hammell	
16:00	16:04	Hammell	
16:31	16:35	Hammell	
17:03	17:07	Hammell	
17:31	17:35	Hammell	
18:02	18:06	Hammell	
18:30	18:34	Hammell	
19:01	19:05	Hammell	
19:32	19:36	Hammell	
20:00	20:04	Hammell	
20:30	20:34	Hammell	
21:01	21:04	Hammell	
21:32	21:35	Hammell	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature: T. Johnson

3rd Watch Review - Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2/24/2013 [redacted] UNIT: CARSON SECTION

CELL NUMBERS IN SECTION 1ST TIER

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10: 02	10: 05	PONCE, A-J.	
10 33	10: 36	PONCE, A.J.	
11: 04	11: 07	PONCE, A-J.	
11: 32	11: 35	PONCE, A.J.	
12: 01	12 04	PONCE, A.J.	
12 33	12: 36	PONCE, A-J.	
13: 04	13: 07	PONCE, A-J.	
13: 30	13: 33	PONCE, A-J.	
14: 00	14: 02	DIX	
14: 30	14: 32	DIX	
15: 00	15: 05	DIX	
15: 30	15: 35	DIX	
16: 02	16: 08	DIX	
16: 33	16: 35	DIX	
17: 03	17: 09	DIX	
17: 33	17: 39	DIX	
18: 01	18: 06	DIX	
18: 31	18: 36	DIX	
19: 00	19: 06	DIX	
19: 30	19: 36	DIX	
20: 01	20: 07	DIX	
20: 31	20: 37	DIX	
21: 00	21: 04	DIX	
21: 30	21: 34	DIX	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature: T. Johnson

3rd Watch Review - Supervisor Signature:

5th Tier

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2013 [redacted] UNIT: CARSON SECTION

CELL NUMBERS IN SECTION Carson J

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10:00	10:05	Jones	
10:25	10:30	Jones	
11:04	11:07	Jones	
11:37	11:40	Jones	
12:03	12:06	Jones	
12:27	12:30	Jones	
13:00	13:05	Jones	
13:25	13:30	Jones	
14:00	14:03	Jones	Jones
14:32	14:35	Jones	Jones
15:01	15:04	Jones	Jones
15:31	15:34	Jones	Jones
16:02	16:05	Jones	Jones
16:32	16:35	Jones	Jones
17:05	17:08	Jones	Jones
17:32	17:36	Jones	Jones
18:00	18:04	Jones	Jones
18:31	18:34	Jones	Jones
19:04	19:07	Jones	Jones
19:34	19:37	Jones	Jones
20:00	20:04	Jones	Jones
20:31	20:34	Jones	Jones
21:01	21:03	Jones	Jones
21:32	21:36	Jones	Jones

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature: R J

3rd Watch Review - Supervisor Signature: G Ale

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5th Tier

SQ 646

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2/25/2013 4TH UNIT: CARSON SECTION

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10:00	10:02		
10:30	10:32		
11:00	11:02		
11:30	11:32		
12:15	12:18		
12:35	12:38		
13:05	13:08		
13:45	13:48		
14:00	14:02		
14:35	14:37		
15:08	15:10		
15:30	15:32		
16:01	16:05		
16:29	16:33		
17:01	17:03		
17:40	17:43		
18:05	18:08		
18:30	18:32		
19:07	19:11		
19:30	19:32		
20:00	20:05		
20:31	20:36		
21:00	21:04		
21:27	21:31		

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

4TH

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: [redacted]2013 UNIT: CARSON SECTION

CELL NUMBERS IN SECTION 3RP

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10:01	10:05	CARROSIO	
1032	10:36	CARROSIO	
1100	1105	CARROSIO	
1131	1134	CARROSIO	
1202	1206	CARROSIO	
12:31	12:35	CARROSIO	
13:03	13:04	CARROSIO	
13:30	13:33	CARROSIO	
14:00	14:05	CARROSIO	
1432	1436	CARROSIO	
15:01	15:05	CARROSIO	
15:33	15:37	CARROSIO	
16:00	16:04	CARROSIO	
16:32	16:36	CARROSIO	
17:04	17:08	MORENO	
17:35	17:40	MORENO	
18:05	18:11	MORENO	
18:31	18:35	CARROSIO	
19:00	19:06	CARROSIO	
19:32	19:37	CARROSIO	
20:03	20:10	MORENO	
20:35	20:42	MORENO	
21:00	21:07	MORENO	
21:30	21:38	MORENO	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2013 [redacted] 2nd Tier UNIT: CARSON SECTION

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10:01	10:04	Phillips	SPh
10:31	10:34	Phillips	SPh
11:00	11:02	Phillips	SPh
11:31	11:37	Phillips	SPh
12:00	12:03	Phillips	SPh
12:31	12:33	Phillips	SPh
13:01	13:04	Phillips	SPh
13:24	13:25	Phillips	SPh
14:00	14:05	Soria	
14:33	14:37	Soria	
15:02	15:08	Soria	
15:34	15:39	Soria	
16:00	16:07	Soria	
16:35	16:40	Soria	
17:00	17:08	Soria	
17:31	17:37	Soria	
18:05	18:09	Soria	
18:30	18:39	Soria	
19:00	19:07	Soria	
19:30	19:36	Soria	
20:02	20:07	Soria	
20:32	20:38	Soria	
21:00	21:07	Soria	
21:29	21:34	Soria	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature: [signature]

3rd Watch Review - Supervisor Signature: [signature]

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2-25 2013 [redacted] UNIT: CARSON SECTION

CELL NUMBERS IN SECTION: 1ST TIER

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10 00	10: 04	CZAJKOWSK	
10 30	10: 33	PONCE, A.J.	
11 02	11.05	PONCE, A.J.	
11: 30	11: 35	Ponce, A.J.	
12 03	12 06	Ponce, A.J.	
12 33	12.38	CZAJKOWSKI	
13: 02	13: 05	CZAJKOWSKI	
13 30	13: 33	CZAJKOWSKI	
14: 00	14: 04		
14: 31	14: 35		
15: 00	15: 08		
15. 31	15: 36		
16: 00	16: 07		
16: 32	16: 40		
17: 03	17: 09		
17: 32	17: 40		
18: 01	18: 08		
18: 31	18: 39		
19: 00	19: 05	Canton	
19: 30	19: 35	Canton	
20:00	20:05	Canton	
20: 30	20: 35	Canton	
21: 00	21: 07		
21: 30	21: 35		

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature: C Pate

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2/13/15 PRISON SAN QUENTIN UNIT/SECTION CARSON SECTION

CELL NUMBERS IN SECTION 1ST TIER

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
12:00	12:04	F. Rivera	
12:30	12:34	F. Rivera	
13:00	13:04	F. Rivera	
13:29	13:33	F. Rivera	
14:00	14:04		
14:31	14:34		
15:02	15:08		
15:33	15:37		
16:00	16:11		
16:32	16:40		
17:01	17:06		
17:31	17:37		
18:00	18:07		
18:31	18:36		
19:00	19:06		
19:32	19:41		
20:00	20:07		
20:30	20:35		
21:00	21:05		
21:30	21:35		
22:08	22:12	COSTALES	
22:43	22:46	COSTALES	
23:00	23:03	COSTALES	
23:45	23:48	COSTALES	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2/13/13 PRISON SAN QUENTIN UNIT/SECTION CARSON SECTION

CELL NUMBERS IN SECTION: 2ND TIER

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
12:01	12:06	Wilson	
12:32	12:39	Wilson	
13:03	13:07	Wilson	
13:30	13:33	Wilson	
14:00	14:03	VIZCARRA	
14:30	14:34	VIZCARRA	
15:01	15:05	VIZCARRA	
15:29	15:33	VIZCARRA	
16:00	16:04	VIZCARRA	
16:30	16:34	VIZCARRA	
17:00	17:04	VIZCARRA	
17:30	17:34	VIZCARRA	
18:00	18:04	VIZCARRA	
18:30	18:34	VIZCARRA	
19:00	19:04	VIZCARRA	
19:31	19:35	VIZCARRA	
20:00	20:04	VIZCARRA	
20:30	20:34	VIZCARRA	
21:00	21:04	VIZCARRA	
21:31	21:35	VIZCARRA	
22:12	22:15	COSTALES	
22:40	22:43	COSTALES	
23:03	23:06	COSTALES	
23:42	23:45	COSTALES	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2/13/13 PRISON SAN QUENTIN UNIT/SECTION CARSON SECTION

CELL NUMBERS IN SECTION: 3RD TIER

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
12: 00	12: 07	THOKEL	
12: 30	12: 33	THOKEL	
13: 02	13: 06	THOKEL	
13:	13:		
14: 07	14: 10	H. Delea	
14: 30	14: 40	H. Delea	
15: 02	15: 12	H. Delea	
15: 29	15: 32	H. Delea	
16: 01	16: 06	DIX	
16: 31	16: 36	DIX	
17: 00	17: 04	DIX	
17: 30	17: 34	DIX	
18: 02	18: 07	DIX	
18: 32	18: 37	DIX	
19: 07	19: 12	DIX	
19: 37	19: 42	DIX	
20: 00	20: 04	DIX	
20: 30	20: 34	DIX	
21: 00	21: 03	DIX	
21: 30	21: 33	DIX	
22: 15	22: 19	COSTALES	
22: 37	22: 40	COSTALES	
23: 06	23: 09	COSTALES	
23: 39	23: 42	COSTALES	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

4th

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2/13/13 PRISON SAN QUENTIN UNIT/SECTION CARSON SECTION

CELL NUMBERS IN SECTION: 4TH TIER

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
12:00	12:04	[illegible]	
12:30	12:34	[illegible]	
13:00	13:04	[illegible]	
13:30	13:34	[illegible]	
14:02	14:10	ARELLO	
14:30	14:35	ARELLO	
15:01	15:08	ARELLO	
15:30	15:35	ARELLO	
16:01	16:06	ARELLO	
16:30	16:40	ARELLO	
17:03	17:15	ARELLO	
17:32	17:40	ARELLO	
18:00	18:18	ARELLO	
18:30	18:39	ARELLO	
19:08	19:10	ARELLO	
19:30	19:42	ARELLO	
20:01	20:08	ARELLO	
20:30	20:36	ARELLO	
21:07	21:10	ARELLO	
21:30	21:35	ARELLO	
22:19	22:21	COSTALES	Klw
22:33	22:37	COSTALES	Klw
23:09	23:12	COSTALES	Klw
23:36	23:39	COSTALES	Klw

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

Revised November 31, 2007 PAGE 2 OF 2

4th

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2/13/13 PRISON SAN QUENTIN UNIT/SECTION CARSON SECTION

CELL NUMBERS IN SECTION 5TH TIER

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
12:00	12:04	T. Unger	
12:30	12:35	T. Unger	
13:00	13:00	T. Unger	
13:31	13:36	T. Unger	
14:00	14:03	Carter	
14:29	14:32	Carter	
15:01	15:06	FAUSER	W Fauser
15:30	15:35	FAUSER	W Fauser
16:00	16:07	FAUSER	W Fauser
16:33	16:37	FAUSER	W Fauser
17:02	17:03	Carter	
17:29	17:37	Carter	
18:02	18:03	Carter	
18:30	18:33	Carter	
19:00	19:03	Carter	
19:29	19:32	Carter	
20:00	20:03	Carter	
20:29	20:32	Carter	
21:00	21:03	Carter	
21:30	21:33	Carter	
22:21	22:24	COSTALES	
22:30	22:33	COSTALES	
23:12	23:14	COSTALES	
23:33	23:30	COSTALES	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2-14-13 PRISON SAN QUENTIN UNIT/SECTION CARSON SECTION

CELL NUMBERS IN SECTION: TIER 2

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
12:00	12:05	BALLARD	
12:30	12:33	BALLARD	
13:00	13:05	BALLARD	
13:28	13:31	GALCZYNSKI	
14:01	14:04	GALCZYNSKI	
14:28	14:38	GALCZYNSKI	
15:00	15:05	GALCZYNSKI	
15:26	15:41	Ceballen	
16:02	16:06	Ceballen	
16:40	16:45	Ceballen	
17:01	17:01	Ceballen	
17:30	17:41	Ceballen	
18:05	18:01	Ceballen	
18:35	18:41	Ceballen	
19:05	19:10	Ceballen	
19:30	19:32	Ceballen	
20:01	20:01	Ceballen	
20:29	20:32	Ceballen	
21:01	21:03	Ceballen	
21:25	21:30	Ceballen	
22:00	22:03	Bailey	
22:30	22:32	Bailey	
23:00	23:03	Bailey	
23:30	23:32	Bailey	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

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ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2-14-13 PRISON SAN QUENTIN UNIT/SECTION CARSON SECTION

CELL NUMBERS IN SECTION: Tier B 4

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
12	12		
12	12		
13	13		
13	13		
14	14		
14	14		
15	15		
15	15		
16	16		
16	16		
17	17		
17	17		
18	18		
18	18		
19	19		
19	19		
20	20		
20	20		
21	21		
21	21		
22	22	Bailey	
22	22	Bailey	
23	23	Bailey	
23	23	Bailey	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

Revised November 31, 2007 PAGE 2 OF 2

12
X
33
396
430
456
200

4

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2-14-13 PRISON SAN QUENTIN UNIT/SECTION CARSON SECTION

CELL NUMBERS IN SECTION: T-TEL-3-

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
12:03	12:05	Borja	
12:33	12:35	Borja	
13:00	13:05	Borja	
13:31	13:31	Filmore	
14:01	14:10	# dell	# dell
14:30	14:35	# dell	# dell
15:02	15:10	# dell	# dell
15:30	15:35	# dell	# dell
16:00	16:12	# dell	# dell
16:30	16:35	# dell	# dell
17:02	17:10	# dell	# dell
17:31	17:33	# dell	# dell
18:00	18:12	# dell	# dell
18:31	18:38	# dell	# dell
19:03	19:10	# dell	# dell
19:31	19:39	# dell	# dell
20:05	20:10	# dell	# dell
20:35	20:40	# dell	# dell
21:05	21:10	# dell	# dell
21:30	21:35	# dell	# dell
22:07	22:09	Bailey	
22:36	22:38	Bailey	
23:07	23:09	Bailey	
23:37	23:39	Bailey	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2/4/13 PRISON SAN QUENTIN UNIT/SECTION CARSON SECTION

CELL NUMBERS IN SECTION: Tier 2

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
12:00	12:01	Phillips	SPh
12:30	12:31	Phillips	SPh
13:00	13:02	Phillips	SPh
13:30	13:37	Phillips	SPh
14:00	14:05	Peters	
14:30	14:34	Peters	
15:01	15:04	Peters	
15:30	15:37	Peters	
16:00	16:05	Peters	
16:30	16:34	Peters	
17:00	17:04	Peters	
17:31	17:34	Jones	Jones
18:01	18:04	Jones	Jones
18:31	18:34	Jones	Jones
19:02	19:05	Jones	Jones
19:33	19:35	Jones	Jones
20:00	20:07	Jones	Jones
20:30	20:36	Jones	Jones
21:01	21:05	Jones	Jones
21:30	21:36	Jones	Jones
22:10	22:12	Bailey	
22:39	22:41	Bailey	
23:10	23:12	Bailey	
23:40	23:45	Bailey	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

AA 2

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2-14-13 PRISON SAN QUENTIN UNIT/SECTION CARSON SECTION

CELL NUMBERS IN SECTION: TIER 1

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
12:00	12:03	Valenzuela	
12:30	12:33	Valenzuela	
13:00	13:03	Valenzuela	
13:30	13:34	Valenzuela	
14:00	14:04		
14:31	14:35		
15:02	15:07		
15:33	15:40		
16:02	16:06		
16:31	16:39		
17:02	17:11		
17:31	17:38		
18:00	18:07		
18:31	18:39		
19:00	19:11		
19:33	19:39		
20:00	20:06		
20:30	20:35		
21:00	21:05		
21:30	21:39		
22:13	22:16	Bailey	
22:42	22:44	Bailey	
23:13	23:15	Bailey	
23:44	23:46	Bailey	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: : 2013 UNIT: CARSON SECTION

CELL NUMBERS IN SECTION 1ST TIER

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10: 00	10: 05	Carter	
10: 30	10: 35	Carter	
11: 00	11: 05	Carter	
11: 30	11: 35	Carter	
12: 05	12: 08	Aleman	
12: 30	12: 35	Carter	
13: 00	13: 05	Carter	
13: 30	13: 35	Carter	
14: 05	14: 20	Asante	
14: 30	14: 39	Asante	
15: 04	15: 10	Asante	
15: 33	15: 41	Asante	
16: 00	16: 04	Asante	
16: 32	16: 39	Asante	
17: 04	17: 11	Asante	
17: 35	17: 42	Asante	
18: 02	18: 10	Asante	
18: 33	18: 39	Asante	
19: 39	19: 05	Asante	
19: 32	19: 40	Asante	
20: 00	20: 08	Asante	
20: 32	20: 37	Asante	
21: 00	21: 08	Asante	
21: 25	21: 30	Asante	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

Revised May 10, 2012 PAGE 2 OF 2

10
14
17

2nd

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: : 2013 UNIT: CARSON SECTION

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10:00	10:05	BALAND	
10:30	10:33	BALAND	
11:00	11:01	BALAND	
11:30	11:33	BALAND	
12:00	12:04	BALAND	
12:31	12:34	BALAND	
13:00	13:04	BALAND	
13:30	13:32	BALAND	
14:00	14:04	Howell	
14:30	14:34	Howell	
15:01	15:05	Howell	
15:30	15:34	Howell	
16:03	16:04	Howell	
16:31	16:35	Howell	
17:02	17:06	Howell	
17:33	17:37	Howell	
18:00	18:04	Howell	
18:30	18:34	Howell	
19:02	19:06	Howell	
19:33	19:37	Howell	
20:03	20:07	Howell	
20:32	20:36	Howell	
21:00	21:05	Howell	
21:30	21:35	Howell	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

Revised May 10, 2012

3rd

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2013 UNIT: CARSON SECTION

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10:00	10:04	CARROLO	
10:31	10:35	CARROSO	
11:01	11:05	CARROSO	
11:32	11:36	CARROSO	
12:00	12:05	CARROSO	
12:31	12:35	CARROSO	
13:00	13:05	CARRO..	
13:30	13:35	Ulrich	
14:05	14:10	# dell	Hall
14:30	14:35	# dell	Hall
15:04	15:12	# dell	Hall
15:31	15:38	# dell	dell
16:00	16:02	AVC	
16:25	16:27	AVC	
17:00	17:02	AVC	
17:35	17:37	AVC	
18:05	18:07	AVC	
18:24	18:27	AVC	
19:04	19:06	AVC	
19:27	19:30	AVC	
20:00	20:03	AVC	
20:32	20:35	AVC	
21:00	21:02	AVC	
21:24	21:26	AVC	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

Revised May 10, 2012

4th

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: : 2013 **UNIT:** **CARSON SECTION**

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10: 00	10: 05		
10: 20	10: 25		
11: 00	11: 05		
11: 20	11: 25		
12: 00	12: 05		
12: 25	12: 32		
13: 00	13: 05		
13: 20	13: 25		
14: 00	14: 05	Spencer	
14: 30	14: 35	Spencer	
15: 00	15: 05	Spencer	
15: 30	15: 35	Spencer	
16: 00	16: 05	Spencer	
16: 30	16: 35	Spencer	
17: 00	17: 05	Spencer	
17: 05	17: 35	Spencer	
18: 00	18: 05	Spencer	
18: 05	18: 35	Spencer	
19: 06	19: 05	Spencer	
19: 05	19: 35	Spencer	
20: 00	20: 05	Spencer	
20: 05	20: 35	Spencer	
21: 00	21: 05	Spencer	
21: 05	21: 35	Spencer	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2/16/ 2013 UNIT: CARSON SECTION

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10:00	10:03	Jones	
10:30	10:33	Jones	
11:00	11:05	Jones	
11:25	11:30	Jones	
12:00	12:03	Jones	
12:33	12:35	Jones	
13:00	13:05	Jones	
13:25	13:30	Jones	
14:02	14:03	Valle	
14:30	14:32	Valle	
15:02	15:01	Valle	
15:31	15:33	Valle	
16:00	16:02	Valle	
16:30	16:35	Ward	
17:00	17:05	Ward	
17:30	17:35	Ward	
18:00	18:05	Ward	
18:30	18:35	Ward	
19:00	19:05	Ward	
19:30	19:35	Ward	
20:00	20:05	Ward	
20:30	20:35	Ward	
21:00	21:05	Ward	
21:30	21:35	Ward	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

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SQ 665

1ST TIER

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2013 2/15/13 UNIT: CARSON SECTION

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10:00	10:03	Valenweld	
10:31	10:35	Valenweld	
11:00	11:05	Gaston	
11:30	11:35	Gaston	
12:00	12:05	Gaston	
12:30	12:35	Gaston	
13:00	13:05	Gaston	
13:30	13:34	Valenweld	
14:00	14:07		
14:31	14:39		
15:00	15:06		
15:32	15:38		
16:01	16:07		
16:33	16:39		
17:04	17:00		
17:31	17:37		
18:00	18:11		
18:32	18:36		
19:01	19:05		
19:33	19:40		
20:02	20:06		
20:30	20:37		
21:00	21:07		
21:30	21:36		

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

SQ 666

2ND TIER

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2013 2/15/13 UNIT: CARSON SECTION

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10: 01	10: 05	A. SULLIVAN	A Sullivan
10: 10	10: 15	[illegible]	
11: 05	11: 10	G.A. [illegible]	
11: 35	11: 40	GAITAN	
12: 00	12: 04	SULLIVAN	
12: 30	12: 34	A SULLIVAN	
13: 01	13: 04	A. SULLIVAN	
13: 32	13: 35	A SULLIVAN	A Sullivan
14: 00	14: 03	Jones	
14: 34	14: 37	Jones	
15: 01	15: 04	Jones	
15: 32	15: 36	Jones	
16: 00	16: 05	Jones	
16: 30	16: 33	Jones	
17: 02	17: 05	Jones	
17: 30	17: 35	Jones	
18: 03	18: 06	Jones	
18: 33	18: 36	Jones	
19: 00	19: 06	Jones	
19: 33	19: 36	Jones	
20: 06	20: 03	Jones	
20: 31	20: 34	Jones	
21: 00	21: 03	Jones	
21: 33	21: 36	Jones	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

3RD TIER

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2013 2/15/13 UNIT: CARSON SECTION

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10: 00	10: 04	Fitzsimmons	
10: 25	10: 29	Fitzsimmons	
11: 00	11: 05	Gaitan	
11: 30	11: 35	Gaitan	
12: 00	12: 04	Fitzsimmons	
12: 30	12: 35	Ulrich	S. Ulrich
13: 01	13: 06	Ulrich	S. Ulrich
13: 30	13: 36	Ulrich	S. Ulrich
14: 01	14: 10	Medic	
14: 30	14: 32	Arm	
15: 02	15: 05	Arm	
15: 25	15: 32	Arm	
16: 00	16: 07	Arm	
16: 30	16: 32	Arm	
17: 00	17: 02	Arm	
17: 30	17: 32	Arm	
18: 05	18: 07	Arm	
18: 24	18: 26	Arm	
19: 04	19: 06	Arm	
19: 32	19: 34	Arm	
20: 05	20: 07	Arm	
20: 35	20: 37	Arm	
21: 00	21: 02	Arm	
21: 24	21: 26	Arm	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

4TH TIER

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: : 2013 2/15/13 UNIT: CARSON SECTION

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10: 00	10: 05	[illegible]	[signature]
10: 20	10: 25	[illegible]	
11: 05	11: 10	Grafton	[signature]
11: 35	11: 40	Grafton	[signature]
12: 00	12: 05	[illegible]	[signature]
12: 20	12: 25	[illegible]	[signature]
13: 00	13: 05	Jones	[signature]
13: 20	13: 25	Jones	[signature]
14: 05	14: 05	Spencer	[signature]
14: 30	14: 35	Spencer	[signature]
15: 00	15: 05	Spencer	[signature]
15: 30	15: 35	Spencer	[signature]
16: 00	16: 05	Spencer	[signature]
16: 30	16: 35	Spencer	[signature]
17: 00	17: 05	Spencer	[signature]
17: 30	17: 35	Spencer	[signature]
18: 00	18: 05	Spencer	[signature]
18: 30	18: 35	Spencer	[signature]
19: 05	19: 05	Spencer	[signature]
19: 30	19: 35	Spencer	[signature]
20: 00	20: 05	Spencer	[signature]
20: 30	20: 35	Spencer	[signature]
21: 00	21: 05	Spencer	[signature]
21: 30	21: 35	Spencer	[signature]

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

5TH TIER

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2/15/ 2013 2/15/13 UNIT: CARSON SECTION

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
10: 00	10: 05	JONES	
10: 30	10:35	[illegible]	
11: 00	11:05	[illegible]	
11: 30	11: 35	[illegible]	
12: 00	12: 03	JONES	
12: 30	1233	JONES	
13:00	13: 05	JONES	
13:25	13: 30	JONES	
14: 00	14: 03	VALLE	
14: 25	14:33	VALLE	
15: 01	15: 04	VALLE	
15: 31	15: 33	VALLE	
16: 02	16: 02	VALLE	
16: 31	16: 32	VALLE	
17: 00	17: 02	VALLE	
17: 31	17: 33	VALLE	
18: 01	18: 04	VALLE	
18: 30	18: 31	VALLE	
19: 00	19: 07	VALLE	
19: 30	19: 33	VALLE	
20: 00	20: 03	VALLE	
20: 30	20: 32	VALLE	
21: 00	21: 04	VALLE	
21: 25	21: 30	VALLE	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

Revised May 10, 2012 PAGE 2 OF 2

7211 9

5TH TIER

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2/15/2012 2/15/13 UNIT: CARSON SECTION

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22: 00	22: 05	K WARNER	
22: 30	22: 35	K WARNER	
23: 00	23: 05	K WARNER	
23: 30	23:35	K WARNER	
00: 00	00: 05	K WARNER	
00:30	00: 35	K WARNER	
01:00	01: 05	K WARNER	
01: 30	01:35	K WARNER	
02: 00	02: 05	K WARNER	
02: 30	02: 35	K WARNER	
03: 00	03: 05	K WARNER	
03: 30	03: 35	K WARNER	
04: 00	04: 05	K WARNER	
04: 30	04: 35	K WARNER	
05: 00	05: 05	K WARNER	
05: 30	05:35	K WARNER	
06: 00	06: 03	Jones	
06: 30	06: 33	Jones	
07: 00	07: 05	Jones	
07: 25	07:30	Jones	
08: 00	08: 03	Jones	
08: 30	08:35	Jones	
09: 00	09: 05	Jones	
09: 25	09:30	Jones	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

5th Tier

SQ 672

4TH TIER

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2012 2/15/13 UNIT: CARSON SECTION

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22: 00	22: 05	K HOFFMAN	K
22: 30	22: 35	K HOFFMAN	K
23: 00	23: 05	K HOFFMAN	K
23: 30	23: 35	K HOFFMAN	K
00: 00	00: 05	K HOFFMAN	K
00: 30	00: 35	K HOFFMAN	K
01: 00	01: 05	K HOFFMAN	K
01: 30	01: 35	K HOFFMAN	K
02: 00	02: 05	K HOFFMAN	K
02: 30	02: 35	K HOFFMAN	K
03: 00	03: 05	K HOFFMAN	K
03: 30	03: 35	K HOFFMAN	K
04: 00	04: 05	K HOFFMAN	K
04: 30	04: 35	K HOFFMAN	K
05: 00	05: 05	K HOFFMAN	K
05: 30	05: 35	K HOFFMAN	K
06: 00	06: 05	[illegible]	[illegible]
06: 30	06: 35	[illegible]	[illegible]
07: 00	07: 05	[illegible]	[illegible]
07: 30	07: 35	[illegible]	[illegible]
08: 00	08: 05	[illegible]	[illegible]
08: 30	08: 35	[illegible]	[illegible]
09: 00	09: 05	[illegible]	[illegible]
09: 30	09: 32	[illegible]	[illegible]

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

3RD TIER

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2013 2/15/13 UNIT: CARSON SECTION

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22: 00	22: 05	K WOFFORD	
22: 30	22: 35	K WOFFORD	
23: 00	23: 05	K WOFFORD	
23: 30	23: 35	K WOFFORD	
00: 00	00: 05	K WOFFORD	
00: 30	00: 35	K WOFFORD	
01: 00	01: 05	K WOFFORD	
01: 30	01: 35	K WOFFORD	
02: 00	02: 05	K WOFFORD	
02: 30	02: 35	K WOFFORD	
03: 00	03: 05	K WOFFORD	
03: 30	03: 35	K WOFFORD	
04: 00	04: 05	K WOFFORD	
04: 30	04: 35	K WOFFORD	
05: 00	05: 05	K WOFFORD	
05: 30	05: 35	K WOFFORD	
06: 00	06: 04	FITZSIMMONS	
06: 29	06: 33	FITZSIMMONS	
07: 00	07: 04	FITZSIMMONS	
07: 27	07: 31	FITZSIMMONS	
08: 00	08: 04	FITZSIMMONS	
08: 29	08: 33	FITZSIMMONS	
09: 00	09: 04	FITZSIMMONS	
09: 30	09: 34	FITZSIMMONS	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

SQ 674

2WD TIER

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2013 2/15/13 UNIT: CARSON SECTION

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22: 00	22: 05	K WOFFORD	KW
22: 30	22: 35	K WOFFORD	KW
23: 00	23: 05	K WOFFORD	KW
23: 30	23: 35	K WOFFORD	KW
00: 00	00: 05	K WOFFORD	KW
00: 30	00: 35	K WOFFORD	KW
01: 00	01: 05	K WOFFORD	KW
01: 30	01: 35	K WOFFORD	KW
02: 00	02: 05	K WOFFORD	KW
02: 30	02: 35	K WOFFORD	KW
03: 00	03: 05	K WOFFORD	KW
03: 30	03: 35	K WOFFORD	KW
04: 00	04: 05	K WOFFORD	KW
04: 30	04: 35	K WOFFORD	KW
05: 00	05: 05	K WOFFORD	KW
05: 30	05: 35	K WOFFORD	KW
06: 00	06: 05	A. SULLIVAN	A. Sullivan
06: 28	06: 31	A. SULLIVAN	A. Sullivan
07: 01	07: 04	A SULLIVAN	A. Sullivan
07: 30	07: 32	A. SULLIVAN	A. Sullivan
08: 00	08: 05	A. SULLIVAN	A. Sullivan
08: 31	08: 34	A. SULLIVAN	A. Sullivan
09: 01	09: 04	A. SULLIVAN	A. Sullivan
09: 31	09: 34	A. SULLIVAN	A. Sullivan

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

SO 675

1ST TIER

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2013 2/15/13 UNIT: CARSON SECTION

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22: 00	22: 05	K. Ho Frace	
22: 30	22: 35	K. Ho Frace	
23: 00	23: 05	K. Ho Frace	
23: 30	23: 35	K. Ho Frace	
00: 00	00: 05	K. Ho Frace	
00: 30	00: 35	K. Ho Frace	
01: 00	01: 05	K. Ho Frace	
01: 30	01: 35	K. Ho Frace	
02: 00	02: 05	K. Ho Frace	
02: 30	02: 35	K. Ho Frace	
03: 00	03: 05	K. Ho Frace	
03: 30	03: 35	K. Ho Frace	
04: 00	04: 05	K. Ho Frace	
04: 30	04: 35	K. Ho Frace	
05: 00	05: 05	K. Ho Frace	
05: 30	05: 35	K. Ho Frace	
06: 00	06: 05	Valenzuela	
06: 31	06: 35	Valenzuela	
07: 00	07: 05	Valenzuela	
07: 31	07: 34	Valenzuela	
08: 00	08: 05	Gaston	
08: 30	08: 35	Gaston	
09: 00	09: 05	Gaston	
09: 30	09: 37	Valenzuela	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2-16-13 [redacted] UNIT: CARSON SECTION

CELL NUMBERS IN SECTION 5th Tier

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22: 03	22: 04	Fishlock	
22: 30	22: 31	Fishlock	
23: 00	23: 01	Fishlock	
23: 30	23: 31	Fishlock	
00: 10	00: 11	BORDFESSA	
00: 32	00: 33	BORDFESSA	
01: 01	01: 02	BORDFESSA	
01: 37	01: 38	BORDFESSA	
02: 02	02: 03	Fishlock	
02: 30	02: 31	Fishlock	
03: 01	03: 02	Fishlock	
03: 31	03: 37	Fishlock	
04: 00	04: 01	Fishlock	
04: 30	04: 31	Fishlock	
05: 01	05: 02	Fishlock	
05: 31	05: 32	Fishlock	
06: 00	06: 03	Jones	
06: 30	06: 33	Jones	
07: 00	07: 05	Jones	
07: 25	07: 30	Jones	
08: 00	08: 03	Jones	
08: 33	08: 35	Jones	
09: 00	09: 05	Jones	
09: 25	09: 30	Jones	

1ST Watch Review - Supervisor Signature: E. Romo

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2-16-13 [redacted] UNIT: CARSON SECTION

CELL NUMBERS IN SECTION 4th Tier

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22: 05	22: 06	Ashlock	
22: 32	22: 33	Ashlock	
23: 02	23: 03	Ashlock	
23: 32	23: 33	Ashlock	
00: 08	00: 09	BORDERA	BB
00: 33	00: 34	BORDERA	BB
01: 02	01: 03	BORDERA	BR
01: 35	01: 36	BORDERA	BR
02: 04	02: 05	Ashlock	
02: 32	02: 33	Ashlock	
03: 03	03: 04	Ashlock	
03: 33	03: 34	Ashlock	
04: 02	04: 03	Ashlock	
04: 32	04: 33	Ashlock	
05: 03	05: 04	Ashlock	
05: 33	05: 34	Ashlock	
06: 00	06: 01		
06: 20	06: 21		
07: 00	07: 01		
07: 29	07: 32		
08: 00	08: 05		
08: 20	08: 30		
09: 00	09: 08		
09: 20	09: 29		

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2-16-13 [redacted] UNIT: CARSON SECTION

CELL NUMBERS IN SECTION 3rd Tier

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22: 07	22: 08	Hshlock	
22: 34	22: 35	Hshlock	
23: 04	23: 05	Hshlock	
23: 34	23: 35	Hshlock	
00: 06	00: 07	BORDESSA	
00: 35	00: 36	BORDESSA	
01: 04	01: 05	BORDESSA	
01: 33	01: 34	BORDESSA	
02: 06	02: 07	Hshlock	
02: 34	02: 35	Hshlock	
03: 05	03: 06	Hshlock	
03: 35	03: 36	Hshlock	
04: 04	04: 05	Hshlock	
04: 34	04: 35	Hshlock	
05: 05	05: 06	Hshlock	
05: 35	05: 36	Hshlock	
06: 00	06: 04	CARROSIO	
06: 31	06: 36	CARROSIO	
07: 02	07: 06	CARROSIO	
07: 31	07: 35	CARROSO	
08: 00	08: 04	CARROSIO	
08: 32	08: 36	CARROSO	
09: 00	09: 05	CARROSO	
09: 30	09: 35	CARROSO	

1ST Watch Review - Supervisor Signature: E. Ramos

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

679 OS

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2-16-13 [redacted] UNIT: CARSON SECTION

CELL NUMBERS IN SECTION 2nd Tier

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22: 09	22: 10	Ashlock	
22: 36	22: 37	Ashlock	
23: 06	23: 07	Ashlock	
23: 36	23: 37	Ashlock	
00: 05	00: 06	RODESKA	
00: 36	00: 37	RODESKA	
01: 05	01: 06	RODESKA	
01: 32	01: 33	RODESKA	
02: 08	02: 09	Ashlock	
02: 36	02: 37	Ashlock	
03: 07	03: 08	Ashlock	
03: 37	03: 38	Ashlock	
04: 06	04: 07	Ashlock	
04: 36	04: 37	Ashlock	
05: 07	05: 08	Ashlock	
05: 37	05: 39	Ashlock	
06: 00	06: 04	BALAND	
06: 30	06: 33	BALAND	
07: 00	07: 05	BALAND	
07: 30	07: 34	BALAND	
08: 00	08: 05	BALAND	
08: 30	08: 36	BALAND	
09: 00	09: 03	BALAND	
09: 30	09: 33	BALAND	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

089 OS

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 1-16-13 2012 UNIT: CARSON SECTION

CELL NUMBERS IN SECTION 1st Tier

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22: 11	22: 12	Ashlock	
22: 38	22: 39	Ashlock	
23: 08	23: 09	Ashlock	
23: 38	23: 39	Ashlock	
00: 03	00: 04	BORDESSA	
00: 37	00: 38	BORDESSA	
01: 07	01: 08	BORDESSA	
01: 31	01: 32	BORDESSA	
02: 10	02: 11	Ashlock	
02: 38	02: 39	Ashlock	
03: 09	03: 10	Ashlock	
03: 39	03: 40	Ashlock	
04: 08	04: 09	Ashlock	
04: 38	04: 39	Ashlock	
05: 09	05: 10	Ashlock	
05: 39	05: 40	Ashlock	
06: 00	06: 05	Compton	
06: 30	06: 35	Compton	
07: 00	07: 05	Compton	
07: 30	07: 35	Compton	
08: 01	08: 05	Aleman	
08: 30	08: 33	Aleman	
09: 03	09: 07	Aleman	
09: 31	09: 35	Aleman	

1ST Watch Review - Supervisor Signature: E. Ramos

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2-14-13 PRISON SAN QUENTIN UNIT/SECTION CARSON SECTION

CELL NUMBERS IN SECTION Tier 1

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
00:01	00:03	Bailey	
00:30	00:32	Bailey	
01:02	01:04	Bailey	
01:30	01:32	Bailey	
02:00	02:02	Bailey	
02:30	02:32	Bailey	
03:01	03:03	Bailey	
03:31	03:33	Bailey	
04:00	04:03	Bailey	
04:30	04:32	Bailey	
05:00	05:02	Bailey	
05:27	05:30	Bailey	
06:00	06:01	Valenuela	
06:31	06:35	Valenuela	
07:00	07:05	Valenuela	
07:31	07:35	Valenuela	
08:00	08:05	Valenuela	
08:31	08:35	Valenuela	
09:00	09:07	Valenuela	
09:30	09:33	Valenuela	
10:00	10:04	Valenuela	
10:30	10:35	Valenuela	
11:00	11:05	Valenuela	
11:32	11:35	Valenuela	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2-14-13 PRISON SAN QUENTIN UNIT/SECTION CARSON SECTION

CELL NUMBERS IN SECTION: Tier 2

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
00:04	00:06	Bailey	R
00:33	00:36	Bailey	R
01:06	01:08	Bailey	R
01:33	01:35	Bailey	R
02:03	02:05	Bailey	R
02:33	02:35	Bailey	R
03:04	03:06	Bailey	R
03:34	03:36	Bailey	R
04:04	04:06	Bailey	R
04:33	04:35	Bailey	R
05:03	05:05	Bailey	R
05:24	05:26	Bailey	R
06:00	06:02	Phillips	SPh
06:31	06:33	Phillips	SPh
07:01	07:03	Phillips	SPh
07:30	07:32	Phillips	SPh
08:00	08:03	Phillips	SPh
08:30	08:33	Phillips	SPh
09:01	09:04	Phillips	SPh
09:30	09:32	Phillips	SPh
10:00	10:04	Phillips	SPh
10:31	10:33	Phillips	SPh
11:00	11:02	Phillips	SPh
11:32	11:34	Phillips	SPh

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

Revised November 31, 2007

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2/14/13 PRISON SAN QUENTIN UNIT/SECTION CARSON SECTION

CELL NUMBERS IN SECTION: Tier 3

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
00:07	00:09	Bailey	K
00:37	00:39	Bailey	K
01:09	01:10	Bailey	K
01:37	01:39	Bailey	K
02:06	02:08	Bailey	K
02:36	02:38	Bailey	K
03:07	03:09	bailey	K
03:37	03:39	Bailey	K
04:07	04:09	Bailey	K
04:36	04:38	Bailey	K
05:06	05:08	Bailey	K
05:21	05:23	Bailey	K
06:05	06:08	Borjon	R
06:33	06:37	Borjon	R
07:00	07:04	FitzSimmons	
07:28	07:32	FitzSimmons	
08:00	08:04	FitzSimmons	
08:35	08:39	Borjon	R
09:02	09:04	Borjon	R
09:29	09:33	FitzSimmons	
10:00	10:04	FitzSimmons	
10:35	10:37	Borjon	R
11:04	11:07	Borjon	R
11:37	11:40	Borjon	R

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

Revised November 31, 2007

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2-14-13 PRISON SAN QUENTIN UNIT/SECTION CARSON SECTION

CELL NUMBERS IN SECTION Tier 4

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
00:10	00:12	Bailey	B
00:40	00:43	Bailey	B
01:11	01:13	Bailey	B
01:40	01:42	Bailey	B
02:09	02:11	Bailey	B
02:39	02:41	Bailey	B
03:10	03:12	Bailey	B
03:41	03:43	Bailey	B
04:10	04:12	Bailey	B
04:39	04:41	Bailey	B
05:09	05:10	Bailey	B
05:18	05:20	Bailey	B
06:05	06:05	Pin	
06:32	06:35	Pin	
07:07	07:10	Pin	
07:30	07:32	Pin	
08:15	08:18	Pin	
08:37	08:33	Pin	
09:02	09:02	Pin	
09:30	09:32	Pin	
10:00	10:		
10:20	10:		
11:00	11:		
11:20	11:		

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2-14-13 PRISON SAN QUENTIN UNIT/SECTION CARSON SECTION

CELL NUMBERS IN SECTION Tier 5

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
00:13	00:15	Bailey	
00:44	00:46	Bailey	
01:14	01:16	Bailey	
01:43	01:45	Bailey	
02:12	02:14	Bailey	
02:42	02:44	Bailey	
03:13	03:15	Bailey	
03:42	03:45	Bailey	
04:13	04:15	Bailey	
04:42	04:44	Bailey	
05:11	05:13	Bailey	
05:15	05:17	Bailey	
06:00	06:05	B Rowland	
06:30	06:33	B Rowland	
07:00	07:05	B Rowland	
07:30	07:33	B Rowland	
08:00	08:04	B Rowland	
08:30	08:32	B Rowland	
09:00	09:03	B Rowland	
09:30	09:34	B Rowland	
10:00	10:05	B Rowland	
10:31	10:36	B Rowland	
11:00	11:04	B Rowland	
11:	11:		

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd. Watch Review - Supervisor Signature:

Revised November 31, 2007

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ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2/13/13 PRISON SAN QUENTIN UNIT/SECTION CARSON SECTION

CELL NUMBERS IN SECTION 5TH TIER

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
00: 00	00: 03	COSTALES	
00: 50	00: 53	COSTALES	
01: 03	01: 07	COSTALES	
01: 41	01: 44	COSTALES	
02: 02	02: 05	COSTALES	
02: 43	02: 47	COSTALES	
03: 00	03: 03	COSTALES	
03: 43	03: 46	COSTALES	
04: 01	04: 03	COSTALES	
04: 42	04: 45	COSTALES	
05: 00	05: 03	COSTALES	
05: 40	05: 43	COSTALES	
06: 07	06: 12	COSTALES	
06: 30	06: 35	T. Unger	
07: 02	07: 07	T. Unger	
07: 30	07: 36	T. Unger	
08: 00	08: 04	T. Unger	
08: 33	08: 37	T. Unger	
09: 01	09: 05	T. Unger	
09: 30	09: 34	T. Unger	
10: 02	10: 05	T. Unger	
10: 31	10: 36	T. Unger	
11: 03	11: 07	T. Unger	
11: 30	11: 34	T. Unger	
1ST Watch Review - Supervisor Signature:			
2nd Watch Review - Supervisor Signature:			
3rd Watch Review - Supervisor Signature:			

Revised November 31, 2007

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2/13/13 PRISON SAN QUENTIN UNIT/SECTION CARSON SECTION

CELL NUMBERS IN SECTION: 4TH TIER

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
00: 03	00: 04	COSTALES	
00: 47	00: 50	COSTALES	
01: 07	01: 10	COSTALES	
01: 39	01: 41	COSTALES	
02: 05	02: 08	COSTALES	
02: 40	02: 43	COSTALES	
03: 03	03: 06	COSTALES	
03: 40	03: 43	COSTALES	
04: 03	04: 06	COSTALES	
04: 39	04: 42	COSTALES	
05: 03	05: 06	COSTALES	
05: 39	05: 40	COSTALES	
06: 01	06: 05	THORN	
06: 32	06: 36	THORN	
07: 05	07: 10	THORN	
07: 34	07: 37	THORN	
08: 40	08: 43	THORN	
08: 30	08: 32	THORN	
09: 00	09: 02	THORN	
09: 25	09: 29	THORN	
10: 00	10: 02	THORN	
10: 30	10: 32	THORN	
11: 07	11: 10	THORN	
11: 30	11: 32	THORN	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

Revised November 31, 2007

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2/13/13 PRISON SAN QUENTIN UNIT/SECTION CARSON SECTION

CELL NUMBERS IN SECTION: 3RD TIER

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
00: 02	00: 09	COSTALES	klw
00: 43	00: 47	COSTALES	klw
01: 10	01: 13	COSTALES	klw
01: 35	01: 38	COSTALES	klw
02: 08	02: 11	COSTALES	klw
02: 30	02: 40	COSTALES	klw
03: 06	03: 09	COSTALES	klw
03: 37	03: 40	COSTALES	klw
04: 06	04: 09	COSTALES	klw
04: 36	04: 39	COSTALES	klw
05: 06	05: 09	COSTALES	klw
05: 35	05: 38	COSTALES	klw
06: 00	06: 04	WILLIAMS	
06: 31	06: 35	WILLIAMS	
07: 01	07: 04	WILLIAMS	
07: 31	07: 33	WILLIAMS	
08: 00	08: 04	WILLIAMS	
08: 31	08: 35	WILLIAMS	
09: 02	09: 05	WILLIAMS	
09: 31	09: 34	WILLIAMS	
10: 02	10: 06	THOMAS	
10: 30	10: 37	THOMAS	
11: 05	11: 09	THOMAS	
11: 32	11: 35	THOMAS	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2/13/13 PRISON SAN QUENTIN UNIT/SECTION CARSON SECTION

CELL NUMBERS IN SECTION 2nd TIER

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
00: 09	00: 11	COSTALES	klw
00: 41	00: 43	COSTALES	klw
01: 13	01: 15	COSTALES	klw
01: 32	01: 35	COSTALES	klw
02: 11	02: 15	COSTALES	klw
02: 34	02: 37	COSTALES	klw
03: 09	03: 11	COSTALES	klw
03: 34	03: 37	COSTALES	klw
04: 09	04: 12	COSTALES	klw
04: 33	04: 36	COSTALES	klw
05: 09	05: 12	COSTALES	klw
05: 33	05: 35	COSTALES	klw
06: 04	06: 06	Wilson	WL
06: 30	06: 35	Wilson	WL
07: 00	07: 02	Phillips	SPh
07: 31	07: 33	Phillips	SPh
08: 00	08: 03	Phillips	SPh
08: 31	08: 34	Phillips	SPh
09: 00	09: 02	Phillips	SPh
09: 31	09: 33	Phillips	SPh
10: 00	10: 04	Wilson	WL
10: 30	10: 32	Phillips	SPh
11: 00	11: 01	Phillips	SPh
11: 30	11: 34	Phillips	SPh

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

Revised November 31, 2007

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2/13/13 PRISON SAN QUENTIN UNIT/SECTION CARSON SECTION

CELL NUMBERS IN SECTION: 1ST TIER

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
00: 11	00: 14	COSTALES	
00: 27	00: 40	COSTALES	
01: 15	01: 18	COSTALES	
01: 30	01: 32	COSTALES	
02: 15	02: 18	COSTALES	
02: 31	02: 34	COSTALES	
03: 11	03: 14	COSTALES	
03: 31	03: 34	COSTALES	
04: 12	04: 15	COSTALES	
04: 30	04: 33	COSTALES	
05: 12	05: 15	COSTALES	
05: 30	05: 33	COSTALES	
06: 00	06: 04	FITZSIMMONS	
06: 28	06: 32	FITZSIMMONS	
07: 00	07: 04	FITZSIMMONS	
07: 45	07: 49	FITZSIMMONS	
08: 07	08: 11	FITZSIMMONS	
08: 27	08: 31	FITZSIMMONS	
09: 01	09: 05	FITZSIMMONS	
09: 29	09: 33	FITZSIMMONS	
10: 00	10: 04	FITZSIMMONS	
10: 31	10: 35	FITZSIMMONS	
11: 08	11: 01	FITZSIMMONS	
11: 30	11: 34	FITZSIMMONS	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd- Watch Review - Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE 2-25-13 2013 UNIT: CARSON SECTION

CELL NUMBERS IN SECTION: 1st Tier

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
00:03	00:04	Ashlock	
00:31	00:32	Ashlock	
01:01	01:02	Ashlock	
01:33	01:34	Ashlock	
00:02	00:03	Ashlock	
00:31	00:32	Ashlock	
01:02	01:03	Ashlock	
01:30	01:31	Ashlock	
02:00	02:03	Wagner	
02:30	02:32	Wagner	
03:02	03:05	Wagner	
03:31	03:33	Wagner	
04:00	04:03	Wagner	
04:30	04:32	Wagner	
05:02	05:05	Wagner	
05:30	05:33	Wagner	
06:~~02~~	06:~~05~~	PONCE, A.J.	
06:31	06:34	PONCE, A.J.	
07:01	07:04	PONCE, A.J.	
07:30	07:33	PONCE, A.J.	
08:00	08:05	CZAJKOWSKI	
08:31	08:35	CZAJKOWSKI	
09:02	09:06	CZAJKOWSKI	
09:32	09:35	CZAJKOWSKI	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

Revised May 10 2012

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE 2-25-13 2013 UNIT CARSON SECTION

CELL NUMBERS IN SECTION 2nd Tier

START TIME	END TIME	PRINT STAFF NAME	STAFF SIGNATURE
05	06	Fishlock	
33	34	Fishlock	
03	04	Fishlock	
35	36	Fishlock	
04	05	Fishlock	
33	34	Fishlock	
04	05	Fishlock	
32	33	Fishlock	
03	05	Wagner	
32	34	Wagner	
05	07	Wagner	
33	35	Wagner	
03	05	Wagner	
32	34	Wagner	
05	07	Wagner	
33	35	Wagner	
00	02	Phillips	
31	33	Phillips	
01	04	Phillips	
30	32	Phillips	
01	03	Phillips	
31	34	Phillips	
00	02	Phillips	
31	33	Phillips	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

Revised May 10, 2012

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE 2-25-13 2013 [redacted] UNIT CARSON SECTION

CELL NUMBERS IN SECTION 3rd Tier

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
00:01	00:08	Ashlock	
00:35	00:36	Ashlock	
01:05	01:06	Ashlock	
01:37	01:58	Ashlock	
00:06	00:07	Ashlock	
00:35	00:36	Ashlock	
01:06	01:07	Ashlock	
01:34	01:35	Ashlock	
02:05	02:07	Wagner	
02:34	02:36	Wagner	
03:07	03:04	Wagner	
03:35	03:37	Wagner	
04:05	04:07	Wagner	
04:34	04:36	Wagner	
05:07	05:09	Wagner	
05:35	05:37	Wagner	
06:00	06:05	CARROSIO	
06:31	06:35	CARROSIO	
07:01	07:05	CARROSIO	
07:32	07:34	CARROSIO	
08:00	08:04	CARROSIO	
08:31	08:35	CARROSIO	
09:00	09:04	CARROSIO	
09:33	09:34	CARROSIO	

1ST Watch Review - Supervisor Signature: [redacted]

2nd Watch Review - Supervisor Signature: [redacted]

3rd Watch Review - Supervisor Signature: [redacted]

Revised May 10 2012

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE 2-25-13 2013 4TH UNIT CARSON SECTION

CELL NUMBERS IN SECTION 1000 Tier

START TIME	END TIME	PRINT STAFF NAME	STAFF SIGNATURE
09	10	Ashlock	
57	58	Ashlock	
07	08	Ashlock	
39	40	Ashlock	
08	09	Ashlock	
37	38	Ashlock	
08	09	Ashlock	
36	37	Ashlock	
07	09	Wagner	
36	38	Wagner	
09	11	Wagner	
37	39	Wagner	
07	09	Wagner	
36	37	Wagner	
09	11	Wagner	
37	39	Wagner	
00	02	Flores	
30	32	Flores	
07	10	Flores	
30	32	Flores	
07	10	Flores	
34	36	Flores	
05	08	Flores	
30	32	Flores	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

Revised May 10, 2012

5th Tier

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE 2-25-13 2013 UNIT CARSON SECTION

CELL NUMBERS IN SECTION 5th Tier

START TIME	END TIME	PRINT LAST NAME	STAFF SIGNATURE
22: 11	22: 12	Ashlock	
22: 39	22: 40	Ashlock	
23: 09	23: 10	Ashlock	
23: 41	23: 42	Ashlock	
00: 10	00: 11	Ashlock	
00: 39	00: 40	Ashlock	
01: 10	01: 11	Ashlock	
01: 38	01: 39	Ashlock	
02: 09	02: 11	Wagner	
02: 37	02: 39	Wagner	
03: 11	03: 13	Wagner	
03: 38	03: 40	Wagner	
04: 09	04: 11	Wagner	
04: 37	04: 39	Wagner	
05: 11	05: 13	Wagner	
05: 38	05: 40	Wagner	
06: 00	06: 03	Jones	
06: 25	06: 30	Jones	
07: 05	07: 08	Jones	
07: 37	07: 40	Jones	
08: 04	08: 07	Jones	
08: 32	08: 35	Jones	
09: 02	09: 05	Jones	
09: 33	09: 36	Jones	

1ST Watch Review - Supervisor Signature: Sgt Bates

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature: Sgt Lee

Revised May 10, 2012

5th Tier

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE 2-24-13 2013 UNIT: CARSON SECTION

CELL NUMBERS IN SECTION 1st TIER

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22:11	22:12	Ashlock	
23:38	23:39	Ashlock	
23:08	23:09	Ashlock	
23:40	23:41	Ashlock	
00:10	00:11	Ashlock	
00:39	00:40	Ashlock	
01:09	01:10	Ashlock	
01:38	01:39	Ashlock	
02:08	02:09	Ashlock	
02:41	02:42	Ashlock	
03:07	03:08	Ashlock	
03:37	03:38	Ashlock	
04:07	04:08	Ashlock	
04:37	04:38	Ashlock	
05:08	05:09	Ashlock	
05:37	05:39	Ashlock	
06:00	06:03	PONCE, A-J.	
06:31	06:34	PONCE, A-J.	
07:01	07:04	PONCE, A-J.	
~~07:30~~	~~07:33~~	~~PONCE, A-J.~~	
08:00	08:03	PONCE, A-J.	
08:31	08:34	PONCE, A-J.	
09:02	09:06	PONCE, A-J.	
09:32	09:35	PONCE, A-J.	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature: T. Johnson

3rd. Watch Review - Supervisor Signature:

SQ 696

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE 2-24-13 2013 [redacted] UNIT CARSON SECTION

CELL NUMBERS IN SECTION 2nd Tier

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
09	10	Ashlock	
36	37	Ashlock	
06	07	Ashlock	
39	39	Ashlock	
08	09	Ashlock	
37	38	Ashlock	
07	08	Ashlock	
36	37	Ashlock	
06	07	Ashlock	
39	40	Ashlock	
09	10	Ashlock	
37	38	Ashlock	
05	06	Ashlock	
35	36	Ashlock	
06	07	Ashlock	
36	37	Ashlock	
00	02	Phillips	
31	34	Phillips	
01	03	Phillips	
32	35	Phillips	
01	04	Phillips	
30	33	Phillips	
02	04	Phillips	
31	35	Phillips	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd–Watch Review - Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE 2-24-13 2013 UNIT CARSON SECTION

CELL NUMBERS IN SECTION 3rd Tier

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22: 07	22:08	Ashlock	
22: 34	22:35	Ashlock	
23: 04	23:05	Ashlock	
23: 36	23:37	Ashlock	
00: 06	00:07	Ashlock	
00: 35	00:36	Ashlock	
01: 05	01:06	Ashlock	
01: 34	01:35	Ashlock	
02: 04	02:05	Ashlock	
02:37	02:38	Ashlock	
03: 07	03:08	Ashlock	
03: 35	03:36	Ashlock	
04: 03	04:04	Ashlock	
04: 33	04:34	Ashlock	
05: 04	05:05	Ashlock	
05: 34	05:35	Ashlock	
06: 05	06: 10	Pope	
06: 40	06: 45	Pope	
07: 09	07: 12	Pope	
07: 40	07: 48	Pope	
08: 06	08: 10	Pope	
08: 29	08: 35	Pope	
09: 05	09: 10	Pope	
09: 45	09: 50	Pope	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd. Watch Review - Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE 2-24-13 2013 UNIT CARSON SECTION

CELL NUMBERS IN SECTION 4th Tier

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
00:05	00:06	Fshlock	
00:32	00:33	Fshlock	
01:02	01:03	Fshlock	
01:34	01:35	Fshlock	
02:04	02:05	Fshlock	
02:33	02:34	Fshlock	
03:03	03:04	Fshlock	
03:32	03:33	Fshlock	
04:02	04:03	Fshlock	
04:35	04:36	Fshlock	
05:05	05:06	Fshlock	
05:33	05:34	Fshlock	
06:01	06:02	Fshlock	
06:31	06:32	Fshlock	
07:02	07:03	Fshlock	
07:32	07:33	Fshlock	
08:00	08:01	Fshlock	
08:30	08:33	Fshlock	
09:05	09:08	Fshlock	
09:30	09:32	Fshlock	
06:00	06:02	Fshlock	~
06:36	06:32	Fshlock	~
07:05	07:08	Fshlock	~
07:34	07:37	Fshlock	~
08:00	08:02	Fshlock	~
08:30	08:33	Fshlock	~
09:05	09:08	Fshlock	~
09:30	09:32	Fshlock	~

1ST Watch Review - Supervisor Signature: [signature]

2nd Watch Review - Supervisor Signature: [signature]

3rd Watch Review - Supervisor Signature:

5th Tier

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE 2-24-13 2013 UNIT CARSON SECTION

CELL NUMBERS IN SECTION 5th Tier

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
02:03	02:04	Ashlock	
02:30	02:31	Ashlock	
03:00	03:01	Ashlock	
03:32	03:33	Ashlock	
00:02	00:03	Ashlock	
00:31	00:32	Ashlock	
01:01	01:02	Ashlock	
01:30	01:31	Ashlock	
02:00	02:01	Ashlock	
02:33	02:34	Ashlock	
03:02	03:03	Ashlock	
03:32	03:33	Ashlock	
04:00	04:01	Ashlock	
04:30	04:31	Ashlock	
05:03	05:04	Ashlock	
05:31	05:32	Ashlock	
06:00	06:03	Jones	
06:30	06:33	Jones	
07:00	07:05	Jones	
07:33	07:35	Jones	
08:00	08:03	Jones	
08:30	08:35	Jones	
09:00	09:05	Jones	
09:25	09:30	Jones	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2-23-13 PRISON SAN QUENTIN UNIT/SECTION CARSON SECTION

CELL NUMBERS IN SECTION TIER 1

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
00:01	00:05	R CASON	R Ca
00:33	00:37	R CASON	R Ca
01:01	01:04	R CASON	R Ca
01:33	01:36	R CASON	R Ca
02:00	02:03	R CASON	R Ca
02:32	02:35	R CASON	R Ca
03:03	03:07	R. CASON	R Ca
03:33	03:36	R CASON	R Ca
04:00	04:03	R CASON	R Ca
04:31	04:34	R CASON	R Ca
05:01	05:04	R CASON	R Ca
05:30	05:33	R CASON	R Ca
06:02	06:05	PONCE, A.J.	
06:30	06:33	PONCE, A.J.	
07:00	07:05	Valenzuela, A	
07:30	07:33	PONCE, A.J.	
08:01	08:04	PONCE, A.J.	
08:30	08:33	Valenzuela	
09:00	09:03	Valenzuela	
09:31	09:35	Valenzuela	
10:00	10:05	Valenzuela	
10:31	10:35	Valenzuela	
11:00	11:05	Valenzuela	
11:31	11:36	Valenzuela	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2-23-13 PRISON SAN QUENTIN UNIT/SECTION CARSON SECTION

CELL NUMBERS IN SECTION TIER 2

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
00:07	00:11	R CASON	R Cas
00:38	00:42	R CASON	R Cas
01:06	01:09	R CASON	R Cas
01:38	01:42	R CASON	R Cas
02:05	02:09	R CASON	R Cas
02:37	02:41	R CASON	R Cas
03:09	03:12	R CASON	R Cas
03:38	03:41	R CASON	R Cas
04:06	04:09	R CASON	R. Cas
04:36	04:39	R. CASON	R Cas
05:06	05:10	R CASON	R Cas
05:34	05:36	R. CASON	R Cas
06:00	06:08	AWOL	
06:25	06:25	AWOL	
07:00	07:02	AWOL	
07:25	07:27	AWOL	
08:05	08:07	AWOL	
08:32	08:35	AWOL	
09:00	09:05	AWOL	
09:30	09:32	AWOL	
10:04	10:06	AWOL	
10:27	10:30	AWOL	
11:00	11:02	AWOL	
11:32	11:34	AWOL	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2-23-13 PRISON SAN QUENTIN UNIT/SECTION CARSON SECTION

CELL NUMBERS IN SECTION TIER 3

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
00:13	00:18	R CASUN	R Ca
00:44	00:48	R CASUN	R Ca
01:11	01:14	R CASUN	R Ca
01:45	01:49	R. CASUN	R Ca
02:11	02:15	R CASUN	R Ca
02:43	02:47	R CASUN	R Ca
03:14	03:18	R CASUN	R Ca
03:43	03:46	R CASUN	R Ca
04:11	04:14	R CASUN	R Ca
04:42	04:45	R CASUN	R Ca
05:12	05:16	R. CASUN	R Ca
05:37	05:40	R CASUN	R Ca
06:00	06:05	CARROSIO	
06:31	06:35	CARROSIO	
07:01	07:06	Ulrich	S. Ulrich
07:30	07:36	ulrich	S. ulrich
08:01	08:05	ulrich	S. ulrich
08:31	08:36	ulrich	S. ulrich
09:00	09:06	ulrich	S. ulrich
09:31	09:36	ulrich	S. ulrich
10:01	10:06	ulrich	S. ulrich
10:31	10:36	Ulrich	S. ulrich
11:00	11:06	Ulrich	S. ulrich
11:31	11:36	ulrich	S. ulrich

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

Revised November 31, 2007

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2-23-13 PRISON SAN QUENTIN UNIT/SECTION CARSON SECTION

CELL NUMBERS IN SECTION TIER 4

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
00: 20	00: 25	R CASUN	R Ca
00: 50	00: 54	R CASUN	R Ca
01: 18	01: 22	R CASUN	R Ca
01: 51	01: 55	R CASUN	R Ca
02: 17	02: 21	R. CASUN	R Ca
02: 50	02: 53	R. CASUN	R Ca
03: 20	03: 24	R CASUN	R Ca
03: 48	03: 51	R CASUN	R Ca
04: 16	04: 19	R CASUN	R Ca
04: 47	04: 51	R CASUN	R Ca
05: 18	05: 22	R. CASUN	R Ca
05: 41	05: 43	R CASUN	R Ca
06: 00	06: 04		
06: 20	06: 24		
07: 00	07: 59		
07: 05	07: 32		
08: 00	08: 04		
08: 20	08: 28		
09: 00	09: 04		
09: 30	09: 35		
10: 00	10: 04		
10: 20	10: 29		
11: 00	11: 04		
11: 20	11: 21		

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

5th Tier

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2-23-13 PRISON SAN QUENTIN UNIT/SECTION CARSON SECTION

CELL NUMBERS IN SECTION Tier 5

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
00:27	00:30	R Cason	R Ca
00:56	00:59	R Cason	R Ca
01:25	01:29	R Cason	R Ca
01:56	01:59	R Cason	R Ca
02:23	02:27	R Cason	R Ca
02:55	02:58	R Cason	R Ca
03:26	03:29	R Cason	R Ca
03:53	03:57	R Cason	R Ca
04:21	04:24	R Cason	R Ca
04:53	04:57	R Cason	R Ca
05:24	05:28	R Cason	R Ca
05:44	05:46	R Cason	R Ca
06:00	06:03	Jones	Jones
06:30	06:33	Jones	Jones
07:00	07:05	Jones	Jones
07:25	07:30	Jones	Jones
08:03	08:05	Jones	Jones
08:30	08:33	Jones	Jones
09:00	09:03	Jones	Jones
09:33	09:35	Jones	Jones
10:00	10:05	Jones	Jones
10:25	10:30	Jones	Jones
11:00	11:03	Jones	Jones
11:30	11:35	Jones	Jones

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

5th Tier

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2-19-13 2013 UNIT: CARSON SECTION

CELL NUMBERS IN SECTION: 1st Tier

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22: 03	22: 04	Ashlock	
22: 30	22: 31	Ashlock	
23: 00	23: 01	Ashlock	
23: 32	23: 33	Ashlock	
00: 01	00: 02	Ashlock	
00: 30	00: 31	Ashlock	
01: 03	01: 04	Ashlock	
01: 32	01: 33	Ashlock	
02: 03	02: 04	Ashlock	
02: 30	02: 31	Ashlock	
03: 02	03: 03	Ashlock	
03: 31	03: 32	Ashlock	
04: 02	04: 03	Ashlock	
04: 32	04: 33	Ashlock	
05: 01	05: 02	Ashlock	
05: 31	05: 32	Ashlock	
06: 04	06: 07	PONCE, A-J.	
06: 31	06: 34	PONCE, A.J.	
07: 02	07: 05	PONCE, A.J.	
07: 30	07: 33	PONCE, A-J.	
08: 03	08: 06	PONCE, A.J.	
08: 30	08: 33	Valenzuela	
09: 00	09: 04	Valenzuela	
09: 31	09: 35	Valenzuela	
1ST Watch Review - Supervisor Signature:			
2nd Watch Review - Supervisor Signature:			
3rd Watch Review - Supervisor Signature:			

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE 2-19-13 2013 [redacted] UNIT: CARSON SECTION

CELL NUMBERS IN SECTION 2nd Tier

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22:05	22:06	Hshock	CA
22:32	22:33	Hshock	CA
23:02	23:03	Hshock	CA
23:34	23:35	Hshock	CA
00:03	00:04	Hshock	CA
00:32	00:33	Hshock	CA
01:05	01:06	Hshock	CA
01:34	01:35	Hshock	CA
02:05	02:06	Hshock	CA
02:32	02:33	Hshock	CA
03:04	03:05	Hshock	CA
03:33	03:34	Hshock	CA
04:04	04:05	Hshock	CA
04:34	04:35	Hshock	CA
05:03	05:04	Hshock	CA
05:33	05:34	Hshock	CA
06:00	06:02	Phillips	SPh
06:31	06:34	Phillips	SPh
07:01	07:04	Phillips	SPh
07:30	07:33	Phillips	SPh
08:02	08:04	Phillips	SPh
08:31	08:34	Phillips	SPh
09:00	09:04	Bean	Bean
09:32	09:35	Phillips	SPh

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature: CE

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE 2-19-13 2013 [redacted] UNIT: CARSON SECTION

CELL NUMBERS IN SECTION 3rd Tier

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22: 07	22: 08	Ashlock	
22: 34	22: 35	Ashlock	
23: 04	23: 05	Ashlock	
23: 36	23: 37	Ashlock	
00: 05	00: 06	Ashlock	
00: 34	00: 35	Ashlock	
01: 07	01: 08	Ashlock	
01: 36	01: 37	Ashlock	
02: 07	02: 08	Ashlock	
02: 34	02: 35	Ashlock	
03: 06	03: 07	Ashlock	
03: 35	03: 36	Ashlock	
04: 06	04: 07	Ashlock	
04: 36	04: 37	Ashlock	
05: 05	05: 06	Ashlock	
05: 35	05: 36	Ashlock	
06: 00	06: 04	Williams	
06: 30	06: 33	Williams	
07: 01	07: 03	Williams	
07: 31	07: 33	Williams	
08: 02	08: 05	Williams	
08: 33	08: 36	Williams	
09: 01	09: 04	Williams	
09: 31	09: 33	Williams	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE 2-19-13 2013 [redacted] 4th UNIT CARSON SECTION

CELL NUMBERS IN SECTION [redacted] Tier

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22: 09	22: 10	Tshlock	
22: 36	22: 37	Tshlock	
23: 06	23: 07	Tshlock	
23: 38	23: 39	Tshlock	
00: 07	00: 08	Tshlock	
00: 36	00: 37	Tshlock	
01: 09	01: 10	Tshlock	
01: 38	01: 39	Tshlock	
02: 09	02: 10	Tshlock	
02: 36	02: 37	Tshlock	
03: 08	03: 09	Tshlock	
03: 37	03: 38	Tshlock	
04: 08	04: 09	Tshlock	
04: 38	04: 39	Tshlock	
05: 07	05: 08	Tshlock	
05: 37	05: 38	Tshlock	
06: 00	06: 01	Flores	
06: 30	06: 33	Flores	
07: 07	07: 10	Flores	
07: 30	07: 32	Flores	
08: 00	08: 01	[illegible]	
08: 20	08: 21	[illegible]	
09: 00	09: 04	[illegible]	
09: 20	09: 28	[illegible]	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

5th Tier

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2-19-13 2013 UNIT CARSON SECTION

CELL NUMBERS IN SECTION 5th Tier

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22: 11	22: 12	Tshlock	
22: 38	22: 39	Tshlock	
23: 08	23: 09	Tshlock	
23: 40	23: 41	Tshlock	
00: 09	00: 10	Tshlock	
00: 38	00: 39	Tshlock	
01: 11	01: 12	Tshlock	
01: 40	01: 41	Tshlock	
02: 11	02: 12	Tshlock	
02: 38	02: 39	Tshlock	
03: 10	03: 11	Tshlock	
03: 39	03: 40	Tshlock	
04: 10	04: 11	Tshlock	
04: 40	04: 41	Tshlock	
05: 09	05: 10	Tshlock	
05: 39	05: 40	Tshlock	
06: 00	06: 03	Jones	
06: 30	06: 33	Jones	
07: 00	07: 05	Jones	
07: 05	07: 30	Jones	
08: 00	08: 03	Jones	
08: 33	08: 35	Jones	
09: 00	09: 05	Jones	
09: 30	09: 33	Jones	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2/20/ 2013 UNIT: CARSON SECTION

CELL NUMBERS IN SECTION 1ST TIER

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22:03	22:05	T. JONES	
22:33	22:35	T. JONES	
23:03	23:05	T. JONES	
23:33	23:35	T. JONES	
00:03	00:05	T. JONES	
00:33	00:35	T. JONES	
01:03	01:05	T. JONES	
01:33	01:35	T. JONES	
02:03	02:05	T. JONES	
02:33	02:35	T. JONES	
03:03	03:05	T. JONES	
03:33	03:35	T. JONES	
04:03	04:05	T. JONES	
04:33	04:35	T. JONES	
05:03	05:05	T. JONES	
05:33	05:35	T. JONES	
06:06	06:04	F. TRSIMMONS	
06:37	06:37	F. TRSIMMONS	
07:01	07:05	F. TRSIMMONS	
07:29	07:33	F. TRSIMMONS	
08:00	08:05	F. TRSIMMONS	
08:31	08:35	F. TRSIMMONS	
~~09:~~ 0854	09: 0854	F. TRSIMMONS	
09:29	09:28	F. TRSIMMONS	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature: G. Polanco

3rd Watch Review - Supervisor Signature:

SQ 712

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2/20/ 2013 UNIT: CARSON SECTION

CELL NUMBERS IN SECTION 2ND TIER

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22: 07	22: 10	T. JONES	
22: 37	22:40	T. JONES	
23: 07	23:10	T. JONES	
23: 37	23:40	T. JONES	
00: 07	00: 10	T. JONES	
00: 37	00: 40	T. JONES	
01: 07	01: 10	T. JONES	
01: 37	01: 40	T. JONES	
02: 07	02: 10	T. JONES	
02: 37	02: 40	T. JONES	
03: 07	03: 10	T. JONES	
03: 37	03: 40	T. JONES	
04: 07	04: 10	T. JONES	
04: 37	04: 40	T. JONES	
05: 07	05: 10	T. JONES	
05: 37	05: 40	T. JONES	
06: 00	06:03	Phillips	
06:31	06:34	Phillips	
07: 01	07: 06	Robinson	
07:30	07:33	Phillips	
08:02	08:04	Phillips	
08: 31	08: 33	Phillips	
09:01	09:03	Phillips	
09: 30	09:32	Phillips	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature: G. Palacio

3rd Watch Review - Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2012 UNIT: CARSON SECTION

CELL NUMBERS IN SECTION 3RD TIER

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22: 12	22: 15	T. JONES	
22: 42	22: 45	T. JONES	
23: 12	23: 15	T. JONES	
23: 42	23: 45	T. JONES	
00: 12	00: 15	T. JONES	
00: 42	00: 45	T. JONES	
01: 12	01: 15	T. JONES	
01: 42	01: 45	T. JONES	
02: 12	02: 15	T. JONES	
02: 42	02: 45	T. JONES	
03: 12	03: 15	T. JONES	
03: 42	03: 45	T. JONES	
04: 12	04: 15	T. JONES	
04: 42	04: 45	T. JONES	
05: 12	05: 15	T. JONES	
05: 42	05: 45	T. JONES	
06: 01	06: 05	THORN	
06: 32	06: 36	THORN	
07: 00	07: 05	THORN	
07: 32	07: 36	THORN	
08: 00	08: 05	THORN	
08: 30	08: 33	THORN	
09: 00	09: 05	THORN	
09: 33	09: 37	THORN	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

SQ 714

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2/20/ 2013 UNIT: CARSON SECTION

CELL NUMBERS IN SECTION 4TH TIER

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22:17	22:20	T. JONES	
22:47	22:50	T. JONES	
23:17	23:20	T. JONES	
23:47	23:50	T. JONES	
00:17	00:20	T. JONES	
00:47	00:50	T. JONES	
01:17	01:20	T. JONES	
01:47	01:50	T. JONES	
02:17	02:20	T. JONES	
02:47	02:50	T. JONES	
03:17	03:20	T. JONES	
03:47	03:50	T. JONES	
04:17	04:20	T. JONES	
04:47	04:50	T. JONES	
05:17	05:20	T. JONES	
05:47	05:50	T. JONES	
06:00	06:02	Flores	
06:40	06:43	Flores	
07:07	07:10	Flores	
07:35	07:40	Flores	
08:02	08:05	Flores	
08:30	08:32	Flores	
09:00	09:02	Flores	
09:30	09:32	Flores	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

SIL OS

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2/20/ 2013 UNIT: CARSON SECTION

CELL NUMBERS IN SECTION 5TH TIER

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22:22	22:25	T. JONES	
22:52	22:55	T. JONES	
23:22	23:25	T. JONES	
23:52	23:55	T. JONES	
00:22	00:25	T. JONES	
00:52	00:55	T. JONES	
01:22	01:25	T. JONES	
01:52	01:55	T. JONES	
02:22	02:25	T. JONES	
02:52	02:55	T. JONES	
03:22	03:25	T. JONES	
03:52	03:55	T. JONES	
04:22	04:25	T. JONES	
04:52	04:55	T. JONES	
05:22	05:25	T. JONES	
05:52	05:55	T. JONES	
06:04	06:08	T. Unger	
06:30	06:34	T. Unger	
07:01	07:06	T. Unger	
07:33	07:37	T. Unger	
08:03	08:06	T. Unger	
08:34	08:38	T. Unger	
09:01	09:07	T. Unger	
09:30	09:36	T. Unger	

1ST Watch Review - Supervisor Signature: D Cambarley

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2.20 2013 UNIT: CARSON SECTION

CELL NUMBERS IN SECTION Tier 4

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22:10	22:12	Bailey	
22:39	22:41	Bailey	
23:10	23:12	Bailey	
23:33	23:35	Bailey	
00:10	00:12	Bailey	
00:39	00:41	Bailey	
01:04	01:06	Bailey	
01:39	01:41	Bailey	
02:05	02:06	Bailey	
02:49	02:52	Bailey	
03:04	03:06	Bailey	
03:42	03:44	Bailey	
04:10	04:12	Bailey	
04:39	04:41	Bailey	
05:10	05:12	~~Floor~~	
05:38	05:39	Bailey	
06:02	06:05	Floor	
06:30	06:32	Floor	
07:04	07:07	Floor	
07:30	07:32	Floor	
08:05	08:05	Floor	
08:30	08:32	Floor	
09:05	09:08	Floor	
09:30	09:32	Floor	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

LIL OS

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2 20 2013 UNIT: CARSON SECTION

CELL NUMBERS IN SECTION Tier 2

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22:04	22:06	Bailey	B
22:33	22:35	Bailey	B
23:04	23:06	Bailey	B
23:39	23:41	Bailey	B
00:04	00:06	Bailey	B
00:33	00:35	Bailey	B
01:00	01:02	bailey	B
01:33	01:35	Bailey	B
02:10	02:13	bailey	B
02:43	02:45	Bailey	B
03:10	03:12	Bailey	B
03:35	03:37	bailey	B
04:04	04:06	bailey	B
04:33	04:35	bailey	B
05:04	05:06	bailey	B
05:34	05:36	Bailey	B
06:01	06:03	Phillips	SPL
06:30	06:32	Phillips	SPL
07:02	07:04	Phillips	SPL
07:30	07:33	Phillips	SPL
08:01	08:04	Phillips	SPL
08:30	08:32	Phillips	SP
09:00	09:02	Phillips	SP
09:31	09:34	Phillips	SPL

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2-20 2013 UNIT: CARSON SECTION

CELL NUMBERS IN SECTION Tier 3

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22:07	22:09	Bailey	
22:36	22:38	Bailey	
23:07	23:09	Bailey	
23:36	23:38	Bailey	
00:07	00:09	Bailey	
00:36	00:38	Bailey	
0107	0109	Bailey	
01:36	01:38	Bailey	
02:07	02:09	Bailey	
02:46	02:48	Bailey	
03:07	03:09	Bailey	
03:38	03:40	Bailey	
04:07	04:09	Bailey	
04:36	04:38	Bailey	
0506	0508	Bailey	
05:35	0537	Bailey	
06:00	06:04	FITZSIMMONS	
06:29	06:33	FITZSIMMONS	
07:01	07:05	FITZSIMMONS	
07:30	07:33	WILLIAMS	
08:00	08:04	FITZSIMMONS	
08:31	08:34	WILLIAMS	
09:01	09:04	WILLIAMS	
09:00	09:03	WILLIAMS	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2-20 2013 UNIT: CARSON SECTION

CELL NUMBERS IN SECTION Tier 5

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22:13	22:15	Bailey	
22:42	22:44	Bailey	
23:13	23:15	Bailey	
23:30	23:32	Bailey	
00:13	00:15	Bailey	
00:42	00:45	Bailey	
01:00	01:03	Bailey	
01:42	01:44	Bailey	
02:01	02:04	Bailey	
02:53	02:55	Bailey	
03:00	03:03	Bailey	
03:45	03:47	Bailey	
04:13	04:15	Bailey	
04:42	04:44	Bailey	
05:16	05:19	Bailey	
05:43	05:45	Bailey	
06:00	06:05	BAILEY	
06:30	06:33	BAILEY	
07:00	07:05	BAILEY	
07:30	07:33	BAILEY	
08:00	08:05	BAILEY	
08:30	08:33	BAILEY	
09:00	09:03	BAILEY	
09:30	09:35	BAILEY	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

SQ 720

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2-20 2018 UNIT: CARSON SECTION

CELL NUMBERS IN SECTION Tier 1

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22:00	22:03	Bailey	B
22:30	22:32	Bailey	B
23:01	23:03	Bailey	B
23:42	23:44	Bailey	B
00:01	00:03	Bailey	B
00:30	00:32	Bailey	B
01:13	01:15	Bailey	B
01:30	01:32	Bailey	B
02:14	02:16	Bailey	B
02:38	02:41	Bailey	B
03:13	03:14	Bailey	B
03:32	03:34	Bailey	B
04:01	04:03	Bailey	B
04:30	04:32	Bailey	B
05:00	05:03	Bailey	B
05:31	05:33	Bailey	B
06:01	06:07	SALDANA	
06:32	06:38	SALDANA	
07:02	07:07	SALDANA	
07:30	07:36	SALDANA	
08:00	08:08	SALDANA	
08:30	08:37	SALDANA	
09:00	09:04	SALDANA	
09:33	09:38	SALDANA	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

5TH/1ER

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2/22/15 PRISON SAN QUENTIN UNIT/SECTION CARSON SECTION

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
00: 00	00: 05	K. FRYE	K. Frye
00: 30	00: 35	K. FRYE	K. Frye
01: 00	01: 05	K. FRYE	K. Frye
01: 30	01: 35	K. FRYE	K. Frye
02: 00	02: 05	K. FRYE	K. Frye
02: 30	02: 36	K. FRYE	K. Frye
03: 00	03: 05	K. FRYE	K. Frye
03: 30	03: 35	K. FRYE	K. Frye
04: 00	04: 05	K. FRYE	K. Frye
04: 30	04: 35	K. FRYE	K. Frye
05: 00	05: 05	K. FRYE	K. Frye
05: 30	05: 35	K. FRYE	K. Frye
06: 00	06: 05	Jones	Jones
06: 30	06: 33	Jones	Jones
07: 00	07: 03	Jones	Jones
07: 25	07: 30	Jones	Jones
08: 00	08: 05	Jones	Jones
08: 30	08: 33	Jones	Jones
09: 00	09: 03	Jones	Jones
09: 25	09: 30	Jones	Jones
10: 00	10: 05	Jones	Jones
10: 33	10: 35	Jones	Jones
11: 00	11: 03	Jones	Jones
11: 30	11: 35	Jones	Jones

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

21, 37, 48

1ST TIER

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2/22/13 PRISON SAN QUENTIN UNIT/SECTION CARSON SECTION

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
00:00	00:05	K WARNOCK	
00:30	00:35	K WARNOCK	
01:00	01:05	K WARNOCK	
01:30	01:35	K WARNOCK	
02:00	02:05	K WARNOCK	
02:30	02:35	K WARNOCK	
03:00	03:05	K WARNOCK	
03:30	03:35	K WARNOCK	
04:00	04:05	K WARNOCK	
04:30	04:35	K WARNOCK	
05:00	05:05	K WARNOCK	
05:30	05:35	K WARNOCK	
06:00	06:05	A Valenzuela	
06:30	06:34	A Valenzuela	
07:00	07:04	A Valenzuela	
07:31	07:35	A. Valenzuela	
08:00	08:04	A Valenzuela	
08:31	08:35	A Valenzuela	
09:00	09:03	A. Valenzuela	
09:30	09:34	A Valenzuela	
10:00	10:05	A Valenzuela	
10:31	10:35	A Valenzuela	
11:00	11:04	A Valenzuela	
11:31	11:36	A Valenzuela	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

2ND TIER

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2/22/13 PRISON SAN QUENTIN UNIT/SECTION CARSON SECTION

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
00: 00	00: 05	K WORRICE	
00: 30	00: 35	K WORRICE	
01: 00	01: 05	K WORRICE	
01: 30	01: 35	K WORRICE	
02: 00	02: 05	K WORRICE	
02: 30	02: 35	K WORRICE	
03: 00	03: 05	K WORRICE	
03: 30	03: 35	K WORRICE	
04: 00	04: 05	K WORRICE	
04: 30	04: 36	K WORRICE	
05: 00	05: 05	K WORRICE	
05: 30	05: 35	K WORRICE	
06: 00	06: 010	A. SULLIVAN	
06: 30	06: 33	A. SULLIVAN	
07: 00	07: 03	A. SULLIVAN	
07: 30	07: 33	A. SULLIVAN	
08: 00	08: 03	A. SULLIVAN	
08: 30	08: 33	A. SULLIVAN	
09: 00	09: 03	A. SULLIVAN	
09: 30	09: 33	A. SULLIVAN	
10: 00	10: 03	A. SULLIVAN	
10: 30	10: 32	A. SULLIVAN	
11: 00	11: 02	A. SULLIVAN	
11: 30	11: 32	A. SULLIVAN	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

3RD TIER

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2/22/13 PRISON SAN QUENTIN UNIT/SECTION CARSON SECTION

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
00: 00	00: 05	LORENZO	
00: 30	00: 35	LORENZO	
01: 00	01: 05	LORENZO	
01: 30	01: 35	LORENZO	
02: 00	02: 05	LORENZO	
02: 30	02: 35	LORENZO	
03: 00	03: 05	LORENZO	
03: 30	03: 35	LORENZO	
04: 00	04: 05	LORENZO	
04: 30	04: 35	LORENZO	
05: 00	05: 05	LORENZO	
05: 30	05: 35	LORENZO	
06: 00	06: 04	FITZSIMMONS	
06: 29	06: 33	FITZSIMMONS	
07: 00	07: 04	FITZSIMMONS	
07: 30	07: 34	FITZSIMMONS	
08: 00	08: 04	FITZSIMMONS	
08: 27	08: 31	FITZSIMMONS	
09: 04	09: 08	FITZSIMMONS	
09: 30	09: 34	FITZSIMMONS	
10: 01	10: 05	FITZSIMMONS	
10: 27	10: 31	FITZSIMMONS	
11: 05	11: 09	FITZSIMMONS	
11: 29	11: 33	FITZSIMMONS	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

ATTACHER

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2/22/13 PRISON SAN QUENTIN UNIT/SECTION CARSON SECTION

CELL NUMBERS IN SECTION

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
00: 00	00: 05	K WERNE	
00: 30	00: 35	K WERNE	
01: 00	01: 05	K WERNE	
01: 30	01: 35	K WERNE	
02: 00	02: 05	K WERNE	
02: 30	02: 35	K WERNE	
03: 00	03: 05	K WERNE	
03: 30	03: 35	K WERNE	
04: 00	04: 05	K WERNE	
04: 30	04: 35	K WERNE	
05: 00	05: 05	K WERNE	
05: 30	05: 35	K WERNE	
06: 00	06: 04	BLASCO	
06: 31	06: 32	BLASCO	
07: 01	07: 03	BLASCO	
07: 32	07: 34	BLASCO	
08: 03	08: 05	BLASCO	
08: 32	08: 34	BLASCO	
09: 01	09: 04	BLASCO	
09: 30	09: 33	BLASCO	
10: 00	10: 02	BLASCO	
10: 31	10: 34	BLASCO	
11: 01	11: 02	BLASCO	
11: 51	11: 54	BLASCO	
1ST Watch Review - Supervisor Signature:			
2nd Watch Review - Supervisor Signature:			
3rd Watch Review - Supervisor Signature:			

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE 2-18-13 2013 UNIT CARSON SECTION

CELL NUMBERS IN SECTION 1st Tier

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22: 03	22: 04	Ashlock	
22: 30	22: 31	Ashlock	
23: 00	23: 01	Ashlock	
23: 32	23: 33	Ashlock	
00: 02	00: 03	Ashlock	
00: 31	00: 32	Ashlock	
01: 01	01: 02	Ashlock	
01: 32	01: 33	Ashlock	
02: 00	02: 01	Ashlock	
02: 31	02: 32	Ashlock	
03: 02	03: 03	Ashlock	
03: 32	03: 33	Ashlock	
04: 00	04: 01	Ashlock	
04: 30	04: 31	Ashlock	
05: 02	05: 03	Ashlock	
05: 31	05: 32	Ashlock	
06: 00	06: 04	HANNAH	
06: 30	06: 33	HANNAH	
07: 00	07: 05	HANNAH	
07: 30	07: 04	HANNAH	
08: 01	08: 05	HANNAH	
08: 37	08: 37	BARR	
09: 02	09: 08	HANNAH	
09: 30	09: 34	HANNAH	

1ST Watch Review - Supervisor Signature: RST

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE 2-18-19 2013 UNIT CARSON SECTION

CELL NUMBERS IN SECTION 2nd Tier

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22:05	22:06	Fishlock	
22:32	22:33	Fishlock	
23:02	23:03	Fishlock	
23:34	23:35	Fishlock	
00:04	00:05	Fishlock	
00:33	00:34	Fishlock	
01:03	01:04	Fishlock	
01:34	01:35	Fishlock	
02:02	02:03	Fishlock	
02:33	02:34	Fishlock	
03:04	03:05	Fishlock	
03:34	03:35	Fishlock	
04:01	04:03	Fishlock	
04:32	04:33	Fishlock	
05:04	05:05	Fishlock	
05:33	05:34	Fishlock	
06:00	06:02	Phillips	SPL
06:31	06:34	Phillips	SPL
07:02	07:05	Phillips	SPL
07:31	07:32	Phillips	SPL
08:02	08:04	Phillips	SPL
08:31	08:33	Phillips	SPL
09:02	09:05	Phillips	SPL
09:30	09:33	Phillips	SPL

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

SQ 727

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2-18-13 2013 [redacted] UNIT: CARSON SECTION

CELL NUMBERS IN SECTION: 3rd Tier

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22:07	22:08	Ashlock	
22:34	22:35	Ashlock	
23:04	23:05	Ashlock	
23:36	23:37	Ashlock	
00:06	00:07	Ashlock	
00:35	00:36	Ashlock	
01:05	01:06	Ashlock	
01:36	01:37	Ashlock	
02:04	02:05	Ashlock	
02:35	02:36	Ashlock	
03:06	03:07	Ashlock	
03:36	03:37	Ashlock	
04:04	04:05	Ashlock	
04:34	04:35	Ashlock	
05:06	05:07	Ashlock	
05:35	05:36	Ashlock	
06:00	06:05	CARROSIO	
06:31	06:35	CARROSIO	
07:01	07:05	CARROSIO	
07:31	07:35	CARROSIO	
08:01	08:04	CARROSIO	
08:32	08:36	CARROSIO	
09:03	09:06	CARROSIO	
09:30	09:34	CARROSIO	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

SQ 728

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE 2-18-13 2013 UNIT CARSON SECTION

CELL NUMBERS IN SECTION 4th Tier

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
09	10	Ashlock	
36	37	Ashlock	
06	07	Ashlock	
38	39	Ashlock	
08	09	Ashlock	
37	38	Ashlock	
07	08	Ashlock	
38	39	Ashlock	
06	07	Ashlock	
37	38	Ashlock	
08	09	Ashlock	
38	39	Ashlock	
06	07	Ashlock	
36	37	Ashlock	
09	09	Ashlock	
37	38	Ashlock	
00	02	Pham	~
33	35	Pham	~
00	02	Pham	~
30	32	Pham	~
00	02	Pham	~
30	32	Pham	~
04	07	Pham	~
30	32	Pham	~

1ST Watch Review - Supervisor Signature: V-JTL

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

5th Tier

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE 2-18-13 2013 UNIT CARSON SECTION

CELL NUMBERS IN SECTION 5th Tier

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
11	12	Ashlock	CA
38	39	Ashlock	CA
08	09	Ashlock	CA
40	41	Ashlock	CA
10	11	Ashlock	CA
39	40	Ashlock	CA
09	10	Ashlock	CA
40	41	Ashlock	CA
08	09	Ashlock	CA
39	40	Ashlock	CA
10	11	Ashlock	CA
40	41	Ashlock	CA
08	09	Ashlock	CA
39	39	Ashlock	CA
10	11	Ashlock	CA
39	40	Ashlock	CA
06: 00	06: 03	Jones	Jones
06:30	06:33	Jones	Jones
07:00	07:05	Jones	Jones
07:25	07:30	Jones	Jones
08: 00	08: 03	Jones	Jones
08:33	08:35	Jones	Jones
09:00	09:05	Jones	Jones
09 25	09:30	Jones	Jones

1ST Watch Review - Supervisor Signature: D-T2

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

5th Tier

SQ 730

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2-17-13 [redacted] UNIT: CARSON SECTION

CELL NUMBERS IN SECTION 1st Tier

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22 03	22 04	Ashlock	
22 30	22 31	Ashlock	
23 00	23 01	Ashlock	
23 30	23 31	Ashlock	
00 01	00 02	Ashlock	
00 32	00 33	Ashlock	
01 02	01 03	Ashlock	
01 31	01 32	Ashlock	
02: 01	02: 02	Ashlock	
02: 30	02: 31	Ashlock	
03: 02	03: 03	Ashlock	
03: 31	03: 32	Ashlock	
04: 01	04: 02	Ashlock	
04: 31	04: 32	Ashlock	
05: 00	05: 01	Ashlock	
05: 30	05: 31	Ashlock	
06: 04	06: 06	SCOTT	
06: 32	06: 34	Scott	
07: 01	07: 03	Scott	
07: 33	07: 35	Scott	
08: 02	08: 04	Scott	
08: 34	08: 36	Scott	
09: 00	09: 02	Scott	
09: 31	09: 33	Scott	

1ST Watch Review - Supervisor Signature:

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2-17-13 [redacted] UNIT: CARSON SECTION

CELL NUMBERS IN SECTION: 2nd Tier

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22: 05	22: 06	Fishlock	[signature]
22 32	22 33	Fishlock	[signature]
23: 02	23: 03	Fishlock	[signature]
23: 32	23: 33	Fishlock	[signature]
00 03	00: 04	Fishlock	[signature]
00 34	00: 35	Fishlock	[signature]
01: 04	01: 05	Fishlock	[signature]
01: 33	01: 34	Fishlock	[signature]
02: 03	02: 04	Fishlock	[signature]
02: 32	02: 33	Fishlock	[signature]
03: 04	03: 05	Fishlock	[signature]
03: 33	03: 34	Fishlock	[signature]
04: 03	04: 04	Fishlock	[signature]
04: 33	04: 34	Fishlock	[signature]
05: 02	05: 03	Fishlock	[signature]
05: 32	05: 33	Fishlock	[signature]
06: 00	06: 02	Phillips	SPL
06: 31	06: 34	Phillips	SPL
07: 01	07: 04	Phillips	SPL
07: 30	07: 32	Phillips	SPL
08: 02	08: 04	Phillips	SPL
08: 31	08: 33	Phillips	SPL
09: 00	09: 02	Phillips	SPL
09: 31	09: 34	Phillips	SPL

1ST Watch Review - Supervisor Signature: DJR

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

Revised May 10, 2012

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2-17-13 [redacted] UNIT: CARSON SECTION

CELL NUMBERS IN SECTION 3rd Tier

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22: 07	22 08	Ashlock	
22: 34	22 35	Ashlock	
23: 04	23: 05	Ashlock	
23: 34	23: 35	Ashlock	
00 05	00 06	Ashlock	
00 35	00 36	Ashlock	
01: 06	01: 07	Ashlock	
01: 36	01: 37	Ashlock	
02: 05	02: 06	Ashlock	
02: 34	02: 35	Ashlock	
03: 06	03: 07	Ashlock	
03: 35	03: 36	Ashlock	
04: 05	04: 06	Ashlock	
04: 35	04: 36	Ashlock	
05: 04	05 05	Ashlock	
05: 34	05: 35	Ashlock	
06: 07	06: 08	GUTIERREZ	
06: 34	06: 35	GUTIERREZ	
07: 06	07: 07	GUTIERREZ	
07: 34	07: 35	GUTIERREZ	
08: 04	08: 05	GUTIERREZ	
08: 34	08: 35	GUTIERREZ	
09: 04	09: 05	GUTIERREZ	
09: 36	09: 37	GUTIERREZ	

1ST Watch Review - Supervisor Signature: D-JR

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE: 2-17-13 [redacted] UNIT: CARSON SECTION

CELL NUMBERS IN SECTION 4th Tier

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22 09	22 10	Ashlock	
22 36	22 37	Ashlock	
23 06	23 07	Ashlock	
23 56	23 37	Ashlock	
00 07	00 08	Ashlock	
00 37	00 38	Ashlock	
01 08	01 09	Ashlock	
01 38	01 39	Ashlock	
02 07	02 08	Ashlock	
02 36	02 37	Ashlock	
03 08	03 09	Ashlock	
03 37	03 38	Ashlock	
04 07	04 08	Ashlock	
04 37	04 38	Ashlock	
05 06	05 07	Ashlock	
05 36	05 37	Ashlock	
06 00	06 02	AWL	
06 25	06 27	AWL	
07 05	07 07	AWL	
07 35	07 37	AWL	
08 00	08 02	AWL	
08 27	08 30	AWL	
09 00	09 03	AWL	
09 32	09 34	AWL	

1ST Watch Review - Supervisor Signature: DJPL

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

SQ 734

5th Tier

ASU 30 MINUTE WELFARE CHECK TRACKING SHEET

DATE 2-17-13 [redacted] UNIT: CARSON SECTION

CELL NUMBERS IN SECTION 5th Tier

START TIME	END TIME	PRINTED STAFF NAME	STAFF SIGNATURE
22:11	22:12	Ashlock	CA
22:38	22:39	Ashlock	CA
23:08	23:09	Ashlock	CA
23:38	23:39	Ashlock	CA
00:09	00:10	Ashlock	CA
00:39	00:40	Ashlock	CA
01:10	01:11	Ashlock	CA
01:40	01:41	Ashlock	CA
02:09	02:10	Ashlock	CA
02:38	02:39	Ashlock	CA
03:10	03:11	Ashlock	CA
03:39	03:40	Ashlock	CA
04:09	04:10	Ashlock	CA
04:39	04:40	Ashlock	CA
05:08	05:09	Ashlock	CA
05:38	05:39	Ashlock	CA
06:00	06:03	Jones	Jones
06:30	06:33	Jones	Jones
07:00	07:05	Jones	Jones
07:25	07:30	Jones	Jones
08:00	08:03	Jones	Jones
08:30	08:33	Jones	Jones
09:00	09:05	Jones	Jones
09:25	09:30	Jones	Jones

1ST Watch Review - Supervisor Signature: DJR

2nd Watch Review - Supervisor Signature:

3rd Watch Review - Supervisor Signature:

Revised May 10, 2012

5th Tier

Exhibit 61

From: O'Meara, Kathleen@CDCR
Sent: Saturday, January 19, 2013 12:10 PM
To: Chaiken, Shama@CDCR
Subject: Re: Fwd: Don Thompson's story

PVE EXHIBIT 12
Date: 3-5-13
Witness
BEARD

Call me. 916 616 5244
I'm floored by what you're telling me.

From: Chaiken, Shama@CDCR
Sent: Saturday, January 19, 2013 12:06 PM Pacific Standard Time
To: O'Meara, Kathleen@CDCR
Subject: RE: Fwd: Don Thompson's story

OK – Catherine is taking over, but she doesn't know much about it yet. Amy was out sick a lot (FMLA covered) and had many other assigned duties. Amy started with one psychologist who we received as a mandatory SROA transfer, because we were worried about his ability to complete a SRE. Based on the findings and some other difficulties he was having completing the work, we convinced him to retire, which was a good outcome. Catherine and I want to go through the mentoring so we understand what is required, and then Catherine will likely take some supervisors through the process so we will have a team of mentors.

Shama Chaiken, Ph.D., CCHP
Chief of Mental Health
California State Prison, Sacramento
Division of Correctional Health Care Services

916-294-3160 Office
916-508-2047 Cell
916-294-3122 Fax
shama.chaiken@cdcr.ca.gov

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

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From: O'Meara, Kathleen@CDCR
Sent: Saturday, January 19, 2013 11:52 AM
To: Chaiken, Shama@CDCR
Subject: Re: Fwd: Don Thompson's story

Please forward plan upon completion. It had been my impression that Amy had begun the process months ago, so I'll look forward to hearing your new strategy.

From: Chaiken, Shama@CDCR
Sent: Saturday, January 19, 2013 11:30 AM Pacific Standard Time
To: O'Meara, Kathleen@CDCR
Subject: RE: Fwd: Don Thompson's story

OK - This has been on the back burner at SAC, but we'll come up with an implementation plan next week.

From: O'Meara, Kathleen@CDCR
Sent: Saturday, January 19, 2013 11:02 AM
To: Chaiken, Shama@CDCR; Telander, Jim@CDCR; Cho, Meg@CDCR; Park, Russell@CDCR; Murray, Todd E.@CDCR; Monthei, Eric@CDCR; McCarthy, Timothy J. (PBSP)@CDCR; Silbaugh, David@CDCR; Perlmutter, Barry@CDCR; Coppola, Anthony@CDCR; Moody, Robert@CDCR
Subject: Fw: Fwd: Don Thompson's story

Suicide remains "the low hanging fruit" for coleman. Please MAKE SURE your SRE Mentor Program is up and running. Thanks

---

From: Belavich, Tim@CDCR
Sent: Friday, January 18, 2013 05:52 PM Pacific Standard Time
To: Stanley, Nathan@CDCR; O'Meara, Kathleen@CDCR; Burleson, Judy@CDCR; Ceballos, Laura@CDCR; Eargle, Amy@CDCR; Morrison, Michael@CDCR
Subject: Fwd: Don Thompson's story

FYI-

Timothy G. Belavich, Ph.D., MSHCA, CCHP,
Deputy Director (A),
Statewide Mental Health Program

Office: 1-916-691-0296
Mobile: 1-661-857-1948

Begin forwarded message:

> **From:** "Toche, Diana@CDCR" <Diana.Toche@cdcr.ca.gov>
> **Date:** January 18, 2013 5:45:47 PM PST

To: "Belavich, Tim@CDCR" <Tim.Belavich@cdcr.ca.gov>
Subject: FW: Don Thompson's story

Diana Toche, DDS
Director(A), DHCS
Deputy Director, Statewide Dental Program, DHCS
916-691-0605 (desk)
916-764-4604 (iPhone)

From: Hoffman, Deborah@CDCR
Sent: Friday, January 18, 2013 5:45 PM
To: Rice, Benjamin@CDCR; Beard, Jeff@CDCR; McDonald, Terri@CDCR; Toche, Diana@CDCR; Hoshino, Martin N@CDCR
Subject: Don Thompson's story

« Back to Article

Report: Too soon for Calif. to control inmate care

DON THOMPSO, Associated Press Copyright 2013 Associated Press. All rights reserved. This material may not be published, broadcast, rewritten or redistributed.

By DON THOMPSON, Associated Press

Updated 4:46 pm, Friday, January 18, 2013

SACRAMENTO, Calif. (AP) — It's too soon for California to retake control of its prison mental health system, a federal court overseer said Friday in dealing a blow to a proposal made by Gov. Jerry Brown last week.

Too many inmates are still committing suicide and going untreated for their mental illness in California prisons, special master Matthew Lopes said in a 609-page report filed Friday in federal court in Sacramento.

Lopes advises the federal judges who will rule on Brown's court motion last week to end the long-running class-action lawsuit over substandard treatment in prisons. The Democratic governor is also asking federal judges to lift a cap on the number of inmates, saying it would be too dangerous to release more prisoners.

"At this time, any attempt at a more abrupt conclusion to court oversight would be, in the opinion of the special master, not only premature but a needless distraction from the important work that is being done in the quality improvement project," Lopes concluded.

Despite years of efforts, the state still has too few mental health staff and beds, inmates can wait weeks before they receive mental health treatment, and inmates are dying by suicide at the rate of one every 11 days, he wrote.

There were 32 inmate suicides last year, a rate that substantially exceeds the national average for state prisons, he said, yet suicide prevention measures agreed to two years ago appear not to have been fully implemented.

He credited the state with making "significant progress" in meeting seven goals set last year by U.S. District Judge Lawrence Karlton, and said officials seem to have made a "serious commitment" to making the necessary improvements.

However, "more work remains to be done before all of these goals are met," he wrote.

Lopes wrote the report before Brown's announcement last week, though the administration had signaled by then that it intended to soon ask Karlton to end federal oversight of the prison system's mental health programs.

Brown's court filing triggered a 90-day clock for the judge to rule if prison conditions now meet constitutional standards.

Terry Thornton, a spokeswoman for the Department of Corrections and Rehabilitation, said she could not immediately comment.

Michael Bien, the lead attorney representing the welfare of mentally ill inmates, said the special master's filing shows that the federal judges should reject Brown's motion to end federal oversight.

"These problems are serious, they're well known to the defendants, the solution is well known, what they need to do is well known, and they've failed to do it," he said. "That is a constitutional violation.... Years and years later, the problems exist and people are dying unnecessarily."

That means the federal courts should also reject Brown's motion to lift the inmate population cap, Bien said. Karlton and two federal judges had ruled in 2009 that reducing crowding was the only way to improve unconstitutionally poor treatment of physically and mentally ill inmates, a decision upheld by the U.S. Supreme Court in 2011.

The state said in a court filing earlier this week that it had missed December's court-ordered benchmark for reducing the population, and will miss the final deadline in June despite sending thousands of less-serious offenders to local jails instead of state prisons under a 14-month-old state law.

The state is supposed to reduce the population of its 33 adult prisons to a total of 110,000 inmates by June, but is on track to exceed that limit by about 10,000 inmates.

Brown argued that the state already has brought conditions up to constitutional standards and should not be forced to further reduce the inmate population.

Read more: http://www.sfgate.com/news/article/Report-Too-soon-for-Calif-to-control-inmate-care-4206629.php#ixzz2INieg9lh

Deborah Hoffman
Assistant Secretary, Communications
California Department of Corrections and Rehabilitation
916-445-4950

CDCR is on Twitter @CACorrections
CDCR is on Facebook www.facebook.com/cacorrections

sign up to get CDCR news as it happens
http://www.cdcr.ca.gov/News/delivered/

From: O'Meara, Kathleen@CDCR
Sent: Saturday, January 19, 2013 12:46 PM
To: Chaiken, Shama@CDCR
Subject: Re: SRE Mentor Program

Awesome Shama!

From: Chaiken, Shama@CDCR
Sent: Saturday, January 19, 2013 12:44 PM Pacific Standard Time
To: Wheeler, (Ralph) David@CDCR
Cc: Prudhomme, Catherine@CDCR; Holliday, Amy@CDCR; O'Meara, Kathleen@CDCR
Subject: SRE Mentor Program

Kathy O'Meara just called me. She would like to help us by mentoring some of our supervisors or other staff on Wednesday and Thursday when she comes out for the Sustainability process. She said that for experienced staff, it takes about an hour. The folks who are mentored next week can then become mentors for others the following week. We need to have made some progress by the time the plaintiff attorneys come out the following Tuesday. During our supervisors meeting on Tuesday, we will need to decide which staff will be involved, and which inmates to conduct evaluations on, and ducat them for this process(since ducats need to go in on Monday for Wednesday, we'll need to have an add-on list and coordinate with custody). This has become the top of the top priorities for next week ☺.

Shama Chaiken, Ph.D., CCHP
Chief of Mental Health
California State Prison, Sacramento
Division of Correctional Health Care Services

916-294-3160 Office
916-508-2047 Cell
916-294-3122 Fax
shama.chaiken@cdcr.ca.gov

PLF EXHIBIT 13
Date: 3-5-13
Witness
BEARD

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

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Exhibit 62

From: Chen, Rachel@CDCR
Sent: Monday, February 04, 2013 3:59 PM
To: O'Meara, Kathleen@CDCR
Cc: Van Burg, Chera@CDCR
Subject: SRE Mentoring
Attachments: SRE Mentoring Program Progress.xlsx

Hi Dr. O'Meara,

Sorry it's taken me so long to get this to you. We have several mentors now and it took me a while to get all of our records straight.

Please see the attached Excel sheet, that captures trainings to date, and which clinicians are scheduled to complete this in February and March.

Thanks!

Rachel J. Chen, Psy.D.
Senior Psychologist
Specialized Care Team
415.454.1460 extension 3735

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Key
New Hire
Alternate Schedules
Mentors
Completed

	Baseline	***Observed Mentor***	***Observed by Ment***	***SPC Addit***	***SRE Docum***	***Planned for***	***Planned for March 2013***
Adams		Y	Chen				
Bashnick	Y	Y	Lippman	Y	Y		
Bencich	Y	Y		Y			X
Berger	Y			Y			X
Bertrand (SPC)	SPC	SPC	SPC	SPC	SPC		
Blackhurst	Y	Y	Miscia	Y	Y		
Bratcher		Y		Y		X	
Brians	Y	Y	Chen	Y	Y		
Burton		Y	Chen	Y	Y		
Callari	Y	Y		Y			X
Cline	Y	Y	Wong	Y			X
Cook	Y	Y		Y		X	
Corrado	Y	Y	Chen	Y	Y		
Deal	Y	Y		Y			X
Dempsey			Wong	Y		X	
Deweese		Y	Bertrand				
Dickson	Y	Y	Chen	Y	Y		
Downey	Y	Y	Miscia	Y	Y		
Dupre	Y	Y		Y		X	
Enos		Y	Burton	Y	Y		
Fong				Y			X
Giamona	Y	Y	Lippman	Y	Y		
Gibbs	Y	Y		Y			X
Gorewitz	Y	Y	Wong				
Hernandez	Y		Wong	Y		X	
Jackson				Y		X	
Jeffers	Y	Y	Bertrand	Y			
Johnson	Y						X
Khan						X	
Langley		Y	Van Burg				
Lippman	Y	Y	Van Burg	Y	Y		

Luckose		Y		Y			X
Maris	Y			Y			X
Milford		Y		Y			X
Miller	Y	Y		Y			X
Miscia	Y	Y	Van Burg	Y	Y		
Murthy		Y	Burton	Y	Y		
Norris	Y	Y	Steiner	Y	Y		
Nunez	Y	Y	Chen	Y			
Palmer	Y	Y	Wong	Y			
Parecki		Y	Chen	Y	Y		
Petracek	Y	Y	Wong				
Pollard		Y		Y			X
Ponath		Y		Y		X	
Pugh	Y	Y	Bertrand	Y			
Reynolds				Y		X	
Ricciardi	Y	Y	Bertrand				
Seaman	Y		Bertrand	Y			
Sheinin	Y	Y		Y			X
Sprick						X	
Stack	Y						X
Stanard	Y	Y	Miscia	Y	Y		
Steiner	Y	Y	Van Burg	Y	Y		
Street		Y	Chen	Y	Y		
Temkova				Y			X
Weisz				Y		X	
Wells	Y				Y	No longer at SQ	
Weyer	Y				Y	No longer at SQ	
Whyte		Y		Y		X	
Wick		Y		Y		X	
Wong, J.			Chen			X	
Wong, L.	Y	Y	Chen	Y			

Exhibit 63

- mood stabilizing labs
  - No data yet

Start Psychiatrist

Down 5½ psychiatrist
- Dr. Kelley blocked hiring a psychiatrist
- upset at first

he has been back leave=
- Dr. Kelley hiring a psychologists

breach conflict between psychiatry & Psychology

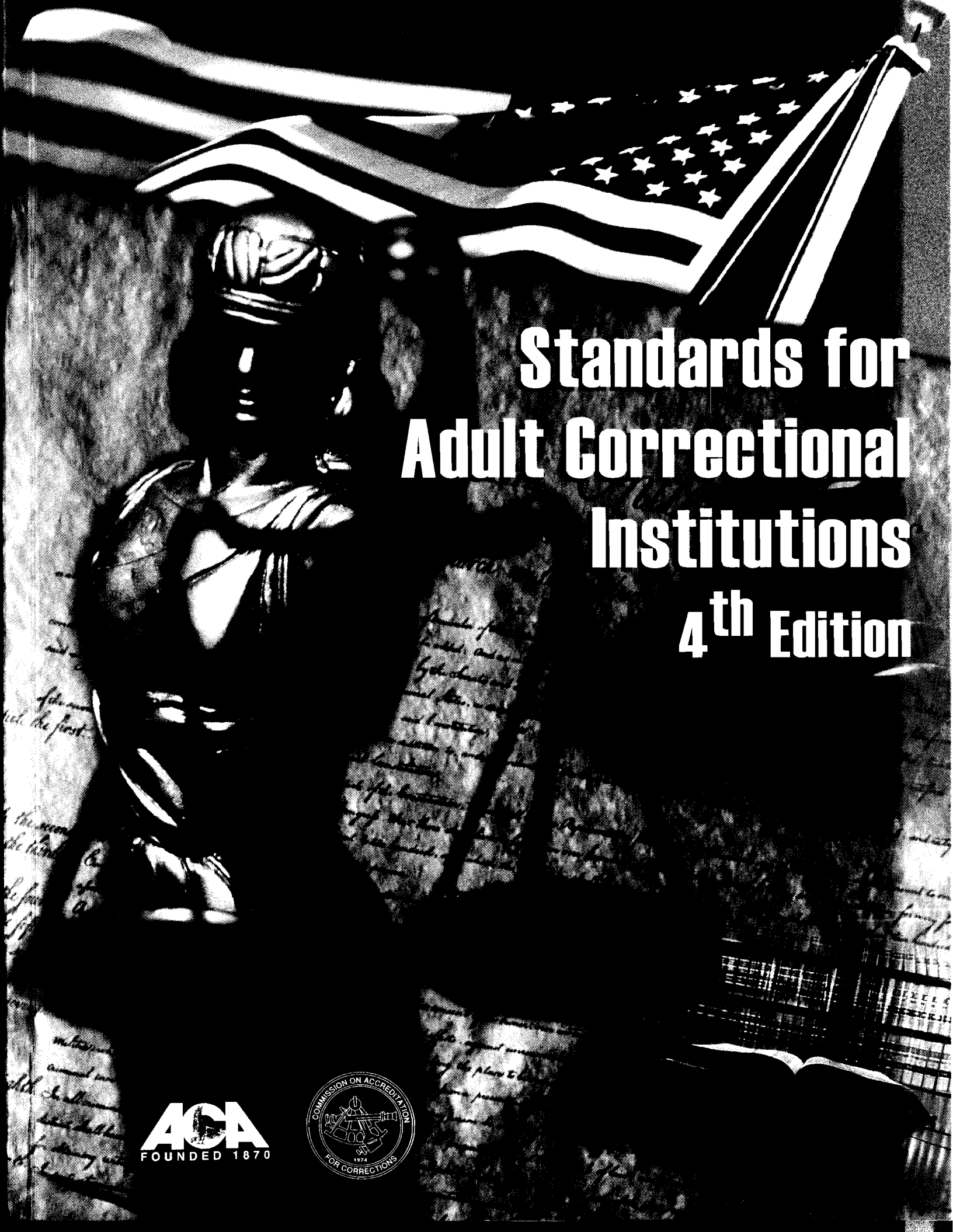
Dr Purcell

Dr. Kaley Not Rev
helpful to ~~psycho~~
psychiatry

- Very dysfunctional place
- concern re: psychiatry
  - we convert: 64/7 psychology dues
- 5 psychiatrists on staff
- started for 10.5 vs 9.5.

why down?
- Hard to recruit
- psychiatrists not Rx's & respected here

Exhibit 64


Standards for
Adult Correctional
Institutions
4th Edition
ACA
FOUNDED 1870
COMMISSION ON ACCREDITATION
FOR CORRECTIONS
1974

STANDARDS FOR ADULT CORRECTIONAL INSTITUTIONS

Fourth Edition

American Correctional Association

in cooperation with the
Commission on Accreditation for Corrections

January 2003

Updated with corrections from the Errata Sheet
of the 4th Edition, July 1, 2003.

continues beyond 30 days, a mental health assessment by a qualified mental health professional is made at least every three months—more frequently if prescribed by the chief medical authority.

Comment: Inmates whose movements are restricted in segregation units may develop symptoms of acute anxiety or other mental problems; regular psychological assessment is necessary to ensure the mental health of any inmate confined in such a unit beyond 30 days.

Supervision

4-4257
(Ref. 3-4245)

Written policy, procedure, and practice require that all special management inmates are personally observed by a correctional officer at least every 30 minutes on an irregular schedule. Inmates who are violent or mentally disordered or who demonstrate unusual or bizarre behavior receive more frequent observation; suicidal inmates are under continuing observation.

Comment: None.

4-4258
(Ref. 3-4246)

Written policy, procedure, and practice provide that inmates in segregation receive daily visits from the senior correctional supervisor in charge, daily visits from a qualified health care official (unless medical attention is needed more frequently), and visits from members of the program staff upon request.

Comment: Because they are restricted from normal movement within the institution, it is imperative that inmates in segregation are visited regularly by key staff members who can ensure that their health and well-being are maintained.

4-4259
(Ref. 3-4247)

Written policy and procedure govern the selection criteria, supervision, and rotation of staff who work directly with inmates in segregation on a regular and daily basis.

Comment: Procedures should be established to supervise and evaluate the on-the-job performance of all staff who work with inmates in segregation, and there should be administrative procedures for promptly removing ineffective staff. Officers assigned to these positions should have completed their probationary period. The need for rotation should be based on the intensity of the assignment.

4-4260
(Ref. 3-4248)

Written policy, procedure, and practice provide that staff operating segregation units maintain a permanent log.

Comment: The log should contain the following information for each inmate admitted to segregation: name, number, housing location, date admitted, type of infraction or reason for admission, tentative release date, and special medical or psychiatric problems or needs. The log also should be used to record all visits by officials who inspect the units or counsel the inmates, all unusual inmate behavior, and all releases.

Exhibit 65

From: Jane E. Kahn <JKahn@rbgg.com>
Sent: Friday, February 15, 2013 14:02
To: Coleman Team - RBG Only
Subject: FW: CDCR/DSH Monthly Reports
Attachments: Coleman Status Report 01-31-13 (2).pdf.pdf; Licensure Report - CL.pdf.pdf; CSVR Signed CL 1-13 .pdf.pdf; Coleman Staff Vacancy Report - January 1, 2013.pdf.pdf; Coleman PIP Staffing Classifications and Vacancy Rate Report. Jan. 25, 2....xlsx; PIP Census 01-25-13.xls.xls

---

From: Debbie Vorous[SMTP:DEBBIE.VOROUS@DOJ.CA.GOV]
Sent: Friday, February 15, 2013 2:00:46 PM
To: Kerry Courtney Hughes, MD; Patricia M. Williams; Haunani Henry; Mary Perrien; Henry D. Dlugacz; Raymond F. Patterson, MD; Kathryn Burns, MD, MPH; Paul Nicoll; Linda Holden; Jeff Metzner; kwalsh@pldw.com; Matt Lopes; Mohamedu Jones; Steve Raffa; Kristina Hector
Cc: Debbie Vorous; Donald Specter; Jane E. Kahn; Michael W. Bien; Debbie Vorous; Steve Fama; William Downer
Subject: CDCR/DSH Monthly Reports
Auto forwarded by a Rule

February 15, 2013

Coleman v. Brown

Dear Special Master Lopes:

Attached are the following reports:

1. DSH cover letter and licensure report for the time period of January 1, 2013 to January 31, 2013;
2. DSH cover letter and monthly staffing and staffing vacancies report as of January 1, 2013; and
3. CDCR census and staffing report for CIW.

Thank you,

CONFIDENTIALITY NOTICE: This communication with its contents may contain confidential and/or legally privileged information. It is solely for the use of the intended recipient(s). Unauthorized interception, review, use or disclosure is prohibited and may violate applicable laws including the Electronic Communications Privacy Act. If you are not the intended recipient, please contact the sender and destroy all copies of the communication.

STATE OF CALIFORNIA — DEPARTMENT OF STATE HOSPITALS EDMUND G. BROWN JR., GOVERNOR

DIVISION OF ADMINISTRATION
Coordination and Logistics Unit
1600 Ninth Street, Room 140
Sacramento, CA 95814

February 1, 2013

Matthew A. Lopes, Jr., Esq.
Office of the Special Master
Pannone, Lopes & Devereaux, LLC
317 Iron Horse Way, Suite 301
Providence, RI 02908

via: Debbie J. Vorous
Deputy Attorney General
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550

RE: MONTHLY REPORT ON THE LICENSURE OF INTERMEDIATE CARE TREATMENT PROGRAMS AT THE CALIFORNIA DEPARTMENT OF STATE HOSPITALS-VACAVILLE AND CALIFORNIA DEPARTMENT OF STATE HOSPITALS-SALINAS VALLEY

In accordance with the July 24, 2007 *Coleman* Court order issued by Judge Karlton, the California Department of State Hospitals (DSH) is to provide a monthly report on the implementation of the expanded Intermediate Care Programs (ICPs) at DSH-Vacaville. In addition to the terms of the Court order, DSH is also providing information on the implementation of the expanded ICPs at DSH-Salinas Valley to optimize transparency and provide the full scope of our expansion of services.

Enclosed is the monthly report providing data on each facility's census and wait list information. The data reflects the time period of January 1, 2013 through January 31, 2013.

If you have any questions or need clarification, please contact Candius Burgess at (916) 654-0090.

Sincerely,

ROB COOK
Staff Services Manager III
Administrative Services Division
Department of State Hospitals

Enclosures

DEPARTMENT OF STATE HOSPITALS
Coordination and Logistics Unit
Monthly Report on the Licensure of Intermediate Care Treatment Programs at the California Department of State Hospitals-Vacaville and the California Department of State Hospitals-Salinas Valley
data as of 01/31/13; prepared 02/01/13

Department of State Hospitals-Vacaville (DSH-Vacaville) Units	CAPACITY	FILLED	HOLD	AVAILABLE
A-2 ICF Low Custody	44	28	0	16
A-3 ICF Low Custody	40	20	2	18
P-3 ICF High Custody	30	30	0	0
HCTC (64 Bed Unit)	64	63	1	0
L-3 ICF High Custody	37	37	0	0

DSH-Salinas Valley Units	Total Beds	Total Occupied	Single Cell Capacity	Single Cell Filled	Single Cell Hold	Single Cell Available	Double Cell Capacity	Double Cell Filled	Double Cell Hold	Double Cell Available	Dorm Capacity	Dorm Filled	Dorm Hold	Dorm Available
TC1	64	52	32	32	0	0					32	20	0	12
TC2	74	74	54	54	0	0	20	20	0	0				

Department of State Hospitals- Salinas Valley (DSH-Salinas Valley) Charlie and Delta Units	Single Cell Capacity	Single Cell Filled	Single Cell Hold	Single Cell Available
C-5	58	58	0	0
C-6	58	57	0	1
D-5	58	57	0	1
D-6	58	56	0	2

DEPARTMENT OF STATE HOSPITALS
Coordination and Logistics Unit
Monthly Report on the Licensure of Intermediate Care Treatment Programs at the California Department of State Hospitals-Vacaville and the California Department of State Hospitals-Salinas Valley
data as of 01/31/13; prepared 02/01/13

WAIT LIST DATA

UNIT	WAIT LIST*
DSH-VACAVILLE	0
DSH-SALINAS VALLEY	0
DSH-SALINAS VALLEY PC 1370	2

WAIT LIST DATA BY HOUSING UNIT/LEVEL OF CARE

FACILITY	PSU	MHCB	ACUTE	AD. SEG - EOP	SHU	EOP	CCCMS	TOTAL
DSH-VACAVILLE A2/A3 ICF LOW CUSTODY	0	0	0	0	0	0	0	0
DSH-VACAVILLE P-3 ICF HIGH CUSTODY	0	0	0	0	0	0	0	0
DSH-VACAVILLE HCTC (64 BED UNIT)	0	0	0	0	0	0	0	0
DSH-VACAVILLE L-3 ICF HIGH CUSTODY	0	0	0	0	0	0	0	0
DSH-SALINAS VALLEY	0	0	0	0	0	0	0	0
DSH-SALINAS VALLEY PC 1370	0	1	0	0	0	1	0	2

Notes:

*There are 28 Inmate/Patients (I/P) whose referrals have been accepted and are pending admissions for less than 30 days. These 28 I/Ps have been pending admission for the following number of days:

- 0-9 days: 13 I/Ps
- 10–19 days: 14 I/Ps
- 20–29 days: 1 I/P
- 50-59 days: 1 I/P

There is 1 I/P who was accepted on 12/11/12, and has been waiting for 52 days. His admission was delayed by CSP/SAC on 01/07/13 due to a Keyhea hearing scheduled for 02/21/13. This I/P will be admitted to DSH-SV the week of 02/25/13.

Data Source: DSH-Salinas Valley and DSH-Vacaville Bed Utilization Management Reports

Exhibit 66

DIVISION OF CORRECTIONAL HEALTH CARE SERVICES
STATEWIDE MENTAL HEALTH PROGRAM
P.O. Box 942883
Sacramento, CA94283-0001

March 1, 2013

Matthew A. Lopes, Jr. Esquire
Office of the Special Master
Pannone Lopes & Devereaux LLC
317 Iron Horse Point Way, Suite 301
Providence, RI 02908

via: Debbie J. Vorous, Esquire
Deputy Attorney General
Department of Justice
1300 "I" Street, Suite 125
P. O. Box 944255
Sacramento, CA 94244-2550

RE: COLEMAN MONTHLY REPORT OF INFORMATION REQUESTED AND RESPONSE TO JANUARY 19, 1999, COURT ORDER REGARDING STAFF VACANCIES

Dear Mr. Lopes:

Enclosed is the Coleman Monthly Report reflective of January, 2013 data (or as otherwise noted). The following is the list of enclosures:

1. Mental Health Services Delivery System (MHSDS) Staffing Allocation and Vacancy History.
2. MHSDS Hiring Activity Report.
3. Health Care Placement Oversight Program (HCPOP) Information Report, Summary and Administrative Segregation Greater than 60 Days.
4. Mental Health Contract Services including Summary and Telemedicine Monthly Report for all disciplines.
5. California Department of Corrections and Rehabilitation (CDCR) Reception Center (RC) Monthly Report.
6. Monthly Summary of Mental Health Crisis Bed use by Institution Titles Inpatient Psychiatric Aging Report.
7. Referrals for Transfer to the Department of State Hospitals (DSH) (including admissions).
8. Atascadero State Hospital (ASH) Discharges.
9. Weekly Enhanced Outpatient Program (EOP)/Outpatient Psychiatric Program.
10. The Department of State Hospitals (DSH) Monthly Report of CDCR Patients in DSH Hospitals -- Summary and Penal Code 2684.
11. Suicide Report.
12. Statistics on Contracted Registered Nurse (RN). **(No Longer Available)**
13. RC Processing for MHSDS Inmate Patients.
14. Medical Technical Assistant (MTA) Vacancy Report. **(No Longer Available)**

16. EOP Inmates Waiting Transfer to a Psychiatric Services Unit (PSU).
17. Audit reports on Psychiatric Technician Rounds in Administrative Segregation at California State Prison, San Quentin (SQ), California State Prison-Corcoran (COR), and Salinas Valley State Prison (SVSP).
18. Mental Health Crisis Beds Wait List.
19. Correctional Treatment Centers and CDCR General Acute Care Hospital Care Placement Issues. **(No longer available)**
20. Transferred and Rescinded Mental Health Crisis Bed Referrals by Institution and Level of Care.

If you have any questions, please contact me at (916) 691-0296.

Sincerely,

Patteau Stanley for

TIMOTHY G. BELAVICH, Ph.D., MSHCA, CCHP
Deputy Director (A)
Statewide Mental Health Program
Division of Correctional Health Care Services

Enclosures

cc: Diana Toche, DDS, Director (A), Division of Correctional Health Care Services (DCHCS)
Mohamedu F., Jones, Esq., *Coleman* Deputy Special Master
Linda Holden, Esq., *Coleman* Deputy Special Master
Jeffrey L. Metzner, M.D., *Coleman* Expert
Kerry C. Hughes, M.D., *Coleman* Expert
Raymond F. Patterson, M.D, *Coleman* Expert
Paul Nicoll, MPA, *Coleman* Monitor
Mary Perrien, Ph.D., *Coleman* Expert
Kathryn A. Burns, M.D., MPH, *Coleman* Expert
Henry A. Dlugacz, Esq., *Coleman* Expert
Kerry F. Walsh, Esq., *Coleman* Monitor
Patricia Williams, Esq., *Coleman* Monitor
Haunani Henry, *Coleman* Monitor
Debbie Vorous, Esq., Office of the Attorney General
Heather McCray Esq., Office of Legal Affairs, CDCR
Michael Stone, Esq., Office of Legal Affairs, CDCR
Michael Bien, Esq., Rosen, Bien and Galvan

Donald Specter, Esq., Prison Law Office
Judy Burleson, Associate Director, Statewide Mental Health Program, DCHCS
Nathan Stanley, Chief, Operational Program Oversight, Statewide Mental Health Program DCHCS
Teresa Owens, Associate Governmental Program Analyst, Operational Program Oversight, DCHCS

State of California California Department of Corrections and Rehabilitation

Memorandum

Date: February 19, 2013

To: Diana Toche
Director (A)
Division of Health Care Services

Subject: **SUMMARY OF INTER-INSTITUTIONAL MENTAL HEALTH CRISIS BED REFERRALS AND TRANSFERS FOR JANUARY 2013**

Attached are summaries regarding the number of Mental Health Crisis Bed (MHCB) referrals and placements coordinated by Health Care Placement Oversight Program (HC-POP) staff. During the month of **January 2013**, there were **332 MHCB** referrals. Of the **332** referrals, **155** were placed. The **177** not placed (**53%** of those referred) were rescinded by the referring clinician. Of the **177** rescinded, **99** no longer required MHCB treatment, **73** were placed in a MHCB internally, **three** paroled, and **two** were not medically cleared.

Attachment 1 summarizes the referrals/transfers/rescinded cases by sending institution and previous levels of care. Additionally, every referral is tallied by classification score.

Attachment 2A (4 pages) provides additional details of the completed referrals/transfers, including transfer timeframes, average number of days waiting to transfer, and prior level of care. For the **155** transferred, the average number of days waiting was **1.07.** Of the **155** transferred, **121** cases were transferred within the required 24 hours.

Attachment 2B (5 pages) provides details regarding those MHCB referrals that were rescinded by the referring institution. **Attachment 2C** summarizes the cases rescinded.

Attachment 3 summarizes, by institution, the average number of days referrals waited before being transferred or rescinded.

Attachment 4 is no longer included as part of the summary. The temporary MHCBs at CMF/Acute Psychiatric Program (APP) have been returned to APP use; thus, Attachment 4 is no longer applicable.

Please let me know if you have any questions about the information provided.

Original Signed By
Robert M. Calderon
Chief/Associate Warden
Health Care Placement Oversight Program
Division of Health Care Services

Attachments

cc: Tim Belavich
Health Care Regional Administrators
Mental Health Regional Administrators
Michael Morrison
Cathy Jefferson
HC-POP Staff

ATTACHMENT 1

SUMMARY
TRANSFERRED AND RESCINDED MHCB REFERRALS
BY INSTITUTION AND PRIOR LEVEL OF CARE
JANUARY 2013

	TOTAL REFERRALS							REFERRED AND TRANSFERRED							REFERRED AND RESCINDED							
	CCCMS	EOP	MHCB	GP	DSH	TOTAL	% TTL	CCCMS	EOP	MHCB	GP	DSH	TOTAL	% TTL	CCCMS	EOP	MHCB	GP	DSH	TOTAL	% TTL
ASP	5	1	0	0	0	6	1.81%	5	1	0	0	0	6	3.87%	0	0	0	0	0	0	0.00%
CAL	2	0	0	6	0	8	2.41%	2	0	0	6	0	8	5.16%	0	0	0	0	0	0	0.00%
CCI	4	0	0	0	0	4	1.20%	4	0	0	0	0	4	2.58%	0	0	0	0	0	0	0.00%
CCI-RC	0	0	0	1	0	1	0.30%	0	0	0	1	0	1	0.65%	0	0	0	0	0	0	0.00%
CEN	1	0	0	3	0	4	1.20%	0	0	0	3	0	3	1.94%	1	0	0	0	0	1	0.56%
CMC	2	11	0	4	0	17	5.12%	0	2	0	1	0	3	1.94%	2	9	0	3	0	14	7.91%
CMF	0	2	0	0	2	4	1.20%	0	0	0	0	2	2	1.29%	0	2	0	0	0	2	1.13%
CMF-DSH	0	0	0	0	2	2	0.60%	0	0	0	0	2	2	1.29%	0	0	0	0	0	0	0.00%
COR	3	8	0	3	0	14	4.22%	1	4	0	1	0	6	3.87%	2	4	0	2	0	8	4.52%
CRC	3	0	0	6	0	9	2.71%	3	0	0	5	0	8	5.16%	0	0	0	1	0	1	0.56%
CTF	3	0	0	0	0	3	0.90%	3	0	0	0	0	3	1.94%	0	0	0	0	0	0	0.00%
DVI	3	2	0	1	0	6	1.81%	3	2	0	1	0	6	3.87%	0	0	0	0	0	0	0.00%
DVI-RC	2	2	0	1	0	5	1.51%	2	2	0	1	0	5	3.23%	0	0	0	0	0	0	0.00%
FOL	2	0	0	0	0	2	0.60%	1	0	0	0	0	1	0.65%	1	0	0	0	0	1	0.56%
HDSP	1	0	0	1	0	2	0.60%	1	0	0	1	0	2	1.29%	0	0	0	0	0	0	0.00%
ISP	2	1	0	2	0	5	1.51%	2	1	0	2	0	5	3.23%	0	0	0	0	0	0	0.00%
KVSP	7	1	0	1	0	9	2.71%	0	1	0	0	0	1	0.65%	7	0	0	1	0	8	4.52%
LAC	4	14	0	4	0	22	6.63%	2	10	0	3	0	15	9.68%	2	4	0	1	0	7	3.95%
LAC-RC	0	0	0	1	0	1	0.30%	0	0	0	0	0	0	0.00%	0	0	0	1	0	1	0.56%
NKSP36	0	2	0	0	0	2	0.60%	0	0	0	0	0	0	0.00%	0	2	0	0	0	2	1.13%
NKSP-RC	20	27	0	23	0	70	21.08%	7	5	0	8	0	20	12.90%	13	22	0	15	0	50	28.25%
PBSP	0	1	0	0	0	1	0.30%	0	1	0	0	0	1	0.65%	0	0	0	0	0	0	0.00%
PVSP	3	0	0	1	0	4	1.20%	3	0	0	1	0	4	2.58%	0	0	0	0	0	0	0.00%
RJD	1	2	0	1	0	4	1.20%	0	0	0	0	0	0	0.00%	1	2	0	1	0	4	2.26%
SAC	0	28	0	3	0	31	9.34%	0	5	0	0	0	5	3.23%	0	23	0	3	0	26	14.69%
SATF	10	1	0	2	0	13	3.92%	4	0	0	1	0	5	3.23%	6	1	0	1	0	8	4.52%
SCC	1	0	0	0	0	1	0.30%	1	0	0	0	0	1	0.65%	0	0	0	0	0	0	0.00%
SOL	2	0	0	1	0	3	0.90%	2	0	0	1	0	3	1.94%	0	0	0	0	0	0	0.00%
SQ	1	0	0	0	0	1	0.30%	0	0	0	0	0	0	0.00%	1	0	0	0	0	1	0.56%
SVSP	11	8	1	3	0	23	6.93%	0	0	0	0	0	0	0.00%	11	8	1	3	0	23	12.99%
VSP	2	0	0	0	0	2	0.60%	2	0	0	0	0	2	1.29%	0	0	0	0	0	0	0.00%
WSP	1	1	0	3	0	5	1.51%	1	1	0	2	0	4	2.58%	0	0	0	1	0	1	0.56%
WSP-RC	19	16	0	13	0	48	14.46%	9	13	0	7	0	29	18.71%	10	3	0	6	0	19	10.73%
TOTAL	**115**	**128**	**1**	**84**	**4**	**332**	100.00%	**58**	**48**	**0**	**45**	**4**	**155**	100.00%	**57**	**80**	**1**	**39**	**0**	**177**	100.00%
% TTL	34.64%	38.55%	0.30%	25.30%	1.20%	100.00%		37.42%	30.97%	0.00%	29.03%	2.58%	100.00%		32.20%	45.20%	0.56%	22.03%	0.00%	100.00%	

Referrals by Classification Score	
Score	Total
0-18	43
19-35	79
36-59	49
60+	110
TOTAL	**281**
Not Calc	51
Grand TTL	**332**

MHCB TRANSFERS BY INSTITUTION AND PRIOR LEVEL OF CARE ATTACHMENT 2A

JANUARY 2013

Transferred From	Transferred To	Referral Date	Transfer Date	Prior LOC	Days Waiting*
ASP	COR	1/6/2013	1/6/2013	CCCMS	0
ASP	MCSP	1/30/2013	1/31/2013	CCCMS	1
ASP	SATF	1/17/2013	1/18/2013	CCCMS	1
ASP	SOL	1/2/2013	1/4/2013	CCCMS	2
ASP	SOL	1/2/2013	1/4/2013	CCCMS	2
ASP	MCSP	1/20/2013	1/21/2013	EOP	1
ASP Average					**1.17**
CAL	RJD	1/5/2013	1/6/2013	CCCMS	1
CAL	RJD	1/11/2013	1/12/2013	CCCMS	1
CAL	SVSP	1/11/2013	1/12/2013	GP/OP	1
CAL	CIM	1/17/2013	1/18/2013	GP/OP	1
CAL	CMC	1/29/2013	1/30/2013	GP/OP	1
CAL	PVSP	1/23/2013	1/25/2013	GP/OP	2
CAL	RJD	1/3/2013	1/4/2013	GP/OP	1
CAL	SVSP	1/24/2013	1/26/2013	GP/OP	2
CAL Average					**1.25**
CCI	CMC	1/5/2013	1/6/2013	CCCMS	1
CCI	CMC	1/5/2013	1/6/2013	CCCMS	1
CCI	PVSP	1/22/2013	1/24/2013	CCCMS	2
CCI	RJD	1/6/2013	1/8/2013	CCCMS	2
CCI Average					**1.50**
CCI-RC	CMC	1/8/2013	1/9/2013	GP/OP	1
CCI-RC Average					**1.00**
CEN	CIM	1/17/2013	1/17/2013	GP/OP	0
CEN	COR	1/12/2013	1/13/2013	GP/OP	1
CEN	KVSP	1/19/2013	1/19/2013	GP/OP	0
CEN Average					**0.33**
CMC	SOL	1/24/2013	1/24/2013	EOP	0
CMC	SOL	1/24/2013	1/25/2013	EOP	1
CMC	CMC	1/6/2013	1/6/2013	GP/OP	0
CMC Average					**0.33**
CMF	CIM	12/27/2012	1/3/2013	DSH	7
CMF	CIM	12/28/2012	1/10/2013	DSH	13
CMF Average					**10.00**
CMF-DSH	CMF	1/16/2013	1/16/2013	DSH	0
CMF-DSH	CMF	1/31/2013	1/31/2013	DSH	0
CMF-DSH Average					**0.00**
COR	CMF	1/19/2013	1/20/2013	CCCMS	1
COR	CMF	1/19/2013	1/20/2013	EOP	1
COR	CMF	1/24/2013	1/25/2013	EOP	1
COR	CMF	1/24/2013	1/25/2013	EOP	1
COR	PVSP	1/2/2013	1/2/2013	EOP	0
COR	CMF	1/19/2013	1/20/2013	GP/OP	1
COR Average					**0.83**
CRC	CMC	1/10/2013	1/11/2013	CCCMS	1
CRC	RJD	1/9/2013	1/9/2013	CCCMS	0
CRC	SATF	1/9/2013	1/10/2013	CCCMS	1
CRC	CMC	1/10/2013	1/11/2013	GP/OP	1
CRC	CMF	1/20/2013	1/21/2013	GP/OP	1

*Days Waiting based on days between referral and transfer, not days between referral and an MHCB becoming available. Field clinicians identify the most urgent cases and HQ MHP senior clinical staff authorize priority placements.

MHCB TRANSFERS BY INSTITUTION AND PRIOR LEVEL OF CARE ATTACHMENT 2A

JANUARY 2013

Transferred From	Transferred To	Referral Date	Transfer Date	Prior LOC	Days Waiting*
CRC	PVSP	1/30/2013	1/30/2013	GP/OP	0
CRC	RJD	1/3/2013	1/3/2013	GP/OP	0
CRC	SVSP	1/26/2013	1/27/2013	GP/OP	1
CRC Average					**0.63**
CTF	CMC	1/5/2013	1/5/2013	CCCMS	0
CTF	SQ	1/4/2013	1/4/2013	CCCMS	0
CTF	SVSP	1/10/2013	1/11/2013	CCCMS	1
CTF Average					**0.33**
DVI	CMF	1/12/2013	1/12/2013	CCCMS	0
DVI	CMF	1/17/2013	1/18/2013	CCCMS	1
DVI	SATF	1/29/2013	1/31/2013	CCCMS	2
DVI	CMF	1/2/2013	1/3/2013	EOP	1
DVI	CMF	1/17/2013	1/18/2013	EOP	1
DVI	CMF	1/2/2013	1/3/2013	GP/OP	1
DVI Average					**1.00**
DVI-RC	CMF	1/5/2013	1/5/2013	CCCMS	0
DVI-RC	CMF	1/10/2013	1/11/2013	CCCMS	1
DVI-RC	CMF	1/5/2013	1/5/2013	EOP	0
DVI-RC	SOL	1/14/2013	1/15/2013	EOP	1
DVI-RC	CMF	1/5/2013	1/5/2013	GP/OP	0
DVI-RC Average					**0.40**
FOL	CMF	1/4/2013	1/4/2013	CCCMS	0
FOL Average					**0.00**
HDSP	SAC	1/18/2013	1/18/2013	CCCMS	0
HDSP	CMC	1/29/2013	1/30/2013	GP/OP	1
HDSP Average					**0.50**
ISP	CIM	1/17/2013	1/18/2013	CCCMS	1
ISP	COR	1/14/2013	1/16/2013	CCCMS	2
ISP	RJD	1/2/2013	1/3/2013	EOP	1
ISP	CIM	1/16/2013	1/17/2013	GP/OP	1
ISP	CIM	1/16/2013	1/17/2013	GP/OP	1
ISP Average					**1.20**
KVSP	CMF	1/11/2013	1/12/2013	EOP	1
KVSP Average					**1.00**
LAC	SOL	12/30/2012	1/1/2013	CCCMS	2
LAC	SVSP	1/26/2013	1/28/2013	CCCMS	2
LAC	CIM	1/28/2013	1/29/2013	EOP	1
LAC	CMC	1/27/2013	1/29/2013	EOP	2
LAC	CMC	1/29/2013	1/30/2013	EOP	1
LAC	CMF	1/6/2013	1/8/2013	EOP	2
LAC	CMF	1/11/2013	1/12/2013	EOP	1
LAC	CMF	1/21/2013	1/22/2013	EOP	1
LAC	CMF	1/21/2013	1/23/2013	EOP	2
LAC	CMF	1/25/2013	1/26/2013	EOP	1
LAC	MCSP	1/25/2013	1/26/2013	EOP	1
LAC	MCSP	1/25/2013	1/26/2013	EOP	1
LAC	CMC	1/8/2013	1/8/2013	GP/OP	0
LAC	SATF	1/28/2013	1/30/2013	GP/OP	2

*Days Waiting based on days between referral and transfer, not days between referral and an MHCB becoming available. Field clinicians identify the most urgent cases and HQ MHP senior clinical staff authorize priority placements.

MHCB TRANSFERS BY INSTITUTION AND PRIOR LEVEL OF CARE ATTACHMENT 2A

JANUARY 2013

Transferred From	Transferred To	Referral Date	Transfer Date	Prior LOC	Days Waiting*
LAC	SOL	12/31/2012	1/1/2013	GP/OP	1
LAC Average					**1.33**
NKSP-RC	CMF	1/12/2013	1/13/2013	CCCMS	1
NKSP-RC	CMF	1/28/2013	1/30/2013	CCCMS	2
NKSP-RC	COR	1/13/2013	1/15/2013	CCCMS	2
NKSP-RC	COR	1/14/2013	1/16/2013	CCCMS	2
NKSP-RC	COR	1/28/2013	1/30/2013	CCCMS	2
NKSP-RC	SAC	1/1/2013	1/3/2013	CCCMS	2
NKSP-RC	SATF	1/7/2013	1/10/2013	CCCMS	3
NKSP-RC	CMC	1/2/2013	1/4/2013	EOP	2
NKSP-RC	CMF	1/23/2013	1/23/2013	EOP	0
NKSP-RC	CMF	1/26/2013	1/27/2013	EOP	1
NKSP-RC	COR	1/15/2013	1/16/2013	EOP	1
NKSP-RC	COR	1/18/2013	1/18/2013	EOP	0
NKSP-RC	COR	1/18/2013	1/18/2013	GP/OP	0
NKSP-RC	CMC	1/3/2013	1/4/2013	GP/OP	1
NKSP-RC	CMF	1/2/2013	1/3/2013	GP/OP	1
NKSP-RC	CMF	1/23/2013	1/24/2013	GP/OP	1
NKSP-RC	CMF	1/26/2013	1/27/2013	GP/OP	1
NKSP-RC	COR	1/13/2013	1/15/2013	GP/OP	2
NKSP-RC	COR	1/16/2013	1/17/2013	GP/OP	1
NKSP-RC	KVSP	1/5/2013	1/5/2013	GP/OP	0
NKSP-RC Average					**1.25**
PBSP	CMF	1/8/2013	1/8/2013	EOP	0
PBSP Average					**0.00**
PVSP	CMF	1/12/2013	1/12/2013	CCCMS	0
PVSP	SATF	1/11/2013	1/11/2013	CCCMS	0
PVSP	SQ	1/8/2013	1/9/2013	CCCMS	1
PVSP	COR	1/11/2013	1/12/2013	GP/OP	1
PVSP Average					**0.50**
SAC	CMF	1/6/2013	1/6/2013	EOP	0
SAC	CMF	1/6/2013	1/6/2013	EOP	0
SAC	MCSP	1/21/2013	1/21/2013	EOP	0
SAC	MCSP	1/21/2013	1/21/2013	EOP	0
SAC	SQ	1/19/2013	1/19/2013	EOP	0
SAC Average					**0.00**
SATF	CMF	1/20/2013	1/21/2013	CCCMS	1
SATF	CMF	1/22/2013	1/23/2013	CCCMS	1
SATF	COR	1/26/2013	1/26/2013	CCCMS	0
SATF	PVSP	1/26/2013	1/27/2013	CCCMS	1
SATF	CMF	1/22/2013	1/23/2013	GP/OP	1
SATF Average					**0.80**
SCC	CMF	1/2/2013	1/3/2013	CCCMS	1
SCC Average					**1.00**
SOL	CMF	1/22/2013	1/23/2013	CCCMS	1
SOL	SQ	1/19/2013	1/19/2013	CCCMS	0
SOL	CMF	1/4/2013	1/4/2013	GP/OP	0
SOL Average					**0.33**
VSP	CMF	1/7/2013	1/8/2013	CCCMS	1

*Days Waiting based on days between referral and transfer, not days between referral and an MHCB becoming available. Field clinicians identify the most urgent cases and HQ MHP senior clinical staff authorize priority placements.

MHCB TRANSFERS BY INSTITUTION AND PRIOR LEVEL OF CARE ATTACHMENT 2A

JANUARY 2013

Transferred From	Transferred To	Referral Date	Transfer Date	Prior LOC	Days Waiting*
VSP	SQ	1/8/2013	1/8/2013	CCCMS	0
VSP Average					**0.50**
WSP	CMF	1/25/2013	1/25/2013	CCCMS	0
WSP	COR	1/12/2013	1/12/2013	EOP	0
WSP	CMF	1/15/2013	1/17/2013	GP/OP	2
WSP	CMF	1/25/2013	1/25/2013	GP/OP	0
WSP Average					**0.50**
WSP-RC	CIM	1/3/2013	1/4/2013	CCCMS	1
WSP-RC	CMF	1/21/2013	1/22/2013	CCCMS	1
WSP-RC	CMF	1/25/2013	1/26/2013	CCCMS	1
WSP-RC	COR	1/28/2013	1/29/2013	CCCMS	1
WSP-RC	KVSP	1/5/2013	1/5/2013	CCCMS	0
WSP-RC	MCSP	1/27/2013	1/28/2013	CCCMS	1
WSP-RC	MCSP	1/28/2013	1/28/2013	CCCMS	0
WSP-RC	MCSP	1/29/2013	1/31/2013	CCCMS	2
WSP-RC	SQ	1/23/2013	1/26/2013	CCCMS	3
WSP-RC	CMC	1/3/2013	1/5/2013	EOP	2
WSP-RC	CMF	1/15/2013	1/17/2013	EOP	2
WSP-RC	CMF	1/25/2013	1/25/2013	EOP	0
WSP-RC	COR	1/6/2013	1/6/2013	EOP	0
WSP-RC	COR	1/11/2013	1/12/2013	EOP	1
WSP-RC	COR	1/11/2013	1/12/2013	EOP	1
WSP-RC	COR	1/14/2013	1/16/2013	EOP	2
WSP-RC	COR	1/28/2013	1/29/2013	EOP	1
WSP-RC	SAC	1/26/2013	1/27/2013	EOP	1
WSP-RC	SAC	1/26/2013	1/27/2013	EOP	1
WSP-RC	SQ	1/18/2013	1/19/2013	EOP	1
WSP-RC	SQ	1/23/2013	1/26/2013	EOP	3
WSP-RC	SVSP	1/7/2013	1/8/2013	EOP	1
WSP-RC	CIM	1/3/2013	1/4/2013	GP/OP	1
WSP-RC	CMC	1/4/2013	1/5/2013	GP/OP	1
WSP-RC	CMC	1/4/2013	1/5/2013	GP/OP	1
WSP-RC	PVSP	1/29/2013	1/31/2013	GP/OP	2
WSP-RC	RJD	1/11/2013	1/12/2013	GP/OP	1
WSP-RC	SQ	1/17/2013	1/19/2013	GP/OP	2
WSP-RC	SQ	1/23/2013	1/26/2013	GP/OP	**3.00**
WSP-RC Average					**1.28**
Grand Average					**1.07**

SUMMARY OF TRANSFERS			
Time Frames	**Total Transfers**	**Average Days Waiting**	**Range for Days Waiting**
Combined	155	1.07	0-13
< or = 1 day	121	0.64	
2 days	28	NA	
3 days	4	NA	
4 or more days	2	10.00	

*Days Waiting based on days between referral and transfer, not days between referral and an MHCB becoming available. Field clinicians identify the most urgent cases and HQ MHP senior clinical staff authorize priority placements.

ATTACHMENT 2B

RESCINDED MHCB REFERRALS
BY INSTITUTION AND PRIOR LEVEL OF CARE
JANUARY 2013

Referred By	Referral Date	Rescind Date	Prior LOC	Rescind Reason	Days Waiting*
CEN	1/25/2013	1/26/2013	CCCMS	Returned to Housing	1
CEN Average					**1.00**
CMC	1/14/2013	1/15/2013	CCCMS	Returned to Housing	1
CMC	1/21/2013	1/22/2013	CCCMS	Admitted	1
CMC	1/2/2013	1/2/2013	EOP	Admitted	0
CMC	1/14/2013	1/15/2013	EOP	Returned to Housing	1
CMC	1/14/2013	1/15/2013	EOP	Returned to Housing	1
CMC	1/21/2013	1/22/2013	EOP	Returned to Housing	1
CMC	1/23/2013	1/23/2013	EOP	Returned to Housing	0
CMC	1/24/2013	1/25/2013	EOP	Admitted	1
CMC	1/24/2013	1/25/2013	EOP	Admitted	1
CMC	1/26/2013	1/26/2013	EOP	Admitted	0
CMC	1/28/2013	1/29/2013	EOP	Admitted	1
CMC	1/2/2013	1/2/2013	GP/OP	Admitted	0
CMC	1/2/2013	1/2/2013	GP/OP	Admitted	0
CMC	1/23/2013	1/23/2013	GP/OP	Returned to Housing	0
CMC Average					**0.57**
CMF	1/14/2013	1/14/2013	EOP	Admitted	0
CMF	1/19/2013	1/19/2013	EOP	Admitted	0
CMF Average					**0.00**
COR	1/1/2013	1/2/2013	CCCMS	Admitted	1
COR	1/30/2013	1/31/2013	CCCMS	Admitted	1
COR	1/3/2013	1/3/2013	EOP	Admitted	0
COR	1/23/2013	1/23/2013	EOP	Returned to Housing	0
COR	1/24/2013	1/24/2013	EOP	Admitted	0
COR	1/24/2013	1/24/2013	EOP	Returned to Housing	0
COR	1/1/2013	1/1/2013	GP/OP	Admitted	0
COR	1/28/2013	1/29/2013	GP/OP	Admitted	1
COR Average					**0.38**
CRC	1/13/2013	1/13/2013	GP/OP	Returned to Housing	0
CRC Average					**0.00**
FOL	1/4/2013	1/4/2013	CCCMS	Returned to Housing	0
FOL Average					**0.00**
KVSP	1/11/2013	1/11/2013	CCCMS	Admitted	0
KVSP	1/14/2013	1/15/2013	CCCMS	Admitted	1
KVSP	1/16/2013	1/16/2013	CCCMS	Admitted	0
KVSP	1/23/2013	1/23/2013	CCCMS	Returned to Housing	0
KVSP	1/27/2013	1/28/2013	CCCMS	Returned to Housing	1
KVSP	1/31/2013	1/31/2013	CCCMS	Admitted	0
KVSP	1/31/2013	1/31/2013	CCCMS	Admitted	0
KVSP	1/28/2013	1/29/2013	GP/OP	Admitted	1
KVSP Average					**0.38**
LAC	1/20/2013	1/20/2013	CCCMS	Admitted	0
LAC	1/26/2013	1/26/2013	CCCMS	Not Medically Cleared	0
LAC	1/13/2013	1/13/2013	EOP	Returned to Housing	0
LAC	1/14/2013	1/15/2013	EOP	Admitted	1
LAC	1/29/2013	1/29/2013	EOP	Returned to Housing	0

*Days Waiting based on days between referral and rescission. Field clinicians identify the most urgent cases and Headquarters' Mental Health Program senior clinical staff authorize priority placements.

RESCINDED MHCB REFERRALS
BY INSTITUTION AND PRIOR LEVEL OF CARE
JANUARY 2013

Referred By	Referral Date	Rescind Date	Prior LOC	Rescind Reason	Days Waiting*
LAC	1/30/2013	1/30/2013	EOP	Returned to Housing	0
LAC	1/29/2013	1/30/2013	GP/OP	Admitted	1
LAC Average					**0.29**
LAC-RC	1/7/2013	1/7/2013	GP/OP	Returned to Housing	0
LAC-RC Average					**0.00**
NKSP	1/22/2013	1/22/2013	EOP	Admitted	0
NKSP	1/23/2013	1/23/2013	EOP	Returned to Housing	0
NKSP Average					**0.00**
NKSP-RC	1/1/2013	1/1/2013	CCCMS	Admitted	0
NKSP-RC	1/2/2013	1/3/2013	CCCMS	Admitted	1
NKSP-RC	1/6/2013	1/7/2013	CCCMS	Returned to Housing	1
NKSP-RC	1/8/2013	1/9/2013	CCCMS	Returned to Housing	1
NKSP-RC	1/10/2013	1/10/2013	CCCMS	Returned to Housing	0
NKSP-RC	1/15/2013	1/15/2013	CCCMS	Returned to Housing	0
NKSP-RC	1/23/2013	1/24/2013	CCCMS	Admitted	1
NKSP-RC	1/24/2013	1/24/2013	CCCMS	Returned to Housing	0
NKSP-RC	1/25/2013	1/25/2013	CCCMS	Returned to Housing	0
NKSP-RC	1/25/2013	1/25/2013	CCCMS	Returned to Housing	0
NKSP-RC	1/27/2013	1/27/2013	CCCMS	Admitted	0
NKSP-RC	1/29/2013	1/29/2013	CCCMS	Returned to Housing	0
NKSP-RC	1/31/2013	1/31/2013	CCCMS	Paroled	0
NKSP-RC	1/1/2013	1/2/2013	EOP	Returned to Housing	1
NKSP-RC	1/4/2013	1/5/2013	EOP	Returned to Housing	1
NKSP-RC	1/4/2013	1/5/2013	EOP	Returned to Housing	1
NKSP-RC	1/5/2013	1/5/2013	EOP	Returned to Housing	0
NKSP-RC	1/5/2013	1/5/2013	EOP	Returned to Housing	0
NKSP-RC	1/6/2013	1/7/2013	EOP	Returned to Housing	1
NKSP-RC	1/7/2013	1/8/2013	EOP	Returned to Housing	1
NKSP-RC	1/9/2013	1/9/2013	EOP	Returned to Housing	0
NKSP-RC	1/10/2013	1/10/2013	EOP	Not Medically Cleared	0
NKSP-RC	1/11/2013	1/11/2013	EOP	Returned to Housing	0
NKSP-RC	1/11/2013	1/12/2013	EOP	Returned to Housing	1
NKSP-RC	1/17/2013	1/18/2013	EOP	Returned to Housing	1
NKSP-RC	1/19/2013	1/19/2013	EOP	Returned to Housing	0
NKSP-RC	1/20/2013	1/20/2013	EOP	Returned to Housing	0
NKSP-RC	1/21/2013	1/21/2013	EOP	Admitted	0
NKSP-RC	1/22/2013	1/22/2013	EOP	Admitted	0
NKSP-RC	1/23/2013	1/24/2013	EOP	Returned to Housing	1
NKSP-RC	1/24/2013	1/24/2013	EOP	Returned to Housing	0
NKSP-RC	1/24/2013	1/24/2013	EOP	Returned to Housing	0
NKSP-RC	1/25/2013	1/25/2013	EOP	Admitted	0
NKSP-RC	1/28/2013	1/28/2013	EOP	Admitted	0
NKSP-RC	1/29/2013	1/29/2013	EOP	Paroled	0
NKSP-RC	1/30/2013	1/30/2013	GP/OP	Admitted	0
NKSP-RC	1/1/2013	1/2/2013	GP/OP	Returned to Housing	1
NKSP-RC	1/2/2013	1/2/2013	GP/OP	Admitted	0
NKSP-RC	1/2/2013	1/3/2013	GP/OP	Returned to Housing	1

*Days Waiting based on days between referral and rescission. Field clinicians identify the most urgent cases and Headquarters' Mental Health Program senior clinical staff authorize priority placements.

RESCINDED MHCB REFERRALS
BY INSTITUTION AND PRIOR LEVEL OF CARE
JANUARY 2013

Referred By	Referral Date	Rescind Date	Prior LOC	Rescind Reason	Days Waiting*
NKSP-RC	1/5/2013	1/5/2013	GP/OP	Returned to Housing	0
NKSP-RC	1/6/2013	1/7/2013	GP/OP	Returned to Housing	1
NKSP-RC	1/8/2013	1/9/2013	GP/OP	Admitted	1
NKSP-RC	1/13/2013	1/14/2013	GP/OP	Admitted	1
NKSP-RC	1/18/2013	1/18/2013	GP/OP	Returned to Housing	0
NKSP-RC	1/20/2013	1/20/2013	GP/OP	Returned to Housing	0
NKSP-RC	1/21/2013	1/21/2013	GP/OP	Returned to Housing	0
NKSP-RC	1/21/2013	1/22/2013	GP/OP	Admitted	1
NKSP-RC	1/25/2013	1/25/2013	GP/OP	Returned to Housing	0
NKSP-RC	1/28/2013	1/28/2013	GP/OP	Returned to Housing	0
NKSP-RC	1/29/2013	1/30/2013	GP/OP	Returned to Housing	1
NKSP-RC Average					**0.38**
RJD	1/27/2013	1/28/2013	CCCMS	Admitted	1
RJD	1/17/2013	1/17/2013	EOP	Returned to Housing	0
RJD	1/29/2013	1/29/2013	EOP	Admitted	0
RJD	1/17/2013	1/17/2013	GP/OP	Returned to Housing	0
RJD Average					**0.25**
SAC	1/2/2013	1/2/2013	EOP	Returned to Housing	0
SAC	1/2/2013	1/2/2013	EOP	Returned to Housing	0
SAC	1/7/2013	1/7/2013	EOP	Admitted	0
SAC	1/7/2013	1/7/2013	EOP	Returned to Housing	0
SAC	1/8/2013	1/8/2013	EOP	Admitted	0
SAC	1/8/2013	1/8/2013	EOP	Admitted	0
SAC	1/8/2013	1/8/2013	EOP	Admitted	0
SAC	1/9/2013	1/9/2013	EOP	Returned to Housing	0
SAC	1/9/2013	1/9/2013	EOP	Returned to Housing	0
SAC	1/14/2013	1/14/2013	EOP	Admitted	0
SAC	1/14/2013	1/14/2013	EOP	Returned to Housing	0
SAC	1/19/2013	1/19/2013	EOP	Admitted	0
SAC	1/19/2013	1/19/2013	EOP	Admitted	0
SAC	1/20/2013	1/20/2013	EOP	Returned to Housing	0
SAC	1/20/2013	1/20/2013	EOP	Returned to Housing	0
SAC	1/22/2013	1/22/2013	EOP	Returned to Housing	0
SAC	1/22/2013	1/22/2013	EOP	Returned to Housing	0
SAC	1/22/2013	1/22/2013	EOP	Returned to Housing	0
SAC	1/22/2013	1/22/2013	EOP	Returned to Housing	0
SAC	1/22/2013	1/23/2013	EOP	Returned to Housing	1
SAC	1/24/2013	1/24/2013	EOP	Admitted	0
SAC	1/27/2013	1/27/2013	EOP	Returned to Housing	0
SAC	1/29/2013	1/29/2013	EOP	Admitted	0
SAC	1/2/2013	1/2/2013	GP/OP	Returned to Housing	0
SAC	1/7/2013	1/7/2013	GP/OP	Returned to Housing	0
SAC	1/19/2013	1/19/2013	GP/OP	Admitted	0
SAC Average					**0.04**
SATF	1/3/2013	1/3/2013	CCCMS	Admitted	0
SATF	1/3/2013	1/3/2013	CCCMS	Returned to Housing	0
SATF	1/15/2013	1/15/2013	CCCMS	Admitted	0

*Days Waiting based on days between referral and rescission. Field clinicians identify the most urgent cases and Headquarters' Mental Health Program senior clinical staff authorize priority placements.

ATTACHMENT 2B

RESCINDED MHCB REFERRALS
BY INSTITUTION AND PRIOR LEVEL OF CARE
JANUARY 2013

Referred By	Referral Date	Rescind Date	Prior LOC	Rescind Reason	Days Waiting*
SATF	1/15/2013	1/15/2013	CCCMS	Admitted	0
SATF	1/21/2013	1/21/2013	CCCMS	Admitted	0
SATF	1/30/2013	1/31/2013	CCCMS	Admitted	1
SATF	1/30/2013	1/31/2013	EOP	Admitted	1
SATF	1/14/2013	1/14/2013	GP/OP	Admitted	0
SATF Average					**0.25**
SQ	1/28/2013	1/29/2013	CCCMS	Paroled	1
SQ Average					**1.00**
SVSP	1/2/2013	1/2/2013	CCCMS	Returned to Housing	0
SVSP	1/3/2013	1/3/2013	CCCMS	Returned to Housing	0
SVSP	1/7/2013	1/7/2013	CCCMS	Returned to Housing	0
SVSP	1/8/2013	1/8/2013	CCCMS	Returned to Housing	0
SVSP	1/9/2013	1/9/2013	CCCMS	Returned to Housing	0
SVSP	1/12/2013	1/13/2013	CCCMS	Admitted	1
SVSP	1/14/2013	1/14/2013	CCCMS	Returned to Housing	0
SVSP	1/17/2013	1/17/2013	CCCMS	Returned to Housing	0
SVSP	1/18/2013	1/18/2013	CCCMS	Returned to Housing	0
SVSP	1/30/2013	1/30/2013	CCCMS	Returned to Housing	0
SVSP	1/31/2013	1/31/2013	CCCMS	Returned to Housing	0
SVSP	1/1/2013	1/1/2013	EOP	Returned to Housing	0
SVSP	1/3/2013	1/3/2013	EOP	Admitted	0
SVSP	1/12/2013	1/12/2013	EOP	Returned to Housing	0
SVSP	1/12/2013	1/12/2013	EOP	Returned to Housing	0
SVSP	1/12/2013	1/12/2013	EOP	Returned to Housing	0
SVSP	1/18/2013	1/18/2013	EOP	Returned to Housing	0
SVSP	1/29/2013	1/29/2013	EOP	Returned to Housing	0
SVSP	1/30/2013	1/30/2013	EOP	Admitted	0
SVSP	1/8/2013	1/8/2013	GP/OP	Returned to Housing	0
SVSP	1/14/2013	1/15/2013	GP/OP	Admitted	1
SVSP	1/18/2013	1/18/2013	GP/OP	Admitted	0
SVSP	1/17/2013	1/17/2013	MHCB	Returned to Housing	0
SVSP Average					**0.09**
WSP	1/25/2013	1/25/2013	GP/OP	Returned to Housing	0
WSP Average					**0.00**
WSP-RC	1/6/2013	1/6/2013	CCCMS	Returned to Housing	0
WSP-RC	1/6/2013	1/6/2013	CCCMS	Returned to Housing	0
WSP-RC	1/16/2013	1/16/2013	CCCMS	Admitted	0
WSP-RC	1/17/2013	1/17/2013	CCCMS	Admitted	0
WSP-RC	1/17/2013	1/18/2013	CCCMS	Admitted	1
WSP-RC	1/17/2013	1/18/2013	CCCMS	Admitted	1
WSP-RC	1/23/2013	1/23/2013	CCCMS	Returned to Housing	0
WSP-RC	1/23/2013	1/24/2013	CCCMS	Returned to Housing	1
WSP-RC	1/27/2013	1/28/2013	CCCMS	Returned to Housing	1
WSP-RC	1/31/2013	1/31/2013	CCCMS	Returned to Housing	0
WSP-RC	1/11/2013	1/11/2013	EOP	Returned to Housing	0
WSP-RC	1/17/2013	1/17/2013	EOP	Returned to Housing	0
WSP-RC	1/25/2013	1/25/2013	EOP	Admitted	0

*Days Waiting based on days between referral and rescission. Field clinicians identify the most urgent cases and Headquarters' Mental Health Program senior clinical staff authorize priority placements.

ATTACHMENT 2B

RESCINDED MHCB REFERRALS
BY INSTITUTION AND PRIOR LEVEL OF CARE
JANUARY 2013

Referred By	Referral Date	Rescind Date	Prior LOC	Rescind Reason	Days Waiting*
WSP-RC	1/10/2013	1/10/2013	GP/OP	Admitted	0
WSP-RC	1/10/2013	1/11/2013	GP/OP	Admitted	1
WSP-RC	1/18/2013	1/18/2013	GP/OP	Returned to Housing	0
WSP-RC	1/20/2013	1/20/2013	GP/OP	Admitted	0
WSP-RC	1/26/2013	1/26/2013	GP/OP	Admitted	0
WSP-RC	1/30/2013	1/31/2013	GP/OP	Admitted	1
WSP-RC Average					**0.32**
Grand Average					**0.28**

SUMMARY OF RESCINDED REFERRALS			
Time Frames	Total Transfers	Average Days Waiting	Range for Days Waiting
Combined	177	0.28	0-1
< or = 1 day	177	0.28	
2 days	0	NA	
3 days	0	NA	
4 or more days	0	NA	

*Days Waiting based on days between referral and rescission. Field clinicians identify the most urgent cases and Headquarters' Mental Health Program senior clinical staff authorize priority placements.

REASON FOR RESCINDED MHCB REFERRALS

ATTACHMENT 2C

JANUARY 2013

	REASON FOR RESCINDED MHCB REFERRALS					
Institution	**Admitted**	**Return to Housing**	**Paroled**	**Out to Court**	**Not Medically Cleared**	**Total Rescinded**
ASP	0	0	0	0	0	**0**
CAL	0	0	0	0	0	**0**
CCC	0	0	0	0	0	**0**
CCI	0	0	0	0	0	**0**
CCI-RC	0	0	0	0	0	**0**
CEN	0	1	0	0	0	**1**
CIM-RC	0	0	0	0	0	**0**
CMC	8	6	0	0	0	**14**
CMF	2	0	0	0	0	**2**
CMF-DSH	0	0	0	0	0	**0**
COR	6	2	0	0	0	**8**
CRC	0	1	0	0	0	**1**
CTF	0	0	0	0	0	**0**
CVSP	0	0	0	0	0	**0**
DVI	0	0	0	0	0	**0**
DVI-RC	0	0	0	0	0	**0**
FOL	0	1	0	0	0	**1**
HDSP	0	0	0	0	0	**0**
ISP	0	0	0	0	0	**0**
KVSP	6	2	0	0	0	**8**
LAC	3	3	0	0	1	**7**
LAC-RC	0	1	0	0	0	**1**
MCSP	0	0	0	0	0	**0**
NKSP	1	1	0	0	0	**2**
NKSP-RC	13	34	2	0	1	**50**
PBSP	0	0	0	0	0	**0**
PVSP	0	0	0	0	0	**0**
RJD	2	2	0	0	0	**4**
RJD-RC	0	0	0	0	0	**0**
SAC	10	16	0	0	0	**26**
SATF	7	1	0	0	0	**8**
SCC	0	0	0	0	0	**0**
SOL	0	0	0	0	0	**0**
SQ	0	0	1	0	0	**1**
SQ-RC	0	0	0	0	0	**0**
SVSP	5	18	0	0	0	**23**
WSP	0	1	0	0	0	**1**
WSP-RC	10	9	0	0	0	**19**
TOTAL	**73**	**99**	**3**	**0**	**2**	**177**

ATTACHMENT 3

AVERAGE DAYS WAITING*
Transferred and Rescinded MHCB Referrals
JANUARY 2013

	TRANSFERS		RESCINDED REFERRALS		TOTAL REFERRALS	
	Number	Avg Days Wait	Number	Avg Days Wait	Number	Avg Days Wait
ASH	0	0.00	0	0.00	0	0.00
ASP	6	1.17	0	0.00	6	1.17
CAL	8	1.25	0	0.00	8	1.25
CCC	0	0.00	0	0.00	0	0.00
CCI	4	1.50	0	0.00	4	1.50
CCI-RC	1	1.00	0	0.00	1	1.00
CEN	3	0.33	1	1.00	4	0.50
CIM-RC	0	0.00	0	0.00	0	0.00
CMC	3	0.33	14	0.57	17	0.53
CMF	2	10.00	2	0.00	4	5.00
CMF/DSH	2	0.00	0	0.00	2	0.00
COCF	0	0.00	0	0.00	0	0.00
COR	6	0.83	8	0.38	14	0.57
CRC	8	0.63	1	0.00	9	0.56
CTF	3	0.33	0	0.00	3	0.33
CVSP	0	0.00	0	0.00	0	0.00
DVI	6	1.00	0	0.00	6	1.00
DVI-RC	5	0.40	0	0.00	5	0.40
FOL	1	0.00	1	0.00	2	0.00
HDSP	2	0.50	0	0.00	2	0.50
ISP	5	1.20	0	0.00	5	1.20
KVSP	1	1.00	8	0.38	9	0.44
LAC	15	1.33	7	0.29	22	1.00
LAC-RC	0	0.00	1	0.00	1	0.00
MCSP	0	0.00	0	0.00	0	0.00
NKSP	0	0.00	2	0.00	2	0.00
NKSP-RC	20	1.25	50	0.38	70	0.63
NSH	0	0.00	0	0.00	0	0.00
PBSP	1	0.00	0	0.00	1	0.00
PVSP	4	0.50	0	0.00	4	0.50
RJD	0	0.00	4	0.25	4	0.25
RJD-RC	0	0.00	0	0.00	0	0.00
SAC	5	0.00	26	0.04	31	0.03
SATF	5	0.80	8	0.25	13	0.46
SCC	1	1.00	0	0.00	1	1.00
SOL	3	0.33	0	0.00	3	0.33
SQ	0	0.00	1	1.00	1	1.00
SVSP	0	0.00	23	0.09	23	0.09
VSP	2	0.50	0	0.00	2	0.50
WSP	4	0.50	1	0.00	5	0.40
WSP-RC	29	1.28	19	0.32	48	0.90
TOTAL	**155**	**1.07**	**177**	**0.28**	**332**	**0.65**

*Average Days Waiting is based on number of days between referral and transfer or rescission. It does not indicate days between referral and an MHCB becoming available. Field clinicians identify the most urgent cases and Headquarters' Mental Health Program senior clinical staff authorize priority placement of these cases into available MHCBs.

Exhibit 67

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, ET AL., Plaintiffs, vs. EDMUND G. BROWN, JR., ET AL., Defendants.	CASE NO.: S 90-0520 LKK-JFM

DEPOSITION OF

JACQUELINE MOORE, RN, PH.D.

THURSDAY, FEBRUARY 21, 2013, 8:50 A.M.

SAN FRANCISCO, CALIFORNIA

REPORTED BY: MEGAN F. ALVAREZ, RPR, CSR NO. 12470

THORSNES LITIGATION SERVICES, LLC

discharge planning at the institution?

MS. VOROUS: Objection. Misstates her testimony.

THE WITNESS: Yes.

BY MR. FISCHER:

Q. Okay. And one last thing on CIM I wanted ask you about in your notes on the final page, 102633.

Most of the way down next to No. 5, it says: "Nurse UNFAM, SE, psy meds."

What does that note refer to?

A. Nurses were unfamiliar with the side effects of psychiatric meds.

Q. I imagine that's on your radar because you're a nurse?

A. I asked them.

Q. Why did you ask this question?

A. I asked all the institutions. That was one of the criteria on my audit tool.

Q. And here -- SE is side effects?

A. Side effects.

Q. And is this particular CIM of concern to you in your analysis?

A. Yes.

Q. Why is that?

A. Because it's a common practice that nurses

know the side effects of the medication that they're giving because very often you are the one that might observe lithium toxicity in an inmate.

Q. So it's important to be aware of the side effects of the psych medications in order to ensure the safety and well-being of those patients?

A. Yes, sir.

Q. Did you observe this problem at any other institutions? Do you remember?

A. Yes.

Q. Do you remember which institutions?

A. All of them except San Quentin.

Q. San Quentin?

A. Knew the side effects.

Q. They were good?

A. They were good.

Q. Did you raise this with -- at the exit interviews?

A. Each and every time.

Q. Did this make it into your report?

Direct you to page 26 of your report, Exhibit 4.

Tell me if I'm looking at the right -- bottom, "Nursing Medication Management." Just a short section.

Is that an issue you think could have been put

I declare under penalty of perjury that the foregoing is true and correct. Subscribed at _____, California, this _____ day of _____, 2013.

_____

JACQUELINE MOORE, RN, PH.D.

Exhibit 68

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, ET AL., Plaintiffs, vs. EDMUND G. BROWN, JR., ET AL., Defendants.	CASE NO.: S 90-0520 LKK-JFM

DEPOSITION OF

JOHN BRIM, M.D.

FRIDAY, MARCH 1, 2013, 9:28 A.M.

SAN FRANCISCO, CALIFORNIA

REPORTED BY: MEGAN F. ALVAREZ, RPR, CSR NO. 12470

THORSNES LITIGATION SERVICES, LLC

was your program relatively full of patients?

A. Yes.

Q. Okay. And was there still pressure on -- there's still new patients arriving? Are there new admissions arriving?

A. Yes.

Q. I note on the top of the second page, in bold, the letter states: "But we need to inform you that we will be working in a state of protest regarding our case load and the rate of admissions. We are also extremely concerned about further attrition of psychiatrists which seems very likely considering the present workload and conditions."

Did you discuss -- let me just ask: Why is there a reference to admissions as being a factor?

MR. RUSSELL: Objection. Vague and ambiguous.

THE WITNESS: My understanding is that there was a general feeling -- and I -- I felt this way -- that we were under pressure from administration to move the old people out -- the old patients out and take in new patients so as to keep our waiting list down.

And many of the psychiatrists -- well, I would say all -- felt that this was resulting in shorter stay for the patients than historically had been the case. And they felt that it was getting to the point that

people were not staying in all cases at least as long as they needed to. There was pressure from administration to get them out quickly so that new people could be brought in.

That does impact the workload, because when a new person comes in, there's quite a bit of work to do on the part of the psychiatrist, research assessment, so on. So as the number of admissions and discharges go up, that means more work for the psychiatrist.

BY MR. BIEN:

Q. You suggest in the last paragraph that one way to alleviate some of the pressure on the Salinas Valley psychiatric program would be to reduce the flow of new admissions; is that correct?

A. Correct.

Q. And did you have any response from the administration to that suggestion?

A. Not aware of any.

Q. To your knowledge, are there still new admissions arriving at Salinas Valley psychiatric program?

A. Yes.

Q. In the first paragraph on the first page, you refer to "a third psychiatrist scheduled to leave within the past six weeks."

You mentioned two that were leaving by retirement, Drs. Weinstein and Sial?

A. Yes.

Q. Who was the third?

A. Dr. Gaines, Gayle Gaines.

Q. Okay. And that's someone who signed this letter?

A. Yes.

Q. Okay. And what was happening with Dr. Gaines?

A. She had accepted a job with the Department of Corrections and was scheduled to leave us the end of the January.

Q. There's also a reference here to -- on the first page, the third paragraph, to the Stockton program.

And that -- I'm looking at the third paragraph down. It says: "When administration visited our facility recently to present the Stockton program."

Did you have a presentation to the staff at Salinas Valley psychiatric program by Department of State Hospital staff about the new program?

A. Yes, we did.

Q. Approximately when was that?

A. I believe late December, early January.

Q. There's also a reference here to -- I'm

turning to the last paragraph on the second page. "We understand that since SVPP is being downsized, then it may be difficult to attract new psychiatrists."

Had you understood -- what were you told about -- when were you first told that the Stockton program was opening? Was it in this presentation in late December, or had you heard about that earlier?

A. No, no. It had been in the works for a least a couple of years.

Q. When do you first recall being informed that the SVPP program was going to be downsized?

A. I believe I found that out in the early part of 2012. I was not at SVPP at the time, but I had contact with some people that were there, and they mentioned that they had been informed that it would be downsized --

Q. Okay.

A. -- quite radically.

Q. And there's a reference in this, I believe the same last paragraph, to the -- preparing to close C and D yards.

Was that what you were informed?

A. Yes.

Q. So the programs on C and D yards would be closed down, but the two 64-bed units would remain

operating?

A. That's my understanding.

Q. Okay. Were you given at any time a schedule for when this closure would take place?

A. Yes.

Q. And when were you told that?

A. We were told at the presentation by the Stockton folks that they would begin taking transfers from our program in later part of July 2013.

Q. And did you understand what the pace of the transition -- what did you understand from that presentation about how the Salinas Valley psychiatric program would be impacted by this transfer of patients?

A. Well, we weren't given a firm schedule for how fast the transfer would take place. Staff was told that they would all have an opportunity to apply for positions with the Stockton program.

Those are the two things that stand out in my mind from that meeting, yeah.

Q. Did you understand that at some point in 2013 you were going to have to find another job either at Stockton or somewhere else?

A. Well, I don't think it was quite that clear because there obviously would be 128 patients, I think, left at Salinas Valley psych program, so they would

require some staff. And it wasn't clear, you know, who might have an opportunity to stay, who might have to go. That was an assumption that would be probably on a seniority basis, but I wasn't really too involved in that because I'm a contractor. I come and go, you know, pretty easily.

Q. Okay. Back on the first page there's a reference to other mental health disciplines such as social work, psychology, and rehab therapy.

Were you aware of the staffing levels in these other disciplines at Salinas Valley?

MS. GOSLING: Vague and ambiguous as to time. I'm assuming when they wrote this letter.

MR. BIEN: Yeah, in January 2013.

THE WITNESS: Well, I knew from my own experience on the D yard where I worked that the disciplines were short of staff. And I understood that to be generally the case in all of the Salinas Valley psych program units.

BY MR. BIEN:

Q. Okay. And did you -- in your personal opinion did you feel that the shortage of other disciplines in psychiatry was greater than it had been in times in the past as of January 2013?

A. It was certainly.

MR. RUSSELL: Objection. Vague and ambiguous. Lacks foundation.

THE WITNESS: It was certainly greater than two years I had spent in the program from 2009 to 211.

BY MR. BIEN:

Q. Did any of the other staff in the other disciplines express to you personally their concern about the level of staffing in the D5/D6 unit where you're working?

A. Yes.

Q. And we're talking about the period since you came back to Salinas Valley?

A. Correct.

Q. And what was said to you and by whom?

If you want to tell me just the person's profession, that's fine with me. I don't care about their name.

A. Okay. Okay. I can do that.

The social workers in particular were concerned because they were stretched so thin. It involved having to cover more people than they felt comfortable covering, having to, in some cases, cover more than one case load.

Q. What do you mean by "more than one case load"?

A. One social worker would have to try to cover

another case load that ordinarily would have its own social worker assigned to it.

Q. Did you discuss with a social worker that spoke with you any strategies to make sure that patient safety was protected in this kind of environment of short staffing?

A. The only strategy that I was aware of that we could pursue was to do the best we could with what we had.

Q. Okay.

A. And, of course, to keep administration informed of the need for more manpower.

Q. Okay. Are you aware of any other disciplines who, through their unions or groups, expressed concerns about the staffing level at Salinas Valley psychiatric program in December or January?

A. Yes. I know that nursing was very short. And I was told by nurses that they were making their concern felt to administration.

The MTA staff also was short, and they also were expressing to me concern about the vacancies in their ranks.

Q. Anyone tell you that there was a hiring freeze that was limiting the ability of the institution to fill vacant positions?

A. I remember reference to that, and then I remember being told that there were exceptions to that or there were ways of hiring people despite that. I really didn't know much about that.

Q. Okay. Were you ever informed that there were limits on overtime work at the facility?

A. Yes, I did hear that.

Q. Okay. And where did you hear that from?

A. Some of the MTA staff, as I recall.

Q. Okay. Had it been your experience at DSH that shortages were sometimes addressed by asking employees to work overtime?

A. Yes.

Q. Do you recall who made the presentation about the Stockton program?

A. Well, I recall that Sterling Price, the executive director, was there with some other members of his staff. I don't recall their names.

Q. At the time of that presentation, did anyone -- were you aware of any communications to Mr. Price or anyone else from, you know, superiors in the Salinas Valley program about the current levels of staffing at the Salinas Valley psychiatric program?

A. I was not aware.

Q. Okay. At the bottom of the first page of the

letter there's a reference to a -- the first completed suicide at SVPP and that "Current staffing levels will create an unacceptable level of risk as far as patients' safety."

Is it correct that there was a suicide at SVPP in late November of 2012?

A. I -- yes. That's correct.

Q. Okay. And that was in the C5/C6 unit?

A. Yes.

Q. Did you participate in any discussions with staff about the circumstances of that, I'm sure, very troubling tragedy?

A. No.

Q. You never talked to anyone about the fact that someone had committed suicide in C5/C6?

A. Yes, I'm sure I talked to people about it. But, you know, as far as there being any organized any discussion at our meetings, no. There was not that I recall.

I'm sure there were, you know, references to that, but that would have fallen under peer review and that would have been taken up by, you know, an assigned group of clinicians. It wouldn't have been the subject of general discussion in a psychiatry meeting.

Q. Okay. Just for the record, we're going to be

discussing some matters in this deposition that are otherwise confidential. There's a protective order in the case. I think everyone here is under it. I'm going to try not to use any patient names on the record. If we do, we can seal that part of the transcript.

A. Okay.

Q. And if there's any concern that you have, I represent the person who committed suicide and the other patients.

A. Understand.

Q. Mr. Russell's here for Department of Corrections, we have Department of State Hospital people here, and this is your lawyer. We're all under the protective order. And I can assure that if we discuss anything, we will treat it as confidential and -- but obviously, any concerns that you have, please raise with your attorney.

MS. GOSLING: Mr. Bien, could we -- just because I'm new to the case, could we go off the record briefly so I could learn a little bit more about the protective order and how that works?

MR. BIEN: Sure.

(Off the record at 10:11 a.m. and back on the record at 10:24 a.m.)

BY MR. BIEN:

Q. Dr. Brim, you understand you're still under oath?

A. Yes, sir.

Q. When I asked you earlier about a statement made to you by another member of the D5/D6 clinical staff, you were reluctant to identify the person by name.

Let me ask you: Have you felt any pressure to -- start again.

Do you have any fear of being retaliated against as a result of your testimony here today?

MS. GOSLING: Objection. Relevance.

But you can go ahead and answer.

THE WITNESS: Not really given my -- my situation as a contractor at the end of my professional life.

BY MR. BIEN:

Q. What do you mean by "not really"?

MS. GOSLING: Same objection.

You can go ahead and answer.

THE WITNESS: Well, there was some discussion at the Salinas Valley psych program as to what would happen if the union sent this letter on to the Coleman court as we rather expected it would. And many of my

colleagues expressed considerable apprehension about being singled out to give testimony, and they pointed out to me that I had sort of reached the end of my working life expectancy, didn't have a whole lot to lose. And I agreed that they were probably right about that.

And I don't know if that was a factor in my being designated to come here but...

BY MR. BIEN:

Q. So am I correct that you think it's possible as a result of your testimony you will lose your ability to work for Department of State Hospitals?

MS. GOSLING: Objection. I think that misstates his testimony.

MR. RUSSELL: Join.

THE WITNESS: Do you want a response to that?

BY MR. BIEN:

Q. Please.

A. Well, I think the Department of State Hospitals that's predecessor to DMH is a good department and they try hard to be fair but the reality of human behavior is it's always a possibility.

Q. Okay. You thought it was important professionally to come forward and to make this information public?

MS. GOSLING: Objection. Misstates his testimony.

THE WITNESS: I agree with your statement. I did feel it was important. And we all did, yeah.

BY MR. BIEN:

Q. And why was that?

A. Because of our concern for the patients.

And of course there was, you know, some concern for personal liability if things went bad.

Q. There was a -- were you aware that Coleman plaintiffs' counsel and psychiatric expert Dr. Pablo Stewart inspected the Salinas Valley psychiatric program, including the DSH program, in late January of 2013?

A. Yes, I heard about that.

Q. Okay. Who did you hear about it from?

A. Some of the other staff members were talking about it. I didn't have any opportunity to interact with any of the people that were visiting.

Q. Were you aware of any instructions that were given to staff concerning that tour?

A. No.

Q. Okay. Did any of the psychiatrists who joined you in writing this letter tell you that they were unable to communicate with Coleman counsel during that

tour about their concerns?

A. I remember some discussion about how -- one or two of the psychiatrists mentioning that they wished they had been approached by Coleman, that they'd had an opportunity to talk with them because they felt that their concerns needed to be heard.

That's all I recall on that subject.

MR. BIEN: I've asked the court reporter to mark as Exhibit 2 a letter dated February 12, 2013, again, signed by a group of psychiatrists at Salinas Valley and addressed to Charles DaSilva.

(Plaintiffs' Exhibit 2 was marked for identification.)

BY MR. BIEN:

Q. Dr. Brim, can you identify this letter, please?

A. Yes. This is a letter that I signed along with seven of my colleagues.

Q. And this was several weeks later after the first letter?

A. Yes. It's dated February 12. Uh-huh.

Q. Between the time you sent the first letter on January 23rd and the time you sent the second letter on February 12, had you received any communication from the administration at Salinas Valley psychiatric program

about the issues you raised?

MR. RUSSELL: Objection. Vague and ambiguous.

THE WITNESS: No.

BY MR. BIEN:

Q. Did you ask Dr. Troncoso if he had received any communications from Mr. DaSilva or anyone else about the concerns raised in the January 23rd letter?

A. Yes, we did.

Q. What did he say?

A. He said that he was reassured that administration was working on the issue but, again, he was given no role in recruiting.

He at that point resigned his position as senior psychiatrist.

Q. Did he explain to you why he resigned his position as senior psychiatrist?

A. No.

Q. I notice there are eight signatories of the second letter, and there were nine, I think, of the first.

A. Yes.

Q. What happened?

A. Dr. Gaines had left for her new job at that point.

Q. Had there been any decrease in the rate of

admission to the program in the period January 23rd, 2013, and the time you sent the second letter, February 12th, 2013, to your knowledge?

A. Not at least for the unit that I was working on.

Q. Okay. In the third sentence in the letter the group says: "Now, as you know, our psychiatry staffing shortage has devolved from serious to crisis level."

A. Yes.

Q. What did you mean by that?

MR. RUSSELL: Objection. Vague and ambiguous.

THE WITNESS: We meant that it had become a crisis.

BY MR. BIEN:

Q. Can you explain a little bit more about that?

A. Yes. I think the feeling among the group was that things were bad three weeks prior. Now they were a lot worse.

Q. Okay. You state that "The psychiatry staff at SVPP have unanimously determined that we cannot safely manage more than 40 patients per psychiatrist."

Were you being asked at that point, February 12, 2013, to manage more than 40 patients as an individual psychiatrist?

A. Beginning, I believe, the week after that

letter was sent, we were scheduled to lose two more of the eight psychiatrists. And that would have meant, let's see, five and three-quarter psychiatrists for 360 patients, which I believe works out to about roughly 60 per psychiatrist.

Q. Who were the two more psychiatrists that were scheduled to leave?

A. Dr. Wei had announced that he was leaving, and Dr. Kapadia had announced that he had a new job and was going to be departing to take that up.

Q. Where was Dr. Kapadia going?

A. He was going to California training facility -- or correction training facility at Soledad, which is one of the CDCR prisons.

Q. Okay. And what about Dr. Wei?

A. Dr. Wei was returning to China because of family illness.

Q. Okay. And I assume that these doctors had made the plan known to the administration, to your knowledge?

A. Yes.

Q. What did the group mean by the fact -- the quote in the last sentence, "We can only provide emergency psychiatry services"?

A. Well, we couldn't ethically abandon patients

out that in his experience it was feasible for the psychiatrists to rely on information from these other staff members about the patients rather than actually seeing the patients in order to make decisions about their treatment.

It was suggested to him this would not be proper because it would be like operating on hearsay and we needed to have time and opportunity to interact with the patients ourselves in order to make responsible decisions about their treatment.

Q. Did you discuss with him reducing new admissions to the unit to reduce the pressure?

A. Yes.

Q. Okay. And what did you say to him and he say to you about that?

A. Well, it was pointed out that the more admissions and discharges you have, the higher the workload because a lot of the work is sort of front-loaded and end-loaded on these patients.

He, you know, responded we had a responsibility to provide our services promptly to those in need, and we did have a waiting list although it was relatively short at that point in time.

That was extent of the discussion on that.

Q. Did he tell you how many people were on the

inmate to his regular cell but restrict his possessions. Sometimes one would limit the possession of sharp objects. Sometimes one would limit the possession of sheets, blankets, things that can be converted pretty easily into nooses.

So there are those other options, yes.

Q. Are there options that involve nursing or other staffing observations, frequency of observation, for someone who's not in that observation cell on suicide watch?

MR. RUSSELL: Objection. Vague and ambiguous. Lacks foundation.

THE WITNESS: I would say there is that option. It's not commonly used because all inmates are checked every 15 minutes. And typically when someone is taken off of one-to-one observation, they go to the every 15 minute that is standard for all inmates.

BY MR. BIEN:

Q. Okay.

A. Although, you know, in theory, you could say every seven minutes or any time in between.

Q. Okay. Can you explain the every 15 minute check that you understand happens in these units at Salinas Valley?

A. Nursing staff make rounds every 15 minutes and

ascertain that every inmate under their care is breathing and appears alive and well.

Q. Okay. And that's something that you rely on in your work, that that is happening?

A. Yes.

Q. Okay. Are you aware of whether there are training on emergency response in your program at Salinas Valley psychiatric?

A. Yes.

Q. And does that include procedures for what to do if you find an inmate in the midst of a suicide attempt?

A. Yes.

Q. I'm looking on -- are you aware of which staff in the program are trained in CPR and emergency response procedures?

A. Everyone.

Q. Okay. If you look on page 2 of Exhibit 3, Doctor.

In your understanding, do social workers have the ability to sound an alarm themselves?

A. Yes.

Q. Is the alarm an electronic device?

A. Yes.

Q. Did you have one when you were in the unit?

A. Typically not, because there are other staff that do.

Q. Okay. Is it your understanding that social workers do have alarms?

A. Yes.

Q. When you've -- as a treating psychiatrist at Salinas Valley psychiatric program since November of 2012, have you ever had complaints from patients about the lack of privileges and lack of treatment in Level 1 -- when they're on Level 1 status?

A. Yes.

MR. RUSSELL: Objection. Vague and ambiguous. Overly broad.

BY MR. BIEN:

Q. Can you share that with me what? Do you recall?

A. Typically patients complain that they have more privileges at the prisons where they came from than they're finding at Level 1 in our program, and they feel like they've been deprived privileges by being sent to our program.

Q. Has a patient ever expressed to you that they had more treatment groups, more hours of treatment when they were in the CDCR prison than they had at your program in Level 1?

A. Yes.

Q. Do you recall how you responded to these patients?

A. I told them I sympathized, I wished we could start their treatment plan immediately, but that we're required by CDCR to postpone their programming until they have their ICC.

Q. Okay.

A. Typically we offer to provide what we can in the way of in-cell materials to help them occupy their time.

Q. Let me mark as -- I've already marked as Exhibit 5 a document that appears to be a manual given to patients at Salinas Valley psychiatric program.

This was mailed to us by a patient, and his name is on the back. So I'm going to put this in the sealed section too.

I'm not going to ask a lot of detailed questions, Doctor, but is this -- this appear to be a copy of a manual that's distributed to patients at Salinas Valley psychiatric program?

A. Yes.

Q. Okay. And what's the purpose of distributing this to patients, if you know?

MR. RUSSELL: Objection. Vague and ambiguous.

Lacks foundation.

THE WITNESS: I would assume the purpose is to introduce them to the program.

BY MR. BIEN:

Q. Okay.

MS. GOSLING: Don't assume. Just state if you know.

BY MR. BIEN:

Q. This is dated April 12. To your knowledge, has this -- is this manual -- this version of the manual still in effect at this time?

A. I don't know.

Q. Okay.

MS. GOSLING: Have you seen this before?

THE WITNESS: I have not.

BY MR. BIEN:

Q. Oh, you have not. Okay.

A. No.

MS. GOSLING: Do you want him to look through it?

MR. BIEN: No, that's okay.

BY MR. BIEN:

Q. You mentioned earlier in the Level 1 status the patient has to be in cuffs when they leave their cell; is that right?

A. Yes, it's my understanding.

Q. Okay. And if someones -- patient is Level 1 and they need to see their psychiatrist, where would you see them?

A. Typically at cellside.

Q. And what does that mean, "at cellside," Doctor?

A. That means we go to the patient's cell and converse with them through the cell door.

Q. Okay. Is that how you do -- I assume in those first couple of weeks, one of the things you're doing is evaluating their need for psychotropic medication?

A. Right.

Q. And discussing side effects and reactions to those medications?

A. Right.

Q. Are you concerned with the confidentiality of such a communication that happens at cell front?

A. Yes.

Q. Why is that?

A. It doesn't really afford confidentiality because even though we try to keep our voices down, I believe the people in the adjoining cells can probably overhear.

Q. In your opinion, why is confidentiality

important for these kind of communications for a psychiatrist with their patient?

MR. RUSSELL: Objection. Vague and ambiguous.

THE WITNESS: Because it's often very sensitive material that people want to discuss or we need to ask about, and they have valid reasons for not wanting other people to know about it.

BY MR. BIEN:

Q. Okay. Have you ever expressed to anyone in administration at Salinas Valley psychiatric program your concern about confidentiality in communications with patients in your work?

A. Yes.

Q. And can you recall when that was and what was communicated?

A. I would have to say on many occasions over the years.

Q. Do you recall any communications since November of 2012?

A. No. I think by that point I had communicated that concern so many times, I didn't seem much point in repeating it. Yeah.

Q. When you had expressed it in the past, had you communicated the option of having the patient removed from their cell and brought to an office and meet

privately with you rather than doing cell front?

MS. GOSLING: Objection. Overly broad. Vague and ambiguous. You're talking about a lengthy career.

BY MR. BIEN:

Q. Okay.

A. Yes. And that routinely happens at least once or twice for each patient because when they first come in and meet the psychiatrist, they are brought out to an interview room. However, you know, MTA staff are present during that time. They are, however, treatment staff and included in the confidentiality umbrella.

And there may be special occasions during the remainder of the hospital stay where patients are able to come out and be interviewed in a more confidential setting. And when they come for their treatment teams, they're brought out of their cell, again interviewed in a more confidential setting.

So there is some of that.

Q. All right. Do you have the option as a psychiatrist you say, you know, "I'm not comfortable with this. I want all my contacts to be confidential"?

Can you -- do you feel like you could do that since November of 2012 at Salinas Valley psychiatric program?

A. Since November of 2012, I have not raised that

issue again because I had raised it many other occasions and I felt it would be pointless to raise it again.

Q. In your opinion, was there sufficient staffing in D5/D6 since November of 2012 to allow psychiatrists who would insist to have all their contacts in confidential spaces outside of cells? Is there sufficient staffing to provide that for psychiatrists and their patients?

MR. RUSSELL: Objection. Vague and ambiguous. Lacks foundation. Calls for speculation.

THE WITNESS: No.

BY MR. BIEN:

Q. Okay. Patients have raised with us, Doctor, an issue which we didn't really understand. We get letters from prisoners all the time, and some of them are -- seem a little bit -- some of them are seriously mentally ill and we're not always sure of reality.

But we've heard from our clients that there's insufficient laundry service, soap, clothing being provided to them at the Salinas Valley psychiatric program in the last few months.

Have you heard complaints like that?

A. Yes.

Q. Have you investigated them?

A. Yes.

Q. What can you tell me about them?

A. The DSH staff that I have talked to who had personal knowledge of this confirm that there has been a severe shortage of clean clothes, bedding, coats. I believe they've made every possible efforts to address this. They place the blame on CDCR, which has the responsibility for their laundry.

Q. When you say "they," is the staff, the DSH staff that you spoke to about the subject?

A. Yes.

Q. Okay. We've also heard complaints about food service, the volume of food, amount of food, quality of food. Have you heard complaints about food service also from patients?

A. Yes.

Q. And have you investigated them?

A. Informally.

Q. And what have you heard?

A. Well, I've inspected the meals and I've been around at feeding time. I've observed the distribution of the meals, the timing. I haven't found any substance to the inmates' complaint about the food. I mean, you know, it's a subjective thing how good it is, but it's provided. It appears to be hygienic. And I know it's under supervision of a registered dietician, so I assume

it's a balanced diet.

Q. Do -- have you investigated whether or not there will be restrictions on number of servings or extra helpings of food?

MR. RUSSELL: Objection. Vague and ambiguous. Lacks foundation.

THE WITNESS: Yes. As a medical facility, there is a prescribed regular diet which includes a certain quantity of food representing a certain number of calories. And that's only varied if there's a medical diet ordered. Medical diets are restricted in the variety available. But there are some. And I believe there religious diets. I don't know the details.

BY MR. BIEN:

Q. I guess my question was not unclear.

Did you investigate whether there's been any limitations beyond prescribed limitations on the amount of food that can be provided to inmates in the program at Salinas Valley in the last two months?

A. I'm not aware of that.

Q. Okay. Are you aware that Salinas Valley psychiatric program performs blood tests on arriving patients from CDCR as a matter of routine?

A. Yes.

Q. And is one of the purposes -- do you understand what the purpose of those blood tests are?

A. Yes.

Q. What are they? What are the purposes?

A. Well, psychotropic medication has some side effects that are harmful to the body, and blood tests can be used to monitor for these. And we also frequently do blood levels of psychotropic medications both to gauge adequacy of the dose and to get an idea of whether it's actually being consumed. So those are two of the purposes.

Of course, if there's a specific medical problem, any necessary test for that -- for the treatment of that will be ordered, too.

Q. Let me show you mark as the next exhibit in order, a document produced by Salinas Valley State Prison in connection with a recent tour. It has production number SP -- SVSP219. It's a one-page document. It says "Salinas Valley Psychiatric Program Medication Analysis Summary Report."

(Plaintiffs' Exhibit 6 was marked for identification.)

MR. BIEN: Let me at the same time mark Exhibit 7, another two-page document produced also in connection with the recent tour. SVSP236, 237. And

this one has to be sealed, please.

(Plaintiffs' Exhibit 7 was marked for identification.)

BY MR. BIEN:

Q. Doctor, have you ever seen Exhibit 6 or a report like Exhibit 6 that summarizes testing results by facility?

A. Yes.

Q. Okay. And is this something that's shared with the psychiatric staff at Salinas Valley psychiatric program?

I'm looking at 6. This one.

A. Oh, I'm sorry.

MS. GOSLING: Does that change your answer?

BY MR. BIEN:

Q. Yeah. That's why I want to make sure.

A. I've seen similar reports. I don't believe it's routinely distributed to psychiatrists, though.

Q. You have seen similar reports about testing and level reference levels?

A. Yes.

Q. Okay. What does a reference level refer to, if you know?

It's also on Exhibit 7 where the column is for reference level.

these were downloaded yesterday from the Department of State Hospital Web site.

MS. GOSLING: Do you want the witness to look through them?

MR. BIEN: Yeah. Just take a...

(Witness reviewing document.)

BY MR. BIEN:

Q. Dr. Brim, this isn't a color chart, which is appears on the computer when I looked at it, but are you able to discern the SVPP line on these various charts? Look at the last two charts, staff injuries and patient injuries.

A. Yes, I can discern that.

Q. Okay. Have you ever had discussions during your work at Salinas Valley psychiatric program about the level of staff and patient injuries?

MR. RUSSELL: Objection. Vague and ambiguous. Overly broad.

BY MR. BIEN:

Q. Since November of 2012?

A. Yes.

Q. And can you tell me about any of those discussions?

A. I have noticed an increase in staff assaults -- assaults by patients on staff -- over the

last few months. I've asked my colleagues if they were seeing the same sort of thing and, they agree that it seems to be increasing.

Q. Okay. And just for the record, these charts cover the period January through September of 2012.

Is it -- has it been your experience that -- is it your perception that staff injuries have been higher at Salinas Valley than in previous times that you've worked at Salinas Valley?

A. Yes.

MR. RUSSELL: Objection. Vague and ambiguous. Lacks foundation.

MS. GOSLING: Join.

BY MR. BIEN:

Q. In any discussions with staff, did anyone discuss with you perhaps the level of staff injuries reflects understaffing in the Salinas Valley psychiatric program?

MR. RUSSELL: Objection. Vague and ambiguous. Overly broad.

THE WITNESS: Yes.

BY MR. BIEN:

Q. Okay. And can you describe that conversation and when that took place?

A. No one conversation stands out in my mind; but

over the last couple of months when the psychiatrists have gotten together in their meetings, there has been ongoing discussion of the increasing dangerousness of the situation, and a number of different psychiatrists have touched on the fact that the injuries appear to be up, relate that to staff not having the time they once had to maintain contact with the patients, monitor how they're doing, keep us informed so that we can do what we can with their medication to help stabilize them.

And we ourselves have all, I think, expressed concern that we're not able to take the time to have the number of face-to-face contacts that we really would like to have to feel comfortable that we are monitoring the patients in the -- a safe and responsible way.

Q. Administration ever inform you that Salinas Valley psychiatric program in 2012 had a higher level of staff and patient injuries than all other state hospital programs?

A. No. Not to my knowledge.

Q. Did Secretary Allenby discuss with you his concern that -- of the high level of staff and patient injuries that were occurring at Salinas Valley psychiatric program at his meeting this week?

MR. RUSSELL: Objection. Vague and ambiguous. Assumes facts not in evidence.

A. Typically smaller, though.

Q. Are there offices for the psychiatrists and other staff in C5/C6 and D5/D6?

A. There are offices, but they're in a separate building.

Q. So they're not inside of C5/C6 or D5/D6?

A. That's correct.

Q. Okay. You've worked in both, I guess, D5/D6 and in T since you've been back in November?

A. Yes.

Q. Okay. Are there any differences in your practice in psychiatry that affect you when you practice in one environment versus the other, the modified building versus the T building, the original building?

MR. RUSSELL: Objection. Vague and ambiguous.

THE WITNESS: Well, some differences to impact patient care. The TC units have individual exercise yards where one person can be let out to exercise without being with the other inmates.

The D and C units have a common exercise yard. They don't have any facilities for one-man yards.

BY MR. BIEN:

Q. Are there any differences in medical records between the two units?

MR. RUSSELL: Objection. Vague and ambiguous.

BY MR. BIEN:

Q. Do you have the same access to medical records?

A. Well, I would say the same. Nonaccess.

Q. What do you mean by that?

A. Well, it's one of the serious problems that medical staff at Salinas Valley psych program face. We are not on the CDCR electronic health record system, so we have no practical way of accessing the last 18 months or two years of health records for the new arrivals.

Q. Is there a package of materials that's provided by CDCR for each patient that transferred to Salinas Valley called a referral package that includes some medical records or information?

A. Yes, typically about two months' worth of records.

Q. Okay. Now, the EUHR system, are you aware that that system is active in the prison part of Salinas Valley?

A. Yes.

Q. Okay. Is it right there on premises?

A. Yes.

Q. Have you ever asked anyone why it couldn't be computer -- couldn't be installed in your units, too, to give you access on EUHR?

A. Well, we have computers that access the system on our units; we simply don't have the log-in and the access password to get at it.

Q. Have you ever asked to get the log-in and access password?

A. Yes.

Q. And who did you ask?

A. Well, we've requested through Dr. Troncoso, when he was senior psychiatrist, acting. And according to minutes I've seen of the psych meetings before I rejoined the program in November through the previous senior psychiatrist, Dr. Safi, and those individuals have passed on the request to their administrative supervisors.

Q. Okay. And as of this week, you still did not have permission to use the EUHR?

A. We still don't have access, correct.

Q. How do you feel that would benefit your ability to provide psychiatric care for your patients?

A. Well, I think it's dangerous not to have access to the old records because they're potentially relevant things in the old records that are not necessarily included in the referral packet. It's just not up to community standards to not have access to relevant recent medical education.

Q. Are the same computers available on -- in the C5/C6 and D5/D6 as are in the T units, to your knowledge? In other words, if you got the password, could you use it in both places?

A. Yes.

Q. Okay. Our expert was informed during his tour of Salinas Valley psychiatric program in late January of 2013, just a few weeks ago -- a month ago now, that an hour -- only an hour or so of treatment was being provided for patients due to staff and space restrictions.

Is that consistent with your understanding of what was going on in the program as recently as last month?

MR. RUSSELL: Objection. Vague and ambiguous. Lacks foundation. Calls for speculation. Overly broad.

THE WITNESS: I don't have any problem believing that. I haven't, you know, made a study of that, but that sounds about it right.

BY MR. BIEN:

Q. Okay. People are getting about one group a day?

A. Uh-huh.

Q. Okay. In your opinion, Doctor, is that less than the optimal treatment that your program is designed

for patients at the ICF level of care?

MR. RUSSELL: Objection. Vague and ambiguous. Lacks foundation. Overly broad.

THE WITNESS: It's less than they got historically when I worked there previously.

BY MR. BIEN:

Q. And do you think the patients could benefit from a -- more than one hour of group a day at their level of care?

MR. RUSSELL: Objection. Vague and ambiguous. Lacks foundation. Overly broad.

THE WITNESS: Yes.

BY MR. BIEN:

Q. And why is that?

A. Well, I think there's ample evidence that within the limits, more treatment produces better outcomes. And certainly one hour a day is not maxing out the potential for recovery.

Q. Okay.

MR. BIEN: I'd like to mark as the next exhibit in order. This will be sealed.

It's a June 17th, 2011, suicide report for inmate -- and I'll call him G, took place at California State Prison at Sacramento.

(Plaintiffs' Exhibit 17 was marked for identification.)

BY MR. BIEN:

Q. If you want to take a few minutes, we can take a break if you want to read that first.

A. Okay.

(Off the record at 1:30 p.m. and back on the record at 1:38 p.m.)

BY MR. BIEN:

Q. Doctor, have you had a chance to review this report?

A. Yes, I have.

Q. First question: Has anyone ever discussed with the psychiatric staff the circumstances of this suicide and any improvement plans for Salinas Valley psychiatric program, to your knowledge? I know you weren't there at every moment during this time. But have you ever been present when discussion of this particular inmate's suicide and any improvements to be taken as a result of it?

MR. RUSSELL: Objection. Vague and ambiguous. Lacks foundation.

THE WITNESS: I don't believe so.

BY MR. BIEN:

Q. Okay. One issue I wanted to ask you about

was: Are you aware of a practice of discharging patients from SVPP back to CDCR in anticipation of their parole date?

A. Yes.

Q. And have you participated in a discharge of a patient due to a parole date upcoming?

A. Yes.

Q. And at times -- is it your understanding that that discharge is to be made whether or not the patient is -- meets the criteria for discharge from the SVPP program otherwise?

MR. RUSSELL: Objection. Vague and ambiguous. Overly broad. Lacks foundation.

BY MR. BIEN:

Q. Do you understand my question?

A. I understand the question. Yes, it's my understanding.

Q. In other words, your understanding is that the necessity to schedule the parole and do the paperwork is the driving force for those discharges?

MS. GOSLING: Objection. Calls for speculation.

MR. RUSSELL: Join.

THE WITNESS: That's my understanding. But I think there needs to be a point of clarification.

BY MR. BIEN:

Q. Please.

A. If somebody were not doing well and were at risk of self-harm or injury to others, we will proceed with the transfer as I understand we're legally required to do; but we would give a heads-up to the receiving institution that they need to assume responsibility for managing the acute illness of this patient. So we wouldn't just wash our hands of them.

Q. I didn't mean to imply that, Doctor, at all.

A. Sure. Sure.

Q. I'm sure that that's what you would do.

Have you ever had the occasion to do that, to be a little concerned that a patient you're discharging from SVPP for parole is a little bit unstable, and did you then communicate that to some CDCR physicians to assure that he was covered? This is since November of 2012.

A. No.

Q. Okay. At any time while you've been working at Salinas Valley psychiatric program, do you recall personally doing that or having someone on your treatment team do that follow-up on a patient who is being paroled by communicating to CDCR?

A. I don't recall any discharges where that was

indicated.

Q. Okay. Are there Spanish language translators available to you at Salinas Valley psychiatric program?

A. Yes.

Q. How do you access such services?

A. We ask the senior MTA to provide a translator.

Q. When you show up for a scheduled appointment for a patient, do you have to do something special or is that already -- if it's a scheduled nonemergency appointment, would that have been taken care of?

A. The translator?

Q. Yes.

A. Yes.

Q. Okay. So you would expect that when you show up, they had read the file and knew the patient?

A. Well, I don't think we expect that of the interpreter, that they read the file.

Q. No, no. I'm sorry. I was referring to the staff, your staff.

MS. GOSLING: Could you reask the question just so I'm clear?

BY MR. BIEN:

Q. I'm talking about time frame November 2012, forward.

A. Okay.

Q. It's been your experience for a scheduled appointment in the Salinas Valley psychiatric program, if that appointment was with a patient who is Spanish-speaking, that you would expect that a translator would be scheduled in advance for a scheduled appointment?

A. Yes, I would.

Q. And has that been happening?

A. Yes.

Q. Okay. Have you ever had a patient who needed a sign language interpreter at Salinas Valley psychiatric program?

A. Not at Salinas Valley psychiatric program, no.

Q. Okay. Would it be your practice at Salinas Valley psychiatric program to do a suicide risk evaluation before discharging a patient?

A. Yes.

Q. Okay. Is it your practice personally to do suicide risk evaluation in a private setting?

A. No. The suicide risk evaluation is delegated to the psychologist and treatment team, and I don't know what setting that's done in.

Q. Could you pull out, Doctor, Exhibit 6 and 7?

A. Okay.

Q. I wanted to -- I'm trying to understand a

little bit more about what Exhibit 7 is.

MR. BIEN: Let me mark the next exhibit as -- go to 19 please.

(Plaintiffs' Exhibit 19 was marked for identification.)

BY MR. BIEN:

Q. So looking at 7 -- and the court reporter has just handed you 19.

A. Okay.

Q. To try to save some trees -- and believe it or not, lawyers do try to save at least one or two.

This large document I have here in front of me in my hand was produced by Salinas Valley psychiatric program.

A. Right.

Q. And it goes from 220 all the way to 282. This was produced today.

A. Okay.

Q. 19 is the first page of that. 220.

And the last page of it is 282.

MR. BIEN: You can look at this, Jay, if you want. Exhibit 7 -- I just found this out -- is a page in the middle of that stack and someone randomly pulled it out. 236.

MS. GOSLING: These are part of same report?

CERTIFICATE OF REPORTER

I, MEGAN F. ALVAREZ, a Certified Shorthand Reporter, hereby certify that the witness in the foregoing deposition was by me duly sworn to tell the truth, the whole truth and nothing but the truth in the within-entitled cause;

That said deposition was taken down in shorthand by me, a disinterested person, at the time and place therein stated, and that the testimony of the said witness was thereafter reduced to typewriting, by computer, under my direction and supervision;

I further certify that I am not of counsel or attorney for either or any of the parties to the said deposition, nor in any way interested in the events of this cause, and that I am not related to any of the parties hereto.

DATED: March 4, 2013

_____

MEGAN F. ALVAREZ

RPR, CSR 12470

Exhibit 69

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, ET AL.,	)	
	)	
Plaintiffs,	)	
	)	CASE NO.:
vs.	)	S 90-0520 LKK-JFM
	)	
EDMUND G. BROWN, JR., ET AL.,	)	
	)	
Defendants.	)	
	)	

DEPOSITION OF

JOEL DVOSKIN, PH.D., ABPP

WEDNESDAY, FEBRUARY 27, 2013, 9:14 A.M.

SAN FRANCISCO, CALIFORNIA

REPORTED BY: MEGAN F. ALVAREZ, RPR, CSR NO. 12470

THORSNES LITIGATION SERVICES, LLC

psychiatric technicians that worked for the receiver's office, but they were -- they weren't officers. Nursing assistant or --

Q. CNA?

A. Correctional nursing assistants.

Q. Right. Did you ever observe them doing suicide watch?

A. Yes.

Q. Okay. And did you see them conversing with the inmates and speaking with them?

A. Let's see. I think I saw both.

I know one -- I remember one, I want to say at SAC, where the person, at least while I was there, didn't talk to the inmate. There was one where -- there were a number of times when the inmate was asleep, so obviously they weren't talking with them. But the one I was just remembering from SAC, I believe it was -- I think the inmate was up. I don't know if they were talking before we got there or not.

Q. Do you know that there's an instruction at CDCR that certified nursing assistants are not to speak to prisoners while on suicide watch?

MS. VOROUS: Objection. Lacks foundation.

THE WITNESS: I did not know that.

BY MR. BIEN:

Q. Would you agree that would be countertherapeutic?

A. Yes. Just to be clear, you're talking about prohibition against talking to them at all?

Q. Yes.

A. Yes, I would be opposed to that.

Q. When you were at SAC, California State Prison at Sacramento, did you observe the ZZ cells at that facility?

A. Yes.

Q. What did you understand them to be?

A. I assume we're talking about the same cells. It's in the sort of a depot where they hold people while they're waiting for transportation. And there's several officers in the area, and there's some cells that people were held in -- sort of like a holding unit except they were individual cells as opposed to a group holding tank while they're waiting for their particular bus or transportation.

When I was there, all of the inmates in those cells had been there for at least a few hours. And it was my understanding that they were used for temporarily housing people while they were waiting for the bus or vehicle that's going to take them somewhere to pick them

I declare under penalty of perjury that the foregoing is true and correct. Subscribed at _____, California, this _____ day of _____, 2013.

_____

JOEL DVOSKIN, PH.D., ABPP

Exhibit 70

UNITED STATES DISTRICT COURTS

EASTERN DISTRICT OF CALIFORNIA

AND NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES DISTRICT COURT COMPOSED OF THREE JUDGES

PURSUANT TO SECTION 2284, TITLE 28 UNITED STATES CODE

RALPH COLEMAN, et al.,	)	
	)	
Plaintiffs,	)	
vs.	)	No. Civ S 90-0520 LKK-JFM P
	)	
EDMUND G. BROWN, JR., et al.,	)	
	)	
Defendants.	)	
MARCIANO PLATA, et al.,	)	
	)	
Plaintiffs,	)	
vs.	)	No. C01-1351 TEH
	)	
EDMUND G. BROWN, JR., et al.,	)	
	)	
Defendants.	)	

DEPOSITION OF

JEFFREY A. BEARD, PH.D.

TUESDAY, MARCH 5, 2013, 9:02 A.M.

SACRAMENTO, CALIFORNIA

REPORTED BY: BRENDA L. MARSHALL, RPR, CSR NO. 6939

THORSNES LITIGATION SERVICES, LLC

are identifying mental health cases. People are properly classifying those cases, and people are putting -- moving those cases onto the higher level of care.

Now, back at the time that we did that, we still had wait lists, as you pointed out, but by July, and, actually, maybe a little bit before July of last year, the wait lists for mental health care went away. There was no wait list anymore. And -- and a proper level of -- so people were able to be identified, moved to the level of care and, in a timely manner, get the treatment that they need.

Q. Okay. And the fact that there's a wait list now, how do you explain that?

MR. MELLO: Objection. It misstates the record. Misstates his prior testimony. Lacks foundation. It's silly.

You can answer.

THE WITNESS: Could I ask you to define what wait list you're talking about?

BY MR. BIEN:

Q. There is currently a wait list for ICF level of care, and there's a wait list for APP level of care, and there's been a wait list throughout this period of time and has never been zero.

MR. MELLO: Objection. Vague.

If that's a question as to the term wait list, you can answer it.

THE WITNESS: Well, I don't know what numbers you're looking at, but the numbers that I looked at said that the wait list for ICF care basically went away, if not before July, when L wing was opened at CFF, it went away at that time.

There was still, at that time, an APP wait list of about 20. And the department tried for quite a few months, and I had some discussions with the special master relative to closing down the 20 MHCB beds that DMH operated at CMF, in converting that over to APP, that would have wiped out that wait list at that time.

We also looked at MHCBs and know there's been disagreements and arguments, but, basically, as a result of realignment, somewhere in January or February of 2012, the MHCB wait list went away. And so there's surplus MHCB space. The latest wait list space I saw on ICF is that that -- there was no space there, unless something all -- all of a sudden came on the wait list. However, there was a developing problem with the APP.

And that list, you know, on any given day, if you take a snapshot, because people can come on and off of a list, can look like you have a substantial list, but the actual list of people who don't get in within the program

guide, which is the 10 days, they think it's under 15, and that problem has already been discussed with DSH.

And just like any other constitutional system would do, if they ran into a problem, there's been discussions about perhaps opening up a second floor of L wing, specifically to address the APP problem.

Now, I don't know where exactly that is because one of the other things that's happening is we've talked about Stockton, which is coming on very quickly, and we know that most of those people in the APP wait list are sitting in MHCB so they're getting care, and they're being properly cared for while they're waiting for the APP placement.

So, yes, there is -- currently, we -- we suddenly have a wait list there and -- but that could be addressed even without Stockton by simply opening one of the two remaining empty wings at L wing at CMF.

BY MR. BIEN:

Q. And when did you have a conversation about doing that at CMF, opening another wing for APP care?

A. I had that conversation maybe a week or two ago with somebody.

Q. And what's the status?

A. I can't tell you the status right at this moment.

Q. Okay.

A. It's not open because, I mean, you can't open something overnight, but I do know that discussions have been had with DSH, relative to that issue.

Q. Okay. How many months is it going to take to open such a facility, seeming you decide to do it?

A. Since it's DSH personnel, I'm not sure how long it would take for them to get the staff up and running. I -- I wouldn't want to speculate. But, you know, we would certainly do it -- if that -- if that list doesn't go away, we would certainly want to do something as quickly as we can.

MR. MELLO: I'm going to interpose a belated objection on the basis that it calls for speculation.

BY MR. BIEN:

Q. You were informed yesterday that there was a wait list of 30 for the APP by the special master.

MR. MELLO: That lacks foundation.

BY MR. BIEN:

Q. Were you --

A. I received a copy of the memo, and I think I've already explained that to you, that the wait list is not 30. The wait list is more under 15 somewhere.

But the number that he gave is a moving target number that, at any point in time, you might have had --

for instance, since you want to speculate, we might have had 10 people today that just were put on the list to go to APP. Well, they're very likely, then, if they show up on a list, to go there. They're not over the 10-day program guide limits.

When we look at who's over the 10-day program guide limits, that's the important number, and that's more like about a 13, or something like that, the last thing that I saw.

Q. So --

A. Irrespective of what it is, it's not being ignored. And I had discussions with staff, prior to seeing the special master's memo. We were aware of it, and we were talking about it and talking to DSH about it.

Q. And were you aware of it -- of the fact that there is an APP wait list of people over -- if you want to just count the way you're counting it, which is saying people over the program guide limit, are you aware that that was -- was in existence in January of 2013, also?

A. No. January 13, I just was getting started here.

Q. Okay. And are you aware that there was a wait list of people over 30 days that the program guide transfer timeline for ICF care in January of 2013?

A. I -- again, I was just getting started, so I

can't answer that question, but the latest list that I saw, which was more in the February time frame, maybe March -- February, March time frame, did not show a wait list for ICF care or may show one inmate that was just being processed or something like that. But not -- not any -- anything like the 200 that was on a wait list back before.

Q. So you agree that there was a wait list for APP and ICF care in January of 2013 for people who were there longer than the transfer timelines?

MR. MELLO: Objection. Misstates his testimony. Lacks foundation. Assumes facts not in evidence.

You can answer.

THE WITNESS: I can't answer on January of '13. I can only answer for the latest thing that I'm aware of.

BY MR. BIEN:

Q. I'm asking you in the month of January 2013.

MR. MELLO: Asked and answered.

THE WITNESS: I can't answer the question because I was just coming on board. I was not getting those documents or talking to people about that specific issue. I've only gotten the document and talked to people about it within the past few weeks.

BY MR. BIEN:

Q. And how many people in January of 2013 were

CERTIFICATION OF DEPOSITION OFFICER

I, BRENDA L. MARSHALL, CSR, duly authorized to administer oaths pursuant to Section 2093(b) of the California Code of Civil Procedure, hereby certify that the witness in the foregoing deposition was by me sworn to testify to the truth, the whole truth and nothing but the truth in the within-entitled cause; that said deposition was taken at the time and place therein stated; that the testimony of said witness was thereafter transcribed by means of computer-aided transcription; that the foregoing is a full, complete and true record of said testimony; and that the witness was given an opportunity to read and correct said deposition and to subscribe the same.

I further certify that I am not of counsel or attorney for either or any of the parties in the foregoing deposition and caption named, or in any way interested in the outcome of this cause named in said caption.

_____

BRENDA L. MARSHALL

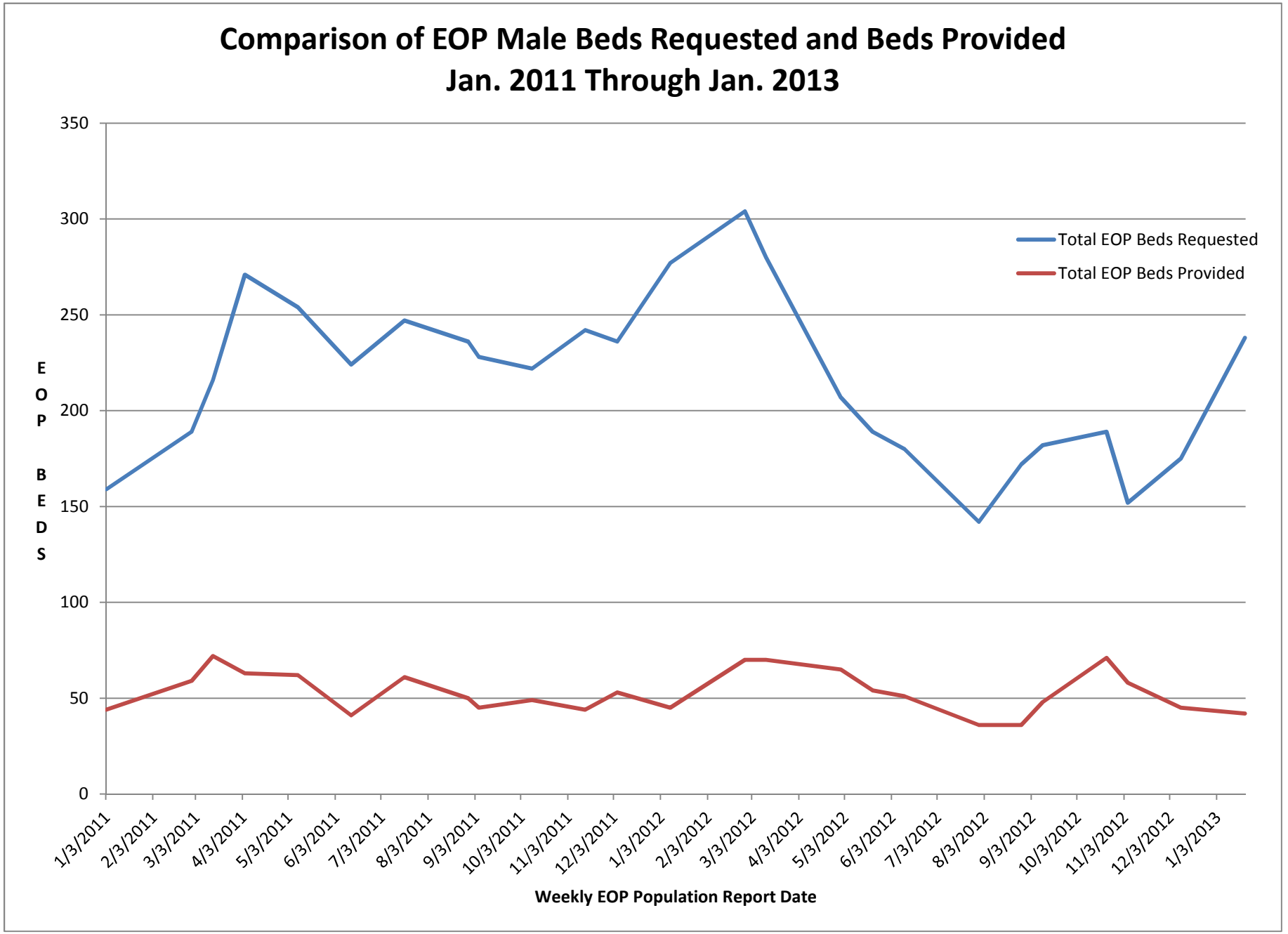
CSR No. 6939

Exhibit 71

From: Jones, Mohamedu <MJones@pldw.com>
Sent: Monday, March 04, 2013 7:20 AM
To: Tim.Belavich@cdcr.ca.gov; Debbie Vorous
Cc: Martin.Hochino@cdcr.ca.gov; Diana.Toche@cdcr.ca.gov; Benjamin Rice; Donald Specter; Steve Fama; Jane E. Kahn; Michael W. Bien; Kerry Courtney Hughes, MD; Patricia M. Williams; Haunani Henry; Mary Perrien; Henry D. Dlugacz; Raymond F. Patterson, MD; Kathryn Burns, MD, MPH; Paul Nicoll; Holden, Linda E.; Kristina Hector; Steve Raffa; Walsh, Kerry F.; Matt Lopes; Jeff Metzner; Aaron Fischer; Lisa Ells; Navarro, Jonelie
Subject: Sustainable Process/APP Waitlist

Tim and Debbie:
At the start of the sustainable process tour at CSP-COR (2/26/2013), we learned that the APP wait list was 29; when we ended the tour on 2/28/2013, it was at 32, with 4 additional inmates waiting for acceptance. Earlier in the month, while we were at the CMF sustainable process tour, the waitlist had been reported in the mid-20s. In addition to the serious circumstances surrounding inmates needing acute care waiting to be placed in beds, this situation goes to the very heart of the "sustainability" of the sustainable process. Moreover, there is also the historical "ripple effect" at other levels of care, such as the MHCB, and the heightened utilization of alternative beds.
Please let me know what, if any, steps CDCR is taking to remedy this serious shortfall, including the possible opening of the L Wing at CMF.
We will continue to monitor the wait list during the remaining sustainable process tours, and look forward to an update from you.
Please contact me if you have questions.
Mohamedu

Exhibit 72



Data from Coleman Monthly Report, Enclosure 9, January 2011 to December 2012

Bed = Bus seat request to transfer the EOP prisoner to the EOP program

DIVISION OF CORRECTIONAL HEALTH CARE SERVICES
STATEWIDE MENTAL HEALTH PROGRAM
P.O. Box 942883
Sacramento, CA94283-0001

FEB 25 2011

Matthew A. Lopes, Jr. Esquire
Office of the Special Master
Pannone Lopes & Devereaux LLC
317 Iron Horse Point Way, Suite 301
Providence, RI 02908

via: Debbie J. Vorous, Esquire
Gregory Gomez, Esq.
Deputy Attorney General
Department of Justice
1300 "I" Street, Suite 125
P. O. Box 944255
Sacramento, CA 94244-2550

RE: COLEMAN MONTHLY REPORT OF INFORMATION REQUESTED AND RESPONSE TO JANUARY 19, 1999, COURT ORDER REGARDING STAFF VACANCIES

Dear Mr. Lopes:

Enclosed is the Coleman Monthly Report reflective of January, 2011, data (or as otherwise noted). The following is the list of enclosures:

1. Mental Health Services Delivery System (MHSDS) Staffing Allocation and Vacancy History.
2. MHSDS Hiring Activity Report.
3. Health Care Placement Oversight Program (HCPOP) Information Report, Summary and Administrative Segregation Greater than 60 Days.
4. Mental Health Contract Services including Summary and Telemedicine Monthly Report for all disciplines.
5. California Department of Corrections and Rehabilitation (CDCR) Reception Center (RC) Monthly Report.
6. Monthly Summary of Mental Health Crisis Bed use by Institution Titles Inpatient Psychiatric Aging Report.
7. Referrals for Transfer to the Department of Mental Health (including admissions).
8. Atascadero State Hospital (ASH) Discharges.
9. Weekly Enhanced Outpatient Program (EOP)/Outpatient Psychiatric Program.
10. The DMH Monthly Report of CDCR Patients in DMH Hospitals--Summary and Penal Code 2684.
11. Suicide Report.
12. Statistics on Contracted Registered Nurse (RN). **(No Longer Available)**
13. RC Processing for MHSDS Inmate Patients. (Please note: Data for SQ is not available, due to MHTS.net conversion).

14. Medical Technical Assistant (MTA) Vacancy Report.
15. Allocated Case Manager Positions and Vacancies for the EOP Administrative Segregated Hub institutions.
16. EOP Inmates Waiting Transfer to a Psychiatric Services Unit (PSU).
17. Audit reports on Psychiatric Technician Rounds in Administrative Segregation at California State Prison-San Quentin (SQ), California State Prison-Corcoran (COR), and Salinas Valley State Prison (SVSP).
18. Mental Health Crisis Beds Wait List.
19. Correctional Treatment Centers and CDCR General Acute Care Hospital Care Placement Issues. **(No longer available)**
20. Transferred and Rescinded Mental Health Crisis Bed Referrals by Institution and Level of Care.

If you have any questions, please contact me at (916) 324-2933.

Sincerely,

JAMES A. SCARAMOZZINO, PH.D.
Director (A)
Statewide Mental Health Program
Division of Correctional Health Care Services

Enclosures

cc: Sharon Aungst, Chief Deputy Secretary, Correctional Health Care Services
Mohamedu F., Jones, Esq., *Coleman* Deputy Special Master
Linda Buffardi, Esq., *Coleman* Deputy Special Master
Jeffrey L. Metzner, M.D., *Coleman* Expert
Kerry C. Hughes, M.D., *Coleman* Expert
Melissa G. Warren, Ph.D., *Coleman* Expert
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Kerry F. Walsh, Esq., *Coleman* Monitor
Angela Shannon, M.D., *Coleman* Expert
Patricia Williams, Esq., *Coleman* Monitor

Haunani Henry, *Coleman* Monitor
J. Ronald Metz, *Coleman* Monitor
William Alvarez, Ph.D., *Coleman* Monitor
Debbie Vorous, Esq., Office of the Attorney General
Gregory Gomez, Esq., Office of the Attorney General
Heather McCray Esq., Office of Legal Affairs
Michael Stone, Esq., Office of Legal Affairs
Michael Bien, Esq., Rosen, Bien and Galvan
Donald Specter, Esq., Prison Law Office
Karen Higgins, M.D., Deputy Director (A), Psychiatry Services, DCHCS
Judy Burleson, Deputy Director, Statewide Mental Health Program, DCHCS
Teresa Owens, Staff Services Analyst, Operational Program Oversight, DCHCS

WEEKLY EOP POPULATION REPORT
(For the Week of JAN. 3, 2011)

Male Institutions	Staffed Capacity	Total Current Pop	Current Vacancies	Percent Filled	Total Seats Requested	Total Seats Provided	Number of Seats Requested for Endorsed Cases, by Sending Location *
SATF SNY II	176	171	5	97%	76	5	***4-CCI,*** 1-CVSP, 6-AVE, 4-CCI, 1-CMC, 1-CRC, 2-CTF, 17-MCSP, 1-SOL, 1-CCIRC, 11-CIM, 1-DVIRC, 12-NKSP, 10-RJDRC, 4-WSP
SATF COD II	88	81	7	92%	12	0	9-CMC, 2-COR, 1-DVIRC
CMC III	580	475	105	82%	6	6	***2-DVIRC, 3-NKSP, 1-WSP***
CMF III	533	467	66	88%	6	6	***1-CMC, 1-SATF, 2-DVIRC, 1-SQRC, 1-HDSPRC***
COR III	150	123	27	82%	0	0	
RJD III	330	294	36	89%	5	5	***1-ISP, 1-PVSP, 1-SAC, 1-CIM, 1-NKSP***
LAC IV (270)	300	234	66	78%	6	6	***3-CMC, 3-SAC***
MCSP SNY III	360	377	-17	105%	7	7	***1-AVE, 2-RJD, 3-SATF, 1-CIM***
MCSP SNY IV (270)	150	158	-8	105%	5	0	2-CMC, 2-SAC, 1-SVSP
RJD SNY IV (270)	150	147	3	98%	3	3	***1-SATF, 2-SVSP***
KVSP SNY IV (180)	96	94	2	98%	24	1	***1-CIM,*** 2-CMC, 4-COR, 1-CTF, 1-LAC, 2-MCSP, 1-PVSP, 2-RJD, 1-SVSP, 4-NKSP, 3-RJDRC, 2-WSP
PBSP IV (180)	66	59	7	89%	3	1	***1-SQRC,*** 1-CMC, 1-RJD
SAC IV (180)	384	382	2	99%	4	4	***1-CMF, 2-SVSP, 1-CIM***
SVSP IV (180)	192	197	-5	103%	2	0	1-PBSP, 1-LAC
TOTALS:	**3555**	**3259**	**296**	**92%**	**159**	**44**	

(per 1-3-11 PSU wait list)

CIW PSU	10	10	0	100%	8	0	1-CCWF, 3-VSPW, 4-CIW
PBSP PSU	128	123	5	96%	33	0	1-PVSP, 1-SAC, 1-NK, 1-KVSP, 2-WSP, 3-RJD, 5-LAC, 2-SVSP, 3-CMC, 1-SQ, 12-COR, 1-SATF
SAC PSU	256	265	-9	104%	66	0	4-DVI, 1-HDSP, 5-WSP, 2-NKSP, 2-PBSP, 1-KVSP, 1-CIM, 1-MCSP, 1-SAC, 1-PBSP, 7-CMC, 8-SVSP, 2-CMF, 9-COR, 1-SQ, 11-RJD, 9-LAC

Female Insts. CCWF	54	45	9	83%	0	0	
CIW	75	66	9	88%	1	1	***1-VSPW***
TOTALS:	**129**	**111**	**18**	**86%**	**1**	**1**	

*Inter-institution transfers only. Numbers/locations in bold/italics indicate bus seats assigned for transport this week.

Prep by: Health Care Placement Oversight Program, Data PASS, 916-327-1250

Note: A small number of EOP beds may be kept vacant for inmates temporarily housed in MHCrisis as part of the 10-day "hold-a-bed" process.

"Total Current Pop" from Population Mgmt. Unit (dated 12-31-10) of the C&PRs' call-ins of the inmates housed in the GP-EOP unit.

Bus seat data source: Transportation Consolidated Worksheet

Final

Level II SNY: Capacity=176; pop.=171 Moved 5 of 76 (7%) Level II COD: Capacity=88; pop.=81 Moved 0 of 12 (0%)

Level III GP: Capacity=1593; pop.=1359 Moved 17 of 17 (100%) Level IV GP: 180 Capacity=642; pop.=638 270 Capacity=300; pop.=234 Moved 11 of 15 (74%)

WEEKLY EOP POPULATION REPORT
(For the Week of JAN. 3, 2011)

Level III SNY: Capacity=360; pop =377 Moved 7 of 7 (100%)

Level IV SNY: Capacity=396; pop.=399 Moved 4 of 32 (13%)

DIVISION OF CORRECTIONAL HEALTH CARE SERVICES
STATEWIDE MENTAL HEALTH PROGRAM
P.O. Box 942883
Sacramento, CA94283-0001

March 30, 2011

Matthew A. Lopes, Jr. Esquire
Office of the Special Master
Pannone Lopes & Devereaux LLC
317 Iron Horse Point Way, Suite 301
Providence, RI 02908

via: Debbie J. Vorous, Esquire
Gregory Gomez, Esq.
Deputy Attorney General
Department of Justice
1300 "I" Street, Suite 125
P. O. Box 944255
Sacramento, CA 94244-2550

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19. Correctional Treatment Centers and CDCR General Acute Care Hospital Care Placement Issues. **(No longer available)**
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If you have any questions, please contact me at (916) 324-2933.

Sincerely,

JAMES A. SCARAMOZZINO, PH.D.
Director (A)
Statewide Mental Health Program
Division of Correctional Health Care Services

Enclosures

cc: Sharon Aungst, Chief Deputy Secretary, Correctional Health Care Services
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Judy Burleson, Deputy Director, Statewide Mental Health Program, DCHCS
Teresa Owens, Staff Services Analyst, Operational Program Oversight, DCHCS

WEEKLY EOP POPULATION REPORT
(For the Week of FEB. 28, 2011)

Male Institutions	Staffed Capacity	Total Current Pop	Current Vacancies	Percent Filled	Total Seats Requested	Total Seats Provided	Number of Seats Requested for Endorsed Cases, by Sending Location *
SATF SNY II	176	175	1	99%	65	0	7-AVE, 1-CRC, 10-MCSP, 11-CIM, 3-LACRC, 19-NKSP, 11-RJDRC, 3-SQRC
SATF COD II	88	86	2	98%	10	1	***1-NKSP,*** 5-CMC, 1-CMF, 2-CIM, 1-RJD
CMC III	580	508	72	88%	18	15	***1-AVE, 1-FOL, 1-PVSP, 2-SQ, 1-DVIRC, 7-LACRC, 2-NKSP,*** 3-LAC
CMF III	533	504	29	95%	6	4	***2-SOL, 1-NKSP, 1-WSP,*** 2-COR
RJD III	330	292	38	88%	6	6	***4-LACRC, 1-DVIRC, 1-COR***
LAC IV (270)	300	227	73	76%	5	5	***1-COR, 1-MCSP, 1-SAC, 1-RJDRC, 1-SQRC***
COR IV (270)	150	13	137	9%	7	7	***4-SAC, 3-SVSP***
MCSP SNY III	360	340	20	94%	16	10	***1-RJD, 1-SVSP, 2-CCIRC, 2-CIM, 1-RJDRC, 3-WSP,*** 2-CTF, 1-CMC, 1-SAC, 2-PVSP
MCSP SNY IV (270)	150	149	1	99%	5	3	***1-SATF, 1-SQRC, 1-HDSP,*** 1-SAC, 1-CMC
RJD SNY IV (270)	150	145	5	97%	19	2	***1-NKSP, 1-HDSP,*** 3-KVSP, 1-CTF, 2-SAC, 2-LAC, 1-CCIRC, 1-SATF, 3-LACRC, 2-CIM, 2-NKSP
KVSP SNY IV (180)	96	99	-3	103%	26	0	5-COR, 1-CCI, 1-LAC, 1-MCSP, 1-PVSP, 1-RJD, 1-SVSP, 2-SATF, 6-NKSP, 1-DVIRC, 2-RJDRC, 2-SQRC, 2-WSP
PBSP IV (180)	66	58	8	88%	0	0	
SAC IV (180)	384	390	-6	102%	6	6	***1-NKSP, 1-CIM, 2-SQRC, 2-CMC***
SVSP IV (180)	192	186	6	97%	0	0	
TOTALS:	**3555**	**3172**	**383**	**89%**	**189**	**59**	

(per 3-1-11 PSU wait list)

CIW PSU	20	16	4	80%	1	1	***1-VSPW***
PBSP PSU	128	111	17	87%	24	2	***1-CMC, 1-SAC,*** 8-COR, 5-LAC, 2-HDSP, 3-CMC, 1-SVSP, 1-MCSP, 1-WSP, 1-SQ
SAC PSU	256	257	-1	100%	70	3	***1-COR, 1-NKSP, 1-PBSP,*** 1-KVSP, 1-SCC, 1-PVSP, 3-SQ, 2-CMF, 1-CTF, 1-SOL, 2-CCI, 1-SATF, 2-PBSP, 8-WSP, 1-DVI, 4-SAC, 2-CMC, 12-LAC, 4-RJD, 1-NKSP, 8-SVSP, 12-COR

Female Insts.							
CCWF	54	53	1	98%	0	0	
CIW	75	51	24	68%	0	0	
TOTALS:	**129**	**104**	**25**	**81%**	**0**	**0**	

*Inter-institution transfers only. Numbers/locations in bold/italics indicate bus seats assigned for transport this week.

Prep by: Health Care Placement Oversight Program (HC-POP) Operations, 916-327-1250

Note: A small number of EOP beds may be kept vacant for inmates temporarily housed in MHCrisis as part of the 10-day "hold-a-bed" process.
"Total Current Pop" from Population Mgmt. Unit (dated 2-25-11) of the C&PRs' call-ins of the inmates housed in the GP-EOP unit.
Bus seat data source: Transportation Consolidated Worksheet

Final

Level II SNY: Capacity=176; pop.=175 Moved 0 of 65 (0%) Level II COD: Capacity=88; pop.=86 Moved 1 of 10 (10%)
Level III GP: Capacity=1443; pop.=1304 Moved 25 of 30 (84%)
Level III SNY: Capacity=360; pop =340 Moved 10 of 16 (63%)
Level IV GP 180 Capacity=642; pop.=634 Moved 6 of 6 (100%)
Level IV GP 270 Capacity=450; pop.=240 Moved 12 of 12 (100%)
Level IV SNY: Capacity=396; pop.=393 Moved 5 of 50 (100%)

DIVISION OF CORRECTIONAL HEALTH CARE SERVICES
STATEWIDE MENTAL HEALTH PROGRAM
P.O. Box 942883
Sacramento, CA94283-0001

APR 29 2011

Matthew A. Lopes, Jr. Esquire
Office of the Special Master
Pannone Lopes & Devereaux LLC
317 Iron Horse Point Way, Suite 301
Providence, RI 02908

via: Debbie J. Vorous, Esquire
Gregory Gomez, Esq.
Deputy Attorney General
Department of Justice
1300 "I" Street, Suite 125
P. O. Box 944255
Sacramento, CA 94244-2550

RE: COLEMAN MONTHLY REPORT OF INFORMATION REQUESTED AND RESPONSE TO JANUARY 19, 1999, COURT ORDER REGARDING STAFF VACANCIES

Dear Mr. Lopes:

Enclosed is the Coleman Monthly Report reflective of March, 2011, data (or as otherwise noted). The following is the list of enclosures:

1. Mental Health Services Delivery System (MHSDS) Staffing Allocation and Vacancy History.
2. MHSDS Hiring Activity Report.
3. Health Care Placement Oversight Program (HCPOP) Information Report, Summary and Administrative Segregation Greater than 60 Days.
4. Mental Health Contract Services including Summary and Telemedicine Monthly Report for all disciplines.
5. California Department of Corrections and Rehabilitation (CDCR) Reception Center (RC) Monthly Report.
6. Monthly Summary of Mental Health Crisis Bed use by Institution Titles Inpatient Psychiatric Aging Report.
7. Referrals for Transfer to the Department of Mental Health (including admissions).
8. Atascadero State Hospital (ASH) Discharges.
9. Weekly Enhanced Outpatient Program (EOP)/Outpatient Psychiatric Program.
10. The DMH Monthly Report of CDCR Patients in DMH Hospitals--Summary and Penal Code 2684.
11. Suicide Report.
12. Statistics on Contracted Registered Nurse (RN). **(No Longer Available)**
13. RC Processing for MHSDS Inmate Patients. (Please note: Data for California State Prison, San Quentin (SQ) not available, due to MHTS.net conversion).

14. Medical Technical Assistant (MTA) Vacancy Report.
15. Allocated Case Manager Positions and Vacancies for the EOP Administrative Segregated Hub institutions.
16. EOP Inmates Waiting Transfer to a Psychiatric Services Unit (PSU).
17. Audit reports on Psychiatric Technician Rounds in Administrative Segregation at SQ, California State Prison-Corcoran (COR), and Salinas Valley State Prison (SVSP).
18. Mental Health Crisis Beds Wait List.
19. Correctional Treatment Centers and CDCR General Acute Care Hospital Care Placement Issues. **(No longer available)**
20. Transferred and Rescinded Mental Health Crisis Bed Referrals by Institution and Level of Care.

If you have any questions, please contact me at (916) 324-2933.

Sincerely,

JAMES A. SCARAMOZZINO, PH.D.
Director (A)
Statewide Mental Health Program
Division of Correctional Health Care Services

Enclosures

cc: Sharon Aungst, Chief Deputy Secretary, Correctional Health Care Services
Mohamedu F., Jones, Esq., *Coleman* Deputy Special Master
Linda Holden, Esq., *Coleman* Deputy Special Master
Jeffrey L. Metzner, M.D., *Coleman* Expert
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Judy Burleson, Deputy Director, Statewide Mental Health Program, DCHCS
Karen Higgins, M.D., Chief of Behavioral Medicine, Mental Health Program, DCHCS
Teresa Owens, Staff Services Analyst, Operational Program Oversight, DCHCS

WEEKLY EOP POPULATION REPORT
(For the Week of MAR. 14, 2011)

Male Institutions	Staffed Capacity	Total Current Pop	Current Vacancies	Percent Filled	Total Seats Requested	Total Seats Provided	Number of Seats Requested for Endorsed Cases, by Sending Location *
SATF SNY II	176	171	5	97%	70	5	***2-WSP, 3-NKSP,*** 6-AVE, 1-CRC, 11-MCSP, 1-CCIRC, 9-CIM, 3-DVIRC, 6-LACRC, 12-NKSP, 9-RJDRC, 4-SQRC, 3-WSP
SATF COD II	88	84	4	95%	12	3	***1-COR, 1-RJD, 1-DVIRC,*** 2-CMF, 7-CMC
CMC III	580	525	55	91%	16	15	***1-AVE, 1-COR, 5-LAC, 2-SOL, 2-DVIRC, 3-LACRC, 1-WSP,*** 1-SVSP
CMF III	533	505	28	95%	10	9	***1-CCC, 1-FOL, 1-LAC, 1-SAC, 2-SQ, 1-HDSPRC, 2-SQRC,*** 1-COR
RJD III	330	305	25	92%	10	10	***1-CMC, 2-COR, 1-CVSP, 1-FOL, 1-SAC, 1-SCC, 1-SOL, 2-WSP***
LAC IV (270)	300	227	73	76%	3	3	***1-DVIRC, 2-WSP***
COR IV (270)	150	46	104	31%	11	11	***7-SAC, 3-SVSP, 1-NKSP***
MCSP SNY III	360	355	5	99%	16	3	***3-CTF,*** 1-RJD, 1-SAC, 3-SATF, 3-LACRC, 1-NKSP, 1-RJDRC, 3-WSP
MCSP SNY IV (270)	150	141	9	94%	9	4	***1-CMC, 1-COR, 2-SAC,*** 1-CMC, 1-KVSP, 1-DVIRC, 1-NKSP, 1-SQRC
RJD SNY IV (270)	150	152	-2	101%	21	0	1-CTF, 1-HDSP, 3-KVSP, 2-LAC, 3-SAC, 1-SATF, 3-SVSP, 1-CCIRC, 2-CIM, 3-LACRC, 1-NKSP
KVSP SNY IV (180)	96	98	-2	102%	29	0	5-NKSP, 3-RJDRC, 1-SQRC, 1-WSP, 5-COR, 1-LAC, 2-MCSP, 1-PVSP, 2-RJD, 1-SAC, 3-SATF, 1-SVSP, 2-CIM, 1-DVIRC
PBSP IV (180)	66	56	10	85%	3	3	***1-CMF, 1-NKSP, 1-WSP***
SAC IV (180)	384	391	-7	102%	4	4	***1-CMC, 1-COR, 1-KVSP, 1-RJDRC***
SVSP IV (180)	192	192	0	100%	2	2	***1-SAC, 1-CTF***
TOTALS:	**3555**	**3248**	**307**	**91%**	**216**	**72**	

(per 3-14-11 PSU wait list)

CIW PSU	20	17	3	85%	1	1	***1-VSPW***
PBSP PSU	128	112	16	88%	26	4	***1-SATF, 1-COR, 2-CMC,*** 6-LAC, 2-HDSP, 6-COR, 4-SVSP, 1-CMC, 1-MCSP, 1-WSP, 1-SQ
SAC PSU	256	244	12	95%	56	0	2-WSP, 1-PVSP, 1-SCC, 1-SAC, 1-KVSP, 1-SOL, 1-CCI, 2-SQ, 1-CMF, 1-PBSP, 1-DVI, 2-CMC, 12-LAC, 1-NKSP, 7-SVSP, 12-COR, 9-RJD

Female Insts.							
CCWF	54	48	6	89%	1	1	***1-VSPW***
CIW	75	49	26	65%	0	0	
TOTALS:	**129**	**97**	**32**	**75%**	**1**	**1**	

*Inter-institution transfers only. Numbers/locations in bold/italics indicate bus seats assigned for transport this week.

Prep by: Health Care Placement Oversight Program, Data PASS, 916-327-1250

Note: A small number of EOP beds may be kept vacant for inmates temporarily housed in MHCrisis as part of the 10-day "hold-a-bed" process.
"Total Current Pop" from Population Mgmt. Unit (dated 3-11-11) of the C&PRs' call-ins of the inmates housed in the GP-EOP unit.
Bus seat data source: Transportation Consolidated Worksheet

Final

Level II SNY: Capacity=176; pop.=171 Moved 5 of 70 (8%) Level II COD: Capacity=88; pop.=84 Moved 3 of 12 (25%)
Level III GP: Capacity=1443; pop.=1335 Moved 34 of 36 (95%) Level IV GP 180 Capacity=642; pop.=639 Moved 9 of 9 (100%)

WEEKLY EOP POPULATION REPORT
(For the Week of MAR. 14, 2011)

Level III SNY: Capacity=360; pop =355 Moved 3 of 16 (19%)

Level IV GP 270 Capacity=450; pop.=273 Moved 14 of 14 (100%)
Level IV SNY: Capacity=396; pop.=391 Moved 4 of 59 (7%)

DIVISION OF CORRECTIONAL HEALTH CARE SERVICES
STATEWIDE MENTAL HEALTH PROGRAM
P.O. Box 942883
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June 1, 2011

Matthew A. Lopes, Jr. Esquire
Office of the Special Master
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317 Iron Horse Point Way, Suite 301
Providence, RI 02908

via: Debbie J. Vorous, Esquire
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Deputy Attorney General
Department of Justice
1300 "I" Street, Suite 125
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Sacramento, CA 94244-2550

RE: COLEMAN MONTHLY REPORT OF INFORMATION REQUESTED AND RESPONSE TO JANUARY 19, 1999, COURT ORDER REGARDING STAFF VACANCIES

Dear Mr. Lopes:

Enclosed is the Coleman Monthly Report reflective of April, 2011, data (or as otherwise noted). The following is the list of enclosures:

1. Mental Health Services Delivery System (MHSDS) Staffing Allocation and Vacancy History.
2. MHSDS Hiring Activity Report.
3. Health Care Placement Oversight Program (HCPOP) Information Report, Summary and Administrative Segregation Greater than 60 Days.
4. Mental Health Contract Services including Summary and Telemedicine Monthly Report for all disciplines.
5. California Department of Corrections and Rehabilitation (CDCR) Reception Center (RC) Monthly Report.
6. Monthly Summary of Mental Health Crisis Bed use by Institution Titles Inpatient Psychiatric Aging Report. (Please note: report is not available, due to MHTS.net conversion).
7. Referrals for Transfer to the Department of Mental Health (including admissions).
8. Atascadero State Hospital (ASH) Discharges.
9. Weekly Enhanced Outpatient Program (EOP)/Outpatient Psychiatric Program.
10. The DMH Monthly Report of CDCR Patients in DMH Hospitals--Summary and Penal Code 2684.
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13. RC Processing for MHSDS Inmate Patients. (Please note: Data for California State Prison, San Quentin (SQ) not available, due to MHTS.net conversion).

14. Medical Technical Assistant (MTA) Vacancy Report.
15. Allocated Case Manager Positions and Vacancies for the EOP Administrative Segregated Hub institutions.
16. EOP Inmates Waiting Transfer to a Psychiatric Services Unit (PSU).
17. Audit reports on Psychiatric Technician Rounds in Administrative Segregation at SQ, California State Prison-Corcoran (COR), and Salinas Valley State Prison (SVSP).
18. Mental Health Crisis Beds Wait List.
19. Correctional Treatment Centers and CDCR General Acute Care Hospital Care Placement Issues. **(No longer available)**
20. Transferred and Rescinded Mental Health Crisis Bed Referrals by Institution and Level of Care.

If you have any questions, please contact me at (916) 324-2933.

Sincerely,

JAMES A. SCARAMOZZINO, PH.D.
Director (A)
Statewide Mental Health Program
Division of Correctional Health Care Services

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Karen Higgins, M.D., Chief of Behavioral Medicine, Mental Health Program, Division of Correctional Health Care Services
Teresa Owens, Staff Services Analyst, Operational Program Oversight, Division of Correctional Health Care Services

WEEKLY EOP POPULATION REPORT
(For the Week of APR. 4, 2011)

Male Institutions	Staffed Capacity	Total Current Pop	Current Vacancies	Percent Filled	Total Seats Requested	Total Seats Provided	Number of Seats Requested for Endorsed Cases, by Sending Location *
SATF SNY II	176	167	9	95%	89	8	***1-CRC, 1-CCIRC, 3-DVIRC, 3-RJDRC,*** 9-AVE, 1-CCI, 1-LAC, 8-MCSP, 17-CIM, 6-LACRC, 19-NKSP, 10-RJDRC, 4-SQRC, 6-WSP
SATF COD II	88	91	-3	103%	19	1	***1-NKSP,*** 7-CMC, 2-CMF, 1-CRC, 1-RJD, 2-CIM, 1-DVIRC, 1-RJDRC, 3-SQRC
CMC III	580	540	40	93%	17	15	***2-COR, 2-CTF, 3-KVSP, 1-RJD, 2-SATF, 1-SCC, 2-CCIRC, 1-NKSP, 1-SQRC,*** 1-CMF, 1-FOL
CMF III	533	504	29	95%	6	5	***1-COR, 1-RJD, 1-SAC, 1-SVSP, 1-HDSPRC,*** 1-COR
RJD III	330	317	13	96%	19	14	***1-AVE, 1-SAC, 2-SOL, 4-CIM, 5-NKSP, 1-SQRC,*** 3-COR, 1-CMF, 1-CMC
LAC IV (270)	300	254	46	85%	3	3	***1-PBSP, 1-SAC, 1-CCIRC***
COR IV (270)	150	77	73	51%	5	5	***1-HDSP, 3-SAC, 1-NKSP***
MCSP SNY III	360	350	10	97%	28	5	***1-RJD, 2-NKSP, 2-WSP,*** 1-CTF, 3-RJD, 2-SAC, 1-SATF, 3-CCIRC, 6-CIM, 2-DVIRC, 2-LACRC, 2-RJDRC, 1-SQRC
MCSP SNY IV (270)	150	156	-6	104%	14	1	***1-LAC,*** 1-CMC, 2-COR, 1-HDSP, 1-RJD, 2-SAC, 1-SVSP, 1-DVIRC, 1-NKSP, 1-SQRC, 2-WSP
RJD SNY IV (270)	150	149	1	99%	28	1	***1-PVSP,*** 2-CMC, 1-COR, 1-CTF, 1-HDSP, 4-KVSP, 3-LAC, 1-MCSP, 1-PBSP, 3-SAC, 2-SATF, 3-SVSP, 1-CCIRC, 1-CIM, 2-LACRC, 1-NKSP
KVSP SNY IV (180)	96	93	3	97%	35	0	1-CMF, 11-COR, 1-FOL, 1-HDSP, 1-LAC, 3-MCSP, 1-PBSP, 4-RJD, 2-SATF, 1-SVSP, 1-CIM, 6-NKSP, 1-RJDRC, 1-SQRC
PBSP IV (180)	66	56	10	85%	1	1	***1-SAC***
SAC IV (180)	384	382	2	99%	4	1	***1-NKSP,*** 1-CMC, 1-CMF, 1-SVSP
SVSP IV (180)	192	184	8	96%	3	3	***3-CMF***
TOTALS:	**3555**	**3320**	**235**	**93%**	**271**	**63**	

(per 4-4-11 PSU wait list)

CIW PSU	20	17	3	85%	0	0	
PBSP PSU	128	123	5	96%	14	1	***1-CMF,*** 1-KVSP, 2-SVSP, 1-WSP, 4-COR, 3-CMC, 2-LAC
SAC PSU	256	254	2	99%	74	2	***2-LAC,*** 11-COR, 10-RJD, 10-LAC, 5-CMC, 1-MCSP, 3-DVI, 1-SCC, 5-SVSP, 1-PBSP, 2-CMF, 8-SAC, 2-KVSP, 2-CCI, 3-WSP, 2-SQ, 1-PVSP, 5-NKSP

Female Insts.							
CCWF	54	47	7	87%	0	0	
CIW	75	53	22	71%	0	0	
TOTALS:	**129**	**100**	**29**	**78%**	**0**	**0**	

*Inter-institution transfers only. Numbers/locations in bold/italics indicate bus seats assigned for transport this week.

Prep by: Health Care Placement Oversight Program - Operations, 916-327-1250

Note: A small number of EOP beds may be kept vacant for inmates temporarily housed in MHCrisis as part of the 10-day "hold-a-bed" process.

"Total Current Pop" from Population Mgmt. Unit (dated 4-1-11) of the C&PRs' call-ins of the inmates housed in the GP-EOP unit.

Bus seat data source: Transportation Consolidated Worksheet

Final

Level II SNY: Capacity=176; pop.=167 Moved 8 of 89 (9%) Level II COD: Capacity=88; pop.=91 Moved 1 of 19 (6%)

Level III GP: Capacity=1443; pop.=1361 Moved 34 of 42 (81%) Level IV GP 180 Capacity=642; pop.=622 Moved 5 of 8 (63%)

WEEKLY EOP POPULATION REPORT
(For the Week of APR. 4, 2011)

Level III SNY: Capacity=360; pop =350 Moved 5 of 28 (18%)

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Level IV SNY: Capacity=396; pop.=398 Moved 2 of 77 (3%)

DIVISION OF CORRECTIONAL HEALTH CARE SERVICES
STATEWIDE MENTAL HEALTH PROGRAM
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July 1, 2011

Matthew A. Lopes, Jr. Esquire
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via: Debbie J. Vorous, Esquire
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RE: COLEMAN MONTHLY REPORT OF INFORMATION REQUESTED AND RESPONSE TO JANUARY 19, 1999, COURT ORDER REGARDING STAFF VACANCIES

Dear Mr. Lopes:

Enclosed is the Coleman Monthly Report reflective of May, 2011, data (or as otherwise noted). The following is the list of enclosures:

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2. MHSDS Hiring Activity Report.
3. Health Care Placement Oversight Program (HCPOP) Information Report, Summary and Administrative Segregation Greater than 60 Days.
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If you have any questions, please contact me at (916) 324-2933.

Sincerely,

JAMES A. SCARAMOZZINO, PH.D.
Deputy Director (A)
Statewide Mental Health Program
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Enclosures

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Teresa Owens, Staff Services Analyst, Operational Program Oversight, Division of Correctional Health Care Services

WEEKLY EOP POPULATION REPORT
(For the Week of MAY 9, 2011)

Male Institutions	Staffed Capacity	Total Current Pop	Current Vacancies	Percent Filled	Total Seats Requested	Total Seats Provided	Number of Seats Requested for Endorsed Cases, by Sending Location *
SATF SNY II	176	173	3	98%	62	3	***3-MCSP,*** 10-AVE, 2-CCI, 1-LAC, 6-MCSP, 14-CIM, 1-DVIRC, 3-LACRC, 11-NKSP, 3-RJDRC, 3-SQRC, 5-WSP
SATF COD II	88	86	2	98%	7	5	***1-CMC, 1-CRC, 2-CIM, 1-DVIRC,*** 2-CMC
CMC III	580	535	45	92%	13	13	***1-CAL, 2-COR, 1-SAC, 1-SATF, 2-DVIRC, 1-LACRC, 1-NKSP, 3-RJDRC, 1-SQRC***
CMF III	533	501	32	94%	10	6	***3-CMC, 1-SATF, 1-SVSP, 1-DVIRC,*** 4-COR
RJD III	330	333	-3	101%	12	0	1-AVE, 2-CMC, 7-COR, 1-LAC, 1-CIM
LAC IV (270)	300	210	90	70%	5	5	***1-CCI, 1-MCSP, 2-SAC, 1-DVIRC***
COR IV (270)	150	90	60	60%	1	1	***1-SAC***
MCSP SNY III	360	369	-9	103%	42	8	***1-CMC, 1-CTF, 1-FOL, 1-SAC, 3-SATF, 1-SOL,*** 2-AVE, 3-CMC, 1-COR, 1-CTF, 3-PVSP, 3-RJD, 3-SAC, 4-SCC, 6-CIM, 1-DVIRC, 1-LACRC, 5-NKSP, 1-RJDRC
MCSP SNY IV (270)	150	154	-4	103%	26	5	***2-KVSP, 1-LAC, 2-RJD,*** 3-COR, 1-HDSP, 2-ISP, 3-SAC, 2-SATF, 1-SCC, 4-SVSP, 1-CIM, 2-RJDRC, 2-WSP
RJD SNY IV (270)	150	152	-2	101%	32	4	***1-KVSP, 2-MCSP, 1-NKSP,*** 2-CMC, 1-COR, 1-CTF, 1-WSP, 1-HDSP, 3-KVSP, 2-LAC, 2-MCSP, 1-PBSP, 4-SAC, 2-SATF, 2-SVSP, 3-LACRC, 3-NKSP
KVSP SNY IV (180)	96	93	3	97%	39	7	***1-COR, 2-MCSP, 1-RJD, 2-SATF, 1-SQRC,*** 1-CMC, 7-COR, 2-HDSP, 2-LAC, 1-MCSP, 1-SATF, 3-SVSP, 2-DVIRC, 5-NKSP, 2-RJDRC, 6-WSP
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SAC IV (180)	384	388	-4	101%	1	1	***1-CMC***
SVSP IV (180)	192	188	4	98%	2	2	***1-PBSP, 1-LAC***
TOTALS:	**3555**	**3331**	**224**	**94%**	**254**	**62**	

(per 5-9-11 PSU wait list)

CIW PSU	20	18	2	90%	0	0	
PBSP PSU	128	113	15	88%	20	6	***1-PVSP, 1-KVSP, 1-SVSP, 1-COR, 2-CMC,*** 2-LAC, 5-COR, 1-SVSP, 2-CMC, 2-MCSP, 1-CCI, 1-CMF
SAC PSU	256	243	13	95%	54	3	***1-NKSP, 1-SVSP, 1-COR,*** 4-COR, 3-CMC, 8-LAC, 7-WSP, 6-NKSP, 1-CIM, 2-CMF, 3-CCI, 5-RJD, 1-SCC, 3-DVI, 1-KVSP, 2-SAC, 3-SVSP, 1-SQ, 1-MCSP

Female Insts.							
CCWF	54	34	20	63%	0	0	
CIW	75	57	18	76%	0	0	
TOTALS:	**129**	**91**	**38**	**71%**	**0**	**0**	

*Inter-institution transfers only. Numbers/locations in bold/italics indicate bus seats assigned for transport this week.

Prep by: Health Care Placement Oversight Program - Operations, 916-327-1250

Note: A small number of EOP beds may be kept vacant for inmates temporarily housed in MHCrisis as part of the 10-day "hold-a-bed" process.

"Total Current Pop" from Population Mgmt. Unit (dated 5-6-11) of the C&PRs' call-ins of the inmates housed in the GP-EOP unit.

Bus seat data source: Transportation Consolidated Worksheet

Final

Level II SNY: Capacity=176; pop.=173 Moved 3 of 62 (5%) Level II COD: Capacity=88; pop.=86 Moved 5 of 7 (72%)

Level III GP: Capacity=1443; pop.=1369 Moved 19 of 35 (55%) Level IV GP 180 Capacity=642; pop.=635 Moved 5 of 5 (100%)

WEEKLY EOP POPULATION REPORT
(For the Week of MAY 9, 2011)

Level III SNY Capacity=360, pop=369 Moved 8 of 42 (19%)

Level IV GP 270 Capacity=450, pop=390 Moved 6 of 6 (100%)
Level IV SNY Capacity=396, pop.=336 Moved 16 of 97 (17%)

DIVISION OF CORRECTIONAL HEALTH CARE SERVICES
STATEWIDE MENTAL HEALTH PROGRAM
P.O. Box 942883
Sacramento, CA94283-0001

AUG 1 2011

Matthew A. Lopes, Jr. Esquire
Office of the Special Master
Pannone Lopes & Devereaux LLC
317 Iron Horse Point Way, Suite 301
Providence, RI 02908

via: Debbie J. Vorous, Esquire
Gregory Gomez, Esq.
Deputy Attorney General
Department of Justice
1300 "I" Street, Suite 125
P. O. Box 944255
Sacramento, CA 94244-2550

RE: COLEMAN MONTHLY REPORT OF INFORMATION REQUESTED AND RESPONSE TO JANUARY 19, 1999, COURT ORDER REGARDING STAFF VACANCIES

Dear Mr. Lopes:

Enclosed is the Coleman Monthly Report reflective of June, 2011, data (or as otherwise noted). The following is the list of enclosures:

1. Mental Health Services Delivery System (MHSDS) Staffing Allocation and Vacancy History.
2. MHSDS Hiring Activity Report.
3. Health Care Placement Oversight Program (HCPOP) Information Report, Summary and Administrative Segregation Greater than 60 Days.
4. Mental Health Contract Services including Summary and Telemedicine Monthly Report for all disciplines.
5. California Department of Corrections and Rehabilitation (CDCR) Reception Center (RC) Monthly Report.
6. Monthly Summary of Mental Health Crisis Bed use by Institution Titles Inpatient Psychiatric Aging Report.
7. Referrals for Transfer to the Department of Mental Health (including admissions).
8. Atascadero State Hospital (ASH) Discharges.
9. Weekly Enhanced Outpatient Program (EOP)/Outpatient Psychiatric Program.
10. The DMH Monthly Report of CDCR Patients in DMH Hospitals--Summary and Penal Code 2684.
11. Suicide Report.
12. Statistics on Contracted Registered Nurse (RN). **(No Longer Available)**
13. RC Processing for MHSDS Inmate Patients.
14. Medical Technical Assistant (MTA) Vacancy Report.

15. Allocated Case Manager Positions and Vacancies for the EOP Administrative Segregated Hub institutions.
16. EOP Inmates Waiting Transfer to a Psychiatric Services Unit (PSU).
17. Audit reports on Psychiatric Technician Rounds in Administrative Segregation at SQ, California State Prison-Corcoran (COR), and Salinas Valley State Prison (SVSP).
18. Mental Health Crisis Beds Wait List.
19. Correctional Treatment Centers and CDCR General Acute Care Hospital Care Placement Issues. **(No longer available)**
20. Transferred and Rescinded Mental Health Crisis Bed Referrals by Institution and Level of Care.

If you have any questions, please contact me at (916) 324-2933.

Sincerely,

JAMES A. SCARAMOZZINO, PH.D.
Deputy Director (A)
Statewide Mental Health Program
Division of Correctional Health Care Services

Enclosures

cc: Sharon Aungst, Director, Correctional Health Care Services
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Karen Higgins, M.D., Chief of Behavioral Medicine, Division of Correctional Health Care Services
Teresa Owens, Staff Services Analyst, *Coleman* Compliance, Division of Correctional Health Care Services

WEEKLY EOP POPULATION REPORT
(For the Week of JUNE 13, 2011)

Male Institutions	Staffed Capacity	Total Current Pop	Current Vacancies	Percent Filled	Total Seats Requested	Total Seats Provided	Number of Seats Requested for Endorsed Cases, by Sending Location *
SATF SNY II	176	170	6	97%	49	1	***1-MCSP,*** 3-MCSP, 7-AVE, 2-CCI, 1-COR, 1-CCIRC, 15-CIM, 13-NKSP, 3-SQRC, 3-WSP
SATF COD II	88	88	0	100%	5	0	1-COR, 1-RJD, 2-RJDRC, 1-SQRC
CMC III	580	533	47	92%	6	6	***1-COR, 1-CTF, 1-DVRC, 1-FOL, 1-SOL, 1-SQRC***
CMF III	533	502	31	94%	5	5	***1-LACRC, 2-PVSP, 1-AVE, 1-CMC***
RJD III	330	332	-2	101%	8	4	***1-AVE, 2-PBSP, 1-NKSP,*** 3-COR, 1-LAC
LAC IV (270)	300	222	78	74%	2	2	***1-COR, 1-MCSP***
COR IV (270)	150	109	41	73%	1	1	***1-SQRC***
MCSP SNY III	360	350	10	97%	44	6	***1-NKSP, 3-DVIRC, 1-HDSPRC, 1-SATF,*** 5-AVE, 2-COR, 3-CTF, 1-LAC, 2-PVSP, 4-RJD, 2-SAC, 4-CIM, 9-NKSP, 1-RJDRC, 1-SQRC, 4-WSP
MCSP SNY IV (270)	150	165	-15	110%	38	3	***1-SVSP, 1-RJD, 1-KVSP,*** 3-CMC, 4-COR, 1-CTF, 1-RJDRC, 2-SQRC, 4-WSP 1-HDSP, 5-SAC, 3-SATF, 6-SVSP, 1-CCIRC, 1-DVIRC, 1-HDSPRC, 1-LACRC, 1-NKSP
RJD SNY IV (270)	150	147	3	98%	25	5	***4-LACRC, 1-MCSP,*** 2-CMC, 1-COR, 1-HDSP, 1-KVSP, 2-MCSP, 1-PBSP, 5-SAC, 1-SATF, 1-CCIRC, 1-CIM, 2-NKSP, 1-SQRC, 1-WSP
KVSP SNY IV (180)	96	87	9	91%	34	6	***4-COR, 2-MCSP,*** 1-CMF, 8-COR, 2-HDSP, 2-LAC, 1-CCIRC, 1-CIM, 1-DVIRC, 6-NKSP, 1-RJDRC, 5-WSP
PBSP IV (180)	66	63	3	95%	1	1	***1-SVSP***
SAC IV (180)	384	397	-13	103%	5	0	2-PBSP, 1-LAC, 1-CMF, 1-CCI
SVSP IV (180)	192	191	1	99%	1	1	***1-MCSP***
TOTALS:	**3555**	**3356**	**199**	**94%**	**224**	**41**	

(per 6-13-11 PSU wait list)

CIW PSU	20	20	0	100%	1	0	1-VSPW
PBSP PSU	128	117	11	91%	20	3	***1-LAC, 1-SVSP, 1-CMF,*** 13-COR, 2-MCSP, 1-CMF, 1-RJD
SAC PSU	256	239	17	93%	57	0	6-COR, 5-CMC, 5-LAC, 6-WSP, 3-NKSP, 9-RJD, 2-DVI, 1-KVSP, 4-SVSP, 3-MCSP, 3-CMF, 2-CIM, 3-CCI, 2-SQ, 3-SAC

Female Insts. CCWF	54	40	14	74%	0	0	
CIW	75	58	17	77%	0	0	
TOTALS:	**129**	**98**	**31**	**76%**	**0**	**0**	

*Inter-institution transfers only. Numbers/locations in bold/italics indicate bus seats assigned for transport this week.

Prep by: Health Care Placement Oversight Program - Operations, 916-327-1250

Note: A small number of EOP beds may be kept vacant for inmates temporarily housed in MHCrisis as part of the 10-day "hold-a-bed" process.

"Total Current Pop" from Population Mgmt. Unit (dated 6-10-11) of the C&PRs' call-ins of the inmates housed in the GP-EOP unit.

Bus seat data source: Transportation Consolidated Worksheet

Final

Level II SNY: Capacity=176; pop.=170 Moved 1 of 49 (2%) Level II COD: Capacity=88; pop.=88 Moved 0 of 5 (0%)

Level III GP: Capacity=1443; pop.=1367 Moved 15 of 19 (79%) Level IV GP 180 Capacity=642; pop.=651 Moved 2 of 7 (29%)

WEEKLY EOP POPULATION REPORT
(For the Week of JUNE 13, 2011)

Level III SNY Capacity=360 pop.=350 Moved 6 of 44 (14%)

Level IV GP 270 Capacity=450, pop.=331 Moved 3 of 3 (100%)
Level IV SNY Capacity=396, pop.=398 Moved 14 of 87 (15%)

DIVISION OF CORRECTIONAL HEALTH CARE SERVICES
STATEWIDE MENTAL HEALTH PROGRAM
P.O. Box 942883
Sacramento, CA94283-0001

September 1, 2011

Matthew A. Lopes, Jr. Esquire
Office of the Special Master
Pannone Lopes & Devereaux LLC
317 Iron Horse Point Way, Suite 301
Providence, RI 02908

via: Debbie J. Vorous, Esquire
Deputy Attorney General
Department of Justice
1300 "I" Street, Suite 125
P. O. Box 944255
Sacramento, CA 94244-2550

RE: COLEMAN MONTHLY REPORT OF INFORMATION REQUESTED AND RESPONSE TO JANUARY 19, 1999, COURT ORDER REGARDING STAFF VACANCIES

Dear Mr. Lopes:

Enclosed is the Coleman Monthly Report reflective of July, 2011, data (or as otherwise noted). The following is the list of enclosures:

1. Mental Health Services Delivery System (MHSDS) Staffing Allocation and Vacancy History.
2. MHSDS Hiring Activity Report.
3. Health Care Placement Oversight Program (HCPOP) Information Report, Summary and Administrative Segregation Greater than 60 Days.
4. Mental Health Contract Services including Summary and Telemedicine Monthly Report for all disciplines.
5. California Department of Corrections and Rehabilitation (CDCR) Reception Center (RC) Monthly Report.
6. Monthly Summary of Mental Health Crisis Bed use by Institution Titles Inpatient Psychiatric Aging Report.
7. Referrals for Transfer to the Department of Mental Health (including admissions).
8. Atascadero State Hospital (ASH) Discharges.
9. Weekly Enhanced Outpatient Program (EOP)/Outpatient Psychiatric Program.
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11. Suicide Report.
12. Statistics on Contracted Registered Nurse (RN). **(No Longer Available)**
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16. EOP Inmates Waiting Transfer to a Psychiatric Services Unit (PSU).
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18. Mental Health Crisis Beds Wait List.
19. Correctional Treatment Centers and CDCR General Acute Care Hospital Care Placement Issues. **(No longer available)**
20. Transferred and Rescinded Mental Health Crisis Bed Referrals by Institution and Level of Care.

If you have any questions, please contact me at (916) 324-2933.

Sincerely,

JAMES A. SCARAMOZZINO, PH.D.
Deputy Director (A)
Statewide Mental Health Program
Division of Correctional Health Care Services

Enclosures

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Teresa Owens, Staff Services Analyst, Operational Program Oversight, Division of Correctional Health Care Services

WEEKLY EOP POPULATION REPORT
(For the Week of JULY 18, 2011)

Male Institutions	Staffed Capacity	Total Current Pop	Current Vacancies	Percent Filled	Total Seats Requested	Total Seats Provided	Number of Seats Requested for Endorsed Cases, by Sending Location *
SATF SNY II	176	163	13	93%	53	9	***2-CCIRC, 1-CIM, 1-DVIRC, 2-NKSP, 1-RJDRC, 2-WSP,*** 9-AVE, 4-CCI, 1-CMC, 1-CMF, 1-COR, 4-MCSP, 2-SCC, 5-CIM, 8-NKSP, 2-SQRC, 7-WSP
SATF COD II	88	76	12	86%	3	3	***1-LAC, 1-SCC, 1-RJDRC***
CMC III	580	541	39	93%	13	13	***1-CMF, 1-CVSP, 1-FOL, 2-LAC, 1-CCIRC, 1-CIM, 2-LACRC, 3-RJDRC, 1-WSP***
CMF III	533	500	33	94%	8	8	***3-CMC, 3-RJDRC, 1-SQRC, 1-WSP***
RJD III	330	317	13	96%	2	2	***1-CMF, 1-SQRC***
LAC IV (270)	300	235	65	78%	2	2	***1-NKSP, 1-CVSP***
COR IV (270)	150	91	59	61%	1	1	***1-SAC***
MCSP SNY III	360	358	2	99%	53	1	***1-ISP,*** 1-CCI, 2-CMF, 1-COR, 5-CTF, 1-LAC, 3-PVSP, 1-RJD, 2-SAC, 4-SATF, 1-SCC, 5-CIM, 2-DVIRC, 3-LACRC, 7-NKSP, 2-RJDRC, 6-SQRC, 6WSP
MCSP SNY IV (270)	150	147	3	98%	38	5	***3-ISP, 1-KVSP, 1-RJD,*** 2-CMC, 5-COR, 1-CTF, 1-HDSP, 1-KVSP, 6-SAC, 2-SATF, 1-SCC, 5-SVSP, 1-DVIRC, 1-HDSPRC, 1-LACRC, 2-SQRC, 4-WSP
RJD SNY IV (270)	150	156	-6	104%	37	6	***1-HDSP, 1-KVSP, 1-MCSP, 2-DVIRC, 1-LACRC,*** 1-CCI, 3-COR, 1-KVSP, 3-MCSP, 1-PBSP, 2-PVSP, 5-SAC, 5-SATF, 1-SCC, 2-CCIRC, 1-CIM, 2-NKSP, 4-WSP
KVSP SNY IV (180)	96	90	6	94%	26	6	***1-MCSP, 3-HDSP, 1-SATF, 1-CCIRC,*** 1-CMF, 9-COR, 1-SATF, 4-NKSP, 5-WSP
PBSP IV (180)	66	61	5	92%	0	0	
SAC IV (180)	384	398	-14	104%	5	1	***1-SVSP,*** 1-CCI, 1-CMC, 2-LAC
SVSP IV (180)	192	190	2	99%	6	4	***1-COR, 1-HDSP, 1-SAC, 1-WSP,*** 1-CMC, 1-NKSP
TOTALS:	**3555**	**3323**	**232**	**93%**	**247**	**61**	

(per 7-15-11 PSU wait list)

CIW PSU	20	19	1	95%	1	0	1-CIW
PBSP PSU	128	115	13	90%	31	1	***1-LAC,*** 2-LAC, 5-CMC, 13-COR, 3-NKSP, 1-DVI, 1-KVSP, 2-CCI, 1-SVSP, 1-WSP, 1-SATF
SAC PSU	256	250	6	98%	41	3	***1-WSP, 1-NKSP, 1-CMC,*** 5-COR, 3-SVSP, 5-CMF, 3-LAC, 3-WSP, 3-CCI, 6-RJD, 2-CMC, 2-SQ, 3-NKSP, 2-CMC, 1-CIM

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*Inter-institution transfers only. Numbers/locations in bold/italics indicate bus seats assigned for transport this week.

Prep by: Health Care Placement Oversight Program - Operations, 916-327-1250

Note: A small number of EOP beds may be kept vacant for inmates temporarily housed in MHCrisis as part of the 10-day "hold-a-bed" process.

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Level II SNY: Capacity=176; pop.=163 Moved 9 of 53 (17%) Level II COD: Capacity=88; pop.=76 Moved 3 of 3 (100%)

Level III GP: Capacity=1443; pop.=1358 Moved 23 of 23 (100%) Level IV GP 180 Capacity=642; pop.=649 Moved 5 of 11 (46%)

WEEKLY EOP POPULATION REPORT
(For the Week of JULY 18, 2011)

Level III SNY: Capacity=360; pop =358 Moved 1 of 53 (2%)

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Level IV SNY: Capacity=396; pop.=393 Moved 17 of 101 (17%)

DIVISION OF CORRECTIONAL HEALTH CARE SERVICES
STATEWIDE MENTAL HEALTH PROGRAM
P.O. Box 942883
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October 3, 2011

Matthew A. Lopes, Jr. Esquire
Office of the Special Master
Pannone Lopes & Devereaux LLC
317 Iron Horse Point Way, Suite 301
Providence, RI 02908

via: Debbie J. Vorous, Esquire
Deputy Attorney General
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If you have any questions, please contact me at (916) 324-2933.

Sincerely,

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WEEKLY EOP POPULATION REPORT
(For the Week of AUG. 29, 2011)

Male Institutions	Staffed Capacity	Total Current Pop	Current Vacancies	Percent Filled	Total Seats Requested	Total Seats Provided	Number of Seats Requested for Endorsed Cases, by Sending Location *
SATF SNY II	176	165	11	94%	53	7	***1-COR, 1-CVSP, 1-DVIRC, 2-NKSP, 2-RJDRC,*** 15-WSP, 1-SQRC, 11-AVE, 5-CCI, 2-SCC, 12-CIM
SATF COD II	88	76	12	86%	1	1	***1-RJD-RC***
CMC III	580	550	30	95%	8	8	***1-CMF, 1-CTF, 1-ISP, 1-PBSP, 1-LACRC, 1-NKSP, 1-SQRC, 1-WSP***
CMF III	533	505	28	95%	6	6	***2-CMC, 4-SQRC***
RJD III	330	311	19	94%	3	3	***1-MCSP, 1-SOL, 1-CIM***
LAC IV (270)	300	245	55	82%	0	0	
COR IV (270)	150	82	68	55%	0	0	
MCSP SNY III	360	357	3	99%	61	11	***2-CMF, 1-RJD, 4-SCC, 1-CCIRC, 1-LACRC, 2-NKSP,*** 7-WSP, 4-SQRC, 2-RJDRC, 1-CRC, 1-COR, 6-CTF, 1-LAC, 4-PVSP, 3-RJD, 4-SATF, 9-CIM, 8-NKSP
MCSP SNY IV (270)	150	150	0	100%	21	3	***1-CTF, 1-KVSP, 1-SVSP,*** 1-CMC, 1-COR, 3-SAC, 2-SATF, 1-SCC, 4-SVSP, 1-DVI, 2-SQRC, 3-WSP
RJD SNY IV (270)	150	155	-5	103%	57	1	***1-ISP,*** 1-CCI, 2-CMC, 1-COR, 3-HDSP, 1-LAC, 5-MCSP, 3-PVSP, 9-SAC, 7-SATF, 1-SCC, 8-SVSP, 1-CCIRC, 2-CIM, 2-LACRC, 6-NKSP, 1-SQRC, 3-WSP
KVSP SNY IV (180)	96	89	7	93%	14	6	***4-COR, 1-ISP, 1-MCSP,*** 2-COR, 1-HDSP, 2-SATF, 1-SCC, 1-RJDRC, 1-WSP
PBSP IV (180)	66	62	4	94%	3	1	***1-LAC,*** 2-LAC
SAC IV (180)	384	394	-10	103%	7	1	***1-SVSP,*** 1-CCI, 2-CMC, 1-COR, 2-LAC
SVSP IV (180)	192	188	4	98%	2	2	***1-NKSP, 1-SAC***
TOTALS:	**3555**	**3329**	**226**	**94%**	**236**	**50**	

(per 8-26-11 PSU wait list)

CIW PSU	20	19	1	95%	6	0	4-VSPW, 2-CIW
PBSP PSU	128	116	12	91%	25	4	***1-SVSP, 2-CMC, 1-LAC,*** 1-KVSP, 4-LAC, 5-COR, 2-WSP, 3-NKSP, 2-CMC, 3-MCSP, 1-SATF
SAC PSU	256	250	6	98%	51	5	***3-COR, 2-CMC,*** 6-COR, 2-WSP, 3-NKSP, 8-RJD, 3-CMC, 2-CMF, 1-SQ, 4-SVSP, 1-CCI, 13-LAC, 2-MCSP, 1-SAC

Female Insts.							
CCWF	54	50	4	93%	0	0	
CIW	75	56	19	75%	0	0	
TOTALS:	**129**	**106**	**23**	**82%**	**0**	**0**	

*Inter-institution transfers only. Numbers/locations in bold/italics indicate bus seats assigned for transport this week.

Prep by: Health Care Placement Oversight Program - Operations, 916-327-1250

Note: A small number of EOP beds may be kept vacant for inmates temporarily housed in MHCrisis as part of the 10-day "hold-a-bed" process.

"Total Current Pop" from Population Mgmt. Unit (dated 8-26-11) of the C&PRs' call-ins of the inmates housed in the GP-EOP unit.

Bus seat data source: Transportation Consolidated Worksheet

Final

Level II SNY: Capacity=176; pop.=165 Moved 7 of 53 (14%) Level II COD: Capacity=88; pop.=76 Moved 1 of 1 (100%)

Level III GP: Capacity=1443; pop.=1366 Moved 17 of 17 (100%) Level IV GP 180 Capacity=642; pop.=644 Moved 4 of 12 (34%)

WEEKLY EOP POPULATION REPORT
(For the Week of AUG. 29, 2011)

Level III SNY: Capacity=360; pop =357 Moved 11 of 61 (18%)

Level IV GP 270 Capacity=450; pop.=327 Moved 0 of 0 (0%)
Level IV SNY: Capacity=396; pop.=394 Moved 10 of 92 (11%)

DIVISION OF CORRECTIONAL HEALTH CARE SERVICES
STATEWIDE MENTAL HEALTH PROGRAM
P.O. Box 942883
Sacramento, CA94283-0001

October 31, 2011

Matthew A. Lopes, Jr. Esquire
Office of the Special Master
Pannone Lopes & Devereaux LLC
317 Iron Horse Point Way, Suite 301
Providence, RI 02908

via: Debbie J. Vorous, Esquire
Deputy Attorney General
Department of Justice
1300 "I" Street, Suite 125
P. O. Box 944255
Sacramento, CA 94244-2550

RE: COLEMAN MONTHLY REPORT OF INFORMATION REQUESTED AND RESPONSE TO JANUARY 19, 1999, COURT ORDER REGARDING STAFF VACANCIES

Dear Mr. Lopes:

Enclosed is the Coleman Monthly Report reflective of September, 2011, data (or as otherwise noted). The following is the list of enclosures:

1. Mental Health Services Delivery System (MHSDS) Staffing Allocation and Vacancy History.
2. MHSDS Hiring Activity Report.
3. Health Care Placement Oversight Program (HCPOP) Information Report, Summary and Administrative Segregation Greater than 60 Days.
4. Mental Health Contract Services including Summary and Telemedicine Monthly Report for all disciplines.
5. California Department of Corrections and Rehabilitation (CDCR) Reception Center (RC) Monthly Report.
6. Monthly Summary of Mental Health Crisis Bed use by Institution Titles Inpatient Psychiatric Aging Report.
7. Referrals for Transfer to the Department of Mental Health (including admissions).
8. Atascadero State Hospital (ASH) Discharges.
9. Weekly Enhanced Outpatient Program (EOP)/Outpatient Psychiatric Program.
10. The DMH Monthly Report of CDCR Patients in DMH Hospitals--Summary and Penal Code 2684.
11. Suicide Report.
12. Statistics on Contracted Registered Nurse (RN). **(No Longer Available)**
13. RC Processing for MHSDS Inmate Patients. (Data for California Institution for Men (CIM) is not available).

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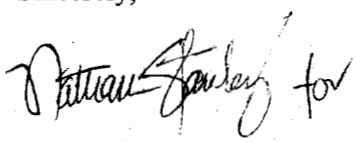
15. Allocated Case Manager Positions and Vacancies for the EOP Administrative Segregated Hub institutions.
16. EOP Inmates Waiting Transfer to a Psychiatric Services Unit (PSU).
17. Audit reports on Psychiatric Technician Rounds in Administrative Segregation at California State Prison, San Quentin (SQ), California State Prison-Corcoran (COR), and Salinas Valley State Prison (SVSP).
18. Mental Health Crisis Beds Wait List.
19. Correctional Treatment Centers and CDCR General Acute Care Hospital Care Placement Issues. **(No longer available)**
20. Transferred and Rescinded Mental Health Crisis Bed Referrals by Institution and Level of Care.

If you have any questions, please contact me at (916) 324-2933.

Sincerely,



JAMES A. SCARAMOZZINO, PH.D.
Deputy Director (A)
Statewide Mental Health Program
Division of Correctional Health Care Services

Enclosures

cc: Sharon Aungst, Director, Correctional Health Care Services
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Karen Higgins, M.D., Chief of Behavioral Medicine, Mental Health Program, Division of Correctional Health Care Services
Teresa Owens, Associate Governmental Program Analyst, Operational Program Oversight, Division of Correctional Health Care Services

WEEKLY EOP POPULATION REPORT
(For the Week of SEP. 5, 2011)

Male Institutions	Staffed Capacity	Total Current Pop	Current Vacancies	Percent Filled	Total Seats Requested	Total Seats Provided	Number of Seats Requested for Endorsed Cases, by Sending Location *
SATF SNY II	176	167	9	95%	48	12	***1-AVE, 1-SAC, 1-CCIRC, 2-CIM, 1-DVIRC, 2-NKSP, 1-RJDRC, 3-WSP,*** 10-AVE, 5-CCI, 2-SCC, 8-CIM, 11-WSP
SATF COD II	88	67	21	76%	5	5	***1-CMC, 1-FOL, 1-SAC, 1-SQ, 1-DVI***
CMC III	580	553	27	95%	7	7	***1-SAC, 1-SQ, 2-CCIRC, 2-NKSP, 1-RJDRC***
CMF III	533	508	25	95%	7	7	***2-CMC, 1-PVSP, 1-DVIRC, 3-SQRC***
RJD III	330	311	19	94%	5	5	***1-CMC, 1-CRC, 1-LAC, 1-PVSP, 1-LACRC***
LAC IV (270)	300	237	63	79%	1	1	***1-COR***
COR IV (270)	150	99	51	66%	3	3	***1-CMC, 1-LAC, 1-NKSP***
MCSP SNY III	360	353	7	98%	55	1	***1-CIM,*** 1-DVIRC, 8-NKSP, 3-RJDRC, 4-SQRC, 6-WSP, 2-COR, 1-CRC, 5-CTF, 1-LAC, 5-PVSP, 4-RJD, 2-SAC, 4-SATF, 8-CIM
MCSP SNY IV (270)	150	151	-1	101%	18	0	1-CMC, 3-COR, 1-CTF, 2-SAC, 1-SATF, 4-SVSP, 1-DVIRC, 2-SQRC, 3-WSP
RJD SNY IV (270)	150	157	-7	105%	61	0	1-AVE, 2-CMC, 1-COR, 4-HDSP, 2-KVSP, 2-LAC, 5-MCSP, 1-PBSP, 3-PVSP, 9-SAC, 8-SATF, 1-SCC, 8-SVSP, 1-CCIRC, 2-CIM, 1-LACRC, 6-NKSP, 1-SQRC, 3-WSP
KVSP SNY IV (180)	96	93	3	97%	10	1	***1-COR,*** 1-MCSP, 2-SATF, 2-SCC, 1-DVIRC, 1-RJDRC, 2-WSP
PBSP IV (180)	66	60	6	91%	3	3	***3-LAC***
SAC IV (180)	384	398	-14	104%	5	0	2-LAC, 1-COR, 2-CMC
SVSP IV (180)	192	190	2	99%	0	0	
TOTALS:	**3555**	**3344**	**211**	**94%**	**228**	**45**	

(per 9-6-11 PSU wait list)

CIW PSU	20	20	0	100%	6	0	4-VSPW, 2-CIW
PBSP PSU	128	126	2	98%	33	0	5-RJD, 1-SAC, 1-DVI, 1-KVSP, 4-LAC, 5-COR, 6-WSP, 3-NKSP, 2-CMC, 1-SATF, 4-MCSP
SAC PSU	256	249	7	97%	42	5	***2-CMF, 1-RJD, 1-SQ, 1-NKSP,*** 4-SVSP, 9-LAC, 3-CMC, 2-MCSP, 5-COR, 2-NKSP, 2-WSP, 8-RJD, 2-SAC

Female Insts.							
CCWF	54	47	7	87%	0	0	
CIW	75	53	22	71%	0	0	
TOTALS:	**129**	**100**	**29**	**78%**	**0**	**0**	

*Inter-institution transfers only. Numbers/locations in bold/italics indicate bus seats assigned for transport this week.

Prep by: Health Care Placement Oversight Program - Operations, 916-327-1250

Note: A small number of EOP beds may be kept vacant for inmates temporarily housed in MHCrisis as part of the 10-day "hold-a-bed" process.

"Total Current Pop" from Population Mgmt. Unit (dated 9-2-11) of the C&PRs' call-ins of the inmates housed in the GP-EOP unit.

Bus seat data source: Transportation Consolidated Worksheet

Final

Level II SNY: Capacity=176; pop.=167 Moved 12 of 48 (25%) Level II COD: Capacity=88; pop.=67 Moved 5 of 5 (100%)

Level III GP: Capacity=1443; pop.=1372 Moved 19 of 19 (100%) Level IV GP 180 Capacity=642; pop.=648 Moved 3 of 8 (38%)

WEEKLY EOP POPULATION REPORT
(For the Week of SEP. 5, 2011)

Level III SNY: Capacity=360; pop =353 Moved 1 of 55 (2%)

Level IV GP 270 Capacity=450; pop.=336 Moved 4 of 4 (100%)
Level IV SNY: Capacity=396; pop.=401 Moved 1 of 89 (2%)

DIVISION OF CORRECTIONAL HEALTH CARE SERVICES
STATEWIDE MENTAL HEALTH PROGRAM
P.O. Box 942883
Sacramento, CA94283-0001

December 1, 2011

Matthew A. Lopes, Jr. Esquire
Office of the Special Master
Pannone Lopes & Devereaux LLC
317 Iron Horse Point Way, Suite 301
Providence, RI 02908

via: Debbie J. Vorous, Esquire
Deputy Attorney General
Department of Justice
1300 "I" Street, Suite 125
P. O. Box 944255
Sacramento, CA 94244-2550

RE: COLEMAN MONTHLY REPORT OF INFORMATION REQUESTED AND RESPONSE TO JANUARY 19, 1999, COURT ORDER REGARDING STAFF VACANCIES

Dear Mr. Lopes:

Enclosed is the Coleman Monthly Report reflective of October, 2011, data (or as otherwise noted). The following is the list of enclosures:

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20. Transferred and Rescinded Mental Health Crisis Bed Referrals by Institution and Level of Care.

If you have any questions, please contact me at (916) 324-2933.

Sincerely,

JAMES A. SCARAMOZZINO, PH.D.
Deputy Director (A)
Statewide Mental Health Program
Division of Correctional Health Care Services

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WEEKLY EOP POPULATION REPORT
(For the Week of OCT. 10, 2011)

Male Institutions	Staffed Capacity	Total Current Pop	Current Vacancies	Percent Filled	Total Seats Requested	Total Seats Provided	Number of Seats Requested for Endorsed Cases, by Sending Location *
SATF SNY II	176	174	2	99%	41	5	***5-WSP,*** 5-AVE, 7-CCI, 1-CTF, 1-CCIRC, 3-CIM, 6-NKSP, 3-RJDRC, 10-WSP
SATF COD II	88	77	11	88%	1	1	***1-CRC***
CMC III	580	546	34	94%	10	10	***1-LAC, 1-SQ, 1-SVSP, 1-CCIRC, 2-CIM, 1-DVIRC, 1-LACRC, 1-NKSP, 1-SQRC***
CMF III	533	518	15	97%	1	0	1-CMC
RJD III	330	311	19	94%	6	6	***1-CMC, 1-CRC, 1-LAC, 1-CIM, 1-DVIRC, 1-NKSP***
LAC IV (270)	300	233	67	78%	2	1	***1-PBSP,*** 1-CMC
COR IV (270)	150	107	43	71%	0	0	
MCSP SNY III	360	352	8	98%	49	8	***2-SAC (per DAI-PMU), 1-CMC, 1-COR, 2-SVSP, 1-LACRC, 1-WSP,*** 2-WSP, 2-AVE, 3-SATF, 3-RJD, 4-PVSP, 1-CTF, 1-SCC, 1-CCIRC, 8-CIM, 2-HDSPRC, 10-NKSP, 3-RJDRC, 1-SQRC,
MCSP SNY IV (270)	150	156	-6	104%	14	4	***4-SAC (per DAI-PMU),*** 3-SVSP, 1-SQRC, 3-WSP, 2-CMC, 1-SATF
RJD SNY IV (270)	150	155	-5	103%	71	1	***1-ISP,*** 1-AVE, 2-CMC, 5-COR, 2-CTF, 4-HDSP, 2-LAC, 5-MCSP, 3-PVSP, 9-SAC, 5-SATF, 12-SVSP, 2-CCIRC, 5-CIM, 1-LACRC, 8-NKSP, 1-SQRC, 3-WSP
KVSP SNY IV (180)	96	89	7	93%	16	8	***1-COR, 1-CTF, 1-SCC, 2-SVSP, 1-CIM, 2-WSP,*** 2-SATF, 2-SVSP, 1-CCIRC, 1-LACRC, 2-RJDRC
PBSP IV (180)	66	62	4	94%	8	4	***2-CMC, 2-CIM,*** 1-SATF, 1-SVSP, 1-CMC, 1-SVSP
SAC IV (180)	384	387	-3	101%	2	0	1-COR, 1-LAC
SVSP IV (180)	192	189	3	98%	1	1	***1-SQRC***
TOTALS:	**3555**	**3356**	**199**	**94%**	**222**	**49**	

(per 10-10-11 PSU wait list)

CIW PSU	20	20	0	100%	8	0	4-CIW, 4-VSPW
PBSP PSU	128	124	4	97%	40	2	***1-COR, 1-SAC,*** 1-CCI, 1-CTF, 1-DVI, 5-SVSP, 3-COR, 7-LAC, 5-RJD, 6-WSP, 1-KVSP, 3-NKSP, 4-CMC, 1-MCSP
SAC PSU	256	255	1	100%	39	6	***1-MCSP, 1-SVSP, 4-RJD,*** 6-COR, 3-WSP, 1-NKSP, 2-CCI, 5-CMC, 4-SVSP, 3-RJD, 4-LAC, 2-CMF, 1-HDSP, 2-SAC

Female Insts.							
CCWF	54	48	6	89%	0	0	
CIW	75	49	26	65%	0	0	
TOTALS:	**129**	**97**	**32**	**75%**	**0**	**0**	

*Inter-institution transfers only. Numbers/locations in bold/italics indicate bus seats assigned for transport this week.

Prep by: Health Care Placement Oversight Program - Operations, 916-327-1250

Note: A small number of EOP beds may be kept vacant for inmates temporarily housed in MHCrisis as part of the 10-day "hold-a-bed" process.

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WEEKLY EOP POPULATION REPORT
(For the Week of OCT. 10, 2011)

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Level IV SNY: Capacity=396; pop.=400 Moved 13 of 101 (13%)

DIVISION OF CORRECTIONAL HEALTH CARE SERVICES
STATEWIDE MENTAL HEALTH PROGRAM
P.O. Box 942883
Sacramento, CA94283-0001

January 3, 2012

Matthew A. Lopes, Jr. Esquire
Office of the Special Master
Pannone Lopes & Devereaux LLC
317 Iron Horse Point Way, Suite 301
Providence, RI 02908

via: Debbie J. Vorous, Esquire
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Sincerely,

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Statewide Mental Health Program
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WEEKLY EOP POPULATION REPORT
(For the Week of NOV. 14, 2011)

Male Institutions	Staffed Capacity	Total Current Pop	Current Vacancies	Percent Filled	Total Seats Requested	Total Seats Provided	Number of Seats Requested for Endorsed Cases, by Sending Location *
SATF SNY II	176	169	7	96%	50	0	2-CCIRC, 6-CIM, 11-NKSP, 3-RJDRC, 12-WSP, 6-AVE, 6-CCI, 1-CTF, 3-MCSP
SATF COD II	88	75	13	85%	1	1	***1-DVIRC***
CMC III	580	520	60	90%	8	8	***1-NKSP, 1-RJDRC, 1-SQRC, 3-SQ, 1-SATF, 1-FOL***
CMF III	533	505	28	95%	4	0	3-CMC, 1-CIM
RJD III	330	319	11	97%	5	5	***2-CMC, 2-CMF, 1-LAC***
LAC IV (270)	300	231	69	77%	7	7	***4-SAC, 2-CMC, 1-NKSP***
COR IV (270)	150	98	52	65%	1	0	1-SAC
MCSP SNY III	360	350	10	97%	43	0	3-AVE, 1-CTF, 2-LAC, 1-PBSP, 4-PVSP, 2-RJD, 3-SATF, 2-SCC, 11-CIM, 1-DVIRC, 1-LACRC, 7-NKSP, 3-RJDRC, 2-WSP
MCSP SNY IV (270)	150	147	3	98%	31	7	***2-WSP, 2-SQ, 1-NKSP, 1-CCIRC, 1-KVSP,*** 2-CMC, 1-CMF, 6-COR, 1-HDSP, 1-PBSP, 4-SAC, 2-SATF, 2-SVSP, 5-WSP
RJD SNY IV (270)	150	162	-12	108%	54	1	***1-AVE,*** 1-AVE, 1-CMC, 2-CTF, 4-COR, 5-HDSP, 5-MCSP, 2-PBSP, 1-PVSP, 11-SAC, 1-SATF, 8-SVSP, 1-CIM, 2-LAC, 2-WSP, 7-NKSP
KVSP SNY IV (180)	96	90	6	94%	19	5	***1-HDSP, 1-SVSP, 1-CCIRC, 1-CIM, 1-WSP,*** 1-CMC, 3-COR, 1-LAC, 3-RJD, 2-SVSP, 1-LACRC, 3-RJDRC
PBSP IV (180)	66	63	3	95%	7	3	***1-SVSP, 1-SATF, 1-KVSP,*** 1-CMF, 1-CMC, 1-LAC, 1-SOL
SAC IV (180)	384	379	5	99%	9	4	***2-CIM, 1-CMF, 1-COR,*** 2-CMF, 1-CMC, 1-LAC, 1-RJD
SVSP IV (180)	192	185	7	96%	3	3	***1-CMF, 1-COR, 1-RJD***
TOTALS:	**3555**	**3293**	**262**	**93%**	**242**	**44**	

(per 11-10-11 PSU wait list)

CIW PSU	20	19	1	95%	10	1	***1-CIW,*** 5-VSPW, 4-CIW
PBSP PSU	128	117	11	91%	41	6	***2-NKSP, 4-LAC,*** 2-CMC, 1-CIM, 1-SATF, 3-COR, 6-LAC, 1-NKSP, 1-KVSP, 6-RJD, 7-WSP, 6-SVSP, 1-CTF
SAC PSU	256	248	8	97%	55	0	1-KVSP, 2-CIM, 3-SATF, 5-RJD, 13-LAC, 2-HDSP, 6-SVSP, 5-CMC, 3-CMF, 1-NKSP, 7-WSP, 3-COR, 2-CCI, 1-MCSP, 1-SAC

Female Insts. CCWF	54	46	8	85%	1	1	***1-VSPW***
CIW	75	64	11	85%	0	0	
TOTALS:	**129**	**110**	**19**	**85%**	**1**	**1**	

*Inter-institution transfers only. Numbers/locations in bold/italics indicate bus seats assigned for transport this week.

Prep by: Health Care Placement Oversight Program - Operations, 916-327-1250

Note: A small number of EOP beds may be kept vacant for inmates temporarily housed in MHCrisis as part of the 10-day "hold-a-bed" process.

"Total Current Pop" from Population Mgmt. Unit (dated 11-10-11) of the C&PRs' call-ins of the inmates housed in the GP-EOP unit.

Bus seat data source: Transportation Consolidated Worksheet

Final

Level II SNY: Capacity=176; pop.=169 Moved 0 of 50 (0%) Level II COD: Capacity=88; pop.=75 Moved 1 of 1 (100%)

Level III GP: Capacity=1443; pop.=1344 Moved 13 of 17 (77%) Level IV GP 180 Capacity=642; pop.=627 Moved 10 of 19 (53%)

WEEKLY EOP POPULATION REPORT
(For the Week of NOV. 14, 2011)

Level III SNY Capacity=350, pop.=350 Moved 0 of 43 (0%)

Level IV GP 2/0 Capacity=450, pop.=329 Moved 7 of 8 (88%)
Level IV SNY Capacity=396, pop.=389 Moved 13 of 104 (13%)

DIVISION OF CORRECTIONAL HEALTH CARE SERVICES
STATEWIDE MENTAL HEALTH PROGRAM
P.O. Box 942883
Sacramento, CA94283-0001

February 1, 2012

Matthew A. Lopes, Jr. Esquire
Office of the Special Master
Pannone Lopes & Devereaux LLC
317 Iron Horse Point Way, Suite 301
Providence, RI 02908

via: Debbie J. Vorous, Esquire
Deputy Attorney General
Department of Justice
1300 "I" Street, Suite 125
P. O. Box 944255
Sacramento, CA 94244-2550

RE: COLEMAN MONTHLY REPORT OF INFORMATION REQUESTED AND RESPONSE TO JANUARY 19, 1999, COURT ORDER REGARDING STAFF VACANCIES

Dear Mr. Lopes:

Enclosed is the Coleman Monthly Report reflective of December, 2011, data (or as otherwise noted). The following is the list of enclosures:

1. Mental Health Services Delivery System (MHSDS) Staffing Allocation and Vacancy History.
2. MHSDS Hiring Activity Report.
3. Health Care Placement Oversight Program (HCPOP) Information Report, Summary and Administrative Segregation Greater than 60 Days.
4. Mental Health Contract Services including Summary and Telemedicine Monthly Report for all disciplines.
5. California Department of Corrections and Rehabilitation (CDCR) Reception Center (RC) Monthly Report.
6. Monthly Summary of Mental Health Crisis Bed use by Institution Titles Inpatient Psychiatric Aging Report.
7. Referrals for Transfer to the Department of Mental Health (including admissions).
8. Atascadero State Hospital (ASH) Discharges.
9. Weekly Enhanced Outpatient Program (EOP)/Outpatient Psychiatric Program.
10. The DMH Monthly Report of CDCR Patients in DMH Hospitals--Summary and Penal Code 2684.
11. Suicide Report.
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13. RC Processing for MHSDS Inmate Patients.
14. Medical Technical Assistant (MTA) Vacancy Report.
15. Allocated Case Manager Positions and Vacancies for the EOP Administrative Segregated Hub institutions.

15. Allocated Case Manager Positions and Vacancies for the EOP Administrative Segregated Hub institutions.
16. EOP Inmates Waiting Transfer to a Psychiatric Services Unit (PSU).
17. Audit reports on Psychiatric Technician Rounds in Administrative Segregation at California State Prison, San Quentin (SQ), California State Prison-Corcoran (COR), and Salinas Valley State Prison (SVSP).
18. Mental Health Crisis Beds Wait List.
19. Correctional Treatment Centers and CDCR General Acute Care Hospital Care Placement Issues. **(No longer available)**
20. Transferred and Rescinded Mental Health Crisis Bed Referrals by Institution and Level of Care.

If you have any questions, please contact me at (916) 324-2933.

Sincerely,

JAMES A. SCARAMOZZINO, PH.D.
Deputy Director (A)
Statewide Mental Health Program
Division of Correctional Health Care Services

Enclosures

cc: Diana Toche, Director (A), Division of Correctional Health Care Services
Mohamedu F., Jones, Esq., *Coleman* Deputy Special Master
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Karen Higgins, M.D., Chief of Behavioral Medicine, Mental Health Program, Division of Correctional Health Care Services
Teresa Owens, Associate Governmental Program Analyst, Operational Program Oversight, Division of Correctional Health Care Services

WEEKLY EOP POPULATION REPORT
(For the Week of DEC. 5, 2011)

Male Institutions	Staffed Capacity	Total Current Pop	Current Vacancies	Percent Filled	Total Seats Requested	Total Seats Provided	Number of Seats Requested for Endorsed Cases, by Sending Location *
SATF SNY II	176	170	6	97%	54	0	10-AVE, 7-CCI, 1-COR, 1-CTF, 3-MCSP, 1-RJD, 2-CCIRC, 6-CIM, 9-NK, 2-RJDRC, 2-SQRC, 10-WSP
SATF COD II	88	72	16	82%	11	11	***9-CMF, 1-CRC, 1-NKSP***
CMC III	580	521	59	90%	15	15	***6-CMF, 1-FOL, 1-COR, 1-CTF, 1-SOL, 2-SVSP, 1-CCIRC, 1-CIM, 1-SQRC***
CMF III	533	496	37	93%	0	0	
RJD III	330	325	5	98%	11	5	***3-CMF, 1-CRC, 1-SCC,*** 6-CMF
LAC IV (270)	300	241	59	80%	4	4	***1-SAC, 1-SVSP, 1-CMF, 1-CEN***
COR IV (270)	150	102	48	68%	1	0	1-SVSP
MCSP SNY III	360	341	19	95%	38	8	***8-NKSP,*** 1-AVE, 2-CMC, 1-COR, 1-CTF, 4-LAC, 2-PVSP, 1-RJD, 3-SATF, 3-SCC, 6-CIM, 3-RJDRC, 3-WSP
MCSP SNY IV (270)	150	154	-4	103%	31	0	2-CMC, 6-COR, 1-HDSP, 3-PBSP, 2-RJD, 4-SAC, 1-SATF, 3-SVSP, 1-CCIRC, 1-CIM, 2-NKSP, 5-WSP
RJD SNY IV (270)	150	161	-11	107%	43	0	3-RJD, 2-LACRC, 5-NK, 1-CIM, 6-SVSP, 7-SAC, 1-SATF, 4-MCSP, 2-PVSP, 2-CTF, 5-HDSP, 1-AVE, 4-COR
KVSP SNY IV (180)	96	87	9	91%	13	8	***3-COR, 1-LAC, 1-RJD, 1-LACRC, 1-NK, 1-RJDRC,*** 2-SVSP, 2-LAC, 1-CMC
PBSP IV (180)	66	65	1	98%	5	0	1-SOL, 1-SAC, 1-CRC, 1-COR, 1-CMC
SAC IV (180)	384	391	-7	102%	6	1	***1-LAC,*** 1-SVSP, 2-CMF, 2-CMC
SVSP IV (180)	192	188	4	98%	4	1	***1-SAC,*** 1-CMF, 1-COR, 1-SAC
TOTALS:	**3555**	**3314**	**241**	**93%**	**236**	**53**	

(per 12-2-11 PSU Wait List)

CIW PSU	20	20	0	100%	9	0	6-VSPW, 3-CIW
PBSP PSU	128	118	10	92%	30	2	***2-RJD,*** 1-NKSP, 1-KVSP, 7-LAC, 3-RJD, 6-SVSP, 3-COR, 1-PVSP, 1-CMF, 2-CMC, 2-WSP, 1-SATF
SAC PSU	256	238	18	93%	48	3	***2-COR, 1-WSP,*** 1-CCI, 2-CMF, 4-SVSP, 2-MCSP, 1-KVSP, 2-NKSP, 5-CMC, 12-LAC, 4-COR, 4-RJD, 3-SATF, 4-WSP, 1-PVSP

Female Insts.							
CCWF	54	44	10	81%	0	0	
CIW	75	63	12	84%	0	0	
TOTALS:	**129**	**107**	**22**	**83%**	**0**	**0**	

*Inter-institution transfers only. Numbers/locations in bold/italics indicate bus seats assigned for transport this week.

Prep by: Health Care Placement Oversight Program - Operations, 916-327-1250

Note: A small number of EOP beds may be kept vacant for inmates temporarily housed in MHCrisis as part of the 10-day "hold-a-bed" process.

"Total Current Pop" from Population Mgmt. Unit (dated 12-2-11) of the C&PRs' call-ins of the inmates housed in the GP-EOP unit.

Bus seat data source: Transportation Consolidated Worksheet

Final

Level II SNY: Capacity=176; pop.=170 Moved 0 of 54 (0%) Level II COD: Capacity=88; pop.=72 Moved 11 of 11 (100%)

Level III GP: Capacity=1443; pop.=1342 Moved 20 of 26 (77%) Level IV GP 180 Capacity=642; pop.=644 Moved 2 of 15 (14%)

WEEKLY EOP POPULATION REPORT
(For the Week of DEC. 5, 2011)

Level III SNY Capacity=350, pop =341 Moved 8 of 38 (21%)

Level IV GP 270 Capacity=450 pop =343 Moved 4 of 5 (80%)
Level IV SNY Capacity=395, pop.=402 Moved 8 of 87 (10%)

DIVISION OF CORRECTIONAL HEALTH CARE SERVICES
STATEWIDE MENTAL HEALTH PROGRAM
P.O. Box 942883
Sacramento, CA94283-0001

March 1, 2012

Matthew A. Lopes, Jr. Esquire
Office of the Special Master
Pannone Lopes & Devereaux LLC
317 Iron Horse Point Way, Suite 301
Providence, RI 02908

via: Debbie J. Vorous, Esquire
Deputy Attorney General
Department of Justice
1300 "I" Street, Suite 125
P. O. Box 944255
Sacramento, CA 94244-2550

RE: COLEMAN MONTHLY REPORT OF INFORMATION REQUESTED AND RESPONSE TO JANUARY 19, 1999, COURT ORDER REGARDING STAFF VACANCIES

Dear Mr. Lopes:

Enclosed is the Coleman Monthly Report reflective of January, 2012, data (or as otherwise noted). The following is the list of enclosures:

1. Mental Health Services Delivery System (MHSDS) Staffing Allocation and Vacancy History.
2. MHSDS Hiring Activity Report.
3. Health Care Placement Oversight Program (HCPOP) Information Report, Summary and Administrative Segregation Greater than 60 Days.
4. Mental Health Contract Services including Summary and Telemedicine Monthly Report for all disciplines.
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7. Referrals for Transfer to the Department of Mental Health (including admissions).
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12. Statistics on Contracted Registered Nurse (RN). **(No Longer Available)**
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18. Mental Health Crisis Beds Wait List.
19. Correctional Treatment Centers and CDCR General Acute Care Hospital Care Placement Issues. **(No longer available)**
20. Transferred and Rescinded Mental Health Crisis Bed Referrals by Institution and Level of Care.

If you have any questions, please contact me at (916) 324-2933.

Sincerely,

JAMES A. SCARAMOZZINO, PH.D.
Deputy Director (A)
Statewide Mental Health Program
Division of Correctional Health Care Services

Enclosures

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Teresa Owens, Associate Governmental Program Analyst, Operational Program Oversight, Division of Correctional Health Care Services

WEEKLY EOP POPULATION REPORT
(For the Week of JAN. 9, 2012)

Male Institutions	Staffed Capacity	Total Current Pop	Current Vacancies	Percent Filled	Total Seats Requested	Total Seats Provided	Number of Seats Requested for Endorsed Cases, by Sending Location *
SATF SNY II	176	163	13	93%	52	1	***1-CMC,*** 9-AVE, 6-CCI, 1-COR, 1-CRC, 1-CTF, 1-PVSP, 1-MCSP, 2-SQ, 4-CCIRC, 3-CIM, 8-NKSP, 5-RJDRC, 9-WSP
SATF COD II	88	86	2	98%	10	1	***1-CMF,*** 2-CMF, 7-CMC
CMC III	580	592	-12	102%	30	15	***8-CMF, 1-PVSP, 1-SATF, 1-SOL, 2-SVSP, 1-CCIRC, 1-WSP,*** 1-AVE, 1-CRC, 1-CTF, 2-FOL, 1-LAC, 2-SQ, 1-HDSPRC, 1-LACRC, 5-NKSP
CMF III	533	398	135	75%	0	0	
RJD III	330	329	1	100%	43	1	1-COR, 5-CMC, 20-CMF, 3-LAC, 1-SCC, 1-SVSP, 1-CCIRC, 2-CIM, 6-LACRC, 2-NKSP, 1-WSP
LAC IV (270)	300	246	54	82%	3	3	***3-COR***
COR IV (270)	150	69	81	46%	5	0	5-MCSP (SNY intake to begin 2-6-12)
MCSP SNY III	360	344	16	96%	22	12	***1-WSP, 4-PVSP, 6-LAC, 1-CCI,*** 1-AVE, 1-RJD, 3-SQ, 3-LACRC, 2-RJDRC
MCSP SNY IV (270)	150	159	-9	106%	47	0	1-CMC, 3-CMF, 4-COR, 3-HDSP, 1-LAC, 1-PVSP, 8-SAC, 2-SATF, 1-SCC, 3-SVSP, 2-CCIRC, 2-CIM, 1-LACRC, 7-NKSP, 8-WSP
RJD SNY IV (270)	150	151	-1	101%	42	6	***5-SAC, 1-ISP,*** 4-COR, 2-CTF, 3-HDSP, 3-MCSP, 4-PVSP, 8-SAC, 2-SATF, 1-SCC, 2-SVSP, 1-CIM, 1-LACRC, 2-NKSP, 3-WSP
KVSP SNY IV (180)	96	93	3	97%	12	2	***1-LAC, 1-COR,*** 1-LAC, 1-PVSP, 2-RJD, 3-SVSP, 1-CIM, 1-NKSP, 1-WSP
PBSP IV (180)	66	63	3	95%	6	3	***1-SVSP, 1-CMC, 1-SAC,*** 1-CMC, 2-SAC
SAC IV (180)	384	383	1	100%	3	0	1-SVSP, 2-CMF
SVSP IV (180)	192	191	1	99%	2	1	***1-PBSP,*** 1-SAC
TOTALS:	**3555**	**3267**	**288**	**92%**	**277**	**45**	

(per 1-9-12 PSU Wait List)

CIW PSU	20	20	0	100%	12	0	3-CIW, 9-VSPW
PBSP PSU	128	113	15	88%	30	7	***1-CMC, 1-SATF, 2-WSP, 1-PVSP, 2-SVSP,*** 7-COR, 7-LAC, 1-SVSP, 3-RJD, 1-MCSP, 1-CIM, 1-CMF, 2-CMC
SAC PSU	256	245	11	96%	35	2	***2-MCSP,*** 2-NKSP, 3-COR, 5-LAC, 2-CCI, 1-SQ, 1-CIM, 2-PVSP, 3-CMC, 3-WSP, 3-SATF, 1-RJD, 1-HDSP, 1-CMF, 1-SVSP, 1-SAC, 1-DVI, 2-MCSP

Female Insts.							
CCWF	54	43	11	80%	1	1	***1-VSPW***
CIW	75	49	26	65%	1	1	***1-CCWF***
TOTALS:	**129**	**92**	**37**	**71%**	**2**	**2**	

*Inter-institution transfers only. Numbers/locations in bold/italics indicate bus seats assigned for transport this week.

Prep by: Health Care Placement Oversight Program - Operations, 916-327-1250

Note: A small number of EOP beds may be kept vacant for inmates temporarily housed in MHCrisis as part of the 10-day "hold-a-bed" process.

"Total Current Pop" from Population Mgmt. Unit (dated 1-6-12) of the C&PRs' call-ins of the inmates housed in the GP-EOP unit.

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WEEKLY EOP POPULATION REPORT
(For the Week of JAN. 9, 2012)

Level III SNY: Capacity=360; pop =344 Moved 12 of 22 (55%)

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Level IV SNY: Capacity=396; pop.=403 Moved 8 of 101 (8%)

DIVISION OF CORRECTIONAL HEALTH CARE SERVICES
STATEWIDE MENTAL HEALTH PROGRAM
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APR 2 2012

Matthew A. Lopes, Jr. Esquire
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317 Iron Horse Point Way, Suite 301
Providence, RI 02908

via: Debbie J. Vorous, Esquire
Deputy Attorney General
Department of Justice
1300 "I" Street, Suite 125
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20. Transferred and Rescinded Mental Health Crisis Bed Referrals by Institution and Level of Care.

If you have any questions, please contact me at (916) 324-2933.

Sincerely,

T. BELAVICH, Ph.D., MSHCA, CCHP
Deputy Director (A)
Statewide Mental Health Program
Division of Correctional Health Care Services

Enclosures

cc: Diana Toche, DDS, Director (A), Division of Correctional Health Care Services (DCHCS)
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WEEKLY EOP POPULATION REPORT
(For the Week of FEB. 27, 2012)

Male Institutions	Staffed Capacity	Total Current Pop	Current Vacancies	Percent Filled	Total Seats Requested	Total Seats Provided	Number of Seats Requested for Endorsed Cases, by Sending Location *
SATF SNY II	176	171	5	97%	22	8	***3-NKSP, 1-CIM, 2-LACRC, 2-RJDRC,*** 7-WSP, 1-RJDRC, 4-NKSP, 1-SCC, 1-CCI
SATF COD II	88	87	1	99%	15	3	***1-NKSP, 1-SOL, 1-CRC,*** 11-CMC, 1-CMF
CMC III	580	570	10	98%	54	9	***1-SVSP, 1-CCIRC, 6-RJDRC, 1-SQRC,*** 1-AVE, 16-CMF, 4-FOL, 1-RJD, 1-SAC, 1-SATF, 2-SOL, 1-SQ, 12-LACRC, 6-RJDRC
CMF III	333	337	-4	101%	15	15	***1-CMC, 1-FOL, 1-SAC, 1-HDSPRC, 6-NKSP, 5-WSP***
RJD III	330	329	1	100%	23	0	9-CMC, 6-CMF, 1-HDSP, 4-LAC, 1-LACRC, 1-NKSP, 1-WSP
LAC IV (270)	300	284	16	95%	6	6	1-CMC, 1-MCSP, 1-RJD, 1-NKSP, 2-WSP
MCSP SNY III	360	330	30	92%	42	0	1-AVE, 1-CCI, 1-CMC, 3-CTF, 1-LAC, 2-PVSP, 1-RJD, 2-SAC, 1-COR, 1-SATF, 2-SCC, 1-SOL, 4-CIM, 6-LACRC, 4-NKSP, 6-RJDRC, 2-SQRC, 3-WSP
COR SNY IV (270)	150	63	87	42%	36	20	***5-NKSP, 3-SAC, 1-PBSP, 6-MCSP, 1-LAC, 2-KVSP, 1-CMF, 1-CAL,*** 1-WSP, 2-CIM, 1-SAC, 12-MCSP
MCSP SNY IV (270)	150	156	-6	104%	48	1	***1-RJD,*** 1-CMC, 3-CMF, 4-COR, 4-HDSP, 2-KVSP, 2-PBSP, 10-SAC, 2-SATF, 1-SCC, 5-SVSP, 1-CIM, 2-LACRC, 3-NKSP, 1-RJDRC, 6-WSP
RJD SNY IV (270)	150	138	12	92%	21	5	***4-SAC, 1-SVSP,*** 2-SATF, 5-SAC, 2-PVSP, 3-LAC, 1-HDSP, 1-LACRC, 2-WSP
KVSP SNY IV (180)	96	97	-1	101%	14	0	5-NKSP, 3-SVSP, 1-SAC, 1-PVSP, 1-MCSP, 2-LAC, 1-HDSP
PBSP IV (180)	66	64	2	97%	1	0	1-SAC
SAC IV (180)	384	394	-10	103%	7	3	***2-CMF, 1-LAC,*** 3-CMC, 1-CMF
SVSP IV (180)	192	184	8	96%	0	0	
TOTALS:	**3355**	**3204**	**151**	**95%**	**304**	**70**	

(per 2-24-12 PSU Wait List)

CIW PSU	20	18	2	90%	7	1	***1-VSPW,*** 2-CIW, 4-VSPW
PBSP PSU	128	124	4	97%	30	0	11-COR, 9-LAC, 2-CMF, 2-MCSP, 4-RJD, 2-SVSP
SAC PSU	256	250	6	98%	26	6	***1-LAC, 2-SVSP, 2-MCSP, 1-RJD,*** 4-CMC, 6-COR, 3-CMF, 2-LAC, 1-MCSP, 1-SOL, 2-RJD, 1-NKSP

Female Insts.							
CCWF	54	51	3	94%	0	0	
CIW	75	43	32	57%	0	0	
TOTALS:	**129**	**94**	**35**	**73%**	**0**	**0**	

*Inter-institution transfers only. Numbers/locations in bold/italics indicate bus seats assigned for transport this week.

Prep by: Health Care Placement Oversight Program - Operations, 916-327-1250

Note: A small number of EOP beds may be kept vacant for inmates temporarily housed in MHCrisis as part of the 10-day "hold-a-bed" process.

"Total Current Pop" from Population Mgmt. Unit (dated 2-24-11) of the C&PRs' call-ins of filled EOP beds.

Bus seat data source: Transportation Weekly Consolidated Worksheet

Final

Level II COD: Capacity 88; pop =87 Moved 3 of 15 (20%)

Level II SNY: Capacity=176; pop.=171 Moved 8 of 22 (37%)

Level IV GP 180 Capacity=642; pop.=642 Moved 3 of 8 (38%)

Level IV GP 270 Capacity=300; pop.=284 Moved 6 of 6 (100%)

WEEKLY EOP POPULATION REPORT
(For the Week of FEB. 27, 2012)

Level III GP: Capacity=1243; pop.=1236 Moved 24 of 92 (26%)
Level III SNY: Capacity=360; pop =330 Moved 0 of 42 (0%)

Level IV SNY 180: Capacity=96; pop.=97 Moved 0 of 14 (0%)
Level IV SNY 270: Capacity=450; pop.=357 Moved 26 of 105 (25%)

DIVISION OF CORRECTIONAL HEALTH CARE SERVICES
STATEWIDE MENTAL HEALTH PROGRAM
P.O. Box 942883
Sacramento, CA94283-0001

May 2, 2012

Matthew A. Lopes, Jr. Esquire
Office of the Special Master
Pannone Lopes & Devereaux LLC
317 Iron Horse Point Way, Suite 301
Providence, RI 02908

via: Debbie J. Vorous, Esquire
Deputy Attorney General
Department of Justice
1300 "I" Street, Suite 125
P. O. Box 944255
Sacramento, CA 94244-2550

RE: COLEMAN MONTHLY REPORT OF INFORMATION REQUESTED AND RESPONSE TO JANUARY 19, 1999, COURT ORDER REGARDING STAFF VACANCIES

Dear Mr. Lopes:

Enclosed is the Coleman Monthly Report reflective of March, 2012, data (or as otherwise noted). The following is the list of enclosures:

1. Mental Health Services Delivery System (MHSDS) Staffing Allocation and Vacancy History.
2. MHSDS Hiring Activity Report.
3. Health Care Placement Oversight Program (HCPOP) Information Report, Summary and Administrative Segregation Greater than 60 Days.
4. Mental Health Contract Services including Summary and Telemedicine Monthly Report for all disciplines.
5. California Department of Corrections and Rehabilitation (CDCR) Reception Center (RC) Monthly Report.
6. Monthly Summary of Mental Health Crisis Bed use by Institution Titles Inpatient Psychiatric Aging Report. (**Not available – report is under review and will be submitted once the information has been validated**).
7. Referrals for Transfer to the Department of Mental Health (including admissions).
8. Atascadero State Hospital (ASH) Discharges. **(Not available due to technical impediments).**
9. Weekly Enhanced Outpatient Program (EOP)/Outpatient Psychiatric Program.
10. The Department of Mental Health (DMH) Monthly Report of CDCR Patients in DMH Hospitals -- Summary and Penal Code 2684. **(Not available due to technical impediments).**
11. Suicide Report.
12. Statistics on Contracted Registered Nurse (RN). **(No Longer Available)**
13. RC Processing for MHSDS Inmate Patients.

[redacted]

14. Medical Technical Assistant (MTA) Vacancy Report. **(No Longer Available)**
15. Allocated Case Manager Positions and Vacancies for the EOP Administrative Segregated Hub institutions.
16. EOP Inmates Waiting Transfer to a Psychiatric Services Unit (PSU).
17. Audit reports on Psychiatric Technician Rounds in Administrative Segregation at California State Prison, San Quentin (SQ), California State Prison-Corcoran (COR), and Salinas Valley State Prison (SVSP).
18. Mental Health Crisis Beds Wait List.
19. Correctional Treatment Centers and CDCR General Acute Care Hospital Care Placement Issues. **(No longer available)**
20. Transferred and Rescinded Mental Health Crisis Bed Referrals by Institution and Level of Care.

If you have any questions, please contact me at (916) 691-0209.

Sincerely,

T. BELAVICH, Ph.D., MSHCA, CCHP
Deputy Director (A)
Statewide Mental Health Program
Division of Correctional Health Care Services

Enclosures

cc: Diana Toche, DDS, Director (A), Division of Correctional Health Care Services (DCHCS)
Mohamedu F., Jones, Esq., *Coleman* Deputy Special Master
Linda Holden, Esq., *Coleman* Deputy Special Master
Jeffrey L. Metzner, M.D., *Coleman* Expert
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[redacted]

Haunani Henry, *Coleman* Monitor
Debbie Vorous, Esq., Office of the Attorney General
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Donald Specter, Esq., Prison Law Office
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Nathan Stanley, Chief, Operational Program Oversight, Statewide Mental Health Program DCHCS
Karen Higgins, M.D., Chief of Behavioral Medicine, Statewide Mental Health Program, DCHCS
Teresa Owens, Associate Governmental Program Analyst, Operational Program Oversight, DCHCS

WEEKLY EOP POPULATION REPORT
(For the Week of MAR. 12, 2012)

Male Institutions	Staffed Capacity	Total Current Pop	Current Vacancies	Percent Filled	Total Seats Requested	Total Seats Provided	Number of Seats Requested for Endorsed Cases, by Sending Location *
SATF SNY II	176	171	5	97%	23	9	***5-AVE, 1-CIM, 1-LACRC, 1-RJDRC, 1-SQRC,*** 7-NKSP, 7-WSP
SATF COD II	88	85	3	97%	11	3	***3-CMC,*** 8-CMC
CMC III	580	575	5	99%	41	15	***1-CMF, 9-LACRC, 4-WSP, 1-HDSPRC,*** 1-AVE, 10-CMF, 2-FOL, 2-LAC, 1-PBSP, 1-RJD, 1-SAC, 1-SATF, 2-SOL
CMF III	333	346	-13	104%	3	1	***1-CMC,*** 1-SOL, 1-WSP
RJD III	330	329	1	100%	19	0	3-LAC, 1-HDSP, 3-CMF, 10-CMC, 1-LACRC, 1-NKSP
LAC IV (270)	300	305	-5	102%	2	0	2-CMC
MCSP SNY III	360	329	31	91%	47	5	***2-LACRC, 2-CCIRC, 1-SOL,*** 1-CCI, 1-COR, 4-CTF, 1-LAC, 2-PVSP, 4-WSP, 1-RJD, 1-SAC, 1-SATF, 2-SCC, 1-SVSP, 4-CIM, 5-LACRC, 2-NKSP, 10-RJDRC, 2-SQRC
COR SNY IV (270)	150	89	61	59%	46	17	***1-CMC, 5-KVSP, 2-LAC, 5-MCSP, 1-PBSP, 2-RJD, 1-SATF,*** 19-RJD, 9-MCSP, 1-KVSP
MCSP SNY IV (270)	150	148	2	99%	47	4	***2-LACRC, 1-ISP, 1-KVSP,*** 1-CCI, 1-CMC, 3-CMF, 5-COR, 4-HDSP, 1-KVSP, 2-PBSP, 1-PVSP, 1-RJD, 9-SAC, 3-SATF, 1-SCC, 4-SVSP, 2-RJDRC, 5-WSP
RJD SNY IV (270)	150	147	3	98%	9	2	***1-LAC, 1-LACRC,*** 1-WSP, 1-SAC, 1-SATF, 2-PVSP, 2-COR
KVSP SNY IV (180)	96	90	6	94%	26	8	***2-SQRC, 1-SATF, 2-SAC, 1-MCSP, 2-COR,*** 1-CMF, 1-HDSP, 5-LAC, 2-PVSP, 1-SAC, 4-SVSP, 1-CCIRC, 3-NKSP
PBSP IV (180)	66	64	2	97%	2	2	***1-LAC, 1-SAC***
SAC IV (180)	384	395	-11	103%	4	4	***1-CMC, 1-LAC, 1-SVSP, 1-WSP***
SVSP IV (180)	192	186	6	97%	0	0	
TOTALS:	**3355**	**3259**	**96**	**97%**	**280**	**70**	

(per 3-9-12 PSU Wait List)

CIW PSU	20	20	0	100%	7	0	2-CIW, 5-VSPW
PBSP PSU	128	116	12	91%	30	2	***2-CMF,*** 12-COR, 8-LAC, 2-MCSP, 1-CMC, 3-RJD, 2-SVSP
SAC PSU	256	241	15	94%	27	4	***1-MCSP, 1-LAC, 2-COR,*** 6-COR, 1-CMC, 1-SVSP, 1-WSP, 1-DVI, 1-MCSP, 1-KVSP, 1-CIM, 1-SAC, 1-SQ, 3-LAC, 1-NKSP, 3-RJD, 1-CMF

Female Insts.							
CCWF	54	47	7	87%	1	1	***1-VSPW***
CIW	75	42	33	56%	1	1	***1-VSPW***
TOTALS:	**129**	**89**	**40**	**69%**	**2**	**2**	

*Inter-institution transfers only. Numbers/locations in bold/italics indicate bus seats assigned for transport this week.

Prep by: Health Care Placement Oversight Program - Operations, 916-327-1250

Note: A small number of EOP beds may be kept vacant for inmates temporarily housed in MHCrisis as part of the 10-day "hold-a-bed" process.
"Total Current Pop" from Population Mgmt. Unit (dated 3-9-11) of the C&PRs' call-ins of filled EOP beds.
Bus seat data source: Transportation Weekly Consolidated Worksheet

Final

Level II COD: Capacity=88; pop =85 Moved 3 of 11 (28%)
Level II SNY: Capacity=176; pop.=171 Moved 9 of 23 (40%)

Level IV GP 180 Capacity=642; pop.=645 Moved 6 of 6 (100%)
Level IV GP 270 Capacity=300; pop.=305 Moved 0 of 2 (0%)

WEEKLY EOP POPULATION REPORT
(For the Week of MAR. 12, 2012)

Level III GP: Capacity=1243; pop.=1250 Moved 16 of 63 (26%)
Level III SNY: Capacity=360; pop =329 Moved 5 of 47 (11%)

Level IV SNY 180: Capacity=96; pop.=90 Moved 8 of 26 (31%)
Level IV SNY 270: Capacity=450; pop.=384 Moved 23 of 102 (23%)

DIVISION OF CORRECTIONAL HEALTH CARE SERVICES
STATEWIDE MENTAL HEALTH PROGRAM
P.O. Box 942883
Sacramento, CA94283-0001

June 4, 2012

Matthew A. Lopes, Jr. Esquire
Office of the Special Master
Pannone Lopes & Devereaux LLC
317 Iron Horse Point Way, Suite 301
Providence, RI 02908

via: Debbie J. Vorous, Esquire
Deputy Attorney General
Department of Justice
1300 "I" Street, Suite 125
P. O. Box 944255
Sacramento, CA 94244-2550

RE: COLEMAN MONTHLY REPORT OF INFORMATION REQUESTED AND RESPONSE TO JANUARY 19, 1999, COURT ORDER REGARDING STAFF VACANCIES

Dear Mr. Lopes:

Enclosed is the Coleman Monthly Report reflective of April, 2012 data (or as otherwise noted). The following is the list of enclosures:

1. Mental Health Services Delivery System (MHSDS) Staffing Allocation and Vacancy History.
2. MHSDS Hiring Activity Report.
3. Health Care Placement Oversight Program (HCPOP) Information Report, Summary and Administrative Segregation Greater than 60 Days.
4. Mental Health Contract Services including Summary and Telemedicine Monthly Report for all disciplines.
5. California Department of Corrections and Rehabilitation (CDCR) Reception Center (RC) Monthly Report.
6. Monthly Summary of Mental Health Crisis Bed use by Institution Titles Inpatient Psychiatric Aging Report.
7. Referrals for Transfer to the Department of Mental Health (including admissions).
8. Atascadero State Hospital (ASH) Discharges.
9. Weekly Enhanced Outpatient Program (EOP)/Outpatient Psychiatric Program.
10. The Department of Mental Health (DMH) Monthly Report of CDCR Patients in DMH Hospitals -- Summary and Penal Code 2684.
11. Suicide Report.
12. Statistics on Contracted Registered Nurse (RN). **(No Longer Available)**
13. RC Processing for MHSDS Inmate Patients.
14. Medical Technical Assistant (MTA) Vacancy Report. **(No Longer Available)**
15. Allocated Case Manager Positions and Vacancies for the EOP Administrative Segregated Hub institutions.
16. EOP Inmates Waiting Transfer to a Psychiatric Services Unit (PSU).

17. Audit reports on Psychiatric Technician Rounds in Administrative Segregation at California State Prison, San Quentin (SQ), California State Prison-Corcoran (COR), and Salinas Valley State Prison (SVSP).
18. Mental Health Crisis Beds Wait List.
19. Correctional Treatment Centers and CDCR General Acute Care Hospital Care Placement Issues. **(No longer available)**
20. Transferred and Rescinded Mental Health Crisis Bed Referrals by Institution and Level of Care.

If you have any questions, please contact me at (916) 324-2933.

Sincerely,

T. BELAVICH, Ph.D., MSHCA, CCHP
Deputy Director (A)
Statewide Mental Health Program
Division of Correctional Health Care Services

Enclosures

cc: Diana Toche, DDS, Director (A), Division of Correctional Health Care Services (DCHCS)
Mohamedu F., Jones, Esq., *Coleman* Deputy Special Master
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Jeffrey L. Metzner, M.D., *Coleman* Expert
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Debbie Vorous, Esq., Office of the Attorney General
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[redacted]

Michael Stone, Esq., Office of Legal Affairs, CDCR
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Karen Higgins, M.D., Chief of Behavioral Medicine, Statewide Mental Health Program, DCHCS
Teresa Owens, Associate Governmental Program Analyst, Operational Program Oversight, DCHCS

WEEKLY EOP POPULATION REPORT
(For the Week of APR. 30, 2012)

Male Institutions	Staffed Capacity	Total Current Pop	Current Vacancies	Percent Filled	Total Seats Requested	Total Seats Provided	Number of Seats Requested for Endorsed Cases, by Sending Location *
SATF SNY II	176	158	18	90%	27	9	***2-WSP, 2-RJDRC, 2-NKSP, 1-CIM, 1-LAC, 1-COR,*** 3-AVE, 2-CCI, 3-NKSP, 4-RJDRC, 6-WSP
SATF COD II	88	84	4	95%	8	5	***4-CMC, 1-CTF,*** 2-CMF, 1-RJD
CMC III	580	576	4	99%	36	15	***1-WSP, 2-RJDRC, 4-NKSP, 1-SVSP, 2-SOL, 1-SCC, 2-SAC, 1-FOL, 1-AVE,*** 7-CMF, 2-LAC, 2-PBSP, 4-NKSP, 6-RJDRC
CMF III	333	336	-3	101%	10	1	***1-CMC,*** 2-AVE, 3-SAC, 1-SCC, 2-NKSP, 1-WSP
RJD III	330	330	0	100%	23	3	***1-LAC, 1-CTF, 1-CMF,*** 1-CMC, 5-CMF, 3-FOL, 1-LAC, 1-PVSP, 3-SAC, 1-SATF, 1-SCC, 1-SOL, 1-DVIRC, 2-WSP
LAC IV (270)	300	302	-2	101%	7	7	***3-SAC, 1-SVSP, 1-PBSP, 1-KVSP, 1-COR***
MCSP SNY III	360	354	6	98%	26	6	***1-WSP, 3-NKSP, 1-PVSP, 1-LAC,*** 1-COR, 1-CTF, 5-RJD, 1-SAC, 1-SATF, 3-SCC, 8-RJDRC
COR SNY IV (270)	150	132	18	88%	24	2	***1-RJD, 1-SATF,*** 1-RJDRC, 1-NKSP, 2-SAC, 16-RJD, 1-KVSP, 1-CMF
MCSP SNY IV (270)	150	145	5	97%	14	2	***1-NKSP, 1-WSP,*** 1-DVIRC, 1-CIM, 6-SAC, 1-SATF, 2-HDSP, 1-CMF
RJD SNY IV (270)	150	147	3	98%	5	5	***1-SATF, 1-MCSP, 1-LAC, 1-CMF, 1-CMC***
KVSP SNY IV (180)	96	93	3	97%	22	5	***1-SQRC, 2-NKSP, 1-DVIRC, 1-SAC,*** 1-CMF, 1-HDSP, 4-LAC, 5-MCSP, 2-PVSP, 2-RJD, 2-SAC
PBSP IV (180)	66	63	3	95%	3	3	***1-KVSP, 1-LAC, 1-CMF***
SAC IV (180)	384	379	5	99%	2	2	***1-SVSP, 1-CMF***
SVSP IV (180)	192	187	5	97%	0	0	
TOTALS:	**3355**	**3286**	**69**	**98%**	**207**	**65**	

(per 4-27-12 PSU Pending List)

CIW PSU	20	20	0	100%	7	0	3-CIW, 4-VSPW
PBSP PSU	128	126	2	98%	27	0	1-SQ, 1-CMC, 1-SCC, 2-WSP, 1-SVSP, 1-MCSP, 1-RJD, 7-LAC, 12-COR
SAC PSU	256	255	1	100%	23	6	***1-COR, 5-LAC,*** 1-MCSP, 4-LAC, 4-COR, 1-SVSP, 3-SAC, 3-RJD, 1-PVSP

Female Insts.							
CCWF	54	43	11	80%	0	0	
CIW	75	42	33	56%	0	0	
TOTALS:	**129**	**85**	**44**	**66%**	**0**	**0**	

*Inter-institution transfers only. Numbers/locations in bold/italics indicate bus seats assigned for transport this week.
"Total Current Pop" from Population Mgmt. Unit (dated 4-27-12) of the C&PRs' call-ins of filled EOP program beds.
Bus seat data source: Transportation Weekly Consolidated Worksheet

Prep by: Health Care Placement Oversight Program - Operations, 916-327-1250

Final

Level II COD: Capacity 88; pop =84 Moved 5 of 8 (63%)
Level II SNY: Capacity=176; pop.=158 Moved 9 of 27 (34%)
Level III GP: Capacity=1243; pop.=1242 Moved 19 of 69 (28%)
Level III SNY: Capacity=360; pop =354 Moved 6 of 26 (23%)

Level IV GP 180 Capacity=642; pop.=629 Moved 5 of 5 (100%)
Level IV GP 270 Capacity=300; pop.=302 Moved 7 of 7 (100%)
Level IV SNY 180: Capacity=96; pop.=93 Moved 5 of 22 (23%)
Level IV SNY 270: Capacity=450; pop.=424 Moved 9 of 43 (21%)

DIVISION OF CORRECTIONAL HEALTH CARE SERVICES
STATEWIDE MENTAL HEALTH PROGRAM
P.O. Box 942883
Sacramento, CA94283-0001

July 3, 2012

Matthew A. Lopes, Jr. Esquire
Office of the Special Master
Pannone Lopes & Devereaux LLC
317 Iron Horse Point Way, Suite 301
Providence, RI 02908

via: Debbie J. Vorous, Esquire
Deputy Attorney General
Department of Justice
1300 "I" Street, Suite 125
P. O. Box 944255
Sacramento, CA 94244-2550

RE: COLEMAN MONTHLY REPORT OF INFORMATION REQUESTED AND RESPONSE TO JANUARY 19, 1999, COURT ORDER REGARDING STAFF VACANCIES

Dear Mr. Lopes:

Enclosed is the Coleman Monthly Report reflective of May, 2012 data (or as otherwise noted). The following is the list of enclosures:

1. Mental Health Services Delivery System (MHSDS) Staffing Allocation and Vacancy History.
2. MHSDS Hiring Activity Report.
3. Health Care Placement Oversight Program (HCPOP) Information Report, Summary and Administrative Segregation Greater than 60 Days. **Due to a server migration issue that occurred during the move to Elk Grove, the following reports are unavailable for the month of May:**
   - R-01: Mental Health Population by Institution
   - R-02: Mental Health ASU/SHU/PSU
     (The "MHSDS Management Information Summary" report has been provided, in lieu of these reports).
   - R-08: EOP and CCCMS in ASU/SHU/PSU - Placements greater than 21 less than 60 days
   - R-09: EOP and CCCMS in ASU/SHU/PSU - Placements greater than 60 less than 90 days
   - R-10: EOP and CCCMS in ASU/SHU/PSU - Placements greater than 90 days
     (Reports not included. Will be provided under separate cover).
4. Mental Health Contract Services including Summary and Telemedicine Monthly Report for all disciplines.
5. California Department of Corrections and Rehabilitation (CDCR) Reception Center (RC) Monthly Report.

6. Monthly Summary of Mental Health Crisis Bed use by Institution Titles Inpatient Psychiatric Aging Report. **(Not included. Will be provided under separate cover)**
7. Referrals for Transfer to the Department of Mental Health (including admissions).
8. Atascadero State Hospital (ASH) Discharges.
9. Weekly Enhanced Outpatient Program (EOP)/Outpatient Psychiatric Program.
10. The Department of Mental Health (DMH) Monthly Report of CDCR Patients in DMH Hospitals -- Summary and Penal Code 2684.
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19. Correctional Treatment Centers and CDCR General Acute Care Hospital Care Placement Issues. **(No longer available)**
20. Transferred and Rescinded Mental Health Crisis Bed Referrals by Institution and Level of Care.

If you have any questions, please contact me at (916) 691-0296.

Sincerely,

T. BELAVICH, Ph.D., MSHCA, CCHP
Deputy Director (A)
Statewide Mental Health Program
Division of Correctional Health Care Services

Enclosures

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Nathan Stanley, Chief, Operational Program Oversight, Statewide Mental Health Program DCHCS
Karen Higgins, M.D., Chief of Behavioral Medicine, Statewide Mental Health Program, DCHCS
Teresa Owens, Associate Governmental Program Analyst, Operational Program Oversight, DCHCS

WEEKLY EOP POPULATION REPORT
(For the Week of MAY 21, 2012)

Male Institutions	Staffed Capacity	Total Current Pop	Current Vacancies	Percent Filled	Total Seats Requested	Total Seats Provided	Number of Seats Requested for Endorsed Cases, by Sending Location *
SATF SNY II	176	163	13	93%	14	8	***3-AVE, 3-CCI-RC, 2-RJDRC,*** 1-CMF, 1-MCSP, 4-RJDRC
SATF COD II	88	82	6	93%	2	2	***2-RJDRC***
CMC III	580	575	5	99%	29	12	***1-WSP, 5-RJDRC, 6-NKSP,*** 1-SVSP, 2-SCC, 1-SATF, 1-SAC, 2-PBSP, 1-LAC, 8-CMF, 1-AVE
CMF III	333	331	2	99%	14	1	***1-CMC,*** 2-AVE, 1-RJD, 4-SAC, 1-SATF, 1-SOL, 1-SVSP, 2-NKSP, 1-WSP
RJD III	330	330	0	100%	20	4	***3-CMC, 1-FOL,*** 2-CMC, 7-CMF, 1-FOL, 1-HDSP, 1-LAC, 1-PVSP, 2-SCC, 1-SOL
LAC IV (270)	300	308	-8	103%	13	2	***2-SAC,*** 1-SATF, 3-NKSP, 5-SAC, 2-CMC
MCSP SNY III	360	365	-5	101%	25	3	***1-NKSP, 1-WSP, 1-CCI,*** 1-CCI, 1-COR, 1-CTF, 1-KVSP, 1-LAC, 4-RJD, 2-SATF, 3-SCC, 8-RJDRC
COR SNY IV (270)	150	155	-5	103%	23	1	***1-CMC,*** 1-CMF, 1-HDSP, 1-LAC, 3-MCSP, 13-RJD, 1-SAC, 1-SATF, 1-SVSP
MCSP SNY IV (270)	150	144	6	96%	10	4	***2-HDSP, 1-KVSP, 1-SCC,*** 1-SATF, 4-SAC, 1-CMF
RJD SNY IV (270)	150	142	8	95%	10	7	***1-CMC, 1-CMF, 1-COR, 2-HDSP, 1-MCSP, 1-NKSP,*** 1-SVSP, 1-SATF, 1-LAC
KVSP SNY IV (180)	96	90	6	94%	25	6	***1-WSP, 1-NKSP, 1-SVSP, 2-RJD, 1-PBSP,*** 1-CMF, 4-COR, 3-LAC, 6-MCSP, 2-PVSP, 3-SAC
PBSP IV (180)	66	62	4	94%	1	1	***1-CMC***
SAC IV (180)	384	384	0	100%	2	2	***1-COR, 1-HDSP***
SVSP IV (180)	192	186	6	97%	1	1	***1-KVSP***
TOTALS:	**3355**	**3317**	**38**	**99%**	**189**	**54**	

(per 5-18-12 PSU Pending List)

CIW PSU	20	18	2	90%	6	0	2-VSPW, 4-CIW
PBSP PSU	128	118	10	92%	25	2	***2-COR,*** 1-CMC, 13-COR, 5-LAC, 1-SVSP, 3-MCSP
SAC PSU	256	242	14	95%	26	6	***3-LAC, 1-COR, 2-CMC,*** 3-LAC, 1-SAC, 3-COR, 1-RJD, 1-CMC, 5-SVSP, 3-MCSP, 2-CMF, 1-CCI

Female Insts. CCWF	54	53	1	98%	0	0	
CIW	75	44	31	59%	0	0	
TOTALS:	**129**	**97**	**32**	**75%**	**0**	**0**	

*Inter-institution transfers only. Numbers/locations in bold/italics indicate bus seats assigned for transport this week.
"Total Current Pop" from Population Mgmt. Unit (dated 5-18-12) of the C&PRs' call-ins of filled EOP program beds.
Bus seat data source: Transportation Weekly Consolidated Worksheet

Prep by: Health Care Placement Oversight Program - Operations, 916-327-1250

Final

Level II COD: Capacity 88; pop =82 Moved 2 of 2 (100%)
Level II SNY: Capacity=176; pop.=163 Moved 8 of 14 (58%)
Level III GP: Capacity=1243; pop.=1236 Moved 17 of 63 (27%)
Level III SNY: Capacity=360; pop =365 Moved 3 of 25 (12%)

Level IV GP 180 Capacity=642; pop.=632 Moved 4 of 4 (100%)
Level IV GP 270 Capacity=300; pop.=308 Moved 2 of 13 (16%)
Level IV SNY 180: Capacity=96; pop.=90 Moved 6 of 25 (24%)
Level IV SNY 270: Capacity=450; pop.=441 Moved 12 of 43 (28%)

DIVISION OF CORRECTIONAL HEALTH CARE SERVICES
STATEWIDE MENTAL HEALTH PROGRAM
P.O. Box 942883
Sacramento, CA94283-0001

August 3, 2012

Matthew A. Lopes, Jr. Esquire
Office of the Special Master
Pannone Lopes & Devereaux LLC
317 Iron Horse Point Way, Suite 301
Providence, RI 02908

via: Debbie J. Vorous, Esquire
Deputy Attorney General
Department of Justice
1300 "I" Street, Suite 125
P. O. Box 944255
Sacramento, CA 94244-2550

RE: COLEMAN MONTHLY REPORT OF INFORMATION REQUESTED AND RESPONSE TO JANUARY 19, 1999, COURT ORDER REGARDING STAFF VACANCIES

Dear Mr. Lopes:

Enclosed is the Coleman Monthly Report reflective of June, 2012 data (or as otherwise noted). The following is the list of enclosures:

1. Mental Health Services Delivery System (MHSDS) Staffing Allocation and Vacancy History.
2. MHSDS Hiring Activity Report.
3. Health Care Placement Oversight Program (HCPOP) Information Report, Summary and Administrative Segregation Greater than 60 Days.
4. Mental Health Contract Services including Summary and Telemedicine Monthly Report for all disciplines.
5. California Department of Corrections and Rehabilitation (CDCR) Reception Center (RC) Monthly Report.
6. Monthly Summary of Mental Health Crisis Bed use by Institution Titles Inpatient Psychiatric Aging Report.
7. Referrals for Transfer to the Department of Mental Health (including admissions).
8. Atascadero State Hospital (ASH) Discharges.
9. Weekly Enhanced Outpatient Program (EOP)/Outpatient Psychiatric Program.
10. The Department of Mental Health (DMH) Monthly Report of CDCR Patients in DMH Hospitals -- Summary and Penal Code 2684.
11. Suicide Report.
12. Statistics on Contracted Registered Nurse (RN). **(No Longer Available)**
13. RC Processing for MHSDS Inmate Patients.
14. Medical Technical Assistant (MTA) Vacancy Report. **(No Longer Available)**
15. Allocated Case Manager Positions and Vacancies for the EOP Administrative Segregated Hub institutions.

16. EOP Inmates Waiting Transfer to a Psychiatric Services Unit (PSU).
17. Audit reports on Psychiatric Technician Rounds in Administrative Segregation at California State Prison, San Quentin (SQ), California State Prison-Corcoran (COR), and Salinas Valley State Prison (SVSP).
18. Mental Health Crisis Beds Wait List.
19. Correctional Treatment Centers and CDCR General Acute Care Hospital Care Placement Issues. **(No longer available)**
20. Transferred and Rescinded Mental Health Crisis Bed Referrals by Institution and Level of Care.

If you have any questions, please contact me at (916) 691-0209.

Sincerely,

T. BELAVICH, Ph.D., MSHCA, CCHP
Deputy Director (A)
Statewide Mental Health Program
Division of Correctional Health Care Services

Enclosures

cc: Diana Toche, DDS, Director (A), Division of Correctional Health Care Services (DCHCS)
Mohamedu F., Jones, Esq., *Coleman* Deputy Special Master
Linda Holden, Esq., *Coleman* Deputy Special Master
Jeffrey L. Metzner, M.D., *Coleman* Expert
Kerry C. Hughes, M.D., *Coleman* Expert
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Patricia Williams, Esq., *Coleman* Monitor
Haunani Henry, *Coleman* Monitor
J. Ronald Metz, *Coleman* Monitor
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Teresa Owens, Associate Governmental Program Analyst, Operational Program Oversight, DCHCS

WEEKLY EOP POPULATION REPORT
(For the Week of JUNE 11, 2012)

Male Institutions	Staffed Capacity	Total Current Pop	Current Vacancies	Percent Filled	Total Seats Requested	Total Seats Provided	Number of Seats Requested for Endorsed Cases, by Sending Location *
SATF SNY II	176	161	15	91%	12	8	***4-NKSP, 3-RJDRC, 1-AVE,*** 1-MCSP, 3-RJDRC
SATF COD II	88	86	2	98%	4	4	***1-CMC, 1-CRC, 1-RJD, 1-RJDRC***
CMC III	580	582	-2	100%	15	6	***1-COR, 1-MCSP, 1-SATF, 2-CIM, 1-NKSP,*** 1-SVSP, 1-SCC, 1-PBSP, 6-CMF
CMF III	333	338	-5	102%	11	3	***1-AVE, 1-COR, 1-SOL,*** 2-SATF, 5-SAC, 1-RJD
RJD III	330	330	0	100%	21	3	***1-CMC, 2-CMF,*** 4-CMF, 1-NKSP, 2-SOL, 2-SCC, 3-SAC, 1-PVSP, 1-HDSP, 1-FOL, 3-CMC
LAC IV (270)	300	305	-5	102%	7	1	***1-KVSP,*** 4-SAC, 2-CMC
MCSP SNY III	360	353	7	98%	40	6	***1-CMC, 1-CIM, 1-HDSPRC, 1-RJDRC, 2-SQRC,*** 4-WSP, 7-RJDRC, 4-NKSP, 2-CIM, 2-SVSP, 2-SCC, 5-RJD, 3-LAC, 1-KVSP, 2-CTF, 2-COR
COR SNY IV (270)	150	145	5	97%	24	1	***1-CMF,*** 1-CMC, 4-MCSP, 1-LAC, 15-RJD, 1-SVSP, 1-NKSP
MCSP SNY IV (270)	150	139	11	93%	7	7	***1-CMC, 1-HDSP, 1-KVSP, 1-SAC, 1-SATF, 1-SVSP, 1-RJDRC***
RJD SNY IV (270)	150	147	3	98%	15	2	***1-NKSP, 1-CMC,*** 1-CMC, 1-CMF, 3-LAC, 1-MCSP, 1-PBSP, 2-SAC, 1-SATF, 3-SVSP
KVSP SNY IV (180)	96	94	2	98%	18	4	***1-CMF, 1-LAC, 2-MCSP,*** 3-SAC, 1-RJD, 2-PVSP, 4-MCSP, 1-LAC, 3-COR
PBSP IV (180)	66	60	6	91%	0	0	
SAC IV (180)	384	378	6	98%	5	5	***1-NKSP, 1-SVSP, 2-MCSP, 1-CMC***
SVSP IV (180)	192	190	2	99%	1	1	***1-SQRC***
TOTALS:	**3355**	**3308**	**47**	**99%**	**180**	**51**	

(per 6-11-12 PSU Pending List)

CIW PSU	20	19	1	95%	8	0	4-VSPW, 4-CIW
PBSP PSU	128	116	12	91%	22	4	***4-COR,*** 1-CMC, 1-RJD, 1-SVSP, 7-COR, 1-CIM, 5-LAC, 2-MCSP
SAC PSU	256	242	14	95%	14	6	***2-RJD, 4-SVSP,*** 1-RJD, 1-LAC, 1-SVSP, 1-MCSP, 2-SAC, 1-CMF, 1-CMC

Female Insts.							
CCWF	54	51	3	94%	0	0	
CIW	75	46	29	61%	3	3	***1-CCWF, 2-VSPW***
TOTALS:	**129**	**97**	**32**	**75%**	**3**	**3**	

*Inter-institution transfers only. Numbers/locations in bold/italics indicate bus seats assigned for transport this week.
"Total Current Pop" from Population Mgmt. Unit (dated 6-8-12) of the C&PRs' call-ins of filled EOP program beds.
Bus seat data source: Transportation Weekly Consolidated Worksheet

Prep by: Health Care Placement Oversight Program - Operations, 916-327-1250

Final

Level II COD: Capacity 88; pop =86 Moved 4 of 4 (100%)
Level II SNY: Capacity=176; pop.=161 Moved 8 of 12 (67%)
Level III GP: Capacity=1243; pop.=1250 Moved 12 of 47 (26%)
Level III SNY: Capacity=360; pop =353 Moved 6 of 40 (15%)

Level IV GP 180 Capacity=642; pop.=628 Moved 6 of 6 (100%)
Level IV GP 270 Capacity=300; pop.=305 Moved 1 of 7 (15%)
Level IV SNY 180: Capacity=96; pop.=94 Moved 4 of 18 (23%)
Level IV SNY 270: Capacity=450; pop.=431 Moved 10 of 46 (22%)

DIVISION OF CORRECTIONAL HEALTH CARE SERVICES
STATEWIDE MENTAL HEALTH PROGRAM
P.O. Box 942883
Sacramento, CA94283-0001

September 4, 2012

Matthew A. Lopes, Jr. Esquire
Office of the Special Master
Pannone Lopes & Devereaux LLC
317 Iron Horse Point Way, Suite 301
Providence, RI 02908

via: Debbie J. Vorous, Esquire
Deputy Attorney General
Department of Justice
1300 "I" Street, Suite 125
P. O. Box 944255
Sacramento, CA 94244-2550

RE: COLEMAN MONTHLY REPORT OF INFORMATION REQUESTED AND RESPONSE TO JANUARY 19, 1999, COURT ORDER REGARDING STAFF VACANCIES

Dear Mr. Lopes:

Enclosed is the Coleman Monthly Report reflective of July, 2012, data (or as otherwise noted). The following is the list of enclosures:

1. Mental Health Services Delivery System (MHSDS) Staffing Allocation and Vacancy History.
2. MHSDS Hiring Activity Report.
3. Health Care Placement Oversight Program (HCPOP) Information Report, Summary and Administrative Segregation Greater than 60 Days.
4. Mental Health Contract Services including Summary and Telemedicine Monthly Report for all disciplines.
5. California Department of Corrections and Rehabilitation (CDCR) Reception Center (RC) Monthly Report.
6. Monthly Summary of Mental Health Crisis Bed use by Institution Titles Inpatient Psychiatric Aging Report.
7. Referrals for Transfer to the Department of Mental Health (including admissions).
8. Atascadero State Hospital (ASH) Discharges.
9. Weekly Enhanced Outpatient Program (EOP)/Outpatient Psychiatric Program.
10. The Department of Mental Health (DMH) Monthly Report of CDCR Patients in DMH Hospitals -- Summary and Penal Code 2684.
11. Suicide Report.
12. Statistics on Contracted Registered Nurse (RN). **(No Longer Available)**
13. RC Processing for MHSDS Inmate Patients.
14. Medical Technical Assistant (MTA) Vacancy Report. **(No Longer Available)**
15. Allocated Case Manager Positions and Vacancies for the EOP Administrative Segregated Hub institutions.
16. EOP Inmates Waiting Transfer to a Psychiatric Services Unit (PSU).

17. Audit reports on Psychiatric Technician Rounds in Administrative Segregation at California State Prison, San Quentin (SQ), California State Prison-Corcoran (COR), and Salinas Valley State Prison (SVSP).
18. Mental Health Crisis Beds Wait List.
19. Correctional Treatment Centers and CDCR General Acute Care Hospital Care Placement Issues. **(No longer available)**
20. Transferred and Rescinded Mental Health Crisis Bed Referrals by Institution and Level of Care.

If you have any questions, please contact me at (916) 324-2933.

Sincerely,

William Stanley for,

TIMOTHY G. BELAVICH, Ph.D., MSHCA, CCHP
Deputy Director (A)
Statewide Mental Health Program
Division of Correctional Health Care Services

Enclosures

cc: Diana Toche, DDS, Director (A), Division of Correctional Health Care Services (DCHCS)
Mohamedu F., Jones, Esq., *Coleman* Deputy Special Master
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Teresa Owens, Associate Governmental Program Analyst, Operational Program Oversight, DCHCS

WEEKLY EOP POPULATION REPORT
(For the Week of JULY 30, 2012)

Male Institutions	Staffed Capacity	Total Current Pop	Current Vacancies	Percent Filled	Total Seats Requested	Total Seats Provided	Number of Seats Requested for Endorsed Cases, by Sending Location *
SATF SNY II	176	175	1	99%	26	0	2-WSP, 1-SQRC, 1-CMC, 1-CRC, 1-LAC, 5-MCSP, 5-CIM, 1-HDPSRC, 3-NKSP, 6-RJDRC
SATF COD II	88	77	11	88%	9	9	***1-WSP, 2-RJDRC, 2-NKSP, 1-SVSP, 2-CMC, 1-CMF***
CMC III	580	567	13	98%	0	0	
CMF III	333	351	-18	105%	12	4	***1-FOL, 1-PVSP, 1-SCC, 1-SVSP,*** 3-SATF, 3-SAC, 1-MCSP, 1-CMC
RJD III	330	328	2	99%	8	2	***1-SAC, 1-CMC,*** 2-CMF, 1-CMC, 1-SATF, 1-PBSP, 1-SAC
LAC IV (270)	300	303	-3	101%	10	3	***1-SAC, 1-SVSP, 1-MCSP,*** 2-SVSP, 2-SAC, 2-PBSP, 1-CMC
MCSP SNY III	360	361	-1	100%	32	5	***1-NKSP, 1-WSP, 1-CIM, 1-LAC, 1-RJD,*** *3-AVE, 3-RJDRC, 2-CIM, 2-SATF, 5-LAC, 2-KVSP, 4-CTF, 6-COR*
COR SNY IV (270)	150	150	0	100%	8	1	***1-MCSP,*** 1-MCSP, 2-LAC, 2-RJD, 2-SAC
MCSP SNY IV (270)	150	142	8	95%	5	5	***1-NKSP, 1-SAC, 1-PVSP, 1-LAC, 1-COR***
RJD SNY IV (270)	150	149	1	99%	12	3	***1-MCSP, 1-PVSP, 1-CMC,*** 1-CMC, 4-LAC, 2-MCSP, 2-SAC
KVSP SNY IV (180)	96	93	3	97%	18	2	***1-WSP, 1-SAC,*** 1-SVSP, 2-SAC, 4-RJD, 4-MCSP, 3-LAC, 1-COR, 1-CMC
PBSP IV (180)	66	62	4	94%	0	0	
SAC IV (180)	384	355	29	92%	0	0	
SVSP IV (180)	192	183	9	95%	2	2	***1-LAC, 1-SAC***
TOTALS:	**3355**	**3296**	**59**	**98%**	**142**	**36**	

(per 7-27-12 PSU Pending List)

CIW PSU	20	18	2	90%	6	0	2-CIW, 4-VSPW
PBSP PSU	128	117	11	91%	9	3	***2-COR, 1-SVSP,*** 1-LAC, 3-CMC, 2-SVSP
SAC PSU	256	238	18	93%	13	4	***2-CMC, 1-COR, 1-CMF,*** 1-RJD, 6-MCSP, 2-CMC

Female Insts.							
CCWF	54	42	12	78%	0	0	
CIW	75	46	29	61%	0	0	
TOTALS:	**129**	**88**	**41**	**68%**	**0**	**0**	

*Inter-institution transfers only. Numbers/locations in bold/italics indicate bus seats assigned for transport this week.
"Total Current Pop" from Population Mgmt. Unit (dated 7-27-12) of the C&PRs' call-ins of filled EOP program beds.
Bus seat data source: Transportation Weekly Consolidated Worksheet

Prep by: Health Care Placement Oversight Program - Operations, 916-327-1250

Final

Level II COD: Capacity 88; pop =77 Moved 9 of 9 (100%)
Level II SNY: Capacity=176; pop.=175 Moved 0 of 26 (0%)
Level III GP: Capacity=1243; pop.=1246 Moved 6 of 20 (30%)
Level III SNY: Capacity=360; pop =361 Moved 5 of 32 (16%)

Level IV GP 180 Capacity=642; pop.=600 Moved 2 of 2 (100%)
Level IV GP 270 Capacity=300; pop.=303 Moved 3 of 10 (30%)
Level IV SNY 180: Capacity=96; pop.=93 Moved 2 of 18 (12%)
Level IV SNY 270: Capacity=450; pop.=441 Moved 9 of 25 (36%)

DIVISION OF CORRECTIONAL HEALTH CARE SERVICES
STATEWIDE MENTAL HEALTH PROGRAM
P.O. Box 942883
Sacramento, CA94283-0001

October 1, 2012

Matthew A. Lopes, Jr. Esquire
Office of the Special Master
Pannone Lopes & Devereaux LLC
317 Iron Horse Point Way, Suite 301
Providence, RI 02908

via: Debbie J. Vorous, Esquire
Deputy Attorney General
Department of Justice
1300 "I" Street, Suite 125
P. O. Box 944255
Sacramento, CA 94244-2550

RE: COLEMAN MONTHLY REPORT OF INFORMATION REQUESTED AND RESPONSE TO JANUARY 19, 1999, COURT ORDER REGARDING STAFF VACANCIES

Dear Mr. Lopes:

Enclosed is the Coleman Monthly Report reflective of August, 2012, data (or as otherwise noted). The following is the list of enclosures:

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2. MHSDS Hiring Activity Report.
3. Health Care Placement Oversight Program (HCPOP) Information Report, Summary and Administrative Segregation Greater than 60 Days.
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18. Mental Health Crisis Beds Wait List.
19. Correctional Treatment Centers and CDCR General Acute Care Hospital Care Placement Issues. **(No longer available)**
20. Transferred and Rescinded Mental Health Crisis Bed Referrals by Institution and Level of Care.

If you have any questions, please contact me at (916) 691-0296.

Sincerely,

for

TIMOTHY G. BELAVICH, Ph.D., MSHCA, CCHP
Deputy Director (A)
Statewide Mental Health Program
Division of Correctional Health Care Services

Enclosures

cc: Diana Toche, DDS, Director (A), Division of Correctional Health Care Services (DCHCS)
Mohamedu F., Jones, Esq., *Coleman* Deputy Special Master
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Teresa Owens, Associate Governmental Program Analyst, Operational Program Oversight, DCHCS

WEEKLY EOP POPULATION REPORT
(For the Week of AUG. 27, 2012)

Male Institutions	Staffed Capacity	Total Current Pop	Current Vacancies	Percent Filled	Total Seats Requested	Total Seats Provided	Number of Seats Requested for Endorsed Cases, by Sending Location *
SATF SNY II	176	170	6	97%	46	3	***1-WSP, 2-NKSP,*** 1-AVE, 1-CMC, 1-COR, 3-LAC, 7-MCSP, 1-PVSP, 1-RJD, 11-CIM, 5-NKSP, 10-RJDRC, 2-WSP
SATF COD II	88	83	5	94%	16	0	1-WSP, 1-NKSP, 4-CIM, 1-SAC, 3-RJD, 3-CMF, 3-CMC
CMC III	580	545	35	94%	8	8	***1-CCC, 1-MCSP, 1-SATF, 2-SCC, 2-NKSP, 1-SQRC***
CMF III	333	333	0	100%	11	5	***1-CTF, 2-LAC, 1-SAC, 1-SOL,*** 1-SATF, 3-SAC, 2-CMC
RJD III	330	321	9	97%	12	6	***1-CMF, 1-DVIRC, 1-SAC, 1-FOL, 2-COR,*** 3-CMC, 1-CMF, 1-SAC, 1-SVSP
LAC IV (270)	300	306	-6	102%	10	1	***1-PBSP,*** 2-SVSP, 6-SAC, 1-COR
MCSP SNY III	360	359	1	100%	32	3	***1-AVE, 1-DVIRC, 1-NKSP,*** 2-AVE, 1-CMC, 3-COR, 4-CTF, 2-KVSP, 5-LAC, 2-SAC, 1-SCC, 1-CIM, 3-RJDRC, 1-SQRC, 4-WSP
COR SNY IV (270)	150	140	10	93%	8	7	***3-SAC, 1-PVSP, 1-SVSP, 1-LAC, 1-KVSP,*** 1-PVSP
MCSP SNY IV (270)	150	133	17	89%	1	1	***1-SAC***
RJD SNY IV (270)	150	156	-6	104%	11	0	4-SAC, 3-LAC, 2-MCSP, 2-CMC
KVSP SNY IV (180)	96	94	2	98%	15	0	6-RJD, 1-SAC, 3-LAC, 4-MCSP, 1-CMC
PBSP IV (180)	66	64	2	97%	0	0	
SAC IV (180)	384	363	21	95%	1	1	***1-CMC***
SVSP IV (180)	192	178	14	93%	1	1	***1-CMF***
TOTALS:	**3355**	**3245**	**110**	**97%**	**172**	**36**	

(per 8-24-12 PSU Pending List)

CIW PSU	20	19	1	95%	5	0	3-VSPW, 2-CIW
PBSP PSU	128	120	8	94%	5	2	***1-RJD, 1-MCSP,*** 1-SVSP, 2-COR
SAC PSU	256	243	13	95%	6	5	***2-LAC, 1-PBSP, 1-MCSP, 1-SVSP,*** 1-MCSP

Female Insts. CCWF	54	41	13	76%	0	0	
CIW	75	46	29	61%	2	2	***2-CCWFRC***
TOTALS:	**129**	**87**	**42**	**67%**	**2**	**2**	

*Inter-institution transfers only. Numbers/locations in bold/italics indicate bus seats assigned for transport this week.
"Total Current Pop" from Population Mgmt. Unit (dated 8-24-12) of the C&PRs' call-ins of filled EOP program beds.
Bus seat data source: Transportation Weekly Consolidatad Worksheet

Prep by: Health Care Placement Oversight Program - Operations, 916-327-1250

Final

Level II COD: Capacity 88; pop =83 Moved 0 of 16 (0%)
Level II SNY: Capacity=176; pop.=170 Moved 3 of 46 (7%)
Level III GP: Capacity=1243; pop.=1199 Moved 19 of 31 (62%)
Level III SNY: Capacity=360; pop =359 Moved 3 of 32 (10%)

Level IV GP 180 Capacity=642; pop.=605 Moved 2 of 2 (100%)
Level IV GP 270 Capacity=300; pop.=306 Moved 1 of 10 (10%)
Level IV SNY 180: Capacity=96; pop.=94 Moved 0 of 15 (0%)
Level IV SNY 270: Capacity=450; pop.=429 Moved 8 of 20 (40%)

DIVISION OF CORRECTIONAL HEALTH CARE SERVICES
STATEWIDE MENTAL HEALTH PROGRAM
P.O. Box 942883
Sacramento, CA94283-0001

November 1, 2012

Matthew A. Lopes, Jr. Esquire
Office of the Special Master
Pannone Lopes & Devereaux LLC
317 Iron Horse Point Way, Suite 301
Providence, RI 02908

via: Debbie J. Vorous, Esquire
Deputy Attorney General
Department of Justice
1300 "I" Street, Suite 125
P. O. Box 944255
Sacramento, CA 94244-2550

RE: COLEMAN MONTHLY REPORT OF INFORMATION REQUESTED AND RESPONSE TO JANUARY 19, 1999, COURT ORDER REGARDING STAFF VACANCIES

Dear Mr. Lopes:

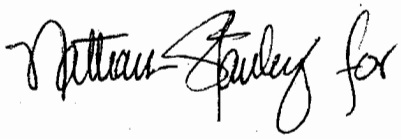
Enclosed is the Coleman Monthly Report reflective of September, 2012, data (or as otherwise noted). The following is the list of enclosures:

1. Mental Health Services Delivery System (MHSDS) Staffing Allocation and Vacancy History.
2. MHSDS Hiring Activity Report.
3. Health Care Placement Oversight Program (HCPOP) Information Report, Summary and Administrative Segregation Greater than 60 Days.
4. Mental Health Contract Services including Summary and Telemedicine Monthly Report for all disciplines.
5. California Department of Corrections and Rehabilitation (CDCR) Reception Center (RC) Monthly Report.
6. Monthly Summary of Mental Health Crisis Bed use by Institution Titles Inpatient Psychiatric Aging Report.
7. Referrals for Transfer to the Department of Mental Health (including admissions).
8. Atascadero State Hospital (ASH) Discharges.
9. Weekly Enhanced Outpatient Program (EOP)/Outpatient Psychiatric Program.
10. The Department of Mental Health (DMH) Monthly Report of CDCR Patients in DMH Hospitals -- Summary and Penal Code 2684.
11. Suicide Report.
12. Statistics on Contracted Registered Nurse (RN). **(No Longer Available)**
13. RC Processing for MHSDS Inmate Patients.
14. Medical Technical Assistant (MTA) Vacancy Report. **(No Longer Available)**
15. Allocated Case Manager Positions and Vacancies for the EOP Administrative Segregated Hub institutions.
16. EOP Inmates Waiting Transfer to a Psychiatric Services Unit (PSU).

17. Audit reports on Psychiatric Technician Rounds in Administrative Segregation at California State Prison, San Quentin (SQ), California State Prison-Corcoran (COR), and Salinas Valley State Prison (SVSP).
18. Mental Health Crisis Beds Wait List.
19. Correctional Treatment Centers and CDCR General Acute Care Hospital Care Placement Issues. **(No longer available)**
20. Transferred and Rescinded Mental Health Crisis Bed Referrals by Institution and Level of Care.

If you have any questions, please contact me at (916) 691-0296.

Sincerely,



TIMOTHY G. BELAVICH, Ph.D., MSHCA, CCHP
Deputy Director (A)
Statewide Mental Health Program
Division of Correctional Health Care Services

Enclosures

cc: Diana Toche, DDS, Director (A), Division of Correctional Health Care Services (DCHCS)
Mohamedu F., Jones, Esq., *Coleman* Deputy Special Master
Linda Holden, Esq., *Coleman* Deputy Special Master
Jeffrey L. Metzner, M.D., *Coleman* Expert
Kerry C. Hughes, M.D., *Coleman* Expert
Raymond F. Patterson, M.D, *Coleman* Expert
Paul Nicoll, MPA, *Coleman* Monitor
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Nathan Stanley, Chief, Operational Program Oversight, Statewide Mental Health Program DCHCS
Karen Higgins, M.D., Chief of Behavioral Medicine, Statewide Mental Health Program, DCHCS
Teresa Owens, Associate Governmental Program Analyst, Operational Program Oversight, DCHCS

WEEKLY EOP POPULATION REPORT
(For the Week of SEP. 10, 2012)

Male Institutions	Staffed Capacity	Total Current Pop	Current Vacancies	Percent Filled	Total Seats Requested	Total Seats Provided	Number of Seats Requested for Endorsed Cases, by Sending Location *
SATF SNY II	176	169	7	96%	48	6	***6-RJDRC,*** 1-AVE, 3-CCI, 1-CMC, 1-PVSP, 1-RJD, 2-SAC, 1-SCC, 1-SVSP, 14-CIM, 2-DVIRC, 8-NKSP, 3-RJDRC, 4-WSP
SATF COD II	88	84	4	95%	25	0	3-CIM, 3-RJD, 13-MCSP, 2-CMF, 4-CMC
CMC III	580	540	40	93%	0	0	
CMF III	333	332	1	100%	10	3	***3-CMC,*** 3-SAC, 1-SATF, 1-SCC, 1-SOL, 1-DVIRC
RJD III	330	323	7	98%	11	11	***1-SVSP, 1-SAC, 1-PBSP, 1-LAC, 4-CMF, 3-CMC***
LAC IV (270)	300	305	-5	102%	12	1	***1-PBSP,*** 1-CMF, 1-COR, 6-SAC, 3-SVSP
MCSP SNY III	360	357	3	99%	36	14	***6-WSP, 1-SQRC, 3-NKSP, 3-RJDRC, 1-CIM,*** 2-AVE, 1-CMC, 4-COR, 4-CTF, 2-KVSP, 5-LAC, 3-RJD, 1-SAC
COR SNY IV (270)	150	144	6	96%	4	4	***2-MCSP, 1-LAC, 1-RJD***
MCSP SNY IV (270)	150	127	23	85%	2	2	***1-CMF, 1-RJD***
RJD SNY IV (270)	150	162	-12	108%	8	0	2-SAC, 3-MCSP, 1-LAC, 2-CMC
KVSP SNY IV (180)	96	96	0	100%	21	2	***2-NKSP,*** 1-SATF, 1-SAC, 5-RJD, 1-PBSP, 6-MCSP, 2-LAC, 1-CMF, 2-CMC
PBSP IV (180)	66	59	7	89%	2	2	***1-RJD, 1-HDSP***
SAC IV (180)	384	361	23	94%	1	1	***1-SVSP***
SVSP IV (180)	192	176	16	92%	2	2	***1-LAC, 1-COR***
TOTALS:	**3355**	**3235**	**120**	**96%**	**182**	**48**	

(per 9-7-12 PSU Pending List)

CIW PSU	20	18	2	90%	3	0	2-VSPW, 1-CIW
PBSP PSU	128	122	6	95%	7	0	1-CMC, 3-COR, 1-CMF, 1-SVSP, 1-RJD
SAC PSU	256	236	20	92%	7	0	3-CMF, 1-COR, 1-MCSP, 1-RJD, 1-LAC

Female Insts. CCWF	54	34	20	63%	0	0	
CIW	75	53	22	71%	0	0	
TOTALS:	**129**	**87**	**42**	**67%**	**0**	**0**	

*Inter-institution transfers only. Numbers/locations in bold/italics indicate bus seats assigned for transport this week.
"Total Current Pop" from Population Mgmt. Unit (dated 9-7-12) of the C&PRs' call-ins of filled EOP program beds.
Bus seat data source: Transportation Weekly Consolidated Worksheet

Prep by: Health Care Placement Oversight Program - Operations, 916-327-1250

Final

Level II COD: Capacity 88; pop = 84 Moved 0 of 25 (0%)
Level II SNY: Capacity=176; pop.=169 Moved 6 of 48 (13%)
Level III GP: Capacity=1243; pop.=1195 Moved 14 of 21 (67%)
Level III SNY: Capacity=360; pop = 357 Moved 14 of 36 (39%)

Level IV GP 180 Capacity=642; pop.= 596 Moved 5 of 5 (100%)
Level IV GP 270 Capacity=300; pop.= 305 Moved 1 of 12 (9%)
Level IV SNY 180: Capacity=96; pop.= 96 Moved 2 of 21 (10%)
Level IV SNY 270: Capacity=450; pop.= 433 Moved 6 of 14 (43%)

DIVISION OF CORRECTIONAL HEALTH CARE SERVICES
STATEWIDE MENTAL HEALTH PROGRAM
P.O. Box 942883
Sacramento, CA94283-0001

December 3, 2012

Matthew A. Lopes, Jr. Esquire
Office of the Special Master
Pannone Lopes & Devereaux LLC
317 Iron Horse Point Way, Suite 301
Providence, RI 02908

via: Debbie J. Vorous, Esquire
Deputy Attorney General
Department of Justice
1300 "I" Street, Suite 125
P. O. Box 944255
Sacramento, CA 94244-2550

RE: COLEMAN MONTHLY REPORT OF INFORMATION REQUESTED AND RESPONSE TO JANUARY 19, 1999, COURT ORDER REGARDING STAFF VACANCIES

Dear Mr. Lopes:

Enclosed is the Coleman Monthly Report reflective of October, 2012, data (or as otherwise noted). The following is the list of enclosures:

1. Mental Health Services Delivery System (MHSDS) Staffing Allocation and Vacancy History.
2. MHSDS Hiring Activity Report.
3. Health Care Placement Oversight Program (HCPOP) Information Report, Summary and Administrative Segregation Greater than 60 Days.
4. Mental Health Contract Services including Summary and Telemedicine Monthly Report for all disciplines.
5. California Department of Corrections and Rehabilitation (CDCR) Reception Center (RC) Monthly Report.
6. Monthly Summary of Mental Health Crisis Bed use by Institution Titles Inpatient Psychiatric Aging Report.
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8. Atascadero State Hospital (ASH) Discharges.
9. Weekly Enhanced Outpatient Program (EOP)/Outpatient Psychiatric Program.
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11. Suicide Report.
12. Statistics on Contracted Registered Nurse (RN). **(No Longer Available)**
13. RC Processing for MHSDS Inmate Patients.
14. Medical Technical Assistant (MTA) Vacancy Report. **(No Longer Available)**
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16. EOP Inmates Waiting Transfer to a Psychiatric Services Unit (PSU).

17. Audit reports on Psychiatric Technician Rounds in Administrative Segregation at California State Prison, San Quentin (SQ), California State Prison-Corcoran (COR), and Salinas Valley State Prison (SVSP).
18. Mental Health Crisis Beds Wait List.
19. Correctional Treatment Centers and CDCR General Acute Care Hospital Care Placement Issues. **(No longer available)**
20. Transferred and Rescinded Mental Health Crisis Bed Referrals by Institution and Level of Care.

If you have any questions, please contact me at (916) 691-0296.

Sincerely,

Matthew Lopes for

TIMOTHY G. BELAVICH, Ph.D., MSHCA, CCHP
Deputy Director (A)
Statewide Mental Health Program
Division of Correctional Health Care Services

Enclosures

cc: Diana Toche, DDS, Director (A), Division of Correctional Health Care Services (DCHCS)
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Karen Higgins, M.D., Chief of Behavioral Medicine, Statewide Mental Health Program, DCHCS
Teresa Owens, Associate Governmental Program Analyst, Operational Program Oversight, DCHCS

WEEKLY EOP POPULATION REPORT
(For the Week of OCT. 22, 2012)

Male Institutions	Staffed Capacity	Total Current Pop	Current Vacancies	Percent Filled	Total Seats Requested	Total Seats Provided	Number of Seats Requested for Endorsed Cases, by Sending Location *
SATF SNY II	264	223	41	84%	69	15	***10-NKSP, 5-WSP,*** 1-WSP, 4-CIM, 2-SCC, 1-PVSP, 43-MCSP, 2-LAC, 1-AVE
SATF COD II	88	83	5	94%	7	5	***2-NKSP, 1-SQRC, 1-CMC, 1-CMF,*** 1-CMC, 1-CMF
CMC III	580	526	54	91%	12	12	***1-LAC, 1-PVSP, 1-RJD, 1-SAC, 1-SATF, 1-SOL, 4-NKSP, 1-SQRC, 1-WSP***
CMF III	333	341	-8	102%	13	0	2-CMC, 1-LAC, 1-PBSP, 1-RJD, 2-SAC, 1-SATF, 3-SOL, 1-SVSP, 1-DVIRC
RJD III	330	320	10	97%	11	11	***1-CMC, 2-CMF, 4-LAC, 1-SAC, 2-SATF, 1-NKSP***
LAC IV (270)	300	305	-5	102%	7	3	***1-SAC, 1-CMC, 1-CMF,*** 2-PBSP, 2-SAC
MCSP SNY III	360	353	7	98%	31	9	***3-KVSP, 1-SATF, 1-SAC, 2-SVSP, 1-NKSP, 1-WSP,*** 6-RJD, 8-LAC, 8-COR
COR SNY IV (270)	150	142	8	95%	7	0	1-KVSP, 1-LAC, 2-RJD, 1-SAC, 1-SATF, 1-SVSP
MCSP SNY IV (270)	150	128	22	85%	10	10	***3-NKSP, 1-RJD, 1-SAC, 2-LAC, 2-COR, 1-CMC***
RJD SNY IV (270)	150	149	1	99%	10	4	***1-WSP, 1-SAC, 2-MCSP,*** 1-CMC, 1-PBSP, 1-LAC, 3-SAC
KVSP SNY IV (180)	96	93	3	97%	10	0	2-SATF, 1-SAC, 1-SVSP, 5-LAC, 1-PVSP
PBSP IV (180)	66	59	7	89%	0	0	
SAC IV (180)	384	356	28	93%	1	1	***1-LAC***
SVSP IV (180)	192	170	22	89%	1	1	***1-LAC***
TOTALS:	**3443**	**3248**	**195**	**94%**	**189**	**71**	

(per 10-19-12 PSU Pending List)

CIW PSU	20	16	4	80%	3	3	***3-CIW***
PBSP PSU	128	119	9	93%	7	2	***2-MCSP,*** 3-SVSP, 1-RJD, 1-COR
SAC PSU	256	240	16	94%	13	3	***1-SAC, 2-SVSP,*** 3-CMC, 2-LAC, 1-MCSP, 3-COR, 1-RJD

Female Insts. CCWF	54	36	18	67%	0	0	
CIW	75	58	17	77%	0	0	
TOTALS:	**129**	**94**	**35**	**73%**	**0**	**0**	

*Inter-institution transfers only. Numbers/locations in bold/italics indicate bus seats assigned for transport this week.
"Total Current Pop" from Population Mgmt. Unit (dated 10-19-12) of the C&PRs' call-ins of filled EOP program beds.
Bus seat data source: Transportation Weekly Consolidated Worksheet

Prep by: Health Care Placement Oversight Program - Operations, 916-327-1250

Final

Level II COD: Capacity 88; pop =83 Moved 5 of 7 (72%)
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Level III SNY: Capacity=360; pop =353 Moved 9 of 31 (29%)

Level IV GP 180 Capacity=642; pop.=585 Moved 2 of 2 (100%)
Level IV GP 270 Capacity=300; pop.=305 Moved 3 of 7 (43%)
Level IV SNY 180: Capacity=96; pop.=93 Moved 0 of 10 (0%)
Level IV SNY 270: Capacity=450; pop.=419 Moved 14 of 27 (52%)

DIVISION OF CORRECTIONAL HEALTH CARE SERVICES
STATEWIDE MENTAL HEALTH PROGRAM
P.O. Box 942883
Sacramento, CA94283-0001

January 3, 2013

Matthew A. Lopes, Jr. Esquire
Office of the Special Master
Pannone Lopes & Devereaux LLC
317 Iron Horse Point Way, Suite 301
Providence, RI 02908

via: Debbie J. Vorous, Esquire
Deputy Attorney General
Department of Justice
1300 "I" Street, Suite 125
P. O. Box 944255
Sacramento, CA 94244-2550

RE: COLEMAN MONTHLY REPORT OF INFORMATION REQUESTED AND RESPONSE TO JANUARY 19, 1999, COURT ORDER REGARDING STAFF VACANCIES

Dear Mr. Lopes:

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18. Mental Health Crisis Beds Wait List.
19. Correctional Treatment Centers and CDCR General Acute Care Hospital Care Placement Issues. **(No longer available)**
20. Transferred and Rescinded Mental Health Crisis Bed Referrals by Institution and Level of Care.

If you have any questions, please contact me at (916) 691-0296.

Sincerely,

Matthew Stanley for

TIMOTHY G. BELAVICH, Ph.D., MSHCA, CCHP
Deputy Director (A)
Statewide Mental Health Program
Division of Correctional Health Care Services

Enclosures

cc: Diana Toche, DDS, Director (A), Division of Correctional Health Care Services (DCHCS)
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Teresa Owens, Associate Governmental Program Analyst, Operational Program Oversight, DCHCS

WEEKLY EOP POPULATION REPORT
(For the Week of NOV. 5, 2012)

Male Institutions	Staffed Capacity	Total Current Pop	Current Vacancies	Percent Filled	Total Seats Requested	Total Seats Provided	Number of Seats Requested for Endorsed Cases, by Sending Location *
SATF SNY II	264	251	13	95%	52	15	***3-WSP, 3-NKSP, 3-DVIRC, 1-CIM, 2-SCC, 2-MCSP, 1-CTF,*** 31-MCSP, 1-SVSP, 1-SAC, 1-RJD, 2-LAC, 1-PVSP
SATF COD II	88	82	6	93%	9	4	***1-WSP, 3-NKSP,*** 2-CIM, 2-CMC, 1-CMF
CMC III	580	524	56	90%	6	6	***1-RJD, 1-SAC, 1-DVIRC, 1-NKSP, 2-SQRC***
CMF III	333	345	-12	104%	22	0	1-DVIRC, 2-SVSP, 6-SOL, 1-SATF, 3-SAC, 1-RJD, 1-PBSP, 2-LAC, 5-CMC
RJD III	330	319	11	97%	13	10	***1-WSP, 1-NKSP, 1-SAC, 4-LAC, 1-CMF, 2-CMC,*** 2-PBSP, 1-LAC
LAC IV (270)	300	296	4	99%	8	8	***1-SVSP, 1-WSP, 3-SAC, 2-PBSP, 1-CMF***
MCSP SNY III	360	349	11	97%	22	5	***3-NKSP, 2-COR,*** 3-COR, 2-KVSP, 5-LAC, 6-RJD, 1-SATF
COR SNY IV (270)	150	147	3	98%	2	2	***1-LAC, 1-SAC***
MCSP SNY IV (270)	150	138	12	92%	2	2	***1-SVSP, 1-SAC***
RJD SNY IV (270)	150	152	-2	101%	6	0	3-SAC, 1-CIM, 1-LAC, 1-CMC
KVSP SNY IV (180)	96	92	4	96%	8	4	***1-SAC, 1-SATF, 1-SVSP, 1-LAC,*** 4-LAC
PBSP IV (180)	66	58	8	88%	0	0	
SAC IV (180)	384	350	34	91%	1	1	***1-SVSP***
SVSP IV (180)	192	179	13	93%	1	1	***1-CMC***
TOTALS:	**3443**	**3282**	**161**	**95%**	**152**	**58**	

(per 11-3-12 PSU Pending List)

CIW PSU	20	17	3	85%	0	0	
PBSP PSU	128	115	13	90%	13	2	***1-SVSP, 1-COR,*** 2-MCSP, 4-CMC, 1-RJD, 2-COR, 2-LAC
SAC PSU	256	235	21	92%	22	5	***5-SAC,*** 1-RJD, 2-SVSP, 3-CMC, 4-COR, 4-LAC, 3-SAC

Female Insts.							
CCWF	54	37	17	69%	0	0	
CIW	75	54	21	72%	0	0	
TOTALS:	**129**	**91**	**38**	**71%**	**0**	**0**	

*Inter-institution transfers only. Numbers/locations in bold/italics indicate bus seats assigned for transport this week.
"Total Current Pop" from Population Mgmt. Unit (dated 11-3-12) of the C&PRs' call-ins of filled EOP program beds.
Bus seat data source: Transportation Weekly Consolidated Worksheet

Prep by: Health Care Placement Oversight Program - Operations, 916-691-0338

Final

Level II COD: Capacity 88; pop =82 Moved 4 of 9 (45%)
Level II SNY: Capacity=264; pop.=251 Moved 15 of 52 (29%)
Level III GP: Capacity=1243; pop.=1188 Moved 16 of 41 (39%)
Level III SNY: Capacity=360; pop =349 Moved 5 of 22 (23%)

Level IV GP 180 Capacity=642; pop.=587 Moved 2 of 2 (100%)
Level IV GP 270 Capacity=300; pop.=296 Moved 8 of 8 (100%)
Level IV SNY 180: Capacity=96; pop.=92 Moved 4 of 8 (50%)
Level IV SNY 270: Capacity=450; pop.=437 Moved 4 of 10 (40%)

DIVISION OF CORRECTIONAL HEALTH CARE SERVICES
STATEWIDE MENTAL HEALTH PROGRAM
P.O. Box 942883
Sacramento, CA94283-0001

February 1, 2013

Matthew A. Lopes, Jr. Esquire
Office of the Special Master
Pannone Lopes & Devereaux LLC
317 Iron Horse Point Way, Suite 301
Providence, RI 02908

via: Debbie J. Vorous, Esquire
Deputy Attorney General
Department of Justice
1300 "I" Street, Suite 125
P. O. Box 944255
Sacramento, CA 94244-2550

RE: COLEMAN MONTHLY REPORT OF INFORMATION REQUESTED AND RESPONSE TO JANUARY 19, 1999, COURT ORDER REGARDING STAFF VACANCIES

Dear Mr. Lopes:

Enclosed is the Coleman Monthly Report reflective of December, 2012, data (or as otherwise noted). The following is the list of enclosures:

1. Mental Health Services Delivery System (MHSDS) Staffing Allocation and Vacancy History.
2. MHSDS Hiring Activity Report.
3. Health Care Placement Oversight Program (HCPOP) Information Report, Summary and Administrative Segregation Greater than 60 Days.
4. Mental Health Contract Services including Summary and Telemedicine Monthly Report for all disciplines.
5. California Department of Corrections and Rehabilitation (CDCR) Reception Center (RC) Monthly Report.
6. Monthly Summary of Mental Health Crisis Bed use by Institution Titles Inpatient Psychiatric Aging Report.
7. Referrals for Transfer to the Department of Mental Health (including admissions).
8. Atascadero State Hospital (ASH) Discharges.
9. Weekly Enhanced Outpatient Program (EOP)/Outpatient Psychiatric Program.
10. The Department of Mental Health (DMH) Monthly Report of CDCR Patients in DMH Hospitals -- Summary and Penal Code 2684.
11. Suicide Report.
12. Statistics on Contracted Registered Nurse (RN). **(No Longer Available)**
13. RC Processing for MHSDS Inmate Patients.
14. Medical Technical Assistant (MTA) Vacancy Report. **(No Longer Available)**
15. Allocated Case Manager Positions and Vacancies for the EOP Administrative Segregated Hub institutions.
16. EOP Inmates Waiting Transfer to a Psychiatric Services Unit (PSU).

17. Audit reports on Psychiatric Technician Rounds in Administrative Segregation at California State Prison, San Quentin (SQ), California State Prison-Corcoran (COR), and Salinas Valley State Prison (SVSP).
18. Mental Health Crisis Beds Wait List.
19. Correctional Treatment Centers and CDCR General Acute Care Hospital Care Placement Issues. **(No longer available)**
20. Transferred and Rescinded Mental Health Crisis Bed Referrals by Institution and Level of Care.

If you have any questions, please contact me at (916) 691-0296.

Sincerely,

Nathan Stanley for

TIMOTHY G. BELAVICH, Ph.D., MSHCA, CCHP
Deputy Director (A)
Statewide Mental Health Program
Division of Correctional Health Care Services

Enclosures

cc: Diana Toche, DDS, Director (A), Division of Correctional Health Care Services (DCHCS)
Mohamedu F., Jones, Esq., *Coleman* Deputy Special Master
Linda Holden, Esq., *Coleman* Deputy Special Master
Jeffrey L. Metzner, M.D., *Coleman* Expert
Kerry C. Hughes, M.D., *Coleman* Expert
Raymond F. Patterson, M.D, *Coleman* Expert
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Henry A. Dlugacz, Esq., *Coleman* Expert
Kerry F. Walsh, Esq., *Coleman* Monitor
Patricia Williams, Esq., *Coleman* Monitor
Haunani Henry, *Coleman* Monitor
Debbie Vorous, Esq., Office of the Attorney General
Heather McCray Esq., Office of Legal Affairs, CDCR
Michael Stone, Esq., Office of Legal Affairs, CDCR
Michael Bien, Esq., Rosen, Bien and Galvan
Donald Specter, Esq., Prison Law Office

Judy Burleson, Associate Director, Statewide Mental Health Program, DCHCS
Nathan Stanley, Chief, Operational Program Oversight, Statewide Mental Health Program DCHCS
Karen Higgins, M.D., Chief of Behavioral Medicine, Statewide Mental Health Program, DCHCS
Teresa Owens, Associate Governmental Program Analyst, Operational Program Oversight, DCHCS

WEEKLY EOP POPULATION REPORT
(For the Week of DEC. 10, 2012)

Male Institutions	Staffed Capacity	Total Current Pop	Current Vacancies	Percent Filled	Total Seats Requested	Total Seats Provided	Number of Seats Requested for Endorsed Cases, by Sending Location *
SATF SNY II	264	262	2	99%	59	2	***1-AVE, 1-CTF,*** 2-WSP, 4-CIM, 1-NKSP, 1-SVSP, 1-SCC, 3-RJD, 1-PVSP, 39-MCSP, 2-LAC, 1-CTF, 1-AVE, 1-CCI
SATF COD II	88	82	6	93%	6	3	***1-RJD, 2-CIM,*** 3-CMF
CMC III	580	539	41	93%	10	10	***1-FOL, 2-LAC, 1-RJD, 1-SAC, 1-SATF, 1-SOL, 1-SVSP, 2-WSP***
CMF III	333	340	-7	102%	28	0	8-CMC, 4-LAC, 1-PBSP, 2-RJD, 2-SAC, 2-SATF, 7-SOL, 2-SVSP
RJD III	330	330	0	100%	5	2	***1-DVIRC, 1-CMC,*** 2-CMC, 1-SAC
LAC IV (270)	300	304	-4	101%	5	3	***1-WSP, 1-SVSP, 1-SAC,*** 1-SVSP, 1-CMF
MCSP SNY III	360	357	3	99%	38	7	***2-SVSP, 1-NKSP, 1-WSP, 1-RJD, 1-KVSP, 1-CMF,*** 5-COR, 3-CTF, 2-KVSP, 8-LAC, 9-RJD, 3-SAC, 1-CIM
COR SNY IV (270)	150	150	0	100%	2	2	***1-SVSP, 1-SAC***
MCSP SNY IV (270)	150	148	2	99%	7	4	***1-RJD, 3-COR,*** 3-SAC
RJD SNY IV (270)	150	165	-15	110%	3	0	1-CIM, 2-SAC
KVSP SNY IV (180)	96	90	6	94%	3	3	***1-MCSP, 2-RJD***
PBSP IV (180)	66	52	14	79%	0	0	
SAC IV (180)	384	344	40	90%	4	4	***1-WSP, 1-SATF, 1-CMF, 1-CMC***
SVSP IV (180)	192	178	14	93%	5	5	***1-WSP, 1-NKSP, 1-SAC, 1-LAC, 1-COR***
TOTALS:	**3443**	**3341**	**102**	**97%**	**175**	**45**	

(per 12-10-12 PSU Pending List)

CIW PSU	20	17	3	85%	0	0	
PBSP PSU	128	117	11	91%	15	1	***1-RJD,*** 4-LAC, 1-MCSP, 1-SVSP, 2-CMC, 6-COR
SAC PSU	256	235	21	92%	15	3	***2-SVSP, 1-SQ,*** 6-COR, 1-SVSP, 1-LAC, 2-MCSP, 2-RJD

Female Insts. CCWF	54	37	17	69%	0	0	
CIW	75	58	17	77%	0	0	
TOTALS:	**129**	**95**	**34**	**74%**	**0**	**0**	

*Inter-institution transfers only. Numbers/locations in bold/italics indicate bus seats assigned for transport this week.
"Total Current Pop" from Population Mgmt. Unit (dated 12-7-12) of the C&PRs' call-ins of filled EOP program beds.
Bus seat data source: Transportation Weekly Consolidated Worksheet

Prep by: Health Care Placement Oversight Program - Operations, 916-327-1250

Final

Level II COD: Capacity 88; pop =82 Moved 3 of 6 (50%)
Level II SNY: Capacity=264; pop.=262 Moved 0 of 59 (0%)
Level III GP: Capacity=1243; pop.=1209 Moved 12 of 43 (28%)
Level III SNY: Capacity=360; pop =357 Moved 7 of 38 (19%)

Level IV GP 180 Capacity=642; pop.=574 Moved 9 of 9 (100%)
Level IV GP 270 Capacity=300; pop.=304 Moved 3 of 5 (60%)
Level IV SNY 180: Capacity=96; pop.=90 Moved 3 of 3 (100%)
Level IV SNY 270: Capacity=450; pop.=463 Moved 6 of 12 (50%)

DIVISION OF CORRECTIONAL HEALTH CARE SERVICES
STATEWIDE MENTAL HEALTH PROGRAM
P.O. Box 942883
Sacramento, CA94283-0001

March 1, 2013

Matthew A. Lopes, Jr. Esquire
Office of the Special Master
Pannone Lopes & Devereaux LLC
317 Iron Horse Point Way, Suite 301
Providence, RI 02908

via: Debbie J. Vorous, Esquire
Deputy Attorney General
Department of Justice
1300 "I" Street, Suite 125
P. O. Box 944255
Sacramento, CA 94244-2550

RE: COLEMAN MONTHLY REPORT OF INFORMATION REQUESTED AND RESPONSE TO JANUARY 19, 1999, COURT ORDER REGARDING STAFF VACANCIES

Dear Mr. Lopes:

Enclosed is the Coleman Monthly Report reflective of January, 2013 data (or as otherwise noted). The following is the list of enclosures:

1. Mental Health Services Delivery System (MHSDS) Staffing Allocation and Vacancy History.
2. MHSDS Hiring Activity Report.
3. Health Care Placement Oversight Program (HCPOP) Information Report, Summary and Administrative Segregation Greater than 60 Days.
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6. Monthly Summary of Mental Health Crisis Bed use by Institution Titles Inpatient Psychiatric Aging Report.
7. Referrals for Transfer to the Department of State Hospitals (DSH) (including admissions).
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10. The Department of State Hospitals (DSH) Monthly Report of CDCR Patients in DSH Hospitals -- Summary and Penal Code 2684.
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12. Statistics on Contracted Registered Nurse (RN). **(No Longer Available)**
13. RC Processing for MHSDS Inmate Patients.
14. Medical Technical Assistant (MTA) Vacancy Report. **(No Longer Available)**

16. EOP Inmates Waiting Transfer to a Psychiatric Services Unit (PSU).
17. Audit reports on Psychiatric Technician Rounds in Administrative Segregation at California State Prison, San Quentin (SQ), California State Prison-Corcoran (COR), and Salinas Valley State Prison (SVSP).
18. Mental Health Crisis Beds Wait List.
19. Correctional Treatment Centers and CDCR General Acute Care Hospital Care Placement Issues. **(No longer available)**
20. Transferred and Rescinded Mental Health Crisis Bed Referrals by Institution and Level of Care.

If you have any questions, please contact me at (916) 691-0296.

Sincerely,

TIMOTHY G. BELAVICH, Ph.D., MSHCA, CCHP
Deputy Director (A)
Statewide Mental Health Program
Division of Correctional Health Care Services

Enclosures

cc: Diana Toche, DDS, Director (A), Division of Correctional Health Care Services (DCHCS)
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Heather McCray Esq., Office of Legal Affairs, CDCR
Michael Stone, Esq., Office of Legal Affairs, CDCR
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Nathan Stanley, Chief, Operational Program Oversight, Statewide Mental Health Program DCHCS
Teresa Owens, Associate Governmental Program Analyst, Operational Program Oversight, DCHCS

WEEKLY EOP POPULATION REPORT
(For the Week of JAN. 21, 2013)

Male Institutions	Staffed Capacity	Total Current Pop	Current Vacancies	Percent Filled	Total Seats Requested	Total Seats Provided	Number of Seats Requested for Endorsed Cases, by Sending Location *
SATF SNY II	264	258	6	98%	82	6	***1-NKSP, 1-LAC, 2-SVSP, 2-DVIRC,*** 9-CIM, 11-NKSP, 8-WSP, 1-SCC, 1-RJD, 1-PVSP, 37-MCSP, 1-LAC, 2-CTF, 1-CRC, 1-CMC, 3-AVE
SATF COD II	88	86	2	98%	4	2	***1-CIM, 1-SAC,*** 1-RJD, 1-CMC
CMC III	580	559	21	96%	16	16	***1-CMF, 5-LAC, 1-MCSP, 1-PBSP, 1-SCC, 1-SVSP, 1-SOL, 2-NKSP, 3-WSP***
CMF III	333	326	7	98%	20	2	***1-DVIRC, 1-CMC,*** 3-SAC, 8-CMC, 3-LAC, 2-SOL, 2-SVSP
RJD III	330	329	1	100%	26	2	***1-DVIRC, 1-WSP,*** 2-SVSP, 1-WSP, 1-SOL, 4-SAC, 3-RJD, 1-PBSP, 1-MCSP, 4-LAC, 7-CMC
LAC IV (270)	300	302	-2	101%	7	7	***1-SVSP, 2-SAC, 3-RJD, 1-PBSP***
MCSP SNY III	360	352	8	98%	44	0	2-WSP, 1-NKSP, 2-CIM, 3-SATF, 3-SAC, 13-RJD, 10-LAC, 4-KVSP, 6-COR
COR SNY IV (270)	150	150	0	100%	4	1	***1-CIM,*** 1-SAC, 1-MCSP, 1-LAC
MCSP SNY IV (270)	150	154	-4	103%	15	0	2-WSP, 2-SVSP, 2-SAC, 3-LAC, 2-KVSP, 2-COR, 2-CMC
RJD SNY IV (270)	150	154	-4	103%	14	0	1-CIM, 3-SVSP, 1-SATF, 3-SAC, 1-PVSP, 2-MCSP, 1-KVSP, 2-COR
KVSP SNY IV (180)	96	90	6	94%	3	3	***1-CMC, 1-SAC, 1-PBSP***
PBSP IV (180)	66	53	13	80%	1	1	***1-LAC***
SAC IV (180)	384	323	61	84%	1	1	***1-COR***
SVSP IV (180)	192	177	15	92%	1	1	***1-WSP***
TOTALS:	**3443**	**3313**	**130**	**96%**	**238**	**42**	

(per 1-18-13 PSU Pending List)

CIW PSU	20	18	2	90%	0	0	
PBSP PSU	128	119	9	93%	14	1	***1-SAC,*** 1-LAC, 1-SVSP, 2-CMC, 5-COR, 1-CMF, 3-MCSP
SAC PSU	256	243	13	95%	18	2	***1-MCSP, 1-LAC,*** 1-SQ, 1-RJD, 1-SVSP, 4-LAC, 2-MCSP, 5-COR, 2-CMC

Female Insts. CCWF	54	37	17	69%	0	0	
CIW	75	56	19	75%	1	1	***1-CCWFRC***
TOTALS:	**129**	**93**	**36**	**72%**	**1**	**1**	

*Inter-institution transfers only. Numbers/locations in bold/italics indicate bus seats assigned for transport this week.
"Total Current Pop" from Population Mgmt. Unit (dated 1-18-13) of the C&PRs' call-ins of filled EOP program beds.
Bus seat data source: Transportation Weekly Consolidated Worksheet

Prep by: Health Care Placement Oversight Program - Operations, 916-327-1250

Final

Level II COD: Capacity 88; pop =86 Moved 2 of 4 (50%)
Level II SNY: Capacity=264; pop.=258 Moved 6 of 82 (8%)
Level III GP: Capacity=1243; pop.=1214 Moved 20 of 62 (33%)
Level III SNY: Capacity=360; pop =352 Moved 0 of 44 (0%)

Level IV GP 180 Capacity=642; pop.=553 Moved 3 of 3 (100%)
Level IV GP 270 Capacity=300; pop.=302 Moved 7 of 7 (100%)
Level IV SNY 180: Capacity=96; pop.=90 Moved 3 of 3 (100%)
Level IV SNY 270: Capacity=450; pop.=458 Moved 1 of 33 (3%)

Exhibit 73

Delays in Access to DSH Hospital Beds and Waitlists

DECEMBER 2012

DSH Units	Number of Patients Provided Care in DSH Dec. 2012	Range of Wait in Days Between Referral and DSH Admission	Percentage of Patients who Waited Longer than Timeline Before DSH Admission	Number of Patients Who Waited Longer than Timeline Before DSH Admission
SVPP	395	0 - 606	55.98%	221
Units at VPP				
APP	253	0 - 504	73.12%	185
ICF/P3	32	0 - 300	43.75%	14
ICF/A2	31	1 - 729	54.84%	17
ICF/A3	25	0 - 175	20%	5
ICF/HCTC	68	1 - 153	27.94%	19
ICF/L3	36	0 - 75	8.33%	3
All ICF Units at VPP	192	0 - 729	30.21%	58

Waitlist	Number of Patients on Waitlist for DSH Care Dec. 2012	Percentage of Patients who Waited Longer than Timeline Before DSH Acceptance	Average Days on WL from DSH Referral to Date of Report (12-31-12)	Range of Days on WL from Referral to date of Report (12-31-12)	Percentage of Patients Waiting Longer than Timeline for DSH Admission	Number of Patients Waiting Longer than Timeline for DSH Admission
SVPP	46	15.22%	33.36	11 - 82	52.17%	24
VPP/APP	12	N/A	15	4 - 33	91.67%	11

Data from Dec. 2012 DSH Monthly Bed Utilization Report, Filed Under Seal, 1-16-13, Exhibit 43 to Kahn Decl.

Program Guide timeline for transfer for Acute DMH APP is within 10 days of referral, Intermediate DMH ICF is within 30 days of referral. *Program Guide 2009 Revision*, 12-1-16.

Delays in Access to DSH Hospital Beds and Waitlists

JANUARY 2013

DSH Units	Number of Patients Provided Care in DSH Jan. 2013	Range of Wait in Days Between Referral and DSH Admission	Percentage of Patients who Waited Longer than Timeline Before DSH Admission	Number of Patients Who Waited Longer than Timeline Before DSH Admission
SVPP	396	0 – 177	58.33%	231
Units at VPP				
APP	252	0 – 504	73.8%	186
ICF/P3	34	0 – 300	32.35%	11
ICF/A2	31	2 – 729	51.61%	16
ICF/A3	23	0 – 175	17.39%	4
ICF/HCTC	68	1 – 153	26.47%	18
ICF/L3	37	0 – 225	8.11%	3
All ICF Units at VPP	193	0 – 729	26.94%	52

Waitlist	Number of Patients on Waitlist for DSH Care Jan. 2013	Percentage of Patients who Waited Longer than Timeline Before DSH Acceptance	Average Days on WL from DSH Referral to Date of Report (1-31-13)	Range of Days on WL from Referral to date of Report (1-31-13)	Percentage of Patients Waiting Longer than Timeline for DSH Admission	Number of Patients Waiting Longer than Timeline for DSH Admission
SVPP	29	24.14%	28.45	6 – 64	34.48%	10
VPP/APP	21	N/A	9.33	0 – 45	28.57%	6

Data from Jan. 2013 DSH Monthly Bed Utilization Report, Filed Under Seal 2-15-13, Exhibit 44 to Kahn Decl.

Program Guide timeline for transfer for Acute DMH APP is within 10 days of referral, Intermediate DMH ICF is within 30 days of referral. *Program Guide 2009 Revision*, 12-1-16.

Exhibit 74

SUMMARY OF CASES IN OUTPATIENT HOUSING UNITS

May 1 - December 31, 2012

Month/Year	Total in OHU	Referred to HC-POP for MHCB	% Referred	Not Referred to HC-POP	% Not Referred	Days in OHU				Total in OHU 3 days or less	% in OHU 3 days or less
						High	Low	Median	Mean		
May-12	148	39	26%	109	74%	20.0	0.0	2.0	3.7	111	75%
Jun-12	178	65	37%	113	63%	19.0	0.0	2.0	3.4	102	68%
Jul-12	224	97	43%	127	57%	31.9	0.0	1.0	3.0	159	88%
Aug-12	234	85	36%	128	70%	17.0	0.0	1.0	1.8	123	90%
Sep-12	188	69	28%	97	75%	13.0	0.0	1.0	1.8	124	95%
Oct-12	96	44	46%	52	54%	6.0	0.0	1.0	1.4	81	84%
Nov-12	92	34	43%	58	63%	4.0	0.0	1.0	1.5	39	97%
Dec-12	82	28	34%	54	70%	4.0	0.0	1.0	1.6	80	98%
TOTAL	1330	467	35%	723	65%					954	88%
AVG/MO	148	60	35%	90	65%	13.2	0.0	1.3	1.9	124	89%

DISPOSITION OF CASES IN OUTPATIENT HOUSING UNITS

Week	MHCB Placement	No MHCB Placement	TOTAL CASES	% Placed
May-12	34	114	148	23%
Jun-12	59	119	178	33%
Jul-12	81	143	224	36%
Aug-12	43	111	154	28%
Sep-12	39	97	136	29%
Oct-12	41	55	96	43%
Nov-12	32	60	92	35%
Dec-12	29	53	82	35%
TOTAL	354	752	1106	32%
AVG/MO	44	94	140	32%

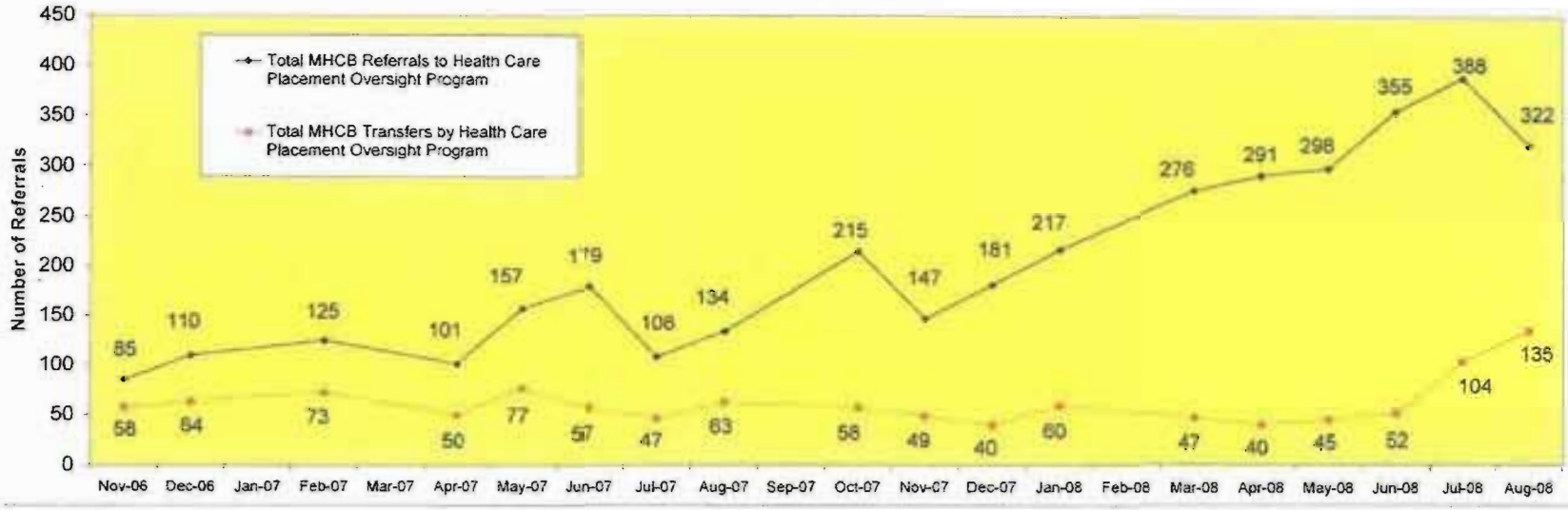
DISPOSITION DETAIL OF CASES REFERRED TO HC-POP					DISPOSITION DETAIL OF CASES NOT REFERRED TO HC-POP					
Week	Transferred to MHCB	Inpatient MHCB Placement	Discharged (Opened no MHCB Outpatient Placement)	TOTAL REFERRED	Returned MHCB Placement	Deemed no MHCB Outpatient Placement	Deemed no MHCB, DSH Placement	Out to Medical	Parole	TOTAL NOT REFERRED
May-12	33	1	5	39	0	109	1	1	1	109
Jun-12	47	6	12	65	1	111	0	0	0	113
Jul-12	67	0	23	97	6	118	1	1	0	127
Aug-12	55	8	8	69	3	121	1	2	0	128
Sep-12	51	1	7	59	7	82	2	6	0	97
Oct-12	30	4	10	44	7	44	1	0	0	52
Nov-12	26	2	11	39	4	47	0	0	1	53
Dec-12	28	0	3	31	1	51	0	0	0	52
TOTAL	287	22	79	387	30	673	7	11	2	723
AVG/MO	37	3	9	50	4	94	1	1	0	92

Rick Johnson
February 25, 2013
Exhibit No. 13
Megan F. Alvarez
RPR, CSR No. 12470

Exhibit 75

Case No. CIV S-90-0520 LKK JFM P (E.D. Cal)
C01-1351 THE (N.D. Cal)
PLTF Exhibit No. P - 263
Date Entered:
Signature:
Alternate Reference:

Mental Health Crisis Bed (MHCB) Unmet Need



	Nov-06	Dec-06	Feb-07	Apr-07	May-07	Jun-07	Jul-07	Aug-07	Oct-07	Nov-07	Dec-07	Jan-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08
Total MHCB Referrals to Health Care Placement Oversight Program	85	110	125	101	157	179	108	134	215	147	181	217	276	291	298	355	388	322
Total MHCB Transfers by Health Care Placement Oversight Program	58	64	73	50	77	57	47	63	58	49	40	60	47	40	45	52	104	135

Please note that missing monthly data reflect those months for which a report was not provided by CDCR.

Source: CDCR's Monthly Summary of Inter-Institutional Mental Health Crisis Bed Referrals and Transfers, Health Care Placement Oversight Program, Division of Correctional Health Care Services. [redacted] Plaintiffs' Exhibit P540-555; P586-587

Exhibit 76

DIVISION OF CORRECTIONAL HEALTH CARE SERVICES
STATEWIDE MENTAL HEALTH PROGRAM
P.O. Box 942883
Sacramento, CA94283-0001

March 1, 2013

Matthew A. Lopes, Jr. Esquire
Office of the Special Master
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317 Iron Horse Point Way, Suite 301
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via: Debbie J. Vorous, Esquire
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Department of Justice
1300 "I" Street, Suite 125
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RE: COLEMAN MONTHLY REPORT OF INFORMATION REQUESTED AND RESPONSE TO JANUARY 19, 1999, COURT ORDER REGARDING STAFF VACANCIES

Dear Mr. Lopes:

Enclosed is the Coleman Monthly Report reflective of January, 2013 data (or as otherwise noted). The following is the list of enclosures:

1. Mental Health Services Delivery System (MHSDS) Staffing Allocation and Vacancy History.
2. MHSDS Hiring Activity Report.
3. Health Care Placement Oversight Program (HCPOP) Information Report, Summary and Administrative Segregation Greater than 60 Days.
4. Mental Health Contract Services including Summary and Telemedicine Monthly Report for all disciplines.
5. California Department of Corrections and Rehabilitation (CDCR) Reception Center (RC) Monthly Report.
6. Monthly Summary of Mental Health Crisis Bed use by Institution Titles Inpatient Psychiatric Aging Report.
7. Referrals for Transfer to the Department of State Hospitals (DSH) (including admissions).
8. Atascadero State Hospital (ASH) Discharges.
9. Weekly Enhanced Outpatient Program (EOP)/Outpatient Psychiatric Program.
10. The Department of State Hospitals (DSH) Monthly Report of CDCR Patients in DSH Hospitals -- Summary and Penal Code 2684.
11. Suicide Report.
12. Statistics on Contracted Registered Nurse (RN). **(No Longer Available)**
13. RC Processing for MHSDS Inmate Patients.
14. Medical Technical Assistant (MTA) Vacancy Report. **(No Longer Available)**

16. EOP Inmates Waiting Transfer to a Psychiatric Services Unit (PSU).
17. Audit reports on Psychiatric Technician Rounds in Administrative Segregation at California State Prison, San Quentin (SQ), California State Prison-Corcoran (COR), and Salinas Valley State Prison (SVSP).
18. Mental Health Crisis Beds Wait List.
19. Correctional Treatment Centers and CDCR General Acute Care Hospital Care Placement Issues. **(No longer available)**
20. Transferred and Rescinded Mental Health Crisis Bed Referrals by Institution and Level of Care.

If you have any questions, please contact me at (916) 691-0296.

Sincerely,

Patteau Stanley for

TIMOTHY G. BELAVICH, Ph.D., MSHCA, CCHP
Deputy Director (A)
Statewide Mental Health Program
Division of Correctional Health Care Services

Enclosures

cc: Diana Toche, DDS, Director (A), Division of Correctional Health Care Services (DCHCS)
Mohamedu F., Jones, Esq., *Coleman* Deputy Special Master
Linda Holden, Esq., *Coleman* Deputy Special Master
Jeffrey L. Metzner, M.D., *Coleman* Expert
Kerry C. Hughes, M.D., *Coleman* Expert
Raymond F. Patterson, M.D, *Coleman* Expert
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Patricia Williams, Esq., *Coleman* Monitor
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Debbie Vorous, Esq., Office of the Attorney General
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Michael Stone, Esq., Office of Legal Affairs, CDCR
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Donald Specter, Esq., Prison Law Office
Judy Burleson, Associate Director, Statewide Mental Health Program, DCHCS
Nathan Stanley, Chief, Operational Program Oversight, Statewide Mental Health Program DCHCS
Teresa Owens, Associate Governmental Program Analyst, Operational Program Oversight, DCHCS

State of California California Department of Corrections and Rehabilitation

Memorandum

Date: February 19, 2013

To: Diana Toche
Director (A)
Division of Health Care Services

Subject: **SUMMARY OF INTER-INSTITUTIONAL MENTAL HEALTH CRISIS BED REFERRALS AND TRANSFERS FOR JANUARY 2013**

Attached are summaries regarding the number of Mental Health Crisis Bed (MHCB) referrals and placements coordinated by Health Care Placement Oversight Program (HC-POP) staff. During the month of **January 2013**, there were **332 MHCB** referrals. Of the **332** referrals, **155** were placed. The **177** not placed (**53%** of those referred) were rescinded by the referring clinician. Of the **177** rescinded, **99** no longer required MHCB treatment, **73** were placed in a MHCB internally, **three** paroled, and **two** were not medically cleared.

Attachment 1 summarizes the referrals/transfers/rescinded cases by sending institution and previous levels of care. Additionally, every referral is tallied by classification score.

Attachment 2A (4 pages) provides additional details of the completed referrals/transfers, including transfer timeframes, average number of days waiting to transfer, and prior level of care. For the **155** transferred, the average number of days waiting was **1.07.** Of the **155** transferred, **121** cases were transferred within the required 24 hours.

Attachment 2B (5 pages) provides details regarding those MHCB referrals that were rescinded by the referring institution. **Attachment 2C** summarizes the cases rescinded.

Attachment 3 summarizes, by institution, the average number of days referrals waited before being transferred or rescinded.

Attachment 4 is no longer included as part of the summary. The temporary MHCBs at CMF/Acute Psychiatric Program (APP) have been returned to APP use; thus, Attachment 4 is no longer applicable.

Please let me know if you have any questions about the information provided.

Original Signed By
Robert M. Calderon
Chief/Associate Warden
Health Care Placement Oversight Program
Division of Health Care Services

Attachments

cc: Tim Belavich
Health Care Regional Administrators
Mental Health Regional Administrators
Michael Morrison
Cathy Jefferson
HC-POP Staff

ATTACHMENT 1

SUMMARY
TRANSFERRED AND RESCINDED MHCB REFERRALS
BY INSTITUTION AND PRIOR LEVEL OF CARE
JANUARY 2013

	TOTAL REFERRALS							REFERRED AND TRANSFERRED							REFERRED AND RESCINDED							
	CCCMS	EOP	MHCB	GP	DSH	TOTAL	% TTL	CCCMS	EOP	MHCB	GP	DSH	TOTAL	% TTL	CCCMS	EOP	MHCB	GP	DSH	TOTAL	% TTL
ASP	5	1	0	0	0	6	1.81%	5	1	0	0	0	6	3.87%	0	0	0	0	0	0	0.00%
CAL	2	0	0	6	0	8	2.41%	2	0	0	6	0	8	5.16%	0	0	0	0	0	0	0.00%
CCI	4	0	0	0	0	4	1.20%	4	0	0	0	0	4	2.58%	0	0	0	0	0	0	0.00%
CCI-RC	0	0	0	1	0	1	0.30%	0	0	0	1	0	1	0.65%	0	0	0	0	0	0	0.00%
CEN	1	0	0	3	0	4	1.20%	0	0	0	3	0	3	1.94%	1	0	0	0	0	1	0.56%
CMC	2	11	0	4	0	17	5.12%	0	2	0	1	0	3	1.94%	2	9	0	3	0	14	7.91%
CMF	0	2	0	0	2	4	1.20%	0	0	0	0	2	2	1.29%	0	2	0	0	0	2	1.13%
CMF-DSH	0	0	0	0	2	2	0.60%	0	0	0	0	2	2	1.29%	0	0	0	0	0	0	0.00%
COR	3	8	0	3	0	14	4.22%	1	4	0	1	0	6	3.87%	2	4	0	2	0	8	4.52%
CRC	3	0	0	6	0	9	2.71%	3	0	0	5	0	8	5.16%	0	0	0	1	0	1	0.56%
CTF	3	0	0	0	0	3	0.90%	3	0	0	0	0	3	1.94%	0	0	0	0	0	0	0.00%
DVI	3	2	0	1	0	6	1.81%	3	2	0	1	0	6	3.87%	0	0	0	0	0	0	0.00%
DVI-RC	2	2	0	1	0	5	1.51%	2	2	0	1	0	5	3.23%	0	0	0	0	0	0	0.00%
FOL	2	0	0	0	0	2	0.60%	1	0	0	0	0	1	0.65%	1	0	0	0	0	1	0.56%
HDSP	1	0	0	1	0	2	0.60%	1	0	0	1	0	2	1.29%	0	0	0	0	0	0	0.00%
ISP	2	1	0	2	0	5	1.51%	2	1	0	2	0	5	3.23%	0	0	0	0	0	0	0.00%
KVSP	7	1	0	1	0	9	2.71%	0	1	0	0	0	1	0.65%	7	0	0	1	0	8	4.52%
LAC	4	14	0	4	0	22	6.63%	2	10	0	3	0	15	9.68%	2	4	0	1	0	7	3.95%
LAC-RC	0	0	0	1	0	1	0.30%	0	0	0	0	0	0	0.00%	0	0	0	1	0	1	0.56%
NKSP36	0	2	0	0	0	2	0.60%	0	0	0	0	0	0	0.00%	0	2	0	0	0	2	1.13%
NKSP-RC	20	27	0	23	0	70	21.08%	7	5	0	8	0	20	12.90%	13	22	0	15	0	50	28.25%
PBSP	0	1	0	0	0	1	0.30%	0	1	0	0	0	1	0.65%	0	0	0	0	0	0	0.00%
PVSP	3	0	0	1	0	4	1.20%	3	0	0	1	0	4	2.58%	0	0	0	0	0	0	0.00%
RJD	1	2	0	1	0	4	1.20%	0	0	0	0	0	0	0.00%	1	2	0	1	0	4	2.26%
SAC	0	28	0	3	0	31	9.34%	0	5	0	0	0	5	3.23%	0	23	0	3	0	26	14.69%
SATF	10	1	0	2	0	13	3.92%	4	0	0	1	0	5	3.23%	6	1	0	1	0	8	4.52%
SCC	1	0	0	0	0	1	0.30%	1	0	0	0	0	1	0.65%	0	0	0	0	0	0	0.00%
SOL	2	0	0	1	0	3	0.90%	2	0	0	1	0	3	1.94%	0	0	0	0	0	0	0.00%
SQ	1	0	0	0	0	1	0.30%	0	0	0	0	0	0	0.00%	1	0	0	0	0	1	0.56%
SVSP	11	8	1	3	0	23	6.93%	0	0	0	0	0	0	0.00%	11	8	1	3	0	23	12.99%
VSP	2	0	0	0	0	2	0.60%	2	0	0	0	0	2	1.29%	0	0	0	0	0	0	0.00%
WSP	1	1	0	3	0	5	1.51%	1	1	0	2	0	4	2.58%	0	0	0	1	0	1	0.56%
WSP-RC	19	16	0	13	0	48	14.46%	9	13	0	7	0	29	18.71%	10	3	0	6	0	19	10.73%
TOTAL	**115**	**128**	**1**	**84**	**4**	**332**	100.00%	**58**	**48**	**0**	**45**	**4**	**155**	100.00%	**57**	**80**	**1**	**39**	**0**	**177**	100.00%
% TTL	34.64%	38.55%	0.30%	25.30%	1.20%	100.00%		37.42%	30.97%	0.00%	29.03%	2.58%	100.00%		32.20%	45.20%	0.56%	22.03%	0.00%	100.00%	

Referrals by Classification Score	
Score	Total
0-18	43
19-35	79
36-59	49
60+	110
TOTAL	**281**
Not Calc	51
Grand TTL	**332**

MHCB TRANSFERS BY INSTITUTION AND PRIOR LEVEL OF CARE ATTACHMENT 2A

JANUARY 2013

Transferred From	Transferred To	Referral Date	Transfer Date	Prior LOC	Days Waiting*
ASP	COR	1/6/2013	1/6/2013	CCCMS	0
ASP	MCSP	1/30/2013	1/31/2013	CCCMS	1
ASP	SATF	1/17/2013	1/18/2013	CCCMS	1
ASP	SOL	1/2/2013	1/4/2013	CCCMS	2
ASP	SOL	1/2/2013	1/4/2013	CCCMS	2
ASP	MCSP	1/20/2013	1/21/2013	EOP	1
ASP Average					**1.17**
CAL	RJD	1/5/2013	1/6/2013	CCCMS	1
CAL	RJD	1/11/2013	1/12/2013	CCCMS	1
CAL	SVSP	1/11/2013	1/12/2013	GP/OP	1
CAL	CIM	1/17/2013	1/18/2013	GP/OP	1
CAL	CMC	1/29/2013	1/30/2013	GP/OP	1
CAL	PVSP	1/23/2013	1/25/2013	GP/OP	2
CAL	RJD	1/3/2013	1/4/2013	GP/OP	1
CAL	SVSP	1/24/2013	1/26/2013	GP/OP	2
CAL Average					**1.25**
CCI	CMC	1/5/2013	1/6/2013	CCCMS	1
CCI	CMC	1/5/2013	1/6/2013	CCCMS	1
CCI	PVSP	1/22/2013	1/24/2013	CCCMS	2
CCI	RJD	1/6/2013	1/8/2013	CCCMS	2
CCI Average					**1.50**
CCI-RC	CMC	1/8/2013	1/9/2013	GP/OP	1
CCI-RC Average					**1.00**
CEN	CIM	1/17/2013	1/17/2013	GP/OP	0
CEN	COR	1/12/2013	1/13/2013	GP/OP	1
CEN	KVSP	1/19/2013	1/19/2013	GP/OP	0
CEN Average					**0.33**
CMC	SOL	1/24/2013	1/24/2013	EOP	0
CMC	SOL	1/24/2013	1/25/2013	EOP	1
CMC	CMC	1/6/2013	1/6/2013	GP/OP	0
CMC Average					**0.33**
CMF	CIM	12/27/2012	1/3/2013	DSH	7
CMF	CIM	12/28/2012	1/10/2013	DSH	13
CMF Average					**10.00**
CMF-DSH	CMF	1/16/2013	1/16/2013	DSH	0
CMF-DSH	CMF	1/31/2013	1/31/2013	DSH	0
CMF-DSH Average					**0.00**
COR	CMF	1/19/2013	1/20/2013	CCCMS	1
COR	CMF	1/19/2013	1/20/2013	EOP	1
COR	CMF	1/24/2013	1/25/2013	EOP	1
COR	CMF	1/24/2013	1/25/2013	EOP	1
COR	PVSP	1/2/2013	1/2/2013	EOP	0
COR	CMF	1/19/2013	1/20/2013	GP/OP	1
COR Average					**0.83**
CRC	CMC	1/10/2013	1/11/2013	CCCMS	1
CRC	RJD	1/9/2013	1/9/2013	CCCMS	0
CRC	SATF	1/9/2013	1/10/2013	CCCMS	1
CRC	CMC	1/10/2013	1/11/2013	GP/OP	1
CRC	CMF	1/20/2013	1/21/2013	GP/OP	1

*Days Waiting based on days between referral and transfer, not days between referral and an MHCB becoming available. Field clinicians identify the most urgent cases and HQ MHP senior clinical staff authorize priority placements.

MHCB TRANSFERS BY INSTITUTION AND PRIOR LEVEL OF CARE ATTACHMENT 2A

JANUARY 2013

Transferred From	Transferred To	Referral Date	Transfer Date	Prior LOC	Days Waiting*
CRC	PVSP	1/30/2013	1/30/2013	GP/OP	0
CRC	RJD	1/3/2013	1/3/2013	GP/OP	0
CRC	SVSP	1/26/2013	1/27/2013	GP/OP	1
CRC Average					**0.63**
CTF	CMC	1/5/2013	1/5/2013	CCCMS	0
CTF	SQ	1/4/2013	1/4/2013	CCCMS	0
CTF	SVSP	1/10/2013	1/11/2013	CCCMS	1
CTF Average					**0.33**
DVI	CMF	1/12/2013	1/12/2013	CCCMS	0
DVI	CMF	1/17/2013	1/18/2013	CCCMS	1
DVI	SATF	1/29/2013	1/31/2013	CCCMS	2
DVI	CMF	1/2/2013	1/3/2013	EOP	1
DVI	CMF	1/17/2013	1/18/2013	EOP	1
DVI	CMF	1/2/2013	1/3/2013	GP/OP	1
DVI Average					**1.00**
DVI-RC	CMF	1/5/2013	1/5/2013	CCCMS	0
DVI-RC	CMF	1/10/2013	1/11/2013	CCCMS	1
DVI-RC	CMF	1/5/2013	1/5/2013	EOP	0
DVI-RC	SOL	1/14/2013	1/15/2013	EOP	1
DVI-RC	CMF	1/5/2013	1/5/2013	GP/OP	0
DVI-RC Average					**0.40**
FOL	CMF	1/4/2013	1/4/2013	CCCMS	0
FOL Average					**0.00**
HDSP	SAC	1/18/2013	1/18/2013	CCCMS	0
HDSP	CMC	1/29/2013	1/30/2013	GP/OP	1
HDSP Average					**0.50**
ISP	CIM	1/17/2013	1/18/2013	CCCMS	1
ISP	COR	1/14/2013	1/16/2013	CCCMS	2
ISP	RJD	1/2/2013	1/3/2013	EOP	1
ISP	CIM	1/16/2013	1/17/2013	GP/OP	1
ISP	CIM	1/16/2013	1/17/2013	GP/OP	1
ISP Average					**1.20**
KVSP	CMF	1/11/2013	1/12/2013	EOP	1
KVSP Average					**1.00**
LAC	SOL	12/30/2012	1/1/2013	CCCMS	2
LAC	SVSP	1/26/2013	1/28/2013	CCCMS	2
LAC	CIM	1/28/2013	1/29/2013	EOP	1
LAC	CMC	1/27/2013	1/29/2013	EOP	2
LAC	CMC	1/29/2013	1/30/2013	EOP	1
LAC	CMF	1/6/2013	1/8/2013	EOP	2
LAC	CMF	1/11/2013	1/12/2013	EOP	1
LAC	CMF	1/21/2013	1/22/2013	EOP	1
LAC	CMF	1/21/2013	1/23/2013	EOP	2
LAC	CMF	1/25/2013	1/26/2013	EOP	1
LAC	MCSP	1/25/2013	1/26/2013	EOP	1
LAC	MCSP	1/25/2013	1/26/2013	EOP	1
LAC	CMC	1/8/2013	1/8/2013	GP/OP	0
LAC	SATF	1/28/2013	1/30/2013	GP/OP	2

*Days Waiting based on days between referral and transfer, not days between referral and an MHCB becoming available. Field clinicians identify the most urgent cases and HQ MHP senior clinical staff authorize priority placements.

MHCB TRANSFERS BY INSTITUTION AND PRIOR LEVEL OF CARE ATTACHMENT 2A

JANUARY 2013

Transferred From	Transferred To	Referral Date	Transfer Date	Prior LOC	Days Waiting*
LAC	SOL	12/31/2012	1/1/2013	GP/OP	1
LAC Average					**1.33**
NKSP-RC	CMF	1/12/2013	1/13/2013	CCCMS	1
NKSP-RC	CMF	1/28/2013	1/30/2013	CCCMS	2
NKSP-RC	COR	1/13/2013	1/15/2013	CCCMS	2
NKSP-RC	COR	1/14/2013	1/16/2013	CCCMS	2
NKSP-RC	COR	1/28/2013	1/30/2013	CCCMS	2
NKSP-RC	SAC	1/1/2013	1/3/2013	CCCMS	2
NKSP-RC	SATF	1/7/2013	1/10/2013	CCCMS	3
NKSP-RC	CMC	1/2/2013	1/4/2013	EOP	2
NKSP-RC	CMF	1/23/2013	1/23/2013	EOP	0
NKSP-RC	CMF	1/26/2013	1/27/2013	EOP	1
NKSP-RC	COR	1/15/2013	1/16/2013	EOP	1
NKSP-RC	COR	1/18/2013	1/18/2013	EOP	0
NKSP-RC	COR	1/18/2013	1/18/2013	GP/OP	0
NKSP-RC	CMC	1/3/2013	1/4/2013	GP/OP	1
NKSP-RC	CMF	1/2/2013	1/3/2013	GP/OP	1
NKSP-RC	CMF	1/23/2013	1/24/2013	GP/OP	1
NKSP-RC	CMF	1/26/2013	1/27/2013	GP/OP	1
NKSP-RC	COR	1/13/2013	1/15/2013	GP/OP	2
NKSP-RC	COR	1/16/2013	1/17/2013	GP/OP	1
NKSP-RC	KVSP	1/5/2013	1/5/2013	GP/OP	0
NKSP-RC Average					**1.25**
PBSP	CMF	1/8/2013	1/8/2013	EOP	0
PBSP Average					**0.00**
PVSP	CMF	1/12/2013	1/12/2013	CCCMS	0
PVSP	SATF	1/11/2013	1/11/2013	CCCMS	0
PVSP	SQ	1/8/2013	1/9/2013	CCCMS	1
PVSP	COR	1/11/2013	1/12/2013	GP/OP	1
PVSP Average					**0.50**
SAC	CMF	1/6/2013	1/6/2013	EOP	0
SAC	CMF	1/6/2013	1/6/2013	EOP	0
SAC	MCSP	1/21/2013	1/21/2013	EOP	0
SAC	MCSP	1/21/2013	1/21/2013	EOP	0
SAC	SQ	1/19/2013	1/19/2013	EOP	0
SAC Average					**0.00**
SATF	CMF	1/20/2013	1/21/2013	CCCMS	1
SATF	CMF	1/22/2013	1/23/2013	CCCMS	1
SATF	COR	1/26/2013	1/26/2013	CCCMS	0
SATF	PVSP	1/26/2013	1/27/2013	CCCMS	1
SATF	CMF	1/22/2013	1/23/2013	GP/OP	1
SATF Average					**0.80**
SCC	CMF	1/2/2013	1/3/2013	CCCMS	1
SCC Average					**1.00**
SOL	CMF	1/22/2013	1/23/2013	CCCMS	1
SOL	SQ	1/19/2013	1/19/2013	CCCMS	0
SOL	CMF	1/4/2013	1/4/2013	GP/OP	0
SOL Average					**0.33**
VSP	CMF	1/7/2013	1/8/2013	CCCMS	1

*Days Waiting based on days between referral and transfer, not days between referral and an MHCB becoming available. Field clinicians identify the most urgent cases and HQ MHP senior clinical staff authorize priority placements.

MHCB TRANSFERS BY INSTITUTION AND PRIOR LEVEL OF CARE ATTACHMENT 2A

JANUARY 2013

Transferred From	Transferred To	Referral Date	Transfer Date	Prior LOC	Days Waiting*
VSP	SQ	1/8/2013	1/8/2013	CCCMS	0
VSP Average					**0.50**
WSP	CMF	1/25/2013	1/25/2013	CCCMS	0
WSP	COR	1/12/2013	1/12/2013	EOP	0
WSP	CMF	1/15/2013	1/17/2013	GP/OP	2
WSP	CMF	1/25/2013	1/25/2013	GP/OP	0
WSP Average					**0.50**
WSP-RC	CIM	1/3/2013	1/4/2013	CCCMS	1
WSP-RC	CMF	1/21/2013	1/22/2013	CCCMS	1
WSP-RC	CMF	1/25/2013	1/26/2013	CCCMS	1
WSP-RC	COR	1/28/2013	1/29/2013	CCCMS	1
WSP-RC	KVSP	1/5/2013	1/5/2013	CCCMS	0
WSP-RC	MCSP	1/27/2013	1/28/2013	CCCMS	1
WSP-RC	MCSP	1/28/2013	1/28/2013	CCCMS	0
WSP-RC	MCSP	1/29/2013	1/31/2013	CCCMS	2
WSP-RC	SQ	1/23/2013	1/26/2013	CCCMS	3
WSP-RC	CMC	1/3/2013	1/5/2013	EOP	2
WSP-RC	CMF	1/15/2013	1/17/2013	EOP	2
WSP-RC	CMF	1/25/2013	1/25/2013	EOP	0
WSP-RC	COR	1/6/2013	1/6/2013	EOP	0
WSP-RC	COR	1/11/2013	1/12/2013	EOP	1
WSP-RC	COR	1/11/2013	1/12/2013	EOP	1
WSP-RC	COR	1/14/2013	1/16/2013	EOP	2
WSP-RC	COR	1/28/2013	1/29/2013	EOP	1
WSP-RC	SAC	1/26/2013	1/27/2013	EOP	1
WSP-RC	SAC	1/26/2013	1/27/2013	EOP	1
WSP-RC	SQ	1/18/2013	1/19/2013	EOP	1
WSP-RC	SQ	1/23/2013	1/26/2013	EOP	3
WSP-RC	SVSP	1/7/2013	1/8/2013	EOP	1
WSP-RC	CIM	1/3/2013	1/4/2013	GP/OP	1
WSP-RC	CMC	1/4/2013	1/5/2013	GP/OP	1
WSP-RC	CMC	1/4/2013	1/5/2013	GP/OP	1
WSP-RC	PVSP	1/29/2013	1/31/2013	GP/OP	2
WSP-RC	RJD	1/11/2013	1/12/2013	GP/OP	1
WSP-RC	SQ	1/17/2013	1/19/2013	GP/OP	2
WSP-RC	SQ	1/23/2013	1/26/2013	GP/OP	**3.00**
WSP-RC Average					**1.28**
Grand Average					**1.07**

SUMMARY OF TRANSFERS			
Time Frames	**Total Transfers**	**Average Days Waiting**	**Range for Days Waiting**
Combined	155	1.07	0-13
< or = 1 day	121	0.64	
2 days	28	NA	
3 days	4	NA	
4 or more days	2	10.00	

*Days Waiting based on days between referral and transfer, not days between referral and an MHCB becoming available. Field clinicians identify the most urgent cases and HQ MHP senior clinical staff authorize priority placements.

ATTACHMENT 2B

RESCINDED MHCB REFERRALS
BY INSTITUTION AND PRIOR LEVEL OF CARE
JANUARY 2013

Referred By	Referral Date	Rescind Date	Prior LOC	Rescind Reason	Days Waiting*
CEN	1/25/2013	1/26/2013	CCCMS	Returned to Housing	1
CEN Average					**1.00**
CMC	1/14/2013	1/15/2013	CCCMS	Returned to Housing	1
CMC	1/21/2013	1/22/2013	CCCMS	Admitted	1
CMC	1/2/2013	1/2/2013	EOP	Admitted	0
CMC	1/14/2013	1/15/2013	EOP	Returned to Housing	1
CMC	1/14/2013	1/15/2013	EOP	Returned to Housing	1
CMC	1/21/2013	1/22/2013	EOP	Returned to Housing	1
CMC	1/23/2013	1/23/2013	EOP	Returned to Housing	0
CMC	1/24/2013	1/25/2013	EOP	Admitted	1
CMC	1/24/2013	1/25/2013	EOP	Admitted	1
CMC	1/26/2013	1/26/2013	EOP	Admitted	0
CMC	1/28/2013	1/29/2013	EOP	Admitted	1
CMC	1/2/2013	1/2/2013	GP/OP	Admitted	0
CMC	1/2/2013	1/2/2013	GP/OP	Admitted	0
CMC	1/23/2013	1/23/2013	GP/OP	Returned to Housing	0
CMC Average					**0.57**
CMF	1/14/2013	1/14/2013	EOP	Admitted	0
CMF	1/19/2013	1/19/2013	EOP	Admitted	0
CMF Average					**0.00**
COR	1/1/2013	1/2/2013	CCCMS	Admitted	1
COR	1/30/2013	1/31/2013	CCCMS	Admitted	1
COR	1/3/2013	1/3/2013	EOP	Admitted	0
COR	1/23/2013	1/23/2013	EOP	Returned to Housing	0
COR	1/24/2013	1/24/2013	EOP	Admitted	0
COR	1/24/2013	1/24/2013	EOP	Returned to Housing	0
COR	1/1/2013	1/1/2013	GP/OP	Admitted	0
COR	1/28/2013	1/29/2013	GP/OP	Admitted	1
COR Average					**0.38**
CRC	1/13/2013	1/13/2013	GP/OP	Returned to Housing	0
CRC Average					**0.00**
FOL	1/4/2013	1/4/2013	CCCMS	Returned to Housing	0
FOL Average					**0.00**
KVSP	1/11/2013	1/11/2013	CCCMS	Admitted	0
KVSP	1/14/2013	1/15/2013	CCCMS	Admitted	1
KVSP	1/16/2013	1/16/2013	CCCMS	Admitted	0
KVSP	1/23/2013	1/23/2013	CCCMS	Returned to Housing	0
KVSP	1/27/2013	1/28/2013	CCCMS	Returned to Housing	1
KVSP	1/31/2013	1/31/2013	CCCMS	Admitted	0
KVSP	1/31/2013	1/31/2013	CCCMS	Admitted	0
KVSP	1/28/2013	1/29/2013	GP/OP	Admitted	1
KVSP Average					**0.38**
LAC	1/20/2013	1/20/2013	CCCMS	Admitted	0
LAC	1/26/2013	1/26/2013	CCCMS	Not Medically Cleared	0
LAC	1/13/2013	1/13/2013	EOP	Returned to Housing	0
LAC	1/14/2013	1/15/2013	EOP	Admitted	1
LAC	1/29/2013	1/29/2013	EOP	Returned to Housing	0

*Days Waiting based on days between referral and rescission. Field clinicians identify the most urgent cases and Headquarters' Mental Health Program senior clinical staff authorize priority placements.

RESCINDED MHCB REFERRALS
BY INSTITUTION AND PRIOR LEVEL OF CARE
JANUARY 2013

Referred By	Referral Date	Rescind Date	Prior LOC	Rescind Reason	Days Waiting*
LAC	1/30/2013	1/30/2013	EOP	Returned to Housing	0
LAC	1/29/2013	1/30/2013	GP/OP	Admitted	1
LAC Average					**0.29**
LAC-RC	1/7/2013	1/7/2013	GP/OP	Returned to Housing	0
LAC-RC Average					**0.00**
NKSP	1/22/2013	1/22/2013	EOP	Admitted	0
NKSP	1/23/2013	1/23/2013	EOP	Returned to Housing	0
NKSP Average					**0.00**
NKSP-RC	1/1/2013	1/1/2013	CCCMS	Admitted	0
NKSP-RC	1/2/2013	1/3/2013	CCCMS	Admitted	1
NKSP-RC	1/6/2013	1/7/2013	CCCMS	Returned to Housing	1
NKSP-RC	1/8/2013	1/9/2013	CCCMS	Returned to Housing	1
NKSP-RC	1/10/2013	1/10/2013	CCCMS	Returned to Housing	0
NKSP-RC	1/15/2013	1/15/2013	CCCMS	Returned to Housing	0
NKSP-RC	1/23/2013	1/24/2013	CCCMS	Admitted	1
NKSP-RC	1/24/2013	1/24/2013	CCCMS	Returned to Housing	0
NKSP-RC	1/25/2013	1/25/2013	CCCMS	Returned to Housing	0
NKSP-RC	1/25/2013	1/25/2013	CCCMS	Returned to Housing	0
NKSP-RC	1/27/2013	1/27/2013	CCCMS	Admitted	0
NKSP-RC	1/29/2013	1/29/2013	CCCMS	Returned to Housing	0
NKSP-RC	1/31/2013	1/31/2013	CCCMS	Paroled	0
NKSP-RC	1/1/2013	1/2/2013	EOP	Returned to Housing	1
NKSP-RC	1/4/2013	1/5/2013	EOP	Returned to Housing	1
NKSP-RC	1/4/2013	1/5/2013	EOP	Returned to Housing	1
NKSP-RC	1/5/2013	1/5/2013	EOP	Returned to Housing	0
NKSP-RC	1/5/2013	1/5/2013	EOP	Returned to Housing	0
NKSP-RC	1/6/2013	1/7/2013	EOP	Returned to Housing	1
NKSP-RC	1/7/2013	1/8/2013	EOP	Returned to Housing	1
NKSP-RC	1/9/2013	1/9/2013	EOP	Returned to Housing	0
NKSP-RC	1/10/2013	1/10/2013	EOP	Not Medically Cleared	0
NKSP-RC	1/11/2013	1/11/2013	EOP	Returned to Housing	0
NKSP-RC	1/11/2013	1/12/2013	EOP	Returned to Housing	1
NKSP-RC	1/17/2013	1/18/2013	EOP	Returned to Housing	1
NKSP-RC	1/19/2013	1/19/2013	EOP	Returned to Housing	0
NKSP-RC	1/20/2013	1/20/2013	EOP	Returned to Housing	0
NKSP-RC	1/21/2013	1/21/2013	EOP	Admitted	0
NKSP-RC	1/22/2013	1/22/2013	EOP	Admitted	0
NKSP-RC	1/23/2013	1/24/2013	EOP	Returned to Housing	1
NKSP-RC	1/24/2013	1/24/2013	EOP	Returned to Housing	0
NKSP-RC	1/24/2013	1/24/2013	EOP	Returned to Housing	0
NKSP-RC	1/25/2013	1/25/2013	EOP	Admitted	0
NKSP-RC	1/28/2013	1/28/2013	EOP	Admitted	0
NKSP-RC	1/29/2013	1/29/2013	EOP	Paroled	0
NKSP-RC	1/30/2013	1/30/2013	GP/OP	Admitted	0
NKSP-RC	1/1/2013	1/2/2013	GP/OP	Returned to Housing	1
NKSP-RC	1/2/2013	1/2/2013	GP/OP	Admitted	0
NKSP-RC	1/2/2013	1/3/2013	GP/OP	Returned to Housing	1

*Days Waiting based on days between referral and rescission. Field clinicians identify the most urgent cases and Headquarters' Mental Health Program senior clinical staff authorize priority placements.

RESCINDED MHCB REFERRALS
BY INSTITUTION AND PRIOR LEVEL OF CARE
JANUARY 2013

Referred By	Referral Date	Rescind Date	Prior LOC	Rescind Reason	Days Waiting*
NKSP-RC	1/5/2013	1/5/2013	GP/OP	Returned to Housing	0
NKSP-RC	1/6/2013	1/7/2013	GP/OP	Returned to Housing	1
NKSP-RC	1/8/2013	1/9/2013	GP/OP	Admitted	1
NKSP-RC	1/13/2013	1/14/2013	GP/OP	Admitted	1
NKSP-RC	1/18/2013	1/18/2013	GP/OP	Returned to Housing	0
NKSP-RC	1/20/2013	1/20/2013	GP/OP	Returned to Housing	0
NKSP-RC	1/21/2013	1/21/2013	GP/OP	Returned to Housing	0
NKSP-RC	1/21/2013	1/22/2013	GP/OP	Admitted	1
NKSP-RC	1/25/2013	1/25/2013	GP/OP	Returned to Housing	0
NKSP-RC	1/28/2013	1/28/2013	GP/OP	Returned to Housing	0
NKSP-RC	1/29/2013	1/30/2013	GP/OP	Returned to Housing	1
NKSP-RC Average					**0.38**
RJD	1/27/2013	1/28/2013	CCCMS	Admitted	1
RJD	1/17/2013	1/17/2013	EOP	Returned to Housing	0
RJD	1/29/2013	1/29/2013	EOP	Admitted	0
RJD	1/17/2013	1/17/2013	GP/OP	Returned to Housing	0
RJD Average					**0.25**
SAC	1/2/2013	1/2/2013	EOP	Returned to Housing	0
SAC	1/2/2013	1/2/2013	EOP	Returned to Housing	0
SAC	1/7/2013	1/7/2013	EOP	Admitted	0
SAC	1/7/2013	1/7/2013	EOP	Returned to Housing	0
SAC	1/8/2013	1/8/2013	EOP	Admitted	0
SAC	1/8/2013	1/8/2013	EOP	Admitted	0
SAC	1/8/2013	1/8/2013	EOP	Admitted	0
SAC	1/9/2013	1/9/2013	EOP	Returned to Housing	0
SAC	1/9/2013	1/9/2013	EOP	Returned to Housing	0
SAC	1/14/2013	1/14/2013	EOP	Admitted	0
SAC	1/14/2013	1/14/2013	EOP	Returned to Housing	0
SAC	1/19/2013	1/19/2013	EOP	Admitted	0
SAC	1/19/2013	1/19/2013	EOP	Admitted	0
SAC	1/20/2013	1/20/2013	EOP	Returned to Housing	0
SAC	1/20/2013	1/20/2013	EOP	Returned to Housing	0
SAC	1/22/2013	1/22/2013	EOP	Returned to Housing	0
SAC	1/22/2013	1/22/2013	EOP	Returned to Housing	0
SAC	1/22/2013	1/22/2013	EOP	Returned to Housing	0
SAC	1/22/2013	1/22/2013	EOP	Returned to Housing	0
SAC	1/22/2013	1/23/2013	EOP	Returned to Housing	1
SAC	1/24/2013	1/24/2013	EOP	Admitted	0
SAC	1/27/2013	1/27/2013	EOP	Returned to Housing	0
SAC	1/29/2013	1/29/2013	EOP	Admitted	0
SAC	1/2/2013	1/2/2013	GP/OP	Returned to Housing	0
SAC	1/7/2013	1/7/2013	GP/OP	Returned to Housing	0
SAC	1/19/2013	1/19/2013	GP/OP	Admitted	0
SAC Average					**0.04**
SATF	1/3/2013	1/3/2013	CCCMS	Admitted	0
SATF	1/3/2013	1/3/2013	CCCMS	Returned to Housing	0
SATF	1/15/2013	1/15/2013	CCCMS	Admitted	0

*Days Waiting based on days between referral and rescission. Field clinicians identify the most urgent cases and Headquarters' Mental Health Program senior clinical staff authorize priority placements.

ATTACHMENT 2B

RESCINDED MHCB REFERRALS
BY INSTITUTION AND PRIOR LEVEL OF CARE
JANUARY 2013

Referred By	Referral Date	Rescind Date	Prior LOC	Rescind Reason	Days Waiting*
SATF	1/15/2013	1/15/2013	CCCMS	Admitted	0
SATF	1/21/2013	1/21/2013	CCCMS	Admitted	0
SATF	1/30/2013	1/31/2013	CCCMS	Admitted	1
SATF	1/30/2013	1/31/2013	EOP	Admitted	1
SATF	1/14/2013	1/14/2013	GP/OP	Admitted	0
SATF Average					**0.25**
SQ	1/28/2013	1/29/2013	CCCMS	Paroled	1
SQ Average					**1.00**
SVSP	1/2/2013	1/2/2013	CCCMS	Returned to Housing	0
SVSP	1/3/2013	1/3/2013	CCCMS	Returned to Housing	0
SVSP	1/7/2013	1/7/2013	CCCMS	Returned to Housing	0
SVSP	1/8/2013	1/8/2013	CCCMS	Returned to Housing	0
SVSP	1/9/2013	1/9/2013	CCCMS	Returned to Housing	0
SVSP	1/12/2013	1/13/2013	CCCMS	Admitted	1
SVSP	1/14/2013	1/14/2013	CCCMS	Returned to Housing	0
SVSP	1/17/2013	1/17/2013	CCCMS	Returned to Housing	0
SVSP	1/18/2013	1/18/2013	CCCMS	Returned to Housing	0
SVSP	1/30/2013	1/30/2013	CCCMS	Returned to Housing	0
SVSP	1/31/2013	1/31/2013	CCCMS	Returned to Housing	0
SVSP	1/1/2013	1/1/2013	EOP	Returned to Housing	0
SVSP	1/3/2013	1/3/2013	EOP	Admitted	0
SVSP	1/12/2013	1/12/2013	EOP	Returned to Housing	0
SVSP	1/12/2013	1/12/2013	EOP	Returned to Housing	0
SVSP	1/12/2013	1/12/2013	EOP	Returned to Housing	0
SVSP	1/18/2013	1/18/2013	EOP	Returned to Housing	0
SVSP	1/29/2013	1/29/2013	EOP	Returned to Housing	0
SVSP	1/30/2013	1/30/2013	EOP	Admitted	0
SVSP	1/8/2013	1/8/2013	GP/OP	Returned to Housing	0
SVSP	1/14/2013	1/15/2013	GP/OP	Admitted	1
SVSP	1/18/2013	1/18/2013	GP/OP	Admitted	0
SVSP	1/17/2013	1/17/2013	MHCB	Returned to Housing	0
SVSP Average					**0.09**
WSP	1/25/2013	1/25/2013	GP/OP	Returned to Housing	0
WSP Average					**0.00**
WSP-RC	1/6/2013	1/6/2013	CCCMS	Returned to Housing	0
WSP-RC	1/6/2013	1/6/2013	CCCMS	Returned to Housing	0
WSP-RC	1/16/2013	1/16/2013	CCCMS	Admitted	0
WSP-RC	1/17/2013	1/17/2013	CCCMS	Admitted	0
WSP-RC	1/17/2013	1/18/2013	CCCMS	Admitted	1
WSP-RC	1/17/2013	1/18/2013	CCCMS	Admitted	1
WSP-RC	1/23/2013	1/23/2013	CCCMS	Returned to Housing	0
WSP-RC	1/23/2013	1/24/2013	CCCMS	Returned to Housing	1
WSP-RC	1/27/2013	1/28/2013	CCCMS	Returned to Housing	1
WSP-RC	1/31/2013	1/31/2013	CCCMS	Returned to Housing	0
WSP-RC	1/11/2013	1/11/2013	EOP	Returned to Housing	0
WSP-RC	1/17/2013	1/17/2013	EOP	Returned to Housing	0
WSP-RC	1/25/2013	1/25/2013	EOP	Admitted	0

*Days Waiting based on days between referral and rescission. Field clinicians identify the most urgent cases and Headquarters' Mental Health Program senior clinical staff authorize priority placements.

ATTACHMENT 2B

RESCINDED MHCB REFERRALS
BY INSTITUTION AND PRIOR LEVEL OF CARE
JANUARY 2013

Referred By	Referral Date	Rescind Date	Prior LOC	Rescind Reason	Days Waiting*
WSP-RC	1/10/2013	1/10/2013	GP/OP	Admitted	0
WSP-RC	1/10/2013	1/11/2013	GP/OP	Admitted	1
WSP-RC	1/18/2013	1/18/2013	GP/OP	Returned to Housing	0
WSP-RC	1/20/2013	1/20/2013	GP/OP	Admitted	0
WSP-RC	1/26/2013	1/26/2013	GP/OP	Admitted	0
WSP-RC	1/30/2013	1/31/2013	GP/OP	Admitted	1
WSP-RC Average					**0.32**
Grand Average					**0.28**

SUMMARY OF RESCINDED REFERRALS			
Time Frames	Total Transfers	Average Days Waiting	Range for Days Waiting
Combined	177	0.28	0-1
< or = 1 day	177	0.28	
2 days	0	NA	
3 days	0	NA	
4 or more days	0	NA	

*Days Waiting based on days between referral and rescission. Field clinicians identify the most urgent cases and Headquarters' Mental Health Program senior clinical staff authorize priority placements.

REASON FOR RESCINDED MHCB REFERRALS

ATTACHMENT 2C

JANUARY 2013

	REASON FOR RESCINDED MHCB REFERRALS					
Institution	**Admitted**	**Return to Housing**	**Paroled**	**Out to Court**	**Not Medically Cleared**	**Total Rescinded**
ASP	0	0	0	0	0	**0**
CAL	0	0	0	0	0	**0**
CCC	0	0	0	0	0	**0**
CCI	0	0	0	0	0	**0**
CCI-RC	0	0	0	0	0	**0**
CEN	0	1	0	0	0	**1**
CIM-RC	0	0	0	0	0	**0**
CMC	8	6	0	0	0	**14**
CMF	2	0	0	0	0	**2**
CMF-DSH	0	0	0	0	0	**0**
COR	6	2	0	0	0	**8**
CRC	0	1	0	0	0	**1**
CTF	0	0	0	0	0	**0**
CVSP	0	0	0	0	0	**0**
DVI	0	0	0	0	0	**0**
DVI-RC	0	0	0	0	0	**0**
FOL	0	1	0	0	0	**1**
HDSP	0	0	0	0	0	**0**
ISP	0	0	0	0	0	**0**
KVSP	6	2	0	0	0	**8**
LAC	3	3	0	0	1	**7**
LAC-RC	0	1	0	0	0	**1**
MCSP	0	0	0	0	0	**0**
NKSP	1	1	0	0	0	**2**
NKSP-RC	13	34	2	0	1	**50**
PBSP	0	0	0	0	0	**0**
PVSP	0	0	0	0	0	**0**
RJD	2	2	0	0	0	**4**
RJD-RC	0	0	0	0	0	**0**
SAC	10	16	0	0	0	**26**
SATF	7	1	0	0	0	**8**
SCC	0	0	0	0	0	**0**
SOL	0	0	0	0	0	**0**
SQ	0	0	1	0	0	**1**
SQ-RC	0	0	0	0	0	**0**
SVSP	5	18	0	0	0	**23**
WSP	0	1	0	0	0	**1**
WSP-RC	10	9	0	0	0	**19**
TOTAL	**73**	**99**	**3**	**0**	**2**	**177**

ATTACHMENT 3

AVERAGE DAYS WAITING*
Transferred and Rescinded MHCB Referrals
JANUARY 2013

	TRANSFERS		RESCINDED REFERRALS		TOTAL REFERRALS	
	Number	Avg Days Wait	Number	Avg Days Wait	Number	Avg Days Wait
ASH	0	0.00	0	0.00	0	0.00
ASP	6	1.17	0	0.00	6	1.17
CAL	8	1.25	0	0.00	8	1.25
CCC	0	0.00	0	0.00	0	0.00
CCI	4	1.50	0	0.00	4	1.50
CCI-RC	1	1.00	0	0.00	1	1.00
CEN	3	0.33	1	1.00	4	0.50
CIM-RC	0	0.00	0	0.00	0	0.00
CMC	3	0.33	14	0.57	17	0.53
CMF	2	10.00	2	0.00	4	5.00
CMF/DSH	2	0.00	0	0.00	2	0.00
COCF	0	0.00	0	0.00	0	0.00
COR	6	0.83	8	0.38	14	0.57
CRC	8	0.63	1	0.00	9	0.56
CTF	3	0.33	0	0.00	3	0.33
CVSP	0	0.00	0	0.00	0	0.00
DVI	6	1.00	0	0.00	6	1.00
DVI-RC	5	0.40	0	0.00	5	0.40
FOL	1	0.00	1	0.00	2	0.00
HDSP	2	0.50	0	0.00	2	0.50
ISP	5	1.20	0	0.00	5	1.20
KVSP	1	1.00	8	0.38	9	0.44
LAC	15	1.33	7	0.29	22	1.00
LAC-RC	0	0.00	1	0.00	1	0.00
MCSP	0	0.00	0	0.00	0	0.00
NKSP	0	0.00	2	0.00	2	0.00
NKSP-RC	20	1.25	50	0.38	70	0.63
NSH	0	0.00	0	0.00	0	0.00
PBSP	1	0.00	0	0.00	1	0.00
PVSP	4	0.50	0	0.00	4	0.50
RJD	0	0.00	4	0.25	4	0.25
RJD-RC	0	0.00	0	0.00	0	0.00
SAC	5	0.00	26	0.04	31	0.03
SATF	5	0.80	8	0.25	13	0.46
SCC	1	1.00	0	0.00	1	1.00
SOL	3	0.33	0	0.00	3	0.33
SQ	0	0.00	1	1.00	1	1.00
SVSP	0	0.00	23	0.09	23	0.09
VSP	2	0.50	0	0.00	2	0.50
WSP	4	0.50	1	0.00	5	0.40
WSP-RC	29	1.28	19	0.32	48	0.90
TOTAL	**155**	**1.07**	**177**	**0.28**	**332**	**0.65**

*Average Days Waiting is based on number of days between referral and transfer or rescission. It does not indicate days between referral and an MHCB becoming available. Field clinicians identify the most urgent cases and Headquarters' Mental Health Program senior clinical staff authorize priority placement of these cases into available MHCBs.

Exhibit 77

MENTAL HEALTH SERVICES DELIVERY SYSTEM

PROGRAM GUIDE

2009 REVISION

Division of Correctional Health Care Services

Department of Corrections & Rehabilitation

- Interact with these inmate-patients daily on scheduled work days (instead of weekly)
- Include in the treatment plan efforts to reduce resistance to participation in group therapy
- Discuss these inmate-patients during the ASU morning meeting with custody
- Consider referral of inmate-patients to higher levels of care and document the results of this consideration.

I. INPATIENT PLACEMENT

Inmates who are found to meet the clinical criteria for referral to the MHCB for inpatient care shall immediately be transferred for such treatment, upon authorization by the Chief of Mental Health of the sending institution. (Refer to Section 5, Mental Health Crisis Bed, for transfer procedure)

If an ASU inmate-patient in an MHCB is determined to meet the clinical criteria for referral to the Department of Mental Health (DMH) program, the Chief of Mental Health or designee, of the sending institution shall initiate the referral process following established procedures to facilitate the admission to a DMH program.

J. STAND-ALONE ADMINISTRATIVE SEGREGATION UNITS

1. No participant in the MHSDS shall be housed in a stand-alone ASU. Any inmate-patient included in the MHSDS, who is inadvertently placed in a stand-alone ASU, shall be transferred out within 24 hours.

2. LPTs shall make rounds seven days a week.

3. A mental health clinician shall conduct an assessment of any inmate in a stand-alone ASU identified and referred by the LPT or any staff immediately or within 24 hours, depending on urgency of the referral. Any inmate who meets criteria for MHSDS shall be transferred to another ASU as soon as possible but no longer than 24 hours following identification.

K. PLACEMENT REVIEW AND CLINICAL INPUT IN CLASSIFICATION COMMITTEE

1. The initial IDTT is held prior to the initial ICC and as often as needed thereafter, at a minimum, once every 90 days. The PC and the Correctional Counselor assigned to the case shall present relevant clinical and custody case factors with recommendations

Exhibit 78

From: Monthei, Eric@CDCR
Sent: Friday, January 27, 2012 6:21 PM
To: Clavere, Stephen@CDCR; Scaramozzino, James@CDCR
Cc: Clark, Jackie@CDCR
Subject: RE: Specialized Care for the Condemned - CTC Expansion
Attachments: Specialized Care for the Condemned - CTC Expansion.doc

Eric E. Monthei, Psy.D.
Chief of Mental Health

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From: Clavere, Stephen@CDCR
Sent: Friday, January 27, 2012 2:05 PM
To: Monthei, Eric@CDCR
Subject: FW: Specialized Care for the Condemned - CTC Expansion

Thanks for the OT numbers. Could you please send me the attachment to your 1/25/12 email to Scar? He says he apparently has misplaced it.

Steve

From: Scaramozzino, James@CDCR
Sent: Thursday, January 26, 2012 2:40 AM
To: Monthei, Eric@CDCR
Cc: Burleson, Judy@CDCR; Clark, Jackie@CDCR; Debbie Vorous; Toche, Diana@CDCR; Jeff Beard; Clavere, Stephen@CDCR
Subject: Re: Specialized Care for the Condemned - CTC Expansion

This is helpful

Thank you

On Jan 25, 2012, at 8:28 PM, "Monthei, Eric@CDCR" <Eric.Monthei@cdcr.ca.gov> wrote:

> For your respective consideration.
>
> **Eric E. Monthei, Psy.D.**
>
> **Chief of Mental Health**
>
> **San Quentin State Prison - Mental Health Service Delivery System (MHSDS)**
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>
> <Specialized Care for the Condemned - CTC Expansion.doc>

DIVISION OF ADULT OPERATIONS
SAN QUENTIN STATE PRISON
San Quentin, CA 94964

Memorandum

Date: January 25, 2012

To: J. Scaramozzino, Ph.D.
Deputy Director
DCHCS

J. Burleson
Deputy Director
DCHCS

From: E. Monthei, Psy.D.
Chief of Mental Health
San Quentin State Prison

Re: Specialized Care for the Condemned: CTC Expansion

Per our conversation and for your respective consideration the below items may be of use in deliberating the proposed Specialized Care for the Condemned CTC Expansion. The below items are presented as a means of strategically planning for the potential benefits and challenges that this approach may entail. These items are proffered as a tool to ensure our collective success and are not designed to be taken as a position paper. Specifically, it should be noted that this document neither represents our support nor our opposition.

Current Practice

- A change of environment vis-a-vis the CTC has never been denied to CDM patients. When clinically indicated a patient can go to the CTC for respite. Despite this, most all want to go back to their assigned housing cell as soon as possible.

- The 5 CDM I/P's identified by *Coleman* as potentially benefiting from DMH-ICF services would likely refuse extended CTC housing. It appears that there is a lack of appreciation for the CDM patients having lived in their "house" for many years. They are settled and connected to their cell, their living environment and their perceived neighborhood.

- The 5 CDM I/P's identified by *Coleman* as potentially benefiting from DMH-ICF services would likely refuse a DMH-ICF referral. Based upon their current level of functioning and the relative improvement that they have shown over the last year each would likely win their respective Vitek hearings.

- Following a potential extended removal from East Block, the 5 CDM I/P's identified by *Coleman* as potentially benefiting from DMH-ICF services will ultimately return to the very same environment that they were removed.

Clinical Factors

- CTC patients receive on average less service than the current Specialized Care for the Condemned participants. Following CTC protocols alone would result in increased isolation, decreased interactions

with primary clinician and psychiatrist and impedes patients' ability to interact with neighbors when compared to the current Specialized Care for the Condemned program, despite 24 hour nursing care.

- Several other CDM patients have already received treatment at DMH APP program for many months (a higher level of care than ICF), and this was less successful than Specialized Care in improving clinical symptoms and return to the housing community.

- We may need to differentiate between a higher level of care, a higher level of service, and a higher level of patient wellness. It appears as though the courts are mixing these concepts and suggesting that it is always the case, that regardless of illness severity, extinction of symptoms can be achieved. This is not founded in science or medicine.

- Long term placement outside of East Block may make readjusting to the neighborhood more difficult and may increase decompensation.

- CHSB yard time is already filled with 33 OHU patients and CTC patients. There is a limit to yard hours due to no yard after dusk. Condemned and other inmates cannot be on the yard at the same time. Yard and out-of-cell access time is a cornerstone of an effective ICF program.

- Creates a new program with no policies or procedures and sets a very clear new "Level of Care" that is different from EOP, EEOP, ICF, CTC, OHU, etc. Defining who does or does not fit into this level of care rapidly becomes indefensible.

- There may be arguments as to whether the 5 CDM I/P's identified by *Coleman* as potentially benefiting from DMH-ICF services would be beholden to use DMH's ICF policies, procedures, and staffing models, or be satisfied by the current uniquely individually tailored Specialized Care program.

- May create a confusing environment in the high-risk area (CTC). This would create a hospital with four separate policies and procedures increasing the risk of errors (ICF, CTC, OHU, Alternative housing pending transfer to CTC).

Potential Legal Arguments

- Conceding that a different setting is indicated eliminates the possible legal defense of hiring independent psychiatrists and psychologists to review the cases and meet with the patients and the team and present findings contrary to the *Coleman* experts.
    - It may negate the possible defense of DMH saying they concur that everything that can be done for these patients is being done already and they have nothing better to offer.
    - It may not give DMH an opportunity to take these patients and receive equal levels of *Coleman* monitor scrutiny and may fail to produce a better outcome.
    - There is nothing in the literature to support "a more attractive room" being predictably or causally effective treatment for delusions or negative symptoms of schizophrenia.
    - Dr. Hughes commented that he felt the patients needed a 'higher level of care', but did not reference any specifics of the care given or what more effective care would look like. Erroneously, he was likely referring to the patients' level of illness, which is not synonymous with level of care.

- It does not answer the core legal argument that condemned inmates are refused equal treatment due to their legal status. "Separate, but equal" was insufficient as a response to civil rights related to segregated schools, and it is likely to fall flat as well in this case.

- Our current outcome measures include decreased CTC admissions and decreased lengths of stay. Long term CTC placement would result in increased CTC admissions with increased lengths of stay.

- May perpetuate the frequent and intensive *Coleman* monitoring of this program and invite PLO attorneys to return with monitoring tours.

- It is not clear that the *Coleman* court experts' opinions of these five patients represents constitutional significant non-compliance with the class-action suit, and not just a professional disagreement in the treatment plan for a very small number of individual patients, and therefore is not in the scope of the current *Coleman* suit.

- If the patients are represented by the PLO or a private attorney, perhaps another first step would be for the attorney to ask each of his clients if they wish to go to an ICF for several months then return to their current housing. If the answer is "no", the patient's civil right to refuse this transfer can be upheld, if it is "yes", this bridge can be crossed at that time if clinically indicated. Current impression is that most patients within the current Specialized Care for the Condemned Program would respond with, 'no'.

- Mixing ICF with CTC patients is not clinically recommended as it may worsen both's course of treatment. Additionally, groups must be separated due to condemned security status. Which also emphasizes that group therapy with solely the severe and persistently mentally ill would be a very low functioning group with no therapeutic models attending the group as a mentor.

- Sets in motion the next legal challenge of "Why did you discharge the patient from ICF-light?" "What were your exact criteria, given that he appears to be not significantly different from before?" "If he is not that different from before over several months, why did you not refer him to DMH?"

- May invite criticism associated with DMH Acute referrals due to increased CTC admissions and increased CTC length of stays.

- It would allow for DMH and monitors to do a more "apples to apples" comparison with a theoretical DMH ICF 'looking' unit.

- May inadvertently derail CDCR's plans and efforts to take over provision of ICF from DMH, and/or hamper national accreditation efforts.

- Long term alternative East Block housing may set precedent for additional housing changes.

- May be perceived as a concession of current East Block housing being inadequate and re-open the multi-million dollar Condemned Inmate Complex project debate.

- May not alleviate criticism of the perceived need for ICF placement and may further their argument given increased CTC admissions.

- There is a long legal precedent about DMH providing ICF and CDCR providing CTC levels of care. It is not clear that this precedent would not trump any attempts to do otherwise. Previous court decisions have said that although DMH may not be perfect, there was a lack of trust that CDCR could effectively staff or operate this level of care. It is not clear that this opinion has been reversed.

- It is unclear how these beds would be differentiated from the parallel argument of maintaining a patient in an "OHU" for lengthy periods of time absent CTC referral.

- We will at some point need to address real world scenarios such as: What happens when CTC beds are full and an acutely ill MCHB level patient has to be in an OHU bed or sent out to another facility because ICF beds are full? What happens when ICF is full and additional patients need ICF? Under this approach and depending on the definition of ICF-eligible CDM patients, this number could exceed the 17 CTC beds that we have available at SQ.

    - Will other patients who are not condemned and need ICF be allowed to use these beds while waiting for DMH. If not, why not? If they are vacant, would it not be a better location than in EOP housing? If a condemned inmate then needed the bed, should the other inmate be returned to EOP housing pending ICF transfer?

- Vitek v Jones is not about a division of State Hospitals and prison, but rather about involuntary hospitalization in mental hospitals without adequate procedural safeguards. Involuntarily, or admitting without voluntary consent of the inmate, into CDCR mental hospital (now defined as an "ICF level of care" and "equivalent to a DMH mental hospital") could trigger a completely new lawsuit that builds on Vitek v Jones. This may in turn require all admissions to OHU and crisis beds go through a Vitek process or even more rigorous procedure, also triggering further compliance monitoring.

> *2. The involuntary transfer of appellee to a mental hospital implicates a liberty interest that is protected by the Due Process Clause of the Fourteenth Amendment. Pp. 445 U. S. 487-494.*
>
> *(a) The District Court properly identified a liberty interest rooted in § 83-180(1), under which a prisoner could reasonably expect that he would not be transferred to a mental hospital without a finding that he was suffering from a mental illness for which he could not secure adequate treatment in prison. The State's reliance on the opinion of a designated physician or psychologist for determining whether the conditions warranting transfer exist neithe removes the prisoner's interest from due process protection nor answers the question of what process is due under the Constitution. Pp. 445 U. S. 488-491.*
>
> *(b) The District Court was also correct in holding that, independently of § 83-180(1), the transfer of a prisoner from a prison to a mental hospital must be accompanied by appropriate procedural protections. Involuntary commitment to a mental hospital is not within the range of conditions of confinement to which a prison sentence subjects an individual. While a conviction and sentence extinguish an individual's right to freedom from confinement for the term of his sentence, they do not authorize the State to classify him as mentally ill and to subject him to involuntary psychiatric treatment without affording him additional due process protections. Here, the stigmatizing consequences of a transfer to a mental hospital for involuntary psychiatric treatment, coupled with the subjection of the prisoner to mandatory behavior modification as a treatment for mental illness, constitute the kind of deprivations of liberty that requires procedural protections. Pp. 491-494.*
>
> *3. The District Court properly identified and weighed the relevant factors in arriving at its judgment. Pp. 445 U. S. 495-496.*
>
> *(a) Although the State's interest in segregating and treating mentally ill patients is strong, the prisoner's interest in not being arbitrarily classified as mentally ill and subjected to unwelcome treatment is also powerful, and the risk of error in making the determinations required by § 83-180(1) is substantial enough to warrant appropriate procedural safeguards against error.*

- If the Death Penalty is repealed in November, the whole issue becomes moot.

Adequate Staffing

- Resolving the understaffing of our current CTC and Specialized Care for the Condemned along with no staffing for the Condemned population as a whole has developed into a multi-year struggle that remains unresolved.

- It is unlikely that any meaningful BCP's will pass during this fiscal year and there are no assurances that what might pass would be sufficient to operate and expand an under funded program in a manner able to withstand legal scrutiny.

- It is not cost-effective to establish a 5-bed ICF. An estimated 20 staff are needed, at an annual cost of $1.8 million, and no guarantee of being able to fill these with civil-service employees (so costs may be higher, yet). Politically, it may be hard to justify a $350,000 per patient per year program.

    - At minimum, just the ICF-alternative will require 2 officers on 2nd and 3rd watch and one on first watch, as condemned inmates require 2-man escorting. This is 9 C.O.'s with relief factor.
        - Depending on BU6's span-of-control ratios, this may require a Sgt position to supervise these C.O.s
    - 7-day presence of 1 psychiatrist, 1 psychologist and 1 Recreation Therapist, with relief means 1.7 of each of these positions.
    - Nursing 1 per shift adds up to 6 nurses, with relief.

- Staffing was attempted to be produced for the original Specialized Care project. Not only did the needed number of clinical and correctional staff positions never become established, the original three "to get things started" were eliminated. Daily CEO and Headquarters calls over several months achieved nothing in terms of being able to hire for over 12-months. Given that the same Headquarters procedures and staff are in place today, and that the budget and personnel processes are worse and further out of the control of CDCR regarding hiring, it is virtually assured no staff will actually be able to be hired in a timely or permanent manner.
    - Notably all positions promised have now been eliminated and psychologists terminated. The Specialized Care psychiatrist (UCSF dual-board certified forensic psychiatrist) has received a layoff letter.
    - Furthermore, the CTC weekend psychiatrist has been laid off and a CTC psychiatrist position was redirected to another prison, further underscoring the unlikelihood of adequate resources being established in a sustainable manner.
    - Due to a 'spreadsheet error' a disproportionate number of Senior Psychologist Supervisors will be eliminated Statewide with 4 of our current 7 scheduled for layoff and/or termination.

- The current position is: "no staff or resources will be diverted from other facilities to help establish a program at San Quentin". Given this position, staff cannot be brought on board or back-filled through mutual assistance as needed to have a stable program at this level of care, importance, and intensity. We often hear of the importance that is associated with our local programs absent any meaningful change that would support that importance.

- Another current position is: "we do not have the authority to change the current AB109 position realignment process", including establishing new positions, halting layoffs, altering voluntary transfer agreements or correcting disproportionate displacement of Senior Psychologist Supervisors. Without anyone who has authority to establish stable permanent full-time funded positions for clinical staff, nursing, and custody, the project will not succeed.

- A final position is: "anything needed we'll find a way to make it happen". Despite intense *Coleman* monitor scrutiny, 18-months of internal redirects and several all parties' reports, headquarters has not provided relief despite a years worth of documented requests. Due to lack of custody positions, the condemned group room and additional group yard that we originally proposed remain unused. With this lack of responsiveness in place, a concerted effort with meaningful change that is realized at the local level is essential to a successful ICF.

Physical Plant Modifications

- The CTC would likely need to repurpose existing space, purchase and install therapeutic modules in order to provide therapeutic groups while on the CTC.

- There is no electricity or cable in the cells, so entertainment and property would be much more restrictive than the East Block comparison.

- Yard space an hours may be inadequate to service 33 OHU beds, 12 CTC beds and 5 ICF beds.

Custody Interface

- Historically, CDM I/P's require a 2:1 escort when off of East Block and would need to be reevaluated under an expanded model.

- CTC procedures would need to be modified during ICF patient movement, and may reduce access to care for CTC patients.

Final Note

- Given adequate staffing, appropriate funding, physical plant modifications, interdisciplinary coordination and sound legal strategies, SQ can accomplish any task.

Cc: J. Clark, RN, MBA
CEO, Health Care
San Quentin State Prison

Exhibit 79

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Attorneys for Plaintiffs

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

ROBERT MITCHELL,

Plaintiff,

v.

TOM FELKER, et al.,

Defendants.

No. 08-CV-01196 JAM EFB

DECLARATION OF DEVIN M. MCDONELL IN SUPPORT OF PLAINTIFFS' MOTION FOR CLASS CERTIFICATION AND MOTION FOR PRELIMINARY INJUNCTION

I, Devin M. McDonell, declare as follows

1. I am an attorney licensed to practice law in the State of California and admitted to practice law before this Court. I make this declaration of my personal knowledge and, if called as a witness, I could and would completely testify to the matters stated herein. I am employed by Bingham McCutchen, and I am a member of Bingham McCutchen's legal team serving as counsel for Plaintiffs in the above captioned matter. I have directed and supervised my office staff in compiling summary data showing all the lockdowns that occurred in California Department of Corrections and Rehabilitation ("CDCR") prisons since January 1, 2010 regarding which the CDCR has provided Plaintiffs documents.

2. Attached hereto as Exhibit A is a summary spreadsheet prepared by me and under my supervision entitled "FRE 1006 Summary of 2010-2011 Program Status Reports Provided to Plaintiffs in Response to Public Records Act Requests and Discovery Requests." (hereinafter "PSR Summary Spreadsheet 2010-2011"). Exhibit A summarizes all the lockdowns in CDCR prisons that were in effect between January 1, 2010 and June 1, 2010, and initiated prior to June 1, 2011, regarding which the CDCR has provided Plaintiffs documentation.

3. The column entitled "Security" in the PSR Summary Spreadsheet 2010-2011 shows that there were a total of 635 security-based lockdowns in CDCR prisons during this period. This category includes lockdowns initiated because of fights, riots, threats of violence, etc. It excludes lockdowns initiated because of staff shortages, and lockdowns caused by medical emergencies (such as quarantines).

4. The column entitled "Race" in the PSR Summary Spreadsheet 2010-2011 shows that there were a total of 339 race-based lockdowns during this period. By "race-based," I mean that the lockdown was imposed upon inmates as identified by the CDCR by their shared ethnic or racial characteristics. Race-based lockdowns listed one or more of the terms "White," "Black," "Hispanic," or "Other" in the "Inmates Affected" column of the Program Status Report: Part B-Plan of Operation / Staff & Inmate Notification forms ("PSR"). Where the "Inmates Affected" column applied to a named gang--e.g. "Black Crips"-- but not to one of the four

classifications above, the lockdown was not labeled as race-based.

5. The column entitled "Recreation" in the PSR Summary Spreadsheet 2010-2011 shows the number of lockdowns during with outdoor recreation was withheld or otherwise restricted.

6. The column entitled "length of lockdown" shows the total number of lockdowns that fit within each range of days. Each column in this section is exclusive of the others.

7. The final column is entitled "Inmates Affected: Race/Ethnicity." This column shows the number of lockdowns that affected inmates identified by each racial or ethnic group. These columns are not exclusive of one another; lockdowns that affected more than one race are listed once for each affected race.

8. Attached hereto as Exhibit B is a summary spreadsheet prepared by me and under my supervision entitled "FRE 1006 Summary of 2011-2012 Program Status Reports Provided to Plaintiffs in Response to Public Records Act Requests and Discovery Requests." (hereinafter "PSR Summary Spreadsheet 2011-2012"). Exhibit B summarizes all the lockdowns in CDCR prisons that were initiated on or after June 1, 2011 regarding which the CDCR has provided Plaintiffs documentation. This spreadsheet does not include PSRs provided to Plaintiffs after October, 2012.

9. The columns in PSR Summary Spreadsheet 2011-2012 represent the same categories of lockdowns as in the PSR Summary Spreadsheet 2010-2011. Exhibit B shows that between June 1, 2011 and November 1, 2012, the CDCR initiated 810 lockdowns, of which 322 affected inmates based on their race or ethnicity.

Source Documents

10. Defendants produced to Plaintiffs copies of thousands of CDCR PSRs in effect between January 1, 2010 and November, 2012 either in response to discovery requests or to Plaintiffs' two requests for public records pursuant to the California Public Records Act, California Government Code Section 6250 et seq. ("Public Records Act"). The PSR Summary Spreadsheets contain information from the PSRs Defendants produced to Plaintiffs and other

documents with information about the lockdowns described in these PSRs.

11. Plaintiffs' first request under the Public Records Act was submitted by the Prison Law Office on June 2, 2011 and sought "copies of all parts of all daily Program Status Reports and weekly spreadsheet data regarding each lockdown, modified program or state of emergency that occurred at a prison under the jurisdiction of CDCR between July 1, 2010 and June 1, 2011." (hereinafter "First Request"). A true and correct copy of this First Request is attached hereto as Exhibit C, as provided to me by the Prison Law Office.

12. Plaintiffs' second Public Records Act request was drafted by me and sent to the CDCR on August 6, 2012 requesting "Program Status Reports ("PSRs") and weekly spreadsheet data regarding all lockdowns, modified programs, or states of emergency which occurred between June 2, 2011, and August 3, 2012 at CDCR facilities." (hereinafter "Second Request"). A true and correct copy of this Second Request is attached hereto as Exhibit D.

13. Plaintiffs received documents responsive to the First Request, as described in ¶ 11, on July 20, 2011, as provided in CDCR's July 19, 2011 letter to Rebekah Evenson of the Prison Law Office, attached hereto as Exhibit E. Plaintiffs received documents responsive to the Second Request, as described in ¶ 12, on October 8, 2012.

14. In response to the Public Records Act requests described in ¶¶ 11 and 12, CDCR provided Plaintiffs with over 6,000 PSRs. Each PSR provided information about specific lockdowns or modified programs as those terms are defined in 15. C.C.R. § 3000 (2012) (collectively "Modified Programs") and contained information relevant to the CDCR's practice of instituting Modified Programs based on racial or ethnic classifications and denying or restricting recreational activity. This large number of PSRs produced, and the vast amount of information contained in each PSR, made it impossible to comprehend the information contained therein merely by reviewing each PSR individually.

15. In response to Plaintiffs' Requests for Production (Set 1), dated August 28, 2012, the CDCR provided Plaintiffs with thousands of pages of documents describing and relating to Modified Programs imposed at CDCR facilities. These documents included thousands of PSRs,

some of which were duplicative of the PSRs provided in response to Plaintiffs' Public Records Act requests, and some of which had not previously been provided to Plaintiffs (hereinafter "Discovery PSRs").

16. I directed, supervised the preparation of, and performed quality control upon review of the 6,000+ PSRs described in ¶ 14 and the Discovery PSRs described in ¶ 15 by Bingham paralegals and a Bingham litigation technology specialist. I instructed the team of paralegals to code all PSRs with a "Yes" or "No" as to whether the reason stated for the PSR was related to security within the facility. I instructed paralegals to code the PSR "Yes" for all PSRs with a potential security rationale for the modified program. I instructed the paralegals to code the PSR with a "No" for PSRs whose stated reason indicated the PSR was initiated for reasons which appeared unrelated to preventing violence involving inmates (e.g. for immunizations or to quarantine inmates in order to protect against potential outbreaks of disease). All PSRs coded with a "Yes" pursuant to the instructions in this ¶ 16 are referred to hereinafter as "Security-Based PSRs."

17. PSR Summary Spreadsheet 2010-2011 summarizes information contained in Security-Based PSRs imposed on CDCR inmates between January 1, 2010 and June 1, 2011. The PSRs Summarized in PSR Summary Spreadsheet 2010-2011 were provided to Plaintiffs by the CDCR either in response to Plaintiffs' June 2, 2011 Public Records Act request described in ¶ 11, or in response to Plaintiffs' Requests for Production (Set 1), dated August 28, 2012. I generated a complete list of the Modified Programs included in PSR Summary Spreadsheet 2010-2011, and a complete and correct copy of this list is attached as Exhibit F.

18. PSR Summary Spreadsheet 2011-2012 summarizes information contained in Security-Based PSRs imposed on CDCR inmates after June 1, 2011. The PSRs Summarized in PSR Summary Spreadsheet 2011-2012 were provided to Plaintiffs by the CDCR either in response to Plaintiffs' August 6, 2012 Public Records Act request described in ¶ 12, or in response to Plaintiffs' Requests for Production (Set 1), dated August 28, 2012. I generated a complete list of the PSR Numbers included in the PSR Summary Spreadsheet 2011-2012, and a

complete and correct copy of this list is attached as Exhibit G.

Process of Compiling Summary Data

19. In order to effectively analyze the Security-Based PSRs provided to Plaintiffs in response to Public Records Act and discovery requests, I directed, supervised the preparation of, and performed quality control regarding a process which accurately coded Security-Based PSRs in a Concordance database, pulled data from that database into Microsoft Excel spreadsheets, and then presented the data in tabular form as seen in Exhibit A and Exhibit B. By creating these Exhibits, Plaintiffs' counsel could determine for each CDCR institution, and across the CDCR system as a whole:

a) the total number of Modified Programs represented in the documents provided by the CDCR in response to Plaintiffs' Public Records Act and discovery requests,

b) the length of time these Modified Programs were in effect,

c) the number of Modified Programs which denied access to or otherwise restricted recreational activities, and the length of time inmates subject to a given Modified Program were either denied recreational activities or allowed only restricted recreational activities,

d) the number of Modified Programs which applied to one or more racial or ethnic classifications, and

e) the number of Modified Programs which applied to specific racial or ethnic classifications.

20. In order to pull information from the Security-Based PSRs into a form which could be analyzed using a spreadsheet, it was necessary to code the Security-Based PSRs provided by the CDCR. I directed, supervised the preparation of, and performed quality control upon the coding of all PSRs received from the CDCR in response to Plaintiffs' Public Records Act and discovery requests in a Concordance database. This coding was done by paralegals under my supervision. Initially, my team coded the PSRs received in response to the Public

Records Act requests. This information was than supplemented with information contained in the Discovery PSRs. All Security-Based PSRs received from the CDCR were coded to capture the following information from each PSR:

a) The date of the Modified Program discussed in the PSR

b) The Institution and Facility to which the Modified Program discussed in the PSR applied

c) The reason for the Modified Program discussed in the PSR, as indicated by the CDCR

d) The CDCR's label of the PSR as Initial, Update, or Closure

e) Whether the Modified Program discussed in the PSR included limitations on recreation

f) The racial, ethnic, gang, disruptive group, or other category(ies) of persons to whom the Modified Program discussed in the PSR applied, as indicated in the Inmates Affected portion of the PSR

g) All comments recorded in the "Remarks" section of the PSR

21. I directed, supervised the preparation of, and performed quality control upon actions taken by paralegals and the litigation technology specialist to prepare the data described in ¶¶ 19 and 20 so that summary tables of all Security-Based PSRs provided by the CDCR to Plaintiffs could be created. For each series of Security-Based PSRs identified with the same PSR number, paralegals created a summary row which accurately reflects information contained in all PSRs sharing the same PSR number. These "Summary Rows" accurately:

a) Indicate whether PSRs within the Modified Program applied to any racial or ethnic classifications, and identified those racial or ethnic classifications, at any time during the Modified Program.

b) Indicate whether the Modified Program denied or restricted recreational activity at any time during the Modified Program.

c) Indicate the start date and an end date of each Modified Program where

possible. The start date was assigned using the earlier of the earliest effective date of the any PSR within a Modified Program, or the starting date of the Modified Program as indicated by documents referencing the same PSR number. The end date was assigned based on the date of the "closure" PSR where possible, or the closure dates as indicated by documents referencing the same PSR number. Paralegals and I used these dates to calculate the length of each Modified Program and recorded these periods in a spreadsheet.

22. I worked with a litigation technology specialist to create the PSR Summary Spreadsheets which accurately count the number of Modified Programs which meet the criteria indicated in each of the heading columns in Exhibit A and Exhibit B. Based on my supervision of and participation in designing, creating, and performing quality control on the process resulting in the creation of Exhibit A and Exhibit B, these Exhibits provide accurate summaries of information contained in the Discovery PSRs and the PSRs provided to Plaintiffs in response to Plaintiffs' Public Records Act requests described in ¶¶ 14 and 15, and in response to discovery requests.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed at San Francisco, California on March 4, 2013.

By: _____
Devin McDonell

EXHIBIT A

FRE 1006 Summary of Program Status Reports CDCR Provided to Plaintiffs In Response to Public Records Act and Discovery Requests

Institution	Security	RACE		Inmates Affected: Race/Ethnicity						
	Number of Security Based Lockdowns	Race-Based	Percent Race-Based	Black	White	Hispanic	Southern (Hispanic)	Northern (Hispanic)	Mexican (National)	Other
ASP - Avenal State Prison	6	5	83.3%	0	0	3	3	0	2	0
CAL - Calipatria State Prison	25	18	72.0%	7	5	8	0	0	0	1
CCC - California Correctional Center	23	16	69.6%	6	5	9	3	6	3	2
CCI - California Correctional Institution	29	6	20.7%	3	1	4	0	0	0	1
CEN - California State Prison, Centinela	21	13	61.9%	5	2	7	0	0	0	1
CIM - California Institution for Men	11	3	27.3%	2	3	4	0	0	0	0
CMC - California Men's Colony	19	2	10.5%	2	0	0	0	0	0	0
CMF - California Medical Facility	15	2	13.3%	1	0	1	1	1	1	0
CRC - California Rehabilitation Center	13	2	15.4%	0	0	2	0	0	1	0
CSATF - California Substance Abuse Treatment Facility	42	20	47.6%	12	2	14	6	5	4	0
CSP-COR: California State Prison-Corcoran	15	12	80.0%	3	3	8	4	2	4	0
CSP-LAC: California State Prison, Los Angeles County	40	7	17.5%	2	1	7	0	0	0	0
CSP-SAC - California State Prison, Sacramento	29	27	93.1%	9	9	11	8	3	1	3
CSP_Solano	71	58	81.7%	19	11	29	13	10	5	2
CTF - Correctional Training Facility	24	8	33.3%	2	3	6	1	0	0	1
CVSP - Chuckawalla Valley State Prison	5	3	60.0%	0	0	1	0	0	0	0
DVI - Deuel Vocational Institution	8	5	62.5%	3	1	3	1	2	0	1
FSP - Folsom State Prison	12	11	91.7%	4	5	4	3	0	0	1
HDP - High Desert State Prison	20	7	35.0%	2	3	5	3	3	2	0
ISP - Ironwood State Prison	17	11	64.7%	5	3	4	0	0	0	0
KVSP - Kern Valley State Prison	40	26	65.0%	13	2	12	9	3	0	5
MCSP - Mule Creek State Prison	1	0	0.0%	0	0	0	0	0	0	0
NKSP - North Kern State Prison	27	19	70.4%	5	5	16	0	0	0	0
PBSP - Pelican Bay State Prison	7	6	85.7%	3	1	3	1	0	0	1
PVSP - Pleasant Valley State Prison	18	8	44.4%	2	0	6	5	1	1	0
RJD - Richard J. Donovan Correctional Facility	15	7	46.7%	6	2	2	0	0	0	0
SCC - Sierra Conservation Center	3	3	100.0%	1	0	3	3	0	0	0
SQ - San Quentin State Prison	28	14	50.0%	3	7	6	2	2	0	0
SVSP - Salinas Valley State Prison	25	13	52.0%	8	3	7	3	4	0	0
WSP - Wasco State Prison	25	6	24.0%	4	1	6	3	1	0	0
* *Statewide Modified Progrom For Mole Institutions*	1	1	100.0%	0	0	1	1	0	0	0
Total	635	330	51.4%	132	78	197	73	43	24	19
Percent of Security Based Lockdowns	100.0%	51.4%		20.8%	12.3%	30.2%	11.5%	6.8%	3.8%	3.0%
Percent of institutions with lockdown in category	100.0%	96.7%		86.7%	73.3%	93.3%	60.0%	43.3%	33.3%	36.7%

* Lockdown across all CDCR institutions in response to an assault on custody staff at Pelican Bay.

FRE 1006 Summary of Program Status Reports CDCR Provided to Plaintiffs In Response to Public Records Act and Discovery Requests
Modified Lockdowns Between July 1, 2011 and Filed December June 1, 2012

	Security	Recreation:		Length of Lockdown (days)								
	Number of Security Based Lockdowns	Outdoor exercise restricted	Percent Outdoor Exercise Restricted	6-Jan	13-Jul	14-20	21-29	30-59	60-89	90-179	180+	Unknown (imcomplete PSR set)
ASP - Avenal State Prison	6	6	100.0%	3	1	1	1	0	0	0	0	0
CAL - Calipatria State Prison	25	23	92.0%	3	6	2	3	8	1	1	0	1
CCC - California Correctional Center	23	21	91.3%	8	6	5	1	0	0	1	0	2
CCI - California Correctional Institution	29	28	96.6%	8	11	4	1	3	0	1	0	1
CEN - California State Prison, Centinela	21	21	100.0%	8	9	3	0	1	0	0	0	0
CIM - California Institution for Men	11	11	100.0%	6	2	1	1	1	0	0	0	0
CMC - California Men's Colony	19	19	100.0%	16	3	0	0	0	0	0	0	0
CMF - California Medical Facility	15	14	93.3%	8	5	1	0	0	0	0	0	1
CRC - California Rehabilitation Center	13	11	84.6%	10	1	0	0	0	0	0	0	2
CSATF - California Substance Abuse Treatment Facility	42	37	88.1%	14	12	0	4	4	0	0	3	5
CSP-COR: California State Prison-Corcoran	15	14	93.3%	3	3	1	0	1	1	0	5	1
CSP-LAC: California State Prison, Los Angeles County	40	38	95.0%	27	7	2	0	3	0	0	0	1
CSP-SAC - California State Prison, Sacramentc	29	29	100.0%	9	11	3	2	1	0	1	2	0
CSP_Solano	71	43	60.6%	18	10	4	4	7	0	0	0	28
CTF - Correctional Training Facility	24	23	95.8%	6	9	6	2	1	0	0	0	0
CVSP - Chuckawalla Valley State Prison	5	5	100.0%	2	3	0	0	0	0	0	0	0
DVI - Deuel Vocational Institution	8	7	87.5%	3	1	2	0	0	1	0	0	1
FSP - Folsom State Prison	12	12	100.0%	6	5	0	0	0	0	1	0	0
HDP - High Desert State Prison	20	19	95.0%	3	2	1	3	6	2	0	2	1
ISP - Ironwood State Prison	17	17	100.0%	5	4	5	3	0	0	0	0	0
KVSP - Kern Valley State Prison	40	40	100.0%	3	8	7	2	7	3	6	4	0
MCSP - Mule Creek State Prison	1	1	100.0%	1	0	0	0	0	0	0	0	0
NKSP - North Kern State Prison	27	27	100.0%	7	8	1	5	5	0	1	0	0
PBSP - Pelican Bay State Prison	7	6	85.7%	2	1	0	1	0	1	0	2	0
PVSP - Pleasant Valley State Prison	18	7	38.9%	1	0	1	0	0	0	3	2	11
RJD - Richard J. Donovan Correctional Facility	15	14	93.3%	6	5	1	2	0	0	0	0	1
SCC - Sierra Conservation Center	3	3	100.0%	0	1	0	0	1	0	1	0	0
SQ - San Quentin State Prison	28	25	89.3%	13	5	2	3	0	0	1	1	3
SVSP - Salinas Valley State Prison	25	25	100.0%	5	2	6	2	3	1	3	3	0
WSP - Wasco State Prison	25	23	92.0%	12	4	2	3	1	2	1	0	0
* *Statewide Madified Program For Male Institutions*	1	1	100.0%	1	0	0	0	0	0	0	0	0
Total	635	570	89.8%	217	14[illegible]	[illegible]	33	53	12	21	24	59
Percent of Security Based Lockdowns	100.0%	[illegible]		[illegible]%	22.8%	9.6%	[illegible]%	[illegible]%	[illegible]%	[illegible]%	[illegible]%	[illegible]%
Percent of institutions with lockdown in category	100.0%	100.0%		96.7%	93.3%	73.3%	60.0%	53.3%	26.7%	40.0%	30.0%	46.7%

* Lockdown across all CDCR institutions in response to an assault on custody staff at Pelican Bay.

EXHIBIT B

Institution	Security	RACE		Inmates Affected: Race/Ethnicity						
	Number of Security Based Lockdowns	Race-Based	Percent Race-Based	Black	White	Hispanic	Southern (Hispanic)	Northern (Hispanic)	Mexican (National)	Other
ASP - Avenal State Prison	8	8	100.0%	0	0	7	5	0	2	0
CAL - Calipatria State Prison	32	19	59.4%	5	4	11	1	0	0	1
CCC - California Correctional Center	15	11	73.3%	4	2	11	8	3	2	0
CCI - California Correctional Institution	27	1	3.7%	1	1	0	0	0	0	0
CEN - California State Prison, Centinela	11	9	81.8%	4	0	4	0	0	0	1
CIM - California Institution for Men	25	6	24.0%	3	3	5	0	0	0	0
CMC - California Men's Colony	41	1	2.4%	0	0	3	0	0	0	0
CMF - California Medical Facility	8	2	25.0%	1	0	2	2	1	0	0
CRC - California Rehabilitation Center	19	1	5.3%	0	1	1	0	0	0	0
CSATF - California Substance Abuse Treatment Facility	75	18	24.0%	3	2	14	9	4	6	0
CSP_COR - California State Prison	23	10	43.5%	3	0	7	6	2	4	0
CSP_LAC - California State Prison	39	6	15.4%	2	0	5	0	0	0	0
CSP_SAC - California State Prison	18	14	77.8%	7	5	7	4	2	2	3
CSP_Solano	44	30	68.2%	8	11	11	6	4	3	1
CTF - Correctional Training Facility	26	7	26.9%	2	2	5	3	0	0	0
* CVMCCF - Central Valley Modified Community Correctional Facility	1	1	100.0%	1	0	1	0	0	0	0
CVSP - Chuckawalla Valley State Prison	3	1	33.3%	0	0	1	0	0	0	0
DVI - Deuel Vocational Institution	20	9	45.0%	3	2	6	3	3	1	0
** DVMCCF - Desert View Modified Community Correctional Facility	1	0	0.0%	0	0	0	0	0	0	0
FSP - Folsom State Prison	20	13	65.0%	3	3	7	7	0	2	3
HDP - High Desert State Prison	27	10	37.0%	6	3	6	1	2	0	0
ISP - Ironwood State Prison	18	9	50.0%	3	2	5	0	0	0	0
KVSP - Kern Valley State Prison	49	20	40.8%	10	1	13	8	1	0	0
LPCC - La Palma Correctional Center	7	3	42.9%	0	1	2	0	2	0	0
MCSP - Mule Creek State Prison	5	0	0.0%	0	0	0	0	0	0	0
*** NFCF - North Fork Correctional Facility	10	7	70.0%	0	3	4	4	0	0	0
NKSP - North Kern State Prison	40	17	42.5%	3	5	14	2	2	0	1
PBSP - Pelican Bay State Prison	17	5	29.4%	1	1	5	1	0	0	0
PVSP - Pleasant Valley State Prison	15	6	40.0%	1	1	5	1	3	0	0
RJD - Richard J. Donovan Correctional Facility	16	3	18.8%	2	0	2	0	0	0	0
* RRCC - Red Rock Correctional Center	12	6	50.0%	0	0	6	5	0	0	0
SCC - Sierra Conservation Center	7	3	42.9%	1	0	3	2	0	0	0
SQ - San Quentin State Prison	35	16	45.7%	1	11	11	3	4	0	0
SVSP - Salinas Valley State Prison	38	17	44.7%	4	0	12	6	4	2	1
*** TCCF - Tallahatchie County Correctional Facility	8	4	50.0%	0	0	4	2	0	0	0
WSP - Wasco State Prison	50	29	58.0%	12	7	23	13	2	0	0
	810	322	39.8%	94	71	233	102	39	24	11
# of institutions with lockdown in category		34		26	21	33	23	15	9	7
Percent of institutions with lockdown in category		94.4%		72.2%	58.3%	91.7%	63.9%	41.7%	25.0%	19.4%

* Community Correctional Facility
** Desert View closed in November, 2011
*** Outisde CA

Institution	Security	Recreation		Length of Lockdown (days)								
	Number of Security Based Lockdowns	Outdoor exercise restricted	Percent Outdoor Exercise Restricted	1-6	7-13	14-20	21-29	30-59	60-89	90-179	180+	Unknown (Incomplete PSR set)
ASP - Avenal State Prison	8	8	100.0%	3	4	0	0	0	0	0	1	0
CAL - Calipatria State Prison	32	31	96.9%	5	11	2	3	7	1	2	0	2
CCC - California Correctional Center	15	15	100.0%	5	7	2	1	0	0	0	0	0
CCI - California Correctional Institution	27	27	100.0%	11	5	6	2	1	0	1	1	0
CEN - California State Prison, Centinela	11	11	100.0%	4	4	0	1	0	0	0	0	2
CIM - California Institution for Men	25	25	100.0%	10	8	1	3	1	0	0	0	1
CMC - California Men's Colony	41	37	90.2%	11	5	1	0	2	1	0	0	1
CMF - California Medical Facility	8	8	100.0%	5	1	0	2	0	0	0	0	0
CRC - California Rehabilitation Center	19	18	94.7%	12	2	1	0	0	0	0	0	2
CSATF - California Substance Abuse Treatment Facility	75	73	97.3%	16	22	9	2	2	2	1	0	1
CSP_COR - California State Prison	23	22	95.7%	5	4	3	1	4	0	0	0	5
CSP_LAC - California State Prison	39	37	94.9%	20	7	0	0	1	0	1	0	2
CSP_SAC - California State Prison	18	18	100.0%	15	2	0	1	0	0	0	0	0
CSP_Solano	44	43	97.7%	24	3	7	7	1	0	0	0	2
CTF - Correctional Training Facility	26	26	100.0%	13	9	2	2	0	0	0	0	0
* CVMCCF - Central Valley Modified Community Correctional Facility	1	1	100.0%	0	1	0	0	0	0	0	0	0
CVSP - Chuckawalla Valley State Prison	3	2	66.7%	1	0	0	0	0	0	0	0	0
DVI - Deuel Vocational Institution	20	19	95.0%	6	4	1	4	1	1	0	1	1
** DVMCCF - Desert View Modified Community Correctional Facility	1	1	100.0%	1	0	0	0	0	0	0	0	0
FSP - Folsom State Prison	20	20	100.0%	7	5	1	0	0	0	0	0	1
HDP - High Desert State Prison	27	26	96.3%	2	4	0	1	7	1	1	1	1
ISP - Ironwood State Prison	18	17	94.4%	5	7	1	0	0	1	0	2	0
KVSP - Kern Valley State Prison	49	47	95.9%	8	12	14	5	3	1	0	1	0
LPCC - La Palma Correctional Center	7	7	100.0%	4	0	0	0	0	0	0	0	1
MCSP - Mule Creek State Prison	5	4	80.0%	5	0	0	0	0	0	0	0	0
*** NFCF - North Fork Correctional Facility	10	7	70.0%	3	0	0	0	0	0	0	0	3
NKSP - North Kern State Prison	40	37	92.5%	9	7	8	3	9	1	2	1	0
PBSP - Pelican Bay State Prison	17	17	100.0%	12	1	2	1	1	0	0	0	0
PVSP - Pleasant Valley State Prison	15	14	93.3%	2	3	2	0	1	0	1	0	4
RJD - Richard J. Donovan Correctional Facility	16	16	100.0%	10	4	0	0	2	0	0	0	0
* RRCC - Red Rock Correctional Center	12	9	75.0%	10	0	0	0	0	0	0	0	2
SCC - Sierra Conservation Center	7	7	100.0%	2	3	0	1	1	0	0	0	0
SQ - San Quentin State Prison	35	30	85.7%	13	10	4	0	4	0	2	0	2
SVSP - Salinas Valley State Prison	38	37	97.4%	7	5	5	3	11	3	1	0	1
*** TCCF - Tallahatchie County Correctional Facility	8	8	100.0%	4	0	0	0	0	0	0	0	0
WSP - Wasco State Prison	50	50	100.0%	19	12	3	5	2	2	2	1	0
	810	775	95.7%	349	180	81	51	75	18	13	9	34
# of institutions with lockdown in category		36		35	29	21	20	20	10	9	7	16
Percent of institutions with lockdown in category		100.0%		97.2%	80.6%	58.3%	55.6%	55.6%	27.8%	25.0%	19.4%	44.4%

* Community Correctional Facility
** Desert View closed in November, 2011
*** Outisde CA

EXHIBIT C

Kelly Knapp

From: Renteria, Simone@CDCR
Sent: Thursday, June 02, 2011 10:43 AM
To: Rebekah Evenson; Tebrock, Katherine@CDCR
Cc: Riley Evans; Jon Wolff; Damon McClain
Subject: RE: Public Records Act Request RE: Lockdown Data

Rebekah

Katherine is out of the office, but I'll forward your request to DAI staff so that they can gather the responsive documents.

Simone A. Renteria
Staff Counsel
CDCR, Institutions & Parole Operations

From: Rebekah Evenson [mailto:revenson@prisonlaw.com]
Sent: Thursday, June 02, 2011 10:38 AM
To: Tebrock, Katherine@CDCR
Cc: Riley Evans; Renteria, Simone@CDCR; Jon Wolff; Damon McClain
Subject: Public Records Act Request RE: Lockdown Data

Katherine,

I am writing pursuant to the Public Records Act, Gov. Code §6250 *et seq.*, to request copies of additional documents in the possession of the California Department of Corrections and Rehabilitation relating to lockdowns and modified programming in CDCR prisons.

Please provide copies of all parts of all daily Program Status Reports and weekly spreadsheet data regarding each lockdown, modified program or state of emergency that occurred at a prison under the jurisdiction of CDCR between July 1, 2010 and June 1, 2011.

If you have any questions, please do not hesitate to contact me. Thank you for your attention to this matter.

Best,
Rebekah

From: Tebrock, Katherine@CDCR [mailto:Katherine.Tebrock@cdcr.ca.gov]
Sent: Friday, March 04, 2011 4:58 PM
To: Rebekah Evenson
Cc: Riley Evans; Renteria, Simone@CDCR; Jon Wolff
Subject: RE: Lockdown Data

Rebekah,
I am in receipt of your email and we are requesting responsive documents. We are working in good faith to gather the documents within the timeframes set out by the PRA.

Katherine K. Tebrock
Chief Deputy General Counsel, Policy
Office of Legal Affairs, CDCR
O: 916-323-2929
BB: 916-956-6834

From: Rebekah Evenson [mailto:revenson@prisonlaw.com]
Sent: Friday, March 04, 2011 3:52 PM
To: Tebrock, Katherine@CDCR
Cc: Riley Evans
Subject: RE: Lockdown Data

Katherine,

I want to request a couple of additional documents pursuant to the public records act. Should I continue to send my requests to you? If not, please advise me as to who should receive them. If so, following are the requested documents:

All parts of all daily Program Status Reports and weekly spreadsheet data regarding each lockdown, modified program or state of emergency that was:

1. instituted at Ironwood State Prison, California State Prison at Corcoran, Kern Valley State Prison, California State Prison Solano, California State Prison Sacramento, and Salinas Valley State Prison from July 1, 2010 to the present.
2. instituted at Ironwood state prison between September 1, 2005 and May 31, 2006, and between January 1, 2007 and December 31, 2008.

Thank you for your assistance.

Best,
Rebekah

Rebekah Evenson
Staff Attorney
PRISON LAW OFFICE
1917 Fifth Street
Berkeley, CA 94710-1916
Telephone (510) 280-2621
Fax (510) 280-2704
www.prisonlaw.com

From: Tebrock, Katherine@CDCR [mailto:Katherine.Tebrock@cdcr.ca.gov]
Sent: Tuesday, December 21, 2010 3:15 PM
To: Rebekah Evenson; Don Specter
Cc: Rice, Benjamin@CDCR; monica.anderson@doj.ca.gov; Renteria, Simone@CDCR
Subject: RE: Lockdown Data

Rebekah,
I am in receipt of your email and have requested responsive documents. We will work toward getting the information but the 10 days may be hard to meet as the information you are requesting is voluminous. We are additionally constrained by

the fact that there are some people who may not be reachable now in light of the upcoming holidays. We are working in good faith to get the information to you.

Katherine K. Tebrock
Chief Deputy General Counsel, Policy
Office of Legal Affairs, CDCR
O: 916-323-2929
BB: 916-956-6834

EXHIBIT D

Devin M. McDonell
Bingham McCutchen LLP
Three Embarcadero Center
San Francisco, CA 94111-4067
Direct Phone: 415.393.2358
Direct Fax: 415.393.2286
devin.mcdonell@bingham.com

August 6, 2012

Via Email: katherine.tebrock@cdcr.ca.gov

Katherine K. Tebrock
Chief Deputy General Counsel, Policy
Office of Legal Affairs, CDCR

Re: Public Records Request

Dear Ms. Tebrock:

I am writing to request that the California Department of Corrections and Rehabilitation ("CDCR") provide public records pursuant to the California Public Records Act, California Government Code Section 6250 et seq., as follows:

1. Program Status Reports ("PSRs") and weekly spreadsheet data regarding all lockdowns, modified programs, or states of emergency which occurred between June 2, 2011, and August 3, 2012 at CDCR facilities.

Please contact me if you have any questions about this request.

Sincerely yours,

Devin M. McDonell

cc: Rebekah Evenson, Prison Law Office

Boston
Frankfurt
Hartford
Hong Kong
London
Los Angeles
New York
Orange County
San Francisco
Santa Monica
Silicon Valley
Tokyo
Washington

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bingham.com

EXHIBIT E

OFFICE OF LEGAL AFFAIRS
Benjamin T. Rice
Assistant Secretary
P.O. Box 942883
Sacramento, CA 94283-0001

RECEIVED
JUL 20 2011

July 19, 2011

Rebekah Evenson
Prison Law Office
1917 Fifth Street
Berkeley, CA 94710-1916

Re: PUBLIC RECORDS ACT REQUEST DATED JUNE 2, 2011

Dear Rebekah:

On the enclosed CD you will find the California Department of Corrections and Rehabilitation's response to your request for public records, dated June 2, 2011, for "copies of all parts of all daily Program Status Reports and weekly spreadsheet data regarding each lockdown, modified program or state of emergency that occurred at a prison under the jurisdiction of CDCR between July 1, 2010 and June 1, 2011."

As indicated in our initial response dated June 13, 2011, we have produced all requested copies of the non-confidential Part B of the Program Status Report. Parts A and C through E, which include the requested weekly reports (Part D) are considered confidential per Gov. Code section 6254, subd. (f) and therefore have not been produced.

Should you have any questions, please contact the undersigned at (916) 445-4687.

Sincerely,

SIMONE A. RENTERIA
Staff Counsel
Office of Legal Affairs

cc: Damon McClain

EXHIBIT F

Lockdowns Summarized in the 2010-2011 PSR Summary Spreadsheet

(Modified Programs In Effect Between Jan. 1 2010 and June 1, 2011 and initiated prior to June 1, 2011)

	Modified Program/Program Status Number (PSN)	Institution
1	ASP-FA5-10-08-0192	ASP - Avenal State Prison
2	ASP-FA5-10-09-0207	ASP - Avenal State Prison
3	ASP-FA5-11-002	ASP - Avenal State Prison
4	ASP-FA5-11-004	ASP - Avenal State Prison
5	ASP-FA5-11-008	ASP - Avenal State Prison
6	ASP-FA5-11-009	ASP - Avenal State Prison
7	CAL-A-10-006	CAL - Calipatria State Prison
8	CAL-A-10-008	CAL - Calipatria State Prison
9	CAL-A-10-008	CAL - Calipatria State Prison
10	CAL-A-11-003	CAL - Calipatria State Prison
11	CAL-A-11-009	CAL - Calipatria State Prison
12	CAL-B-10-009	CAL - Calipatria State Prison
13	CAL-B-10-010	CAL - Calipatria State Prison
14	CAL-B-10-017	CAL - Calipatria State Prison
15	CAL-B-10-019	CAL - Calipatria State Prison
16	CAL-B-10-030	CAL - Calipatria State Prison
17	CAL-B-11-004	CAL - Calipatria State Prison
18	CAL-B-11-006	CAL - Calipatria State Prison
19	CAL-B-11-008	CAL - Calipatria State Prison
20	CAL-C-10-013	CAL - Calipatria State Prison
21	CAL-C-10-016	CAL - Calipatria State Prison
22	CAL-C-10-018	CAL - Calipatria State Prison
23	CAL-C-10-020	CAL - Calipatria State Prison
24	CAL-C-11-001	CAL - Calipatria State Prison
25	CAL-C-11-005	CAL - Calipatria State Prison
26	CAL-C-11-007	CAL - Calipatria State Prison
27	CAL-D-10-011	CAL - Calipatria State Prison
28	CAL-D-10-014	CAL - Calipatria State Prison
29	CAL-INST-10-007	CAL - Calipatria State Prison
30	CAL-INST-10-012	CAL - Calipatria State Prison
31	CAL-INST-10-015	CAL - Calipatria State Prison
32	CCC-ARN-10-07-021	CCC - California Correctional Center
33	CCC-ARN-10-08-022	CCC - California Correctional Center
34	CCC-CAS-10-07-020	CCC - California Correctional Center
35	CCC-CAS-10-12-030	CCC - California Correctional Center
36	CCC-CAS-10-12-031	CCC - California Correctional Center
37	CCC-CAS-11-01-001	CCC - California Correctional Center
38	CCC-CAS-11-02-005	CCC - California Correctional Center
39	CCC-CAS-11-03-006	CCC - California Correctional Center
40	CCC-CAS-11-04-008	CCC - California Correctional Center
41	CCC-CAS-11-04-009	CCC - California Correctional Center
42	CCC-LAS-10-06-019	CCC - California Correctional Center
43	CCC-LAS-10-09-025	CCC - California Correctional Center
44	CCC-LAS-10-12-032	CCC - California Correctional Center
45	CCC-LAS-11-02-004	CCC - California Correctional Center
46	CCC-LAS-11-05-010	CCC - California Correctional Center
47	CCC-MAI-10-11-028	CCC - California Correctional Center
48	CCC-MAI-11-01-002	CCC - California Correctional Center

Lockdowns Summarized in the 2010-2011 PSR Summary Spreadsheet

(Modified Programs In Effect Between Jan. 1 2010 and June 1, 2011 and initiated prior to June 1, 2011)

	Modified Program/Program Status Number (PSN)	Institution
49	CCC-SIE-10-08-023	CCC - California Correctional Center
50	CCC-SIE-10-09-024	CCC - California Correctional Center
51	CCC-SIE-10-10-026	CCC - California Correctional Center
52	CCC-SIE-11-03-007	CCC - California Correctional Center
53	LASSEN	CCC - California Correctional Center
54	PENDING	CCC - California Correctional Center
55	CCI-4B-10-037	CCI - California Correctional Institution
56	CCI-CS-11-002	CCI - California Correctional Institution
57	CCI-I-10-006	CCI - California Correctional Institution
58	CCI-I-10-029	CCI - California Correctional Institution
59	CCI-I-10-030	CCI - California Correctional Institution
60	CCI-I-10-036	CCI - California Correctional Institution
61	CCI-I-11-006	CCI - California Correctional Institution
62	CCI-I-11-008	CCI - California Correctional Institution
63	CCI-II-11-001	CCI - California Correctional Institution
64	CCI-II-11-007	CCI - California Correctional Institution
65	CCI-II-11-012	CCI - California Correctional Institution
66	CCI-II-11-014	CCI - California Correctional Institution
67	CCI-III-10-017	CCI - California Correctional Institution
68	CCI-III-10-025	CCI - California Correctional Institution
69	CCI-III-10-031	CCI - California Correctional Institution
70	CCI-III-10-033	CCI - California Correctional Institution
71	CCI-III-10-034	CCI - California Correctional Institution
72	CCI-III-11-010	CCI - California Correctional Institution
73	CCI-III-11-013	CCI - California Correctional Institution
74	CCI-III-11-033	CCI - California Correctional Institution
75	CCI-IVA-10-023	CCI - California Correctional Institution
76	CCI-IVA-10-027	CCI - California Correctional Institution
77	CCI-IVA-10-035	CCI - California Correctional Institution
78	CCI-IVA-11-003	CCI - California Correctional Institution
79	CCI-IVA-11-004	CCI - California Correctional Institution
80	CCI-IVA-11-005	CCI - California Correctional Institution
81	CCI-IVB-10-026	CCI - California Correctional Institution
82	CCI-IVB-11-009	CCI - California Correctional Institution
83	CCI-IVB-11-011	CCI - California Correctional Institution
84	CEN-A-10-012	CEN - California State Prison, Centinela
85	CEN-A-10-015	CEN - California State Prison, Centinela
86	CEN-B-10-011	CEN - California State Prison, Centinela
87	CEN-B-10-013	CEN - California State Prison, Centinela
88	CEN-B-10-016	CEN - California State Prison, Centinela
89	CEN-B-10-019	CEN - California State Prison, Centinela
90	CEN-B-10-022	CEN - California State Prison, Centinela
91	CEN-B-10-026	CEN - California State Prison, Centinela
92	CEN-B-11-005	CEN - California State Prison, Centinela
93	CEN-C-10-017	CEN - California State Prison, Centinela
94	CEN-C-10-018	CEN - California State Prison, Centinela
95	CEN-C-10-020	CEN - California State Prison, Centinela
96	CEN-C-10-023	CEN - California State Prison, Centinela

Lockdowns Summarized in the 2010-2011 PSR Summary Spreadsheet

(Modified Programs In Effect Between Jan. 1 2010 and June 1, 2011 and initiated prior to June 1, 2011)

	Modified Program/Program Status Number (PSN)	Institution
97	CEN-C-10-024	CEN - California State Prison, Centinela
98	CEN-C-11-006	CEN - California State Prison, Centinela
99	CEN-D-10-021	CEN - California State Prison, Centinela
100	CEN-D-11-002	CEN - California State Prison, Centinela
101	CEN-D-11-004	CEN - California State Prison, Centinela
102	CEN-INST-11-003	CEN - California State Prison, Centinela
103	CEN-OCS-10-009	CEN - California State Prison, Centinela
104	CEN-OCS-10-025	CEN - California State Prison, Centinela
105	CIM-CIMI-10-007	CIM - California Institution for Men
106	CIM-CIMI-10-012	CIM - California Institution for Men
107	CIM-CIMI-11-006	CIM - California Institution for Men
108	CIM-CIMI-11-007	CIM - California Institution for Men
109	CIM-CIMI-11-008	CIM - California Institution for Men
110	CIM-CIMI-11-009	CIM - California Institution for Men
111	CIM-RCC-10-011	CIM - California Institution for Men
112	CIM-RCE-10-008	CIM - California Institution for Men
113	CIM-RCE-10-010	CIM - California Institution for Men
114	CIM-RCE-11-003	CIM - California Institution for Men
115	CIM-RCE-11-005	CIM - California Institution for Men
116	CMC-E-10-10-0029	CMC - California Men's Colony
117	CMC-E-10-11-0033	CMC - California Men's Colony
118	CMC-EAQ-10-08-0024	CMC - California Men's Colony
119	CMC-EAQ-10-08-0025	CMC - California Men's Colony
120	CMC-EAQ-10-10-0028	CMC - California Men's Colony
121	CMC-EAQ-10-11-0034	CMC - California Men's Colony
122	CMC-EAQ-11-04-0038	CMC - California Men's Colony
123	CMC-EAQ-11-05-0040	CMC - California Men's Colony
124	CMC-ECQ-10-10-0027	CMC - California Men's Colony
125	CMC-ECQ-11-05-0039	CMC - California Men's Colony
126	CMC-EDQ-10-11-0032	CMC - California Men's Colony
127	CMC-W-10-10-030	CMC - California Men's Colony
128	CMC-W-11-03-0037	CMC - California Men's Colony
129	CMC-WU1-10-10-0031	CMC - California Men's Colony
130	CMC-WU2-10-07-0022	CMC - California Men's Colony
131	CMC-WU2-10-12-0036	CMC - California Men's Colony
132	CMC-WU2-11-02-0060	CMC - California Men's Colony
133	CMC-WU4-10-12-0035	CMC - California Men's Colony
134	CMC-WU4-10-8-0026	CMC - California Men's Colony
135	CMF-10-018	CMF - California Medical Facility
136	CMF-10-023	CMF - California Medical Facility
137	CMF-10-024	CMF - California Medical Facility
138	CMF-10-025	CMF - California Medical Facility
139	CMF-10-028	CMF - California Medical Facility
140	CMF-10-033	CMF - California Medical Facility
141	CMF-11-002	CMF - California Medical Facility
142	CMF-11-003	CMF - California Medical Facility
143	CMF-11-005	CMF - California Medical Facility
144	CMF-11-006	CMF - California Medical Facility

Lockdowns Summarized in the 2010-2011 PSR Summary Spreadsheet

(Modified Programs In Effect Between Jan. 1 2010 and June 1, 2011 and initiated prior to June 1, 2011)

	Modified Program/Program Status Number (PSN)	Institution
145	CMF-11-007	CMF - California Medical Facility
146	CMF-11-008	CMF - California Medical Facility
147	CMF-11-009	CMF - California Medical Facility
148	CMF-11-011	CMF - California Medical Facility
149	CMF-11-012	CMF - California Medical Facility
150	COR-03A-10-03-010	CRC - California Rehabilitation Center
151	CRC-CSO-10-010	CRC - California Rehabilitation Center
152	CRC-CSO-10-013	CRC - California Rehabilitation Center
153	CRC-CSO-10-014	CRC - California Rehabilitation Center
154	CRC-CSO-11-001	CRC - California Rehabilitation Center
155	CRC-HF1-10-011	CRC - California Rehabilitation Center
156	CRC-HF2-10-015	CRC - California Rehabilitation Center
157	CRC-HF3-10-007	CRC - California Rehabilitation Center
158	CRC-HF3-10-008	CRC - California Rehabilitation Center
159	CRC-HF3-10-012	CRC - California Rehabilitation Center
160	CRC-HF3-11-006	CRC - California Rehabilitation Center
161	CRC-HF3-11-008	CRC - California Rehabilitation Center
162	CRC-HF4-10-009	CRC - California Rehabilitation Center
163	(modified program closing 3/11/2011)	CSATF - California Substance Abuse Treatment Facility
164	(modified program closing 1/21/2011)	CSATF - California Substance Abuse Treatment Facility
165	SATF-0001-10-03-0087	CSATF - California Substance Abuse Treatment Facility
166	SATF-0001-10-08-0309	CSATF - California Substance Abuse Treatment Facility
167	SATF-0001-10-08-0310	CSATF - California Substance Abuse Treatment Facility
168	SATF-0001-10-10-0415	CSATF - California Substance Abuse Treatment Facility
169	SATF-0001-10-11-0433	CSATF - California Substance Abuse Treatment Facility
170	SATF-0001-11-02-0049	CSATF - California Substance Abuse Treatment Facility
171	SATF-0001-11-03-0116	CSATF - California Substance Abuse Treatment Facility
172	SATF-0002-10-10-0419	CSATF - California Substance Abuse Treatment Facility
173	SATF-0002-11-02-0070	CSATF - California Substance Abuse Treatment Facility
174	SATF-0002-11-05-0168	CSATF - California Substance Abuse Treatment Facility
175	SATF-0003-09-06-0235	CSATF - California Substance Abuse Treatment Facility
176	SATF-0003-09-06-0252	CSATF - California Substance Abuse Treatment Facility
177	SATF-0003-10-05-0188	CSATF - California Substance Abuse Treatment Facility
178	SATF-0003-10-06-0215	CSATF - California Substance Abuse Treatment Facility
179	SATF-0003-10-08-0319	CSATF - California Substance Abuse Treatment Facility
180	SATF-0003-10-12-0494	CSATF - California Substance Abuse Treatment Facility
181	SATF-0003-11-01-0018	CSATF - California Substance Abuse Treatment Facility
182	SATF-0003-11-01-0020	CSATF - California Substance Abuse Treatment Facility
183	SATF-0003-11-03-0095	CSATF - California Substance Abuse Treatment Facility
184	SATF-0003-11-05-0166	CSATF - California Substance Abuse Treatment Facility
185	SATF-0003-11-06-0193	CSATF - California Substance Abuse Treatment Facility
186	SATF-0004-10-06-0220	CSATF - California Substance Abuse Treatment Facility
187	SATF-0004-10-06-0226	CSATF - California Substance Abuse Treatment Facility
188	SATF-0004-10-08-0275	CSATF - California Substance Abuse Treatment Facility
189	SATF-0004-10-08-0284	CSATF - California Substance Abuse Treatment Facility
190	SATF-0004-10-09-0358	CSATF - California Substance Abuse Treatment Facility
191	SATF-0004-10-09-0367	CSATF - California Substance Abuse Treatment Facility
192	SATF-0004-10-10-0397	CSATF - California Substance Abuse Treatment Facility

Lockdowns Summarized in the 2010-2011 PSR Summary Spreadsheet

(Modified Programs In Effect Between Jan. 1 2010 and June 1, 2011 and initiated prior to June 1, 2011)

	Modified Program/Program Status Number (PSN)	Institution
193	SATF-0004-11-01-0003	CSATF - California Substance Abuse Treatment Facility
194	SATF-0004-11-02-0045	CSATF - California Substance Abuse Treatment Facility
195	SATF-0004-11-02-0080	CSATF - California Substance Abuse Treatment Facility
196	SATF-0004-11-05-0171	CSATF - California Substance Abuse Treatment Facility
197	SATF-0005-10-12-0484	CSATF - California Substance Abuse Treatment Facility
198	SATF-0005-11-02-0050	CSATF - California Substance Abuse Treatment Facility
199	SATF-0006-10-06-0208	CSATF - California Substance Abuse Treatment Facility
200	SATF-0006-10-10-0406	CSATF - California Substance Abuse Treatment Facility
201	SATF-0006-10-11-0433	CSATF - California Substance Abuse Treatment Facility
202	SATF-0006-10-11-0442	CSATF - California Substance Abuse Treatment Facility
203	SATF-0006-11-01-0039	CSATF - California Substance Abuse Treatment Facility
204	SATF-03-11-03-0094	CSATF - California Substance Abuse Treatment Facility
205	CAL-JAN-11-11-004	CSP_Solano
206	CDCR-DAI-11-001	CSP_Solano
207	CSP-AUGUST-23-10-033	CSP_Solano
208	CSP-DEC-12-10-050	CSP_Solano
209	CSP-DEC-12-10-054	CSP_Solano
210	CSP-FEB-14-11-0010	CSP_Solano
211	CSP-JAN-01-11-006	CSP_Solano
212	CSP-JAN-11-11-004	CSP_Solano
213	CSP-JAN-19-11-005	CSP_Solano
214	CSP-OCTOBER-11-10-041	CSP_Solano
215	CSP-OCTOBER-11-10-042	CSP_Solano
216	CSP-OCTOBER-20-10-044	CSP_Solano
217	CSP-OCTOBER-25-10-045	CSP_Solano
218	CSP-OCTOBER-31-10-048	CSP_Solano
219	CSP-SOL-AUG-13-10-030	CSP_Solano
220	CSP-SOL-AUG-16-10-031	CSP_Solano
221	CSP-SOL-AUG-30-10-035	CSP_Solano
222	CSP-SOL-JAN-8-11-002	CSP_Solano
223	CSP-SOL-OCT-20-10-044	CSP_Solano
224	CSP-SOL-SEP-02-10-036	CSP_Solano
225	CSP-SOL-SEP-23-10-038	CSP_Solano
226	CSP-SOL-SEP-26-10-040	CSP_Solano
227	CSP-SOL-SEP-8-10-037	CSP_Solano
228	SOL-11-MARCH-015	CSP_Solano
229	SOL-AUGUST-02-10-029	CSP_Solano
230	SOL-AUGUST-18-10-032	CSP_Solano
231	SOL-AUGUST-27-10-034	CSP_Solano
232	SOL-AUGUST-27-10-039	CSP_Solano
233	SOL-DEC-12-10-050	CSP_Solano
234	SOL-DECEMBER-20-10-052	CSP_Solano
235	SOL-DECEMBER-27-10-053	CSP_Solano
236	SOL-FEB-14-11-0010	CSP_Solano
237	SOL-FEBRUARY-05-11-007	CSP_Solano
238	SOL-FEBRUARY-11-11-009	CSP_Solano
239	SOL-FEBRUARY-27-11-011	CSP_Solano
240	SOL-FEBRUARY-5-11-007	CSP_Solano

Lockdowns Summarized in the 2010-2011 PSR Summary Spreadsheet

(Modified Programs In Effect Between Jan. 1 2010 and June 1, 2011 and initiated prior to June 1, 2011)

	Modified Program/Program Status Number (PSN)	Institution
241	SOL-FEBRUARY-5-11-008	CSP_Solano
242	SOL-JAN-07-11-0001	CSP_Solano
243	SOL-JAN-09-11-003	CSP_Solano
244	SOL-JAN-19-11-005	CSP_Solano
245	SOL-JAN-29-11-006	CSP_Solano
246	SOL-JAN-8-11-002	CSP_Solano
247	SOL-JUL-08-10-026	CSP_Solano
248	SOL-JUL-6-10-019	CSP_Solano
249	SOL-JULY-02-10-025	CSP_Solano
250	SOL-JULY-11-10-027	CSP_Solano
251	SOL-JUNE-06-10-0-019	CSP_Solano
252	SOL-JUNE-14-10-0023	CSP_Solano
253	SOL-JUNE-21-10-024	CSP_Solano
254	SOL-JUNE-6-10-0-019	CSP_Solano
255	SOL-MAR-01-11-012	CSP_Solano
256	SOL-MAR-14-11-015	CSP_Solano
257	SOL-MAR-16-11-016	CSP_Solano
258	SOL-MAR-31-11-017	CSP_Solano
259	SOL-MARCH-7-11-013	CSP_Solano
260	SOL-MAY-10-11-019	CSP_Solano
261	SOL-MAY-11-019	CSP_Solano
262	SOL-MAY-11-020	CSP_Solano
263	SOL-MAY-11-11-019	CSP_Solano
264	SOL-MAY-11-11-022	CSP_Solano
265	SOL-MAY-13-11-021	CSP_Solano
266	SOL-MAY-13-11-023	CSP_Solano
267	SOL-MAY-9-11-0018	CSP_Solano
268	SOL-NOVEMBER-07-10-0	CSP_Solano
269	SOL-OCTOBER	CSP_Solano
270	SOL-OCTOBER-11-10-042	CSP_Solano
271	SOL-OCTOBER-11-10-043	CSP_Solano
272	SOL-OCTOBER-26-10-046	CSP_Solano
273	SOL-OCTOBER-30-10-047	CSP_Solano
274	SOL-OCTOBER-31-10-048	CSP_Solano
275	SOL-SEPTEMBER-25-10-039	CSP_Solano
276	COR-03A-06-10-0466	CSP-COR: California State Prison-Corcoran
277	COR-03A-10-02-003	CSP-COR: California State Prison-Corcoran
278	COR-03A-10-03-005	CSP-COR: California State Prison-Corcoran
279	COR-03A-10-11-010	CSP-COR: California State Prison-Corcoran
280	COR-03A-10-11-011	CSP-COR: California State Prison-Corcoran
281	COR-03A-11-03-002	CSP-COR: California State Prison-Corcoran
282	COR-03A-11-06-004	CSP-COR: California State Prison-Corcoran
283	COR-03B-09-08-008	CSP-COR: California State Prison-Corcoran
284	COR-03B-10-07-007	CSP-COR: California State Prison-Corcoran
285	COR-03B-10-09-008	CSP-COR: California State Prison-Corcoran
286	COR-03B-11-02-001	CSP-COR: California State Prison-Corcoran
287	COR-03B-11-04-003	CSP-COR: California State Prison-Corcoran
288	COR-03C-10-10-009	CSP-COR: California State Prison-Corcoran

Lockdowns Summarized in the 2010-2011 PSR Summary Spreadsheet

(Modified Programs In Effect Between Jan. 1 2010 and June 1, 2011 and initiated prior to June 1, 2011)

	Modified Program/Program Status Number (PSN)	Institution
289	COR-0L1-10-12-012	CSP-COR: California State Prison-Corcoran
290	COR-3A-10-03-010	CSP-COR: California State Prison-Corcoran
291	LAC-A-10-039	CSP-LAC: California State Prison, Los Angeles County
292	LAC-A-10-048	CSP-LAC: California State Prison, Los Angeles County
293	LAC-A-10-053	CSP-LAC: California State Prison, Los Angeles County
294	LAC-A-11-015	CSP-LAC: California State Prison, Los Angeles County
295	LAC-B-10-034	CSP-LAC: California State Prison, Los Angeles County
296	LAC-B-10-042	CSP-LAC: California State Prison, Los Angeles County
297	LAC-B-10-052	CSP-LAC: California State Prison, Los Angeles County
298	LAC-B-10-055	CSP-LAC: California State Prison, Los Angeles County
299	LAC-B-11-003	CSP-LAC: California State Prison, Los Angeles County
300	LAC-B-11-008	CSP-LAC: California State Prison, Los Angeles County
301	LAC-B-11-010	CSP-LAC: California State Prison, Los Angeles County
302	LAC-B-11-020	CSP-LAC: California State Prison, Los Angeles County
303	LAC-C-10-031	CSP-LAC: California State Prison, Los Angeles County
304	LAC-C-10-032	CSP-LAC: California State Prison, Los Angeles County
305	LAC-C-10-044	CSP-LAC: California State Prison, Los Angeles County
306	LAC-C-10-047	CSP-LAC: California State Prison, Los Angeles County
307	LAC-C-10-050	CSP-LAC: California State Prison, Los Angeles County
308	LAC-C-11-005	CSP-LAC: California State Prison, Los Angeles County
309	LAC-C-11-007	CSP-LAC: California State Prison, Los Angeles County
310	LAC-C-11-017	CSP-LAC: California State Prison, Los Angeles County
311	LAC-D-10-035	CSP-LAC: California State Prison, Los Angeles County
312	LAC-D-10-036	CSP-LAC: California State Prison, Los Angeles County
313	LAC-D-10-040	CSP-LAC: California State Prison, Los Angeles County
314	LAC-D-10-043	CSP-LAC: California State Prison, Los Angeles County
315	LAC-D-10-045	CSP-LAC: California State Prison, Los Angeles County
316	LAC-D-10-051	CSP-LAC: California State Prison, Los Angeles County
317	LAC-D-10-054	CSP-LAC: California State Prison, Los Angeles County
318	LAC-D-11-002	CSP-LAC: California State Prison, Los Angeles County
319	LAC-D-11-004	CSP-LAC: California State Prison, Los Angeles County
320	LAC-D-11-012	CSP-LAC: California State Prison, Los Angeles County
321	LAC-D-11-013	CSP-LAC: California State Prison, Los Angeles County
322	LAC-LAC-10-030	CSP-LAC: California State Prison, Los Angeles County
323	LAC-LAC-10-033	CSP-LAC: California State Prison, Los Angeles County
324	LAC-LAC-10-038	CSP-LAC: California State Prison, Los Angeles County
325	LAC-LAC-11-006	CSP-LAC: California State Prison, Los Angeles County
326	LAC-LAC-11-009	CSP-LAC: California State Prison, Los Angeles County
327	LAC-LAC-11-014	CSP-LAC: California State Prison, Los Angeles County
328	LAC-LAC-11-016	CSP-LAC: California State Prison, Los Angeles County
329	LAC-LAC-11-018	CSP-LAC: California State Prison, Los Angeles County
330	LAC-LAC-11-019	CSP-LAC: California State Prison, Los Angeles County
331	SAC-B-10-001	CSP-SAC - California State Prison, Sacramento
332	SAC-B-10-015	CSP-SAC - California State Prison, Sacramento
333	SAC-B-10-021	CSP-SAC - California State Prison, Sacramento
334	SAC-B-10-024	CSP-SAC - California State Prison, Sacramento
335	SAC-B-10-028	CSP-SAC - California State Prison, Sacramento
336	SAC-B-10-030	CSP-SAC - California State Prison, Sacramento

Lockdowns Summarized in the 2010-2011 PSR Summary Spreadsheet

(Modified Programs In Effect Between Jan. 1 2010 and June 1, 2011 and initiated prior to June 1, 2011)

	Modified Program/Program Status Number (PSN)	Institution
337	SAC-B-10-032	CSP-SAC - California State Prison, Sacramento
338	SAC-B-11-001	CSP-SAC - California State Prison, Sacramento
339	SAC-B-11-003	CSP-SAC - California State Prison, Sacramento
340	SAC-B-11-004	CSP-SAC - California State Prison, Sacramento
341	SAC-B-11-008	CSP-SAC - California State Prison, Sacramento
342	SAC-B-11-009	CSP-SAC - California State Prison, Sacramento
343	SAC-C-10-016	CSP-SAC - California State Prison, Sacramento
344	SAC-C-10-017	CSP-SAC - California State Prison, Sacramento
345	SAC-C-10-018	CSP-SAC - California State Prison, Sacramento
346	SAC-C-10-019	CSP-SAC - California State Prison, Sacramento
347	SAC-C-10-020	CSP-SAC - California State Prison, Sacramento
348	SAC-C-10-022	CSP-SAC - California State Prison, Sacramento
349	SAC-C-10-023	CSP-SAC - California State Prison, Sacramento
350	SAC-C-10-025	CSP-SAC - California State Prison, Sacramento
351	SAC-C-10-026	CSP-SAC - California State Prison, Sacramento
352	SAC-C-10-027	CSP-SAC - California State Prison, Sacramento
353	SAC-C-10-029	CSP-SAC - California State Prison, Sacramento
354	SAC-C-10-031	CSP-SAC - California State Prison, Sacramento
355	SAC-C-10-033	CSP-SAC - California State Prison, Sacramento
356	SAC-C-11-002	CSP-SAC - California State Prison, Sacramento
357	SAC-C-11-005	CSP-SAC - California State Prison, Sacramento
358	SAC-C-11-006	CSP-SAC - California State Prison, Sacramento
359	SAC-C-11-007	CSP-SAC - California State Prison, Sacramento
360	CTF-CENTRAL-003	CTF - Correctional Training Facility
361	CTF-CENTRAL-10-006	CTF - Correctional Training Facility
362	CTF-CENTRAL-10-007	CTF - Correctional Training Facility
363	CTF-CENTRAL-10-008	CTF - Correctional Training Facility
364	CTF-CENTRAL-10-009	CTF - Correctional Training Facility
365	CTF-CENTRAL-10-010	CTF - Correctional Training Facility
366	CTF-CENTRAL-10-011	CTF - Correctional Training Facility
367	CTF-CENTRAL-10-012	CTF - Correctional Training Facility
368	CTF-CENTRAL-10-013	CTF - Correctional Training Facility
369	CTF-CENTRAL-10-014	CTF - Correctional Training Facility
370	CTF-CENTRAL-11-001	CTF - Correctional Training Facility
371	CTF-NORTH-10-003	CTF - Correctional Training Facility
372	CTF-NORTH-10-004	CTF - Correctional Training Facility
373	CTF-NORTH-10-006	CTF - Correctional Training Facility
374	CTF-NORTH-10-007	CTF - Correctional Training Facility
375	CTF-NORTH-11-003	CTF - Correctional Training Facility
376	CTF-SOUTH-10-004	CTF - Correctional Training Facility
377	CTF-SOUTH-10-005	CTF - Correctional Training Facility
378	CTF-SOUTH-10-006	CTF - Correctional Training Facility
379	CTF-SOUTH-10-007	CTF - Correctional Training Facility
380	CTF-SOUTH-10-008	CTF - Correctional Training Facility
381	CTF-SOUTH-11-001	CTF - Correctional Training Facility
382	CTF-SOUTH-11-002	CTF - Correctional Training Facility
383	CTF-SOUTH-11-003	CTF - Correctional Training Facility
384	CVP-DYD-11-001	CVSP - Chuckawalla Valley State Prison

Lockdowns Summarized in the 2010-2011 PSR Summary Spreadsheet

(Modified Programs In Effect Between Jan. 1 2010 and June 1, 2011 and initiated prior to June 1, 2011)

	Modified Program/Program Status Number (PSN)	Institution
385	CVSP-AYD-11-0003	CVSP - Chuckawalla Valley State Prison
386	CVSP-CYD-10-0004	CVSP - Chuckawalla Valley State Prison
387	CVSP-CYD-11-0002	CVSP - Chuckawalla Valley State Prison
388	CVSP-CYD-11-0004	CVSP - Chuckawalla Valley State Prison
389	DVI-EEO-10-08-0005	DVI - Deuel Vocational Institution
390	DVI-EEO-10-09-0006	DVI - Deuel Vocational Institution
391	DVI-EEO-10-10-0007	DVI - Deuel Vocational Institution
392	DVI-EEO-11-01-0001	DVI - Deuel Vocational Institution
393	DVI-EEO-11-01-0002	DVI - Deuel Vocational Institution
394	DVI-EEO-11-01-0003	DVI - Deuel Vocational Institution
395	DVI-EEO-11-04-0004	DVI - Deuel Vocational Institution
396	DVI-EEO-11-04-0005	DVI - Deuel Vocational Institution
397	FSP-09-09-008	FSP - Folsom State Prison
398	FSP-10-08-009	FSP - Folsom State Prison
399	FSP-11-01-001	FSP - Folsom State Prison
400	FSP-11-01-002	FSP - Folsom State Prison
401	FSP-11-01-003	FSP - Folsom State Prison
402	FSP-11-02-004	FSP - Folsom State Prison
403	FSP-11-03-005	FSP - Folsom State Prison
404	FSP-11-04-006	FSP - Folsom State Prison
405	FSP-11-04-007	FSP - Folsom State Prison
406	FSP-11-04-008	FSP - Folsom State Prison
407	FSP-11-05-009	FSP - Folsom State Prison
408	FSP-11-05-010	FSP - Folsom State Prison
409	HDP-A-10-015	HDP - High Desert State Prison
410	HDP-A-10-019	HDP - High Desert State Prison
411	HDP-A-10-026	HDP - High Desert State Prison
412	HDP-B-10-022	HDP - High Desert State Prison
413	HDP-B-10-023	HDP - High Desert State Prison
414	HDP-B-10-024	HDP - High Desert State Prison
415	HDP-C-09-018	HDP - High Desert State Prison
416	HDP-C-10-013	HDP - High Desert State Prison
417	HDP-C-10-016	HDP - High Desert State Prison
418	HDP-C-10-025	HDP - High Desert State Prison
419	HDP-D-10-014	HDP - High Desert State Prison
420	HDP-D-10-018	HDP - High Desert State Prison
421	HDP-D-10-020	HDP - High Desert State Prison
422	HDP-D-10-027	HDP - High Desert State Prison
423	HDP-D-11-003	HDP - High Desert State Prison
424	HDP-DASU-10-017	HDP - High Desert State Prison
425	HDP-DASU-10-021	HDP - High Desert State Prison
426	HDP-DASU-11-001	HDP - High Desert State Prison
427	HDP-INST-11-002	HDP - High Desert State Prison
428	HDP-Z-10-011	HDP - High Desert State Prison
429	ISP-A-10-010	ISP - Ironwood State Prison
430	ISP-A-10-012	ISP - Ironwood State Prison
431	ISP-A-10-013	ISP - Ironwood State Prison
432	ISP-A-10-016	ISP - Ironwood State Prison

Lockdowns Summarized in the 2010-2011 PSP Summary Spreadsheet
(Modified Programs In Effect Between Jan. 1 2010 and June 1, 2011 and initiated prior to June 1, 2011)

	Modified Program/Program Status Number (PSN)	Institution
433	ISP-A-11-001	ISP - Ironwood State Prison
434	ISP-B-10-015	ISP - Ironwood State Prison
435	ISP-C-10-008	ISP - Ironwood State Prison
436	ISP-C-10-009	ISP - Ironwood State Prison
437	ISP-D-10-007	ISP - Ironwood State Prison
438	ISP-D-10-011	ISP - Ironwood State Prison
439	ISP-D-10-014	ISP - Ironwood State Prison
440	ISP-D-10-017	ISP - Ironwood State Prison
441	ISP-D-10-018	ISP - Ironwood State Prison
442	ISP-D-11-003	ISP - Ironwood State Prison
443	ISP-D-12-018	ISP - Ironwood State Prison
444	ISP-INST-11-005	ISP - Ironwood State Prison
445	ISP-MSF-11-002	ISP - Ironwood State Prison
446	KVP-A-09-019	KVSP - Kern Valley State Prison
447	KVP-A-10-007	KVSP - Kern Valley State Prison
448	KVP-A-10-017	KVSP - Kern Valley State Prison
449	KVP-A-10-024	KVSP - Kern Valley State Prison
450	KVP-A-10-035	KVSP - Kern Valley State Prison
451	KVP-A-10-036	KVSP - Kern Valley State Prison
452	KVP-A-10-037	KVSP - Kern Valley State Prison
453	KVP-A-11-001	KVSP - Kern Valley State Prison
454	KVP-A-11-003	KVSP - Kern Valley State Prison
455	KVP-A-11-009	KVSP - Kern Valley State Prison
456	KVP-A-11-011	KVSP - Kern Valley State Prison
457	KVP-B-10-013	KVSP - Kern Valley State Prison
458	KVP-B-10-021	KVSP - Kern Valley State Prison
459	KVP-B-10-025	KVSP - Kern Valley State Prison
460	KVP-B-10-026	KVSP - Kern Valley State Prison
461	KVP-B-10-027	KVSP - Kern Valley State Prison
462	KVP-B-10-028	KVSP - Kern Valley State Prison
463	KVP-B-10-033	KVSP - Kern Valley State Prison
464	KVP-B-10-034	KVSP - Kern Valley State Prison
465	KVP-B-10-038	KVSP - Kern Valley State Prison
466	KVP-B-11-002	KVSP - Kern Valley State Prison
467	KVP-B-11-005	KVSP - Kern Valley State Prison
468	KVP-B-11-012	KVSP - Kern Valley State Prison
469	KVP-C-10-023	KVSP - Kern Valley State Prison
470	KVP-C-10-030	KVSP - Kern Valley State Prison
471	KVP-C-10-035	KVSP - Kern Valley State Prison
472	KVP-C-11-006	KVSP - Kern Valley State Prison
473	KVP-CO-09-010	KVSP - Kern Valley State Prison
474	KVP-CO-10-005	KVSP - Kern Valley State Prison
475	KVP-CO-11-007	KVSP - Kern Valley State Prison
476	KVP-D-10-006	KVSP - Kern Valley State Prison
477	KVP-D-10-015	KVSP - Kern Valley State Prison
478	KVP-D-10-016	KVSP - Kern Valley State Prison
479	KVP-D-10-018	KVSP - Kern Valley State Prison
480	KVP-D-10-020	KVSP - Kern Valley State Prison

Lockdowns Summarized in the 2010-2011 PSR Summary Spreadsheet

(Modified Programs In Effect Between Jan. 1 2010 and June 1, 2011 and initiated prior to June 1, 2011)

	Modified Program/Program Status Number (PSN)	Institution
481	KVP-D-10-022	KVSP - Kern Valley State Prison
482	KVP-D-10-029	KVSP - Kern Valley State Prison
483	KVP-D-11-004	KVSP - Kern Valley State Prison
484	KVP-D-11-008	KVSP - Kern Valley State Prison
485	KVP-D-11-010	KVSP - Kern Valley State Prison
486	MCSP-FAC-11-01-0001	MCSP - Mule Creek State Prison
487	NKSP-A&M-11-0001	NKSP - North Kern State Prison
488	NKSP-A-10-0019	NKSP - North Kern State Prison
489	NKSP-A-10-0020	NKSP - North Kern State Prison
490	NKSP-A-10-0023	NKSP - North Kern State Prison
491	NKSP-A-10-0026	NKSP - North Kern State Prison
492	NKSP-A-10-08-0021	NKSP - North Kern State Prison
493	NKSP-A-11-0006	NKSP - North Kern State Prison
494	NKSP-A-11-0012	NKSP - North Kern State Prison
495	NKSP-A-11-0013	NKSP - North Kern State Prison
496	NKSP-B-10-0022	NKSP - North Kern State Prison
497	NKSP-B-10-0024	NKSP - North Kern State Prison
498	NKSP-B-10-0025	NKSP - North Kern State Prison
499	NKSP-B-10-0025	NKSP - North Kern State Prison
500	NKSP-B-10-0028	NKSP - North Kern State Prison
501	NKSP-B-11-0002	NKSP - North Kern State Prison
502	NKSP-B-11-0005	NKSP - North Kern State Prison
503	NKSP-B-11-0007	NKSP - North Kern State Prison
504	NKSP-B-11-0009	NKSP - North Kern State Prison
505	NKSP-B-11-0010	NKSP - North Kern State Prison
506	NKSP-B-11-0011	NKSP - North Kern State Prison
507	NKSP-B-11-0014	NKSP - North Kern State Prison
508	NKSP-B-11-005	NKSP - North Kern State Prison
509	NKSP-D-10-0018	NKSP - North Kern State Prison
510	NKSP-D-10-0027	NKSP - North Kern State Prison
511	NKSP-D-10-0028	NKSP - North Kern State Prison
512	NKSP-D-11-0003	NKSP - North Kern State Prison
513	NKSP-D-11-0008	NKSP - North Kern State Prison
514	PBP-A-10-005	PBSP - Pelican Bay State Prison
515	PBP-B-08-002	PBSP - Pelican Bay State Prison
516	PBP-B-08-004	PBSP - Pelican Bay State Prison
517	PBP-B-10-003	PBSP - Pelican Bay State Prison
518	PBP-B-11-002	PBSP - Pelican Bay State Prison
519	PBP-CS-10-004	PBSP - Pelican Bay State Prison
520	PBP-CS-11-001	PBSP - Pelican Bay State Prison
521	PVP-FBP-10-10-0373	PVSP - Pleasant Valley State Prison
522	PVP-FCS-10-7-0229	PVSP - Pleasant Valley State Prison
523	PVP-NOU-FA-2-04-11-0484	PVSP - Pleasant Valley State Prison
524	PVP-NOU-FA-3-03-11-0436	PVSP - Pleasant Valley State Prison
525	PVSP-FAP-10-03-0103	PVSP - Pleasant Valley State Prison
526	PVSP-FAP-10-05-0150	PVSP - Pleasant Valley State Prison
527	PVSP-FAP-10-08-0280	PVSP - Pleasant Valley State Prison
528	PVSP-FAP-11-03-0116	PVSP - Pleasant Valley State Prison

Lockdowns Summarized in the 2010-2011 PSR Summary Spreadsheet

(Modified Programs In Effect Between Jan. 1 2010 and June 1, 2011 and initiated prior to June 1, 2011)

	Modified Program/Program Status Number (PSN)	Institution
529	PVSP-FBP-10-02-0079	PVSP - Pleasant Valley State Prison
530	PVSP-FBP-10-06-0196	PVSP - Pleasant Valley State Prison
531	PVSP-FBP-11-03-0111	PVSP - Pleasant Valley State Prison
532	PVSP-FCP-10-08-0264	PVSP - Pleasant Valley State Prison
533	PVSP-FCP-10-08-0301	PVSP - Pleasant Valley State Prison
534	PVSP-FCP-10-10-0357	PVSP - Pleasant Valley State Prison
535	PVSP-FCP-10-11-0396	PVSP - Pleasant Valley State Prison
536	PVSP-FCP-10-11-0417	PVSP - Pleasant Valley State Prison
537	PVSP-FCP-11-03-0100	PVSP - Pleasant Valley State Prison
538	PVSP-FDP-10-06-0202	PVSP - Pleasant Valley State Prison
539	RJD-01-10-0014	RJD - Richard J. Donovan Correctional Facility
540	RJD-02-10-0016	RJD - Richard J. Donovan Correctional Facility
541	RJD-02-10-0018	RJD - Richard J. Donovan Correctional Facility
542	RJD-02-10-0019	RJD - Richard J. Donovan Correctional Facility
543	RJD-03-10-0017	RJD - Richard J. Donovan Correctional Facility
544	RJD-03-10-12-0017	RJD - Richard J. Donovan Correctional Facility
545	RJD-03-11-0001	RJD - Richard J. Donovan Correctional Facility
546	RJD-04-10-0012	RJD - Richard J. Donovan Correctional Facility
547	RJD-04-10-0013	RJD - Richard J. Donovan Correctional Facility
548	RJD-04-10-0015	RJD - Richard J. Donovan Correctional Facility
549	RJD-04-11-0003	RJD - Richard J. Donovan Correctional Facility
550	RJD-07-10-0011	RJD - Richard J. Donovan Correctional Facility
551	RJD-09-10-0014	RJD - Richard J. Donovan Correctional Facility
552	RJD-11-03-0002	RJD - Richard J. Donovan Correctional Facility
553	RJD-11-03-0004	RJD - Richard J. Donovan Correctional Facility
554	SCC-CAL-11-1-0008	SCC - Sierra Conservation Center
555	SCC-CAL-11-10-0205	SCC - Sierra Conservation Center
556	SCC-MAR-10-09-0180	SCC - Sierra Conservation Center
557	SQ-III-10-023	SQ - San Quentin State Prison
558	SQ-III-10-028	SQ - San Quentin State Prison
559	SQ-III-10-029	SQ - San Quentin State Prison
560	SQ-III-10-038	SQ - San Quentin State Prison
561	SQ-III-11-010	SQ - San Quentin State Prison
562	SQ-IV-10-021	SQ - San Quentin State Prison
563	SQ-IV-10-022	SQ - San Quentin State Prison
564	SQ-IV-10-026	SQ - San Quentin State Prison
565	SQ-IV-10-031	SQ - San Quentin State Prison
566	SQ-IV-10-033	SQ - San Quentin State Prison
567	SQ-IV-10-034	SQ - San Quentin State Prison
568	SQ-IV-10-035	SQ - San Quentin State Prison
569	SQ-IV-11-001	SQ - San Quentin State Prison
570	SQ-IV-11-003	SQ - San Quentin State Prison
571	SQ-IV-11-004	SQ - San Quentin State Prison
572	SQ-IV-11-007	SQ - San Quentin State Prison
573	SQ-IV-11-008	SQ - San Quentin State Prison
574	SQ-IV-11-009	SQ - San Quentin State Prison
575	SQ-IV-11-011	SQ - San Quentin State Prison
576	SQ-IV-11-012	SQ - San Quentin State Prison

Lockdowns Summarized in the 2010-2011 PSR Summary Spreadsheet

(Modified Programs In Effect Between Jan. 1 2010 and June 1, 2011 and initiated prior to June 1, 2011)

	Modified Program/Program Status Number (PSN)	Institution
577	SQ-IV-11-036	SQ - San Quentin State Prison
578	SQP-11-IV-013	SQ - San Quentin State Prison
579	SQP-IV-10-037	SQ - San Quentin State Prison
580	SQ-V-10-0030	SQ - San Quentin State Prison
581	SQ-V-10-024	SQ - San Quentin State Prison
582	SQ-V-10-025	SQ - San Quentin State Prison
583	SQ-V-10-032	SQ - San Quentin State Prison
584	SQ-V-11-002	SQ - San Quentin State Prison
585	CDCR-DAI-11-001	Statewide Modified Program For Male Institutions
586	SVSP-CEN-11-001	SVSP - Salinas Valley State Prison
587	SVSP-CEN-11-002	SVSP - Salinas Valley State Prison
588	SVSP-CEN-11-007	SVSP - Salinas Valley State Prison
589	SVSP-FA-10-037	SVSP - Salinas Valley State Prison
590	SVSP-FA-10-039	SVSP - Salinas Valley State Prison
591	SVSP-FA-10-040	SVSP - Salinas Valley State Prison
592	SVSP-FA-10-045	SVSP - Salinas Valley State Prison
593	SVSP-FB-10-031	SVSP - Salinas Valley State Prison
594	SVSP-FB-10-032	SVSP - Salinas Valley State Prison
595	SVSP-FB-10-044	SVSP - Salinas Valley State Prison
596	SVSP-FC-10-029	SVSP - Salinas Valley State Prison
597	SVSP-FC-10-031	SVSP - Salinas Valley State Prison
598	SVSP-FC-10-036	SVSP - Salinas Valley State Prison
599	SVSP-FC-10-043	SVSP - Salinas Valley State Prison
600	SVSP-FC-10-046	SVSP - Salinas Valley State Prison
601	SVSP-FC-10-047	SVSP - Salinas Valley State Prison
602	SVSP-FC-11-003	SVSP - Salinas Valley State Prison
603	SVSP-FC-11-005	SVSP - Salinas Valley State Prison
604	SVSP-FC-11-008	SVSP - Salinas Valley State Prison
605	SVSP-FD-10-034	SVSP - Salinas Valley State Prison
606	SVSP-FD-10-035	SVSP - Salinas Valley State Prison
607	SVSP-FD-10-038	SVSP - Salinas Valley State Prison
608	SVSP-FD-10-042	SVSP - Salinas Valley State Prison
609	SVSP-FD-11-004	SVSP - Salinas Valley State Prison
610	SVSP-FD-11-006	SVSP - Salinas Valley State Prison
611	WSP-FAY-10-07-0320	WSP - Wasco State Prison
612	WSP-FAY-10-08-0373	WSP - Wasco State Prison
613	WSP-FAY-10-10-0499	WSP - Wasco State Prison
614	WSP-FAY-11-01-0047	WSP - Wasco State Prison
615	WSP-FAY-11-01-0054	WSP - Wasco State Prison
616	WSP-FAY-11-02-0063	WSP - Wasco State Prison
617	WSP-FAY-11-02-0070	WSP - Wasco State Prison
618	WSP-FAY-11-03-0102	WSP - Wasco State Prison
619	WSP-FAY-11-03-0111	WSP - Wasco State Prison
620	WSP-FAY-11-03-0149	WSP - Wasco State Prison
621	WSP-FAY-11-04-0212	WSP - Wasco State Prison
622	WSP-FBY-10-07-0301	WSP - Wasco State Prison
623	WSP-FBY-10-07-0334	WSP - Wasco State Prison
624	WSP-FBY-10-11-0539	WSP - Wasco State Prison

Lockdowns Summarized in the 2010-2011 PSR Summary Spreadsheet

(Modified Programs In Effect Between Jan. 1 2010 and June 1, 2011 and initiated prior to June 1, 2011)

	Modified Program/Program Status Number (PSN)	Institution
625	WSP-FBY-11-05-0264	WSP - Wasco State Prison
626	WSP-FCY-10-10-0493	WSP - Wasco State Prison
627	WSP-FCY-11-01-0014	WSP - Wasco State Prison
628	WSP-FCY-11-04-0182	WSP - Wasco State Prison
629	WSP-FCY-11-05-0247	WSP - Wasco State Prison
630	WSP-FDY-10-12-0563	WSP - Wasco State Prison
631	WSP-FDY-11-01-0035	WSP - Wasco State Prison
632	WSP-FDY-11-04-0158	WSP - Wasco State Prison
633	WSP-FDY-11-05-0238	WSP - Wasco State Prison
634	WSP-FHY-10-10-0490	WSP - Wasco State Prison
635	WSP-FHY-11-01-0001	WSP - Wasco State Prison

EXHIBIT G

List of Lockdowns Summarized in the 2011-2012 PSR Summary Spreadsheet
(Modified Programs Initiated On Or After June 1, 2011)

	Modified Program/Program Status Number (PSN)	Institution
1	ASP-FA1-11-010	ASP - Avenal State Prison
2	ASP-FA1-11-013	ASP - Avenal State Prison
3	ASP-FA5-11-011	ASP - Avenal State Prison
4	ASP-FA5-11-012	ASP - Avenal State Prison
5	ASP-FA6-08-09-0250	ASP - Avenal State Prison
6	ASP-FAD-11-014	ASP - Avenal State Prison
7	ASP-FAE-12-002	ASP - Avenal State Prison
8	ASP-FAF-12-01-001	ASP - Avenal State Prison
9	CAL-A-11-011	CAL - Calipatria State Prison
10	CAL-A-11-016	CAL - Calipatria State Prison
11	CAL-A-12-002	CAL - Calipatria State Prison
12	CAL-A-12-005	CAL - Calipatria State Prison
13	CAL-A-12-013	CAL - Calipatria State Prison
14	CAL-A-12-014	CAL - Calipatria State Prison
15	CAL-A-12-017	CAL - Calipatria State Prison
16	CAL-B-11-012	CAL - Calipatria State Prison
17	CAL-B-11-013	CAL - Calipatria State Prison
18	CAL-B-11-014	CAL - Calipatria State Prison
19	CAL-B-11-017	CAL - Calipatria State Prison
20	CAL-B-12-001	CAL - Calipatria State Prison
21	CAL-B-12-003	CAL - Calipatria State Prison
22	CAL-B-12-006	CAL - Calipatria State Prison
23	CAL-B-12-010	CAL - Calipatria State Prison
24	CAL-B-12-018	CAL - Calipatria State Prison
25	CAL-B-12-019	CAL - Calipatria State Prison
26	CAL-B-12-023	CAL - Calipatria State Prison
27	CAL-B-12-024	CAL - Calipatria State Prison
28	CAL-C-11-015	CAL - Calipatria State Prison
29	CAL-C-12-004	CAL - Calipatria State Prison
30	CAL-C-12-007	CAL - Calipatria State Prison
31	CAL-C-12-008	CAL - Calipatria State Prison
32	CAL-C-12-011	CAL - Calipatria State Prison
33	CAL-C-12-016	CAL - Calipatria State Prison
34	CAL-C-12-020	CAL - Calipatria State Prison
35	CAL-D-11-019	CAL - Calipatria State Prison
36	CAL-D-12-012	CAL - Calipatria State Prison
37	CAL-INST-12-015	CAL - Calipatria State Prison
38	CAL-INST-12-021	CAL - Calipatria State Prison
39	CAL-INST-12-022	CAL - Calipatria State Prison
40	CAL-MSF-12-018	CAL - Calipatria State Prison
41	CCC-FACA-11-11-018	CCC - California Correctional Center
42	CCC-FACA-12-005	CCC - California Correctional Center
43	CCC-FACA-12-006	CCC - California Correctional Center
44	CCC-FACA-12-009	CCC - California Correctional Center
45	CCC-FACB-12-003	CCC - California Correctional Center
46	CCC-FACB-12-004	CCC - California Correctional Center
47	CCC-FACB-12-007	CCC - California Correctional Center
48	CCC-FACB-12-02-001	CCC - California Correctional Center
49	CCC-FACC-11-10-017	CCC - California Correctional Center
50	CCC-FACC-12-008	CCC - California Correctional Center
51	CCC-FACC-12-03-002	CCC - California Correctional Center
52	CCC-LAS-11-06-011	CCC - California Correctional Center
53	CCC-LAS-11-08-013	CCC - California Correctional Center

List of Lockdowns Summarized in the 2011-2012 PSR Summary Spreadsheet (Modified Programs Initiated On Or After June 1, 2011)

	Modified Program/Program Status Number (PSN)	Institution
54	CCC-LAS-11-08-014	CCC - California Correctional Center
55	CCC-LAS-11-09-015	CCC - California Correctional Center
56	CCI-4B-11-019	CCI - California Correctional Institution
57	CCI-A-12-003	CCI - California Correctional Institution
58	CCI-A-12-004	CCI - California Correctional Institution
59	CCI-A-12-008	CCI - California Correctional Institution
60	CCI-A-12-012	CCI - California Correctional Institution
61	CCI-B-12-005	CCI - California Correctional Institution
62	CCI-B-12-007	CCI - California Correctional Institution
63	CCI-B-12-011	CCI - California Correctional Institution
64	CCI-B-12-013	CCI - California Correctional Institution
65	CCI-B-12-016	CCI - California Correctional Institution
66	CCI-C-12-002	CCI - California Correctional Institution
67	CCI-C-12-010	CCI - California Correctional Institution
68	CCI-C-12-015	CCI - California Correctional Institution
69	CCI-CS-11-021	CCI - California Correctional Institution
70	CCI-D-12-001	CCI - California Correctional Institution
71	CCI-D-12-009	CCI - California Correctional Institution
72	CCI-E-12-014	CCI - California Correctional Institution
73	CCI-I-11-024	CCI - California Correctional Institution
74	CCI-II-11-017	CCI - California Correctional Institution
75	CCI-II-11-020	CCI - California Correctional Institution
76	CCI-II-11-025	CCI - California Correctional Institution
77	CCI-III-11-016	CCI - California Correctional Institution
78	CCI-III-11-023	CCI - California Correctional Institution
79	CCI-IVA-11-026	CCI - California Correctional Institution
80	CCI-IVB-11-015	CCI - California Correctional Institution
81	CCI-IVB-11-018	CCI - California Correctional Institution
82	CCI-IVB-11-027	CCI - California Correctional Institution
83	CEN-A-11-014	CEN - California State Prison, Centinela
84	CEN-B-11-013	CEN - California State Prison, Centinela
85	CEN-B-12-009	CEN - California State Prison, Centinela
86	CEN-C-11-007	CEN - California State Prison, Centinela
87	CEN-C-11-008	CEN - California State Prison, Centinela
88	CEN-C-11-012	CEN - California State Prison, Centinela
89	CEN-C-11-015	CEN - California State Prison, Centinela
90	CEN-C-11-016	CEN - California State Prison, Centinela
91	CEN-C-12-005	CEN - California State Prison, Centinela
92	CEN-D-11-017	CEN - California State Prison, Centinela
93	CEN-D-12-008	CEN - California State Prison, Centinela
94	CIM-A-12-008	CIM - California Institution for Men
95	CIM-CIM1-11-011	CIM - California Institution for Men
96	CIM-CIM1-11-014	CIM - California Institution for Men
97	CIM-FAA-12-007	CIM - California Institution for Men
98	CIM-FAA-12-008	CIM - California Institution for Men
99	CIM-FAA-12-013	CIM - California Institution for Men
100	CIM-FAA-12-017	CIM - California Institution for Men
101	CIM-FAB-12-005	CIM - California Institution for Men
102	CIM-FAC-12-002	CIM - California Institution for Men
103	CIM-FAC-12-010	CIM - California Institution for Men
104	CIM-FAC-12-012	CIM - California Institution for Men
105	CIM-FAC-12-015	CIM - California Institution for Men
106	CIM-FAC-12-016	CIM - California Institution for Men

List of Lockdowns Summarized in the 2011-2012 PSR Summary Spreadsheet
(Modified Programs Initiated On Or After June 1, 2011)

	Modified Program/Program Status Number (PSN)	Institution
107	CIM-FAD-12-003	CIM - California Institution for Men
108	CIM-FAD-12-004	CIM - California Institution for Men
109	CIM-FAD-12-006	CIM - California Institution for Men
110	CIM-FAD-12-009	CIM - California Institution for Men
111	CIM-FAD-12-011	CIM - California Institution for Men
112	CIM-FAD-12-014	CIM - California Institution for Men
113	CIM-RCC-11-0016	CIM - California Institution for Men
114	CIM-RCC-11-0018	CIM - California Institution for Men
115	CIM-RCC-11-017	CIM - California Institution for Men
116	CIM-RCE-11-012	CIM - California Institution for Men
117	CIM-RCE-11-013	CIM - California Institution for Men
118	CIM-RCE-11-015	CIM - California Institution for Men
119	(modified program in effect 8/12/11)	CMC - California Men's Colony
120	CMC-AS-12-05-0014	CMC - California Men's Colony
121	CMC-E-AQ-11-07-0044	CMC - California Men's Colony
122	CMC-E-AQ-11-07-0045	CMC - California Men's Colony
123	CMC-E-AQ-11-08-0051	CMC - California Men's Colony
124	CMC-E-AQ-11-12-0063	CMC - California Men's Colony
125	CMC-E-BQ-11-08-0048	CMC - California Men's Colony
126	CMC-E-BQ-11-09-0057	CMC - California Men's Colony
127	CMC-E-CQ-11-08-0049	CMC - California Men's Colony
128	CMC-E-CQ-11-08-0050	CMC - California Men's Colony
129	CMC-FACA-12-10-0030	CMC - California Men's Colony
130	CMC-FACC-12-01-0001	CMC - California Men's Colony
131	CMC-FACC-12-02-0003	CMC - California Men's Colony
132	CMC-FACC-12-02-0004	CMC - California Men's Colony
133	CMC-FACC-12-02-0005	CMC - California Men's Colony
134	CMC-FACC-12-04-0012	CMC - California Men's Colony
135	CMC-FACC-12-05-0013	CMC - California Men's Colony
136	CMC-FACC-12-09-0029	CMC - California Men's Colony
137	CMC-FACD-12-02-0007	CMC - California Men's Colony
138	CMC-FACD-12-03-0008	CMC - California Men's Colony
139	CMC-FACD-12-03-0010	CMC - California Men's Colony
140	CMC-FACD-12-03-008	CMC - California Men's Colony
141	CMC-FACD-12-08-0024	CMC - California Men's Colony
142	CMC-FACD-12-08-0025	CMC - California Men's Colony
143	CMC-FACD-12-09-0026	CMC - California Men's Colony
144	CMC-FACD-12-09-0027	CMC - California Men's Colony
145	CMC-FACD-12-09-0028	CMC - California Men's Colony
146	CMC-FACE-12-02-0006	CMC - California Men's Colony
147	CMC-FACE-12-03-0009	CMC - California Men's Colony
148	CMC-FACE-12-07-0019	CMC - California Men's Colony
149	CMC-FACE-12-07-0020	CMC - California Men's Colony
150	CMC-FACE-12-07-0021	CMC - California Men's Colony
151	CMC-FACE-12-08-0022	CMC - California Men's Colony
152	CMC-FACF-12-02-0002	CMC - California Men's Colony
153	CMC-FACF-12-06-0018	CMC - California Men's Colony
154	CMC-FACF-12-08-0023	CMC - California Men's Colony
155	CMC-FACG-12-04-0011	CMC - California Men's Colony
156	CMC-FACG-12-06-0016	CMC - California Men's Colony
157	CMC-W-U1-11-06-0042	CMC - California Men's Colony
158	CMC-W-U4-11-06-0043	CMC - California Men's Colony
159	CMC-W-U4-11-10-0060	CMC - California Men's Colony

List of Lockdowns Summarized in the 2011-2012 PSR Summary Spreadsheet
(Modified Programs Initiated On Or After June 1, 2011)

	Modified Program/Program Status Number (PSN)	Institution
160	CMF-11-013	CMF - California Medical Facility
161	CMF-11-014	CMF - California Medical Facility
162	CMF-11-014	CMF - California Medical Facility
163	CMF-12-003	CMF - California Medical Facility
164	CMF-12-004	CMF - California Medical Facility
165	CMF-H-3-12-007	CMF - California Medical Facility
166	CMF-M-12-005	CMF - California Medical Facility
167	CMF-M-12-006	CMF - California Medical Facility
168	CRC-CSO-11-010	CRC - California Rehabilitation Center
169	CRC-CSO-11-012	CRC - California Rehabilitation Center
170	CRC-CSO-11-013	CRC - California Rehabilitation Center
171	CRC-CSO-11-014	CRC - California Rehabilitation Center
172	CRC-HF3-11-009	CRC - California Rehabilitation Center
173	CRC-HF3-11-010	CRC - California Rehabilitation Center
174	CRC-HF3-11-015	CRC - California Rehabilitation Center
175	CRC-HFA-12-004	CRC - California Rehabilitation Center
176	CRC-HFA-12-006	CRC - California Rehabilitation Center
177	CRC-HFA-12-011	CRC - California Rehabilitation Center
178	CRC-HFB-11-016	CRC - California Rehabilitation Center
179	CRC-HFB-12-001	CRC - California Rehabilitation Center
180	CRC-HFB-12-003	CRC - California Rehabilitation Center
181	CRC-HFB-12-005	CRC - California Rehabilitation Center
182	CRC-HFC-12-002	CRC - California Rehabilitation Center
183	CRC-HFC-12-010	CRC - California Rehabilitation Center
184	Internal	CRC - California Rehabilitation Center
185	Internal	CRC - California Rehabilitation Center
186	Internal	CRC - California Rehabilitation Center
187	(modified program in effect 3/21/12)	CSATF - California Substance Abuse Treatment Facility
188	(modified program in effect 3/23/12)	CSATF - California Substance Abuse Treatment Facility
189	(modified program in effect 6/6/11)	CSATF - California Substance Abuse Treatment Facility
190	(modified program in effect 9/4/11)	CSATF - California Substance Abuse Treatment Facility
191	(modified program in effect 3/23/12)	CSATF - California Substance Abuse Treatment Facility
192	SATF-0001-12-02-0083	CSATF - California Substance Abuse Treatment Facility
193	SATF-0002-10-10-0419	CSATF - California Substance Abuse Treatment Facility
194	SATF-0002-11-08-0301	CSATF - California Substance Abuse Treatment Facility
195	SATF-0002-11-08-0323	CSATF - California Substance Abuse Treatment Facility
196	SATF-0002-11-12-0516	CSATF - California Substance Abuse Treatment Facility
197	SATF-0002-12-01-0034	CSATF - California Substance Abuse Treatment Facility
198	SATF-0002-12-03-0127	CSATF - California Substance Abuse Treatment Facility
199	SATF-0003-11-09-0351	CSATF - California Substance Abuse Treatment Facility
200	SATF-0003-11-10-0393	CSATF - California Substance Abuse Treatment Facility
201	SATF-0003-11-10-0412	CSATF - California Substance Abuse Treatment Facility
202	SATF-0003-11-11-0473	CSATF - California Substance Abuse Treatment Facility
203	SATF-0003-11-12-0512	CSATF - California Substance Abuse Treatment Facility
204	SATF-0003-12-01-0016	CSATF - California Substance Abuse Treatment Facility
205	SATF-0003-12-02-0076	CSATF - California Substance Abuse Treatment Facility
206	SATF-0003-12-03-0113	CSATF - California Substance Abuse Treatment Facility
207	SATF-0003-12-03-0119	CSATF - California Substance Abuse Treatment Facility
208	SATF-0003-12-03-0122	CSATF - California Substance Abuse Treatment Facility
209	SATF-0004-11-09-0353	CSATF - California Substance Abuse Treatment Facility
210	SATF-0004-11-09-0377	CSATF - California Substance Abuse Treatment Facility
211	SATF-0004-11-09-0384	CSATF - California Substance Abuse Treatment Facility
212	SATF-0004-11-10-0409	CSATF - California Substance Abuse Treatment Facility

List of Lockdowns Summarized in the 2011-2012 PSR Summary Spreadsheet (Modified Programs Initiated On Or After June 1, 2011)

	Modified Program/Program Status Number (PSN)	Institution
213	SATF-0004-11-11-0433	CSATF - California Substance Abuse Treatment Facility
214	SATF-0004-11-12-0488	CSATF - California Substance Abuse Treatment Facility
215	SATF-0004-12-01-0031	CSATF - California Substance Abuse Treatment Facility
216	SATF-0004-12-01-0032	CSATF - California Substance Abuse Treatment Facility
217	SATF-0004-12-01-0038	CSATF - California Substance Abuse Treatment Facility
218	SATF-0004-12-02-0048	CSATF - California Substance Abuse Treatment Facility
219	SATF-0004-12-02-0073	CSATF - California Substance Abuse Treatment Facility
220	SATF-0005-11-09-0356	CSATF - California Substance Abuse Treatment Facility
221	SATF-0005-12-01-0042	CSATF - California Substance Abuse Treatment Facility
222	SATF-0005-12-03-0091	CSATF - California Substance Abuse Treatment Facility
223	SATF-0007-11-07-0283	CSATF - California Substance Abuse Treatment Facility
224	SATF-0007-12-01-0029	CSATF - California Substance Abuse Treatment Facility
225	SATF-0008-11-11-0442	CSATF - California Substance Abuse Treatment Facility
226	SATF-0010-11-07-0289	CSATF - California Substance Abuse Treatment Facility
227	SATF-02-11-11-0457	CSATF - California Substance Abuse Treatment Facility
228	SATF-02-12-01-0017	CSATF - California Substance Abuse Treatment Facility
229	SATF-02-12-01-0034	CSATF - California Substance Abuse Treatment Facility
230	SATF-02-12-02-0066	CSATF - California Substance Abuse Treatment Facility
231	SATF-03-11-06-0193	CSATF - California Substance Abuse Treatment Facility
232	SATF-03-11-06-0241	CSATF - California Substance Abuse Treatment Facility
233	SATF-03-11-07-0284	CSATF - California Substance Abuse Treatment Facility
234	SATF-03-11-07-284	CSATF - California Substance Abuse Treatment Facility
235	SATF-03-11-08-0306	CSATF - California Substance Abuse Treatment Facility
236	SATF-03-11-09-0357	CSATF - California Substance Abuse Treatment Facility
237	SATF-03-11-10-0412	CSATF - California Substance Abuse Treatment Facility
238	SATF-03-11-10-0416	CSATF - California Substance Abuse Treatment Facility
239	SATF-03-11-11-0469	CSATF - California Substance Abuse Treatment Facility
240	SATF-03-11-12-0510	CSATF - California Substance Abuse Treatment Facility
241	SATF-03-11-12-0512	CSATF - California Substance Abuse Treatment Facility
242	SATF-03-12-01-0016	CSATF - California Substance Abuse Treatment Facility
243	SATF-07-12-01-0029	CSATF - California Substance Abuse Treatment Facility
244	SATF-A-12-005	CSATF - California Substance Abuse Treatment Facility
245	SATF-B-12-013	CSATF - California Substance Abuse Treatment Facility
246	SATF-B-12-015	CSATF - California Substance Abuse Treatment Facility
247	SATF-B-12-017	CSATF - California Substance Abuse Treatment Facility
248	SATF-C-12-0008	CSATF - California Substance Abuse Treatment Facility
249	SATF-C-12-003	CSATF - California Substance Abuse Treatment Facility
250	SATF-C-12-004	CSATF - California Substance Abuse Treatment Facility
251	SATF-C-12-006	CSATF - California Substance Abuse Treatment Facility
252	SATF-C-12-012	CSATF - California Substance Abuse Treatment Facility
253	SATF-C-12-021	CSATF - California Substance Abuse Treatment Facility
254	SATF-C-12-022	CSATF - California Substance Abuse Treatment Facility
255	SATF-D-12-0001	CSATF - California Substance Abuse Treatment Facility
256	SATF-D-12-007	CSATF - California Substance Abuse Treatment Facility
257	SATF-D-12-009	CSATF - California Substance Abuse Treatment Facility
258	SATF-D-12-019	CSATF - California Substance Abuse Treatment Facility
259	SATF-D-12-020	CSATF - California Substance Abuse Treatment Facility
260	SATF-F-12-010	CSATF - California Substance Abuse Treatment Facility
261	SATF-F-12-023	CSATF - California Substance Abuse Treatment Facility
262	CDCR-DA1-12-001	CSP_COR - California State Prison
263	CDCR-DAI-12-001	CSP_COR - California State Prison
264	COR-03A-11-06-005	CSP_COR - California State Prison
265	COR-03A-11-10-008	CSP_COR - California State Prison

List of Lockdowns Summarized in the 2011-2012 PSR Summary Spreadsheet
(Modified Programs Initiated On Or After June 1, 2011)

	Modified Program/Program Status Number (PSN)	Institution
266	COR-03A-12-01-002	CSP_COR - California State Prison
267	COR-03A-12-02-004	CSP_COR - California State Prison
268	COR-03A-12-04-009	CSP_COR - California State Prison
269	COR-03A-12-09-012	CSP_COR - California State Prison
270	COR-03B-11-07-006	CSP_COR - California State Prison
271	COR-03B-11-11-009	CSP_COR - California State Prison
272	COR-03B-11-11-010	CSP_COR - California State Prison
273	COR-03B-12-02-003	CSP_COR - California State Prison
274	COR-03B-12-02-005	CSP_COR - California State Prison
275	COR-03B-12-02-006	CSP_COR - California State Prison
276	COR-03B-12-03-006	CSP_COR - California State Prison
277	COR-03B-12-06-010	CSP_COR - California State Prison
278	COR-04A/04B-12-03-007	CSP_COR - California State Prison
279	COR-0L1-12-08-011	CSP_COR - California State Prison
280	COR-3A-11-06-004	CSP_COR - California State Prison
281	COR-3B-11-11-011	CSP_COR - California State Prison
282	COR-4A/4B-11-09-007	CSP_COR - California State Prison
283	COR-4B-11-09-007	CSP_COR - California State Prison
284	COR-L1-11-12-012	CSP_COR - California State Prison
285	LAC-A-11-021	CSP_LAC - California State Prison
286	LAC-A-11-024	CSP_LAC - California State Prison
287	LAC-A-11-028	CSP_LAC - California State Prison
288	LAC-A-11-030	CSP_LAC - California State Prison
289	LAC-A-11-038	CSP_LAC - California State Prison
290	LAC-A-11-041	CSP_LAC - California State Prison
291	LAC-A-12-001	CSP_LAC - California State Prison
292	LAC-A-12-018	CSP_LAC - California State Prison
293	LAC-B-11-025	CSP_LAC - California State Prison
294	LAC-B-11-039	CSP_LAC - California State Prison
295	LAC-B-11-042	CSP_LAC - California State Prison
296	LAC-B-12-006	CSP_LAC - California State Prison
297	LAC-B-12-008	CSP_LAC - California State Prison
298	LAC-B-12-009	CSP_LAC - California State Prison
299	LAC-B-12-011	CSP_LAC - California State Prison
300	LAC-B-12-012	CSP_LAC - California State Prison
301	LAC-B-12-014	CSP_LAC - California State Prison
302	LAC-B-12-017	CSP_LAC - California State Prison
303	LAC-C-11-022	CSP_LAC - California State Prison
304	LAC-C-11-043	CSP_LAC - California State Prison
305	LAC-C-12-003	CSP_LAC - California State Prison
306	LAC-C-12-004	CSP_LAC - California State Prison
307	LAC-C-12-005	CSP_LAC - California State Prison
308	LAC-C-12-015	CSP_LAC - California State Prison
309	LAC-D-11-023	CSP_LAC - California State Prison
310	LAC-D-11-029	CSP_LAC - California State Prison
311	LAC-D-11-032	CSP_LAC - California State Prison
312	LAC-D-11-036	CSP_LAC - California State Prison
313	LAC-D-12-002	CSP_LAC - California State Prison
314	LAC-D-12-003	CSP_LAC - California State Prison
315	LAC-D-12-007	CSP_LAC - California State Prison
316	LAC-D-12-010	CSP_LAC - California State Prison
317	LAC-D-12-013	CSP_LAC - California State Prison
318	LAC-D-12-018	CSP_LAC - California State Prison

List of Lockdowns Summarized in the 2011-2012 PSR Summary Spreadsheet (Modified Programs Initiated On Or After June 1, 2011)

	Modified Program/Program Status Number (PSN)	Institution
319	LAC-LAC-11-026	CSP_LAC - California State Prison
320	LAC-LAC-11-031	CSP_LAC - California State Prison
321	LAC-LAC-11-035	CSP_LAC - California State Prison
322	LAC-LAC-11-037	CSP_LAC - California State Prison
323	LAC-LAC-12-009	CSP_LAC - California State Prison
324	SAC-A-11-019	CSP_SAC - California State Prison
325	SAC-B/C-11-009	CSP_SAC - California State Prison
326	SAC-B-11-012	CSP_SAC - California State Prison
327	SAC-B-11-015	CSP_SAC - California State Prison
328	SAC-B-11-016	CSP_SAC - California State Prison
329	SAC-B-12-001	CSP_SAC - California State Prison
330	SAC-B-12-003	CSP_SAC - California State Prison
331	SAC-B-12-005	CSP_SAC - California State Prison
332	SAC-B-12-006	CSP_SAC - California State Prison
333	SAC-C-11-010	CSP_SAC - California State Prison
334	SAC-C-11-011	CSP_SAC - California State Prison
335	SAC-C-11-013	CSP_SAC - California State Prison
336	SAC-C-11-014	CSP_SAC - California State Prison
337	SAC-C-11-017	CSP_SAC - California State Prison
338	SAC-C-11-018	CSP_SAC - California State Prison
339	SAC-C-12-002	CSP_SAC - California State Prison
340	SAC-C-12-004	CSP_SAC - California State Prison
341	SAC-C-12-007	CSP_SAC - California State Prison
342	(modified program in effect 9/10/11)	CSP_Solano
343	CSP-SOL-AUG-21-11-031	CSP_Solano
344	CSP-SOL-NOV-20-11-040	CSP_Solano
345	(modified program in effect 10/2/11)	CSP_Solano
346	SOL-A-12-021	CSP_Solano
347	SOL-APR-A-12-013	CSP_Solano
348	SOL-APR-B-12-010	CSP_Solano
349	SOL-APR-C-12-011	CSP_Solano
350	SOL-AUG-29-11-032	CSP_Solano
351	SOL-B-12-019	CSP_Solano
352	SOL-DEC-22-11-044	CSP_Solano
353	SOL-FEB-13-02-12-002	CSP_Solano
354	SOL-INST-12-018	CSP_Solano
355	SOL-JUL-A-06-12-017	CSP_Solano
356	SOL-JULY-04-11-027	CSP_Solano
357	SOL-JULY-06-12-016	CSP_Solano
358	SOL-JULY-11-07-026	CSP_Solano
359	SOL-JULY-23-11-028	CSP_Solano
360	SOL-JULY-25-11-029	CSP_Solano
361	SOL-JULY-28-10-028	CSP_Solano
362	SOL-JULY-31-11-030	CSP_Solano
363	SOL-JUNE-20-11-025	CSP_Solano
364	SOL-MAR-03-12-003	CSP_Solano
365	SOL-MAR-07-12-004	CSP_Solano
366	SOL-MAR-08-12-005	CSP_Solano
367	SOL-MAR-21-12-007	CSP_Solano
368	SOL-MAR-21-12-008	CSP_Solano
369	SOL-MAR-23-16-006	CSP_Solano
370	SOL-MAR-29-12-009	CSP_Solano
371	SOL-MARCH-16-12-006	CSP_Solano

List of Lockdowns Summarized in the 2011-2012 PSR Summary Spreadsheet (Modified Programs Initiated On Or After June 1, 2011)

	Modified Program/Program Status Number (PSN)	Institution
372	SOL-MAY-27-11-024	CSP_Solano
373	SOL-MAY-A-12-015	CSP_Solano
374	SOL-MAY-B-12-014	CSP_Solano
375	SOL-NOV-21-11-041	CSP_Solano
376	SOL-NOV-27-11-043	CSP_Solano
377	SOL-OCT-02-11-036	CSP_Solano
378	SOL-OCT-12-11-037	CSP_Solano
379	SOL-OCT-12-11-039	CSP_Solano
380	SOL-OCTOBER-02-11-036	CSP_Solano
381	SOL-OCTOBER-13-11-038	CSP_Solano
382	SOL-SEPTEMBER-10-11-033	CSP_Solano
383	SOL-SEPTEMBER-11-10-033	CSP_Solano
384	SOL-SEPTEMBER-11-11-034	CSP_Solano
385	SOL-SEPTEMBER-14-11-035	CSP_Solano
386	CTF-CEN-12-011	CTF - Correctional Training Facility
387	CTF-CEN-12-012	CTF - Correctional Training Facility
388	CTF-CENTRAL-11-004	CTF - Correctional Training Facility
389	CTF-CENTRAL-11-005	CTF - Correctional Training Facility
390	CTF-CENTRAL-11-006	CTF - Correctional Training Facility
391	CTF-CENTRAL-11-007	CTF - Correctional Training Facility
392	CTF-CENTRAL-11-008	CTF - Correctional Training Facility
393	CTF-CENTRAL-11-009	CTF - Correctional Training Facility
394	CTF-CENTRAL-12-001	CTF - Correctional Training Facility
395	CTF-CENTRAL-12-002	CTF - Correctional Training Facility
396	CTF-CENTRAL-12-003	CTF - Correctional Training Facility
397	CTF-CENTRAL-12-007	CTF - Correctional Training Facility
398	CTF-CENTRAL-12-009	CTF - Correctional Training Facility
399	CTF-NOR-12-010	CTF - Correctional Training Facility
400	CTF-NORTH-11-004	CTF - Correctional Training Facility
401	CTF-NORTH-11-005	CTF - Correctional Training Facility
402	CTF-NORTH-11-007	CTF - Correctional Training Facility
403	CTF-NORTH-11-06	CTF - Correctional Training Facility
404	CTF-NORTH-12-001	CTF - Correctional Training Facility
405	CTF-NORTH-12-008	CTF - Correctional Training Facility
406	CTF-SOUTH-11-004	CTF - Correctional Training Facility
407	CTF-SOUTH-11-005	CTF - Correctional Training Facility
408	CTF-SOUTH-11-006	CTF - Correctional Training Facility
409	CTF-SOUTH-11-007	CTF - Correctional Training Facility
410	CTF-SOUTH-12-001	CTF - Correctional Training Facility
411	CTF-SOUTH-12-005	CTF - Correctional Training Facility
412	CCF-CEN-11-06-0008	CVMCCF - Central Valley Modified Community Correctional Facility
413	CVP-DYD-11-0006	CVSP - Chuckawalla Valley State Prison
414	CVP-INST-11-007	CVSP - Chuckawalla Valley State Prison
415	CVP-INST-12-0001	CVSP - Chuckawalla Valley State Prison
416	DVI-CSV-12-003	DVI - Deuel Vocational Institution
417	DVI-EEC-11-06-0006	DVI - Deuel Vocational Institution
418	DVI-EEO-11-06-0007	DVI - Deuel Vocational Institution
419	DVI-EEO-11-06-0008	DVI - Deuel Vocational Institution
420	DVI-EEO-11-07-0009	DVI - Deuel Vocational Institution
421	DVI-EEO-11-07-0010	DVI - Deuel Vocational Institution
422	DVI-EEO-11-08-0011	DVI - Deuel Vocational Institution
423	DVI-EEO-11-08-0012	DVI - Deuel Vocational Institution
424	DVI-EEO-11-08-0013	DVI - Deuel Vocational Institution

List of Lockdowns Summarized in the 2011-2012 PSR Summary Spreadsheet
(Modified Programs Initiated On Or After June 1, 2011)

	Modified Program/Program Status Number (PSN)	Institution
425	DVI-EEO-11-10-0014	DVI - Deuel Vocational Institution
426	DVI-EEO-12-01-0001	DVI - Deuel Vocational Institution
427	DVI-EEO-12-01-0002	DVI - Deuel Vocational Institution
428	DVI-EEO-12-03-0002	DVI - Deuel Vocational Institution
429	DVI-OPRT-12-007	DVI - Deuel Vocational Institution
430	DVI-PROGII-12-008	DVI - Deuel Vocational Institution
431	DVI-PROGIII-12-005	DVI - Deuel Vocational Institution
432	DVI-PROGIII-12-006	DVI - Deuel Vocational Institution
433	DVI-RC1-11-013	DVI - Deuel Vocational Institution
434	DVI-RC1-12-001	DVI - Deuel Vocational Institution
435	DVI-RCI-12-002	DVI - Deuel Vocational Institution
436	MOD-06-17-11	DVMCCF - Desert View Modified Community Correctional Facility
437	FSP-11-06-011	FSP - Folsom State Prison
438	FSP-11-06-012	FSP - Folsom State Prison
439	FSP-11-07-013	FSP - Folsom State Prison
440	FSP-11-08-014	FSP - Folsom State Prison
441	FSP-11-08-015	FSP - Folsom State Prison
442	FSP-11-08-016	FSP - Folsom State Prison
443	FSP-11-09-017	FSP - Folsom State Prison
444	FSP-11-10-018	FSP - Folsom State Prison
445	FSP-11-12-019	FSP - Folsom State Prison
446	FSP-12-02-001	FSP - Folsom State Prison
447	FSP-12-03-002	FSP - Folsom State Prison
448	FSP-12-03-003	FSP - Folsom State Prison
449	FSP-CUS-12-004	FSP - Folsom State Prison
450	FSP-CUS-12-005	FSP - Folsom State Prison
451	FSP-CUS-12-006	FSP - Folsom State Prison
452	FSP-CUS-12-007	FSP - Folsom State Prison
453	FSP-CUS-12-008	FSP - Folsom State Prison
454	FSP-CUS-12-010	FSP - Folsom State Prison
455	FSP-CUS-12-011	FSP - Folsom State Prison
456	FSP-CUS-12-09-007	FSP - Folsom State Prison
457	HDP-A-11-010	HDP - High Desert State Prison
458	HDP-A-12-003	HDP - High Desert State Prison
459	HDP-A-12-006	HDP - High Desert State Prison
460	HDP-A-12-008	HDP - High Desert State Prison
461	HDP-A-12-009	HDP - High Desert State Prison
462	HDP-A-12-012	HDP - High Desert State Prison
463	HDP-B-11-011	HDP - High Desert State Prison
464	HDP-B-12-002	HDP - High Desert State Prison
465	HDP-B-12-003	HDP - High Desert State Prison
466	HDP-C-09-018	HDP - High Desert State Prison
467	HDP-C-10-013	HDP - High Desert State Prison
468	HDP-C-11-005	HDP - High Desert State Prison
469	HDP-C-11-008	HDP - High Desert State Prison
470	HDP-C-11-013	HDP - High Desert State Prison
471	HDP-C-12-001	HDP - High Desert State Prison
472	HDP-C-12-004	HDP - High Desert State Prison
473	HDP-C-12-005	HDP - High Desert State Prison
474	HDP-C-12-007	HDP - High Desert State Prison
475	HDP-D-11-004	HDP - High Desert State Prison
476	HDP-D-11-006	HDP - High Desert State Prison
477	HDP-D-11-007	HDP - High Desert State Prison

List of Lockdowns Summarized in the 2011-2012 PSR Summary Spreadsheet
(Modified Programs Initiated On Or After June 1, 2011)

	Modified Program/Program Status Number (PSN)	Institution
478	HDP-D-11-009	HDP - High Desert State Prison
479	HDP-D-11-012	HDP - High Desert State Prison
480	HDP-D-12-010	HDP - High Desert State Prison
481	HDP-D-12-013	HDP - High Desert State Prison
482	HDP-INST-12-011	HDP - High Desert State Prison
483	HDP-Z-11-014	HDP - High Desert State Prison
484	ISP-A-11-015	ISP - Ironwood State Prison
485	ISP-B-12-005	ISP - Ironwood State Prison
486	ISP-C-11-006	ISP - Ironwood State Prison
487	ISP-C-11-011	ISP - Ironwood State Prison
488	ISP-C-11-012	ISP - Ironwood State Prison
489	ISP-C-12-002	ISP - Ironwood State Prison
490	ISP-C-12-007	ISP - Ironwood State Prison
491	ISP-D-11-007	ISP - Ironwood State Prison
492	ISP-D-11-008	ISP - Ironwood State Prison
493	ISP-D-12-003	ISP - Ironwood State Prison
494	ISP-D-12-004	ISP - Ironwood State Prison
495	ISP-D-12-009	ISP - Ironwood State Prison
496	ISP-D-12-010	ISP - Ironwood State Prison
497	ISP-E-12-001	ISP - Ironwood State Prison
498	ISP-INST-11-010	ISP - Ironwood State Prison
499	ISP-INST-11-013	ISP - Ironwood State Prison
500	ISP-INST-11-014	ISP - Ironwood State Prison
501	ISP-INST-12-006	ISP - Ironwood State Prison
502	KVP-A-11-013	KVSP - Kern Valley State Prison
503	KVP-A-11-020	KVSP - Kern Valley State Prison
504	KVP-A-11-024	KVSP - Kern Valley State Prison
505	KVP-A-11-025	KVSP - Kern Valley State Prison
506	KVP-A-11-026	KVSP - Kern Valley State Prison
507	KVP-A-11-028	KVSP - Kern Valley State Prison
508	KVP-A-11-030	KVSP - Kern Valley State Prison
509	KVP-A-11-033	KVSP - Kern Valley State Prison
510	KVP-A-12-001	KVSP - Kern Valley State Prison
511	KVP-A-12-007	KVSP - Kern Valley State Prison
512	KVP-A-12-009	KVSP - Kern Valley State Prison
513	KVP-A-12-012	KVSP - Kern Valley State Prison
514	KVP-A-12-013	KVSP - Kern Valley State Prison
515	KVP-A-12-015	KVSP - Kern Valley State Prison
516	KVP-A-12-018	KVSP - Kern Valley State Prison
517	KVP-B-10-013	KVSP - Kern Valley State Prison
518	KVP-B-11-015	KVSP - Kern Valley State Prison
519	KVP-B-11-016	KVSP - Kern Valley State Prison
520	KVP-B-11-021	KVSP - Kern Valley State Prison
521	KVP-B-11-023	KVSP - Kern Valley State Prison
522	KVP-B-11-027	KVSP - Kern Valley State Prison
523	KVP-B-11-031	KVSP - Kern Valley State Prison
524	KVP-B-12-003	KVSP - Kern Valley State Prison
525	KVP-B-12-004	KVSP - Kern Valley State Prison
526	KVP-B-12-008	KVSP - Kern Valley State Prison
527	KVP-B-12-011	KVSP - Kern Valley State Prison
528	KVP-B-12-016	KVSP - Kern Valley State Prison
529	KVP-B-12-019	KVSP - Kern Valley State Prison
530	KVP-B-12-020	KVSP - Kern Valley State Prison

List of Lockdowns Summarized in the 2011-2012 PSR Summary Spreadsheet
(Modified Programs Initiated On Or After June 1, 2011)

	Modified Program/Program Status Number (PSN)	Institution
531	KVP-B-12-021	KVSP - Kern Valley State Prison
532	KVP-B-12-025	KVSP - Kern Valley State Prison
533	KVP-C-11-014	KVSP - Kern Valley State Prison
534	KVP-C-11-022	KVSP - Kern Valley State Prison
535	KVP-C-11-034	KVSP - Kern Valley State Prison
536	KVP-C-12-005	KVSP - Kern Valley State Prison
537	KVP-C-12-010	KVSP - Kern Valley State Prison
538	KVP-C-12-017	KVSP - Kern Valley State Prison
539	KVP-C-12-024	KVSP - Kern Valley State Prison
540	KVP-CO-12-002	KVSP - Kern Valley State Prison
541	KVP-D-11-017	KVSP - Kern Valley State Prison
542	KVP-D-11-018	KVSP - Kern Valley State Prison
543	KVP-D-11-019	KVSP - Kern Valley State Prison
544	KVP-D-11-029	KVSP - Kern Valley State Prison
545	KVP-D-11-032	KVSP - Kern Valley State Prison
546	KVP-D-12-006	KVSP - Kern Valley State Prison
547	KVP-D-12-014	KVSP - Kern Valley State Prison
548	KVP-D-12-022	KVSP - Kern Valley State Prison
549	KVP-D-12-023	KVSP - Kern Valley State Prison
550	KVSP-B-12-019	KVSP - Kern Valley State Prison
551	CBU-LPCC-12-01-001	LPCC - La Palma Correctional Center
552	CBU-LPCC-12-02-0003	LPCC - La Palma Correctional Center
553	CBU-LPCC-12-08-0009	LPCC - La Palma Correctional Center
554	COCF-LPCC-11-07-0025	LPCC - La Palma Correctional Center
555	COCF-LPCC-11-09-0036	LPCC - La Palma Correctional Center
556	COCF-LPCC-11-09-031	LPCC - La Palma Correctional Center
557	COCF-LPCC-11-11-0045	LPCC - La Palma Correctional Center
558	MCSP-AGYM-11-12-005	MCSP - Mule Creek State Prison
559	MCSP-FACA-11-11-004	MCSP - Mule Creek State Prison
560	MCSP-FACB-11-10-002	MCSP - Mule Creek State Prison
561	MCSP-MSF-11-10-003	MCSP - Mule Creek State Prison
562	MCSP-MSF-12-07-003	MCSP - Mule Creek State Prison
563	COCF-CCA-11-10-0043	NFCF - North Fork Correctional Facility
564	COCF-NFCF-11-06-0021	NFCF - North Fork Correctional Facility
565	COCF-NFCF-11-07-0024	NFCF - North Fork Correctional Facility
566	COCF-NFCF-11-08-0027	NFCF - North Fork Correctional Facility
567	COCF-NFCF-11-08-0028	NFCF - North Fork Correctional Facility
568	COCF-NFCF-11-09-0032	NFCF - North Fork Correctional Facility
569	COCF-NFCF-11-09-0034	NFCF - North Fork Correctional Facility
570	COCF-NFCF-11-10-0041	NFCF - North Fork Correctional Facility
571	CONF-NFCF-10-06-0021	NFCF - North Fork Correctional Facility
572	CONF-NFCF-11-06-0021	NFCF - North Fork Correctional Facility
573	NKSP-A-11-0013	NKSP - North Kern State Prison
574	NKSP-A-11-0017	NKSP - North Kern State Prison
575	NKSP-A-11-0018	NKSP - North Kern State Prison
576	NKSP-A-11-0020	NKSP - North Kern State Prison
577	NKSP-A-11-0021	NKSP - North Kern State Prison
578	NKSP-A-12-0001	NKSP - North Kern State Prison
579	NKSP-A-12-0002	NKSP - North Kern State Prison
580	NKSP-A-12-0013	NKSP - North Kern State Prison
581	NKSP-A-12-021	NKSP - North Kern State Prison
582	NKSP-B-11-0015	NKSP - North Kern State Prison
583	NKSP-B-11-0022	NKSP - North Kern State Prison

List of Lockdowns Summarized in the 2011-2012 PSR Summary Spreadsheet
(Modified Programs Initiated On Or After June 1, 2011)

	Modified Program/Program Status Number (PSN)	Institution
584	NKSP-B-11-0023	NKSP - North Kern State Prison
585	NKSP-B-11-0024	NKSP - North Kern State Prison
586	NKSP-B-11-0027	NKSP - North Kern State Prison
587	NKSP-B-11-0028	NKSP - North Kern State Prison
588	NKSP-B-11-0029	NKSP - North Kern State Prison
589	NKSP-B-11-0030	NKSP - North Kern State Prison
590	NKSP-B-11-016	NKSP - North Kern State Prison
591	NKSP-B-11-019	NKSP - North Kern State Prison
592	NKSP-B-12-0003	NKSP - North Kern State Prison
593	NKSP-B-12-0004	NKSP - North Kern State Prison
594	NKSP-B-12-0005	NKSP - North Kern State Prison
595	NKSP-B-12-0007	NKSP - North Kern State Prison
596	NKSP-B-12-0015	NKSP - North Kern State Prison
597	NKSP-B-12-008	NKSP - North Kern State Prison
598	NKSP-B-12-009	NKSP - North Kern State Prison
599	NKSP-B-12-010	NKSP - North Kern State Prison
600	NKSP-B-12-011	NKSP - North Kern State Prison
601	NKSP-B-12-012	NKSP - North Kern State Prison
602	NKSP-B-12-016	NKSP - North Kern State Prison
603	NKSP-B-12-022	NKSP - North Kern State Prison
604	NKSP-B-12-024	NKSP - North Kern State Prison
605	NKSP-B-12-025	NKSP - North Kern State Prison
606	NKSP-D-12-014	NKSP - North Kern State Prison
607	NKSP-D-12-017	NKSP - North Kern State Prison
608	NKSP-D-12-017	NKSP - North Kern State Prison
609	NKSP-D-12-018	NKSP - North Kern State Prison
610	NKSP-D-12-026	NKSP - North Kern State Prison
611	NKSP-D-12-027	NKSP - North Kern State Prison
612	NKSP-D-12-03-0006	NKSP - North Kern State Prison
613	PBP-A-11-005	PBSP - Pelican Bay State Prison
614	PBP-A-11-006	PBSP - Pelican Bay State Prison
615	PBP-A-12-001	PBSP - Pelican Bay State Prison
616	PBP-A-12-003	PBSP - Pelican Bay State Prison
617	PBP-A-12-004	PBSP - Pelican Bay State Prison
618	PBP-A-12-005	PBSP - Pelican Bay State Prison
619	PBP-A-12-006	PBSP - Pelican Bay State Prison
620	PBP-A-12-007	PBSP - Pelican Bay State Prison
621	PBP-A-12-010	PBSP - Pelican Bay State Prison
622	PBP-A-12-011	PBSP - Pelican Bay State Prison
623	PBP-B-08-004	PBSP - Pelican Bay State Prison
624	PBP-B-11-003	PBSP - Pelican Bay State Prison
625	PBP-B-12-002	PBSP - Pelican Bay State Prison
626	PBP-B-12-008	PBSP - Pelican Bay State Prison
627	PBP-CS-11-004	PBSP - Pelican Bay State Prison
628	PBP-M-11-007	PBSP - Pelican Bay State Prison
629	PBP-PSU-12-009	PBSP - Pelican Bay State Prison
630	PVSP-FAP-11-07-0255	PVSP - Pleasant Valley State Prison
631	PVSP-FAP-11-08-0273	PVSP - Pleasant Valley State Prison
632	PVSP-FAP-11-09-0304	PVSP - Pleasant Valley State Prison
633	PVSP-FBP-11-04-0132	PVSP - Pleasant Valley State Prison
634	PVSP-FBP-11-09-0314	PVSP - Pleasant Valley State Prison
635	PVSP-FBP-11-12-0390	PVSP - Pleasant Valley State Prison
636	PVSP-FBP-12-01-0007	PVSP - Pleasant Valley State Prison

List of Lockdowns Summarized in the 2011-2012 PSR Summary Spreadsheet
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	Modified Program/Program Status Number (PSN)	Institution
637	PVSP-FBP-12-02-0046	PVSP - Pleasant Valley State Prison
638	PVSP-FCP-11-09-0330	PVSP - Pleasant Valley State Prison
639	PVSP-FCP-11-12-0396	PVSP - Pleasant Valley State Prison
640	PVSP-FCP-12-005	PVSP - Pleasant Valley State Prison
641	PVSP-FCP-12-006	PVSP - Pleasant Valley State Prison
642	PVSP-FCP-12-01-0021	PVSP - Pleasant Valley State Prison
643	PVSP-FCP-12-06-004	PVSP - Pleasant Valley State Prison
644	PVSP-FDP-11-11-0372	PVSP - Pleasant Valley State Prison
645	RDJ-CEN-12-0004	RJD - Richard J. Donovan Correctional Facility
646	RJD-01-11-0006	RJD - Richard J. Donovan Correctional Facility
647	RJD-03-11-0005	RJD - Richard J. Donovan Correctional Facility
648	RJD-03-11-0007	RJD - Richard J. Donovan Correctional Facility
649	RJD-03-11-0009	RJD - Richard J. Donovan Correctional Facility
650	RJD-A-12-0007	RJD - Richard J. Donovan Correctional Facility
651	RJD-A-12-0009	RJD - Richard J. Donovan Correctional Facility
652	RJD-A-12-002	RJD - Richard J. Donovan Correctional Facility
653	RJD-C-12-0005	RJD - Richard J. Donovan Correctional Facility
654	RJD-C-12-0006	RJD - Richard J. Donovan Correctional Facility
655	RJD-C-12-0008	RJD - Richard J. Donovan Correctional Facility
656	RJD-C-12-001	RJD - Richard J. Donovan Correctional Facility
657	RJD-CEN-12-0003	RJD - Richard J. Donovan Correctional Facility
658	RJD-CEN-12-0004	RJD - Richard J. Donovan Correctional Facility
659	RJD-D-11-0010	RJD - Richard J. Donovan Correctional Facility
660	RJD-D-11-0011	RJD - Richard J. Donovan Correctional Facility
661	CBU-RRCC-12-01-0002	RRCC - Red Rock Correctional Center
662	CBU-RRCC-12-03-0004	RRCC - Red Rock Correctional Center
663	CBU-RRCC-12-07-0006	RRCC - Red Rock Correctional Center
664	COCF-CCA-11-10-0043	RRCC - Red Rock Correctional Center
665	COCF-COCF-11-09-0033	RRCC - Red Rock Correctional Center
666	COCF-RRCC-11-06-0022	RRCC - Red Rock Correctional Center
667	COCF-RRCC-11-09-0029	RRCC - Red Rock Correctional Center
668	COCF-RRCC-11-09-0030	RRCC - Red Rock Correctional Center
669	COCF-RRCC-11-09-0033	RRCC - Red Rock Correctional Center
670	COCF-RRCC-11-09-0037	RRCC - Red Rock Correctional Center
671	COCF-RRCC-11-10-0040	RRCC - Red Rock Correctional Center
672	COCF-RRCC-11-11-0044	RRCC - Red Rock Correctional Center
673	(modified program in effect 7/29/11)	SCC - Sierra Conservation Center
674	SCC-FACA-12-001	SCC - Sierra Conservation Center
675	SCC-FACA-12-003	SCC - Sierra Conservation Center
676	SCC-FACB-11-12-0179	SCC - Sierra Conservation Center
677	SCC-FACC-12-002	SCC - Sierra Conservation Center
678	SCC-FCOP-12-02-0015	SCC - Sierra Conservation Center
679	SCC-MAR-11-06-0078	SCC - Sierra Conservation Center
680	SQ-11-12-007	SQ - San Quentin State Prison
681	SQ-12-II-018	SQ - San Quentin State Prison
682	SQ-12-V-015	SQ - San Quentin State Prison
683	SQ-II-11-025	SQ - San Quentin State Prison
684	SQ-II-12-009	SQ - San Quentin State Prison
685	SQ-II-12-012	SQ - San Quentin State Prison
686	SQ-II-12-014	SQ - San Quentin State Prison
687	SQ-II-12-016	SQ - San Quentin State Prison
688	SQ-III-11-025	SQ - San Quentin State Prison
689	SQ-III-11-026	SQ - San Quentin State Prison

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	Modified Program/Program Status Number (PSN)	Institution
690	SQ-III-12-013	SQ - San Quentin State Prison
691	SQ-III-12-014	SQ - San Quentin State Prison
692	SQ-IV-11-014	SQ - San Quentin State Prison
693	SQ-IV-11-018	SQ - San Quentin State Prison
694	SQ-IV-11-020	SQ - San Quentin State Prison
695	SQ-IV-11-021	SQ - San Quentin State Prison
696	SQ-IV-11-023	SQ - San Quentin State Prison
697	SQ-IV-11-024	SQ - San Quentin State Prison
698	SQ-IV-11-027	SQ - San Quentin State Prison
699	SQ-IV-12-002	SQ - San Quentin State Prison
700	SQ-IV-12-004	SQ - San Quentin State Prison
701	SQ-IV-12-006	SQ - San Quentin State Prison
702	SQP-IV-11-016	SQ - San Quentin State Prison
703	SQP-IV-11-022	SQ - San Quentin State Prison
704	SQP-IV-12-003	SQ - San Quentin State Prison
705	SQP-IV-12-016	SQ - San Quentin State Prison
706	SQP-V-12-008	SQ - San Quentin State Prison
707	SQ-V-11-005	SQ - San Quentin State Prison
708	SQ-V-11-015	SQ - San Quentin State Prison
709	SQ-V-11-016	SQ - San Quentin State Prison
710	SQ-V-11-017	SQ - San Quentin State Prison
711	SQ-V-11-019	SQ - San Quentin State Prison
712	SQ-V-12-001	SQ - San Quentin State Prison
713	SQ-V-12-005	SQ - San Quentin State Prison
714	SQ-V-12-017	SQ - San Quentin State Prison
715	SVSP-A-11-014	SVSP - Salinas Valley State Prison
716	SVSP-CEN-11-012	SVSP - Salinas Valley State Prison
717	SVSP-CEN-12-023	SVSP - Salinas Valley State Prison
718	SVSP-FA-11-011	SVSP - Salinas Valley State Prison
719	SVSP-FA-12-003	SVSP - Salinas Valley State Prison
720	SVSP-FA-12-005	SVSP - Salinas Valley State Prison
721	SVSP-FA-12-006	SVSP - Salinas Valley State Prison
722	SVSP-FA-12-021	SVSP - Salinas Valley State Prison
723	SVSP-FA-12-025	SVSP - Salinas Valley State Prison
724	SVSP-FB-11-009	SVSP - Salinas Valley State Prison
725	SVSP-FB-11-013	SVSP - Salinas Valley State Prison
726	SVSP-FB-11-015	SVSP - Salinas Valley State Prison
727	SVSP-FB-11-018	SVSP - Salinas Valley State Prison
728	SVSP-FB-11-020	SVSP - Salinas Valley State Prison
729	SVSP-FB-12-001	SVSP - Salinas Valley State Prison
730	SVSP-FB-12-008	SVSP - Salinas Valley State Prison
731	SVSP-FB-12-009	SVSP - Salinas Valley State Prison
732	SVSP-FB-12-011	SVSP - Salinas Valley State Prison
733	SVSP-FB-12-013	SVSP - Salinas Valley State Prison
734	SVSP-FB-12-015	SVSP - Salinas Valley State Prison
735	SVSP-FB-12-016	SVSP - Salinas Valley State Prison
736	SVSP-FB-12-018	SVSP - Salinas Valley State Prison
737	SVSP-FB-12-022	SVSP - Salinas Valley State Prison
738	SVSP-FC-11-010	SVSP - Salinas Valley State Prison
739	SVSP-FC-11-016	SVSP - Salinas Valley State Prison
740	SVSP-FC-11-019	SVSP - Salinas Valley State Prison
741	SVSP-FC-12-002	SVSP - Salinas Valley State Prison
742	SVSP-FC-12-007	SVSP - Salinas Valley State Prison

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	Modified Program/Program Status Number (PSN)	Institution
743	SVSP-FC-12-010	SVSP - Salinas Valley State Prison
744	SVSP-FC-12-012	SVSP - Salinas Valley State Prison
745	SVSP-FC-12-014	SVSP - Salinas Valley State Prison
746	SVSP-FC-12-017	SVSP - Salinas Valley State Prison
747	SVSP-FC-12-020	SVSP - Salinas Valley State Prison
748	SVSP-FC-12-024	SVSP - Salinas Valley State Prison
749	SVSP-FD-11-017	SVSP - Salinas Valley State Prison
750	SVSP-FD-12-004	SVSP - Salinas Valley State Prison
751	SVSP-FD-12-018	SVSP - Salinas Valley State Prison
752	SVSP-FD-12-019	SVSP - Salinas Valley State Prison
753	CBU-TCCF-11-12-0047	TCCF - Tallahatchie County Correctional Facility
754	COCF-CCA-11-10-0043	TCCF - Tallahatchie County Correctional Facility
755	COCF-TCCF-11-06-0020	TCCF - Tallahatchie County Correctional Facility
756	COCF-TCCF-11-06-0023	TCCF - Tallahatchie County Correctional Facility
757	COCF-TCCF-11-08-0026	TCCF - Tallahatchie County Correctional Facility
758	COCF-TCCF-11-09-0035	TCCF - Tallahatchie County Correctional Facility
759	COCF-TCCF-11-09-0039	TCCF - Tallahatchie County Correctional Facility
760	COCF-TCCF-11-11-0046	TCCF - Tallahatchie County Correctional Facility
761	WSP-FAY-10-07-0322	WSP - Wasco State Prison
762	WSP-FAY-11-06-0279	WSP - Wasco State Prison
763	WSP-FAY-11-09-0457	WSP - Wasco State Prison
764	WSP-FAY-11-09-0476	WSP - Wasco State Prison
765	WSP-FAY-11-10-0507	WSP - Wasco State Prison
766	WSP-FAY-11-11-0554	WSP - Wasco State Prison
767	WSP-FAY-11-12-0554	WSP - Wasco State Prison
768	WSP-FAY-11-12-0592	WSP - Wasco State Prison
769	WSP-FAY-11-12-0598	WSP - Wasco State Prison
770	WSP-FAY-12-005	WSP - Wasco State Prison
771	WSP-FAY-12-006	WSP - Wasco State Prison
772	WSP-FAY-12-007	WSP - Wasco State Prison
773	WSP-FAY-12-010	WSP - Wasco State Prison
774	WSP-FAY-12-03-0104	WSP - Wasco State Prison
775	WSP-FBY-11-06-0297	WSP - Wasco State Prison
776	WSP-FBY-11-08-0397	WSP - Wasco State Prison
777	WSP-FBY-12-002	WSP - Wasco State Prison
778	WSP-FBY-12-003	WSP - Wasco State Prison
779	WSP-FBY-12-009	WSP - Wasco State Prison
780	WSP-FBY-12-01-0007	WSP - Wasco State Prison
781	WSP-FBY-12-016	WSP - Wasco State Prison
782	WSP-FBY-12-018	WSP - Wasco State Prison
783	WSP-FBY-12-02-0054	WSP - Wasco State Prison
784	WSP-FBY-12-02-0063	WSP - Wasco State Prison
785	WSP-FBY-12-03-0095	WSP - Wasco State Prison
786	WSP-FCY-11-10-0493	WSP - Wasco State Prison
787	WSP-FCY-12-03-0131	WSP - Wasco State Prison
788	WSP-FCY-12-08-014	WSP - Wasco State Prison
789	WSP-FDY-02-11-0338	WSP - Wasco State Prison
790	WSP-FDY-11-06-0304	WSP - Wasco State Prison
791	WSP-FDY-11-06-0314	WSP - Wasco State Prison
792	WSP-FDY-11-07-0343	WSP - Wasco State Prison
793	WSP-FDY-11-07-0361	WSP - Wasco State Prison
794	WSP-FDY-11-08-0434	WSP - Wasco State Prison
795	WSP-FDY-11-09-0473	WSP - Wasco State Prison

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	Modified Program/Program Status Number (PSN)	Institution
796	WSP-FDY-11-10-0496	WSP - Wasco State Prison
797	WSP-FDY-11-10-0512	WSP - Wasco State Prison
798	WSP-FDY-11-10-0515	WSP - Wasco State Prison
799	WSP-FDY-11-10-0529	WSP - Wasco State Prison
800	WSP-FDY-11-12-0581	WSP - Wasco State Prison
801	WSP-FDY-12-001	WSP - Wasco State Prison
802	WSP-FDY-12-004	WSP - Wasco State Prison
803	WSP-FDY-12-011	WSP - Wasco State Prison
804	WSP-FDY-12-012	WSP - Wasco State Prison
805	WSP-FDY-12-013	WSP - Wasco State Prison
806	WSP-FDY-12-015	WSP - Wasco State Prison
807	WSP-FDY-12-017	WSP - Wasco State Prison
808	WSP-FHY-11-11-0558	WSP - Wasco State Prison
809	WSP-FHY-12-008	WSP - Wasco State Prison
810	WSP-FHY-12-011	WSP - Wasco State Prison

Exhibit 80

Transcript of the Testimony of:

Jeffrey A. Beard, Ph.D.

Coleman v. Brown

March 5, 2013

Volume I

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UNITED STATES DISTRICT COURTS

EASTERN DISTRICT OF CALIFORNIA

AND NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES DISTRICT COURT COMPOSED OF THREE JUDGES

PURSUANT TO SECTION 2284, TITLE 28 UNITED STATES CODE

RALPH COLEMAN, et al.,	)	
	)	
Plaintiffs,	)	
vs.	)	No. Civ S 90-0520 LKK-JFM P
	)	
EDMUND G. BROWN, JR., et al.,	)	
	)	
Defendants.	)	
_____	)	
MARCIANO PLATA, et al.,	)	
	)	
Plaintiffs,	)	
	)	
vs.	)	No. C01-1351 TEH
	)	
EDMUND G. BROWN, JR., et al.,	)	
	)	
Defendants.	)	
_____	)	

DEPOSITION OF

JEFFREY A. BEARD, PH.D.

TUESDAY, MARCH 5, 2013, 9:02 A.M.

SACRAMENTO, CALIFORNIA

REPORTED BY: BRENDA L. MARSHALL, RPR, CSR NO. 6939

THORSNES LITIGATION SERVICES, LLC

UNITED STATES DISTRICT COURTS
EASTERN DISTRICT OF CALIFORNIA
AND NORTHERN DISTRICT OF CALIFORNIA
UNITED STATES DISTRICT COURT COMPOSED OF THREE JUDGES
PURSUANT TO SECTION 2284, TITLE 28 UNITED STATES CODE

RALPH COLEMAN, et al., Plaintiffs, vs. EDMUND G. BROWN, JR., et al., Defendants.	No. Civ S 90-0520 LKK-JFM P
MARCIANO PLATA, et al., Plaintiffs, vs. EDMUND G. BROWN, JR., et al., Defendants.	No. C01-1351 TEH

The Deposition of JEFFREY A. BEARD, PH.D., taken on behalf of the Plaintiffs, before Brenda L. Marshall, Certified Shorthand Reporter No. 6939, Registered Professional Reporter, for the State of California, commencing at 9:02 a.m., at the California Department of Corrections and Rehabilitation Headquarters, 1515 S Street, Sacramento, California.

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I N D E X

EXAMINATION By Mr. Bien 6

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EXHIBITS MARKED FOR IDENTIFICATION

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MARKED QUESTION

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that. Maybe Dr. Toche told me that. Maybe somebody else told me that. I don't know.

Q. Okay. And do you think that's reliable information?

A. I have always found that the information that I have gotten has been reliable, yes.

Q. Okay. And if you found out that, in fact, there were 200 EOP inmates today who are in places they were not getting appropriate care, would that concern you, as a secretary?

MR. MELLO: Objection. Vague. It's an incomplete hypothetical. It lacks foundation. It misstates the evidence. You can -- it's vague and ambiguous.

THE WITNESS: I would certainly want to know what the plan of action is to deal with the issue, if that kind of situation existed. Yes.

BY MR. BIEN:

Q. Okay. You've been told that there are severe, drastic staffing shortages of psychiatrists at several prisons?

MR. MELLO: Objection. Vague.

You can answer.

THE WITNESS: I don't know that --

BY MR. BIEN:

Q. I use silly words.

You've been told that there are serious staffing shortages?

MR. MELLO: Same objection.

THE WITNESS: I've been told there are staffing shortages, yes.

BY MR. BIEN:

Q. Okay. And have you ever been told, since the time you started working on the Coleman issues, that some of those staffing shortages were serious?

MR. MELLO: The word "serious"?

MR. BIEN: That's correct.

THE WITNESS: I don't know if I would use the word "serious." There have been some times when there have been some -- some pretty good staffing shortages.

I -- I don't recollect what institution, but, you know, at the end of the day, nobody ever told me somebody wasn't getting care because of those shortages. That's what would really concern me.

Certainly, we want to staff things the way they should be staffed, but if it isn't staffed accordingly, then the question is, are people getting the care?

And even when we went around again with people who do this on a regular basis, and I'm talking about the special master's clinicians, you know, nobody pointed out,

oh, we have a severe, serious psychiatric shortage, and somebody isn't getting care. People were always getting the care that they needed.

And if you want to talk about staffing, the staffing that apparently was agreed to somewhere along the way is very rich, much richer than I had in Pennsylvania, and probably much richer than many other states had.

BY MR. BIEN:

Q. So if you had the opportunity, you will cut that staffing down?

A. Absolutely not. This is what was agreed to, and so the staffing will stay the way the staffing is. I don't have any intent of cutting staffing.

I'm saying that the staffing in California, when you say, and some people have said, experts have said, that, you know, it exceeds constitutional standards, one of the areas that I would think that maybe that's the case is with staffing, whereas, you know, California has probably twice as many, or more, psychiatrists per capita than we did in Pennsylvania.

So any shortage below what it's supposed to be is concerning. That is being worked on to fill that. I know that there's -- they actually have Dr. Tarasoff working on getting a bunch of psychiatrists, and I think some of the shortages that have been noted are probably

going to be rectified. But irrespective of that fact, the care is still being provided, even at the lower levels of staffing.

Q. Okay. And you rely -- you've relied repeatedly on information provided to you by the Coleman special master -- master to make that statement?

A. I rely on it.

MR. MELLO: Misstates his testimony.

THE WITNESS: I rely on a number of things. I never got into all the things that I rely on. I rely on my direct observation, which I think I told you some of the things that I did, talked to staff, talked to inmates, and everything else; I rely on the Coleman experts; I rely on the experts that were brought in by the Attorney General's office and some of what they saw and what they stated; I rely on the fact that I have never seen in a report that people aren't getting the care because of a staffing shortage, and, you know, I don't know that anybody else has ever told me that because of a staffing shortage that there's a lack of care.

BY MR. BIEN:

Q. So why should you, as a responsible public official, allow this heavy level of staffing to continue? Isn't it a waste of money?

A. The level of staffing that is here is not -- is

are identifying mental health cases. People are properly classifying those cases, and people are putting -- moving those cases onto the higher level of care.

Now, back at the time that we did that, we still had wait lists, as you pointed out, but by July, and, actually, maybe a little bit before July of last year, the wait lists for mental health care went away. There was no wait list anymore. And -- and a proper level of -- so people were able to be identified, moved to the level of care and, in a timely manner, get the treatment that they need.

Q. Okay. And the fact that there's a wait list now, how do you explain that?

MR. MELLO: Objection. It misstates the record. Misstates his prior testimony. Lacks foundation. It's silly.

You can answer.

THE WITNESS: Could I ask you to define what wait list you're talking about?

BY MR. BIEN:

Q. There is currently a wait list for ICF level of care, and there's a wait list for APP level of care, and there's been a wait list throughout this period of time and has never been zero.

MR. MELLO: Objection. Vague.

If that's a question as to the term wait list, you can answer it.

THE WITNESS: Well, I don't know what numbers you're looking at, but the numbers that I looked at said that the wait list for ICF care basically went away, if not before July, when L wing was opened at CFF, it went away at that time.

There was still, at that time, an APP wait list of about 20. And the department tried for quite a few months, and I had some discussions with the special master relative to closing down the 20 MHCB beds that DMH operated at CMF, in converting that over to APP, that would have wiped out that wait list at that time.

We also looked at MHCBs and know there's been disagreements and arguments, but, basically, as a result of realignment, somewhere in January or February of 2012, the MHCB wait list went away. And so there's surplus MHCB space. The latest wait list space I saw on ICF is that that -- there was no space there, unless something all -- all of a sudden came on the wait list. However, there was a developing problem with the APP.

And that list, you know, on any given day, if you take a snapshot, because people can come on and off of a list, can look like you have a substantial list, but the actual list of people who don't get in within the program

guide, which is the 10 days, they think it's under 15, and that problem has already been discussed with DSH.

And just like any other constitutional system would do, if they ran into a problem, there's been discussions about perhaps opening up a second floor of L wing, specifically to address the APP problem.

Now, I don't know where exactly that is because one of the other things that's happening is we've talked about Stockton, which is coming on very quickly, and we know that most of those people in the APP wait list are sitting in MHCB so they're getting care, and they're being properly cared for while they're waiting for the APP placement.

So, yes, there is -- currently, we -- we suddenly have a wait list there and -- but that could be addressed even without Stockton by simply opening one of the two remaining empty wings at L wing at CMF.

BY MR. BIEN:

Q. And when did you have a conversation about doing that at CMF, opening another wing for APP care?

A. I had that conversation maybe a week or two ago with somebody.

Q. And what's the status?

A. I can't tell you the status right at this moment.

Q. Okay.

A. It's not open because, I mean, you can't open something overnight, but I do know that discussions have been had with DSH, relative to that issue.

Q. Okay. How many months is it going to take to open such a facility, seeming you decide to do it?

A. Since it's DSH personnel, I'm not sure how long it would take for them to get the staff up and running. I -- I wouldn't want to speculate. But, you know, we would certainly do it -- if that -- if that list doesn't go away, we would certainly want to do something as quickly as we can.

MR. MELLO: I'm going to interpose a belated objection on the basis that it calls for speculation.

BY MR. BIEN:

Q. You were informed yesterday that there was a wait list of 30 for the APP by the special master.

MR. MELLO: That lacks foundation.

BY MR. BIEN:

Q. Were you --

A. I received a copy of the memo, and I think I've already explained that to you, that the wait list is not 30. The wait list is more under 15 somewhere.

But the number that he gave is a moving target number that, at any point in time, you might have had --

for instance, since you want to speculate, we might have had 10 people today that just were put on the list to go to APP. Well, they're very likely, then, if they show up on a list, to go there. They're not over the 10-day program guide limits.

When we look at who's over the 10-day program guide limits, that's the important number, and that's more like about a 13, or something like that, the last thing that I saw.

Q. So --

A. Irrespective of what it is, it's not being ignored. And I had discussions with staff, prior to seeing the special master's memo. We were aware of it, and we were talking about it and talking to DSH about it.

Q. And were you aware of it -- of the fact that there is an APP wait list of people over -- if you want to just count the way you're counting it, which is saying people over the program guide limit, are you aware that that was -- was in existence in January of 2013, also?

A. No. January 13, I just was getting started here.

Q. Okay. And are you aware that there was a wait list of people over 30 days that the program guide transfer timeline for ICF care in January of 2013?

A. I -- again, I was just getting started, so I

can't answer that question, but the latest list that I saw, which was more in the February time frame, maybe March -- February, March time frame, did not show a wait list for ICF care or may show one inmate that was just being processed or something like that. But not -- not any -- anything like the 200 that was on a wait list back before.

Q. So you agree that there was a wait list for APP and ICF care in January of 2013 for people who were there longer than the transfer timelines?

MR. MELLO: Objection. Misstates his testimony. Lacks foundation. Assumes facts not in evidence.

You can answer.

THE WITNESS: I can't answer on January of '13. I can only answer for the latest thing that I'm aware of.

BY MR. BIEN:

Q. I'm asking you in the month of January 2013.

MR. MELLO: Asked and answered.

THE WITNESS: I can't answer the question because I was just coming on board. I was not getting those documents or talking to people about that specific issue. I've only gotten the document and talked to people about it within the past few weeks.

BY MR. BIEN:

Q. And how many people in January of 2013 were

report that was written by Lindsey Hayes was not provided because Mr. Hayes went beyond what he was asked to provide. He was asked to focus on the use of OHUs, which he believes is appropriate, if cells are in proper conditions and everything, but the original report he wrote went beyond that and touched on other issues beyond the issue at hand.

BY MR. BIEN:

Q. And who told you that explanation about why the report wasn't provided to the special master?

MR. MELLO: If you recall.

THE WITNESS: I'm not sure that I can specifically say that. It could have come from a number of different people.

BY MR. BIEN:

Q. Okay. Did you ask Mr. Rice to see the complete Lindsey Hayes report?

MR. MELLO: Vague as to time.

BY MR. BIEN:

Q. Prior to January 2013?

A. Yes.

Q. Okay. And did he provide it to you?

A. Yes.

Q. And when was that?

A. I don't recall. It would have been maybe not

Q. Okay. Were you told to keep it secret?
A. I was told it was an attorney-client privilege and, you know, that I wasn't supposed to -- since they weren't going to release it -- go talk to the special master about it. I don't think anybody would use the term "secret" or anything else. I mean, there wasn't really anything secret.
Q. Well, it wasn't being disclosed to the special master; correct?
A. Right.
MR. MELLO: Asked and answered.
BY MR. BIEN:
Q. And it wasn't being disclosed to plaintiffs' counsel?
A. Correct.
Q. And it -- and you had no idea whether it was being disclosed to the clinicians in CDCR who were responsible for suicide prevention?
MR. MELLO: Asked and answered and vague as to time.
MR. BIEN: At that time.
THE WITNESS: At that time, back in January, February, whenever I got it, I don't know who else got it within CDCR.
BY MR. BIEN:

verbally talk about." Do you recall --

A. Yes.

Q. -- the use of an audit tool?

A. Yes.

Q. What do you recall about the audit tool? I know it was sent to you in advance of the inspection.

MR. MELLO: What does he recall of the audit tool. Okay.

THE WITNESS: I remember looking over the audit tool, and I don't know if I got it in advance of the inspection or not, but I did get it, and I did have some comments that I thought could enhance the tool. There was some things that I felt maybe should be in the tool, rightfully or wrongfully, which I believe I verbally gave to the attorney, who was at the scene and talked to him about.

BY MR. BIEN:

Q. And who was that, if you recall?

A. Patrick.

Q. Are you aware that the audit tool was substantially modified, during the course of the inspections, by the experts?

MR. MELLO: Objection. Vague.

You can answer.

THE WITNESS: No.

BY MR. BIEN:

Q. Do you recall that rather than -- are you aware that rather than adding additional sections, sections were deleted from the audit tool?

A. No. I really don't know what they did with the audit tool, beyond having looked at the original and making some recommendations.

Q. You felt that their tour of CMF was disorganized?

A. I felt that in the beginning of the tour they seemed a little bit disorganized as they were trying to get their feet on the ground. However, in subsequent tours, they did a much better job, they were much more focused, and they moved along much quicker and better.

Q. What was your role on that tour?

MR. MELLO: At CMF?

MR. BIEN: Yes.

THE WITNESS: My role was to go along and watch what they were doing and also to, myself, look at things, you know, like I had been doing during the sustainable process and during the mini MHARP, to look at what was going on, look at the facilities, become more aware of what was happening.

You know, some of these facilities, I visited over 20, and some of them I visited three and four times,

CERTIFICATION OF DEPOSITION OFFICER

I, BRENDA L. MARSHALL, CSR, duly authorized to administer oaths pursuant to Section 2093(b) of the California Code of Civil Procedure, hereby certify that the witness in the foregoing deposition was by me sworn to testify to the truth, the whole truth and nothing but the truth in the within-entitled cause; that said deposition was taken at the time and place therein stated; that the testimony of said witness was thereafter transcribed by means of computer-aided transcription; that the foregoing is a full, complete and true record of said testimony; and that the witness was given an opportunity to read and correct said deposition and to subscribe the same.

I further certify that I am not of counsel or attorney for either or any of the parties in the foregoing deposition and caption named, or in any way interested in the outcome of this cause named in said caption.

_____

BRENDA L. MARSHALL

CSR No. 6939

Exhibit 81

Transcript of the Testimony of:

Tim Belavich, Ph.D.

Coleman v. Brown

February 22, 2013

Volume I

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UNITED STATES DISTRICT COURTS

EASTERN DISTRICT OF CALIFORNIA

AND NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES DISTRICT COURT

COMPOSED OF THREE JUDGES PURSUANT TO SECTION 2284,

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RALPH COLEMAN, et al.,

Plaintiffs,

-vs- No. CIV S 90-0520 LLK-JFMP

EDMUND G. BROWN, JR, et al.,

Defendants.

_____/

MARCIANO PLATA, et al.,

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-vs-

No. C01-1351 TEH

EDMUND G. BROWN, JR., et al.,

Defendants.

_____/

DEPOSITION OF TIM BELAVICH, PH.D.

UNITED STATES DISTRICT COURTS

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, et al.,

Plaintiffs,

-vs- No. CIV S 90-0520 LLK-JFM

EDMUND G. BROWN, JR, et al.,

Defendants.

_____/

DEPOSITION OF TIM BELAVICH, PH.D.

DATE: February 22, 2013

TIME: 9:01 a.m.

LOCATION: 315 Montgomery Street, 10th Floor
San Francisco, CA

REPORTED BY: Joanna Broadwell
Certified Shorthand Reporter
License No. 10959

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(916)324-5345

Also appearing: Heather McCray and Margot Mendelson.

--o0o--

told you either in person or over the telephone about Mr. Hayes' contract?

A. Yes.

Q. Good. What did she tell you?

A. She -- she did not tell me that we would not be using his contract. She told me that she could not get any movement on whether we were using his contract.

Q. She could not get any movement from whom?

A. I don't know.

Q. What does that mean to you, not getting any movement?

A. To me it meant that there was -- there were individuals above her who were making the decision as to whether or not we would use the contract.

Q. And did she convey to you why those individuals above her had decided not to use the contract?

MS. VOROUS: Objection. Misstates his testimony. He's saying she'd get movement on his contract, not that they wouldn't use his contract.

You can answer the question.

THE DEPONENT: I've forgotten the question. I'm sorry.

BY MR. GALVAN

Q. Did she tell you why she couldn't get movement

Q. I'm sorry. On the fourth bullet point you'll see that the document starts on Page 12, third paragraph from the bottom. So let's turn to Page 12 of Exhibit 5. And in Exhibit 4, the document says on Page 12, 3rd paragraph from the bottom, reads, quote, "When an inmate patient verbalizes suicidal ideation without other signs and symptoms of increased risk of suicide, the mental health clinician is responsible for evaluation any contributing environmental stressors, and communicating with custody staff and supervisors regarding any potentially solvable custody issues," period, end quote.

"This paragraph is seemingly referring to inmates who are using the threat of suicide to gain cell relocation, i.e., are viewed as manipulative and/or malingering. My concern is that inmates who present as manipulative and/or malingering can still be suicidal and require placement on suicide observation status. I would recommend that this paragraph be reviewed again and clarified if necessary."

Before today, were you made aware of this recommendation?

A. I don't know that -- if I was.

Q. Is it possible that you -- that today is the first time you became aware of this recommendation?

A. I don't believe so.
Q. It's your belief that you were made aware of this recommendation earlier than today?
A. Yes, but I can't say with certainty.
Q. Do you recall doing anything in response to being made aware of this recommendation?
A. No.
Q. As you look at this here today, do you have an opinion as to whether this recommendation is correct?
MS. VOROUS: Objection. Lacks foundation. Argumentative.
THE DEPONENT: I wouldn't form an opinion without input from my SMEs on this.
BY MR. GALVAN:
Q. By "SMEs," you mean subject matter experts?
A. I'm sorry, yes. Capital S, capital M, capital E. Yes, subject matter expert.
Q. Do you recall ever asking your subject matter experts for their views on this?
MS. VOROUS: Objection. Asked and answered.
THE DEPONENT: I don't recall asking them, but I don't know if we've had conversations on this.
BY MR. GALVAN
Q. Do you recall your subject matter experts ever offering you their opinions or feedback on this

suicidal ideation or threats, right?
A. That's correct.
Q. So his recommendation was treat the OHU discharges the same as the crisis bed discharges if the person was in for suicide risk assessment, right?
A. I can't say that for sure based on the language of the program guide.
Q. Okay. Were you ever made aware before today of this recommendation regarding clinical follow-up after OHU discharge?
A. I don't know if I was.
Q. Do you have an opinion about this recommendation?
A. Not without receiving input from my SMEs.
Q. Have you ever asked the subject matter experts for that input?
A. I don't know that I have.
Q. Looking at Exhibit 4, Bates-number 70, which is Page 6 of the exhibit, the consultant wrote in the first full bullet point on the page, "On Page 19 under both Discharge or Return and MHCB discharge, I would recommend deleting the word, quote, imminent, end quote, from the paragraphs, as previously detailed about the lack of imminent or immediate danger of self-harm should not be the only criteria for removal

from suicide observation status."

And going back to -- looking at Exhibit 5, the program guides chapter, the language he's talking about is in the bottom of Page 19 under MHCB discharge, "A psychiatrist or licensed psychologist in consultation with the IDDT shall write the order to discontinue an inmate patient from suicide precaution or suicide watch when the inmate is no longer in imminent danger of self-harm."

Were you ever made aware of this recommendation to change the program guide?

A. I don't recall if I was.

Q. Do you have any opinion about this recommendation as you read it today?

A. Not without consulting with my SMEs.

Q. Have you ever asked your subject matter experts for such a consultation?

MS. VOROUS: Objection. Argumentative. Lacks foundation.

THE DEPONENT: I don't think I have.

BY MR. GALVAN

Q. Sticking with Exhibit 4, same page, Bates-number 70, the next paragraph refers to the program guide chapter, Exhibit 5, Page 20. And looking first at the program guide chapter, Page 20, last

of Exhibit 4, at the bottom of the page that, quote, "The conditions within the OHU were quite bad with poor lighting, visibility and sanitation problems. I had difficulty observing inmates through the cell windows. Many cells contained tile floors with pieces of tile previously removed that could easily be utilized for self-injurious behavior."

A. Again, similar to my previous response, I was made aware of issues like these, but I can't say that there was any particular place connected with it.

Q. And when were you made aware of issues like these?

A. I believe it was the spring of 2012.

Q. Did you ask which prisons had these problems?

A. I don't know if I asked which prisons had the problems, but I also don't know -- I can't recall that someone didn't say at place "X," this is a problem. I can't recall the conversations.

Q. And these conversations in spring of 2012, this is after you became deputy director?

A. Yes. Yes.

Q. Did you direct the people who were giving you the information to do anything about it?

A. I believe so.

Q. What did you tell them to do?

A. I recall instructing my regionals who I had in place at that time to tour their facilities and to inspect the OHU cells.

Q. And did they report back to you on those tours?

A. I didn't instruct them to report back to me.

Q. Go ahead.

A. Because we had them work with one of my SMEs to work on a directive to the field on cleanliness and maintenance of OHU cells.

Q. And was that a directive issue?

A. Yes.

Q. Going back to Exhibit 4, Bates-number 74, Page 10, still on the big -- the paragraph that continues on the top of the page, about DVI, around the middle of the paragraph -- actually, I'm sorry. It's the first -- the second complete sentence on that page. He says, "Conditions in the OHU overflow were worse and quite deplorable. All of the inmates in this unit were on constant one-to-one observation with one certified nursing assistant, CNA, assigned to each inmate at significant expense to the CDCR due to the hazardous conditions in each cell. The OHU overflow is situated in the same area as the OSU. Upon my entrance into the unit, there was a foul odor apparently left from the

to see the process.

Q. What process --

A. I'm not sure what this is hanging on the door handle.

Q. What process would make this appropriate?

A. I can't say with certainty without consulting my SMEs and the program guide.

Q. You visited this cell, right?

A. No.

Q. You visited the ZZ cells in Sacramento?

A. Yes. I saw the ZZ cells.

Q. And when you saw them, were you aware that they were being used for suicide observation?

MS. VOROUS: Objection. Lacks foundation. Assumes facts not in evidence.

THE DEPONENT: When I saw them, they were not being used for suicide observation.

BY MR. GALVAN

Q. When did you see them?

A. I want to say late October of 2012.

Q. And when you say they were not being used for suicide observation, you mean right at that moment when you saw them?

A. Yes.

Q. Is it your testimony that these are not used

MR. GALVAN: So I'll ask the court reporter please to read it back.

(The record was read back by the reporter as follows:)

"Q. Right. So that's the question. With the information you have now, in other words, there's no information available. It's just Dr. Belavich here. With all of the information you've accumulated in your lifetime up until now and nothing else is coming, okay, do you have a professional opinion now, this moment, whether the Mental Health program at Salinas Valley State Prison is actually operating adequately with the level of psychiatric vacancies that it's had from May 2012 until now?"

THE DEPONENT: I can't say with certainty. I believe they're getting the job done with the resources they have.

BY MR. GALVAN

Q. Okay. You can't say with certainty -- trying to get a sense of what you can't say with certainty. You can't say with certainty whether you have an opinion, or you can't say with certainty what your

opinion is?

A. Yes, I have an opinion, and my opinion is that they are getting the job done with the resources they currently have.

Q. Okay. So if they are getting the job done with the resources they currently have, why are you making an effort to get more psychiatrists?

A. Because I believe it can be better.

Q. But it's your opinion that it is adequate now with 5.5 psychiatrists?

A. I believe they're getting the job done for now with what they have.

Q. So it's your opinion that this level of staffing is adequate?

A. No. That's not what I said.

Q. It's your opinion that this level of staffing is adequate to get the job done?

A. No.

Q. Okay.

A. There are times when we are short-staffed where people do more than they usually do, and people have to step up. And I'm assuming that's what's going on for the psychiatry staff at Salinas Valley.

Q. Okay. So any requests, then, to add psychiatrists above what they have now would be extra?

MS. VOROUS: Objection. Misstates his testimony.

BY MR. GALVAN

Q. We're in a fiscal crisis. The State is in a fiscal crisis. You've testified that with the psychiatrists they have now at Salinas Valley, if everybody steps up, which you assume they're doing, they can get the job done adequately. So therefore, it's your testimony, isn't it, that any additional hiring there is extra?

MS. VOROUS: Objection. Misstates his testimony.

THE DEPONENT: Yeah. I think you've come up with quite a yarn there.

BY MR. GALVAN

Q. So you do need additional hiring there at Salinas Valley?

A. Yes. I'd like to hire more.

Q. I'm not asking if you'd like to. I know you'd like to. I'd like to hire more too, but is it necessary to hire more? It is a necessary expenditure of the State's short funds?

MS. VOROUS: Objection. Argumentative. Lacks foundation. Ambiguous.

BY MR. GALVAN

Q. Do you agree that the State is in a fiscal crisis?
A. Yes.
Q. Given that you agree that the State is in a fiscal crisis, would you recommend hiring psychiatrists if it weren't necessary?
A. If it weren't necessary?
Q. Yes, if it weren't necessary, would you recommend hiring?
A. I don't think that I would have an opinion on that. I would hire the psychiatrists that I'm allotted.
Q. Even if they weren't necessary, you would hire them?
A. If there was a staffing model that says they're needed, then I would trust the staffing model.
Q. Even if you knew it was just waste? You would still hire them?
MS. VOROUS: Objection. Argumentative.
THE DEPONENT: Potentially, yes. I would follow my direction.
BY MR. GALVAN
Q. Sir, are you aware of -- moving from psychiatry to recreational therapists -- first of all, recreational therapists. Do recreational therapists

medication 10 percent of the time is absolutely not. But an issue having to do with, you know, whether, you know, a chrono was appropriately dated or stamped, I don't know that that always has to hit at 90 percent.

Q. You mentioned the documentation that is required for the special master's institutional tours, I think. Were you referring to the institutional tour documentation?

A. Well, no. Just all of the documentation, because there is institutional documentation as well as there are monthly reports that we turn over. But there are also regular requests that we get on other issues that we have quick turnaround and we try to comply with.

Q. But the institutional documentation is one of them, one of the issues?

A. Yes.

Q. And in fact, you attached, I think as Exhibit 8 to your declaration, a sample institutional document request. There's no tabs on these, so it's a little tricky to find Exhibit 8.

A. I got it.

Q. You got it. Look at that. So once -- if you got rid of the special master and this reporting requirement, I'm just looking at the things that are

audited here, and I just want to get a sense of what you would stop doing. So for example, would you stop auditing medication management? Would you stop having the institutions produce documents about medication management?

A. No. I believe we have a process in place through MAPIT, M-A-P-I-T, all caps, that monitors that.

Q. Okay. So you would keep doing that?

A. Or something similar to that.

Q. Would you stop auditing DMH referrals?

A. In what way?

Q. Would you stop requiring the institutions to produce reports to headquarters in the regular course of business on their DMH -- I guess it's now DSH -- referrals?

A. No. I believe that's part of our sustainable process that we've instituted and worked with the special master on, and I believe it's quite successful. So I believe that process makes sense.

Q. So in the post Coleman world, you would continue doing that?

A. Yes.

Q. Would you stop auditing Mental Health Crisis Bed referrals?

A. I don't believe so. I'm not sure. In what

way are you asking that?

Q. Would you have the institutions produce to headquarters regular documents regarding the numbers of persons referred to crisis beds, their length of stay, their waiting times, those kinds of figures?

A. I already capture all that in headquarters.

Q. And you capture that institution by institution, right?

A. Yes.

Q. And that's not particularly burdensome for you, is it?

A. It's not "not burdensome." Sorry for being double negative.

Q. You would do it regardless of the Coleman?

A. I believe it's important, yes.

Q. And would you stop auditing in the post Coleman -- once there was no special master requirement, the use of mental -- I'm sorry. Mental Health outpatient housing units and other outpatient housing units?

A. No.

Q. Would you stop auditing use of alternative housing?

A. No.

Q. Would you stop auditing the length of stay of

EOP patients in administrative segregation?

A. No.

Q. Would you stop auditing the question of whether you have enough intake cells for recent arrivals in segregation?

MS. VOROUS: Objection. Lacks foundation.

THE DEPONENT: I don't know if I would or not.

BY MR. GALVAN

Q. It's one of -- okay. What would be the considerations? What -- how would you make that decision?

A. I would need to gather my stakeholders and ask, you know, pros and cons of monitoring, the burden of monitoring this or auditing this, you know, whether it is an issue, whether it's a resolved issue.

Q. Would you stop auditing or monitoring the meetings of the suicide prevention review and -- I can't remember the rest of the acronym -- FIT, the SPR FIT committees at the institutions?

A. I would change the auditing of those.

Q. How would you change it?

A. I don't -- I wouldn't -- I don't know that I would make it so -- such a burden that every member is at every meeting over a time period. For example, I know that's monitored. I think that it can be

A. I would probably monitor that.
Q. Would you monitor -- or would you have the institutions report to headquarters on their ability to provide group therapy as -- to schedule a certain number of hours of group sessions?
A. Yes, but I would do it differently.
Q. Would you have the institutions monitor or report to you on the time it takes to transfer someone to the psychiatric services unit?
MS. VOROUS: Objection. Lacks foundation.
THE DEPONENT: Yes.
BY MR. GALVAN
Q. Would you have the institutions report to you -- report to headquarters on the time it takes to transfer someone to an EOP administrative segregation hub?
A. I'm sorry. What?
Q. If you didn't have the Coleman special master monitoring, would you still require the institutions to report to headquarters on EOP and ASU hubs, including length of stay, time to transfer in and out?
MS. VOROUS: Objection. Vague and ambiguous. Lacks foundation.
THE DEPONENT: I think I would have them monitor that.

Q. Including these cages, correct?
A. If this is what the institution has designated.
Q. So it's your testimony that in order to operate your system with the resources you've been given, you still need to use these cages, correct?
MS. VOROUS: Objection. Misstates his testimony. Argumentative.
THE DEPONENT: Yeah.
BY MR. GALVAN
Q. I'm going to ask you another question. Can you walk out of this deposition today, pick up the phone and order someone to stop using these cages or not?
A. I can walk out of here, make a phone call, and those two cages would not be used. Yes.
Q. And why is it that you don't do that? Why isn't that the next thing you're going to do when you leave here today?
MS. VOROUS: Objection. Lack of foundation. Incomplete hypothetical. Speculative.
THE DEPONENT: I can't say that's not the thing I'm going to do when I walk out of here.
(Off the record from 5:00 p.m. to 5:12 p.m.)

CERTIFICATION OF DEPOSITION OFFICER

I, JOANNA BROADWELL, duly authorized to administer oaths pursuant to Section 2093 (b) of the California Code of Civil Procedure, hereby certify that the witness in the foregoing deposition was by me sworn to testify to the truth, the whole truth, and nothing but the truth in the within-entitled cause; that said deposition was taken at the time and place therein stated; that the testimony of said witness was thereafter transcribed by means of computer-aided transcription; that the foregoing is a full, complete and true record of said testimony; and that the witness was given an opportunity to read and correct said deposition and to subscribe the same.

I further certify that I am not of counsel or attorney for either or any of the parties in the foregoing deposition and caption named, or in any way interested in the outcome of this cause named in said caption.

_____

JOANNA BROADWELL

CSR 10959

Exhibit 82

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Transcript of the Testimony of:

John Brim, M.D.

Coleman v. Brown

March 1, 2013

Volume I

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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, ET AL., Plaintiffs, vs. EDMUND G. BROWN, JR., ET AL., Defendants.	CASE NO.: S 90-0520 LKK-JFM

DEPOSITION OF

JOHN BRIM, M.D.

FRIDAY, MARCH 1, 2013, 9:28 A.M.

SAN FRANCISCO, CALIFORNIA

REPORTED BY: MEGAN F. ALVAREZ, RPR, CSR NO. 12470

THORSNES LITIGATION SERVICES, LLC

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, ET AL., Plaintiffs, vs. EDMUND G. BROWN, JR., ET AL., Defendants.	CASE NO.: S 90-0520 LKK-JFM

The Deposition of JOHN BRIM, M.D., taken on behalf of the Plaintiffs, before Megan F. Alvarez, Certified Shorthand Reporter No. 12470, Registered Professional Reporter, for the State of California, commencing at 9:28 a.m., Friday, March 1, 2013, at Rosen, Bien, Galvan & Grunfeld, LLP, 315 Montgomery Street, 10th Floor, San Francisco, California.

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The feeling of the staff was that it was appropriate to inform the union of what was going on since this impacted our working conditions.

Q. Okay. And who is Katherine Warburton?

A. She is the chief psychiatrist for the Department of State Hospitals.

Q. Okay. And had you ever interacted with her directly?

A. No.

Q. But you understood she was -- what did you understand her position to be?

A. Well, I understand her position to be in chain of command for the psychiatrists and the highest person in that chain who is a psychiatrist.

Q. Were your -- when you wrote this letter in January of 2013 --

MS. GOSLING: Objection. Misstates his testimony. He did not write the letter by himself. I assume you're saying "you" collectively, meaning the signatories.

MR. BIEN: I agree.

BY MR. BIEN:

Q. I was referring to you in the plural.

A. Yes, understand.

Q. Okay. When your group prepared this letter,

was your program relatively full of patients?

A. Yes.

Q. Okay. And was there still pressure on -- there's still new patients arriving? Are there new admissions arriving?

A. Yes.

Q. I note on the top of the second page, in bold, the letter states: "But we need to inform you that we will be working in a state of protest regarding our case load and the rate of admissions. We are also extremely concerned about further attrition of psychiatrists which seems very likely considering the present workload and conditions."

Did you discuss -- let me just ask: Why is there a reference to admissions as being a factor?

MR. RUSSELL: Objection. Vague and ambiguous.

THE WITNESS: My understanding is that there was a general feeling -- and I -- I felt this way -- that we were under pressure from administration to move the old people out -- the old patients out and take in new patients so as to keep our waiting list down.

And many of the psychiatrists -- well, I would say all -- felt that this was resulting in shorter stay for the patients than historically had been the case. And they felt that it was getting to the point that

people were not staying in all cases at least as long as they needed to. There was pressure from administration to get them out quickly so that new people could be brought in.

That does impact the workload, because when a new person comes in, there's quite a bit of work to do on the part of the psychiatrist, research assessment, so on. So as the number of admissions and discharges go up, that means more work for the psychiatrist.

BY MR. BIEN:

Q. You suggest in the last paragraph that one way to alleviate some of the pressure on the Salinas Valley psychiatric program would be to reduce the flow of new admissions; is that correct?

A. Correct.

Q. And did you have any response from the administration to that suggestion?

A. Not aware of any.

Q. To your knowledge, are there still new admissions arriving at Salinas Valley psychiatric program?

A. Yes.

Q. In the first paragraph on the first page, you refer to "a third psychiatrist scheduled to leave within the past six weeks."

You mentioned two that were leaving by retirement, Drs. Weinstein and Sial?

A. Yes.

Q. Who was the third?

A. Dr. Gaines, Gayle Gaines.

Q. Okay. And that's someone who signed this letter?

A. Yes.

Q. Okay. And what was happening with Dr. Gaines?

A. She had accepted a job with the Department of Corrections and was scheduled to leave us the end of the January.

Q. There's also a reference here to -- on the first page, the third paragraph, to the Stockton program.

And that -- I'm looking at the third paragraph down. It says: "When administration visited our facility recently to present the Stockton program."

Did you have a presentation to the staff at Salinas Valley psychiatric program by Department of State Hospital staff about the new program?

A. Yes, we did.

Q. Approximately when was that?

A. I believe late December, early January.

Q. There's also a reference here to -- I'm

turning to the last paragraph on the second page. "We understand that since SVPP is being downsized, then it may be difficult to attract new psychiatrists."

Had you understood -- what were you told about -- when were you first told that the Stockton program was opening? Was it in this presentation in late December, or had you heard about that earlier?

A. No, no. It had been in the works for a least a couple of years.

Q. When do you first recall being informed that the SVPP program was going to be downsized?

A. I believe I found that out in the early part of 2012. I was not at SVPP at the time, but I had contact with some people that were there, and they mentioned that they had been informed that it would be downsized --

Q. Okay.

A. -- quite radically.

Q. And there's a reference in this, I believe the same last paragraph, to the -- preparing to close C and D yards.

Was that what you were informed?

A. Yes.

Q. So the programs on C and D yards would be closed down, but the two 64-bed units would remain

operating?

A. That's my understanding.

Q. Okay. Were you given at any time a schedule for when this closure would take place?

A. Yes.

Q. And when were you told that?

A. We were told at the presentation by the Stockton folks that they would begin taking transfers from our program in later part of July 2013.

Q. And did you understand what the pace of the transition -- what did you understand from that presentation about how the Salinas Valley psychiatric program would be impacted by this transfer of patients?

A. Well, we weren't given a firm schedule for how fast the transfer would take place. Staff was told that they would all have an opportunity to apply for positions with the Stockton program.

Those are the two things that stand out in my mind from that meeting, yeah.

Q. Did you understand that at some point in 2013 you were going to have to find another job either at Stockton or somewhere else?

A. Well, I don't think it was quite that clear because there obviously would be 128 patients, I think, left at Salinas Valley psych program, so they would

require some staff. And it wasn't clear, you know, who might have an opportunity to stay, who might have to go. That was an assumption that would be probably on a seniority basis, but I wasn't really too involved in that because I'm a contractor. I come and go, you know, pretty easily.

Q. Okay. Back on the first page there's a reference to other mental health disciplines such as social work, psychology, and rehab therapy.

Were you aware of the staffing levels in these other disciplines at Salinas Valley?

MS. GOSLING: Vague and ambiguous as to time. I'm assuming when they wrote this letter.

MR. BIEN: Yeah, in January 2013.

THE WITNESS: Well, I knew from my own experience on the D yard where I worked that the disciplines were short of staff. And I understood that to be generally the case in all of the Salinas Valley psych program units.

BY MR. BIEN:

Q. Okay. And did you -- in your personal opinion did you feel that the shortage of other disciplines in psychiatry was greater than it had been in times in the past as of January 2013?

A. It was certainly.

MR. RUSSELL: Objection. Vague and ambiguous. Lacks foundation.

THE WITNESS: It was certainly greater than two years I had spent in the program from 2009 to 211.

BY MR. BIEN:

Q. Did any of the other staff in the other disciplines express to you personally their concern about the level of staffing in the D5/D6 unit where you're working?

A. Yes.

Q. And we're talking about the period since you came back to Salinas Valley?

A. Correct.

Q. And what was said to you and by whom?

If you want to tell me just the person's profession, that's fine with me. I don't care about their name.

A. Okay. Okay. I can do that.

The social workers in particular were concerned because they were stretched so thin. It involved having to cover more people than they felt comfortable covering, having to, in some cases, cover more than one case load.

Q. What do you mean by "more than one case load"?

A. One social worker would have to try to cover

another case load that ordinarily would have its own social worker assigned to it.

Q. Did you discuss with a social worker that spoke with you any strategies to make sure that patient safety was protected in this kind of environment of short staffing?

A. The only strategy that I was aware of that we could pursue was to do the best we could with what we had.

Q. Okay.

A. And, of course, to keep administration informed of the need for more manpower.

Q. Okay. Are you aware of any other disciplines who, through their unions or groups, expressed concerns about the staffing level at Salinas Valley psychiatric program in December or January?

A. Yes. I know that nursing was very short. And I was told by nurses that they were making their concern felt to administration.

The MTA staff also was short, and they also were expressing to me concern about the vacancies in their ranks.

Q. Anyone tell you that there was a hiring freeze that was limiting the ability of the institution to fill vacant positions?

out that in his experience it was feasible for the psychiatrists to rely on information from these other staff members about the patients rather than actually seeing the patients in order to make decisions about their treatment.

It was suggested to him this would not be proper because it would be like operating on hearsay and we needed to have time and opportunity to interact with the patients ourselves in order to make responsible decisions about their treatment.

Q. Did you discuss with him reducing new admissions to the unit to reduce the pressure?

A. Yes.

Q. Okay. And what did you say to him and he say to you about that?

A. Well, it was pointed out that the more admissions and discharges you have, the higher the workload because a lot of the work is sort of front-loaded and end-loaded on these patients.

He, you know, responded we had a responsibility to provide our services promptly to those in need, and we did have a waiting list although it was relatively short at that point in time.

That was extent of the discussion on that.

Q. Did he tell you how many people were on the

waiting list at that time?
A. I believe there was a reference to the number 20 or so.
Q. Okay. Did he express to you that he was unable to restrict admissions because of that waiting list?
A. There was discussion -- a statement on his part that the court wanted people to be expeditiously admitted to our facility.
Q. Did he tell you that the governor represented that there was no wait list in filings with the federal court in January of 2013?
A. No.
(Plaintiffs' Exhibit 3 was marked for identification.)
BY MR. BIEN:
Q. Let me show you what's been marked as Exhibit 3 to your deposition. This is going to be an exhibit that's under seal because it's a peer review kind of document and it's a suicide report concerning an inmate who died of suicide at Salinas Valley psychiatric program in late November of 2012.
He actually died in a hospital on December 4th of 2012?
A. Right.

issue again because I had raised it many other occasions and I felt it would be pointless to raise it again.

Q. In your opinion, was there sufficient staffing in D5/D6 since November of 2012 to allow psychiatrists who would insist to have all their contacts in confidential spaces outside of cells? Is there sufficient staffing to provide that for psychiatrists and their patients?

MR. RUSSELL: Objection. Vague and ambiguous. Lacks foundation. Calls for speculation.

THE WITNESS: No.

BY MR. BIEN:

Q. Okay. Patients have raised with us, Doctor, an issue which we didn't really understand. We get letters from prisoners all the time, and some of them are -- seem a little bit -- some of them are seriously mentally ill and we're not always sure of reality.

But we've heard from our clients that there's insufficient laundry service, soap, clothing being provided to them at the Salinas Valley psychiatric program in the last few months.

Have you heard complaints like that?

A. Yes.

Q. Have you investigated them?

A. Yes.

Q. What can you tell me about them?
A. The DSH staff that I have talked to who had personal knowledge of this confirm that there has been a severe shortage of clean clothes, bedding, coats. I believe they've made every possible efforts to address this. They place the blame on CDCR, which has the responsibility for their laundry.
Q. When you say "they," is the staff, the DSH staff that you spoke to about the subject?
A. Yes.
Q. Okay. We've also heard complaints about food service, the volume of food, amount of food, quality of food. Have you heard complaints about food service also from patients?
A. Yes.
Q. And have you investigated them?
A. Informally.
Q. And what have you heard?
A. Well, I've inspected the meals and I've been around at feeding time. I've observed the distribution of the meals, the timing. I haven't found any substance to the inmates' complaint about the food. I mean, you know, it's a subjective thing how good it is, but it's provided. It appears to be hygienic. And I know it's under supervision of a registered dietician, so I assume

these were downloaded yesterday from the Department of State Hospital Web site.

MS. GOSLING: Do you want the witness to look through them?

MR. BIEN: Yeah. Just take a...

(Witness reviewing document.)

BY MR. BIEN:

Q. Dr. Brim, this isn't a color chart, which is appears on the computer when I looked at it, but are you able to discern the SVPP line on these various charts? Look at the last two charts, staff injuries and patient injuries.

A. Yes, I can discern that.

Q. Okay. Have you ever had discussions during your work at Salinas Valley psychiatric program about the level of staff and patient injuries?

MR. RUSSELL: Objection. Vague and ambiguous. Overly broad.

BY MR. BIEN:

Q. Since November of 2012?

A. Yes.

Q. And can you tell me about any of those discussions?

A. I have noticed an increase in staff assaults -- assaults by patients on staff -- over the

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last few months. I've asked my colleagues if they were seeing the same sort of thing and, they agree that it seems to be increasing.

Q. Okay. And just for the record, these charts cover the period January through September of 2012.

Is it -- has it been your experience that -- is it your perception that staff injuries have been higher at Salinas Valley than in previous times that you've worked at Salinas Valley?

A. Yes.

MR. RUSSELL: Objection. Vague and ambiguous. Lacks foundation.

MS. GOSLING: Join.

BY MR. BIEN:

Q. In any discussions with staff, did anyone discuss with you perhaps the level of staff injuries reflects understaffing in the Salinas Valley psychiatric program?

MR. RUSSELL: Objection. Vague and ambiguous. Overly broad.

THE WITNESS: Yes.

BY MR. BIEN:

Q. Okay. And can you describe that conversation and when that took place?

A. No one conversation stands out in my mind; but

over the last couple of months when the psychiatrists have gotten together in their meetings, there has been ongoing discussion of the increasing dangerousness of the situation, and a number of different psychiatrists have touched on the fact that the injuries appear to be up, relate that to staff not having the time they once had to maintain contact with the patients, monitor how they're doing, keep us informed so that we can do what we can with their medication to help stabilize them.

And we ourselves have all, I think, expressed concern that we're not able to take the time to have the number of face-to-face contacts that we really would like to have to feel comfortable that we are monitoring the patients in the -- a safe and responsible way.

Q. Administration ever inform you that Salinas Valley psychiatric program in 2012 had a higher level of staff and patient injuries than all other state hospital programs?

A. No. Not to my knowledge.

Q. Did Secretary Allenby discuss with you his concern that -- of the high level of staff and patient injuries that were occurring at Salinas Valley psychiatric program at his meeting this week?

MR. RUSSELL: Objection. Vague and ambiguous. Assumes facts not in evidence.

THE WITNESS: Not as I recall.
BY MR. BIEN:
Q. You assume that the secretary of the Department of State Hospitals is aware of the level of staff injuries and patient injuries in his facilities?
MS. GOSLING: Objection. Calls for speculation. Don't assume anything.
BY MR. BIEN:
Q. You can answer the question.
MS. GOSLING: Do you know?
THE WITNESS: I would assume that, yes.
BY MR. BIEN:
Q. That's part of his job, isn't it?
A. I would assume so.
MR. BIEN: Why don't we take lunch now?

(Whereupon the luncheon recess was taken at 12:09 p.m.)

--o0o--

A. Well, we have computers that access the system on our units; we simply don't have the log-in and the access password to get at it.

Q. Have you ever asked to get the log-in and access password?

A. Yes.

Q. And who did you ask?

A. Well, we've requested through Dr. Troncoso, when he was senior psychiatrist, acting. And according to minutes I've seen of the psych meetings before I rejoined the program in November through the previous senior psychiatrist, Dr. Safi, and those individuals have passed on the request to their administrative supervisors.

Q. Okay. And as of this week, you still did not have permission to use the EUHR?

A. We still don't have access, correct.

Q. How do you feel that would benefit your ability to provide psychiatric care for your patients?

A. Well, I think it's dangerous not to have access to the old records because they're potentially relevant things in the old records that are not necessarily included in the referral packet. It's just not up to community standards to not have access to relevant recent medical education.

Q. Are the same computers available on -- in the C5/C6 and D5/D6 as are in the T units, to your knowledge? In other words, if you got the password, could you use it in both places?

A. Yes.

Q. Okay. Our expert was informed during his tour of Salinas Valley psychiatric program in late January of 2013, just a few weeks ago -- a month ago now, that an hour -- only an hour or so of treatment was being provided for patients due to staff and space restrictions.

Is that consistent with your understanding of what was going on in the program as recently as last month?

MR. RUSSELL: Objection. Vague and ambiguous. Lacks foundation. Calls for speculation. Overly broad.

THE WITNESS: I don't have any problem believing that. I haven't, you know, made a study of that, but that sounds about it right.

BY MR. BIEN:

Q. Okay. People are getting about one group a day?

A. Uh-huh.

Q. Okay. In your opinion, Doctor, is that less than the optimal treatment that your program is designed

for patients at the ICF level of care?

MR. RUSSELL: Objection. Vague and ambiguous. Lacks foundation. Overly broad.

THE WITNESS: It's less than they got historically when I worked there previously.

BY MR. BIEN:

Q. And do you think the patients could benefit from a -- more than one hour of group a day at their level of care?

MR. RUSSELL: Objection. Vague and ambiguous. Lacks foundation. Overly broad.

THE WITNESS: Yes.

BY MR. BIEN:

Q. And why is that?

A. Well, I think there's ample evidence that within the limits, more treatment produces better outcomes. And certainly one hour a day is not maxing out the potential for recovery.

Q. Okay.

MR. BIEN: I'd like to mark as the next exhibit in order. This will be sealed.

It's a June 17th, 2011, suicide report for inmate -- and I'll call him G, took place at California State Prison at Sacramento.

CERTIFICATE OF REPORTER

I, MEGAN F. ALVAREZ, a Certified Shorthand Reporter, hereby certify that the witness in the foregoing deposition was by me duly sworn to tell the truth, the whole truth and nothing but the truth in the within-entitled cause;

That said deposition was taken down in shorthand by me, a disinterested person, at the time and place therein stated, and that the testimony of the said witness was thereafter reduced to typewriting, by computer, under my direction and supervision;

I further certify that I am not of counsel or attorney for either or any of the parties to the said deposition, nor in any way interested in the events of this cause, and that I am not related to any of the parties hereto.

DATED: March 4, 2013

_____

MEGAN F. ALVAREZ

RPR, CSR 12470

Exhibit 83

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Transcript of the Testimony of:

Joel Dvoskin, Ph.D., ABPP

Coleman v. Brown

February 27, 2013

Volume I

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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, ET AL., Plaintiffs, vs. EDMUND G. BROWN, JR., ET AL., Defendants.	CASE NO.: S 90-0520 LKK-JFM

DEPOSITION OF

JOEL DVOSKIN, PH.D., ABPP

WEDNESDAY, FEBRUARY 27, 2013, 9:14 A.M.

SAN FRANCISCO, CALIFORNIA

REPORTED BY: MEGAN F. ALVAREZ, RPR, CSR NO. 12470

THORSNES LITIGATION SERVICES, LLC

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, ET AL., Plaintiffs, vs. EDMUND G. BROWN, JR., ET AL., Defendants.	CASE NO.: S 90-0520 LKK-JFM

The Deposition of JOEL DVOSKIN, PH.D., ABPP, taken on behalf of the Plaintiffs, before Megan F. Alvarez, Certified Shorthand Reporter No. 12470, Registered Professional Reporter, for the State of California, commencing at 9:14 a.m., on Wednesday, February 27, 2013, at Rosen, Bien, Galvan & Grunfeld, LLP, 315 Montgomery Street, 10th Floor, San Francisco, California.

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was $100,000?
A. That's correct.
Q. I'm sorry. Going back to the second page of the document, 103092.
You understood this was a contract for expert witness services?
The first sentence there.
A. That's what the contract says.
Q. Okay.
A. And so I proceeded on the -- you never know if you're actually going to be an expert witness when you start working on these, but that was the contract and that was the way I proceeded.
Q. You understood that you're being retained for litigation purposes?
A. Yes.
Q. Okay. And the field -- it describes your field as psychology and prison administration?
A. I think that's what they said, yeah.
Q. Do you agree that's your field?
A. Those are some of my fields.
Q. Okay. And if you go down to the last four pages of this first part, starting with 103098, is that a copy of your CV?
A. At the time, yes.

expert report itself?

I think you mentioned that you -- for part of that time, you were meeting face-to-face with Dr. Scott to work on the report.

A. The vast majority of it.

Q. Was that in Sacramento?

A. Yes.

Q. Okay.

A. In his office.

Q. Was that in December of 2012?

A. I'm pretty sure it was.

Q. Okay. And do you know -- was that more than one day?

A. Yes.

Q. Can you give me an estimate how many days that was?

A. At least two. I think maybe three.

Q. Did Dr. Scott have his assistants with him, too, helping?

A. No.

Q. Okay. Anyone else there with you besides you and Dr. Scott?

A. No. A couple of times, like, his secretary popped in the room, but not to work on the project with us.

Q. Okay. And Dr. Moore was not present for this process of writing a report?

A. No.

Q. Okay. And I understood from -- we took her deposition last week, early this week. I don't remember.

MS. VOROUS: Last week.

BY MR. BIEN:

Q. She had some illness in her family in December; is that right?

A. I don't remember. She had some logistical issues that made it more difficult to schedule with her. I think her mom may have had some serious medical issue.

Q. So you --

A. And I think she was in car accident. There were several different things that made it more challenging to get together with her.

Q. Okay. And how did you and Dr. Scott get input from Dr. Moore into the report?

A. Well, the attorney general -- whenever I'm doing a report like this, I always ask the attorney whether it's a plaintiff or a defense attorney. What is it that you're -- assuming we were in court, what would you be likely to ask us on direct? And we kind of build the report around the referral questions.

So these -- what the AGs wanted was essentially a robust report about our opinions regarding the constitutionality of the mental health care in the prisons we visited.

We had always had a exit conference at every prison where we each went around and communicated our findings pretty -- reasonably detailed to the warden and the CEO and the mental health director of the prison. So we knew what Dr. Moore's findings were at each of the prisons, with one exception. I believe Centinela she was unable to join us, and I did some of that work there.

I actually don't know whether she went back there or not. There was some -- we weren't clear whether she was going to go visit Centinela or not. With that exception, we knew what her findings were at each prison.

And so we put those in the report essentially as place holders, and then sent it to her. Dr. Scott e-mailed it to her and said, you know, "Did we quote you right? Add anything you want? Delete anything that you want."

And my recollection is that she told Dr. Scott that she liked the report. And she had some -- made some additions, but I don't -- I actually don't remember

what her specific additions -- I don't think she had many changes to what we had written. But I think she added some stuff, which is what we intended.

Q. Did she provide written materials to you, notes or findings about individual prisons?

A. To me? No.

Q. Or to Dr. Scott?

A. I don't believe so.

Q. Okay. So when it came time to write the report, you and Dr. Scott wrote it. You used your recollection of her presentations at each of the exits, and then you sent it to her for her review and approval?

A. Yeah. We were just trying to make it as easy for her as we could, least amount of time-consuming because we believed she was pretty tied up with some -- with things that made it -- would have made it difficult for her to join us. So we -- but we were very encouraging of her to -- if there was something she disagreed with, to change it.

Q. Okay. This is -- let me -- I'm going to hand you a check for $2,100. We're entitled to seven hours of deposition today. I'm sure we'll use it. And that way you don't have to send me an invoice. And all I need -- at some point you can sign -- give me your taxpayer ID number.

mean to imply in any way that he was not honorable or competent. He is both of those things.

Q. Do you understand that he had been using the same terms and analysis in all the reports that he's done on this case?

A. Yes.

Q. Okay. And so one reason that he may be doing it that way is that that is the way it has been consistently done on this case?

MS. VOROUS: Objection. Speculative.

You can answer.

BY MR. BIEN:

Q. In other words --

A. The question is: Is it possible that he did it because it's a bad habit? Yeah. I mean, I -- it's not a particularly good reason to do something because that's the way we've always done it, but it's -- I mean, I don't know. You have to ask him why he used that language.

Perhaps he was explicitly asked to use that language. I don't find the language helpful for the reasons I explained in my report.

Q. Okay. You're familiar with the work of Lindsay Hayes?

A. Very familiar.

Q. And what's your -- do you have an opinion as to his reputation in the field?

A. I have written that Lindsay has saved many lives. He's a good man who -- who became impassioned about jail suicide prevention before anyone cared about it.

We worked together many, many years ago. My staff did the first statewide jail suicide prevention. So I --

Q. That was in New York?

A. In New York. We had some dealings with him at that time. I think he's incredibly knowledgeable. Very honorable. Occasionally stubborn, but he's a good guy. I love Lindsay, and I recommend him often.

Q. Okay.

A. I think very highly of him.

Q. Okay. You were aware during the course of your work that Lindsay was working also with California as a suicide prevention expert?

A. Yes.

Q. Okay. And were you aware that he had prepared a report for California and provided it to them?

A. Yes.

Q. When did you first become aware of Mr. Hayes' report to California?

A. I don't remember exactly when. It was relatively early in the process, but I don't remember when. I had heard that he had written a report.
Q. Was that report provided to you at any time?
A. Yes.
Q. Okay. And when was it provided to you?
A. In the last month.
Q. Okay.
A. I don't remember the exact date, but...
Q. So it was in 2013?
A. Yes.
Q. Okay. And that was -- was it before or after you prepared your report in this case?
A. It was after -- are you talking about the report that Dr. Scott and I collaborated on?
Q. Yes.
A. It was after that.
Q. And was it before or after you prepared your reports -- your report about the 2011 suicides?
A. After.
Q. After that?
A. Yes, sir.
Q. So pretty recent?
A. Yes.
Q. Who provided the report to you?

not believe that that study says that there are no long-term effects of segregation that are negative. We were just, in that study, unable to identify them. And there are some specific things in Colorado that may have been responsible for those particular findings.

Q. Again, rather than go into the details, is it still correct that at this time you think there's still not definitive research about whether or not long-term housing in segregation is dangerous and can cause permanent harm to people?

A. Yes. I think that's still true.

Q. Okay. That means -- would you agree it's possible that long-term housing in segregation does cause psychological harm?

A. Yes.

Q. And you're less -- I think I interpreted this correctly --

A. I'm sorry. Can I just clarify? I took your question not to mean that it necessarily does, but that it could on -- for an individual.

Q. Right. That's correct.

A. So the answer is yes.

Q. And you're less -- I understood this article to say that as to the mentally ill, there already has been research and that it is harmful to -- for the

meeting. The clinicians were able to ask for a private meeting if they felt it was appropriate even if the inmate didn't.

So I think, in general, that they were trying to bring treatment to people that were in SHU that met their needs.

And then -- again, I saw no exception to the belief -- to my belief that if someone became acutely psychotic or suicidal, that they would be removed from their -- I didn't go track down people who weren't there anymore.

Q. Right.

A. But I didn't see people who appeared to me -- now, keep in mind, I didn't hit every cell. These were randomly selected inmates that I talked with and randomly selected cell blocks that I would talk to the officers.

Q. How many residents of the Corcoran SHU who were CCCMS did you speak with?

A. I don't remember. I documented the ones that were comfortable with my documenting their name. I always give people the choice if they want to speak and not have their name associated with it. So I don't recall. And in SHU, it would have been one by one.

And in some places I would talk to groups of

inmates and just get kind of general opinions, but that wouldn't have happened in the SHU.

Q. You think it was -- can you give me any estimate of how many people you talked to?

A. I can't remember. I'm sorry.

Q. 10?

A. More than 10.

Q. More than 20?

A. Probably, but I'm not sure.

Q. Okay. Was it -- you think you did a scientific study of how conditions were affecting the mentally ill in the Corcoran SHU?

A. No, I do not think that.

Q. Okay. So you didn't really answer in any way the question that was opened in this article about what the long-term effects of housing mentally ill are in a SHU environment?

A. That's correct.

Q. Okay. And you still believe that it's possible that there are no long-term effects and it's possible that there are long-term effects?

A. What I believe -- let me distinguish between what I believe versus what I think has been scientifically or empirically demonstrated.

What I believe is that for some people there

about was the one I just mentioned. And nobody -- I asked, "Has there been any cases in the last few months where you tried to transfer somebody and were told no?" And no one had one.

Q. Okay.

A. So it seemed to be -- I'm not sure about what I'm about to say, but my general impression was it was older information and that it may have been true previously. But I don't know that.

Q. Okay. You didn't go and review the last 10 rejections from Patton to evaluate them?

A. I did not.

Q. You didn't look to see whether it actually said on the rejection, "This person meets our mental health criteria but is, you know, too dangerous for us to handle"?

A. That's correct.

Q. Okay.

A. I didn't -- I just want to be clear I didn't assess the Department of State Hospitals at all.

Q. Okay.

A. I -- I wasn't asked to do that. So I don't have any -- really any opinion at all about Patton or any of the other DSH facilities.

Q. I was going to ask you about that, Doctor.

You understand that inpatient psychiatric care for males in the Department of Correction is provided by the Department of State Hospitals?

A. With the exception of the crisis beds, yes.

Q. Okay. And you didn't -- as you sit here today, you have no opinion about the quality of care that's being provided inside of the Department of State Hospital facilities?

A. That's correct.

Q. Okay. And you didn't -- did you inspect any of the Department of State Hospital facilities during this time in California?

A. If I remember correctly, we may have looked briefly or not at the one at Salinas Valley, but I honestly can't remember. I didn't do any assessment of the -- their treatment, their practices, their staffing, any of that.

Q. Right.

A. And, to my knowledge, none of my colleagues did either.

Q. Okay. When was the decision made that your -- you would not offer an opinion concerning Department of State Hospitals?

A. I was never asked to look at the Department of State Hospitals.

inmates who needed ICF care and doing this other program?

MS. VOROUS: Objection. Lacks foundation. Vague and ambiguous.

THE WITNESS: The way you asked the question --

BY MR. BIEN:

Q. It was a terrible question. Let me start over again.

A. Okay.

Q. So you have no opinion, as you sit here today, about the adequacy of the care being provided to death row prisoners who may have needed ICF care?

MS. VOROUS: Objection. Misstates his testimony.

THE WITNESS: I wasn't asked to assess -- well, there was some talk about doing a separate assessment of that program. It was my understanding that was the subject of some litigation or some lawyer stuff.

I was then told, "We're not going to do that right now. We might do it at some time in the future." So I didn't ask about that program for that reason.

I did talk -- I'm sure that many of the people I talked to had something to do with that program, but I

didn't ask them about that program.
BY MR. BIEN:
Q. Okay.
A. That's why the question was a little difficult to answer.
Q. As you sit here today, you don't have an opinion about -- one way or the other about the adequacy of that program which you didn't evaluate?
Sort of an obvious question.
A. In theory, the way it was described to me, it could be okay; but I didn't see it, so I can't say that it was okay.
Q. Right. Would you agree that it would be inappropriate for California to -- assuming that there were some men who needed ICF level of care, to not provide access to it either at San Quentin, an equivalent, or provide access to the ICF program run by DSH?
A. The question is virtually tautological. People should get what they need. ICF is bit of a conundrum for me. It's not something that most systems have.
In New York, for example, we had a -- we had crisis beds in the prison that are -- we called satellite beds. Then we had an inpatient hospital. The

average length of stay there was about 45 days. It varied 30 to 60 days. And then what you're calling intermediate care, we actually provided in units that we called intermediate care units, which were the model for your EOPs. So the EOP is kind of an intermediate level of care. That's the idea of it.

So you guys -- California has kind of introduced this thing between acute inpatient and EOP that other places don't have. So I don't think there's a constitutional duty to do it since no one else does it, but there is a constitutional duty to meet a person's needs.

So if I looked at an inmate and said his needs are not being met at an EOP, then he needs something else. However -- either you bring it to him or him to it, but he needs whatever he needs.

Q. Right. In other words, the same principle you said before. I mean, you have to -- the system has a duty to provide the level of care that someone needs, either bring it to them or buy it on the outside or -- but you can't say because this person is sentenced to death, he's not going to get the mental health care he needs?

A. Correct.

Q. Okay. You've written that "Timely access to

inpatient psychiatric hospitalization is an element of an appropriate mental health program."

Is that correct?

A. I don't recall specifically, but I'm sure I did.

Q. Yeah. And you agree with that statement?

A. I believe it, yes.

Q. Okay. And did you evaluate whether or not prisoners in California were getting timely access to inpatient psychiatric care?

A. That was a bit of a moving answer, because early on in our visits, the waiting list had previously been even higher than when -- our first visit.

By our first visit, the waiting list had begun to drop, but they continued to drop throughout this project to the point where they're, as far as I know, essentially nonexistent now. And largely that had to do with a couple of things. One was the creation of additional crisis beds, and the other one was the -- the -- there was a drop in the census from the realignment. But, whatever the reasons, the waiting list appears to be pretty close to nonexistent.

And when I looked at the results of -- the special master at CDCR did this project. I forget what they called it.

about words "acute" and "intermediate," because every system uses those differently and I didn't assess the actual care.

But if somebody's -- you know, there's a bunch of ways --

BY MR. BIEN:

Q. I'm just focusing on acute, and I'm focusing on how California uses the definition. And you evaluated that issue.

A. Yeah. I would say -- well, the simpler answer is that clinical judgments are presumptively constitutional, but you're supposed to act on them. So if clinicians all agree that's what the person needs, then that's what should happen.

Q. Okay.

A. I can't give you an exact amount of time, but the sooner the better.

Q. Would you be concerned if -- I know you have disparaged the program guide and its standards, but the program guide has a transfer guideline for APP.

Yes?

A. I disparaged the program guide?

Q. You've said that it is overly detailed and gets in the way.

A. No, no, no. I -- I'm sorry to interrupt.

Please allow me to clarify.

Having great policies and procedures, I do not disparage. Being monitored for every one of your policies and procedures is unheard of.

Q. Okay.

A. That's a very different thing.

The program guide is -- I mean, I criticized the State for not having policies and procedures, whatever it was, 12 years ago.

Q. 20.

A. Geez. Getting old so fast.

Q. Me, too.

A. But I just want to be clear. I'm not opposed to having great policies and procedures. There are some changes I would recommend in the program guide. And the inability -- the State's perceived inability to make changes in the program guide is terrible, but I'm not -- I don't disparage the program guide. If I led you to believe that, I apologize. That's not how I feel.

Q. So the program guide has a transfer guideline.

A. Uh-huh.

Q. And I think the transfer guideline says not more than 10 days for -- from the time of referral to actual admission and, you know, physically moving the patient to -- to an inpatient psychiatric bed. In fact,

don't think 10 days is an unfair expectation.
Q. So your understanding from the records you received and the information you received from Dr. Toche -- actually, she's not Dr. Toche, is she?
A. Toche.
MS. VOROUS: Toche.
BY MR. BIEN:
Q. But she's not a doctor -- yes, she is. She's a doctor.
A. Sure she is.
Q. Dr. Toche. Excuse me.
-- and from -- I know you asked information from the attorney general's office from time -- was that there was no wait list for acute psychiatric care?
A. No wait list beyond the parameters --
Q. Beyond the 10 days or whatever it is.
A. -- of the program guide. I should have been more clear.
Q. So that was your understanding?
A. Yes.
Q. Okay. That's part of the basis of your opinion?
A. Yes.
Q. What about ICF care?
I know you've been talking about it, not quite

That's even with good documentation. Where you stand depends on where you sit.

BY MR. BIEN:

Q. Do you recall being told that one of the grounds for delaying admission to a DSH facility was that the inmate had swallowed objects due to his illness?

In other words, everyone agreed he needed inpatient psychiatric care, but he had ingested some substance or object?

A. Someone told me that, and I believe I had a note about it in my notes. But I don't remember which facility it was.

Q. Did you investigate whether that was, in fact, a barrier to access to DSH?

A. What I -- yes. And my recollection of what I was told was that we -- they have to be medically stable. And that was the receiver.

So I didn't really get into it because it was a medical question. And I don't remember if I passed that along to Dr. Scott or Dr. Moore or not. But what they told me was it's not true that if you swallow, you can't come; but we got to make sure people are medically stable before they're transferred.

And that's a very common principle in health

In terms of the assessment or the monitoring of "Were people underserved?" I think that also came into the -- I'm not sure if you're referring to that as well. That was probably a good thing to do once because it demonstrated that there were surprisingly few people that were undertreated.

And then I really am not offering an opinion about the monitoring of that process, but I -- but I think some of the changes they made in the referral processing probably were helpful.

Q. Okay. You understand that there had been -- that one of the issues that had been found by the court in the past was that CDCR was not referring patients that required a higher level of care to these inpatient psychiatric programs?

MS. VOROUS: Objection.

THE WITNESS: You mean several years ago?

BY MR. BIEN:

Q. Yes.

A. Yes, I was told that.

Q. And did you investigate yourself whether or not -- let me start over.

As part of your work in California, did you make an investigation as to whether or not there was an unmet need for any kind of mental health care in CDCR?

A. In general, yes. I looked for undertreated, untreated, and asked about undertreated and untreated people every place I went.

Q. What was your methodology for looking for untreated or undertreated people?

A. Variety of things. When I visited -- depends on the type of unit. If it's lockdown units, it's a little more challenging. Let me start with those.

For locked units, I would ask the officers, "Who is the -- if you had to pick the two most psychotic or difficult or quirky or usual inmates" -- I would say any euphemism that you want to use -- "who's your all-star team of, you know, inmates that I, as a psychologist, should be concerned about?"

And it's by far the best source of information. They never hesitate. They tell me two names, three names; sometimes one; sometimes five, and then I go talk to those people.

I also then, typically, if they're -- usually there's a few inmates that seem, on their face, to be credible informants that are relatively reasonable, and I might say to them, "Is there anybody you think I should talk to?"

And they might say, "Cell 2," real quietly.

And in order to not throw them in, I'll see

somebody else and then eventually wander over to Cell 2.

It's a good methodology for identifying who in that group is likely to need more than they're getting.

In general population, I do it that way as well as by eyeballing people. And if somebody appears to be disoriented or confused -- sometimes they turn out to be developmentally disabled or maybe they have a medical illness -- but you ask, say, "I notice you look a little confused. How are you doing today?" You start a conversation with them. And then, depending upon the beginning of the conversation, I might look at their record or might ask about them, or I might have an in-depth conversation with them.

Then I do a lot of cell front, walking cell to cell. "How you doing?"

"Fine."

And often the person will say something, even in that brief interaction, that leads me to believe that I need to look further into them.

Or a cellmate will roll their eyes. You know, there's a variety of ways that you do it. But I -- usually, the list I come up with is a pretty good list --

Q. Okay.

A. -- of people who appear to need more treatment

than they're getting.

Q. What about the people who are not in the mental health delivery system? What work did you do to see whether or not they needed care?

A. I just told you. That would have been in locked units that were not PSUs or hubs, but in ad seg. And I would walk the yard, if there was a yard. For like -- for the women's facility, women all over the yard, I just wondered around. "I'm a psychologist. Got any friends you think I should talk to? How do you like the doctors here? If you have a problem, what do you do?"

When I'm walking around the yard, I don't know if they're CCC or not. A lot will say, "Yeah, I'm CCC."

Then I'll ask them, "Do you know who your primary clinician is?

"You mean Dr. Smith? Yeah, she's really nice.

"How often do you see Dr. Smith?

"Whenever I want to, but she calls me out once every 30 days or every 90 days, depending on the level of care.

"Do you have a doctor?

"Yeah. I can't remember his name. That Indian guy. He's a short little guy.

"What's he like?

"He's really nice." You know, or --

And frankly, I was shocked at the consistency with which people knew their doctor and their primary clinician and the generally high opinion that they expressed of them. It was shocking to me. Better than I've ever seen in a prison system.

Q. Okay. Let's go back to people who are -- so this -- you felt that one of the things that you were tasked to do was determine whether there was an unmet need for mental health care in the California system?

A. Yes.

Q. And your opinion is that there is not?

A. Well, I was asked to assess it in the context of did I feel the system was constitutionally adequate or not. There's always unmet need. No question about it.

The -- if I had unlimited resources, there are many things that you could do that would improve the system and make it better.

But using my understanding of constitutional minima as a criterion, then the answer is I think they are meeting the constitutional obligations.

Q. When you were part of the Scarlet Carp team, one of the issues at that point was determining whether or not California had an unmet need for mental health

Steve Martin.

Q. You just turned to look at something?

A. On the next-to-the-last page, I actually -- when I go into a big meeting, I have a habit of making a little seating chart so that I can remember -- there was a lot of new faces to me, and I wanted to make sure I remembered who people were.

So as the people introduced themselves, I do it in the same -- I've been doing this for many years.

Q. So you're on page 103262?

A. Yes.

Q. Okay.

A. Do you want me to read the names to you?

Q. Sure.

A. Steve Martin. Jim Scaramozzino, S-C-A-R-M-A-Z-I-N-O, although I think that's a misspelling. I think there's an A missing there.

Judy Burleson, B-U-R-L-E-S-O-N.

Debbie Juarez, J-U-A-R-E-Z.

Pat McKinney, M-c-K-I-N-N-E-Y.

Jackie Moore.

Martin -- I think I spelled his name wrong.

Q. Is that Martin Hoshino?

A. Yeah. I have A-S-H-I-N-O, but I think it's --

Q. That's okay. I don't need you to read what's

there. Let's just go over the names.

Was it Debbie Vorous that was there rather than Juarez?

A. Oh, yes, it was.

THE WITNESS: You must not have spoken very loudly at the time.

BY MR. BIEN:

Q. I'm just going to go through the names. Tell me if I'm right.

Rick Subia, he's from Department of Corrections?

A. Yes.

Q. And Katherine Tebrock, lawyer for Department of Corrections?

A. Yes.

Q. Ben Rice, who's CDCR general counsel?

A. Yes.

Q. Cynthia Rodriguez? It says "counsel at DMH."

A. Yes.

Q. And David Brice, another AG?

A. Yes.

Q. Gabriel Sanchez, another deputy AG?

A. Yes.

Q. And then Rodney Reed from UC Davis?

A. Yes.

wasn't clear, so I don't know what it refers to.

Q. What about the number at the bottom? Is that a dollar sign? Can you read what that says there?

A. "$42 million monitoring."

Q. What was that a reference to?

A. It was -- there was some discussion about the inordinate expense that went with the monitoring as opposed to care -- as opposed to approving care, that the monitoring itself bore an unprecedented expense.

Q. Who informed you of that at the meeting?

A. I would -- I don't remember which person, but it could have been almost anybody in the room except for the four of us and the two fellows. It was, I think, a widespread belief that monitoring costs were excessive.

Q. Did they explain what they meant by "excessive"?

A. Too much.

Q. Too much. Too much relative to what?

A. I inferred from the discussion that they thought that the monitoring wasn't focused enough; that it was micromanagerial in nature; that details were being monitored at great expense.

There was a comment made that there were four full-time attorneys working for the special master and the -- that no one -- something to the effect of, "I

have no idea what they do."

There was expressed a belief that there was sort of a gotcha type of monitoring; that they would go and sort of try to find things wrong instead of sticking to the, you know, robust, simple things that the system itself agreed had needed to be fixed.

There was an expression of a belief that it wasn't very fair; that the department had done a whole bunch of things to dramatically improve its mental health services and wasn't really being given credit for it.

That -- I think it's fair to say there was an acknowledgement that there was a time when some of this may have been necessary or appropriate, but that as the system improved, that the monitoring should have shrunk and the expense of the monitoring should have shrunk and didn't.

I think that's a fair summary of the conversation.

Q. During your work from this time forward -- it's now been almost 18 months -- have you come to form an opinion about the Coleman monitoring and whether it's excessive or too expensive?

A. Yes.

Q. What is that opinion?

A. I think that the -- the manner of monitoring, it could be done very effectively at much less expense, and it could be done -- I have enormous respect for the experts that the special master has hired. I don't know every single one of them, but I know a fair number of them and they're a great bunch.

I think that the manner in which the reports are written where the special master doesn't quote them but he rewrites what they said, and he says "the monitor" to mean all of the individual experts. I think that's very problematic because it precludes a discussion about, "Well, wait a second, there's a reason why we do this and what if we did it a different way. How would you recommend doing it?"

In my report, my response to the suicide report -- and I fear that I hurt Ray's feelings, and it wasn't my intention -- but I pointed out that getting a report on suicide a year after the suicide doesn't help anybody. And Ray's response said, "That's not my fault, that the State was slow getting me the information."

Well, whatever the reason is, it's a really bad way to do business. In my opinion, those questions or findings should be communicated a couple days -- as soon as they're known, within days. So -- before the investigation's completed so they can be built into the

investigation.

I don't understand why anybody would do it this way. It just makes no sense to me.

And I also think that a bunch of details are counted that either don't matter or, in some cases, are actually counterproductive.

An example of that is that the IDTTs are so prescripted that they're not -- at least at one facility that told me that the special master specially praised their IDTTs. We hated them. They did every single thing right, but there was no meaningful conversation with the inmate, which is the main purpose of it.

It was, you know, at some point you just take a step back and you say do we really need to visit 25 facilities, because the things that -- that they think are not okay are much more focused than that. They -- you know, they allege that the suicide prevention activities should be improved. Some of those recommendations I agreed with.

Most of that can be -- can be monitored without ever getting on an airplane. I mean, that information could be electronically communicated to Dr. Patterson.

Q. So you thought that Dr. Patterson withheld information through this process, whether or not

Q. To your knowledge, at the time you wrote your expert opinion in January of 2013, had this been implemented?

A. I don't know.

Q. Okay. While you were touring the prisons, one of the things that was happening, I think, during the period when you were out there is the department was installing suicide-resistant beds in the MHCB; is that correct?

A. Yes.

Q. Is that correct, yes?

A. Yes.

Q. And did you see some MHCBs that had the beds and some that had them about to be installed in the next couple of months?

A. Yes. There were a few places that hadn't installed the beds yet, but they were -- they said they were expecting them shortly. I don't remember the -- where or which ones but...

Q. Okay. Do you agree that -- with the recommendation that suicide-resistant beds should be installed in MHCBs?

A. Not the ones they installed. I wouldn't have -- I mean, my understanding is they spent a fortune on beds; that they could have made suicide-resistant

CDCR took various measures to be less punitive in its procedures for people on suicide watch or observation?

MS. VOROUS: Objection. Lacks foundation.

THE WITNESS: I don't remember using that exact language, but it's a recommendation I frequently make: In general, that suicide watch should not be a punitive experience, and whatever reasonable steps you can take to make it feel less punitive to inmates are good to do.

BY MR. BIEN:

Q. Didn't you also recommend that if someone's on one-on-one observation on suicide watch, that they needn't take away the person's clothes in every case?

A. Yes, I did. And I think that.

Q. And did you observe that at least in some locations the practice was to universally take people's clothes and then replace them with suicide smocks?

A. Yes.

Q. Okay.

A. Not just in California. That's a very common practice nationally.

Q. Okay.

A. In fact, I'd say most -- more common than not. It's relatively rare that people on suicide watch are allowed to have their clothes, but I think they should

and Lindsay thinks they should.

Q. Is the fact that something is done other places make it better or worse, in your mind?

A. Not better or worse but it -- it -- depending on the judge, it sometimes has important legal implications. So when I'm asked what the standard is, I usually ask the court, "Do you want the prescriptive standard, what do I think it should be, or the descriptive standard of what" -- so if you ask what is the standard of care, lawyers will tell you one of two things: Either what would a reasonably prudent practitioner do under similar circumstances, or what should. And they can be very different answers, and that's an example of that.

So I usually ask the judge which -- "How do you want me to answer the question?" So, in my opinion, that shouldn't be the standard, but it is.

Q. Okay. So, in your opinion, you agree with this recommendation that beds should be provided for CDCR prisoners who are on suicide watch in MHCBs?

A. Yes.

Q. Okay. And did CDCR inform you that they disagreed with that recommendation and objected to it?

MS. VOROUS: Objection. Lacks foundation. Vague and ambiguous.

enthusiastically.

Q. Okay. On the top of the next page, page 5 of Mr. Hayes' report, he makes the recommendation that other characteristics that he observed in units that were doing suicide watch and observation could be perceived as punitive because people were stripped of their clothes, they had no -- they had reduced privileges. They weren't allowed access to shower, out-of-cell time, telephone calls, and that he thought CDCR should consider whether or not it could make those conditions less punitive.

He was using the word "punitive" to mean not like punishment but more like this would be perceived by the prisoner who's receiving this suicide watch as being a negative experience if you look at it from afar. And that, as I understood, Mr. Hayes was recommending that CDCR look at these practices and see whether they could be less restrictive and -- so that eventually suicide watch would be viewed as less punitive.

Do you agree with that recommendation? It was a long question but --

A. Yes. I make the same recommendation in other places. It is a -- what Lindsay's recommending -- not for the first time -- is a sea change, a fundamental change in how suicide watch is done nationally. And I

agree with him.

I think that those are the normal conditions of suicide watch, and I think -- Lindsay, myself, and others -- I think Ray and Jeff have probably -- Ray Patterson and Jeff Metzner have made the same observation, that that's something that should be looked at and changed. So I guess I do agree with him.

Q. Did you observe on your tours -- did you tour the OHUs?

A. Yes.

Q. Okay. And when you toured the prison, you viewed the OHUs along with all the other facilities? OHUs being outpatient housing units.

A. Yes.

Q. And did you observe that in the OHUs they didn't have beds?

A. I can't remember for sure, but I think that's right.

Q. Did you ever see someone on suicide watch or suicide observation in an OHU during your inspection?

A. Yes.

Q. Did you ever see someone on suicide watch or observation in an ad seg unit during your inspection?

A. Not that I can recall. Suicide watch, not that I -- well, they were -- they had made a change in

psychiatric technicians that worked for the receiver's office, but they were -- they weren't officers. Nursing assistant or --

Q. CNA?

A. Correctional nursing assistants.

Q. Right. Did you ever observe them doing suicide watch?

A. Yes.

Q. Okay. And did you see them conversing with the inmates and speaking with them?

A. Let's see. I think I saw both.

I know one -- I remember one, I want to say at SAC, where the person, at least while I was there, didn't talk to the inmate. There was one where -- there were a number of times when the inmate was asleep, so obviously they weren't talking with them. But the one I was just remembering from SAC, I believe it was -- I think the inmate was up. I don't know if they were talking before we got there or not.

Q. Do you know that there's an instruction at CDCR that certified nursing assistants are not to speak to prisoners while on suicide watch?

MS. VOROUS: Objection. Lacks foundation.

THE WITNESS: I did not know that.

BY MR. BIEN:

Q. Would you agree that would be countertherapeutic?

A. Yes. Just to be clear, you're talking about prohibition against talking to them at all?

Q. Yes.

A. Yes, I would be opposed to that.

Q. When you were at SAC, California State Prison at Sacramento, did you observe the ZZ cells at that facility?

A. Yes.

Q. What did you understand them to be?

A. I assume we're talking about the same cells. It's in the sort of a depot where they hold people while they're waiting for transportation. And there's several officers in the area, and there's some cells that people were held in -- sort of like a holding unit except they were individual cells as opposed to a group holding tank while they're waiting for their particular bus or transportation.

When I was there, all of the inmates in those cells had been there for at least a few hours. And it was my understanding that they were used for temporarily housing people while they were waiting for the bus or vehicle that's going to take them somewhere to pick them

BY MR. BIEN:

Q. Okay. Coming back to your meeting in Sacramento, Exhibit 6, if you pull that out. It's your handwritten notes.

MR. BIEN: This is Aaron Fischer from my office.

THE WITNESS: Hi, Aaron.

BY MR. BIEN:

Q. On page 2, could you -- there's some discussion four rows down, they measure and report 120 items by level of care.

Was this some of the discussion that you already talked about about the special master's monitoring?

A. Yeah. I was just taking notes as they were presenting the status of things.

Q. Okay. And, again, so they were -- I'll just say complaining about the extent of the monitoring and the detail orientedness of the monitoring; is that a fair summary?

A. Yeah, that's a fair summary.

Q. What does it say at the top of the page?

A. I was afraid you were going to ask me about that.

It says: "Judge Karlton hates State and AG."

And I probably wish I hadn't written that note, but I think there was a general belief that any time there was a disagreement between the special master and the State, that the judge would simply agree with the special master. So that they didn't feel like it was a level playing field, I guess, to put it -- and I wish I hadn't written that.

Q. You wrote it down because it was stated at that meeting?

A. Yeah, I believe so.

Q. Do you know who said that?

A. I do not.

Q. How did you select the number of prisons -- the prisons that you toured?

A. We had a meeting -- might have been that same day or shortly thereafter -- where we -- we kind of sat around, and I asked for a list of, like, which kind of programs are at which programs. And there were people from CDCR there, and I asked them questions about, you know, I say "I"; we all did.

All four of us weighed in about -- we wanted a reasonable sample that would cover the types of programs that existed. We asked specifically for one prison that didn't have much of anything. I think we picked Centinela for that.

And then people would give us -- "Here are some prisons that have this level of care." And we said, "We've got to go see that one."

As we began our trip, it became clear to us there were a couple places we should go see, Pelican Bay being an obvious choice because they had one of the two PSUs and we thought that we shouldn't not go to Pelican Bay.

And then we wanted to revisit -- our first visits were a little chaotic; we weren't sure what we were doing. We were still working on our methodology. We went back to CMF, and I think we went back to SAC, if I'm not mistaken. I know we went back to CMF to make sure that we had asked all the questions we needed to ask.

Q. So why didn't you go to 33 prisons?

A. Expense.

Q. Okay.

A. It would have been a lot more money.

Q. Okay.

A. I shouldn't say that. That was my assumption.

Q. Okay.

A. I don't think that was said to me, but I didn't even ask the question because I assumed it would be very, very expensive to do that.

Q. Okay. Did you think that going to 9 of the 33 prisons allowed you to make an opinion about the total operations of the California Department of Corrections?

MS. VOROUS: Objection.

THE WITNESS: I think it's 13, isn't it?

BY MR. BIEN:

Q. What's 13?

A. All the ones we visited.

Q. Okay. How many did you go to?

A. I thought we visited 13.

Q. 13 prisons. Okay. I have it all down.

A. I'm sorry. I know I wouldn't be able to list all 13 for you.

Q. I do have a list here. Let's assume you went to 13 prisons.

A. I think it is.

Q. Okay.

A. But I'm willing to stand corrected if that's incorrect.

Q. On what basis do you feel that you can render an opinion about the full California Department of Corrections, which is 33 prisons right now plus 9,000 people out of state?

A. I certainly don't -- I don't offer an opinion about the people who are out of state.

Q. Okay.
A. For the rest of the prisons, in addition to going to prisons, we talked to inmates who had been in most of the prisons. So if there had been any kind of meaningful allegation that something was an outlier in a -- while you're doing that, can I use the restroom real quick?
Q. Sure.
(Off the record at 2:32 p.m. and back on the record at 2:36 p.m.)
BY MR. BIEN:
Q. I think you were in the middle of an answer so to be fair, I'd like to -- why don't you read back the question and the answer?
(Record read as follows:
"QUESTION: On what basis do you feel that you can render an opinion about the full California Department of Corrections, which is 33 prisons right now plus 9,000 people out of state?
"ANSWER: I certainly don't -- I don't offer an opinion about the people who are out of state.
"QUESTION: Okay.
"ANSWER: For the rest of the prisons,

court opinion that came out in the summer of 2009?
A. Regarding crowding?
Q. Yes.
A. Not that I recall in that meeting. And it probably would have been the same answer because that really was the same question as what the Supreme Court addressed as I understand it, so...
Q. Okay. Your expert report does not include the word "crowding" or "overcrowding," to my understanding; is that correct?
A. I don't remember using that word.
Q. Okay. Do you have an opinion concerning whether California prisons -- let me back up.
Do you disagree with the Supreme Court decision finding that crowding was the primary cause of the ongoing constitutional violations in California prisons?
MS. VOROUS: Objection. The overcrowding issue is not something Dr. Dvoskin was asked to evaluate or render opinions on in connection with this case.
THE WITNESS: So shall I answer?
BY MR. BIEN:
Q. Is that correct? Dr. Dvoskin, did you understand that you were asked not to render opinions concerning crowding?

A. No, that's not what she said and that's --
Q. Okay.
A. There's a difference between asking me not to and not asking me to. I was not asked to render an opinion -- well, in this matter, I was not asked to render an opinion.
Can we go off the record for a second? I have a question.
MR. BIEN: Sure.
(Off the record at 2:43 p.m. and back on the record at 2:44 p.m.)
BY MR. BIEN:
Q. Do you have something you would like to clarify?
A. The AG office asked me sometime previously if I might be an expert witness on that issue in Plata. And I was not an expert witness for the State in Plata.
Q. You mean the underlying three-judge court trial?
A. Yeah. The technical answer to your question was, well, I had been asked. But what I think you meant was in this matter was I asked, and I just didn't want to give you a misleading answer.
Q. So just to be clear so we have it all straight, you're not rendering any opinions in your

So, for example, there's prisons that are rated at single cell, but they're double celled, and they've taken the right steps in terms of infrastructure where it might be okay. So if it's a fair rating -- it's an accurate rating of what the real capacity the prison is, then I would say, yes, 180 percent is by definition overcrowded.

BY MR. BIEN:

Q. Did CDCR inform you at any time that they had made a decision to overcrowd CCWF with women since the time that you toured the prison?

MS. VOROUS: Objection. Lacks foundation. Argumentative.

THE WITNESS: No.

BY MR. BIEN:

Q. Do you know that CDCR closed down Valley State Prison for Women and moved the women from Valley State across the street to CCWF since the time you toured CCWF?

A. I heard that there was going to be a repurposing of a whole bunch of prisons, and I believe that specifically -- that the -- I don't remember if I knew the details, but that there was going to be some reorganization of where women were housed and some repurposing of facilities.

Q. Okay. Did they ask your opinion about whether it would be okay to go above 180 percent for that facility given you toured it and were prepared to render an opinion about mental health care there?

MS. VOROUS: Objection. Lacks foundation.

THE WITNESS: No.

BY MR. BIEN:

Q. Assuming what I learned on the tour, that staff represented they had received no additional mental health staffing yet now are operating at over 180 percent, would you agree that your prior opinion about the adequacy of care at CCWF needs to be reevaluated?

MS. VOROUS: Objection. Lacks foundation. Vague and ambiguous.

THE WITNESS: I mean, I guess I would say that my opinions are based upon the time I visited the prison. And I couldn't speak to -- if there's been specific changes in the purpose, utilization of the prison, its census, the nature of its census, then my opinions apply to what it was like at the time I visited it, not now.

BY MR. BIEN:

Q. Would you be concerned if -- about the adequacy of CCWF to deliver mental health care if it was

much more willing to use mental health services than men.

So we sort of, you know, overstaff women's facilities. And they were -- you know, their staffing model is higher than it is for a male facility for that reason, appropriately so. But as far as where they stand right now, I can't say.

BY MR. BIEN:

Q. Okay. So when you asked Dr. Toche about the groups, did she tell you that there had been a significant change in CCWF since the time you toured?

A. Well, they had already told me that there was going to be repurposing, but I didn't ask her about -- all I asked her was -- I was going over my notes. I said, you know, "That went from 100 to 15. Do you know what" -- and I think at the time, she might have even been with us on the tour. I can't remember. But it was said to me this was temporary.

So I think I wrote -- I either made a mental note to check back and see where things stood. I asked -- I don't know if it was a few weeks later. I don't know if there had been that change or not.

Q. She didn't volunteer the information to you?

A. I don't remember her saying that.

Q. And she didn't -- you have no idea about

whether or not 75 groups are being offered at CCWF except for what from Dr. Toche told you?

A. I think that's -- I think it was Dr. Toche. I'm not sure, but...

Q. You didn't go back?

A. I did not go back.

Q. Okay. Were you informed by the attorney general's office that there was an order in this case requiring that they give notice before their experts do inspections of the prisons?

MS. VOROUS: Objection. Lacks foundation. Argumentative.

THE WITNESS: If I was, I don't remember it.

BY MR. BIEN:

Q. Okay.

A. I was given an awful lot of documents. If I saw it, I don't recall it.

Q. And did you -- were you ever informed that the order states that the reason to give notice to the other side is that the other side would have a chance to bring an attorney and their own experts along on tours?

MS. VOROUS: Objection. Lacks foundation. Argumentative.

THE WITNESS: I don't know that.

BY MR. BIEN:
Q. No one told you that?
A. No.
Q. Okay. Well, no one told you the order -- no one told you that there was an agreement in this case by order and it's reflected in the order that the parties would give each other notice before they did prison inspections?
MS. VOROUS: Objection. Lacks foundation. Argumentative.
THE WITNESS: I don't know anything about that.
BY MR. BIEN:
Q. Okay. When you did your inspections in Coleman originally, you were accompanied by plaintiffs' counsel, were you not?
A. I actually don't remember. I know on some of the tours I was accompanied by plaintiffs' experts.
Q. I was going to say that, too. And plaintiffs' experts were along also on some of your tours?
A. I think Don Specter was on some of the tours. But it was a long time ago; I don't remember very well.
Q. Okay.
A. But I do remember making a tour with Dr. Metzner and also with Dr. Haney, but I don't

remember if that was for Coleman or Madrid.

Q. One of the methods you used to gather information on your prison inspections was to interview staff; is that correct?

A. Yes.

Q. And you also -- you also interviewed patients?

A. Yes.

Q. Okay. And who gave you permission to interview patients?

MS. VOROUS: Objection. Lacks foundation. Argumentative.

THE WITNESS: I guess I just interviewed them.

BY MR. BIEN:

Q. Okay. What did you say to a prisoner when you interviewed them?

A. I said, "Hi. I'm Dr. Dvoskin. I'm a consultant to the State, trying to find out about the mental health care in the prison. If it" -- "Interested in how you're doing. Do you want to talk to me?"

Most of the time they said yes.

And then I said, "Well, do you know what level of care you're at? What services do you get? Do you know who your primary clinician is? How often do you see that person? What do you think about them?"

Same sort of questions with the psychiatrist.

Q. Did -- you explained that you were working for the attorney general's office?

MS. VOROUS: Objection. Lacks foundation.

THE WITNESS: I think I usually said the State.

BY MR. BIEN:

Q. The State?

A. I may have said the attorney general, but I think I usually said the State.

Q. Did you make a reference to the Coleman case?

A. Almost always the inmates did. They said -- the minute I said I was Dr. Dvoskin, they said, "Are you Coleman?"

And I said, "Well, we're not the monitors. We've been hired by the attorney general's office and the department to look at the system and make recommendations, but we don't work for the monitors. That's a different thing."

And typically, inmates, when they say "Coleman," they mean the special master and his experts. At least that was my impression.

Q. You understood that one of the things that Coleman monitors do when they investigate the prisons is speak to staff and speak to inmates; is that correct?

A. I'm sure they do, knowing the monitors.

Q. You've worked with Jeff Metzner, and you know that he goes in and has different methods he uses to evaluate programs; is that right?
A. Yes.
Q. And you've actually done that with him?
A. Yes.
Q. And he will walk in and pick some inmates out and ask similar questions to what you did?
A. I don't know what he does in Coleman.
Q. Right.
A. But typically that's what he does.
Q. Okay.
A. Typically, our methods are pretty similar.
Q. Did you develop a list of people you wanted to interview before walking into a unit, or did you use more the method that you described earlier this morning of kind of walking in and asking guards for help?
A. Both.
Q. Okay.
A. Well, it wasn't just the officers; it was also inmates. I gave a more complete answer than that.
But often, in the initial meeting, I would -- we had a long -- usually almost a half-a-day discussion of how things work, what sort of data did he keep, what's your quality improvement process, who runs which

committee, who's your SPR-FIT coordinate. Those kinds of questions.

In the course of that, I might ask a lot of different questions. "What" -- "Was there any recent suicide attempts? Is there anybody you're having a problem big with?"

So occasionally I would have a name that I might scribble on the front page of my note. That would be somebody I would look for.

Or in the course of the day, names would come up through a variety of mechanisms. I'd be talking to a staff member that might say, "I had a really hard time with inmate Joel."

And I'd say, "Where is he? Could you look him up for me, get his location?"

Then I'd find him and see him myself.

Q. Okay.

A. So it was a combination.

Q. You weren't trying to do -- for example, you could have a method where the State gave you a printout of all the inmates that were in the prison on that day, and you randomly selected every 10th or 20th, and then made sure you those. You didn't use a method like that?

A. No.

Q. Okay.

A. That would have taken more time. We had two days for each prison, so that wouldn't have been a realistic way to go about it. It wouldn't have been any better. In my opinion, we got a really good picture of the system.

Q. When you said "random samples," you meant the method you described?

A. I would randomly pick inmates in the housing unit or people I observed -- like I might walk past a bunch of cells if I saw somebody who I thought I should talk to or if another inmate mentioned their name. So it was both random and nonrandom.

Q. You did exit interviews after -- at the end of the day or at the end of the second day of each tour?

A. Yes.

Q. And for some of the prisons, did you go for one day? Or were they all two-day?

A. I think they were all two days except for the second visit to CMF. And I think -- I can't remember Centinela.

Q. How about Centinela?

A. That might have been one day.

Q. Our records have one day for that.

A. I think Centinela was one day.

Q. Is it correct that on some of the visits you

were alone? You went to Pelican Bay by yourself?
A. No. I didn't do any of them -- I don't think I did any of them by myself.
Q. Okay.
A. I think Dr. Scott missed one day at Pelican -- no. He couldn't make it to Pelican Bay. His plane -- he literally couldn't get there.
Q. That's what our records show, too.
A. And I think that Dr. Moore also wasn't there. I think it was just me and Steve Martin for Pelican Bay.
Q. Okay. And you already mentioned that Dr. Moore didn't make it to Centinela, right?
A. Yeah.
Q. Okay. Were there some prisons that Steve Martin, to your knowledge, didn't go to?
A. I -- no. I think he made all of them.
Q. Okay. And you think Dr. Scott went to all the ones except for that -- Pelican Bay?
A. Yeah. And he did Pelican Bay -- a lot of what he did actually was interviews with the chief psychiatrist and looking at records. So he did Pelican Bay; he didn't go to Pelican Bay.
Q. He did it by telephone or --
A. Yeah.
Q. Were you given access to the electronic

records system for CDCR as part of your work?

A. Technically, yes. Practically, no. It is a disaster.

Q. What --

A. I never had any success getting on it. So when I wanted to see something, I just asked somebody to find it for me.

So I was able to look at the EUHR for people, but I always had a guide because I found it very difficult to use. I would look for a treatment plan in the treatment plan section, and the person would laugh and say, "Well, might be there, but it might be somewhere else." And so we'd look in the "All Forms" tab and just -- so it was pretty time-consuming.

I think I made pretty clear in my record I cannot for the life of me understand why they don't have electronic medical record. It's inexplicable.

Q. What do you mean? They call that an electronic medical record.

A. No, they don't. Nobody calls it that.

Q. What do you --

A. I don't know who said that, but not with a straight face. It is not an electronic medical record.

Q. Okay. What -- in your mind, what's the difference between what you called an electronic medical

record and the EUHR system that you saw at CDCR?

A. Well, first of all, it's very time-consuming for clerical staff. They have to scan documents into it. Documents are often difficult to read because they're handwritten.

An electronic medical record is where everything is electronic. Forms are filled out electronically. They're instantaneously available. You don't have to wait for them to be scanned in. They're organized in a more useable fashion. The -- where things are filed isn't a matter of chance based on who scanned it but, rather, the form itself is designed to be in a predictable place.

This is not an electronic medical record.

Q. Okay. When I was touring the last couple of weeks, I was also -- been in the prisons. I had the experience, and I assume from your notes that you had the same experience, where you'd be in some unit and the -- the electronic medical record wasn't available because there was no computer.

Did you experience that when you were in CDCR?

In other words, to access the electronic medical record, you need to have a computer attached to the system. That seems obvious, but...

A. I quit asking about that early on. So what I

would do is if I had questions that I needed to look up, I would go back to office, and that way I could get a guide, somebody who could sit with me for half hour or an hour, whatever it took, and find the things.

So I would say, "I saw this guy, and he said he wasn't seen in the last two months. Can you look him up? I want to see if there's a progress note." Things like that.

Q. Okay. As one of your -- I know you made recommendations to CDCR along the way, both at individual prisons and other places, when you had these meetings with CDCR officials.

Did you ever make a recommendation about improving their medical records?

MS. VOROUS: Objection. Lacks foundation.

THE WITNESS: I probably complained about the lack of an electronic medical record 100 times --

BY MR. BIEN:

Q. Okay.

A. -- if I did it once, to anybody who would listen, including you. I just found it to be, you know, a pain in the neck. I mean, it's not CDCR, that's -- the receiver's in charge of that.

Q. Okay.

A. My very clear impression was that everybody

centralized that you either got something or you got nothing, which I thought was -- left people hanging out to dry.

Q. Okay. Were there a particular set of -- I think you've said in your report that the fact that a particular unit, let's say -- let's use an EOP unit, for example. That was one of your responsibilities, wasn't it, evaluating EOP units?

A. Uh-huh.

Q. Is it correct that, in your opinion, EOP unit could be delivering a constitutional level of care even if none of the inmates were receiving 10 hours a week of therapeutic treatment and 10 hours of out-of-cell time?

A. Yes.

Q. Okay. And what standard did you apply to make that evaluation?

A. Let me clarify for you that the 10 and 10 language, as Dr. Metzner and I had used it, came in a -- out of settings where people are locked down 23 hours a day. The EOPs are not that.

So you could have a -- you know --

Q. Change the question to the hub. EOP ad seg hub or the PSU.

A. For the hub, I would be more concerned about because that's a lockdown setting.

Q. Okay.

A. And if they're 9 hours, I would certainly -- I mean, it -- this is -- as I said before, it's a bit of an arbitrary number.

So if they're trying hard, the inmates feel cared for, they're -- I could certainly see that it would -- you know, if it's a reasonably therapeutic environment and they're doing okay there, that's constitutional, whether they're doing 10 hours or 8 hours.

Q. What standard did you apply in evaluating an EOP ad seg hub or a PSU which are both providing care for the same level of patient in a high-security unit if you were not using the 10-hour standard?

A. Well, I -- the 10-hour standard was in my mind, and I -- I -- it's just not -- it's not the 11th Commandment, but it's a meaningful benchmark, and I agree with it.

But I looked at -- the standard I looked at was whether or not there appeared to be deliberate indifference to their serious medical needs or not. And so the 10 hours is one informative piece of data. I don't mean to diminish it; it's an important one.

But I also looked at the fact that inmates overwhelmingly had a positive relationship with their

treaters, both the primary clinicians and their psychiatrist, their interactions with the officers, and, you know, how hard people were trying to get care to people was part of the assessment.

Q. How hard who was trying?

A. The clinicians.

Were the officers cooperative advocates for treatment or getting in the way of it?

There isn't a formula for this. It is my judgment. It's a judgment call.

Q. Okay. Okay. I notice that there are these protocols or instruments that you guys developed to do your work, but then it appears that -- I'm not sure how they were used.

The audit tool. Can you explain what the audit tool was and how you used it?

A. At the very beginning, the attorney's general suggested to us that we should put together an audit tool.

And kind of against my vote, it included a lot of things that -- because they were being monitored by the special master, I wanted to have a simpler, more robust set of questions along the lines that I just articulated to you.

Q. Was there a plan at one point to actually fill

out these audit tools and then calculate -- make up some mathematical calculations based on that that would be part of your opinion?

A. Absolutely not. There was never an intention to quantify these things but to use them as guided judgment tool. But I didn't find them helpful. From the very beginning, I argued that there's no substitute for talking to inmates. And that that's the most important thing to me, talking to inmates in a program and asking them about it.

Q. In some of the audit tools, I saw there was -- early on there was a list saying you should hit 10 inmates for this unit and five for this unit. And then later on in the audit tools, it seems like it said, "Leave that blank. Do whatever you thought was appropriate."

A. Yeah. I think people came around to my way of thinking as we visited several prisons, that -- that it was it wasn't particularly helpful to do these, and it was very time-consuming.

If I talked to an inmate and I say, "How often do you see your primary clinician?" and the inmate says, "Every week like clockwork," why do I need to go look in the EUHR which takes me 45 minutes to find the last progress note? It's a waste of time.

So that's how I did it.

Q. Okay. I noticed in -- in your report -- and you repeated here today -- that you felt it was a significant factor that inmates you spoke to knew the names of their doctor and medication. Is that correct?

A. And, even more importantly, that they expressed some positive feeling toward the person or a belief that the person cared about their well-being.

Q. Okay. Can you -- did you calculate how many of the inmates you spoke to knew their doctors' names versus didn't know them?

A. I wouldn't go by name. If they said, "Oh, you mean that short Indian guy? I can't pronounce his name," that was a yes.

It was so overwhelmingly positive that I didn't need to count them. It was well in excess of 80 percent of the people I talked to. It might have been 90 percent.

Q. Did you actually calculate?

A. No.

Q. And did you calculate how many people knew their medication versus how many didn't know it?

A. The name of the medication, I can give you a rough estimate. I didn't calculate it, but it was over 50 percent. But if you gave them credit for being in

the ballpark, like, "He's got me on an antidepressant. I can't remember the name of it," that would be a yes. And then it would be over 80 percent of people.

Q. Okay. And did you then take -- go to the EUHR and determine whether the information the inmate gave you was correct or incorrect about the name of their doctor or the name of the medication?

A. Yes and no. I would -- I often -- when I met with treatment teams, I would ask the name of the doctor who's responsible if it was by housing unit. So I did it enough to verify but not -- I didn't systematically do that.

Q. Is it correct you really didn't do that as a practice? I mean, I didn't go through all your notes, but I don't see anything where you verified that the inmates' recollection expressed to you of their medication, their doctor, was verified by you or anyone else. Is that correct?

A. No. For the most part, I believed the inmates. If they talked about their doctor warmly, I had no reason to doubt that they felt good about their doctor. And if they got his name wrong, it wouldn't have changed my mind anyway.

The fact that somebody says, "Yeah, he's a good doctor; he listens to me," is much more important

to me than whether he knew the doctor's name or not.

A lot of the doctors have hard names to pronounce. Often it was clear they were butchering the name but that they had a good feeling about the clinician or the physician.

Q. On the bottom of page 11, you talk about staffing. You talk about -- you see that paragraph that has a 1 on it?

A. Yes. Well, there's two of those.

Q. You're right. The bottom paragraph on the page.

A. Yes.

Q. And you're talking about -- about the fact that you encountered quite a few prisons on your tour where it was expressed to you that they had staffing shortages, right?

A. Uh-huh.

Q. Is that correct?

A. Yes. Sorry.

Q. And then you talked about it overall there, in this paragraph that goes over from pages 11 and 12, that there were staffing shortfalls during the time that you were touring the prisons.

A. Yes.

Q. Okay. And were you aware there was a hiring

would take responsibility for those decisions, but they also wouldn't say it was voluntary that they made cuts. They might say, "There's not enough money to do all the things that need doing, and I was forced to cut a lot of things that I didn't want to cut."

When you use the word "voluntary" -- and that's my answer to you.

BY MR. BIEN:

Q. You were told that -- let me back up and try this again.

What's your basis to say that the staffing shortages that you saw in the California system, when you inspected it, were unavoidable?

A. Well, what I was referring to there is what I said a minute ago, was that one of the main reasons for staffing shortages where -- they had jobs. The jobs weren't taken, and they weren't frozen, but they couldn't hire until the bumping process -- that's what I was referring to -- until the bumping process was completed.

And that's a state personnel law. And I suppose you could change that law, but that's what the law is. And it's not just in California; it's almost everywhere where people have bumping rights as part of the layoff procedure.

Q. So in your opinion, if a staffing shortage at a particular prison results from this public employment law, then it doesn't count in a -- looking at whether or not the care is constitutional?

MS. VOROUS: Objection. Misstates testimony.

THE WITNESS: I didn't say that. No, I don't think that.

BY MR. BIEN:

Q. Why did you include in your opinion the idea that they're trying hard and it's not evidence of lack of commitment? Why is that relevant to your opinion?

A. Because there's a subjective component to deliberate indifference and trying matters. It doesn't -- it's not dispositive. So if you're trying hard, but you have one psychologist for 75,000 inmates, you could still be deliberately indifferent as a state. But that's not the same thing as saying "trying is irrelevant." It's not irrelevant.

Q. What was your evidence that people were trying hard to fill their vacant mental health positions?

A. I talked at length with the leadership about the issue of whatever I observed, what appeared to me to be staff shortages, or what were complained of as staff shortages. I would typically ask Dr. Toche, "What's the status of this?"

And she said, "You know, when the smoke clears, the staffing plan is funded, and they'll have enough staff to do it. But right now they're right, they don't; and we have to wait."

And then she would explain to me what the process was and what the timing was regarding putting the staff on.

Q. What's your understanding about when the smoke will clear? How long do we have to wait?

A. You know, I don't know the answer to that because I think there are multiple waves of repurposes. So it may be that it affects different prisons at different times. And I don't know the answer to that.

MR. BIEN: Okay. Let's take a break.

(Off the record at 3:51 p.m. with and back on the record at 4:00 p.m.)

MR. BIEN: I'm going to mark a series of exhibits, several sets of handwritten notes.

First is Sacramento 2/29/12 on the front page, the first page of which is DEXP104255.

(Plaintiffs' Exhibit 8 was marked for identification.)

MR. BIEN: And the next is three pages of notes, first page of which is DEXP105100.

(Plaintiffs' Exhibit 19 was marked for identification.)

BY MR. BIEN:

Q. Let me ask you about 19.

Is that your notes or Ms. Moore's notes?

A. Mine.

Q. Those are yours?

A. Yeah. I didn't have one of my yellow pads, so I wrote it on a 8 1/12-by-11.

MR. BIEN: Next is Centinela, 104320 through -34.

(Plaintiffs' Exhibit 20 was marked for identification.)

MR. BIEN: And then I think I'm at the last of this series. CMF, 2/27/12, 104283 through -319.

(Plaintiffs' Exhibit 21 was marked for identification.)

BY MR. BIEN:

Q. One question that I wanted to ask you before we start looking at your notes a little bit is about one of issues that you reviewed was emergency response for attempted suicide. Is that correct?

A. Mainly, Jackie Moore did that. I looked at it in -- when I looked at the suicides in responding to Dr. Patterson's reports.

Q. Okay.
A. It gives people a chance to say if they're in medical distress also.
Q. Do you understand that that function is traditionally performed by custody officers?
A. Yes.
Q. And you think that's appropriate?
A. Yeah.
Q. Okay. And in CDCR, are welfare checks performed in ad seg and SHU?
A. Yeah. I think they go once every hour in ad seg and SHU to make sure the person's alive and to give an opportunity to ask for something.
Q. Okay. Are you aware of a --
A. Actually -- I'm sorry. I didn't give you a complete answer. For the first 21 days in segregation, I think it's every half hour.
Q. Every half hour?
A. Yeah.
Q. Okay. And Ms. Moore in her deposition recommended --
A. Dr. Moore.
Q. -- sorry -- Dr. Moore, in her deposition, recommended that CDCR adopt 30-minute welfare checks for all prisoners in ad seg consistent with ACA standard

standards.

MS. VOROUS: Objection. Lacks foundation.

BY MR. BIEN:

Q. Do you agree with that?

A. I don't remember what the ACA standard is about that. But if Jackie said that, there's a very good chance she's right. She knows the standards pretty well.

I'm not sure how much or what it would help. It's not a bad idea. It just costs -- you know, it's a lot of staff time to do it. I'm kind of neutral about it. Certainly not a bad idea.

Q. You understand that in reviewing suicides, which is one of your jobs, you reviewed some of the completed suicides; is that correct?

A. Yes, sir.

Q. You saw cases where it was reported that the inmate had rigor mortis at the time he was found?

A. Yes.

Q. Okay. And you did some investigation -- I could see from your notes -- as to what rigor mortis was and what the details were; is that right?

A. Yeah. I did a little checking of -- my recollection was that -- well, let me back up.

Rigor mortis is often misconstrued by lay

alive and begins emergency medical response?

A. It theoretically could. I'm aware of that happening. Very few times in my career that I've seen that happen. But it could if they got lucky.

Q. You're -- very few times you've seen someone saved to -- attempted suicide and their lives are saved?

A. No. No.

Q. I didn't understand your testimony.

A. Where an officer happened to see the guy trying to kill himself and intervened quickly. It happens all the time when other inmates say, "There's a man down," and they yell, and officers respond quickly. I've seen lives saved many times like that. But it's much more common it would be an inmate than an officer, unless the person was in an easily visible space.

Sometimes -- if there's a guy they're worried about, they'll move him to the most visible cell, or maybe there's a cell with a bigger vision panel and then that, the officer might be likely to catch.

Q. Just focus on the 30-minute welfare checks.

A. Okay.

Q. Do you agree that lives can be saved by -- if California expanded 30-minute welfare checks to include all prisoners who are mentally ill in segregation for the time that they're in segregation?

A. Yeah, I would say it could.
Q. Would you also agree that approximately 40 to 50 percent of the suicides are people who are not mentally ill? Is that correct?
A. I believe that's approximately right, yes.
Q. You also agree it would be beneficial and save lives for California --
A. I'm sorry. By "not mentally ill," I assume you mean not identified mental health service recipients.
Q. That's correct. That question was vague.
Would you also agree that it might save more lives if California did 30-minute welfare checks for everyone in ad seg?
MS. VOROUS: Vague and ambiguous. Lacks foundation.
THE WITNESS: It might.
BY MR. BIEN:
Q. It's possible that somebody would be identified early enough to open the cell and maybe stop his bleeding or provide CPR or other emergency medical services?
A. It's possible.
Q. Okay. Do you disagree with the ACA standard being 30 minutes as being an appropriate national

There are differences between ethnic groups on suicide. That can actually work in either direction. These are just hypotheses for exploration.

Q. Segregation. Do you think California uses segregation more than other systems?

A. It appears to me to be true, but I've never looked at a systematic study of various states. Some places use different names for statuses.

And I told you earlier that it's my opinion that segregation is used nationwide too much. But that's just my opinion. It's not -- I haven't really gone and said, "Of the people in segregation, here's how many truly need to be there."

Q. Right. You recommended to California that they should expedite the movement of people who were in segregation for sensitive needs out of segregation?

A. If that's the only reason they're there, absolutely. I said put them at the very top of the list.

Q. One of the reasons is you think it's a countertherapeutic place. It's not a safe place to be if you're mentally ill.

MS. VOROUS: Objection. Misstates testimony. Lacks foundation.

THE WITNESS: I just think you shouldn't be in

segregation unless you -- there's no other way to keep the prison or you safe. But they have sensitive needs yards for that purpose.

And I understand there may be a -- you know, if somebody needs a particular level sensitive need yard, there may be a challenge in getting them there, but put them at the top of the list in terms of priority of trying to get them off. And my understanding is that they've done that.

BY MR. BIEN:

Q. And who told you they've done that?

A. I believe it was Mike -- I can't remember his last name.

Q. Okay.

A. I -- I can't remember his last name.

Q. You think California's unusual in terms of its length of stay that the mentally ill spend in segregation and in SHU?

MS. VOROUS: Objection. Lacks foundation.

THE WITNESS: I don't know. I've never done a systematic study of various states. Even if they weren't high, it doesn't mean it's the right number because of what I said a moment ago. Because it's my general opinion that everybody uses it too much. But that's just an opinion. I've never seen a study of

that.
BY MR. BIEN:
Q. In the last five years, have you done a systematic study of mental health delivery in any other prison system in the United States?
A. Well, Hawaii, I mainly work at the Oahu Correctional Center, which is a jail. But they have a unified jail prison system. I've looked at Oahu, which is their big prison on Oahu.
Q. My question is -- I'll go one by one: Did you do a systematic study of mental health care in the Hawaii prison system in the last five years?
A. I wouldn't say a systematic study, no.
Q. Any other states in the last five years you've done a study of their mental health delivery system to see if it's constitutional?
A. Well, Michigan, I think, is still within the last five years, when I was the monitor there or one of two monitors.
Q. Okay. And when was that done?
A. I think we finished about three years ago. Maybe four.
Q. Okay.
A. And it was four years before that.
Q. Okay.

Q. Okay. Do you remember when you were at CIM that you observed in the ad seg unit a large number of mentally ill inmates who were there because they were designated for sensitive needs?

A. There were 12 of them in CIM in Charlie Unit. And that was a sensitive need unit, and they were -- they weren't getting groups. And I made a pretty strong criticism of that, that -- as I recall, the mental health director said, "Well, the clinicians in that unit are really busy. They got a lot of CCCs."

I said, "Well, you know, these guys are EOP. You've got to give them EOP care."

That doesn't mean, by the way, that groups are essential. Groups are the most cost-effective way of delivering care if you did an equivalent amount of individual, but I didn't think they were doing that.

Q. Okay.

A. So they weren't neglecting the guys, but they weren't giving them the EOP level of care, and they had been deemed to need that. So I was critical of that.

MS. VOROUS: Can you show him where in the CIM that you're referring to?

MR. BIEN: I wish I could.

THE WITNESS: I actually remember that one.

BY MR. BIEN:

Q. If you can find the CIM one, you can look and refresh your recollection.

A. CIM is when I was in Charlie yard.

Q. Let me see if I can help you out here.

MS. VOROUS: CIM is Exhibit 13.

BY MR. BIEN:

Q. Okay. Let's see if I can help you out.

A. There's a note on page 10, 104449, the fourth checkmark. It says: "Move EOPs out of here. Prioritize."

That was related to the same observation, and then...

Q. Okay. So let's look at that page. Higher up on that page it says: "LOB no," with an exclamation mark.

What were you referring to there?

A. That stood for -- we just go figured that out yesterday. Just figured that out.

Q. Also, on the next page, I see a reference to LOB again.

A. Got it. Okay. Thank you.

What that was was -- so if somebody was in segregation for no other reason than there wasn't a bed for them. Lack of bed.

Q. LOB stands for lack of bed?
A. I don't know why I used an acronym. I hate acronyms. I think maybe they called it that status.
Anyway, on the next page, what it says is -- I said, "Well, wait a second. If I'm in seg just because I need a place to sleep, why am I confined to my house? Why can't I be treated like a regular old inmate if I haven't done anything?"
And they said, "Oh, we do that." If it's a row of LOBs, they let them all out.
If it's interspersed because they didn't have a bed next door to a seg inmate, then they said, "We don't do it for them."
I think they were afraid of letting a seg inmate out.
I said, "That's not okay. Put signs on the door. Figure it out. You shouldn't lock me down if I didn't do anything. It's not fair."
Q. You understand when you visited CIM in May of 2012 that there was a -- a shortage of the particular kind of beds that were necessary for these men who were in -- called LOB?
MS. VOROUS: Objection. Lacks foundation. Vague and ambiguous.
THE WITNESS: Yeah. I don't think they were

mentally ill. They were just regular old inmates. They may have been CCC or not. It was just a practice when someone had just moved and there was no bed for them -- I don't think it was very long.

I said, "It ain't right. If I didn't do anything, open my cell. Let me out on the yard, and then I'll sleep in the bed. Who cares where I sleep?"

BY MR. BIEN:

Q. Did you call back to -- when you made checkmarks on this, on 449 and the next page, does this reflect issues you raised with the -- in the exit, or did you call back to the institution? What do the checkmarks mean?

A. Usually I check them off when I -- it might mean that I want to include it in the mention of the exit conference. It might mean I want to mention it to somebody. I don't remember specifically what it was at the time.

Q. And you recall encountering people throughout the system that were waiting for -- who were mentally ill, either CCC or EOP, who were waiting for a transfer to a place that was designed to provide housing and treatment for their level of care?

A. You talking about the ones that we were mentioning before, the EOP inmates?

This had to do with the investigation of -- that staff malfeasance was pulled out of the suicide unit and given to internal affairs, and then that's the last that the suicide folks heard of it.

And I thought they needed -- they don't need to know all the details, but they at least need to know, "Yeah, that's being investigated. There was a problem. It's been dealt with." It can be vague, but they have to -- there has to be some feedback loop.

Q. On the top of -- I think it's page 4583 --

A. Yeah, I got it.

Q. -- when you write "REC," that means recommendation?

A. Yeah.

Q. Okay. And that -- can you read that recommendation?

A. "Recommendation: Not necessary for all inmates to be in module."

Q. And did you recommend -- I've seen this a couple times in your notes, Doctor, that CDCR consider an individualized assessment as to whether or not inmates need to be treated in modules rather than having a blanket rule that applied to groups of inmates, like in particular units or areas.

A. Yes.

Q. And why was that?

A. Let me say there may be groups of inmates where it's legitimate. For example, somebody's in SHU, I'm not particularly offended by putting everybody in the module. I don't think that you have to do it that way, but it's reasonable.

If somebody's in ad seg for their personal protection, it makes no sense whatsoever to me to require them to be in a module. So it should be an advised assessment.

Q. And the same in -- you have the same opinion about MHCB and the use of modules in the MHCBs?

A. Yes.

Q. That should be individualized assessment?

A. Yeah. In fact, Dr. Scott did the modules more than I did, but I would think it would be the minority of cases where it would need a module.

If somebody's a danger -- the way I did it, if somebody's a danger -- if somebody's a danger to themselves and to others, then it's fine to put them in a module. But if they're just a danger to themselves, then I don't get it. I wouldn't do that unless there's a good reason to do it.

Q. If you turn to the next page, is that your interview with an inmate?

on a list."

A. Yeah.

Q. Okay.

A. And I checked that with other inmates and staff, and they all said that wasn't true.

Q. The next page, Jackson, on the bottom, says: "LPCs don't go cell to cell."

A. Yes.

Q. Right?

A. That's why I asked.

Q. So that was two different inmates, right?

A. I take that back.

Several inmates made that allegation. I asked several different officers that weren't around each other, and I asked a bunch of inmates, and it was my conclusion that that wasn't true.

Q. Okay. Did you investigate any logs to confirm whether or not that was happening?

A. No, I didn't, because Dr. Moore was looking at the rounds log. And once -- if I hadn't gotten so many people telling me it wasn't true, I might have looked. But the inmates themselves told me, and they kind of, you know, implied that the guys who were saying that were complainers, I guess is the best way to put it.

I'm tired. Trying to concentrate.

Q. The area you've starred, do you recall what that refers to?

A. That was so bizarre. I can't really explain it to you.

The officers were telling me, "We're required to stay within X number of feet of the CTC because of the licensing regulations. So we can't move these inmates. We got to wait for two escorts to come even though we're standing here." And it was just -- years ago I thought that the licensure of the CTCs was going to be a problem, and that was an example. So I starred it.

Q. Did you investigate the use of the cuffing policy within CTCs, which inmates that the CDCR policy concerned who has to be cuffed when they come out of their cell and who doesn't?

A. I did not. Dr. Scott focused on the CTC, so I didn't pay any attention.

Q. Okay. Can we take a look at the Pelican Bay -- are you okay with time?

A. 20 to.

Q. Okay. Pelican Bay.

A. Which one is that one? Toward the end, right?

MS. VOROUS: Exhibit 14.

THE WITNESS: Got it.

CERTIFICATE OF REPORTER

I, MEGAN F. ALVAREZ, a Certified Shorthand Reporter, hereby certify that the witness in the foregoing deposition was by me duly sworn to tell the truth, the whole truth and nothing but the truth in the within-entitled cause;

That said deposition was taken down in shorthand by me, a disinterested person, at the time and place therein stated, and that the testimony of the said witness was thereafter reduced to typewriting, by computer, under my direction and supervision;

I further certify that I am not of counsel or attorney for either or any of the parties to the said deposition, nor in any way interested in the events of this cause, and that I am not related to any of the parties hereto.

DATED: March 1, 2013

_____

MEGAN F. ALVAREZ

RPR, CSR 12470

Exhibit 84

Transcript of the Testimony of:

Lindsay M. Hayes

Coleman v. Brown

February 18, 2013

Volume I

THORSNES LITIGATION SERVICES, LLC
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IN THE UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

No. S 90-0520 LKK-JFM

- -

RALPH COLEMAN, et al.,

Plaintiffs

vs.

EDMUND G. BROWN, JR., et al.,

Defendants

- -

DEPOSITION OF LINDSAY M. HAYES

Monday, February 18, 2013 8:53 a.m.

Intelligent Office

265 Franklin Street, Boston, MA 02110

Reporter: Janet M. McHugh, RMR, CRR, CLR

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until December of 2010.

Q. What are 30-minute welfare checks?

A. 30-minute welfare checks are simply cell checks made by correctional staff in particular areas of an institution, normally required in what is called special housing. They could be mental health units. They could be medical units. They could be administrative and disciplinary Seg units.

It's a standard practice in correctional systems around the country, I will say outside of California. It's been a requirement of the ACA, the American Correctional Association standards for as long as I've read the ACA standards to conduct 30-minute checks in special housing units.

Q. And are these -- who conducts these checks under ACA standards?

A. Normally, it's the officers.

Q. Correctional officers?

A. Correct.

Q. And what are they looking for?

A. They're looking for an inmate that's alive, an inmate that's in their cell. Those are the two main -- main reasons why welfare checks are called. That's why the term is called "welfare." I think that it's not used as a suicide observation, because

So, you know, whether they were uninformed or not, I am not sure. I just remember there was a tremendous amount of resistance by the CDCR personnel.

I think that there were some -- although most of the CDCR representatives were clinicians, I think there were also correctional officials that were at this meeting, as well.

Q. Okay. Another issue that you discussed in this 2006 declaration was treating non-disciplinary inmates different from disciplinary inmates in Ad-Seg. Can you explain what that refers to, Mr. Hayes? I'm referring to Page 7 and 8 of your declaration, beginning at Paragraph 16.

A. I believe that there was a discussion that, for a variety of reasons that I don't recall, that there were non-disciplinary inmates being housed within the Ad-Seg units. And the concern was that they were being managed as if they were disciplinary inmates.

In other words, there was very little movement. In other words, lack of out-of-cell time. Their property was limited. So they were being treated as if they were disciplinary inmates, but they did not have disciplinary orders.

And we were -- there was a discussion that this could also be one reason why there's a disproportionate number of suicides in the Ad-Seg unit, because inmates in these units were very frustrated, and their mental health was deteriorating, and their stress level was increasing because they're there for reasons other than discipline, and yet they're being treated it as if they were disciplinary inmates and being locked down up to 24 hours a day and not being given yard and normal property.

And that this -- and I think that there was -- it wasn't an issue that I necessarily brought up. I think it was a general agreement amongst the folks that were at this summit conference that this -- this could perhaps be one of the reasons why there was this disproportionate number of suicides within the Ad-Seg unit.

Q. Turning forward in time, could you take a look at what's been marked as Exhibit 3, please, which is the contract between National Center of Institutions and Alternatives and CDCR.

A. Yes.

(Witness complies.)

Q. Can you explain how you came to be -- to

Exhibit 14.)

MR. BIEN: What numbers are those?

COURT REPORTER: Thirteen and fourteen.

BY MR. BIEN:

Q. Mr. Hayes, I can represent to you I was present when these pictures were taken. And these are pictures taken by CDCR staff, who accompanied plaintiffs' counsel and our experts on a tour on February 7, 2013.

Do you -- looking at this picture, does this look like the MOHU cells that you observed at Mule Creek State Prison during your tour?

A. You know, my recollection is not that good from two years ago. They -- all these OHU cells look pretty much the same to me. But -- I mean, this is reflective of there not any beds in them.

This cell is four concrete walls, a sink-toilet combo, stainless steel commode, and that's about it.

Q. You expressed an opinion in your reports to CDCR that MOHU -- cells such as this that's portrayed in these photos should not be used for various purposes. Is that correct?

MR. RUSSELL: Objection. Vague, ambiguous, ambiguous, overly broad, lacks

foundation.

A. I think my specific opinion was in most of the cells that I observed for -- that were designated -- identified to me as being designated to house inmates on suicide observation, and most of these were in the OHU units, because I have probably a separate opinion for the crisis bed cells I saw, but for the OHU cells in all three facilities, including Mule Creek, the furnishings were so stark and non-existent and the lighting and the sanitary conditions were so poor that my opinion was that it was unlikely -- that its stark presence is a deterrent for inmates to come forth who are suicidal and seek out mental health services or confide in staff that they're suicidal because of the -- of the treatment that they would receive once they were put into the cells.

That basically, they were clothed in safety smocks and not much else, not allowed to have many possessions, if any, not allowed out of their cells except to shower every other day.

So under those conditions, it's -- it's difficult to believe that someone who was suicidal was going to want to come back in there again if they were -- if their suicidal ideation came back. And,

housing.

So when I heard that they were being used for a several-day length, then that became concerning enough for me to put this brief section in my report.

Q. Did the ZZ cells that you observed have beds in them?

A. Let me -- I don't think I address that within my report. Let me see if I did within my notes, if you could just bear with me for a second. I don't see any reference to them in my notes. I'm sorry.

Q. Okay. During your observation of CDCR prisons on these tours, did you encounter any CDCR staff that were actually doing suicide watch of an inmate on a one-to-one?

A. Yes. I observed the certified nursing aides doing almost all of the watches.

Q. And can you describe to me what you observed? What were they doing?

A. I remember one housing unit very clearly, because -- I believe it was at DVI, there's an OHU overflow unit, which is on the other side of the administrative Seg unit. It's basically one unit divided in half.

As I recall it, the left side was the administrative Seg unit, and a series of linear cells. I don't know the length, but quite -- quite a few. And if you came on to the unit and took a right, you would go through a door on to what is referred to as the OHU overflow unit.

And when we walked in, I remember distinctly, because there was this very foul smell when we walked around the unit. And it was -- I was told it was the aftermath of pepper spray that was dispensed on the -- in the administrative Seg side of it. But it had filtered on to the overflow unit. And we walked in, and it was rather surreal.

There were -- almost all the inmates -- I think every single inmate that was housed on the overflow unit was on suicide observation status, they were all on a one-on-one status. And there were -- each -- outside of each cell was a certified nursing aide sitting in a chair or standing outside the cell. And they were assigned to that individual inmate. And there was a line of them.

If there were 10 or 15 or 20 of these aides, they were all lined up down the linear cell block area. And all -- most of them had surgical masks on because of the stench of the aftermath of this pepper

spray. And it was just a surreal-looking visual.

Almost all the inmates were either sitting or standing, facing outward, just looking out at us as we're walking through or looking at the CNA or trying to have a conversation with the CNA.

I -- when I inquired as to -- I had a number of questions when I saw all this. But one of them was, why are all these inmates needing one-on-one? And then I realized as I looked into one of these cells that one of the reasons were that they were very dangerous cells.

There was no lighting, if any. There might have been some minor lighting, but that could have been just the light from the outside cell block. You could not see very clearly into the cells.

They were not suicide-resistant. I believe they did have bunks, but the bunks were very dangerous, and there were unsafe ventilation grates.

So it was obvious that these cells were not suicide-resistant, and, therefore, some of the reasons why they were on one-on-one is because the cells were unsafe, not necessarily that these inmates were at the highest risk of suicide requiring one-on-one status, but they were being housed -- because it was an overflow unit, they were being

C E R T I F I C A T E

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, SS.

I, Janet M. McHugh, a Registered Merit Reporter and a Notary Public within and for the Commonwealth of Massachusetts do hereby certify:

THAT LINDSAY M. HAYES, the witness whose testimony is hereinbefore set forth, was duly sworn by me and that such testimony is a true and accurate record of my stenotype notes taken in the foregoing matter, to the best of my knowledge, skill and ability.

I further certify that I am not related to any parties to this action by blood or marriage; and that I am in no way interested in the outcome of this matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 19th day of February, 2013.

_____
JANET M. MCHUGH
Notary Public

My Commission Expires:
July 11, 2014

Exhibit 85

Transcript of the Testimony of:

Richard Johnson

Coleman v. Brown

February 25, 2013

Volume I

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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, ET AL., Plaintiffs, vs. EDMUND G. BROWN, JR., ET AL., Defendants.	CASE NO.: S 90-0520 LKK-JFM

DEPOSITION OF

RICHARD JOHNSON

MONDAY, FEBRUARY 25, 2013, 8:58 A.M.

SAN FRANCISCO, CALIFORNIA

REPORTED BY: MEGAN F. ALVAREZ, RPR, CSR NO. 12470

THORSNES LITIGATION SERVICES, LLC

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, ET AL., Plaintiffs, vs. EDMUND G. BROWN, JR., ET AL., Defendants.	CASE NO.: S 90-0520 LKK-JFM

The Deposition of RICHARD JOHNSON, taken on behalf of the Plaintiffs, before Megan F. Alvarez, Certified Shorthand Reporter No. 12470, Registered Professional Reporter, for the State of California, commencing at 8:58 a.m., Monday, February 25, 2013, at the Rosen, Bien, Galvan & Grunfeld, LLP, 315 Montgomery Street, 10th Floor, San Francisco, California.

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I N D E X

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E X H I B I T S

Q. And when DSH provides you with the pending transfer list, what does that list look like?

A. That lists each of the DSH hospitals or -- I'm still going to -- even those in the CDCR prisons, can refer to those as hospitals?

Q. Please.

A. Okay. Then for each of the DSH hospital settings that house our inmate patients, they have what they call a BUM report, which is the -- it's the daily utilization management reports.

And on those BUM reports, it has their pending transfer list.

Q. And does that show the date that the patient was referred to DSH?

A. I'm not familiar if every -- each of the hospitals does because their BUM reports are different. And for the information that we receive, which is different -- for example, that those are from a -- one of their hospitals versus in a CDCR institution, I know that some of their BUM reports have that information, but I can't confirm that they all do.

Q. Does a BUM report show the date accepted?

A. I don't think that's included in the information that -- that we get for each of the BUM reports, because the BUM report is a very -- it's a much

more comprehensive document that DSH has than what we get the portion of for our placements.

And so -- so I -- I don't know if each of the hospitals give us the information where it has the accepted date for each of their patients.

Q. So how do you know that this is a list of prisoners that are pending transfer?

A. The portion of the document that we work off of is their face sheet, and on the face sheet it has totals. And so it will have like a column that says the pending or referrals, and then they'll have a separate column for the -- for any wait list, which would be those above the -- beyond the Coleman time frames. And so it's like a summary information that -- that we receive.

Q. So you're receiving a summary of their referral acceptance and wait list data?

A. Correct.

Q. Okay. So, in other words, you do not have the underlying data?

A. I'm not sure because I -- for the portion -- I haven't gone to each of the tabs and seen what available is -- you know, which information is available for each of the BUM reports, and so I cannot confirm that.

Q. But what the -- DSH pending list is a --

the...
BY MS. KAHN:
Q. Okay. Okay. Paragraph 13 of your declaration, you write that "As of December 17th, 2012, there were no inmates waiting for acute or inpatient care. There were 13 inmates pending admission to acute care (accepted by DSH) but none had waited more than 10 days, and there were 45 inmates pending admission to intermediate care (accepted by DSH), the majority pending two weeks or less."
So what is the source of the data reported in paragraph 13?
A. In paragraph 13, it was the -- it was the BUM reports generated by DSH.
MS. KAHN: I think I'm going to mark one more exhibit, now, and then I think we should take a break.
So this is Exhibit 4.
(Plaintiffs' Exhibit 4 was marked for identification.)
BY MS. KAHN:
Q. I just want to direct your attention to first the fourth box -- no -- first, are you familiar with this document?
A. Yes, I am.
Q. Okay. What is this?

those beds?
BY MS. KAHN:
Q. Should a -- would -- what about logging prisoners who are placed in holding cells inside of a housing unit who have reported suicidality and are awaiting to be evaluated by a clinician for possible placement in an MHCB? Should they be logged?
MR. RUSSELL: Objection. Vague and ambiguous. Calls for speculation. Lacks foundation. Incomplete hypothetical.
THE WITNESS: And what I'm aware of is that in the circumstances -- or in the policy and the training directive, that if they're in a holding area because there's not a mental health crisis bed available at the institution, then that's when they should be logged on to the alternative housing log.
BY MS. KAHN:
Q. Okay. Does HCPOP have a list of all alternative placements used at each prison?
A. No.
Q. Why not?
MR. RUSSELL: Objection. Vague and ambiguous. Lacks foundation. Calls for speculation.
THE WITNESS: For our placement purposes, it doesn't matter to us, you know, because our oversight is

with the placements and with the referral time frames. And so it doesn't matter to us as far as meeting the -- being placed within transfer time frames where they're housed in alternative housing.

BY MS. KAHN:

Q. Okay. Are you aware of whether mental health program has a list of all alternative placements?

MR. RUSSELL: Objection. Vague and ambiguous. Calls for speculation.

THE WITNESS: No, I'm not aware if there's a comprehensive list.

BY MS. KAHN:

Q. Okay. When were you last inside of a prison?

A. Say 2012. Could be down at CMF. Was looking at some of their new programs down at CMF. And that's the last that I remember being in a prison.

Q. Have you ever seen any of the alternative placement locations identified in the memorandum or program guide section?

A. I have been in many correctional treatment centers, so I'm aware of some of their, like, triage areas within the -- within the CTCs. And I've been to Mule Creek where they have, for example, their MOHU.

Q. Do you have an opinion about whether this is an appropriate location to house a suicidal prisoner?

accepted and has been waiting since then. And the report is dated December 31st, 2012.

Has he been waiting more than 10 days for placement in the acute program?

MR. RUSSELL: Objection. Vague and ambiguous. Lacks foundation. Calls for speculation.

THE WITNESS: And I'm not familiar with their report, and so I know -- I know how our data is calculated, but this is the first time that I've seen this report and I would have to know more about it.

BY MS. KAHN:

Q. Okay. Is that your answer?

A. Yes.

Q. Mr. Johnson, I just want to remind you that said as chief of health care placement oversight and the program itself is responsible for tracking capacity and census and wait list data for Department of State Hospitals, correct?

A. Correct.

Q. And you've never seen this detailed data which the Department of State Hospitals provides per court order to the Coleman special master and plaintiffs' counsel and filed with the court?

A. I have not.

Q. This is not provided to HCPOP?

A. I don't remember seeing this report.
Q. And you filed a signed declaration with the court attesting to lack of wait list and stating that certain numbers of people have not been attesting to the waits on waiting -- the numbers of patients waiting to be admitted to these programs without being informed or provided with this data or that knowledge of this data?
A. DSH has told us that their official document on their census and wait list is their BUM reports that come from the hospitals, and that's what we used to compile our data.
Q. Well, if you were aware that this report existed, would you compile a different type of wait list with that -- knowing that?
MR. RUSSELL: Objection. Vague and ambiguous. Lacks foundation. Calls for speculation.
BY MS. KAHN:
Q. Would you investigate this data differently if you were aware that the department compiled data that showed the date of referral to an inpatient program?
MR. RUSSELL: Objection. Vague and ambiguous. Lacks foundation. Calls for speculation.
THE WITNESS: I would look into it.
BY MS. KAHN:
Q. Would you have signed a declaration that

stated what it stated if you had this data in front of you and could have reviewed it?

MR. RUSSELL: Objection. Vague and ambiguous. Calls for speculation.

THE WITNESS: I don't know. It would depend on what I was informed what this report is and how it's collected.

BY MS. KAHN:

Q. Do you want to read the entire report first?

Let me first take you to another page first. Do you want to see the wait list for ICF? Turn to page 17.

Starting at 862, continues to the next page. But the names from 862 through 885 have all been waiting more than 30 days for admission to Salinas Valley psychiatric program from the date of referral.

If you turn to page 23.

MR. RUSSELL: There's no question pending.

THE WITNESS: Okay.

BY MS. KAHN:

Q. Turn to page 23, 1170 and 1171. There are two prisoners waiting for admission to Atascadero who were referred more than 30 days ago and accepted.

I'll ask my question again.

If you had had full information available that

is filed under seal and provided to plaintiffs, to the Coleman special master, which the attorney general's office was aware of, CDCR legal was aware of, if this information had been provided to you before you signed your declaration under penalty of perjury, would you have changed the statements that were made in your declaration?

MR. RUSSELL: Objection. Vague and ambiguous. Lacks foundation. Calls for speculation.

THE WITNESS: And I cannot say that I would change anything because we have these source documents that the data comes from in coming to our data. But if I'm ever shown anything that differs from -- another source of data that differs from our data, then it is something I will look into or have my staff look into.

BY MS. KAHN:

Q. Okay. And do you feel like this data contradicts what you said in your declaration?

A. Not necessarily.

Q. So you have to look into this data?

A. Yes.

Q. And you plan to look into this data?

MR. RUSSELL: Objection.

BY MS. KAHN:

Q. I'd like to refresh your memory of what you

Q. Okay. Have you been involved in any bed planning meetings for CCC prisoners?

A. Yes.

Q. What were those or when were those?

A. Those were -- they've been discussions during the implementation of the workload study. Then what was the -- the prev-mix process. You know, the prev-mix was on our same time that the department does the fall and spring projections. And that's when we used to also look at making the adjustments on the mental health populations and then -- but that was based on the preworkload study model.

And then under the -- and so now under the workload study model, we're going to be doing something similar but not identical to the prev-mix and so that's the process I referred to earlier that we're just beginning to, now that AB 109 is -- you know, the conversions of the institutions are getting their completion. And so we're looking at the -- to see if we're in balance with our CCCMS and EOP like you referred to based on the new alignments of the institutions. And then to see if we need to make realignments of our mental health staffing due to AB 109.

Q. This is your special assignment that you

referred to earlier in the depo?
A. Yes.
Q. So this will also be looking at whether there are adequate number of, for example, SNY yards for CCC prisoners?
A. Yes. That will be included.
Q. That will be included.
And these meetings are ongoing?
A. Yes. And we're just at a point with the AB 109 conversions getting to the tail end of their conversions that we could really start sitting down and working with -- and also the mental health staff will be involved, you know, in those decisions along with DAI. And so we're just beginning to -- even though it's been the plan to do this for, you know, the planning meetings, but we're finally at the point where things are getting settled with the realignment conversions that we can now address the mental health alignments.
Q. Okay.
MS. KAHN: I want to mark another exhibit.
(Plaintiffs' Exhibit 18 was marked for identification.)
BY MS. KAHN:
Q. Okay. Are you familiar with this report?
A. Yes.

other issues with the data, too, which I'm not familiar with the details.

Q. Okay. So this -- this particular section of this report identifies EOPs that are in nonhub institutions for more than 90 days.

And, you know, if you could turn to DVI, it's a good example. It's on R1017. There are, you know, two prisoners housed there for 281 and 175 days.

When you were speaking earlier about being proactive, I guess the question is: What does HCPOP do with this data which is generated and provided monthly to all sorts of parties to -- to ensure that EOPs who should be transferred within 30 days to a -- well, let me first ask you. Does DVI have a hub?

A. No.

Q. Okay. There are two EOPs here who have been housed here, one for more than nine months and one for close to six months.

A. And --

MR. RUSSELL: There's no question.

BY MS. KAHN:

Q. Okay. And so what would -- what is HCPOP's role with regard to this data?

A. Well, on list data is that we believe and the mental health program believes that our other data banks

are better, more accurate information than who is in the -- mental health who's in ad segs. And so we use those to cross-check each other.

When we have checked this data and there's been errors, like for the, you know, cases being on this list, and so the systems that we cross-reference with are the COMPSTAT and the mental health tracking system and our own -- and to some extent our SOMS, you know, information.

Q. So you ignore this data?

MR. RUSSELL: Objection. Vague and ambiguous. Lacks foundation. Misstates testimony.

THE WITNESS: No, I don't ignore it.

BY MS. KAHN:

Q. Have you -- is this data reviewed?

A. I'm not sure what our unit does with the information, who sent this to Coleman. So I would have to verify. I don't know if this is part of the data -- the information that are actually EOP CC3 uses.

Q. But as chief, you're responsible for your unit, correct? You were in December.

A. I was.

Q. If you want to turn to page R1018 in Folsom. Again, it's CIM.

A. And the question?

So the idea, just so I understand, is to come up with a plan that could meet all these needs and perhaps designate new prisons?

A. Or new --

Q. Yards?

A. Possibly new yards or even expand on some, like, for example, where we do have some capacity maybe to increase --

Q. Or increase --

A. -- increase a program locally.

Q. Okay.

A. Then you could increase locally or you could look at some other institutions, yards that could be expanded or new yards and do a conversion.

Q. But there's no new staffing plan that's being developed with this, is there?

A. No, no.

Q. So it's the staffing plan that was developed and will exist after you've completed this project?

A. Correct. And the staffing would just follow where the census is.

Q. Okay. And so this is to address the changes in population as a result of AB 109?

A. That's correct.

Q. Okay. Is there a timeline for completing

this?

A. Once again, not a deadline, but we'll be -- you know, we recognize the deed and so -- and I, you know, discussed it with Tim and some others last week because we're just starting to -- you know, the AB 109 is at a point now where at least I believe that we could start actually looking at where we might be able to make the adjustments.

And so we're identifying with the mental health program right now, you know, with -- because we have had meetings with DAI and the stakeholders in this before, but the timing wasn't right because of all the AB 109 conversions. But just based on correspondence I've had with the stakeholders in DAI and mental health program, we all believe that it is the time to actually start identifying the adjustments that need to be made.

And so we're looking at the data now, you know, and setting up the, you know, meetings with who will be the primarily drivers of this.

Q. Who are the stakeholders?

A. Stakeholders would be the mental health program, which would be the population -- or the staff, which is Dr. McAloon still has her hands in it, Sharon McCarver, the regionals, because they know their institutions.

Q. Right.
A. And it will be briefing, of course, you know, the -- Nathan, Judy, and Tim as we're going along.
And then with DAI, they have Dennis Halverson who's there. He's the new Ross Meier, so their population management chief.
And then Becky Alkire is the chief of classification services.
And so they're already -- we've already all discussed it and there will be a meeting first at our level just to say like this is the kickoff of actually going forward with this and then we'll bring in other secondary stakeholders as needed.
Q. Are there any preliminary results about where you think -- what you think needs to be done, or it's too early?
A. It will be primarily based on our population management reports, like the EOP report that you showed earlier.
Q. Right.
A. So using our own reports showing where we may have a -- where our greatest demand is.
Q. Okay.
A. And then we'll go off to where our greatest demand is and identify what the need is, you know, based

on. This is outpatient that we'll be doing this for.

Q. Right.

A. So it will be CCCMS and EOP.

And then looking for the common ground. I mean, we're all committed into finding the solutions to the need, but we always start off with a wish list that we all have that works best and then we try and find -- you know, we come to a compromise wherever we need to. You know, the mental health will have its priority, ones that they would like to expand to. DAI will have their priority list. And then we start working together.

Q. Does HCPOP create a report for CCC that's similar to that EOP bed need report?

A. There is a similar report.

Q. Okay. Just has never been provided?

A. (Witness nods head.)

Q. I appreciate this.

I guess the last thing I want to ask you is: Is there anything that you feel at this point you'd like to correct in your declaration?

MR. RUSSELL: Objection. Vague and ambiguous. Overly broad.

BY MS. KAHN:

Q. Well, we can go through each paragraph if you'd like but if you want to take a moment, and I guess

CERTIFICATE OF REPORTER

I, MEGAN F. ALVAREZ, a Certified Shorthand Reporter, hereby certify that the witness in the foregoing deposition was by me duly sworn to tell the truth, the whole truth and nothing but the truth in the within-entitled cause;

That said deposition was taken down in shorthand by me, a disinterested person, at the time and place therein stated, and that the testimony of the said witness was thereafter reduced to typewriting, by computer, under my direction and supervision;

I further certify that I am not of counsel or attorney for either or any of the parties to the said deposition, nor in any way interested in the events of this cause, and that I am not related to any of the parties hereto.

DATED: March 7, 2013

_____

MEGAN F. ALVAREZ

RPR, CSR 12470

Exhibit 86

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

---oOo---

RALPH COLEMAN, et al., Plaintiffs, vs. EDMUND G. BROWN, JR., et al., Defendants.	No. Civ S 90-0520 LKK-JFM Volume I Page 1 - 300

DEPOSITION OF

STEVE J. MARTIN

THURSDAY, FEBRUARY 28, 2013

CONFIDENTIAL PURSUANT TO PROTECTIVE ORDER

REPORTED BY:

HOLLY THUMAN, CSR No. 6834, RMR, CRR

JAN BROWN & ASSOCIATES

WORLDWIDE DEPOSITION & VIDEOGRAPHY SERVICES

701 Battery Street, 3rd Floor, San Francisco, CA 94111

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Deposition of STEVE J. MARTIN, taken by the Plaintiffs, at K&L GATES LLP, Four Embarcadero Center, Suite 1200, San Francisco, California 94111, commencing at 9:27 a.m., on THURSDAY, FEBRUARY 28, 2013, before me, HOLLY THUMAN, CSR, RMR, CRR.

--o0o--

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ALSO PRESENT: ELDON VAIL

discussed was the -- he wanted -- my particular role, he wanted my best assessment of where the system was relative to constitutional minimum. I don't recall whether we discussed at all what was motivating that inquiry. I certainly did not have the impression or do not recall him saying, we are going to attempt to -- how did you phrase it -- get out from under Coleman?

Q. Uh-huh.

A. No.

Q. Were you surprised, then, when you read about them filing a motion which is pending now?

MR. McKINNEY: Objection. Calls for speculation, vague and ambiguous.

THE WITNESS: No. No, I was not surprised.

MR. BORNSTEIN: Q. Okay. Why not?

A. Well, Counsel, I've been in the business quite some time in a variety of capacities, law-trained, legal capacities in cases that were of this magnitude and understand strategies in this arena.

And it doesn't take a rocket scientist to figure out that if somebody is telling the State that they're doing this or doing that, that they might use that to then set a course of action.

Q. In the course of your work, were you told that there had been some sort of an agreement that there was

supposed to be notice to the plaintiffs about when you as experts went into the prisons?

A. Oh, no. That type of thing was never -- I looked at it and understood that I was being retained -- or the discussions of retention were just as a consultant that had utterly, mind you, nothing to do with plaintiffs or courts or anything else. It's -- having been in that position myself as Agency counsel and Special Assistant Attorney General myself, we routinely retained consultants on matters that -- for a variety of reasons.

Q. Did you in your work -- would you agree that the State's prison system is still overcrowded?

MR. McKINNEY: Objection. Vague and ambiguous, vague as to time.

THE WITNESS: That was not my charge, to make that assessment. But being acutely aware of the Coleman/Plata case and knowing many of the actors and experts, and trying to stay acquainted with the law, I was certainly -- and having been through probably near a thousand institutions for 40 years, as I was going through the facilities, I was certainly attuned to signs that I typically associate with overcrowdedness in a constitutional sense.

MR. BORNSTEIN: Q. And what were those signs

that were you attuned to?

MR. McKINNEY: Objection. Vague as to time.

THE WITNESS: Well, that the infrastructures were compromised, the inmate movement is impeded by shear numbers, that spatial densities are extremely limited. Staffing flow, staffing deficiencies. There's a whole myriad of signs an experienced person would look for.

MR. BORNSTEIN: Q. And you weren't asked to look for those things?

A. I was not.

Q. But in the course of your work, did you form an opinion about whether the State's systems are -- prison system is still overcrowded?

MR. McKINNEY: Objection. Vague and ambiguous.

THE WITNESS: When you say an opinion, are you asking for Steve Martin's observations of having gone through some number of facilities relative to their general operation? I mean, I don't -- I want to be real careful with what you're asking here.

I wasn't asked to render opinions on crowding.

MR. BORNSTEIN: Q. Right. And now I'm asking you, based on your training and experience and the myriad of things that you've just told me about, whether you have an opinion.

should be met by the State of California?

A. I have no opinion on that, because I haven't done the examination that I would need to do to render such an ultimate opinion. I did not see -- well, I'll just stand on what I've testified thus far.

Q. And in order to render such an opinion, what would you have to do?

A. I would probably want to look at certainly staffing complements. I would want to look at access to programming by the inmate populations. The whole array of -- when I say programming, I'm talking about stem to stern, everything from out-of-cell rec time to service delivery, mental health, medical, vocational, the whole array.

I would look at spatial densities, and I would want to calculate very -- with as much precision as I could the in-cell time of the typical -- of the majority of the inmate populations, the time they literally are locked up at some point in the evening and what time they're able to come out in the morning.

I would want a full-scale, absolute inventory of all housing units by space, by cell space, dorm space, immediate adjacent common space.

Q. And --

A. I would --

Q. Go ahead, sorry.

A. You'll get used to me pausing. I apologize for that.

Q. Please, don't.

A. But I would also look at the common indices that correctional managers look at, such as inmate-on-inmate violence, staff-on-inmate violence, disciplinary rates, seg rates, the full data that's available that tells you on a 24/7 basis how a facility is operating.

I of course would want to look at probably individual facility budget -- budgets and requests to determine with what the particular physical plant, how it's operating in terms of dishwashers and laundry machines and all that type of thing, to try to establish whether those things are being -- they are getting -- those things are being accelerated. I would do a full-scale look at maintenance schedules, the ability -- you know, one quick way is to see how many down cells you had at a given point in time on a day.

Probably a lot of these things a lot of the experts in this case didn't do, to my understanding, to reach these magical reduction numbers that are somewhat arbitrary at best, in my view, absent doing this type of thing.

But that's how -- I mean, I do a very -- as I did a lot of my work, you dig it out of the dirt, and what you do, you can render a pretty reliable opinion of whether something is -- you know, whether the inmate population has outstripped the physical plant and outstripped the ability of the managers to operate it safely.

Q. I mean no disrespect, but are you actually qualified to do that kind of work and render that kind of opinion?

MR. McKINNEY: Well, objection. He's not being offered for that purpose. It's been asked and answered.

MR. BORNSTEIN: Q. Go ahead.

A. Yes, having come from a system in which all those things were at issue in the largest scale case in the history of American corrections other than the Coleman/Plata case, the Ruiz case. That's what we did, all those things. And I worked hand-in-hand with professionals and experts that did just that.

Q. And that's because there was a cap -- there still is a cap in Texas, isn't there?

A. It depends on how you look at it, but yeah.

Q. Soft cap?

A. Yeah.

Q. As opposed to a hard cap?

And that's how this originated.

Q. So did the State prepare this audit tool for you, or did you prepare it?

A. No, we -- on this particular issue, when we got to it, Patrick and -- I don't recall who all was present or whatever, but the -- I said -- probably was very quick to say, this is what I am going to look at, given what you want me to do. And they probably said, what is it that you're going to look at? And I said, 1, 2, 3, 4, 5, 6.

Q. There's actually 9.

A. Well, whatever. You ought to share the entire document with me, Counsel.

Q. I mean to, and I apologize for not having it. But I'm going to go get it for you.

MS. CESARE-EASTMAN: It's on its way down.

THE WITNESS: Is that like the check is in the mail?

MR. BORNSTEIN: Q. No, we'll get it for you. If you want to take a break until we get it --

A. No, I know what's on there. I did it.

Q. How did you decide what -- let me ask it this way: Why didn't you go to all of the prisons in California?

A. Time, expense.

Q. Okay. So -- well, there certainly was enough time, because you had -- you started in September of 2011, and this is February of 2013, I guess the last day of February of 2013. So you had time. If -- is that -- you -- there certainly was enough time to do it.

MR. McKINNEY: Objection. Asked and answered.

THE WITNESS: Counsel, are you intimately familiar with my calendar and commitments?

MR. BORNSTEIN: Q. Ah. So it was your schedule?

A. Yeah. I carry 20-plus cases at any given time, monitoring four or five systems. Don't be so cavalier with my time.

Q. Was it -- how did you decide on the ones you went to?

A. Good question. With four experts, I think at least two of -- well, three of us, three of us had varying levels of working familiarity with the CDCR over a variety of years and circumstances. We had our own ideas on institutions that we needed to visit and to set a number where it could confidently be said that what we've seen is representative, generally representative of how the system is operating, save the possibility of a rogue facility that's out there that we just didn't get on our list and is inconsistent with observations we

might render on others.

But generally, we wanted to get 10 to 12 to 13 facilities that we believed, as professionals, once we went through them, would give us a fairly illustrative representative idea of how the system was operating, with respect to my particular issues, at least.

Q. So from that sample size, you were then -- you would then have a sense, I guess, of what you thought was going on in all the prisons?

A. It's better than a sense, because if you're -- in my areas -- I'm just going to speak to my areas. But if you've confirmed and established that a set of regs, policies, procedures, are in place, and they're State regs, and they're vigorously monitored both externally and internally, and there's all these mechanisms and all these reviews being done, you know, like OIG and the -- you know, whatever -- that if those are in place at 10 to 13 institutions, there is a very strong likelihood they're in place at the remaining ones, save, you know, the possible anomaly, the possible, you know, rogue facility that just simply is -- whatever, is not abiding by regs, which those tend to be -- in a system that has this kind of scrutiny, you can't hide those too long. So I doubt there's -- I'd be surprised if there's a rogue facility out there that's abandoned the

Q. No, I hear you.

The State's lawyers were with you when you did it, though. Right?

A. When I interviewed inmates?

Q. Yes.

A. Not necessarily -- you mean standing beside me?

Q. Well, they were in the facility --

A. Oh, yes.

Q. -- with you while you did it.

MR. McKINNEY: That's a different question.

MR. BORNSTEIN: Q. Right?

MR. McKINNEY: Compound. Objection. That's a totally separate question you just asked.

THE WITNESS: They were --

MR. BORNSTEIN: Q. Let me start over.

When you went on your tours, you were accompanied by State Attorney Generals and CDCR lawyers. Correct?

A. Not always CDCR lawyers. I think almost all instances, out of the AG's office.

Q. Was it Pat who was with you?

A. More often that not, but sometimes Deborah.

Q. Okay.

A. And there was a third. I can't recall his name.

Q. And they were with you in the units when you went into the units.

MR. McKINNEY: Objection. Calls for speculation.

THE WITNESS: No. Again, I operate differently. I don't like a lot of you folks around me. It interferes with what I do, it compromises what I do, and if there's any way I can avoid any of you, I pointedly do.

And that -- I'm neutral on that. That's plaintiffs, defendants, anybody.

MR. BORNSTEIN: Q. So who took you around?

A. I had typically asked for a lieutenant, I asked for a coordinator, I asked for a CDCR employee intimately familiar with that facility.

Q. When you did your interviews with inmates, where did those interviews take place?

A. Variety of settings. I would do cell-front interviews, I would call some out for particular-purpose interviews, in a dedicated interview space. Yard interviews, common space, day-room interviews. Quite a variety of inmate interviews.

Q. Did the -- did you tell the inmates that you were working on the Coleman matter?

A. Certainly those inmates that I specifically

whether you have enough staff or whether you're able to do this and so forth, but I did not catalog those.

MR. BORNSTEIN: Q. But did you get feedback that, well, we're in a -- we are doing the best we can, but we need more people?

MR. McKINNEY: Objection.

THE WITNESS: Counsel, I have never spoken with a correctional administrator that they don't tell you that.

MR. BORNSTEIN: Q. Okay. I'm just trying to make sure we're talking about --

A. Ever. Ever.

Q. That's what they said to you. Didn't they?

MR. McKINNEY: Objection. Vague and ambiguous.

THE WITNESS: I didn't catalog -- I know -- I remember one lieutenant that I was -- particularly took to for whatever reason, because I was impressed with him, said, Mr. Martin, you know that we can always use more staff. Does it compromise what we're doing? You know, make -- it makes it difficult, but no, we get our business done. Which is a typical refrain.

MR. BORNSTEIN: Q. It becomes important where you've got mental health people in ADSEG or other restrictive environments, and they need escort staff or other people to get them out of their cells so they can

go to programming, doesn't it?

MR. McKINNEY: Objection. Lack of foundation, vague and ambiguous, vague as to time.

THE WITNESS: You must have staff to move prisoners from Point A to Point B to deliver or bring -- deliver that inmate to the service or bring the service to the inmate, yes.

MR. BORNSTEIN: Q. And in -- particularly in those ADSEG units, you need two staff to move inmates. Right?

MR. McKINNEY: Objection. Lack of foundation, lack of personal knowledge, assumes facts not in evidence, vague and ambiguous.

THE WITNESS: Yeah, I -- I don't know that you need. Do they typically require, I -- yes, they do.

MR. BORNSTEIN: Q. Okay. Now, whether they actually should require is a different question.

A. Yes.

Q. But that's their requirement?

A. Yes.

Q. And they make the inmates cuff up, and then they have two staff move them from place to place. Correct?

MR. McKINNEY: Objection. Vague and ambiguous, vague as to time, lack of foundation.

THE WITNESS: There are certainly categories of inmates that when they come out of their cells, they're placed in restraints.

MR. BORNSTEIN: Q. Well, I'm talking about in the ADSEG units.

A. Yes, that's what I mean.

Q. And in the ADSEG units, if you're there because you're an aggressor or you're there because -- for protection or special needs, you're treated the same. Is that right?

MR. McKINNEY: Objection. Compound -- pardon me, Counsel. Objection. Compound, vague and ambiguous. Lack of foundation.

THE WITNESS: I did not survey that, but I had discussions with fellow team members about that issue as to my view, in observation of the systems.

MR. BORNSTEIN: Q. But your observation was that they were treated the same.

MR. McKINNEY: Objection. Lack of foundation, vague and ambiguous.

MR. BORNSTEIN: Let me rephrase the question.

Q. Your observation was that there was one set of rules for people in a particular unit.

A. Counsel, I didn't directly observe that. I'm basing my -- what I'm telling you on what was

represented to me by a fellow team member.

Q. And what was that?

A. That they were.

Q. And who was that who told you that?

A. Joel Dvoskin.

Q. And what did he say?

A. Basically that.

Q. And from your experience, wouldn't it be more appropriate to make decisions based on the individual inmate you're dealing with?

MR. McKINNEY: Objection. Vague and ambiguous, argumentative.

THE WITNESS: Well, I embraced the proposition that -- well, I don't favor blanket rules applying to segregated populations. That is to say, if they're in that population because they're recently, seriously, frequently violent, that's one set of protocols. If they're separated because they need protection from the general population, that's a separate set of protocols.

Very different protocols. Oftentimes, that's not made. It's -- the overarching ADSEG dictates the protocols.

MR. BORNSTEIN: Q. And there should be separate protocols for the two populations you're talking about. Right?

MR. McKINNEY: Objection. Vague and ambiguous.

THE WITNESS: What I think I just said.

MR. BORNSTEIN: Q. I just want to make sure, because I've now got prison noise behind me.

And the problem is, when you mix those two populations together in a unit -- which is what CDCR does; isn't that right?

MR. McKINNEY: Objection. Assumes facts not in evidence, argumentative, vague and ambiguous.

THE WITNESS: What's the question?

MR. BORNSTEIN: Q. Isn't that what CDCR does, they mix those populations together, at least according to what the other experts told you that you're working with?

A. That came up at a particular facility in a conversation during the day, and I don't even know whether I'm recalling it, you know, with accurate detail. So I don't know if there's a -- I certainly can't render an observation or opinion on what CDCR is doing as a general practice with respect to that issue.

Q. Assuming they are doing what I just said, is that of concern based on your expertise?

MR. McKINNEY: Objection. Vague and ambiguous. It's an incomplete hypothetical, argumentative.

THE WITNESS: It would be.

MR. BORNSTEIN: Q. Why?

A. Well, because other than -- a PC inmate that doesn't otherwise represent a threat to anybody, but somebody is a threat to him, once you physically separate him in a housing unit, then he ought to be managed just like any other general population inmate. There's no need to keep him locked up, if he's with like offenders.

Q. Is it a sign of overcrowding if you are forced to have your -- your inmate population in one unit in a segregated unit because that's the only way you can protect them?

MR. McKINNEY: Objection. Vague and ambiguous.

THE WITNESS: Well, the critical operative word there is, if you are forced to do it, that would be a sign. But I know any number of operations that have no space issues that do it. So again, you've got to dig deeper.

MR. BORNSTEIN: Q. So it's both. It -- it's not right to do it.

A. It's not in my view correctionally sound and appropriate to treat --

Q. Is it unconstitutional, in your opinion?

A. I believe it could be, if there are onerous or punitive conditions, a de facto type of punishment when

the offender hasn't done anything. Due process implications, if nothing else. If not Eighth Amendment.

Q. Like being confined in your cell for 23 hours a day, for instance?

MR. McKINNEY: Objection. Vague and ambiguous, argumentative.

THE WITNESS: Yeah, because you're gay?

MR. BORNSTEIN: Q. Or because you have special needs --

A. Or because you have special needs or whatever. It could be a whole array of things, yeah.

If the effect of that is corporally, you know, punitive, then I think there's an issue.

Q. In your views of the various facilities, you went to some that had SHUs. Right?

A. Yes.

Q. Did you notice that in -- if you got an inmate in a SHU who comes out and then goes into ADSEG because there's no space available in the SNY yard, isn't that just more punishment for that inmate?

MR. McKINNEY: Objection. Lack of foundation, lack -- hold on, Steve. Lack of personal knowledge, compound, vague and ambiguous, argumentative.

THE WITNESS: Again, not just per se, no.

MR. BORNSTEIN: Q. Why not --

that. That was bad question, so let me withdraw that.

Q. The total mental health caseload in the prison population is approximately 30 percent, more or less.

MR. McKINNEY: Objection. Vague as to time. It's not a question, either. There's no question pending currently.

THE WITNESS: It's in the ballpark. I mean, data tells us that, so I don't -- but yeah, it's not outlandish, what you just said.

MR. BORNSTEIN: Q. No, no, but it's in that neighborhood, in that range. Is that right?

A. It's my understanding, somewhere in that neighborhood.

Q. Did you do any sort of -- I don't care, counting, if no other word, the number of use-of-force incidents against mental health inmates/patients versus the number of use-of-force incidents against non-mental health inmates? Did you do that?

A. I didn't do that counting. I saw data that's routinely reported in the Special Master's office and the CDCR's own data as to that.

Q. I think CDCR said at the end of 2012, there was about 26 percent of the population were mental health.

A. Well, whatever it says, yeah. I mean, I don't know. I don't recall all those figures.

Q. But the CDCR tracks the number of use-of-force incidents against the mental health population, don't they?

A. Absolutely.

Q. And it's significantly higher than 26 percent.

MR. McKINNEY: Objection. Argumentative.

THE WITNESS: It's my understanding that's so.

MR. BORNSTEIN: Q. Okay. And in fact, I'll just give you an example from your files. Next in order, please.

(Deposition Exhibit 3 was marked for identification.)

MR. BORNSTEIN: Q. This is from -- I guess is that your writing at the top, "RJD Pat"?

A. Yes.

Q. "3-7-12"?

A. It is.

Q. So that's Mr. --

A. Yes.

Q. -- McKinney?

A. Yes.

Q. Who's here?

A. Yes.

Q. And he gave you this. Right?

A. In an email, yes.

especially in a pattern and practice.

What I would do is, say, that's a problem here. That's an issue here --

MR. BORNSTEIN: Q. Okay. Well, in fact --

A. -- that will come back to bite you type of --

Q. That's how you do it?

A. Well, at the time, on an individual case, yeah, until I have an understanding of whether it's a pattern and practice.

Q. It is true --

A. What would you have me do? Go around arresting these people or something, accusing them, or --

Q. Well, I don't know. You tell me. What do you think should be done if somebody's using excessive force?

A. Well, they'd be enjoined to stop it in a class action. Don't talk to me about that. I've reformed more facilities in this country on that than you'll ever even think about.

Q. So you agree with --

A. Don't even question that.

Q. I'm not. I'm asking you --

A. I've put myself in harm's way physically, politically, and every other way to stop this kind of thing.

Q. Because it's very hard to do, isn't it?

A. It's difficult to do. But more than that, it hurts people. It's inhumane, it's immoral.

Q. What's inhumane?

A. To hurt somebody when it's not necessary.

Q. Right. I agree with you.

But my question to you, though, is, this particular policy that you helped to create -- or inspire, let me put it that way -- I mean, this should have been done long before they hired you, shouldn't it?

MR. McKINNEY: Objection. Vague and ambiguous, it's argumentative.

THE WITNESS: Well, I would answer this by saying, where have all your experts been and the Special Master's experts been and the Court been while this has been going on in plain view?

MR. BORNSTEIN: Q. So they should have --

A. I mean, you want to always focus on the agency. This has not been secret, what I've identified here. This has been out there for everybody to see. But people count beans. The Special Master just counts events. They haven't looked at actual applications. Your people haven't. I mean, there's got to be some equity in these things here. This is unfair.

Q. It's unfair for outsiders to run the

institution?

A. No. No. It's unfair to hold them to a high standard that y'all don't seem to have to meet.

Q. Whose prison is it?

A. It's the public's.

Q. But who runs it?

A. The public trustees. The agency officials.

Q. Well, those are CDCR people.

A. Yes. No, I'm not trying to diminish their responsibility. They -- it is their responsibility.

Q. Okay. They're the ones --

A. I'm just wondering, you know, where's everybody else been in this thing?

Q. Well, I don't know. But I know -- I'm trying to find out where you're at and where they're at, and that's what I'm trying to figure out.

A. And I'm trying to answer that.

Q. And I appreciate that. But my question to you is, it seems like what you've suggested here and what they have adopted is something that should have been adopted a long time ago.

MR. McKINNEY: Objection. Calls for --

MR. BORNSTEIN: Q. Would you agree with that?

MR. McKINNEY: Objection. Calls for speculation, it's argumentative.

THE WITNESS: Well, I -- it should have been adopted when they had enough information to know that, through their reviews, their investigations, and their oversight, that there is a potential problem here.

MR. BORNSTEIN: Q. All right. And you would -- does it surprise you -- well, let me ask it this way. Hypothetically, have you heard -- no, let me do it this way:

In your tours, when you interviewed command staff at whatever prison you were at, did they tell you that they prefer using spray as opposed to other means to extract prisoners from cells?

A. Yes. I think that's generally true.

Q. And that's because of what they call officer safety?

A. And inmate safety, likewise.

Q. And in general, there's nothing wrong with that as far as you're concerned, so long as they do it in a sensitive way and not an excessive way.

A. Well, I would couch it more in terms of a tactical, sound manner.

Q. Okay.

A. That accomplishes the objective of the force, which is to neutralize aggression. I look at it very coldly, very objectively.

of what that incident is, they use MK-9, but I've not ever seen that being carried on a person on line level.

Q. And you're comparing it to what kinds of other systems? I mean, is California --

A. I've been in so many. I've probably been in confinement operations in 40 of the 50 states.

Q. So nobody else does it like this.

A. Not that I recall. I've never seen an MK-9 being standard issue on a line level.

Q. What about in the last 5 years?

A. No.

Q. How many different kinds of institutions have you been to in the last 5 years?

A. I'd have to study that, but I typically during a 12-month period find my way in between, you know, 5 and 10 facilities a year, so I -- you know, I could very well have been in 30 to 50 facilities in the past 5 years, easily.

Q. And you said you -- I think during the past year you've been working on 20 different cases or something? Sorry, I didn't --

A. It went down wrong. I've got 20 different client -- cases, yeah, if you will.

Q. And are some of them -- I mean, are the -- can you discuss which ones they are?

A. Well, four or five of them are -- I'm a federal court monitor in New York City jails, federal court monitor in the state juvenile system in Ohio, federal court monitor in state prison in Mississippi. Those are my monitoring.

I'm also working as an appointed expert in a Taser class action case in the State of Ohio in Franklin County, which is Columbus.

I've got a large class action use-of-force litigation in LA County jail, I've got another LA County jail use-of-force involving five plaintiffs damage case. I've got cases in Louisiana.

Some I'm just not -- not coming to mind.

Q. The LA County cases --

A. Denver, an in-custody death case, use of force, in Denver Jail. Strip-search case in LA County Jail.

That gives you a good -- crowding conditions case in Birmingham, Alabama, Jefferson County.

Q. That's a good sample.

Speaking of strip-searching, is it in your experience in the prison setting, something in a Level 4 facility, like an ADSEG or a Level 4 yard, would there -- would it be common to strip-search an inmate every time they come in or out of their cell?

MR. McKINNEY: Objection. Ambiguous, compound,

practice, you want to look -- obviously, in my view, you should separate. Because quite frankly, in pattern-and-practice cases, I find unnecessary force to typically be the problem that has to be addressed, you know, through training, investigation, supervision, and so forth.

Q. Okay. Let's turn to the first page of your -- well, with the -- 105138. And the -- there are four recommendations that you made regarding use of force. Right?

A. Yes.

Q. Why didn't you include these in your report?

A. Well, they're best practice, and counsel -- which I think appropriately -- can make that call. I mean, it's not my call; it's their call. Wanted that report limited to constitutional issues. It's as simple as that.

Q. What -- well, let's talk about that.

So you told counsel that you found these things and you thought they were important, they should be changed.

MR. McKINNEY: Objection.

MR. BORNSTEIN: Q. Right?

MR. McKINNEY: Objection. Vague and ambiguous.

THE WITNESS: Yes, I think that's basically

correct.

MR. BORNSTEIN: Q. And counsel said to you, well, are they constitutional, or is it best practices?

MR. McKINNEY: Objection. Vague and ambiguous, argumentative.

THE WITNESS: I probably categorized them as such.

MR. BORNSTEIN: Q. At what point would it be constitutional as opposed to a best practice? Help me to understand that.

A. Well, this -- I mean, let me take number 2.

You know, where I say there's virtually no guidance regarding use of the expandable baton.

Q. Yep.

A. If I'm finding frequent instances where it's used unnecessarily or excessively, then that lack of guidance is very close at hand to being unconstitutional. I mean, you've got to establish a nexus, but I mean, I don't think it would take a great leap of imagination to suggest they use it whenever they want to.

Well, how are they able to do that? Because there's nothing that tells them they can't.

Q. Well, you found numerous instances in which it was used to intervene in inmate-on-inmate assaults, and

impose -- the classification people administratively need to say, do we need to put him in a higher security setting by reclassifying him close.

Q. Did you review any of those classification decisions as it related to mental health inmates who were assessed with some, you know, recommendation by a mental health person that, gee, you need to take this into consideration, or yes, I think their mental illness played a role in this, and you, you know, should mitigate it?

Did you look at any of the classification decisions that follow those RVR proceedings?

A. You know, as they were referred for the ICC?

Q. Uh-huh.

A. No, I did not.

Q. Is there a mental health component in the ICC process?

A. I hope so.

Q. Well, do you know?

A. No.

Q. We know that there is in the RVR process, because there's a whole written policy and procedure about it. Right?

A. Yes.

Q. Have you seen any written policy and procedure

about the classification process and -- as it results from an RVR referral or finding?

A. I have not. I just did not look in that, you know --

Q. Is that a hole in the system?

MR. McKINNEY: Objection. Argumentative, calls for speculation.

THE WITNESS: It's a hole in my review that I didn't look at it.

MR. BORNSTEIN: Q. Well, were you asked to look at it?

A. No.

Q. Were you told that, well, this is only part of this thing, part of the sanctions that might be imposed?

A. No, no, because -- Jeffrey, that's not a sanction, and that's why I didn't look at it.

Q. Why is it not a sanction?

A. It's an administrative decision. A classification decision is an administrative decision based entirely on objective variables. It's not a sanction. It's not a penal decision. It's an administrative decision.

Q. Well, it can be penal.

A. It in effect can be, certainly.

Q. If you take someone --

A. Right.

Q. Okay. So there's all sorts of reasons why somebody might need an assistant. Right?

A. Yes.

Q. And did you find a process in place to provide them with assistance?

A. There is, but I did not go into that.

Q. Is it a formal process, or does it vary from institution?

A. I think it's a -- I mean, there's formal regs. I mean, there's regs that set that out, state regs.

Q. Isn't it at the discretion of the hearing officer?

MR. McKINNEY: Objection.

MR. BORNSTEIN: Q. Whether somebody gets a Staff Assistant or not?

MR. McKINNEY: Objection. Calls for speculation. The witness has testified he didn't examine this issue.

MR. BORNSTEIN: Q. Okay. If you --

A. I don't know. I just did not look at that.

Q. Okay. Is that something that, though, ought to be considered as part of a review of a disciplinary process, what procedures are in place to help inmates who need it?

Did you do that?

A. No.

Q. What do you think of this?

A. I -- not much.

Q. Why?

A. Well, it's -- it wasn't any revelation to me. I mean, there's programs like that around the country.

Q. You agree with this, though, don't you?

A. Oh, yeah, yeah, I agree with the substance of it, yeah.

Q. In other words, there should be a way for inmates to gain additional privileges in segregation. Right?

A. Yeah, I endorse it as a correctionally sound approach, certainly.

Q. Does CCR?

A. I did not look at the operation of the programs to the extent Joel did. I know Joel and I bounced around -- I know we had discussions about it, that he, I think, believed there were some things that -- additional things could be done.

Q. And you agree, too, don't you?

A. As --

MR. McKINNEY: Objection. Asked and answered.

THE WITNESS: As a corrections professional,

yeah, I always supported programs that reduced the length of stay in high-security environments, because they're expensive, they're oppressive, or can be, and they can become counterproductive if people are in there too long.

So yeah, I endorse any program that can shorten that.

MR. BORNSTEIN: Q. Okay. So we've talked a lot today about your basic opinions, which are, as far as you're concerned, there's no constitutional violation in the way in which the use-of-force is being administered in the California prisons. Is that right?

A. This is -- in a pattern and practice --

Q. In pattern and practice.

A. -- practice of excessive or unnecessary force, I did not see that. Did not find it.

Q. You found individual instances of use of force that could be considered unnecessary or unconstitutional. Is that correct?

A. Correct.

Q. And you also found a review process for -- or at least you agree that there is a review process that needs to be improved.

MR. McKINNEY: Objection. That misstates the opinion.

CERTIFICATE OF REPORTER

I, HOLLY THUMAN, a Certified Shorthand Reporter, hereby certify that the witness in the foregoing deposition was by me duly sworn to tell the truth, the whole truth, and nothing but the truth in the within-entitled cause; that said deposition was taken down in shorthand by me, a disinterested person, at the time and place therein state, and that the testimony of said witness was thereafter reduced to typewriting, by computer, under my direction and supervision;

That before completion of the deposition review of the transcript [] was [X] was not requested. If requested, any changes made by the deponent (and provided to the reporter) during the period allowed are appended hereto.

I further certify that I am not of counsel or attorney for either or any of the parties to the said deposition, nor in any way interested in the event of this cause, and that I am not related to any of the parties thereto.

DATED: March 4, 2013

HOLLY THUMAN, CSR

Exhibit 87

TLS | THORSNES litigation services

Transcript of the Testimony of:

Christopher Richard Meyer

Coleman v. Brown

February 27, 2013

Volume I

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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, et al., No. S 90-0520 LKK JFM

Plaintiffs,

vs.

EDMUND G. BROWN, JR., et al.,

Defendants.

/

DEPOSITION OF CHRISTOPHER RICHARD MEYER

DATE: February 27, 2013

TIME: 9:08 a.m.

LOCATION: ROSEN BIEN GALVAN & GRUNFELD
315 Montgomery Street
Tenth Floor
San Francisco, California

REPORTED BY: Mary E. Garland
Certified Shorthand Reporter
License Number 4721

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with what I observed in the way of subcontractor coordination.

Q. At that stage, did you believe there would be delays due to the performance of the contractor?

MR. RUSSELL: Objection. Vague and ambiguous.

THE WITNESS: I believe I asked my team to evaluate whether or not there would be delays of the project. I did not specifically say due to contractor poor performance.

BY MS. MENDELSON:

Q. And did your team do that?

A. They did.

Q. And so when did you become aware that there were delays in the project?

A. It doesn't work that way.

Q. Okay. Tell me how it works.

A. If you're trying to estimate a year out when a project's going to be done, it's a very, very difficult thing to do.

Q. I would imagine.

A. We have -- we have good analytical tools, critical path schedules, and other ways that we try to determine if a project is going to complete when the estimated date is. Typically what happens is that I'll become concerned by what I see.

And in this case, it was enhanced by watching the same contractor do the CIW project, looking at what their level of completion was -- because these projects are very, very similar -- at about the same point in time, and then looking at what happened between that point and the end of the project.

When I was convinced that I thought the probability of the project being finished as currently scheduled was very, very low, I then reported that to the courts. But the actual completion date of a project is always a guess; and the further out you are, the harder it is to guess on when it's going to be done.

Q. Sure. Okay.

Is it your role to predict how long the project will take, or do you work with others on that?

A. I have the final say on what gets reported as to when a project will be completed. And I spend time with my staff. If there's any inkling on their part that a project may slip, I will usually work with them to validate -- if there's ways that we can recover -- to initiate the recovery, or if I don't believe it's recoverable, to report to the courts. But those are my calls.

Q. Sure. What does "validate" mean in this context?

A. I think it gets released tomorrow.
Q. And what will that entail, that new schedule?
A. Oh, I'm sorry. The activation schedule.
I don't believe -- or I don't know if they have an actual completion date in the current activation schedule. My sense -- we've had discussions on schedule over the last few weeks. And we're probably looking right now, in what I know, early 2014, we'll have the conversion done.
But until they come back to me with a target date -- so they may or may not have an actual date in the filing, this month's filing.
Q. Okay.
A. If not, I would guess they will see it next month.
Q. Also, by "released tomorrow," you mean a new activation schedule --
A. Correct.
Q. -- will be released --
A. Yes.
Q. -- tomorrow?
A. Right.
Q. Understood. Thank you.
Do you know if the building is in use at all right now?

A. I understand that they are using some of the office spaces. It was -- so the conversion that needed to be done was to harden the treatment space, but that the office space was good to go. And the institution is actually -- has some staff using the office portion of that building; but it's just hearsay.

Q. What does it mean to harden treatment space?

A. Ah. That some of the walls -- in this room, you have regular sheetrock walls? For higher-security inmates, we put in a harder wall surface, so they're not damaged so easily. And things -- you know, basically, appropriate security and facilities measures for higher-security inmates.

Q. And so that means there are no inmates using that facility right now?

A. I -- I would assume not.

Q. So when attorneys from our office toured LAC on January 31st, they said they weren't allowed into certain parts of the building because the prison had not yet taken legal possession.

Is that a concept that means anything to you?

MR. RUSSELL: Objection. Vague and ambiguous. Lacks foundation. Calls for speculation.

THE WITNESS: I have -- do not know what the legal position -- possession means. However, during

construction, control of the site belongs to the contractor, not the owner.

And we tell the institution staffs that until activation is complete and there's a handing of the baton to the institution, they do not have control of the facilities. And that's done primarily for safety reasons, of institution staff stepping into a construction zone.

BY MS. MENDELSON:

Q. So attached to Exhibit 13, attached to your termination declaration, there's some photos of LAC.

A. Okay.

Q. You can turn to them, if you'd like.

I'm just wondering if you know whether those spaces are in use?

A. For LAC, again, I understand through hearsay that they are using the office space, because that does not need to be converted. They are not using the treatment space, because that does need to be converted.

Q. And the photos that you took -- I'll pull them up; I think you have them there -- are they of office space or treatment space?

MR. RUSSELL: Objection. Misstates testimony.

BY MS. MENDELSON:

Q. Exhibit 13 is page 69.

THE WITNESS: I believe the activation group participates in it, but so do all sorts of other folks.
BY MS. MENDELSON:
Q. And to the best of your knowledge, will the EOP-ASU facility being built not service the EOP-GP inmates that it was originally intended to service?
A. That's a program question. That's -- I have no idea.
Q. Okay. Thank you.
I'm looking at paragraphs 17 and 18 of your termination declaration. Paragraph 17 discusses a health care facility improvement project at Mule Creek State Prison. It says that on December 14th, 2012, the PWB established that project.
Are you familiar with that project?
A. From a global-scope position, yes.
Q. And it says it includes a sub-project to design and construct new AD SEG primary care and AD SEG EOP mental health clinic for inmates housed in Facility C.
Do you know if there's an activation schedule for that project yet?
A. I doubt it. It's -- we just got approval to get started on it. Activation schedules usually come a little bit further in -- along in the design process.
Q. So if was just established by the PWB, what

would the next steps typically be?

A. Hire a designer. Hire the various consultants to evaluate whether or not they need to file an environmental document on it. And if we do, then to start the CEQA process.

And then to have stakeholder meetings, to bring in all of the stakeholders associated with it to scope in detail exactly what the project needs are.

Q. So is it fair to say there's not a projected date for finishing construction yet?

A. There may be a -- as was shown earlier in the activation schedules, there may be -- and I believe there is -- a conceptual schedule of how projects, all of our projects, will lay out over the next three or four years. But, again, until we sit down and actually design the building, we can't establish exactly how long it's going to take and when we expect it to activate. It's the difference between conceptual and detailed.

Q. If it's been through the PWB, remind me, does that mean that it's gotten funding?

A. I don't know if these projects had to go to PMIB; but as far as we're concerned, it's funded. We're out hiring designers and get going on it; so to me, that means that we have funding.

Q. Are you certain that the project will be

all the components of it.

Q. Sure. So these improvement programs tend to be not specific to just one component, but, rather, involve various; is that correct?

A. Correct. It's both mental health and health, dental, ADA. So, yes, it involves many aspects of the total health care delivery.

Q. And like MCSP, is that now at the stage where designers are designing the buildings?

A. We're -- I believe we've hired those designers, and we're starting with preliminary stakeholder meetings.

Q. What's a preliminary stakeholder meeting?

A. We bring in all the stakeholders and we say, "Okay, we got some money, we have a mission, and let's figure it out."

Q. Do you attend those meetings?

A. No, I do not attend those meetings.

Q. But there's not yet a projected date for completion?

A. Oh, it's -- again, I would guess that there is a conceptual date for the overall design and construction period that -- from funding that that project's going to take; but until we have a detailed design, we will not have a detailed schedule.

Q. Do you know when the conceptual date of completion is?

A. It typically takes about a year to design a project, but that can vary, depending on the complexity and -- basically, on complexity of the project.

But the answer to your question is no.

Q. And do you know what the projections for the completion of the construction are?

A. No, not off the top of my head.

Q. Your termination declaration also mentions the Dewitt. Nelson Correctional Annex Project. It says it will add 1,133 beds, of which 953 will be health care beds. Let me pull out the activation schedule for that one. This will be No. 11.

(Plaintiff's Exhibit No. 11 marked for identification.)

BY MS. MENDELSON:

Q. I see that you're listed on the top as the "Responsible Person"?

A. Yes.

Q. What does the "Responsible Person" mean?

A. It's the name that they put on the top of the activation schedule.

Q. That's the only meaning it has to you?

A. It's -- that is, honestly, the only real

meaning that has to me. Our Facilities group is responsible for producing the report; it's done under my general supervision.

Q. So the "Responsible Person" doesn't refer to the project, perhaps it just refers to the schedule; is that what you're saying?

A. When we present the activation schedule at the court coordination meetings, if my name is on it, I present --

Q. Okay.

A. -- if Deborah's name is on it, she presents.

Q. Fair enough.

It says in your declaration that the Dewitt project is scheduled to open with the first inmate admission on February 17th, 2014, and to be fully occupied by May 31st, 2014.

A. Correct.

Q. Is that still true, to the best of your knowledge?

A. It's -- projecting out a year is always tricky; but, yes. There are issues associated with that project that I'm concerned about, but nothing that has risen to the level that I'm yet ready to -- or may never -- decide that it's going to be impacted.

But right now, those are the dates that we're

planning and constructing to.

Q. What kinds of issues have come up?

A. We decided to put a single perimeter fence around both CHCF and Dewitt Nelson, which makes the endgame, the last month or so of the project, more problematic, more difficult.

The contractors now will be going through a secured institution to try and complete the punch list work in Dewitt Nelson, rather than a freestanding institution from CHCF.

So we have a group of people trying to figure out when we can do the cutover to have the least impact on construction -- it's a big impact. If you go from free access to now everybody has to go through a sally port, it can impact it. However, we have a bunch of very smart people trying to figure out ways not to impact it.

Q. So the fence is already up, or is it planned to go up?

A. It's planned to go up for Dewitt Nelson. We're just completing the electric fence on CHCF, but we have not yet started the electric fence on CHCF -- or on Dewitt Nelson. And then we will also have to breach the fence at CHCF when we connect the two up for a single perimeter. So it's a tricky engineering and

accelerations, there's a cost associated?
A. Yes.
Q. You pay to accelerate --
A. You do.
Q. -- is that correct?
A. Yes.
Q. You do.
A. And if you don't manage it very intelligently, you will spend the money and not get any schedule improvement; and in some cases, you will actually get the project slowing down.
Q. Am I correct that you've presented at policy meetings before, Coleman policy meetings?
A. Yes.
Q. What kind of things have you had to explain at those meetings?
A. Oh, probably the most extensive explanation was the slip on CMC --
Q. Okay.
A. -- when made an independent evaluation, based on a lot of study that I did, that the contractor's projections of when he was going to be done were unrealistic, and that I was not going to give the courts unrealistic projections of when I thought things were going to be done.

One of the issues that happened at CIW was, I believe in the last six months of that project, the project slipped a month every month. Contractor would give you his critical path schedule update, say he was going to be done in two months; and then a month later, he would give his update and say it's going to be done in two months. And there was no way that I wanted to go through that again with CMC.

So I went out with staff, did a completely independent analysis after visiting the project, and came back to the court and said, "I know you're going to beat me up, but I honestly don't think that this thing is going to be done until July or -- June or July, or something like that, of 2013."

Q. So when you were at the policy meeting, was your role to explain the sources of the delays?

A. It was to explain the analysis that went into my decision to forecast -- again, it's still a forecast -- that there would be a delay in the project that was significant. And to do it as early as possible, as soon as I truly believed that that was going to be the reality.

Q. And by "forecast," you mean -- what do you mean by "forecast"?

A. An analysis of when something in the future is

going to be done, when there's still hundreds, if not thousands, of variables that can impact that completion date.

And, you know, there is often disagreement between experts and professionals when you're that -- there's just -- there's too many unquantifiable variables in it. But there -- I had enough concern with what I saw on the project, that I did not believe that the contractor's term schedule was realistic.

Q. So then you sort of had a policy meeting, trying to explain the exigencies of contracting to people who don't know contracting?

A. It actually went better than I thought it would. But, yes, I did the best I could to explain the reasoning behind my forecast.

Q. Who attends policy meetings? I haven't been to one myself.

A. Everybody in the world. It's a large group. There's probably at least 25 or 30 people in the room. And I don't know most of them. But, yeah, it's -- I go do my little construction thing, and then they're --

Q. What kinds of questions do they have?

(Reporter requesting clarification.)

THE WITNESS: -- and then they're off to their policy decisions, so ...

changed, if I understand correctly, before they got to you, anyway. So it didn't matter that much to your work; is that correct?

MR. RUSSELL: Objection. Vague and ambiguous.

THE WITNESS: So, again, I pick it up when it's funded and then I run with it. And although I am aware of discussions going on, I don't pay a lot of attention to it, because I can't influence it.

BY MS. MENDELSON:

Q. But then there are also cases where the plan changes partway through, like the LAC rescope or the CCWF rescope; is that correct?

A. Not halfway through. In the case of --

Q. Okay.

A. -- LAC, it was after it was done; and at CCWF, it was before it started.

Q. Is that challenging?

MR. RUSSELL: Objection. Vague and ambiguous.

THE WITNESS: No more so than any other aspect of construction. It's, you know, a -- converting a completed project is not nearly the level of effort as it is building a new project.

And since -- you know, in the case of CCWF, I think we had -- design was already going, so now we're back to square one on design. So it's a waste of money.

But from the process of design and construction, you just move the starting point again and go through the same process.

BY MS. MENDELSON:

Q. But doesn't it suggest that no project will, certainly, open until the minute it opens?

MR. RUSSELL: Objection. Vague and ambiguous.

THE WITNESS: I would not -- I would not hire or have working for me anybody that maintained the position is "it happens when it happens." It happens when we manage it to happen, with a realistic intention to the variables and risks associated with it.

So I do believe that management makes a difference, and I believe it makes a big difference. The key is to focus on the best management you can do to deliver as quickly as possible. That does not mean that there won't be things that come up that mess up your plan.

BY MS. MENDELSON:

Q. Because you could have managed LAC perfectly, but the end of the day, it didn't get to be the thing that it was intended to be?

A. I thought we did manage LAC perfectly.

Q. Okay. But at the end of the day, did it end up being the thing you thought it would be?

On page 7, there's a project schedule, item number 8. It states here that the construction will be complete on May 2015, in May 2015. It says that preliminary plans will start September 2012.

Do these constitute the preliminary plans?

A. No.

Q. Do you know if the preliminary plans have started?

A. The project was approved, and we're -- we hired the designers. I don't know where -- I don't know where they're at in the preliminary design at this point in time, but they're working on it.

Q. Do you think that it's realistic, May 5th, 2015, as a deadline for all 22 facilities?

MR. RUSSELL: Objection. Vague and ambiguous. Lacks foundation.

THE WITNESS: As I said previously, until we do the site assessments and get into the detail, we have no basis.

BY MS. MENDELSON:

Q. Okay. No basis for?

A. Realistic, could it be done earlier? I don't know yet. Is it going to take longer than that? I don't know yet. We need to go do the individual site assessments and put the design team on it. It does not

seem to me at all unreasonable that it could --
Q. Okay.
A. -- be done by this point in time.
Q. Okay. Thank you.
So the plan, as you understand it, has been through the PWB?
A. For med distribution, is funded.
Q. Not just as to specific sites, but the full roster?
MR. RUSSELL: Objection. Vague and ambiguous. Lacks foundation.
THE WITNESS: I would have to go look at exactly what is approved. But the fact that we started on it, and it was a single program, is a pretty good indication that --
BY MS. MENDELSON:
Q. Okay. Thanks a lot.
A. -- we're going forward with everything.
Q. Okay. Great.
Let's turn back to your declaration for a moment, your termination declaration, which would be Exhibit 1. I want to ask you a couple questions about SAC; California State Prison, Sacramento, which we refer to as "SAC." Is that how you refer to it?
A. Yeah, CSP SAC --

of what they call the MHCBU, Mental Health Crisis Bed Unit, which is an unlicensed 20-bed space.

Are you familiar with it?

A. I am not.

Q. Were you aware it existed?

MR. RUSSELL: Objection. Vague and ambiguous.

THE WITNESS: I don't recall.

BY MS. MENDELSON:

Q. Are you aware of any plans to close that unit?

MR. RUSSELL: Objection. Vague and ambiguous. Lacks foundation. Assumes facts not in evidence.

THE WITNESS: I'm not aware of it, no.

BY MS. MENDELSON:

Q. So I want to ask you a little bit -- no exhibits here, just some questions -- about the Condemned Inmate Complex at San Quentin that was cancelled by Governor Brown in April 2011.

Are you familiar with the project?

A. Yes.

Q. Had you worked on the project?

A. No.

Q. Do you know if it had mental health capacity?

A. I don't know.

Q. Who would know that, in your department?

A. The project director that managed the design

phase of that would know that.
Q. So it had been through the design phase, to your knowledge?
A. The design was complete.
Q. So if we were looking at an activation schedule, where would we be on the activation schedule before it was cancelled?
MR. RUSSELL: Objection. Vague and ambiguous. Lacks foundation.
THE WITNESS: At the bid stage.
BY MS. MENDELSON:
Q. At the bid stage. So there had not been -- well, before I say that, let me look at an activation report.
So before the bid stage is the funding request, the legislative approval, the board approval, the loan request; is this all correct?
A. Yes.
Q. Also the preliminary plans?
A. Yes.
Q. CEQA?
A. Yes.
Q. The Joint Legislative Budget Committee approval?
A. Yes.

Q. And working drawings?
A. Yes.
Q. So to your knowledge, all those stages have been completed?
A. Yes.
MR. RUSSELL: Objection. Lacks foundation. Calls for speculation.
BY MS. MENDELSON:
Q. Did you know it was going to be cancelled before it was cancelled?
A. No.
Q. You heard just at the same time as everyone else?
A. Yes.
MR. RUSSELL: Objection. Vague and ambiguous. Lacks foundation.
BY MS. MENDELSON:
Q. To your knowledge, are all projects subject to cancellation by the governor, all construction projects on CDCR sites?
MR. RUSSELL: Objection. Vague and ambiguous. Lacks foundation. Overly broad.
THE WITNESS: I'm not an attorney, I don't know what authority he has, but he's the boss. He wants to cancel it, it gets cancelled.

THE WITNESS: I would have to be aware of the specific instance where it did. And I'm not aware of a specific instance where it did.

BY MS. MENDELSON:

Q. Do you have concerns about the condition of CIM?

MR. RUSSELL: Objection. Vague and ambiguous.

THE WITNESS: I do.

BY MS. MENDELSON:

Q. What are your concerns?

A. Some of the special repairs at that project are not at the state that I'd like to see. So some of the rep. replacements, some of the electrical distribution. Not any worse than some of our other institutions, but there is a need for some infrastructure repair and maintenance at that institution.

Q. Do you know of any on the books?

MR. RUSSELL: Objection.

THE WITNESS: I would have to go --

MR. RUSSELL: Objection. Vague and ambiguous. Lacks foundation.

THE WITNESS: Not without looking at the reports.

BY MS. MENDELSON:

Q. Would those kinds of repairs you described be

major works?

MR. RUSSELL: Objection. Vague and ambiguous. Lacks foundation. Calls for speculation.

THE WITNESS: What do you mean by "major"?

BY MS. MENDELSON:

Q. Well, earlier you said that you don't know of any major projects going on, scheduled construction or renovation projects, at CIM. I'm wondering if --

A. So I'm referring to major capital outlay.

Q. Mm-hm.

A. I believe most -- major capital outlay is defined by the dollar investment in the particular project. I'm not aware of any single repair items out there that would be major capital outlay. It'd probably be a minor outlay or Section 6s.

Q. Do you think CIM is in worse condition than other prisons?

MR. RUSSELL: Objection. Vague and ambiguous. Lacks foundation. Calls for speculation.

THE WITNESS: I think there are institutions that are worse than CIM.

BY MS. MENDELSON:

Q. Which ones?

A. CRC.

Q. CRC. Any others? You said "institutions."

A. Where did I get them, in the first place?
Q. Mm-hm.
A. Off the project list.
Q. Off the project list?
A. Mm-hm.
Q. What project list?
A. List of projects.
Q. You keep a running list of projects?
MR. RUSSELL: Objection. Vague and ambiguous.
THE WITNESS: Yes.
BY MS. MENDELSON:
Q. You do? Okay.
Is that the written list that you keep?
A. No. I mean, it's a piece of paper that I make notes on; and I change it, and throw it out, and redo it occasionally.
Q. So you got these facts and figures from a piece of paper that you change and throw away?
A. Ah. The draft of the declaration was prepared by counsel.
Q. Okay.
A. I then had it vetted for facts, and figures, and correctness. I then reviewed it and edited it.
Q. And Mr. Borg, you said, vetted it?
A. Mr. Borg vetted it, in combination with

representatives from Department of Finance.
Q. When you edited it, were you editing the figures and facts at that stage?
A. I did not edit the figures and the facts.
Q. Okay. So those came from first counsel, then Mr. Borg?
A. That's correct.
Q. And does that include the dates of activation, projected and past?
A. It did.
Q. Do you know what forms or documents they used to get -- to vet those?
A. I do not.
Q. To get to --
MR. RUSSELL: Who is -- I'm sorry.
BY MS. MENDELSON:
Q. To vet them?
MR. RUSSELL: Objection. Vague and ambiguous. Who is "they"?
MS. MENDELSON: Mr. Borg and the Department of Finance. I'm sure you know that we made a request for production related to any documents relied upon in the declaration.
MR. RUSSELL: And you've gotten them.
BY MS. MENDELSON:

Q. And so to go through: Counsel would be responsible for the first draft. Beyond that, it was not vetted by -- it was vetted by Dr. Borg and Department of Finance --

A. Dean Borg.

Q. Excuse me.

-- Dean Borg and the Department of Finance --

A. Yes.

Q. -- and you're not sure according to which document?

A. Right. I don't know what documents they use to -- to vet it. I would imagine it was PWB submission -- submittals.

Q. Then when it came back to you, what did you check it against?

A. Statements that I was not comfortable with, was, basically, what I checked it against.

Q. What would make you uncomfortable with a statement?

MR. RUSSELL: Objection. To the extent that you can answer that without discussing attorney-client privileged communications, you can answer.

THE WITNESS: One statement referred to the CHCF as a state-of-the-art facility. I have no basis, professional basis, to determine whether or not it was a

state-of-the-art facility, because that's a programmatic call, not a construction call. So I struck it from the declaration.

BY MS. MENDELSON:

Q. Okay. Anything else?

MR. RUSSELL: Objection. Vague and ambiguous. Lacks foundation. Overly broad.

To the extent you can answer without discussing attorney-client communications, you're free to answer.

THE WITNESS: I'm not aware of any other statements that I struck without talking to counsel first.

BY MS. MENDELSON:

Q. Okay. So you said that you checked it against statements you're uncomfortable with. Did you check it against any particular documents?

A. No, I did not.

Q. So you trusted that Dean Borg would get the facts right?

A. I did.

Q. Would you say that you have personal knowledge of all the facts, including prices, square feet, dates?

A. "Personal knowledge." These are facts of record; we have records that have those facts. Whether or not I -- well, I have seen them, them all. So, yes.

I would say the answer to that is yes.
Q. You've seen all the records that --
A. I have seen the square footages and I've seen the prices.
Q. When did you see those?
MR. RUSSELL: Objection. Overly broad.
THE WITNESS: Over the last four years.
BY MS. MENDELSON:
Q. In what kinds of documents?
MR. RUSSELL: Objection. Overly broad.
THE WITNESS: Monthly reports. Project documents that go across my desk.
BY MS. MENDELSON:
Q. What kind of project documents would they be?
MR. RUSSELL: Objection. Vague and ambiguous. Overly broad.
THE WITNESS: Occasionally there'll be a submittal that goes over to Department of Finance that will cross my desk, or a request from plaintiffs that will cross my desk, related to basic information about projects. Also, some of this information is available on the public websites, for square footage and cost.
BY MS. MENDELSON:
Q. So I just want to clarify that the basis for the facts in your declaration, that it was first created

by counsel, then Dean Borg vetted the facts and figures, and --

A. With the assistance of Department of Finance.

Q. With the assistance of the Department of Finance.

A. Right.

Q. You didn't go through the facts and figures specifically to make sure they were correct?

MR. RUSSELL: Objection. Vague and ambiguous. Misstates testimony. Argument --

BY MS. MENDELSON:

Q. Excuse me. Did you go through --

THE REPORTER: Excuse me. One at a time.

MR. RUSSELL: Please, don't interrupt me.

Objection. Vague and ambiguous. Overly broad. Misstates testimony. Argumentative.

THE WITNESS: I rely on Dean to vet it, as I do with many documents. And if something catches my eye when it hits my desk, I'll inquire about it.

There was nothing to lead me to believe that anything that staff had prepared in the declaration -- or vetted in the declaration was anything but true and accurate.

BY MS. MENDELSON:

Q. So the documents that were relied on for this

were not ones that you individually relied on?
MR. RUSSELL: Objection. Vague and ambiguous. Misstates testimony. Argumentative.
If you understand the question, you can try to answer.
THE WITNESS: I don't know what particular documents they used to vet the draft.
BY MS. MENDELSON:
Q. But in terms of the documents that you keep personally, you said that there is a monthly report that has the status of all projects, in various phases; correct?
A. That's correct.
Q. And it's generated by all the people who work on those projects?
A. That's correct.
Q. Okay. And it's called monthly report?
A. That's correct.
Q. And that would include infill projects?
A. It includes infill projects, that's correct.
Q. Would it include renovations?
A. It includes --
MR. RUSSELL: Objection. Vague and ambiguous.
THE WITNESS: It would include any renovation projects that are being run through our shop.

CERTIFICATION OF DEPOSITION OFFICER

I, MARY E. GARLAND, duly authorized to administer oaths pursuant to Section 2093(b) of the California Code of Civil Procedure, do hereby certify that the witness in the foregoing deposition was duly sworn by me to testify to the truth, the whole truth and nothing but the truth in the within-entitled cause; that said deposition was taken at the time and place therein stated; that the testimony of said witness was thereafter transcribed by means of computer-aided transcription under my direction; that the foregoing is a full, complete and true record of said testimony. And that the witness was given an opportunity to read and correct said deposition and to subscribe to the same.

I further certify that I am not of counsel or attorney for either or any of the parties in the foregoing deposition and caption named, nor in any way interested in the outcome of the cause named in said caption.

Executed March 7, 2013, at San Francisco, California.

MARY E. GARLAND, CSR 4721

Exhibit 88

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Transcript of the Testimony of:

Jacqueline Moore, R.N., Ph.D.

Coleman v. Brown

February 21, 2013

Volume I

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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, ET AL., Plaintiffs, vs. EDMUND G. BROWN, JR., ET AL., Defendants.	CASE NO.: S 90-0520 LKK-JFM

DEPOSITION OF

JACQUELINE MOORE, RN, PH.D.

THURSDAY, FEBRUARY 21, 2013, 8:50 A.M.

SAN FRANCISCO, CALIFORNIA

REPORTED BY: MEGAN F. ALVAREZ, RPR, CSR NO. 12470

THORSNES LITIGATION SERVICES, LLC

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, ET AL.,

Plaintiffs,

vs.

EDMUND G. BROWN, JR., ET AL.,

Defendants.

CASE NO.:
S 90-0520 LKK-JFM

The Deposition of JACQUELINE MOORE, RN, PH.D., taken on behalf of the Plaintiffs, before Megan F. Alvarez, Certified Shorthand Reporter No. 12470, Registered Professional Reporter, for the State of California, commencing at 8:50 a.m., Thursday, February 21, 2013, at the Rosen, Bien, Galvan & Grunfeld, LLP, 315 Montgomery Street, 10th Floor, San Francisco, California.

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A. No.

Q. When was the last time you spoke with Dr. Dvoskin or Dr. Scott?

A. I spoke with Dr. Dvoskin prior to finalization of the report.

I never spoke to Dr. Scott; I communicated with him by e-mail.

Q. What do you mean you never spoke with Dr. Scott?

A. I didn't speak -- when we were working on the report, I didn't -- the last time. The last time I spoke with Dr. Scott would have been during the last site survey that we did.

MR. FISCHER: Okay. Mark as Exhibit 2.

(Plaintiffs' Exhibit 2 was marked for identification.)

BY MR. FISCHER:

Q. Do you recognize this document?

A. Yes.

Q. Can you tell me what it is?

A. It's expert witness work that I've done in my consulting practice.

Q. Does it also include your CV?

A. Yes, it does.

Q. Okay. And the publication section of your CV,

Q. On the middle of the page about halfway down, it says "Overmonitoring." And can you just read what you have in that note? The 11th line.

A. "Overmonitoring in number of prisons looked at."

Q. What does that refer to? Do you remember?

A. There was a lot of monitoring going on in the prisons, that they were going back several times looking at things, that they felt -- whoever related this felt that there was an overmonitoring on the part.

Q. And this was someone from CDCR or the AG's office?

A. It was someone. I don't know who.

Q. Okay. And they said they felt that there was overmonitoring being done?

A. Being done, yes.

Q. Further down, you mention cost drivers, the fourth line from the bottom. It says "Cost Drivers." Can you read the rest of that?

A. "Attorneys and their own law firms and the monitors."

Q. Do you remember what this refers to?

A. To the cost of the Coleman monitors and the attorneys that are the -- that handle the reports.

Q. What did they tell you about this

specifically?
A. That they bill a lot of money.
Q. On the next page, 101026.
On this page at the top says "Presiding Judge Karlton."
Do you recall what they told you about presiding Judge Karlton at this meeting?
A. I think that's the judge on the case.
Q. What else did they tell you about him?
A. Well, anything else I would have written down if I thought that it was important. I mean, they didn't really tell me much. This was the presiding judge.
Q. And the fifth line says: "Karlton does not like state AG office."
A. Yeah. Someone said that, so I wrote it down.
Q. Did they say anything else about that?
A. No. If they said something else, I would have written it. I'm a Catholic school schoolgirl; I write down everything.
Q. And the line below, can you read what the line below says?
A. "Rules of evidence not applied uniformly."
Q. Do you recall what that is?
A. It meant that sometimes the monitors would pick certain things up at one institution and not bring

the same things together at another institution.
Q. Here were they talking about the monitors or were they talking about the court?
A. I think -- I think it was the court. It was the court.
Q. And so what did they -- what was being related as far as the court here?
A. That it was an uphill battle for the attorney general.
Q. Two lines below what you just read, what does that say?
A. "Takes plaintiff's finding as truth."
Q. And the next line?
A. Words the plaintiff would use, like "languishing" or "dying," you know, they were descriptive terms that would be in a plaintiff's report.
Q. This is again talking about Judge Karlton?
A. Judge Karlton.
Q. What was being related here?
A. Other than what I have written here -- and this was many, many, many months ago, and it was just an overview meeting -- quite frankly, I never referred to these notes again.
Q. Do you remember this meeting?
A. I remember being there. I remember all of the

improvement and suicide prevention.

Q. What are these five bullet points? What do they represent?

A. These were the areas that we reviewed.

Q. Are these the five areas that you reviewed based on your discussions with the other consultants and with counsel?

A. Yes.

Q. Are there any other areas that you considered including but did not?

A. The only other area that I see that I looked at that did not get into the report was an area on restraints.

Q. Do you know why it wasn't included?

A. I think it was overlooked, that there was -- there were no issues with the restraint process.

Q. You said it was overlooked?

A. I may not have gotten it to them. I may not have seen that it was missing when I read the report.

Q. Okay. Had you decided that restraints were an important issue for -- to be included in the report?

A. I think we looked at it under rule violation and reports. And I did that section.

Q. But that section is not in the report?

A. No, but I take responsibility for not putting

it there.

Q. Were you asked to look at any treatment or office space issues in completing your report?

A. We all did. We all made site visits.

Q. Were you asked by CDCR counsel or the AG's office to look at treatment or office space issues related to mental health care?

MS. VOROUS: Vague and ambiguous as to what you mean by looking at treatment and office space issues.

THE WITNESS: I don't know what you mean. I mean, how big the things were, whether you could have confidential meetings. I'm not sure what you mean.

BY MR. FISCHER:

Q. Were you asked to -- had you determined to look at that issue at all at the prisons prior to doing your site visit? For example, confidentiality, what you just said.

A. No one asked us to look at anything prior to doing our site visits. We found our own findings while we did our site visits.

Q. Okay. You said you started your site visits in November 2011; is that correct?

MS. VOROUS: Objection.

THE WITNESS: We had our first meeting in

November -- the first site visit may have been in February.

BY MR. FISCHER:

Q. This is not including the initial visit to Sac; is that correct?

A. Exactly.

Q. Okay. Before I move ahead, in your report, is there any discussion of the overcrowding trial?

A. Not that I'm aware of.

Q. You're aware that Supreme Court made their decision in the overcrowding case in the summer of 2011?

A. Yes.

Q. Was there a decision not to include any discussion of overcrowding in this report?

MS. VOROUS: Objection. The questions with respect to overcrowding are beyond the scope of the issue -- beyond the scope of the issues raised in the motion to terminate and beyond the scope of what was requested in terms of the expert consultancy in this case.

Go ahead and answer if you can.

THE WITNESS: We didn't look at overcrowding.

BY MR. FISCHER:

Q. Did you think that overcrowding wasn't relevant to the issues that you were asked to look at?

MS. VOROUS: Objection. Again, beyond the scope of the issues to terminate in Coleman and the scope of the consultancy of Dr. Moore in this case.

Go ahead and answer if you can.

THE WITNESS: We had specific issues that we were looking at, and those issues consumed four of us for the time we were on site. We didn't have time to become involved in every issue that CDCR has.

BY MR. FISCHER:

Q. Including overcrowding?

A. Including overcrowding.

Q. Okay. On your tours, did you find that crowding was impacting care at any of the institutions?

MS. VOROUS: Objection. Beyond the scope of the issues that are in dispute with respect to the motion to terminate. Beyond the scope of Dr. Moore's motion to consult in this case and expert report.

I'm sorry. I'm speaking too low. Beyond the scope of the issues that are in dispute and beyond the scope of Dr. Moore's expert opinion in this case.

THE WITNESS: Do you want me to answer?

BY MR. FISCHER:

Q. Yes, please.

A. The areas that I went to -- and I did not go to every housing area in the jail -- I did not find that

BY MR. FISCHER:

Q. This is an e-mail dated July 20th, 2012, from Patrick McKinney with Dr. Moore, your name, in the "To" line along with Dr. Dvoskin, Dr. Scott, and Mr. Martin.

Do you recall receiving this e-mail?

A. Yes.

Q. Mr. McKinney is one of the counsel that you worked with on this consultancy; is that correct?

A. Correct.

Q. In the second paragraph under "Preparation of Reports," Mr. McKinney writes in the third line: "We understand that you'll prepare separate reports."

Did you prepare separate reports?

A. I prepared a draft report, but then we didn't use it. I had some errors in it. But I started, and you'll even find I was getting ready to do that because my notes from R.J. Donovan were typed, which they hadn't been. So I started --

Q. How many -- I'm sorry.?

A. -- and then we decided that we weren't going to do it this way.

Q. When did that decision not to do it this way occur?

A. Sometime around September.

Q. September 2012?

A. Right.
Q. What was the reason for that decision?
A. They wanted all the reports together.
Q. Who wanted all the reports together?
A. The attorney general's office decided all the reports should be together. And Steve Martin felt that his should be separate because it was so different.
Q. Did you feel that yours should be separate?
A. No. I thought there was overlap on all of our reports.
Q. How many institutions had you drafted reports for at that point?
A. Eight.
Q. Is any of the content for those reports not included in the final joint report?
A. There were, as in any draft report, at least when I first do a report, I put everything in it, whether it's relevant or not. And then -- then I take it out. You know, this doesn't really belong, this doesn't really mean anything, this isn't true.

But the content on these reports, in the final report, I had a lot of it done. So yes, they had it.

I mean, I gave it -- we talked about it. We met. We discussed things.
Q. Who is "we"?

So we looked at the same topic but from different angles.

Q. Are you qualified to give an expert opinion of the areas that you just mentioned Dr. Scott having reviewed?

A. No, I wouldn't have given an expert on the areas Dr. Scott reviewed. The areas I reviewed were under the purview of nursing.

Q. And the areas that Dr. Scott reviewed are under the purview of what?

A. A physician or a psychiatrist.

Q. Are there any other areas of the report for which you feel that you were not qualified to give individual expert opinion?

A. I didn't work with the suicidality of the inmates. I reviewed the emergency response of the suicide patients and other patients there. And certainly looked at the timeliness. As far as suicide prevention and adequacy of care, I relied on Joel Dvoskin.

Q. So the -- certain areas regarding suicidality you feel you're not qualified to give individual expert opinion on?

A. I felt that -- yes, I don't think feel that I'm a suicidal expert.

Q. Any other areas of the report for which you felt that you would not be individually qualified?

A. There were areas where they looked at consistency of diagnosis. I don't diagnose.

Q. Which sections of the report related to consistency of diagnosis?

A. I couldn't tell you what page it's on. I know it was a quality assurance indicator, and, you know, I looked at it as a quality assurance indicator. But I know that -- I mean, I don't have this report listed out as to what page each item is on. I'd have to find it for you.

But I know that Joel Dvoskin and Dr. Scott looked at that issue. And I may have pointed it out from a quality assurance meeting and brought it to them, and then they would have looked at medical records.

Q. My question is, is which sections of the report --

A. Did I do?

Q. Which sections of the report contain issues related to consistency of diagnosis?

MS. VOROUS: Asked and answered.

THE WITNESS: I don't know. I'd have to read the whole report and find it for you. I just can't tell you just right now.

BY MR. FISCHER:

Q. Would it be in several sections?

MS. VOROUS: Same objection. Asked and answered.

THE WITNESS: I don't know. I don't even know if it's in there.

BY MR. FISCHER:

Q. Okay. You said earlier that you were asked to offer opinion as to whether the system was constitutional; is that correct?

A. Yes.

Q. What are -- what is the measure of whether a system is constitutional, in your opinion?

A. Whether the inmates have access to care, whether they have benefit of a physician judgment, whether they receive the care that's ordered, and whether or not there are no deliberate omissions in care that would create harm to a patient.

Q. Anything else?

A. No. That's what I would use.

Q. Go through those.

First you said "access to care." What do you mean by "access to care"?

A. The right of the inmate to access care when they feel that they need it.

A. Of course.

MR. FISCHER: Exhibit 6.

(Plaintiffs' Exhibit 6 was marked for identification.)

BY MR. FISCHER:

Q. Exhibit 6 is another e-mail from Patrick McKinney. It appears to be a chart. In one column, date; the other column, institution.

Do you recognize the chart?

A. Yes.

Q. Or what it -- and what is the information contained on that chart?

A. That's the site visit that we went to.

Q. Did you attend all of these site visits?

A. I didn't always attend them when the group went, as it said. I went to California Women's on June 26th and Corcoran on June 27th and 28toh.

Q. And both of those were separate from Dr. Scott and Dvoskin?

A. Yes.

And I didn't go to the visit in Centinela.

Q. Why didn't you go to Centinela?

A. I had problems with my plane.

MS. VOROUS: The plane had problems.

THE WITNESS: The plane had problems, and I

didn't get in until very, very late that night, and the group had already left. And so I would have gotten up early the next morning to go, but I would have had to get up at 4:00 and they finally said to me don't bother.

BY MR. FISCHER:

Q. Did you make an effort to return to Centinela at a later date?

A. No. They told me that it was a very small desert facility, and that they had done my part while they were there.

And I didn't go to Pelican Bay either.

Q. Why didn't you go to pelican bay?

A. I was in an accident.

Q. Did you attempt to return to Pelican Bay at a later date?

A. No. I talked to Patrick about it.

MS. VOROUS: Objection.

THE WITNESS: No.

BY MR. FISCHER:

Q. Is there a reason that you didn't go to Pelican Bay at a later date?

A. There weren't sufficient crisis beds or ad seg beds. It was a very small mental health area.

Q. Defendants' counsel told you that?

A. I actually saw a grid.

Q. The other institutions listed on here, you did attend on the dates identified?

A. Yes.

Q. Okay. In your report on the tours, it says that you and the other experts interviewed patients; is that correct?

A. Yes.

Q. Can you just explain the process for interviewing patients on the tour?

A. My process was generally to interview inmates that were housed in administrative segregation, although at one point I interviewed inmates at Corcoran that were housed in protective custody, protective housing because it was right next to the ad seg units.

Q. Is this the SHU, segregated housing unit?

A. I think so. It could be.

Q. How many -- in the course of your consulting, how many individuals patients would you say that you interviewed inside CDCR?

A. On each visit I tried to interview five patients.

Q. That's a total of about 50 patients?

A. Yes.

Q. And to -- say you're in an administrative segregation unit. How would you identify which patients

to interview?

A. I asked the LPT to indicate which patients were EOP patients and were receiving meds. Or sometimes the psychiatrist, if there was a psychiatrist on the unit.

Q. And then what was the process?

A. I would get a vest, I would go up to where the patient was, and introduce myself.

Q. Okay. At cell front?

A. At cell front.

I would tell them who I was and why I was there.

Q. What did you say?

A. "My name is Jackie Moore. I'm a registered nurse. I'm working with the attorney general's office. We're going to evaluate the quality of mental and health care at this facility. I'm going to ask you about a few questions about your care. Do you care to talk to me? Will you answer my questions?"

Q. Did you mention the Coleman case?

A. No.

Q. Is it --

A. I don't believe so. I don't know for sure.

Q. What if -- did any inmates patients refuse to speak to you?

A. Rarely. If one did, then I would just find another. Rarely.

Q. Do you recall any patients having questions about who you were?

A. No, because I told them. They wanted to -- sometimes, regardless of what I told them, they wanted to know if I was going to come to work there the next day. Was I going to come back, you know, those kind of questions. I mean, even though I told them, I'm not sure they always comprehended. You know, "Are you going to be a new here? You ought to come here." I mean, they would get to the part where I'm a registered nurse. "Oh, yeah, we need nurses."

Q. Is that what they said, "We need nurses"?

A. That's what they would say to me. "Oh, yeah, we need new nurses."

Q. Did you ask them what they meant by that?

A. No. I just laughed. I would say, "No, that's not why I'm here."

There was always someone in attendance with me when I did the interview. They stepped back; they didn't stand right next to me. I stood at the side of the door so I could hear.

Q. Uh-huh. Who -- who would be with you?

A. It could be the LPT. It could be the nursing

supervisor if that's who was giving me the tour of the grounds.

Q. Was there ever a custody officer there with you?

A. Never. Never.

Q. Was there ever someone from the attorney general's office with you?

A. No, never.

Q. Ever anyone from CDCR counsel?

A. No, but one time the secretary watched me and I didn't know it.

Q. The secretary watched you?

A. The secretary.

Q. The Secretary Beard?

A. No.

Q. This is the previous secretary, Secretary Cate?

A. Yeah, but he wasn't standing right there. He was in the general area.

Q. Where was that?

A. Salinas.

Q. Did he join you on the tour at Salinas?

A. No. He just -- he was standing in the middle of this area, and I was interviewing an inmate.

Q. When did you find out it was Secretary Cate?

back. I mean, we always had to have an officer so that we could have access to the inmate, but they were never right there with us; they always were back.

Q. Was it your understanding they were able to hear the discussions?

A. No, they couldn't hear the discussion.

I could barely hear the discussions.

Q. Do you recall how -- Dr. Dvoskin would introduce himself during these interviews?

A. No, I don't. It was early on. And I don't know how he introduced himself.

I'm sure I introduced myself the way that I said I do because that's what I've done for 35 years.

Q. Sure.

A. That's what I do.

I know he introduced himself. I don't know what else he said.

Q. At the end of the interviews, did any of the patients ask how you were going to use the information that you received?

A. I told them, and sometimes I didn't even take their names down because I didn't want to get into individual people in trouble.

I told them that it was just an informal survey. I was just interested in their opinion about

how the care was going. I asked them how long they had been on the unit, how often somebody came by and talked to them about their welfare, what the welfare checks consisted of, how often they saw their primary clinician, how often they saw their psychiatrist, how often did they get to IDTT meetings.

Did they go to group therapy. If they didn't go, why didn't they go.

Were they on any medications. Did they have side effects of the medications. Did they know what the side effects were.

Did they know how to call mental health for an emergency. And did they know how to call -- how did they get medical care, because I wanted to make sure the mental health patients got medical care, too.

Q. Sure.

A. And then at the end, I would ask them to rate them. Sometimes they would give me a number. Sometimes they would say the care is great. Sometimes they would split the scores.

Q. Did some patients say the care was not great?

A. They never said that about mental health. They did say that about medical.

Q. Interesting.

Did you tell them you'd be writing a report at

the end of your tour?

A. I told them that we were here in the institution and that we were going to various housing units and interviewing various inmates at random, and that -- you know, they were just happened to be picked and would it be all right. I mean, I always asked for permission before I just assumed that they were going to talk to me.

Q. Sure.

A. And I didn't put down any particular inmate in my report.

Q. Okay. But they didn't know you were there to write a report at the end of your tour?

A. They knew we were doing an evaluation of that facility, so...

Q. A few more questions and then we can take a break.

A. I mean, these inmates were so used to being talked to.

Q. They were used to being talked to?

A. Yeah. I mean, when I would walk through the yard, they would sometimes say, "Oh, she's with Coleman."

Q. Who would say that?

A. The inmates.

I mean, if they saw a suit, that was their assumption.

Q. Did any inmates ever mistake you for being with the special master team for Coleman?

A. I never asked them what they thought.

Q. Okay. You said that you asked them a number of questions about their clinician and their medications. And in the report, I noticed that you said that their knowing their clinicians or their medications was unusual.

Do you recall that?

A. I didn't think it was unusual. I thought it was great.

Q. Thought it was great.

Did you think that it indicated that they were receiving an appropriate level of care?

A. Yes, because they knew who the people were. They knew who they had access to.

Q. Are you aware of any studies that show that whether the patient knows their psychiatrist or their primary clinician is a -- an appropriate measure for quality of care?

A. I'm not aware of quality assurance studies as such.

Q. Are you aware of any quality assurance studies

or any studies that validate that whether a patient knows what medication they're on is a measure of quality of care?

A. I'm not aware of any studies, but my personal opinion is is that that's a good thing.

Q. Are you aware of any studies as to whether they expressed positive or neutral feelings or mixed scores as an appropriate measure of the quality of care?

A. I think that that's a study that's done in hospitals all the time. They ask inmates about satisfaction.

Q. Okay. Do you think if that a patient knows his clinician's name or the medications that he's receiving, that is he receiving an appropriate level of mental health care?

A. Yes.

MR. FISCHER: Okay. Let's take a five-minute break.

(Off the record at 10:10 a.m. and back on the record at 10:18 a.m.)

BY MR. FISCHER:

Q. Dr. Moore, you mentioned that you thought whether the patient knew the name of their clinician or the medications they were receiving is an indication of quality of care, correct?

A. Yes.
Q. And you asked those questions during your interviews; is that right?
A. Yes.
Q. Did you follow up to confirm that what the patients told you was correct?
A. No, I did not.
Q. Is there -- in other systems that you reviewed, do you use the same method of determining quality of care?
A. No. It depends on what I'm looking at. I might ask different questions.
Q. What were you looking at here that led you to use this line of questioning?
A. I was looking to see that patients that were in administrative seg were seen by their preliminary clinicians once a week, seen by their psychiatrist every 30 days, that they went to IDTT meetings, that they were offered group therapy, that they were receiving their meds. That was the first question I asked, "Are you taking any medications?"
Q. Did you review records of each of the people you interviewed to confirm what they were telling you was correct?
A. If I had an inmate that complained to me about

Q. Who is Nate Mills?
A. He was an IT person.
Q. With which office?
A. I don't know.
Q. With defense counsel?
MS. VOROUS: Objection. Asked and answered.
BY MR. FISCHER:
Q. Was Nate Mills an IT person for defendants' counsel?
A. He was sometimes on our tours. He helped us with IT issues.
Q. But you don't know what office he was from?
A. No.
Q. And what was the outcome of those discussions as to whether to enter this -- the data into the audit tool?
A. At first we were going to put all the data into the audit tools. And the attorney general asked us to fill out the audit tools.
But then we didn't do that. And we decided that we didn't want to be that specific in our report, that we wanted to be more global. So we didn't have to go through and do each and every.
Q. Was any data entered into a computer system from the audit tool?

A. Not by me.
Q. Are you aware if it was entered by any of the other consultants?
A. I don't know.
Q. Why did you think that you wanted to be more global and less specific?
A. You'd have to ask the attorney general.
Q. So that was the attorney general's decision?
A. That we were going to have a broader report rather than specific.
Q. How much time did you spend making this audit tool, you individually?
A. I don't know. I don't know how many days we worked on it, because we had meetings in Sacramento and then we had phone calls. And I really don't know. I'd have to look at my invoices, and I might be able to tell you. But I couldn't tell you off the top of my head.
Q. Would you say you spent more than 20 hours?
A. I don't know.
Q. Did you find the audit tool to be useful on your tours?
A. I used all of the questions. I used this to make sure that I asked every question. Before I left an area, I would say, "Wait a minute. Let me look at my audit tool and make sure I asked everything here." And

in that report?
A. No.
Q. Next one, quality management audit tool on page 18.
A. Yes.
Q. This was an area you looked at?
A. Yes.
Q. Same thing with medication management?
A. Yes.
Q. And emergency response?
A. Yes.
Q. I want to turn back to Exhibit 4. This is the joint report.
Are there specific parts of this report that you authored?
A. Yes. I contributed to it, yes.
Q. Are there any sections in which you were the primary author?
A. No.
Q. Who was the primary author?
A. I don't know. It could have been Dr. Scott or Dr. Dvoskin.
Q. You were not the primary author on any of the sections?
A. No. I had input.

Q. When revisions were made to the report, how was that handled by the -- by the group?
A. They sent an e-mail out with the draft of the report. They asked if we would review it and -- and respond.
Q. Were defendants' counsel included on those e-mails?
A. I believe I sent you the e-mails that I received. I can't recall without seeing them who was included.
Q. Were there times when it was just the experts sharing information?
A. I'm sorry. Without seeing the e-mails, I don't recall.
Q. Okay. Dr. Moore, take some time going through some of the findings in your report.
A. Okay.
Q. Let's start on page 11 of the report.
A. I'm going to use my copy, if you don't mind. Unfortunately, I dropped it this morning on my way up.
Q. Okay. Let me know when you're ready.
MS. VOROUS: I prefer that you use the exhibit. If you need to look at something, we can look at it. But use the exhibit.
THE WITNESS: Okay. It's going to take me

Q. In your opinion?
A. "Unavoidable" means it's unforeseen. You can't predict it. Maybe there are insufficient staff in the area.
Q. Can unavoidable staff shortages affect mental health care for prisoners?
A. Yes.
Q. In that same paragraph it says that -- the temporary -- it says: "Staffing shortages were temporary unavoidable" -- "temporary and unavoidable."
Have you followed up on the staffing shortages that you identified on your tours?
A. Yes, I did.
Q. Were they all temporary?
A. Many of them were, yes. They've hired other people. And they are instituting a program with San Quentin for telemedicine.
Q. Are you aware of any institutions where there are still staff shortages?
A. No, I have not done a staffing study of California staffing. I don't know that.
Q. So you looked staffing at the time of your tours?
A. At the time of our tours.
Q. Did you look at staffing of any of the

facilities that you didn't tour?

A. No.

Q. How did you determine which institutions you were going to tour?

A. It was a collective decision made by the group, primarily by Steve Martin.

I think we all had input, but Steve Martin made the final decision.

Q. Were there any institutions that you thought were essential to visit?

A. Most of the big ones that had crisis units.

Q. Did defendants' counsel offer any input?

MS. VOROUS: Objection to the extent that calls for communications between Dr. Moore and your attorney. You're not to answer that question.

BY MR. FISCHER:

Q. On page 12 at the top, it says: "In our opinion, the CDCR mental health staffing plan will provide adequate resources to meet the mental health needs of inmates."

MS. VOROUS: So page 10 of the report or page 10 of the --

MR. FISCHER: I'm going to go off the report numbers rather than the docket.

MS. VOROUS: What page did you say?

A. Yes.
Q. And what about -- you said also affects the IDTT process. What did you mean by that?
A. That may not have been true at Salinas. That was true at another facility.
Q. That staffing shortages would affect IDTT meeting --
A. Yes.
Q. And how did it affect the IDTT meeting?
A. The psychiatrist wasn't always present.
Q. And you think the psychiatrist is an important member of the interdisciplinary treatment team for patients?
A. Yes.
Q. Were are they an important member?
A. Because they make adjustments to the medication.
Q. And in the same paragraph, there appears to be a suggested solution with the introduction of telepsychiatry to support the efforts of the on-site psychiatrists.
Was that a recommendation of the -- you and the other consultants?
A. I'm sure it was.
Q. Did you make that recommendation?

A. No, but I would have.
Q. What is the benefit of telepsychiatry in a place like Salinas Valley?
A. It's a difficult place for -- to recruit psychiatrists. Psychiatrists routinely don't want to live there. The inmates don't want to be transferred to another facility. They don't like to leave their cell mate or cell block, whatever. Telepsychiatry works very, very well in almost every prison system that I know of in the United States.
Q. When you say "works very well," what do you mean?
A. They use telepsychiatry for -- to do psychiatry at remote facilities.
Q. So to provide psychiatric --
A. To provide psychiatric services.
Q. Are you aware that telepsychiatry still hasn't been instituted at Salinas Valley State Prison?
MS. VOROUS: Objection. Lacks foundation.
THE WITNESS: I don't know.
BY MR. FISCHER:
Q. Did you find out whether telepsychiatry has been implemented there?
A. No. I was not asked to.
Q. Okay. Would that have been important

you discuss this with staff at the institution?

A. Yes.

Q. What did they tell you?

A. They said that there were staffing shortages. They were working on system to put in place where they were tracking medication renewals. In their QI meeting, they were getting better.

Q. Did you follow up after the tour at CMC to find out whether a new psychiatrist had been hired?

A. A new psychiatrist has been hired.

Q. How many -- what -- how many psychiatrist vacancies were at CMC? Do you remember?

A. I would have to look at my notes.

Q. Was it more than one?

A. I don't know.

Q. Okay. Number 8 on the same page, at the Substance Abuse Treatment Facility, SATF.

It says: "Mental health staff reported dramatic mental health staffing shortages."

Did you observe this during your SATF tour?

A. There was staffing shortages. I'm not sure I would use the word "dramatic." I did observe IDTT meetings where there was not a psychiatrist in attendance.

That did not mean that the psychiatrist did

not adjust the patient's medication. He just was not present at the IDTT meetings. It was another step that they went to.

Q. In your opinion, would it have been better for the psychiatrist to be present with the other treatment team members to discuss medication?

A. It would have been better, but the care was still rendered.

Q. Okay. You went to SATF in November?

A. In November.

Q. Are you aware of what efforts have been taken to address the staffing shortages at SATF?

A. No, I'm not.

Q. Are you aware of whether any additional hiring has been done?

A. No, I'm not.

Q. Okay. Move forward to page 16, if that's okay.

On page 16 near the bottom of the page it says that the Central California Women's Facility, CCWF, "We" -- the experts -- "were informed that only 15 groups were being offered to CCCMS female inmates whereas nearly a hundred groups had previously been provided."

Did you observe this on the tour?

Q. The specific number of hours you said you don't know?
A. Yes.
Q. But to have access to some groups would be appropriate -- would be necessary for CCCMS inmates?
A. Yes.
Q. And does this opinion apply in the CCCMS general population?
A. Yes.
Q. And would it apply to CCCMS inmates in segregation?
A. CCCMS inmates in segregation, I don't believe have groups at this point. I'm not sure.
Q. Do you think it's important for them to have access to groups?
A. Yes. If they'll come out, yes.
Q. Do you have concerns that in certain ASUs in California prisons, there is no access to groups for CCCMS prisoners?
MS. VOROUS: Objection. Overly broad. Vague and ambiguous. Lacks foundation.
THE WITNESS: I didn't evaluate the CCCMS inmates, so it's very difficult for me to answer these questions because Dr. Dvoskin did this. And so I'm not as familiar with this ground, and I feel uncomfortable

giving you answers.
BY MR. FISCHER:
Q. You don't have any opinion as to whether CCCMS --
A. No, I don't.
Q. -- inmates in ad seg require groups?
A. No.
MS. VOROUS: Let him finish his question.
THE WITNESS: No, I have no opinion.
BY MR. FISCHER:
Q. Okay. Did you observe any other staffing problems on the tours that you went on that we have not already discussed?
MS. VOROUS: Objection. Vague and ambiguous as to what -- "staffing problems."
Answer if you can.
THE WITNESS: I don't recall any others.
BY MR. FISCHER:
Q. Is it possible that there is another institution that had staffing problems?
MS. VOROUS: Objection. Vague and ambiguous. Lacks foundation.
THE WITNESS: I don't recall without my reports.
MR. FISCHER: This is Exhibit 10.

BY MR. FISCHER:

Q. Was part of your role with this consultancy to provide recommendation as to ways to improve care?

A. We did -- at each exit conference, we provided recommendations.

Q. At each institution there was an exit conference at which you provided recommendations?

A. Yes.

Q. Did you follow up after that exit conference at any point to determine whether those recommendations had been implemented?

A. No.

Q. Go back to page 102411, eighth line.

In your typewritten notes, you write: "If urgent problem, seen day of arrival. If not, maybe seen second or third day."

This is under the "Reception Center" heading. What does this note mean?

A. These are new intakes that were coming in. They have 72 hours to complete the intake.

If the patient had an urgent problem, they were seen that day. If not, they may be seen the second or third day.

Q. Where did you get this information?

A. Observed and reviewed 10 intake records.

BY MR. FISCHER:

Q. In your opinion, do you think an individual assessment should be done for ad seg inmates placed in ad seg for their own safety as to whether they should be cuffed for MHCB, IDTT meetings?

A. Yes.

Q. Would the same apply for inmates coming from ad seg who have been placed in ad seg pending transfer to a general population or SNY yard?

MS. VOROUS: Objection. Lacks foundation. Compound question.

THE WITNESS: These are really getting into questions you should be asking Joel Dvoskin.

BY MR. FISCHER:

Q. Do you have an opinion on this?

A. No.

Q. Okay. Were there any other institutions that you visited for which you visited MHCBs at which they had this positive practice of assessing an individual where the individual needed to be cuffed for the IDTT meeting?

A. No. That was the only one that I saw.

Q. Okay. And you observed IDTT meetings in the other crisis units that you --

A. As often as I could.

places CDCR in the upper echelon of state prison mental health systems."

What -- what was your methodology for reaching that conclusion?

A. For myself -- and I can only speak for myself -- it was the work that I have done in Indiana, North Carolina, Kentucky, New Mexico, Utah, Maine, and Delaware.

Q. And in all these institutions, you've looked at the state prison mental health system?

A. As part of the component of the review that I was doing. I looked at the entire state. I wasn't just hired to look at mental health.

Q. So you listed seven states?

A. I listed seven states. I could probably list more.

Puerto Rico.

Q. Did you look at any current data from those states to do a contemporary comparison between the state mental health systems?

A. I have data from those systems. I have data from North Carolina, New Mexico, Puerto Rico.

Q. Did you use that data?

A. And I have Indiana data that's current.

Did I use that data? No. I wasn't asked to

do that.

Q. At the bottom of page 14, there's some discussion about the special master monitors.

It states that the special master monitoring results, quote, in scrutiny not of constitutional standards but of the department's own policies and procedures.

Are you aware that the program guide is a court-ordered remedy in the Coleman case?

MS. VOROUS: Objection. Lacks foundation.

THE WITNESS: If you're telling me that, yes, I am aware of that.

BY MR. FISCHER:

Q. Do you have an opinion as to what the special master should be doing instead of looking at the program guide standards?

A. I think the program guide standards or the interpretation of the timelines might be too exacting; that if someone is one day late, then they are in noncompliance, where in the free world or in other prison systems, they're not held to such rigid requirements.

Q. Do you have specific problems with the program guide guidelines?

A. In some of them, yes, I do.

the special master had asked for the same information?
A. Or similar.
Q. And was that information that you needed in order to make your -- to form your opinions?
A. I don't know what the special master asked for. I never looked at their binders.
Q. Did the data that you and the other consultants asked for, was that information that you used in order to form your opinions in the case?
A. It was information from the audit tools.
Q. And that was information that you used in order to reach your conclusions as to whether the care is constitutional?
A. Yes.
Q. So my question is: Is some of that same data also data that the special master requests in their monitoring?
MS. VOROUS: Objection. Asked and answered.
THE WITNESS: I don't know what he asks for.
BY MR. FISCHER:
Q. Okay. You -- I understood that you just said that some of the data they had already collected for the special masters?
A. That's what the staff said.
Q. On the same page, it says: "Second, any

positive innovation that the department wishes to employ to improve its services to inmates with mental illness becomes a criterion against which their compliance is measured."

Further down: "This serves as a disincentive to system improvements."

Were you told any examples of positive innovations that were not implemented because of the special master's involvement?

A. Please redirect that question to Dr. Dvoskin.

Q. Why am I redirecting that question to Dr. Dvoskin?

A. Because he would be the author of that.

Q. He wrote that. Okay.

Do you have a different opinion?

A. No. I just didn't write that.

Q. Do you agree with this opinion?

A. Yes.

Q. Do you have any examples of any positive innovations that weren't implemented because of special master's involvement?

A. No, I don't.

Q. Okay. Pages 15 and 16 under the section on the correctional clinical case management system patients, CCCMS -- CCCMS.

A. These would not have been sections that I wrote.
Q. Did you interact with the CCCMS inmates?
A. Not specifically, no.
Q. Did you interact with CCCMS inmates in administrative segregation?
A. If they were there and I got them by accident. Usually I wanted the EOP inmates.
Q. You weren't interested in the CCCMS inmates?
MS. VOROUS: Objection. Misstates her testimony.
THE WITNESS: I was interested but, I was more interested in the EOP patients.
Dr. Dvoskin had that responsibility. You're asking me about sections that I didn't review.
BY MR. FISCHER:
Q. Okay. I'm just trying to get a sense of which sections those are.
A. Do you want me to tell you the ones I reviewed?
Q. It will be easier as we go. I don't want to waste more time.
But this section on CCCMS you did not review, you have no opinion --
A. No.

Q. -- on these issues?
And that's from page 15 to 16?
A. Correct.
Q. On page 16 is the EOP discussion.
Did you have any involvement on this?
A. Yes.
Q. You did. Okay.
Did you write portions of this section, the EOP section?
A. I didn't write any of it. Verbally told them. And they wrote notes from their conversations with me and dialogues of exit conferences.
Q. Verbally told who?
A. Dr. Dvoskin and Dr. Scott.
Q. Okay. So you didn't write this section or anything --
A. I didn't write anything on this report.
Q. The report was finalized on January 4th. In the weeks prior to the finalization of the report, were there any sections of the report that you felt uncomfortable with?
A. No.
Q. There were none?
A. No.
Q. You agreed with -- with everything that

BY MR. FISCHER:

Q. Doctor, this is an e-mail dated August 21st, 2012, from Patrick McKinney and your name is on the "To" list.

Do you recognize this e-mail?

A. Yes.

Q. It provides an agenda for the August 21st meeting at 1515 S Street.

A. Yes.

Q. Did you attend a meeting on August 21st in Sacramento?

A. Yes.

Q. And on the agenda, the first item, 10:00 to 11:00 a.m., it says: "Discussions concerning overall systemic constitutional findings of the mental health care system based on the 10 site visits. Includes representatives of the governor's office, CDCR, Department of Finance, and Department of State Hospitals."

Do you recall this meeting?

A. Yes.

Q. At this meeting, was -- were systemic constitutional findings discussed?

A. We discussed our findings.

Q. At that point, there had been 10 site visits;

is that correct?

A. Correct.

Q. When was the decision made to go to three more institutions?

A. We only went to two more, but it was following this meeting. But I don't know exactly what date.

Q. What was your understanding of why you went to three more -- two or three more?

A. I don't recall.

I do know there was a discussion. I just don't recall the reason.

Q. Were you part of that discussion?

A. Yes.

Q. Did you indicate that you wanted to visit more institutions?

A. No, I didn't.

Q. At that point, had you reached your conclusion as to systemic constitutional findings?

A. On the 10 sites or eight sites -- nine, I guess, sites that I visited, yes.

Q. What about as to the CDCR system as a whole?

A. I felt that was constitutionally adequate.

Q. What was your basis for finding the mental health care at the institutions that you hadn't toured constitutionally adequate?

A. We did a sample of the institutions. It was never our intent to visit every single institution.
Q. Did you ever ask to see any data from the other institutions?
A. No.
Q. Prior to the final visits at CMC and SATF, you had already made your conclusion that CDCR had not acted with systemic deliberate indifference?
A. I did, yes.
Q. Did anybody go to Pelican Bay --
A. Yes.
Q. -- from the consultants team?
A. Yes.
Q. Who went?
A. Joel Dvoskin.
Q. Only Joel Dvoskin?
A. Yes.
Q. Was it your understanding that Dr. Dvoskin, Dr. Scott had reached the same conclusion as to constitutional care as of the August 21st meeting?
A. Yes.
Q. Did anyone ever question as to the necessity of going to these other institutions?
A. I'm not aware. I don't recall.
Q. Do you recall whose idea it was to go to the

Q. Was it more than half the institutions you visited?

A. Sorry. Without going through my notes, I don't have it.

But I know in my notes I've addressed it.

Q. In the same paragraph you write, the report writes: "We also observed some groups that appear to consist primarily of showing the inmate a movie or entertainment video."

And then below that, it says: "We understand that recreation and entertainment may be an appropriate aspect of group therapy so long as the majority of the group therapy time is devoted to psychotherapeutic rehabilitative skill building and psychoeducational activities."

Do you agree with this finding?

A. Yes.

Q. Did you observe some groups that -- during which only movies were shown?

A. Yes.

Q. What is the certain about -- that you have about showing movies for treatment groups?

A. It wasn't very therapeutic. They didn't really discuss the movie or its impact or how it would alter what they were thinking or anything else.

Q. Do you recall any of the movies that they were showing?

A. No, I don't.

Q. Okay. And about how many institutions did you observe this?

A. One or two at the most.

Q. Did you follow up as to whether any changes had been made in light of this recommendation at those institutions?

A. No.

Q. With respect to your recommendation to increase the quantity of groups, how did you make that determination at a particular institution whether more groups should be offered?

A. There were some CQI studies that I looked at that would only show 70 percent of the inmates going to IDTT.

And sometimes when I talked to the inmates about why they don't go, they said that the groups were boring.

Q. How does that relate to your recollection to increase the quantity of groups that are offered?

A. Well, sometimes if they didn't have enough LPTs -- at Salinas is a good example -- where we talked -- where they didn't have LPTs and they had lost

frequently. The first time I saw it, I thought it was good idea.

Q. First time you saw it where?

A. In Connecticut.

Q. Why did you think it was a good idea?

A. Because they could bring inmates out from various classifications and have group therapy with them and the inmates would feel safe, whereas they might not be able to get this grouping of inmates together.

Q. Is it your opinion that the therapeutic modules can be overused, used in situations where they're not required?

MS. VOROUS: Objection. Vague and ambiguous. Lacks foundation.

THE WITNESS: I don't know that. I don't know that they -- I'm trying to think if I saw group therapy where they didn't use therapeutic modules.

BY MR. FISCHER:

Q. In the California prisons?

A. In the California prisons.

Q. What about in the other states? Philadelphia, Connecticut, Indiana, North Carolina, Kentucky, New Mexico, Utah, Maine, Delaware, Puerto Rico?

A. Puerto Rico didn't use modules. There was not an emphasis on group therapy as there has been here in

the state of California in many of the other states that I've gone to.

Q. What about individual treatment?

A. Individual treatment, yes.

Q. And did any of these other states use therapeutic modules for individual treatment?

A. No.

Q. And that's all the states that you -- including Connecticut?

A. I'm sorry. I didn't hear you.

Q. All the states other than California that you've worked in the adult prisons have not used therapeutic modules for individual treatment?

A. Not that I can remember.

Q. Okay. First time you saw the therapeutic module -- therapeutic modules here in California, what was your -- what was your response?

MS. VOROUS: Objection. Vague and ambiguous.

If you can, answer that question.

THE WITNESS: I refer to them as a cage.

BY MR. FISCHER:

Q. Did you have any other opinions or thoughts about their use?

A. On one of my reports, I made some notations of it. It was a very early report.

(Plaintiffs' Exhibit 12 was marked for identification.)

MR. FISCHER: Exhibit 12.

BY MR. FISCHER:

Q. Exhibit 12 are handwritten notes. At the top it says "SAC Folsom."

Does this refer to your CSP Sacramento tour on February 29 and March 1st?

A. Yes.

Q. And I'll direct you to DEXP103015.

At the bottom, it says -- last four lines: "Sometimes group's not dynamic. Cages - terrible hard metal stools. Hard to be in cage for two hours."

Were those your impressions?

A. I knew you were going to find this.

Yes. I knew you were going to find this. This was one of my early, early visits before I understood the therapeutic modules.

Q. This was one of your initial impressions of the modules?

A. Yes. It may have been the first time.

Q. The first time?

A. That I had seen this -- these therapeutic modules in California.

Q. And so can you tell me a little more about

during your tours?

MS. VOROUS: Let me clarify. During her tours -- not Mule Creek.

BY MR. FISCHER:

Q. I recognize that the experts did not go to Mule Creek. But were there other similar treatments settings that you observed at other institutions?

A. Not that I'm aware of.

Q. Not that you're aware of?

A. Not that I recall.

Q. In this photograph, there are three modules filled with inmates with two clinicians conducting one-to-one treatments.

Did you observe individual treatment being conducted in this manner on any of your tours?

A. Not that I recall. Sorry.

Q. Do you have any concerns about conducting one-to-one treatment in such a setting?

MS. VOROUS: Objection. Lacks foundation. Argumentative.

Go ahead.

THE WITNESS: My concern would be the confidentiality of the interview.

BY MR. FISCHER:

Q. Because they're so close?

A. Because they're so close.

And especially the -- inmate at the end has nothing better to do than to listen.

Q. Inmate on the left side is just listening?

A. Right.

Q. Would a more appropriate treatment space be an individual office for these individual contacts?

MS. VOROUS: Objection. Lacks foundation. Speculative. Argumentative.

THE WITNESS: Do you want an answer?

BY MR. FISCHER:

Q. Uh-huh.

A. If it was available.

Q. You're aware from some of your tours that individual treatment space is not available at some of the institutions at this time?

A. Yes.

Q. Let me go back for one more minute to Exhibit 13.

In your experience what is the impact that -- or the effect of having one-to-one contacts in a nonconfidential setting similar to what you see here?

MS. VOROUS: Objection. Lacks foundation as far as her experience in having this kind of experience.

THE WITNESS: The inmate will not be as

truthful or forthcoming with their issues.
BY MR. FISCHER:
Q. And that would negatively affect the treatment?
A. That would affect the treatment.
Q. Okay. Move to page 19 of the report.
Subsection B versus the one EOP section, states: "At California Institution for Men, CIM. There were some inmates waiting for EOP special needs yards beds reportedly housed in administrative segregation unit for their own protection; not because they posed a danger to others."
Did you observe this during your tour of CIM?
A. I didn't look at special needs yards, so I wouldn't be aware of this.
Q. Did you observe any administrative segregation units?
A. Yes.
Q. In any of the ad seg units, were inmates waiting for EOP special need yard beds housed?
A. I would have to look at my notes. I don't recall.
MR. FISCHER: Exhibit 14.
(Plaintiffs' Exhibit 14 was marked for identification.)

A. Okay.
Q. Are you aware?
A. Yes. Yes.
Q. Okay. Did you visit the administrative segregation unit at CIM? I think you said you did.
A. Um.
Q. Direct you to top of the 10266, top two issues: "EOP not transfer fast enough. That's not getting 10 hours RX" --
A. Treatment.
Q. "RX" is treatment?
A. Treatment.
Q. "Now nine in seg."
Were you documenting that there were nine EOPs awaiting transfer in this segregation unit?
A. Yes.
Q. And they were not there for disciplinary reasons; is that your understanding?
A. Yes.
Q. They were there because they were awaiting for a bed to open?
A. Yes.
Q. Okay. On the page just before that, 102620, near the bottom you write: "Lack of beds."
Is this related to same issue?

A. Lack of beds in general population.
Q. So there were lack of beds for EOP and there were lack of beds for -- related to the general population?
A. Yes.
Q. Were there more inmates than appropriate beds?
A. Yes.
Q. It's your understanding?
Were there more EOPs than appropriate beds in the system?
MS. VOROUS: Objection.
BY MR. FISCHER:
Q. Trying to understand what your --
A. More EOPs -- they couldn't transfer EOPs to other institutions.
Q. For lack of available beds?
A. Lack of available beds.
Q. Okay. Do you recall, did you interview any of the EOPs in segregation awaiting transfer when you were at CIM?
A. This -- these may have been the inmates on page 102626.
Q. Uh-huh.
Based on your interviews with these inmates, were you able to reach an opinion as to whether they

were receiving appropriate level of care treatment?

A. They were sick inmates. They were very sick inmates. And --

Q. Do you remember anyone specifically?

A. No. Just by what I'm -- I wrote down about the fact that -- that they were hearing voices or that they were having auditory hallucinations or that one inmate was seeing signs of his grandmother. They were sick inmates; they needed to be somewhere else.

Q. In your opinion, was the administrative segregation unit an appropriate area for these inmates?

MS. VOROUS: Objection. Assumes that these inmates were ad seg.

THE WITNESS: If these inmates were in ad seg.

BY MR. FISCHER:

Q. Based on your memory, you interviewed inmates in ad seg?

A. I thought these were the inmates in ad seg. I'm not sure. I'd have to look at the numbers to be sure.

Q. On the page after which you were reading where it again says "Seg" at the top. This is 102627.

About halfway down, it says "LOB" -- "Make a note LOB." Does that stand for lack of bed?

MS. VOROUS: Are you asking her whether --

MR. FISCHER: Yeah.

THE WITNESS: I don't know what LOB stands for anymore.

BY MR. FISCHER:

Q. You don't recall or you didn't ask?

A. I don't remember anymore. I don't know what my abbreviation was.

Q. Were you made aware that there were some EOP reception center inmates in the administrative segregation unit?

A. Yes.

Q. Based on lack of beds?

A. Yes.

Q. If you go back to the first page, the cover page of Exhibit 14, 102619, I just want to understand. You wrote -- about halfway down it says: "EOP 39 (15) in MHCB"?

A. Mental health crisis beds.

Q. Does that note that 15 of EOPs -- 15 of the 39 EOPS at the institution were in the mental health crisis beds?

A. Yes.

Q. Did you consider that to be a high number of EOPs, high percentage of EOPs requiring mental health crisis care?

components I looked at.

Q. One of the audit tool components for your --

A. For my criteria, yes. And so the nurse brought me to this meeting.

Q. And so do I understand that your finding was that there were more CCCMS prisoners than there were staff to be able to do discharge planning, including patrol medications with them?

MS. VOROUS: Objection. Misstates testimony.

THE WITNESS: No, no, no.

BY MR. FISCHER:

Q. Go ahead.

A. No, no, no. The parole meds were done differently than the discharge planning.

My premise was that there weren't enough discharge planners to fill out the social security applications, make sure people had housing, other therapies.

Q. Various aspects of discharge planning were not done for the CCCMS population?

A. Correct.

Q. Okay. Thank you for clarifying. Maybe I can get my question correct this time.

Your finding was that there were more CCCMS prisoners at CIM than there were staff available to do

discharge planning at the institution?

MS. VOROUS: Objection. Misstates her testimony.

THE WITNESS: Yes.

BY MR. FISCHER:

Q. Okay. And one last thing on CIM I wanted ask you about in your notes on the final page, 102633.

Most of the way down next to No. 5, it says: "Nurse UNFAM, SE, psy meds."

What does that note refer to?

A. Nurses were unfamiliar with the side effects of psychiatric meds.

Q. I imagine that's on your radar because you're a nurse?

A. I asked them.

Q. Why did you ask this question?

A. I asked all the institutions. That was one of the criteria on my audit tool.

Q. And here -- SE is side effects?

A. Side effects.

Q. And is this particular CIM of concern to you in your analysis?

A. Yes.

Q. Why is that?

A. Because it's a common practice that nurses

know the side effects of the medication that they're giving because very often you are the one that might observe lithium toxicity in an inmate.

Q. So it's important to be aware of the side effects of the psych medications in order to ensure the safety and well-being of those patients?

A. Yes, sir.

Q. Did you observe this problem at any other institutions? Do you remember?

A. Yes.

Q. Do you remember which institutions?

A. All of them except San Quentin.

Q. San Quentin?

A. Knew the side effects.

Q. They were good?

A. They were good.

Q. Did you raise this with -- at the exit interviews?

A. Each and every time.

Q. Did this make it into your report?

Direct you to page 26 of your report, Exhibit 4.

Tell me if I'm looking at the right -- bottom, "Nursing Medication Management." Just a short section.

Is that an issue you think could have been put

in the report if you were writing it?

A. I think I would have phrased it differently.

Q. What would you have phrased differently?

A. I would have made a recommendation that nursing education emphasize the side effects of the medication and that they have handouts or signs available where they dispense the medications so these things would be in front of them all the time.

Q. All right. Back on page 19 very briefly. It says: "At Corcoran, inmates reported from the EOP special needs yard that yard time was canceled for various reasons on a relatively frequent basis."

You didn't visit the EOP special needs yard?

A. No, I did not.

Q. Were you aware of this issue at the institution?

A. No, I was not.

Q. From a mental health perspective, is it concerning to you, given your expertise, for EOPs to be denied yard time?

A. Yes.

Q. And why is that?

A. Inmates need to go outside, exercise, socialize.

Q. And the lack of that opportunity can adversely

Exhibit 15.

(Plaintiffs' Exhibit 15 was marked for identification.)

BY MR. FISCHER:

Q. This is from Lindsay Hayes, project director, National Center on Institutions and Alternatives, dated August 16th, 2011. And it's re "CDCR Suicide Prevention Consultation."

I assume you have not seen this document before?

A. No, sir.

Q. And this is dated before you began your consultancy?

A. Yes.

Q. Very shortly before; is that correct?

A. Correct.

Q. Is this a report that would have been -- you would have considered in reaching your opinions had you been given it earlier?

MS. VOROUS: Objection. She hasn't --

THE WITNESS: I don't know.

MS. VOROUS: -- hasn't read the report.

THE WITNESS: I don't know. I haven't reviewed it.

BY MR. FISCHER:

Q. Okay. Based on your short review, does it look like something you would have considered?

A. I would have considered every document that I got.

Q. Including this one?

A. Including this one.

Q. On page 2, at the top, there's a finding of problems of emergency response to suicide, 7 of 25 suicides.

Would Lindsay Hayes' finding as to emergency response been important to your consideration on that topic in the course of your review?

MS. VOROUS: Objection. Speculative. Lacks foundation.

THE WITNESS: It doesn't talk about emergency response.

BY MR. FISCHER:

Q. At the very top of page 2.

A. "Following a review of these 25 cases, I informally made the following calculations."

Oh, the emergency response incident. Yes, I agree with Lindsay Hayes with the emergency response incident.

Q. What do you agree?

A. That there were cases where the response was not timely.

Q. What days cases did you review? From what time period? Do you remember?

A. They're all in my report, every one of them that I reviewed and from what time period from the time that I first started doing these audits until the very last one.

But these are in 2010.

Q. Did you review more recent suicides?

A. I reviewed -- if the case involved a suicide, if the emergency response involved a suicide, I reviewed it.

When I first started doing these audits, I wasn't sure what I was supposed to do with these emergency responses, so I would review medical emergency responses as well.

As time went on, I became less interested in a cardiac response or an asthma response, and I became more familiar with the documents and I only went to look for the mental health responses.

Q. I see. And you said you found problems with emergency response as to the suicides -- as to the suicides that you reviewed?

A. Yes. There were a few, yes.

Q. And were there some as to the medical as well?
A. Yes.
Q. And do you know what -- do you remember what time period you reviewed?
A. Between 2011 and 2012.
Q. And as you just noticed -- mentioned, Lindsay Hayes' report covers 2010 suicide?
A. Yes.
Q. And you found problems with emergency response in 2010?
A. Yes.
Q. And you found problems with emergency response in 2011 and 2012?
A. Yes.

MR. FISCHER: Exhibit 16.

(Plaintiffs' Exhibit 16 was marked for identification.)

BY MR. FISCHER:

Q. Exhibit 16, at the top it says "LAC CSP." Are these your notes from the Lancaster tour that you did?
A. LAC Lancaster, no.
Q. Los Angeles County?
A. Los Angeles County.
Q. Is that correct?

A. CSP, yes. Los Angeles.
Q. Okay. I'm just going to -- what was the date of this tour? I'm sorry.
A. May 3rd and 4th.
Q. Page 102630. At the top, it says "Emergency Response"?
A. Yes.
Q. And do I understand correctly that below you reviewed specific cases involves emergency response?
A. Yes.
Q. I just want to go through those quickly.
The first one, about a third of the way down, you write: "No account for delay of time from custody to nurse"?
A. Yes.
Q. Was that an example of a delayed response, if I understand that correctly?
A. Yes.
Q. And on the next page, you review a particular inmate's case and at the conclusion of that, on 102604, about a third of the way down, you write: "Inadequate response time"?
A. Yes.
Q. That was your finding?
A. Yes.

Q. Next one, conclusion of the bottom of 102604, you write: "Response time adequate"?
A. Yes.
Q. On the next page you have another inmate review. And almost at the bottom -- am I reading correctly? It says: "Response time adequate"?
A. Yes.
Q. Next page, another inmate review. And you write -- is that -- am I understanding correctly? -- "Adequate time"?
A. Adequate time for the paramedics to arrive, but I was critical that they didn't call 911 from the yard or have 911 called.
Q. So there was some delay you identified there?
A. Some delay. But once the paramedics were called, they arrived.
Q. They arrived quickly?
A. They arrived quickly.
Q. Two more on the final page.
First one halfway down says: "Response time inadequate. Training staff involved complete first responder"?
A. Right.
Q. What does that refer to? If you recall.
A. The nursing staff assigned to the suicide

watch activated a personal alarm where she should have gone in and been the responder. She could have done both.

Q. And that was a case of suicide in custody, correct?

A. I don't know if the patient committed suicide or not.

Q. It was an attempted suicide?

A. It was attempted suicide.

Q. And your finding was response time inadequate?

A. Yes.

Q. And then at the bottom, the final inmate, your finding is: "Responsive time inadequate"?

A. Yes.

Q. So of the seven cases that you reviewed from your response at CSP LAC, five of the seven you found inadequate emergency response time?

A. Yes.

Q. Is this consistent with what you saw at any other institutions?

A. Many of them.

Q. Any specifically? If you remember.

A. Corcoran, if that's the gang -- very difficult institution.

Q. There were difficult --

Q. Are you aware of any guidelines as to wellness checks in segregation environments?

A. Done by the LPT or by whom?

Q. Anything about NCCHC or ACA guidelines as to wellness checks in segregation.

A. Done -- performed by -- who do you want them to be performed by.

Q. Are you aware of who the guidelines say -- what the guidelines say about that?

A. The only guidelines that I'm aware of relating to checks in segregation for suicide watches, and those -- your inmates are not in segregation if they're on suicide watch.

Q. Are you aware of any national guidelines as to welfare checks for all prisoners in segregation?

A. They vary from 30 minutes to an hour to 15 minutes, depending upon -- depending upon the acuity that the inmate is displaying.

Q. Based on your expertise and experience, do you have any opinion as to the appropriate practice as to welfare checks in segregation?

A. It's recommended that they be staggered, that they not be done exactly at 30 minutes, only every half hour.

Q. Did you observe at some institutions problems

with staggered welfare checks?
A. I never checked.
Q. You didn't look at that issue?
A. I didn't look at it.
Q. Are you aware of guidelines that welfare checks should be done regularly for all inmates during the entire period that they're in segregation?
A. Yes. Yes.
Q. You're aware of that guideline?
A. Yes.
Q. Are you aware that CDCR has welfare checks only for first 21 days?
A. No, I'm not.
Q. Do you have any opinion as to the appropriateness of that policy?
A. Based on just what you've told me?
Q. Sure.
A. I think it should be continued indefinitely, that you should have welfare checks.
Q. Welfare checks?
A. Every day.
Q. For all inmates in segregation?
A. Yes.
Q. For the entire time they're in segregation?
A. Yes.

A. Yes.
Q. You can see that it goes from DEXP102775 to 102784. Is that right?
A. Yes.
Q. And that -- I'm sorry -- one -- yeah. And then shortly after that is 102801 on Exhibit 21.
Are you able to -- I know that they're fairly blank. Are you able to confirm whether this is the CCWF audit tool or not?
A. Yes. It has the CCWF medication -- medication is stapled to the back at the end.
Q. So this is the CCWF audit tool, Exhibit 21?
A. Yes.
Q. Okay. Can I have you turn to DEXP102813?
A. Yes.
Q. On there, under "Administrative Segregation Unit," did you write: "No groups at ad seg"?
A. Yes.
Q. Does that remind you whether there are groups in ad seg?
A. Yes.
Q. And there are not groups in administrative segregation at CCWF?
A. Yes.
Q. Is this a barrier to appropriate treatment for

EOPs in the ad seg unit at CCWF, in your opinion?

MS. VOROUS: Objection. Misstates the content of the document we're looking at.

The section that you're referring to, this page 10283 -- 813 relates to general ad seg. It does not relate to the EOP ad seg hub.

BY MR. FISCHER:

Q. Do you recall whether there was treatment at any of the segregation units at CCWF?

A. The unit that I went to, the ad seg unit that I went to, also held the condemned women in it. So I don't know if it was the EOP ad seg or the general ad seg.

Q. On the next page of the exhibit, 102814, it says under "EOP ASU Hub," it says: "Meeting number of hours of structured therapeutic activities offered per week?" You write "No."

A. "None."

Q. "None"?

A. That's what written, "none."

Q. Do you agree that the lack of structured therapeutic activities in this unit was a barrier to treatment to EOP women?

A. Yes.

Q. And CCCMS women at CCWF?

A. No.
Q. Did anybody look at emergency response for those 10 suicides, to your knowledge?
A. In 2010?
Q. The 2010 and 2011 suicides at CMC.
A. I looked at 2011.
Let's take a look at -- the report -- the emergency response report that's there because I looked at some suicides. Let's look at my reports.
MS. VOROUS: Let him ask questions.
BY MR. FISCHER:
Q. So you may have is your answer?
A. He's do very well without me.
Q. On page 31 under "Suicide Prevention," near the bottom, Section B, Subsection 3, there's a finding that the response to mental health-related emergencies was timely and appropriate in each institution.
We discussed earlier -- is this a finding that you disagree with?
A. I disagree with it.
Q. Did either Dr. Dvoskin or Dr. Scott look at this issue, to your knowledge?
A. Dr. Dvoskin did.
Q. Dr. Dvoskin looked at it.
Did you ever discuss this issue with

Dr. Dvoskin?

A. If I had individual cases that I was concerned with, yes, I brought them to his attention at the facilities.

Q. But in drafting the, report there was no further discussion?

A. No.

Q. Go to page 33.

Subsection 4, this is on recommendations as to suicide reports. There's a recommendation: "We strongly recommend avoiding use of the term 'preventable' without a very specific and timely explanation of the manner in which the suicide could have been prevented."

Is this an issue that you looked at?

A. No. That was Joel Dvoskin.

Q. Starting at the bottom of page 32, Section 1 through Section 15 on page 37. Is this Dr. Dvoskin's section to write?

A. Yes.

Q. Did you have -- are any of the opinions in here something that you looked at, paragraphs 1 through 15?

A. I read them.

Q. Are any of these issues issues that you

specifically looked at in the course of your review?

A. I looked at the suicide response and the timeliness of it.

Q. And nothing else?

A. Nothing else.

Q. Okay. Do you agree with this recommendation that the use of "preventable" should be avoided in reviewing completed suicides?

A. I don't take suicide cases. I wouldn't know how to answer that.

Q. Okay.

A. In my private practice, in my consulting practice.

Q. Are you aware of whether attempted suicides are tracked by CDCR?

A. I had some statistical forms from some of the sites. I couldn't tell you what's been tracked at this point.

Q. Do you know whether attempted suicides are tracked in individual's EUHRs?

A. Yes.

Q. Do you know?

A. There would be a progress note.

Q. Do you know whether they're tracked for non-mental health case load prisoners?

Q. What was your impression of the mental health care being provided in the condemned unit?
A. It was excellent.
Q. It was excellent?
A. It was excellent.
Q. Were you aware of the -- the blanket ban of condemned prisoners requiring intermediate care inpatient hospitalization?
A. No.
Q. No?
A. No.
Q. Were you aware of the specialized program for prisoners in the condemned unit requiring ICF inpatient level of care?
A. No.
Q. Did you interview or review any records for any inmates who had been identified as requiring ICF inpatient level of care?
MS. VOROUS: Objection. Lacks foundation.
THE WITNESS: Not that I was aware of.
BY MR. FISCHER:
Q. Were you told anything about inpatient access -- inpatient hospitalization access for the condemned in San Quentin?
A. No. I interviewed the psychiatrist.

Q. Do you remember the psychiatrist's name?
A. He was on the unit. He was housed on the unit. He was a young psychiatrist.
Q. Okay. Was it Dr. Monthei?
A. I don't know his name.
He didn't bring up those issues.
Q. And you didn't know to ask?
A. I didn't know to ask.
Q. Do you have any opinion on any blanket ban to an inpatient level of care for the condemned at San Quentin?
MS. VOROUS: Objection. Lacks foundation.
THE WITNESS: I would need to have more information on what that policy meant.
BY MR. FISCHER:
Q. And you haven't been provided information other than what I just told you?
A. Yes.
MR. FISCHER: Okay. 23.
(Plaintiffs' Exhibit 23 was marked for identification)
BY MR. FISCHER:
Q. At the top it says "Salinas State Prison." I assume this refers to your handwritten notes for Salinas Valley State Prison; is that correct?

A. Yes.
Q. Okay. When you were at Salinas Valley State Prison, did you visit any of the DMH or DSH patients at the facility?
A. Yes. There was one DMH facility that was on the ground, but I was there very briefly only to find out about the Clozaril inmates because that's where they gave the Clozaril.
Q. To inmates?
A. For Salinas Valley.
Q. For the Salinas Valley non-DMH inmates?
A. Correct.
Q. So did you look at any treatment issues in DMH --
A. No.
Q. -- at SVPP?
A. No. I asked about the Clozaril patients. They briefly showed me one of the wings just so if I wanted to see it, and then I was out of there very quickly.
Q. Do you know whether Dr. Dvoskin or Dr. Scott looked at the DMH treatment programs at SVSP?
A. No, they didn't.
Q. When you were at California Medical Facility, CMF, did you or any of the other experts look at the DMH

inpatient treatment units at CMF?

A. We saw the new unit.

Q. Which new unit? Do you recall?

A. The new unit that they were building.

Q. Is that the L3 ICF unit?

A. Right.

Q. Had it been activated when you were there?

A. No.

Q. Did you go to any of the operational DMH units while you were there?

A. No.

Q. Neither did Dr. Dvoskin or Dr. Scott?

A. As to my knowledge.

Q. Okay. Were you provided any information about those treatment units at either SVPP or at VPP -- Vacaville Psychiatric Program at CMF? I'm sorry.

A. No. We were told that that was not part of our -- our mission was to look at the Department of Mental Health.

Q. Who told you that?

A. In the beginning when we were discussing the program, we were only looking at referrals. We weren't looking at the level of care provided by the Department of Mental Health.

Q. You were looking at referrals to --

A. No.
Q. Psychologist Craig Haney?
A. No.
Q. Psychiatrist Ed Kaufman?
A. I've seen the name. I don't know if I know him.
Q. Okay. What about Jeanne Woodford?
A. No.
Q. Former warden of San Quentin?
A. No.
Q. What about Eldon Vail?
A. No.
Q. Have you ever worked with Lindsay Hayes?
A. Yes.
Q. When was the last time that you worked with Lindsay Hayes?
A. It would have been in 2006 or '7.
Q. What was the context of your work together?
A. A county jail in Colorado had three suicides in the course of a year. And it was the client of a company that I worked for, and I recommended that they call Lindsay Hayes in to do an evaluation.
Q. Evaluation of the suicide --
A. And the process that was occurring at the jail.

Q. You must have respected his expertise?
A. Yes.
Q. Did he provide some recommendations in that case?
A. Yes, and they were excellent.
Q. Do you know if they were implemented?
A. Yes, they were.
Q. Do you know the status of the suicide prevention program there at that facility now?
A. I don't know because I left the company. But there was an article in the Denver Post that talked about the positive response and, of course, the county took all the credit for bringing Lindsay in.
Q. Didn't mention you?
A. No.
Q. What was the name of the facility?
A. Jefferson County -- Jefferson County Jail or something along that line, a detention center.
MR. FISCHER: Okay. Let's take a short break.
(Off the record at 4:07 p.m. and back on the record at 4:13 p.m.)
BY MR. FISCHER:
Q. Dr. Moore, you said earlier that you've now read the 25th report of the special master --
A. Yes.

CERTIFICATE OF REPORTER

I, MEGAN F. ALVAREZ, a Certified Shorthand Reporter, hereby certify that the witness in the foregoing deposition was by me duly sworn to tell the truth, the whole truth and nothing but the truth in the within-entitled cause;

That said deposition was taken down in shorthand by me, a disinterested person, at the time and place therein stated, and that the testimony of the said witness was thereafter reduced to typewriting, by computer, under my direction and supervision;

I further certify that I am not of counsel or attorney for either or any of the parties to the said deposition, nor in any way interested in the events of this cause, and that I am not related to any of the parties hereto.

DATED: February 25, 2013

_____

MEGAN F. ALVAREZ

RPR, CSR 12470

CERTIFICATE OF REPORTER

I, MEGAN F. ALVAREZ, a Certified Shorthand Reporter, hereby certify that the witness in the foregoing deposition was by me duly sworn to tell the truth, the whole truth and nothing but the truth in the within-entitled cause;

That said deposition was taken down in shorthand by me, a disinterested person, at the time and place therein stated, and that the testimony of the said witness was thereafter reduced to typewriting, by computer, under my direction and supervision;

I further certify that I am not of counsel or attorney for either or any of the parties to the said deposition, nor in any way interested in the events of this cause, and that I am not related to any of the parties hereto.

DATED: February 25, 2013

Megan F. Alvarez

MEGAN F. ALVAREZ

RPR, CSR 12470

Exhibit 89

TLS | THORSNES litigation services

Transcript of the Testimony of:

Charles Scott, M.D.

Coleman v. Brown

March 8, 2013

Volume I

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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, ET AL., Plaintiffs, vs. EDMUND G. BROWN, JR., ET AL., Defendants.	CASE NO.: S 90-0520 LKK-JFM

DEPOSITION OF

CHARLES SCOTT, M.D.

FRIDAY, MARCH 8, 2013, 9:06 A.M.

DAVIS, CALIFORNIA

REPORTED BY: MEGAN F. ALVAREZ, RPR, CSR NO. 12470

THORSNES LITIGATION SERVICES, LLC

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, ET AL., Plaintiffs, vs. EDMUND G. BROWN, JR., ET AL., Defendants.	CASE NO.: S 90-0520 LKK-JFM

The Deposition of CHARLES SCOTT, M.D., taken on behalf of the Plaintiffs, before Megan F. Alvarez, Certified Shorthand Reporter No. 12470, Registered Professional Reporter, for the State of California, commencing at 9:06 a.m., Friday, March 8, 2013, at the UC Davis Immigration Law Clinic, Building TB-34, Davis, California.

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the psychiatric medication piece, I was also asked to look at that. For example, there were some IDTTs I attended on an EOP and in some CCCMS settings to look at the medication management and settings not isolated to the mental health crisis beds.

To the degree that parole medications were being provided to inmates upon release from the prison and to the degree that there were quality assurance monitoring relevant to psychiatry medication management, I reviewed those as well.

And looked at the psychiatry meetings that they had as part of their organization. Also reviewed if there were policies relevant to medication management, such as Clozaril medication management policy. Had they developed a medication management policy relevant to heat risk medications. And were issues related to the medication monitoring both at a local and at a statewide level in place.

Q. Anything else that was on your plate?

A. Those were the primary issues. There may have been some isolated site-specific areas where I was present or sitting in, but those were the primary areas of my focus.

Q. Do you recall what Dr. Dvoskin was tasked with?

A. In general.
Q. What were those things?
A. Looking at the quality of mental health care provided outside of the medication administration in the different levels of care. Doing a suicide review or review of the suicide risk assessment management and policies and procedures.

I've already talked about his involvement in different levels of care and the provision of care at those different levels.

He also met with and was -- the SPR-FIT coordinators. And to the degree that quality assurance or improvement projects overlapped with the provision of nonpsychiatric care, he may have reviewed that aspect as well.

And, in general, access to care through the different levels of care he was involved in assessing.
Q. And what about Dr. Moore?
A. My understanding of Dr. Moore was that she was as a nurse looking at issues related to nursing medication administration. And that could include medication refusals or sign-offs on medicines.

In some instances, checking with pharmacy about parole medications and how that process was administered. Emergency response. And also she may

have had some involvement in the screening aspect as well.

Q. And was Dr. Martin -- Mr. Martin present at your meeting as well?

A. Yes.

Q. Would it be fair to say he was tasked with use of force and rules violations?

A. Yes.

Q. Were you asked to look at all at the inpatient level of care at the Department of State Hospitals?

A. No.

Q. Do you recall if anyone was asked to look at that?

A. If they were, I wasn't present when that was requested.

Q. Were you asked to look at the impact of overcrowding on the delivery of care?

A. I was asked to look at, with the current both staffing levels and prison population, was appropriate care psychiatric care provided to inmates and was there evidence that the California Department of Corrections was deliberately indifferent to the inmates based on the population at the time that I did the evaluation.

Q. You had published at least one article about the overcrowding decision in this case, right?

A. Yes.
Q. Fair to say you had read the three-judge court opinion and the Supreme Court opinion?
A. A while back, yes.
Q. Had you already formed an opinion as to whether those overcrowding findings -- the one in the three-judge court opinion and the Supreme Court opinion -- were incorrect or correct?
MR. McKINNEY: Objection. Vague and ambiguous.
THE WITNESS: No. The article summarized information that was provided to the court.
BY MR. GALVAN:
Q. So coming into this engagement, you didn't have an opinion one way or the other as to whether the system was overcrowded?
A. I knew what the percentage numbers were as far as the number of prisoners per designated housing. So I knew that by that number designation, it was over the 100 percent capacity mark.
Q. And do you recall reviewing the findings regarding the evidence in the trial about the relationship between the capacity, the cell capacity mark that you described, and the medical and mental health care infrastructure?

A. From the court decision?
Q. Yes.
A. I remember what the court said, yes.
Q. Do you recall the court saying that although the system had been built with a certain single-cell capacity and then could accommodate much higher capacity at double cells, it hadn't been built with a medical or mental health care infrastructure for that higher capacity?
A. I recall that that was one of the comments the court made.
Q. Did you form an opinion as to whether that was a reasonable way to measure overcrowding in a medical and mental health care case?
MR. McKINNEY: Objection. Vague and ambiguous.
THE WITNESS: I wasn't asked to render an opinion on the court's reasonableness of how they defined "overcrowding."
BY MR. GALVAN:
Q. But as you were doing your own scholarly work before this engagement, did you form your own opinion about that?
A. Did I form my own opinion about the judge's definition of "overcrowding"? Is that the question?

Q. Yes. Did you form your own opinion as you were reviewing the case for your scholarly work about whether it was reasonable for the judges to take into consideration the medical and mental health care infrastructure in their findings as to whether the system was too crowded to deliver adequate mental health care?

MR. McKINNEY: Objection. Vague and ambiguous.

THE WITNESS: What I did not glean from the court's decision was how they considered different facilities and the prevalence of mental illness per facility. For example, you might have one facility with very few individuals with a mental illness, but they may be over capacity.

So it was impossible to know how they consider that, if at all, in the ruling. And I don't have any of the other documents that they may have reviewed.

BY MR. GALVAN:

Q. Your medical school has a relationship with Sacramento County Jail involving the delivery of mental health care; is that right?

A. Yes.

Q. Are you involved with that?

A. I have been in the past, but I'm not currently

A. Yes.
Q. And what -- at that point, just at that first meeting, what methodology -- did you settle on a methodology? Or were things left to be determined?
A. You're talking about the first meeting or in general?
Q. Just the first meeting for now.
A. At the first meeting, the best of my recollection, the detail of precise methodology wasn't finalized there.
Q. Did you have a general framework settled?
A. A general framework, yes.
Q. Can you describe that?
A. General framework would be that we would tour institutions that were representative of the CDCR at large, meaning with different locations, different programs. And Mr. Martin would be reviewing primarily the use of force. Dr. Moore would be looking primarily at issues related to nursing administration and medication. Dr. Dvoskin would be looking overall at those institutions about the provision of mental health care. And I'd be focusing primarily on the psychiatric medication management piece.
Q. At that point, did your methodology include any quantitative element; that is, would you be

collecting data and tabulating it in some way?

A. I don't recall if on the very first meeting there was an organized data collection procedure finalized on the first meeting.

Q. Okay. Did you ever work up an organized data collection procedure?

A. Yes.

Q. When did that happen?

A. Over several months following that first meeting, a tool to help look at different components important to care, or potentially important to care, was developed. And my input was primarily into the medication piece. And to the degree that that also related to the mental health crisis bed, I had input into that as well.

Q. And was the plan to tabulate data from that collection and include it in your report?

MR. McKINNEY: Objection. Vague and ambiguous.

THE WITNESS: No, the plan wasn't to per se include all the data collection pieces in the final report.

BY MR. GALVAN:

Q. What were you going to do with the data collection pieces?

A. Have them available for review should we have an opinion that people would want to know the basis for the opinion.

Q. And did you actually do that? Do you have them available for review?

A. I turned them over, I believe, yes.

Q. When you say "turned them over" -- ask a different question.

When you talk about having something for review, do you mean something in which you -- you broke out or rolled up the results of your tabulation in terms of percentages or scores in some way?

A. I provide the entire data set so someone could verify it for themselves rather than rely on my own summary.

Q. Did you ever make your own summary?

A. I have a general impression from having reviewed the data. So having been at the institutions and collected the data, it's easy to learn it as you do it.

Q. Do you have a document with a summary of the data?

A. No, just what's in my head.

Q. Is it possible -- or do you know whether Dr. Bobb has a document with a summary of the data?

ambiguous.

THE WITNESS: Not based on the IDT [sic] and the information shared during that IDT. The answer is no.

BY MR. GALVAN:

Q. Were you told at some point that there was no waiting list to go to APP?

MR. McKINNEY: Objection. Vague and ambiguous.

THE WITNESS: My understanding is that the waiting list has been substantially decreased and there's not a wait list for DSH acute care now.

BY MR. GALVAN:

Q. When you say "now," what time period do you mean?

A. I would have to look at the grids over time to see -- there's not a waiting list now.

Q. Now, March 8th, 2013?

A. Yes.

Q. You testified earlier you haven't done any work since you finished the report.

Did you want to clarify that?

A. No.

Q. Okay. So you've consulted the DSH list -- waiting list for today, March 8th, 2013?

monitoring them for changes in weight or glucose. But to put your hands around an inmate and measure their waist circumference and that being a requirement in a correctional environment had some unique challenges as far as who did it, when you do it, how you do it.

And so I knew that was part of the MAPIP audit tool, and it was something the psychiatrists were aware of at the different institutions as being a mandated monitor and, at the same time, they were monitoring the risk in other ways.

Q. Was the MAPIP -- did CDCR psychiatrists, to your knowledge, have input into what was included and not included in MAPIP?

A. I only know that they had MAPIP training. And I understand from my individual discussions with a psychiatrist that after the MAPIP tool was created, they did voice their opinions to the chief psychiatrist.

Q. Okay. Next page, very first word is "Chaiken." Is that Dr. Shama Chaiken?

A. Yes.

Q. And the note is: "Chaiken does 0 IT audits"?

A. No. It's "QIT audits."

Q. Okay. Going down about two-thirds of the way down, there's a note that starts: "Lab goes to where" -- and I can't read the rest of it.

A. "Lab goes to where it was ordered."

And so, for example, if you're on the equivalent of a CTC and you order the lab, there's a possibility that some of the labs may go back to the CTC. And the person, if they're no longer on that site, the piece of paper has to be scanned in. So that's how it's different than an immediate electronic system where it would just appear.

Q. Was that a problem?

MR. McKINNEY: Objection. Vague and ambiguous.

THE WITNESS: Not necessarily. I mean, if you know what the lab is, if you're informed of the lab and you have that knowledge, then it's not a problem. But it would be easier if it's scanned in automatically. Or part of it -- not even scanned, part of the electronic system.

BY MR. GALVAN:

Q. On the next page, 895, you have some notes here at the bottom about a suicide case?

A. Yes.

Q. I'm not sure if this is all part of the same note: "400 Keyheas not staffed for here, 2602."

What's the significance of that note?

A. Two separate notes.

MARCH 8, 2013 AFTERNOON SESSION 1:09 P.M.

--o0o--

BY MR. GALVAN:

Q. Doctor, there was -- we've talked earlier about the material that the attorney general would prepare for you in advance of your tours.

MR. McKINNEY: Just to clarify, we sent it.

BY MR. GALVAN:

Q. Right. The material that the attorney general would send to you in advance of your tours.

MR. GALVAN: I'd like to mark an Exhibit 9.

(Plaintiffs' Exhibit 9 was marked for identification.)

BY MR. GALVAN:

Q. Could you take a look, Doctor, at Exhibit 9? This is an e-mail. It says from Patrick McKinney to Dvoskin, Martin, Moore, Scott, copying a couple of people, including David Spagnolo.

He works for you?

A. He works for the university.

Q. What's his -- what was his role on this project?

A. He's an administrative assistant.

Q. Skipping down to bottom of the e-mail.

Mr. McKinney wrote: "In addition to these

documents, I have gathered a number of documents that include current data from the 33 institutions and will send them to you on a DVD."

Do you remember getting that DVD?

A. No. I remember that Mr. Spagnolo would print out and hand me all hard copies of all documents versus -- so if he got DVD, I never got it. I instruct him, so that I know the volume and the bulk of records, to just print them all out and put them in a box for me. So he may have gotten a DVD, but I know that I had hard copies.

Q. Did he even give you -- did he give you hard copies also of spreadsheets that wouldn't print beyond, you know, on one page, big long spreadsheets?

A. Yes.

Q. How did you work with those?

A. You can position them.

Q. Okay. So you would never have seen, then, the disc that came?

A. That's correct.

Q. This is the disc I got from the attorney general with folders, as you can see here. This CD is Exhibit 4 in our transcript.

They divided it up for me by institution, so had we started, for example, with CMF. And as you can

see, there are a number of spreadsheets here.

I'm just going to look inside one of them and maybe -- it may be that some of this looks familiar from the hard copies you looked at.

So this one has -- it called CCCMS.3.ad seg in addition to its Bates number, which is DEXP13765 to 67.

As you look across at these columns, Doctor, does this look like something that David might have printed out for you?

A. Vaguely. Many of the documents -- for example, review of ad seg care was not my area that I was working on. My -- so my focus on was documents related to medication management.

Q. Also MHCB?

A. And MHCB.

Q. So if we look at one of the MHCB ones, for example, there's one that's called MHCB.8, Bates No. 23286 to 785.

First group, A through F, does this look like something David might have printed out for you?

A. Yes.

Q. I'll just -- I'm going to go to the right and look at some of the other columns.

Are you familiar with this term in Column F 7447MH?

A. Not offhand, but I may have at the time. I'm not recalling what 7447 stands for.

Q. Is that possibly the suicide risk evaluation, 7447? I'll represent that it's the CDCR form for suicide risk evaluation.

A. Okay.

Q. Does that sound possible?

A. I don't know the number anymore.

Q. When he printed these -- do you have any understanding as to where this data came from? Stop moving it around.

A. On a broad level, data entered through MHTS.net is my general understanding.

Q. What's your understanding of what MHTS.net is?

A. It's a data tracking system for specific monitors, and there's data entry relevant to those for the individuals.

Q. So, for example, this one with the 7447 suicide risk evaluation, would you review these, the printouts, in advance of your tours for this purpose?

A. I would see them. What -- what I felt was more productive and useful was to actually look on-site at the mental health crisis bed, at the charts in front of me, because it gave me more information than this kind of grid did. Then if I had questions about a

particular case, I could look further, whereas this wasn't as easy to use.

Q. Did you ask anyone, like Drs. Reid or Bobb, to look at these for any anomalies or red flags?

A. No.

Q. As we look at this one, MHCB 88, so it has one row for -- each row seems to be an event and you had multiple rows for an inmate. And then it seems like we have something like five -- 5,800 rows, so it's a lot.

A. Uh-huh.

Q. And then you said the event seems to be the completion of the suicide risk evaluation. Does that seem right?

MR. McKINNEY: Objection based on counsel's representation.

BY MR. GALVAN:

Q. Based on my representation that 7447 --

A. If 7447 stands for that.

Q. And did you form any understanding as to what this Column G with the zero percent, 100 percent means in MHTS.net?

A. Yes.

Q. What does it mean?

A. Did they have a compliance within a program guide specified period of time.

Q. Still sticking with Exhibit 4 and the folder for Vacaville, which was the first place you went, I'm going to go to the one called DMH, has Bates No. 18735 to 738. This also seems to be arranged in rows with one row per -- sometimes an inmate has multiple rows, generally it's inmate and row and events.

Do you remember seeing a printout of this that David might have made for you?

A. I believe those were the packets, yes.

Q. Did you form an understanding as to significance of this table?

A. Yes.

Q. What is its significance?

A. What I think it's trying to communicate is how many days a person may have been on an wait list to DMH.

Q. And the wait days would be Column F?

A. Those are the days some office technician entered, yes.

Q. Just looking here at the first screen, the first entry for this Mr. Ackley, Row 2, 95 days waiting for -- DMH intermediate psychiatric referral?

MR. McKINNEY: Objection. Calls for speculation.

BY MR. GALVAN:

Q. Is that what's entered on the chart?

A. That's what's entered on the spreadsheet.
Q. If we go down two more rows, we have 99 days; is that right?
A. That's what's entered on the spreadsheet.
Q. Go down three more rows, 98 days?
A. Correct.
Q. But it's your testimony that you didn't ask Drs. Bobb or Reid to examine this data for issues of red flags?
A. That's correct.
Q. Second DMH is -- it's called DMH.1-2, Bates No. 18731 to 734.
Do you remember seeing a chart like this printed out?
A. I believe that was in the stack of records, yes.
Q. Fair to say the difference between this one and the one we just looked at, DMH, is that this is acute care versus intermediate care?
MR. McKINNEY: Objection. Calls for speculation.
THE WITNESS: The Excel sheet I'm reading says "DMH acute psychiatric referral" under the D column event.

speculation.
THE WITNESS: That's the number listed on that Excel sheet.
BY MR. GALVAN:
Q. And then we've got Mr. Gutierrez, 30 days?
MR. McKINNEY: Objection. Calls for speculation.
BY MR. GALVAN:
Q. Right?
A. That's the number on the Excel sheet.
Q. We've got Mr. Pauley, 77 days?
MR. McKINNEY: Objection. Calls for speculation.
BY MR. GALVAN:
Q. Right.
A. That's what it says, yes.
Q. We've got Mr. Hill, 78 days, right?
MR. McKINNEY: Objection. Calls for speculation.
THE WITNESS: That's what it says on that slide projection.
BY MR. GALVAN:
Q. After you got this spreadsheet in advance of your CMF tour, did you direct Drs. Bobb, Reid or anybody to check whether these wait times were due to concurrent

medical care?

A. No. My focus of my part of the review was on on-site medication management by the psychiatrist, not as the expert reviewing the length of stay and wait period for the acute care.

Q. We were talking about CSP SAC, which was the second location you went to.

Would it be correct that you reviewed printouts made from spreadsheets for CSP SAC as well?

A. Yes.

Q. And if there were in here DMH grids that showed long waiting times, your testimony would be the same: You didn't direct anyone to check into those situations?

A. Yes. Because I testified earlier, my role was to look at the psychiatric medication management, not at DMH bed wait days.

Q. And your role was also to look at MHCBs, right?

A. The care provided on the MHCB to the individuals.

Q. So if we go into the SAC folder here, we look at MHCB.8, which is Bates No. 42285.

You see this spreadsheet looks similar to what we looked at before for the 7477s for Vacaville that we

looked at?
A. Yes.
Q. This looks like something that would have been printed out for SAC?
A. It's similar, yes.
Q. And it has -- Column H, it has the Text Box 10, the scoring of whether the -- whether the event was documented or not?
MR. McKINNEY: Objection. Vague and ambiguous. Misstates prior testimony.
THE WITNESS: It only has a compliance percentage, as I understand it, if it was documented within a compliance period in accordance with the program guide.
BY MR. GALVAN:
Q. Do you know what the compliance period is?
A. I don't want to misstate off my memory. So, offhand, I'd pull the program guide.
Q. Is it important to have a deadline to do a suicide risk evaluation?
A. As a general concept, yes.
Q. Why?
A. Depending on the case and depending on the reason for referral to evaluate the person for risk of suicide.

Q. If I go slowly down through Column H, you see the first few are you've got group of 100 percent and group of zeros?

A. Yes.

Q. Roughly the same size.

Then if I scroll slowly down, you see it's true I'm scrolling for quite a while before I get to another hundred?

A. Many of them are the same patient. So, for example, they could be on a one-to-one, and they can be refusing to answer the suicide risk evaluation but they're being watched. So the clinician will miss each deadline because the person is refusing to speak, but they maintain them on a suicide watch.

Therefore, they -- the compliance will report as zero, but that doesn't reflect deliberate indifference by the clinician. So if the person will not answer your question and you can't complete the SRE but they're still on a watch or there's some other reason, then you could have a zero but it doesn't mean that they were deliberately indifferent.

Q. If you look at Row 76 through Row 91 on Bates 42285, you've got William Warren?

A. Right.

Q. He's got -- let's see. Column F is the -- due

date, it's a date related to the event. I don't know what date it is. But it seems to be that he gets a new row every week, right? 9/11, 9/18, 9/25, 10/2, 10/9 all the way up to Christmas, 12/25/2011?

A. Right.

Q. And every one of those is a zero, right?

A. Yes.

Q. So you're testifying it's possible that he just kept refusing to participate, right?

A. That's one possibility.

Q. From September 11th to December 25th?

A. He could have had a medical issue or reason. It could have been done and not scanned in.

If they had during those two-month period of time a deficit in office technician and then it wasn't entered into the statewide database.

Various reasons why that could happen.

Q. But you didn't -- when you went to SAC, or at any time, you didn't check to see whether any of those circumstances explained all these zeros in Mr. Warren's part of the spreadsheet, right?

A. I checked for people who were actually on the mental health crisis bed to see if their suicide risk evaluations were done appropriately. I did not investigate if there were administrative reasons through

office technicians that things were not scanned in.

Q. So you checked the people who were there the day you were there?

A. Yes.

Q. In general, these crisis bed units have capacities of something like 20, 30 beds?

A. In general.

Q. You checked some sample from 20 or 30 people, right?

A. It depended on the site. Yes.

Q. But you had been given about -- at least on this spreadsheet -- 828 admissions at least -- or 821 events? Some people have many events.

MR. McKINNEY: Objection. Vague and ambiguous.

BY MR. GALVAN:

Q. Over a long period of time, right?

MR. McKINNEY: Vague and ambiguous. Compound.

THE WITNESS: There was some information. However, because there were various reasons why that information may or may not accurately reflect the care being given, I thought it was more important to review the actual care delivered versus an Excel sheet that may or may not be accurate.

BY MR. GALVAN:
Q. Actual care delivered on the day you were there?
A. The days I was there, yes.
Q. On a day set out in a schedule in October 2011, right?
MR. McKINNEY: Objection. Calls for speculation.
THE WITNESS: I don't know that the facility knew we were coming.
BY MR. GALVAN:
Q. They knew you were coming at least a month in advance, right?
MR. McKINNEY: Objection. Calls for speculation.
THE WITNESS: I honestly don't know.
BY MR. GALVAN:
Q. You and Mr. McKinney met and set the schedule, right?
A. No.
Q. And you, Mr. McKinney, Dr. Moore, and Dr. Dvoskin met and set the schedule, right?
A. In general, we agreed upon dates where we could be -- all be available.
Q. And the schedule was set more than a week

the witness.

MR. McKINNEY: Mr. Galvan --

MR. GALVAN: These objections are coaching the doctor into how to answer, and I really think it should stop.

MR. McKINNEY: I cannot disagree with you in more stronger terms. The court has precluded the parties from presenting live testimony at the hearing on this matter. This is my one and only chance to make a record, and I will do so.

BY MR. GALVAN:

Q. Focusing narrowly on the quality of MHCB care, leaving aside medication, your evaluation of the constitutionality of MHCB care, your method for doing that evaluation was to examine information about a sample of the patients present and being cared for in the MHCBs on the day of your tour?

MR. McKINNEY: Can you read that back, please?

MR. GALVAN: Correct.

(Record read as follows:

"QUESTION: Focusing narrowly on the quality of MHCB care, leaving aside medication, your evaluation of the constitutionality of MHCB care, your method for doing that evaluation was to

examine information about a sample of the patients present and being cared for in the MHCBs on the day of your tour?")

MR. McKINNEY: Objection. Vague and ambiguous. Compound.

THE WITNESS: Sorry. That was part of the evaluation.

BY MR. GALVAN:

Q. What was the rest of the evaluation?

A. Interviewing actual inmates, sitting in on IDTTs, interviewing staff, interviewing custodial officers and for nursing staff, reviewing the actual record at the time.

Q. Breaking that down, the first thing you said was interviewing inmates.

What inmates are you talking about?

A. Inmates who were housed on the mental health crisis bed.

Q. On the day you were there?

A. Yes.

Q. Second part, IDTTs, which IDTTs are you talking about?

A. IDTTs that were occurring on the mental health crisis beds.

Q. For patients that were being cared for on the day you were there?
A. Some of the patients, they had pre-IDTT meetings, so there would be informational sharing in addition to the actual IDTT. But it was related to inmates who were on the crisis bed unit at the time.
Q. Third one was records. Records of patients that were in the crisis bed unit on the day you were there?
A. Yes.
Q. Any other records?
A. EUHR records relevant to the patient prior to their admission. That would be an EUHR.
Q. Which patients?
A. The MHCB patients.
Q. Who were being cared for on the day you were there?
A. Yes.
Q. Any other records?
A. Some components of MHTS.net.
Q. For the patients being cared for on the day you were there?
A. Yes.
Q. Fair to say, Doctor, based on all that you just testified to under oath, that your review of

patient care was limited to the patients who were present on the MHCB being cared for on the day you were there?

A. No. And the reason is that many of the medication reviews that I did of the over 130 had prior MHCB admissions. There's a special tab on EUHR. So those could be months or years before. So, of those, you can also look at MHCB admissions unrelated to the day I was there.

Q. So the second part, then, is the people you were reviewing anyway for medication review, medication monitoring. If they had prior MHCB admissions, you include them as the basis for your opinion on MHCBs?

A. I would look at the care provided on the MHCB and include that in my analysis, yes.

Q. And for SAC, how many -- how many persons would you estimate fell into that latter set that you just described?

A. Two or three.

Q. Two or three. Okay.

But you had this data that Mr. Spagnolo printed out for you regarding care for the several months prior to your tour during the period when the institution had no notice that you were coming. But you did not direct Dr. Bobb, Dr. Reid, or anybody else to

review this data for any issues?

MR. McKINNEY: Objection. Compound. Vague and ambiguous.

THE WITNESS: That was not my directive to them, no.

BY MR. GALVAN:

Q. Let's go back to Exhibit 8. We're still in SAC, CSP SAC.

On Bates No. 903, you have a note here. Let's see. After -- about the sixth line down: "Primary clinician not present."

I think these notes are regarding an IDTT, it says on the page before, right?

A. In part. They also did have on that day a classification hearing they had to do, so one of these may reflect -- I believe the warden was present for this classification hearings, maybe a classification hearing.

Q. So this note may not be about an IDTT?

A. That particular one, because the warden is present.

Q. Okay. Does it change your recollection if you go back to the prior page and see under the line -- under the second line, it says "Initial IDTT"? Is it possible -- I don't know if we're still looking at the same event or not.

provide because there can be a time period to turn them over. So that's something they're aware of and they're caution about.

The next note is this individual told me that they may get anywhere between two to three hundred requests from the population or referral to them a month, and the majority are routine. So they felt that they could see, and they did see, about five to six referrals a day.

Q. So a referral -- a referral in this context is a request for services from an individual?

A. It could be a request for services from an individual.

Q. And the transfers, are they mistaken because people on the mental health case load aren't supposed to go to Centinela? Is that what "mistaken" means?

A. I don't know their definition of "mistaken."

Q. Keep 11 handy. You might refer to it as we're looking at the audit tool.

MR. GALVAN: Mark Exhibit 12, please.

(Plaintiffs' Exhibit 12 was marked for identification.)

BY MR. GALVAN:

Q. So in your Centinela folder that they produced was this version of a few pages from the audit tool

where the entries are typed.
A. Yes.
Q. Was this your work filling this out?
A. Yes.
Q. Okay. And was Dr. Moore absent, so you were doing the quality management part, too?
A. Correct.
Q. Okay. Toward the bottom of the quality management part, you had typed: "Psychiatrist can't attend QA meetings"?
A. Yes.
Q. Is that a concern for you?
MR. McKINNEY: Objection. Vague and ambiguous.
THE WITNESS: No in this case because of her review of the minutes, ongoing communication, input, and being proactive vocal regarding the quality of the care, it was not a concern to me.
BY MR. GALVAN:
Q. And you also filled out the medication management tool on page 29, which is Bates 986 of Exhibit 12, one of your question in this part of the tools is: What the maximum length of bridge orders?
What is a bridge order?
A. A bridge order is a description of a

know if any happened in these particular cases, but it can happen on some.

The two fields to go through are general comments and diagnosis. Those would typically put more information specific to general comments and diagnosis because the Bento box is bigger.

MR. GALVAN: I'd like to mark Exhibit 14.

(Plaintiffs' Exhibit 14 was marked for identification.)

BY MR. GALVAN:

Q. Exhibit 14 we took from the court file. It's the joint report that the State filed for you and Dr. Dvoskin and Dr. Moore and...

So could you discuss the -- the process for writing this report? I'll ask you a few specific questions about it.

I think you've already testified that the process did not include you drafting a separate report and then somehow putting them together, right?

A. Yes. Yes.

Q. What was the process for drafting this?

A. The process for drafting the report was discussing our findings at each of the sites and then summarizing those findings in a combined report.

Q. And when did you actually start doing that?

A. I don't know the exact date. May have been in November, that time frame, of 2012.

Q. And did all three of you get together in one place to do this?

A. No.

Q. How did it work?

A. Joel Dvoskin and I were in the same place to do our portions of the report. And then having created sort of the general format, the areas left for Dr. Moore were for her to have her opinions represented. And so she was included in that process.

Q. If you turn to page 7 of the joint report.

The first paragraph says at the end that "We also reviewed data from studies conducted by CDCR and the special master's team."

Do you remember specifically what data you reviewed?

A. I was aware -- I won't be able to cite you the exact report, but there was a report that looked at trying to identify underserved or unidentified inmates in the CDCR system. I don't know if the number was in 40s or the 70s, but it was a low number from that report of individuals who were felt to require a higher level of care or mental health treatment that had not been identified.

Q. On the next page, staffing discussion, last sentence in the paragraph that continues at the top of the page -- this is page 12 of Exhibit 14: "Finally, in our opinion, the CDCR mental health staffing plan will provide adequate resources."

Did you review their CDCR mental health staffing plan?

A. That wasn't my role, no.

Q. This is not a Dr. Scott part; that's a Dr. Dvoskin part?

A. Best I understand, yes.

Q. So you don't have an opinion one way or the other whether their staffing plan is good, bad, inadequate, adequate?

A. That's not exactly what I said. As far as psychiatric care, that even in those institutions that identify there were -- the staffing of psychiatrists was not at full level, they were still deliberately indifferent to the mental health needs of inmates, and they were providing constitutionally appropriate care.

Q. But to the extent that this part of the report expresses an opinion about a plan, a mental health staffing plan, you didn't do any review of that plan to determine whether that plan was adequate to meet constitutional standards, right?

A. That's correct.

Q. Did you didn't do any review to determine whether that plan was necessary to meet constitutional standards?

A. Correct. I looked at the care currently provided and did it meet constitutional standards.

Q. Also on page 12 there's a discussion here under numbered paragraph 4 regarding Los Angeles County -- California State Prison Los Angeles County regarding, quote -- I'm just going to quote it:

"Significant limitations on office and interview space for the mental health staff, particularly psychiatrists. While these limitations were not intentional or due to a lack of effort" -- I just want to focus on those words, "intentional or due to lack of effort."

How do you know whether the limitations were intentional or not?

A. This part was investigated or written by Dr. Dvoskin. I was aware that there were -- the office space for psychiatrist was limited. And then he did the follow-up on that, and I did my medication reviews.

Q. As far as you know, the limitations on the office space for psychiatrists might have been intentional?

MR. McKINNEY: Objection. Calls for speculation.

THE WITNESS: I have no evidence that they were intentional.

BY MR. GALVAN:

Q. But you don't know one way or the other whether they were intentional or not?

A. I didn't investigate that, so I have evidence that they were one way or the other.

Q. Were you informed that CDCR was building -- had a building project at LAC to eliminate this problem?

A. Yes.

And the psychiatrist was aware of that as well and felt that that would address their space problems.

Q. And have you done anything to learn the current status of that building project?

A. No.

Q. Would it change your opinion if you learned the building project was not complete?

A. Wouldn't change my opinion on the constitutionality of the medication management and care.

Q. On the same page, numbered Item 5, concerning Salinas Valley State Prison. First bullet point discusses concerns expressed by the mental health director regarding staffing and space shortages.

BY MR. GALVAN:

Q. On the next page, page 13, there's a numbered paragraph 6 regarding Pelican Bay.

You didn't actually go to Pelican Bay, right?

A. That's correct.

Q. Anything here about staffing shortages would be Dr. Dvoskin's work?

A. Correct.

Q. And the next paragraph about California Men's Colony says: "Mental staff reported mental health staffing shortages that adversely impacted their ability to provide care to inmates."

Do you agree with that statement?

A. That statement is, as I understand it, was in part by the work Dr. Dvoskin did. So I would let him speak to that. I didn't do that part of the investigation.

Q. And then the last paragraph on the page discusses staff shortages at substance abuse treatment facility.

Are you -- are you the author of this part?

A. I was aware there were staffing shortages for psychiatry. And I did -- I did put this in the report, yes.

Q. When you say "this," you mean the part about

psychiatrist. So this was the chart review part of it.

Q. So when you spoke to an inmate, you didn't enter those results in the Bento box?

A. No.

Q. On page 14 of the report, Exhibit 14, there are discussion about comparison with other systems. There's a heading, "Comparison With Other Systems."

What was your methodology for comparing CDCR to other systems?

A. This is primarily the work of Dr. Dvoskin. However, I have worked as a treating clinician in both jails, Hunt Correctional Facility in Louisiana, maximum security facilities for inmates, and in the -- as a military officer working with detained soldiers, and also in a jail in Ohio. So, for me, it was comparing the experience of actually working in state correctional systems and comparing those systems to the CDCR.

Q. So let's break -- I want to break it down to just talk about state correctional systems because that what it says in the report here.

A. Okay.

Q. "Numerous state correction systems."

So you listed a few things, but I might have missed it. I'm not sure which of those were state correctional systems.

So can you tell me which state correctional systems have you worked in?

A. Louisiana.

Q. Okay. So one state, Louisiana.

So the basis for your opinion that -- let me look at the exact words. The basis for your opinions involving comparisons between CDCR and numerous state correctional systems is a comparison been CDCR and Louisiana?

MR. McKINNEY: Objection. Mischaracterizes the report. Mischaracterizes prior testimony.

THE WITNESS: Only in part.

BY MR. GALVAN:

Q. What other state correctional systems are you comparing California to?

A. Because I am asked to review care on individual cases in state prisons in other states, I have an opportunity to review both their policies and procedures, the assessment process, and medication management in different states. So those would include Florida, Illinois, Ohio, Alabama. I believe Arizona.

And I also believe New Mexico. I just remembered a New Mexico case.

Q. And all of those cases -- the Florida, Illinois, Ohio, Alabama, Arizona, and New Mexico

cases -- those were individual liability cases?

A. Combined. They were individual liability, also constitutionality of care provided under Section 1983. And then some involved ADA, American With Disabilities Act, allegations for violations. But in addition to deviation from the standard of care, I believe they all involved constitutional of care as well.

Q. What was at issue in those cases was whether there was liability for injury to an individual, correct?

A. Not an -- not alone, no. That's not correct.

Q. Let me ask the question differently.

Were any of these cases, cases for injunctive relief?

A. I would have to go back and review to see if that was part of the complaint.

Q. Were any of these cases, cases for money damages?

A. There may have been. I'd have to look at the actual complaint.

Q. Did all of these cases involved the facts and circumstances surrounding either the death of or injury to an individual?

A. In part but not solely.

A. I did sit in on several EOP IDTTs and felt that IDTTs were appropriate, engaged, and involved. And so that part of this opinion, I personally witnessed.

Q. Does what you just said have anything to do with transferring EOP inmates out of segregation?

A. Well, you asked me to comment on "i." And so part of my opinion is relevant to "i."

Q. Okay. Focusing on the statement here that there are efforts to expedite the transfer of EOP inmates out of segregation, you have no basis for that statement?

A. No.

Q. To the extent that there are statements in the report about placing EOP inmates in segregation for their own protection, that would be Dr. Dvoskin's work? It Wouldn't be part of your study?

A. That was his focus, not mine, that's correct.

Q. So you wouldn't have any opinions about that?

A. That wasn't the focus of my role as the expert in this case.

Q. When we get to chapter here, the section on page 19 on the mental health crisis bed unit, would it be fair to say that this section is your section?

A. In part, but not in totality.

Q. It starts by saying: "At every prison visited

with an MHCB or CTC, a member of our team assessed the program by doing several things."

Is that true for Pelican Bay where you didn't go?

A. Yes.

Q. But you weren't there to interview randomly selected inmates, correct?

A. That's correct.

Q. Did Dr. Dvoskin do that for you?

A. It was my understanding he did.

Q. And he went to IDTT meetings and deducted interviews?

A. I don't have his notes in front of me. I can't speak to that.

Q. But you did -- I saw in your notes -- review medical records from Pelican Bay?

A. Yes.

Q. Did Dr. Dvoskin report to you about his observation regarding the care at Pelican Bay?

A. Yes.

Q. Do you remember what he reported to you?

A. He felt that there was confusion about the technical term for a suicide watch versus suicide precaution and that, in his experience having visited there, that he did not find a suicide risk evaluation

So I don't know his knowledge of the medical database.

Q. So when you see a phenomenon in the world like someone being prescribed Haldol without a diagnosis, and Axis 1 diagnosis, would the rule of parsimony apply in terms of what the explanation is?

A. I don't understand your question.

Q. If you're given a choice between two explanations for a phenomenon, one that requires a certain multiplication of entities like hypothesizing that the clinician has read some literature that says that you have -- you could use this off-label use for Axis 2, or you have a possible explanation that's more parsimonious that requires fewer entities, i.e., that they're simply short-staffed and can't get the job done, why would you choose the less parsimonious explanation?

MR. McKINNEY: Objection. Compound. Vague and ambiguous.

THE WITNESS: I like the word "parsimony," though.

First of all, Dr. -- with all due respect to Dr. Dvoskin, he's not a physician and he -- his understanding of the appropriateness for prescribing in an acute setting Haldol would -- may not be -- I wouldn't necessarily defer to him in that decision.

If you look at standard of care in emergency

a lower level of observation is, in general, a good guideline.

I think that follow-up after discharge from a mental health crisis bed to a lower level of care is also a general good guideline.

So those would be the overall guidelines. I also, though, understand that, for example, at RJD, they will go out, a team -- Dr. Laura Leard-Hansson and a psychologist -- and do the evaluations in advance even of getting to the mental health crisis bed and can do the suicide risk assessment. Whether or not that's entered into MHTS.net following the technical admission would be an example of a very early SRE that may not get coded for.

BY MR. GALVAN:

Q. Going ahead to page 26 in the report.

There's a Roman III at the top, "Medication Management," which is decided into two sections. There's A, nursing medication management, and, B, psychiatry medication management.

Is it correct to say that nursing medication management would be Dr. Moore's section?

A. On those prisons where she attended, I believe, on one of my CMF visits, I also spoke on -- with the nursing staff and we reviewed my notes in --

relevant to that.
Q. Did you do any review for Item No. 3, potential hoarding of medication?
A. No.
Q. So this would all be on Dr. Moore's work?
A. Correct.
Q. And looking at B, this would be your section, correct?
A. Primarily, yes.
Q. And your Conclusion No. 2 regarding consistency with diagnosis would be based on -- the basis for that would be your chart reviews that are in your notes, your chart reviews that in the Bento box, and your MAPIP reviews?
MR. McKINNEY: Objection. Mischaracterizes prior testimony.
THE WITNESS: In part with the MAPIP reviews but also with interviews of inmates and in observing IDTTs, the discussion of what their diagnosis and the medication treatment.
BY MR. GALVAN:
Q. And have you been -- with regard to No. 3, you've discussed the difficulty of using the EUHR to find lab results.
Have you received any follow-up information

care? Would that be an element you would look at?

MR. McKINNEY: Objection. Vague and ambiguous.

THE WITNESS: I would look to see is there a mechanism in place to review decisions that may not be agreed upon because clinicians have different skills and different understanding of level of care. So a psychiatric technician, who may be called a clinician or may be clinician, recommending to DSH may be different than another provider. Likewise, they may not have an understanding of DSH level of care or not. So the question would be: Is there a system in place to help resolve those differences?

Because it's fairly common both in community care, private hospital care, and in correctional care that people can have different opinions about the level of care. And so does the system have a mechanism to review those kind of case?

BY MR. GALVAN:

Q. What would your opinion be in a situation where there was a system with such a mechanism and all the levels of review agreed that the person should go to inpatient care, but then the department in charge of the inpatient care, the Department of State Hospitals, simply pointed to the MOU and said, "It doesn't matter

that your clinician and our clinician wants to admit this patient. The MOU says we don't have to and we're not going to"?

Would that impact your opinion?

MR. McKINNEY: Objection. Calls for speculation. Incomplete hypothetical.

THE WITNESS: I would have to see the memorandum of understanding, the particulars of the case. But if it's out of a large system, was this something that was endemic to the system or was it isolated cases. So that could also make a difference.

BY MR. GALVAN:

Q. What would your opinion be if it was endemic to the system?

A. If every single case or the majority of cases referred to Department of State Hospitals refused to go or refused to be accepted.

Q. That would be your definition of "endemic," the majority?

A. Not necessarily. But I did not find, in speaking with clinicians directly at the 12 facilities I visited that there is any consistency, any endemic concern by people recommending the transfer that DSH was blocking those transfers.

Q. What if they're consistently blocking the

transfers in a certain type of case? Keeping in mind that, as you've said, every case is different, there's a wide spectrum of symptoms and conditions.

If you have a circumstance where even though it's not the majority of cases but every time it's a certain type of case -- in other words, actively psychotic, in need of inpatient care but violent, history of violence -- that in those cases, despite clinician unanimity as to the appropriateness of the referral, DSH simply points to their memorandum and says, "Don't have to take them. They're violent"?

MR. McKINNEY: Objection. Vague and ambiguous.

BY MR. GALVAN:

Q. So we're not talking about the endemic -- something that's endemic to a big system with 30,000 patients. We're talking about a little slice of the system and a consistent practice in that slice.

In that hypothetical, would your opinion be that there's a problem in terms of the institutional level of care?

MR. McKINNEY: Same objection. Vague and ambiguous. Incomplete hypothetical. Calls for speculation.

THE WITNESS: No.

BY MR. GALVAN:

Q. So it's your opinion that even though there's clinical unanimity with regard to a group of referrals, that in a situation where the agency that's the gatekeeper to the state hospitals refuses to provide that level of care, pointing to something in its MOU, that the system can still be constitutional?

MR. McKINNEY: Objection. Asked and answered.

THE WITNESS: Two or three points.

First, you have to look at the memorandum of understanding.

Secondly, does the receiving Department of State Hospital have the adequate monitoring of security to safely provide care to that patient.

BY MR. GALVAN:

Q. Assume that it doesn't. Assume it doesn't, it doesn't have adequate safety and security. Someone's made a conscious decision not to provide it. Okay? Make that assumption. So those patients just don't go; they just don't get that care.

Is it deliberately indifferent not to provide them that care or not?

MR. McKINNEY: Objection. Vague and ambiguous. Incomplete hypothetical. Asked and answered.

THE WITNESS: If you were providing the best care available in the system, I do not believe you're being deliberately indifferent.

BY MR. GALVAN:

Q. So in your opinion in assessing constitutionality, if you're providing the best care available in your system, then your actions are constitutional?

A. No. Not -- not in and of itself. In a particular case where you have a few high-risk patients who are both extremely violent and in an unstructured setting of a hospital could kill other patients or staff but they are psychotic, and you have a correctional setting where security can be provided and mental health care in a mental health crisis bed can be provided, that those subset of cases, trying to figure out the best place and the safest place for both staff and the patient and those who treat them and having disagreements in those isolated cases about that, does mean you're unconstitutional.

Q. So in those cases it's okay for custody to overrule the clinicians? Remember, in my hypothetical, all the clinicians agree this patient needs to be in the inpatient level; crisis bed is not enough.

But because someone's made a conscious

decision not to have sufficient custody protections in the hospital, they won't take them. All the clinicians agree, but they're overruled.

That's okay constitutionally?

MR. McKINNEY: Objection. One, it's a different question. Vague and ambiguous. Incomplete hypothetical.

THE WITNESS: The important aspect would be are they getting care in the setting they're in that meets their serious medical needs or are they not receiving the care.

BY MR. GALVAN:

Q. Does not my hypothetical imply that they're not receiving the care that all clinicians say that they need?

A. Not necessarily. Because the mental health crisis bed has a recommendation for a 10-day limit. And if you're not resolved by then, then you -- one of the triggers for transfer to DSH is that your symptoms haven't been addressed or resolved in that 10-day period of time.

However, you can still provide the appropriate medications, the observations, suicide watch if necessary, and you're not being deliberately indifferent to that individual if the system interlapping between

the two have decided that safety plus treatment of mental illness is best handled in a correctional environment.

Q. Did you find any evidence that clinicians are referring to inpatient care because -- only because they've hit a 10-day limit in the crisis bed?

MR. McKINNEY: Objection. Vague and ambiguous.

THE WITNESS: Not only because they hit a 10-day limit, no.

MR. GALVAN: Mark Exhibit 16, please.

MR. McKINNEY: Can we take a quick break at some point?

(Plaintiffs' Exhibit 16 was marked for identification.)

BY MR. GALVAN:

Q. Doctor, you won't have seen this before. I you will represent to you that it is a document that my office receives from CDCR on a monthly basis. It lists the names and status of persons referred to this state hospital system for inpatient care.

Now if you turn to -- if you turn to page 18, page 18 has the gray bar and then it starts at Row 882 and down to 899. And then you see in the -- there's a column called "Date of Admission" toward the middle of

Q. Do you remember what your recommendations were?
A. Yes.
Q. What were they?
A. I remember that if the electronic record system could be streamlined, that might -- or information more easily accessed, that might help do some of the audits.
I recommended that the MAPIP audits -- or commented is better than the word "recommended" -- that the MAPIP audits were monitoring psychiatric medication in a very detailed manner, and that the amount of medication monitoring that was currently being conducted did not represent deliberate indifference for psychiatric treatment.
Q. Any other recommendations?
A. No. Those are the ones I recall.
Q. Was there a point in the project where you were sharing responsibility for reviewing suicide prevention with Dr. Dvoskin?
A. To the extent that I was looking at the mental health crisis bed and suicide watches, but I wasn't working on the suicide prevention piece.
Q. Did you learn at some point that the CDCR had commissioned a report from Lindsay Hayes on suicide

prevention?
A. No, I don't -- I don't recall that.
Q. Okay. Even after your work was done, did you learn about that?
A. From Lindsay Hayes?
Q. Yes.
A. No, I'm not aware of -- I don't recall it.
Q. Okay. So you've never seen his report or heard that there was a report?
A. I read Dr. Dvoskin's report. And if he referenced it in that, then I would have had a reference from reading his reports.
Q. If I told you that he -- one of his recommendations was that CDCR take steps to do two things in conjunction with regard to the crisis beds, one, lower the threshold for putting people on suicide precautions, both watch and the other level, and in order to deal with the increase, then, in people that you need to watch, use the nonlicensed outpatient housing units more for suicide precautions?
A. Last bit again.
Q. Use the nonlicensed outpatient housing more and also -- I'll back up before I ask the question and give you more background representation.
The way the system operates now, the guideline

CERTIFICATE OF REPORTER

I, MEGAN F. ALVAREZ, a Certified Shorthand Reporter, hereby certify that the witness in the foregoing deposition was by me duly sworn to tell the truth, the whole truth and nothing but the truth in the within-entitled cause;

That said deposition was taken down in shorthand by me, a disinterested person, at the time and place therein stated, and that the testimony of the said witness was thereafter reduced to typewriting, by computer, under my direction and supervision;

I further certify that I am not of counsel or attorney for either or any of the parties to the said deposition, nor in any way interested in the events of this cause, and that I am not related to any of the parties hereto.

DATED: March 11, 2013

_____

MEGAN F. ALVAREZ

RPR, CSR 12470

Exhibit 90

Transcript of the Testimony of:

Diana Toche

Coleman v. Brown

February 22, 2013

Volume I

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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, ET AL., Plaintiffs, vs. EDMUND G. BROWN, JR., ET AL., Defendants.	CASE NO.: S 90-0520 LKK-JFM

DEPOSITION OF

DIANA TOCHE

FRIDAY, FEBRUARY 22, 2013, 9:00 A.M.

SAN FRANCISCO, CALIFORNIA

REPORTED BY: MEGAN F. ALVAREZ, RPR, CSR NO. 12470

THORSNES LITIGATION SERVICES, LLC

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, ET AL.,	)	
	)	
Plaintiffs,	)	
	)	CASE NO.:
vs.	)	S 90-0520 LKK-JFM
	)	
EDMUND G. BROWN, JR., ET AL.,	)	
	)	
Defendants.	)	
	)	

The Deposition of DIANA TOCHE, taken on behalf of the Plaintiffs, before Megan F. Alvarez, Certified Shorthand Reporter No. 12470, Registered Professional Reporter, for the State of California, commencing at 9:00 a.m., Friday, February 22, 2013, at the offices of Rosen, Bien, Galvan & Grunfeld, LLP, 315 Montgomery Street, 10th Floor, San Francisco, California.

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ALSO PRESENT:

MARC SHINN-KRANTZ, PARALEGAL

I N D E X

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--o0o--

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WITNESS INSTRUCTED NOT TO ANSWER

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Q.	When you had those conference calls or meetings where they told you what they had found, how did they do that?	55	5
Q.	Will you tell me now what recommendations Ms. Moore made in those earlier meetings?	233	10

Q. What about Dr. Canning? Do you remember anything specifically that you discussed regarding the report?
A. No.
Q. And Ms. Eargle or Dr. Eargle?
A. Dr. Eargle.
Q. Did do you remember anything you discussed?
A. No.
Q. Okay. While we're on the subject of this special master and his reports, turn to paragraph 9 of your declaration. You write there, on line 22, of this page: "The continued Coleman monitoring has increasingly diverted attention and resources away from the central goal of providing and maintaining the constitutional level of mental health care."
What do you mean when you say "diverted attention"?
A. What I mean is that the load that's created by the monitoring rounds and doing the monitoring and providing the reports and the like is very -- is very heavy.
Q. Okay.
A. That's a large lift for the institutions and for the headquarters. And so -- and in so that we have to do that, it diverts attention from providing direct

patient care.
Q. So one example of that that you provide here is that there are, quote, onerous reporting obligations.
A. Whose quoted onerous? Me?
Q. On line 34.
A. Okay.
Q. And also line 27.
A. Okay.
Q. What do you mean by "onerous reporting obligations"?
A. That it's -- you know, they ask for a lot of information that is a heavy lift and a lot of extra stuff --
Q. What specifically --
A. -- to gather.
Q. I'm sorry?
A. It's a lot of stuff to gather.
Q. What specifically do they ask for?
A. There's a whole request for -- for the monitoring part.
Q. And why --
A. So I don't know specifically.
Q. Do you know what in that request is new for the special master? What is --
A. I don't know.

Q. Okay. If the special master weren't there, you weren't requesting these things, do you know what information the institutions would cease -- would stop producing?

A. I don't know.

Q. Okay. In the same paragraph, also line 25, you write: "The clinical staff expended considerable resources preparing for prison visits."

Do you know how much time is spent preparing for those visits?

A. Specifically?

Q. What's your understanding?

A. I understand it's a tremendous amount of time.

Q. What do you mean by "tremendous"?

A. A lot.

Q. Can you give me a ballpark?

A. No.

Q. Does "a lot" to you mean 10 hours?

A. No.

Q. Do you believe that it's more than 10 hours?

A. Yes.

Q. Do you believe that it's more than 20 hours?

MR. MCKINNEY: I'm going to object to that question as vague and ambiguous. I'm not sure if we're talking about one institution or systemwide. I just

want to be clear on that.

You can answer.

THE WITNESS: I don't know the hours. So you can keep naming hours, and I'll keep saying "I don't know." To be honest, I don't know the hours.

BY MS. STONE-MANISTA:

Q. But you know that it's a lot?

A. Yeah.

Q. Do you know what exactly is entailed in preparing for those visits? What does the institution actually do?

A. No.

Q. Do you know what information the special master requests that isn't prepared in the ordinary course of business for those visits?

A. No.

Q. Do you know what information he requests that can't be pulled out of existing databases?

A. No.

Q. Have you attended any of the special master's monitoring tours?

A. I believe so.

Q. Do you recall what tour you might have attended?

A. Mule Creek.

Q. Did you, at any time after this e-mail, reach out to Mr. Hayes about his report?
A. No.
Q. So that e-mail was written on August 21st --
A. Uh-huh.
Q. -- and you were cc'd. And the next e-mail thread from September 4th was Mr. Hayes' response to Dr. Belavich, again cc'ing you.
A. Uh-huh.
Q. And then the next e-mail in the thread is from January 8th, 2013, also from Mr. Hayes to Dr. Belavich cc'ing you.
Do you recall receiving this e-mail in January?
A. Yes, I do.
Q. When you received this e-mail, did you discuss it with Dr. Belavich?
A. I -- you know, I don't specifically remember if I discussed it with him, but I'm sure that we discussed it. I mean, I -- but I don't remember positively, but I'm sure we did.
Q. Okay. Between August 21st, at which time -- Dr. Belavich wrote: "Please give us a few days to make further contacts within CDCR so that we can contact you and formulate ideas about potential consulting

opportunities for you with CDCR."

Between August 21st and January 8th of this year, did you and Dr. Belavich -- did you reach out to anyone within CDCR about further work from Mr. Hayes?

A. I believe I discussed this with counsel, legal counsel.

Q. Do you recall with whom you discussed it specifically?

A. I think I talked about it with Debbie Vorous.

Q. Beyond speaking with Ms. Vorous --

A. But I'm not positive. It could have been Tom Gilevich as well since he was on the string. So I'm not sure.

Q. So beyond speaking with counsel, from the attorney general --

A. Right.

Q. -- did you reach out to anyone else within the department about potential consulting opportunities for Mr. Hayes?

A. I don't remember.

Q. Okay. To your knowledge, did Dr. Belavich --

A. I don't know.

Q. -- reach out to anyone?

You don't know?

A. I don't know.

broadly, but I may get some of the finer points not exactly right.

And so I will say that we've always, in the mental health program, been focused on hiring what we call the big three: The psychiatrist, the clinical social workers and psychologists.

Q. Right.

A. And when we were rolling out all the positions that were approved for the mental health staffing, along with what was going to be happening with the realignment and the shift of the inmate patients, that there -- begins with the voluntary transfer process.

So if there's a -- and they noticed based on whatever. I can't remember the specifics. And so -- and so people can voluntarily transfer anywhere in the state. Statewide.

Q. Okay.

A. Once those people land, then options happen. And then people are either given the right -- either you're high enough on the seniority list and you maintain your position, or there may be some bumping, or you may go into a vacancy or something like that, but that only happens within the county.

Q. Okay.

A. So if there are, let's say, five office

technicians in one county and there's only four spaces for people to be at, then one person may eventually be laid off.

Q. Okay.

A. Okay. So during this time of the shuffling of people, there might be small windows to fill, but you have to -- you can't say you can voluntarily transfer to these vacancies and then, in the meantime, been filling those vacancies.

So when you asked "Is there a freeze?" -- I mean, it's dependent on the point in time that you're talking about and the classification and the county, and that sort of thing. Okay? So it's a little bit more complicated than yes or no.

Q. I'm aware it's very complicated.

A. I hope I explained that well. But, you know, we're not really ever supposed to talk about it, because there's so many nuances with different bargaining units. So I'm hoping that, broadly, I explained it well enough.

Q. You mentioned that there might, in some cases, be layoffs.

Are you aware of any layoffs that have happened yet in 2013, just in the last two months?

A. I believe we're close to something happening.

Q. So to your knowledge, there may be layoffs

A. Why you tell me what you think it is, and then I'll correct you.

Q. I've been trying and trying to figure out -- so when I actually read those words "freeze exemption request process," that implies to me that there is a freeze from which an exemption must be requested.

Is that -- am I wrong in that understanding?

A. Well, there's a process, and I think that might be the name; and there may or may not be a freeze depending on where we are in the layoff process and the clarification.

Q. So where we are in space and time.

A. Yeah. And so what I'm saying is that if we had to come up with a new name for the form and a new form for all the different points in time, it would be very confusing for the field. So you stick the same name and the same form.

Q. Regardless of --

A. Regardless of.

Q. Okay. That's interesting. This is something I've been trying to understand as well as everybody else.

Are there particular -- we talked about it kind of depends on where you are --

A. Right.

rough idea, across the system, of how many mental health positions are currently filled by the registry?

A. Personally, breakdown, I don't know.

Q. Okay. Do you -- are you aware of any downsides to using people off the registry?

A. Currently, right now, no.

Q. Does use of the registry ever cause problems in -- I imagine you have to train people. Is that ever a problem for an institution?

A. That would be more in Dr. Belavich's realm.

Q. As far as the actual use of registry?

A. Management and use, yes.

Q. Okay. In the data we were looking at a little bit ago, it mentions adjustments for new hires.

Can you explain that to me?

A. It's my understanding the SCO is -- there's a certain cutoff date for data, and then maybe people will be hired after that and they wouldn't be captured in the SCO data.

Q. Okay. That's interesting.

Okay. So that sort of -- you mentioned earlier there's kind of a pipe line.

A. Kind of like a flux.

Q. Okay. I see that. That makes sense.

And adjustments for long-term sick leave, I'm

have they raised up something to my level to say something's wrong?

Q. Has a problem come to your attention?

A. They have not raised something up to my level.

Q. Okay.

A. They may be discussing something with Tim or regional. I don't know. But nothing has been raised up to my level.

Q. You haven't had further discussions with Dr. Belavich about CMC specifically about staffing shortages?

A. About staffing at CMC? I think that we always have discussions about CMC, because we're also -- have the new 50 beds being developed there. So there's discussions about staffing.

Q. I see.

A. So there's additional factors.

Q. Okay. What about department of state hospital's facilities? Do you get data about vacancies at DSH facilities?

A. Staffing vacancies, no.

Q. You never review data about those facilities?

A. No.

Q. So you couldn't speak to, for instance, staffing at SVPP or --

A. 43.75.

Q. We talked a little bit earlier about 30 percent and the system could be adequate at 30 percent.

Do you think that SCC is running an adequate program at 43.75 percent vacancies?

MR. MCKINNEY: Objection. Compound. Calls for speculation. Argumentative.

THE WITNESS: I would need -- I would actually need to talk to Dr. Belavich to see what he has to say about the care being provided here per the vacancy rate, who's working here.

BY MS. STONE-MANISTA:

Q. So you don't -- as we sit here today, you don't have a personal opinion?

A. Without all the facts -- because I -- I -- Tim and I have discussed SCC, and so there's -- I know that there's certain things about it. And so I just -- you know, I would prefer to talk to Tim before I answer that question.

Q. What have you and Dr. Belavich discussed about SCC?

A. About the personnel there and the -- and the mental health caseloads and the like. So I just would be comfortable in discussing that with him more.

MR. MCKINNEY: Objection. Vague and ambiguous. Calls for speculation. Calls for legal conclusion.

THE WITNESS: So I recently visited Pelican Bay -- well, not recently -- last year -- so it's been a new year -- and spoke with the CEO and the chief of mental health, and they showed me the -- their -- the program of how they're following it and how they're delivering care and how they're assessing themselves. And Dr. Dvoskin was there as well. And it was, you know, of my opinion and of Dr. Dvoskin's opinion, while we were there, that the care being delivered there was adequate.

BY MS. STONE-MANISTA:

Q. Was Dr. Dvoskin the only expert to come on that tour? Do you recall?

A. Steve Martin was there as well.

Q. So with respect to Pelican Bay, because you'd recently visited or you visited last fall with Dr. Dvoskin and Steve Martin, you're comfortable saying that care there is adequate?

A. Yes, because I went there myself.

Q. So we've been talking through things. It sounds like there's a lot more information you would like to have in front of you and a lot of conversations

with Dr. Belavich.

Is there anyone else on whom you rely in making these kinds of assessments about care at particular institutions other than Dr. Belavich?

A. Well, as I alluded to, is that we have -- we have the structure in the system and the processes. And so for me, as the director of health care, I rely on Dr. Belavich, who's the director of the mental health program. All right? He has his direct reports that report to him who he relies on.

Q. I understand.

A. And so in meetings I rely -- if we're in a meeting about a specific subject matter, there may be a SME that will also inform Dr. Belavich and myself for further education or knowledge base, but it's not like I'm going to go and contact someone at an institution, a chief of mental health at an institution and circumvent all these other people. Because they --

Q. Is that something you've ever done, contacted a chief of mental health at an institution?

A. Personally, I have -- I have, but then you have to circle around and keep everybody in the loop.

So even before I was the director of health care over dental health and mental, I was just the director over the dental program. Same structure. You

have the -- you -- we had the regional structure and the regional structure reported to my associate director in that circumstance. So relatively similar structure.

It's not like I went down and talked to supervising dentists every day. Okay? I did do it, and then people got mad because then they're out of the loop. Everybody needs to know what's going on, what's important.

So if it's important enough to me to want to reach down, then obviously I think that someone like Tim would want to know, the regional would want to know.

Q. Okay. So when you wrote in your declaration, quote, adequate numbers of mental health professionals and administrators proactively diagnosis and treat inmates' serious mental health needs, what was the basis for that statement?

A. For that statement.

So the basis for that statement is that throughout 2012 I visited a number of institutions with the Coleman experts, see the sustainable process. I visited numerous expert -- numerous institutions with the DAG experts: Dr. Dvoskin and Dr. Scott, Jackie Moore. And also receiving reports from the regionals as they report out on the sustainable process and the care being delivered.

And so, you know, personal observation, reports, the wait list is at zero. You know, the care that I observed personally out at these institutions, from the staff. I mean, they care. You got people staying there as long as it takes. They're -- this is a dedicated staff dedicated to providing care.

So if we're there doing some sort of tour, they're there staying late or coming in early so that they can see the inmate patients.

Q. So your visits to the institutions?

A. My visits to institution, conversations with the Coleman experts.

Q. Okay.

A. Conversations with the deputy attorney general experts. Conversations with the staff at the institutions.

Q. So just a second ago, before I forget, when you said DAG experts, you meant deputy attorney general?

A. Yes.

Q. Okay. We have acronyms for everything.

MR. MCKINNEY: One acronym you didn't know.

BY MS. STONE-MANISTA:

Q. Okay.

A. I'm trying to distinguish between the experts. It's hard, though.

CERTIFICATE OF REPORTER

I, MEGAN F. ALVAREZ, a Certified Shorthand Reporter, hereby certify that the witness in the foregoing deposition was by me duly sworn to tell the truth, the whole truth and nothing but the truth in the within-entitled cause;

That said deposition was taken down in shorthand by me, a disinterested person, at the time and place therein stated, and that the testimony of the said witness was thereafter reduced to typewriting, by computer, under my direction and supervision;

I further certify that I am not of counsel or attorney for either or any of the parties to the said deposition, nor in any way interested in the events of this cause, and that I am not related to any of the parties hereto.

DATED: March 5, 2013

_____

MEGAN F. ALVAREZ

RPR, CSR 12470

Exhibit 91

STATE OF CALIFORNIA
STANDARD AGREEMENT
STD 213 (Rev 06/03)

AGREEMENT NUMBER: 11-6459
REGISTRATION NUMBER: eP 11 82434

1. This Agreement is entered into between the State Agency and the Contractor named below:

STATE AGENCY'S NAME
DEPARTMENT OF JUSTICE

CONTRACTOR'S NAME
JOEL A. DVOSKIN, Ph.D., A.B.P.P.

2. The term of this Agreement is: **9/1/11** through **6/30/12**

3. The maximum amount of this Agreement is: **$ 100,000.00** One Hundred Thousand Dollars and No Cents.

4. The parties agree to comply with the terms and conditions of the following exhibits which are by this reference made a part of the Agreement.

Exhibit A – Scope of Work	1 page
Exhibit B – Budget Detail and Payment Provisions	2 pages
Exhibit C* – General Terms and Conditions	GTC 610
Check mark one item below as Exhibit D:	
☒ Exhibit - D Special Terms and Conditions (Attached hereto as part of this agreement)	3 pages
☐ Exhibit - D* Special Terms and Conditions	
Exhibit E – Contractor's Resume	4 pages

DOJ Docket No.: **48170 286 CF1997CS0003** DAG: **Patrick McKinney**
Case Name: **Coleman v. Brown**

Items shown with an Asterisk (*), are hereby incorporated by reference and made part of this agreement as if attached hereto. These documents can be viewed at www.ols.dgs.ca.gov/Standard+Language/default.htm

IN WITNESS WHEREOF, this Agreement has been executed by the parties hereto.

CONTRACTOR

CONTRACTOR'S NAME *(if other than an individual, state whether a corporation, partnership, etc.)*
JOEL A. DVOSKIN, Ph.D., A.B.P.P.

BY *(Authorized Signature)*: ✍ [signature] — DATE SIGNED *(Do not type)*: 9/19/11

PRINTED NAME AND TITLE OF PERSON SIGNING
JOEL A. DVOSKIN, Ph.D., A.B.P.P.

ADDRESS
668 E. Weckl Place
Tucson, AZ 85704-6076 Telephone: **(520) 577-3051**

STATE OF CALIFORNIA

AGENCY NAME
DEPARTMENT OF JUSTICE

BY *(Authorized Signature)*: ✍ [signature] — DATE SIGNED *(Do not type)*: OCT 18 2011

PRINTED NAME AND TITLE OF PERSON SIGNING
STEPHEN F. NAPOLILLO, Manager, Contracts Unit

ADDRESS
1300 I Street, 8th Floor
Sacramento, CA 95814

California Department of General Services Use Only

APPROVED
OCT 26 2011
DEPT OF GENERAL SERVICES

☐ Exempt per:

[signature]

DEXP 103091

STATE OF CALIFORNIA
STANDARD AGREEMENT
STD 213A (Rev 06/03)

☐ CHECK HERE IF ADDITIONAL PAGES ARE ATTACHED Pages

AGREEMENT NUMBER	AMENDMENT NUMBER
11-6453	1
REGISTRATION NUMBER	

1. This Agreement is entered into between the State Agency and the Contractor named below:

STATE AGENCY'S NAME
DEPARTMENT OF JUSTICE

CONTRACTOR'S NAME
STEVE J. MARTIN, ESQ.

2. The term of this Agreement is: **9/1/11** through **6/30/13**

3. The maximum amount of this Agreement is: **$ 100,000.00** One Hundred Thousand Dollars and No Cents

4. The parties mutually agree to this amendment as follows. All actions noted below are by this reference made a part of the Agreement and incorporated herein:
This Amendment is effective as of 6/29/12.

- Change the termination date of the Agreement from 6/30/12 to 6/30/13.

All other terms and conditions shall remain the same.

Case Name: **Coleman v. Brown**
Docket No.: **48170 286 CF1997CS0003**
DAG: **Patrick McKinney**

All other terms and conditions shall remain the same.

IN WITNESS WHEREOF, this Agreement has been executed by the parties hereto.

CONTRACTOR

CONTRACTOR'S NAME (If other than an individual, state whether a corporation, partnership, etc.)
STEVE J. MARTIN, ESQ.

BY (Authorized Signature): Steve J. Martin — DATE SIGNED (Do not type): 7/23/12

PRINTED NAME AND TITLE OF PERSON SIGNING
STEVE J. MARTIN, ESQ.

ADDRESS
8513 Adirondack Trail
Austin, Texas 78759 Telephone: **(512) 346-7607**

STATE OF CALIFORNIA

AGENCY NAME
DEPARTMENT OF JUSTICE

BY (Authorized Signature): — DATE SIGNED (Do not type):

PRINTED NAME AND TITLE OF PERSON SIGNING
STEPHEN F. NAPOLILLO, Manager, Contracts Unit

ADDRESS
1300 I Street, Suite 820
Sacramento, CA 95814

California Department of General Services Use Only

"Exempt From DGS Approval Per DGS Exemption Letter No.52"

☐ Exempt per:

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SANTA BARBARA • SANTA CRUZ

DEPARTMENT OF PSYCHIATRY
5316 STOCKTON BOULEVARD
SACRAMENTO, CA 95819
916-734-6870

UNIVERSITY OF CALIFORNIA, DAVIS
MEDICAL CENTER, SACRAMENTO
2315 STOCKTON BOULEVARD
SACRAMENTO, CALIFORNIA 95817

October 8, 2012

Patrick McKinney
Deputy Attorney General
California Department of Justice
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Ph: 415-703-5500

RE: Coleman, et al. v. Brown, et al.
DOJ Docket No.: 48170286CF1997CS0003
Standard Agreement No. 11-8512

Dear Mr. McKinney,

Below is an itemized list of charges regarding the above named case for September 11, 2012 through October 5, 2012:

Date	Service	Time	Rate (per hour)	Total
9/11/2012	Record review / Report preparation	8.00 hrs	$200.00	$1,600.00
9/12/2012	Travel – Sacramento to Vacaville	0.75 hrs	$200.00	$150.00
9/12/2012	Consultation / Review	5.00 hrs	$200.00	$1,000.00
9/12/2012	Travel – Vacaville to Sacramento	0.75 hrs	$200.00	$150.00
9/12/2012	Consultation	1.00 hrs	$200.00	$200.00
10/1/2012	Record review	1.50 hrs	$200.00	$300.00
10/2/2012	Record review / Report preparation	8.50 hrs	$200.00	$1,700.00
10/3/2012	Record review / Report preparation	2.50 hrs	$200.00	$500.00

10/5/2012	Record review	0.50 hrs	$200.00	$100.00
10/5/2012	Record review / Report preparation	1.50 hrs	$200.00	$300.00
	Total:	**30.00 hrs**		**$6,000.00**

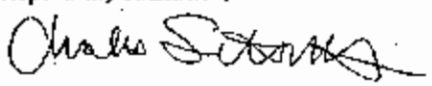
Please make the check payable to: **UC REGENTS**

The appropriate tax I.D. number is: **94-6036494**. For tax reporting purposes, the income is reported as UC Regents **NOT Charles L. Scott, M.D.**

Please include on the check the reference number 01-016786876, and mail check to:

Cashier's Office
University of California, Davis
P.O. Box 989062
West Sacramento, CA 95798-9062

Respectfully submitted,



Charles L. Scott, M.D.
Chief, Division of Psychiatry and the Law
Professor of Clinical Psychiatry
Department of Psychiatry & Behavioral Sciences
University of California, Davis Medical Center – Sacramento

STATE OF CALIFORNIA
STANDARD AGREEMENT
STD 213A (Rev 06/03)

☐ CHECK HERE IF ADDITIONAL PAGES ARE ATTACHED . _____ Pages

AGREEMENT NUMBER	AMENDMENT NUMBER
11-8512	1
REGISTRATION NUMBER	

1. This Agreement is entered into between the State Agency and the Contractor named below:
   STATE AGENCY'S NAME
   DEPARTMENT OF JUSTICE
   CONTRACTOR'S NAME
   Regents of the University of California, Davis
2. The term of this Agreement is: 09/01/11 through 06/30/13
3. The maximum amount of this Agreement is: $ 100,000.00 (One Hundred Thousand Dollars and No Cents)
4. The parties mutually agree to this amendment as follows. All actions noted below are by this reference made a part of the Agreement and incorporated herein:
   - This Amendment is effective as of June 29, 2012
   - Extend the termination date of the Agreement from June 30, 2012 to June 30, 2013.

All other terms and conditions shall remain the same.

IN WITNESS WHEREOF, this Agreement has been executed by the parties hereto.

CONTRACTOR

CONTRACTOR'S NAME (If other than an individual, state whether a corporation, partnership, etc.)
Regents of the University of California, Davis

BY (Authorized Signature)
DATE SIGNED (Do not type)
8-31-2012

PRINTED NAME AND TITLE OF PERSON SIGNING
ANNALEE WOLF, DIRECTOR, HUMAN SUBJECTS COMMITTEE

ADDRESS
Dept. of Psychiatry & Behavioral Sciences, 7230 Stockton Blvd., 2nd Floor
Sacramento, CA 95817

STATE OF CALIFORNIA

AGENCY NAME
DEPARTMENT OF JUSTICE

BY (Authorized Signature)
DATE SIGNED (Do not type)
SEP 13 2012

PRINTED NAME AND TITLE OF PERSON SIGNING
STEPHEN F. NAPOLILLO, Manager, Contracts Unit

ADDRESS
1300 I Street, Suite 820
Sacramento, CA 95814

California Department of General Services Use Only

"Exempt From DGS Approval Per DGS Exemption Letter No. 52"

☐ Exempt per:

DEXP 102004

Exhibit 92

From: McDonald, Terri@CDCR
Sent: Sunday, January 27, 2013 6:41 PM
To: Dickinson, Kathleen@CDCR; Stainer, Michael@CDCR; Allison, Kathleen@CDCR
Cc: Acosta-Hoshall, Christina@CDCR
Subject: FW: Suicide Compendium V5
Attachments: Suicide_Compendium_1-27-13_MJM_v5.pdf

Importance: High

FYI

Chris, please print

Thx

From: Toche, Diana@CDCR
Sent: Sunday, January 27, 2013 4:04 PM
To: Rice, Benjamin@CDCR; Hoshino, Martin N@CDCR; Beard, Jeff@CDCR; McDonald, Terri@CDCR
Subject: FW: Suicide Compendium V5

Attached please find the latest version in preparation for Tuesday's meeting. Please let me know if you would like additional clarification or information. MH is on stand by if needed.

Diana Toche, DDS
Director (A), DHCS
Deputy Director, Statewide Dental Program California Department of Corrections and Rehabilitation
501 J Street, Suite 400
Sacramento, CA 95814
916.691.0605 (desk)
916.764.4604 (BB)

From: Morrison, Michael@CDCR
Sent: Sunday, January 27, 2013 10:12 AM
To: Toche, Diana@CDCR; Rice, Benjamin@CDCR
Cc: Belavich, Tim@CDCR

Subject: Suicide Compendium V5

Good Morning, attached is version 5 with 25th round additions. Please let me know if any other changes are needed. The best way to sum up this project is to compare it to "herding cats." Thank you for your patience.

Mike

Michael Morrison
Health Program Specialist
Statewide Mental Health Program
DHCS-CDCR
Mobile: 916-764-4996

Compendium of Suicide Recommendations

Completed: 34	Ongoing: 9	Total: 80
In Process: 29	Unable to Proceed: 3	
Disagree: 13	Non-Issue: 2	

Source	Recommendation	Status	Status Explained	Next Steps	Extra
2006 Court Order	Intake Cells	Ongoing	Each institution has intake cells, use of these cells is audited on an ongoing level. When the audits yield bad results, it is addressed.	Work with DAI to ensure intake cells are being used appropriately; Ensure there are enough intake cells at each institution.	
2006 Court Order	Retrofit Intake Cells	Completed	Addressed in 2010 Submittal		
2006 Court Order	Title 15 Requirements for out of cell time/priority	In Process	Auditing is difficult; numerous barriers to meet mandated hours	Follow Up with DAI HQ Staff at MH/DAI ASU workgroup	
2006 Court Order	Confidential MH interviews in ASU	Completed	Has been implemented at institutions when space permits		
2006 Court Order	Reduction in Length Of Stay	Completed	Reviewed all inmate-patients in ASU for more than 30 days, reviewed CDMH STAT data and waiting lists for ASU transfer. Hubs has been reduced		
2006 Court Order	Return from court "Bad News" Information	Completed	Addressed in 2010 Submittal		
2006 Court Order	Pre-Placement Suicide Prevention Screening	Completed	Addressed in 2010 Submittal		
2006 Court Order	Post Placement Screening	Ongoing	Review on an ongoing basis from data from MHTS.Net	Continue to work with DAI Staff when issues arise	
2006 Court Order	Daily Coordination	Completed	Addressed in 2010 Submittal	Daily huddles are occurring with ASU Sergeant and ASU MH Clinician; suicide information from MHTS.net is communicated with custodial staff	
2006 Court Order	Minimum stay at EOP ASU Hubs	Ongoing	Monitored on an ongoing level using HOPOP data, minimum LOS is 60 days	Follow up with institutions to ensure minimum LOS is being met	

Source	Recommendation	Status	Status Explained	Next Steps	Extra
2006 Court Order	Auditing of Case Manager Review of Weekly Rounds Notes	Completed	Addressed in 2010 Submittal		
2006 Court Order	Audit of Screening refusals	Completed	Addressed in 2010 Submittal		
2006 Court Order	Audit of ASU Suicide Prevention	Completed	Addressed in 2010 Submittal		
2006 Court Order	Non Disciplinary Segregation	Unable to Proceed	No plans to implement ;have discussed the issue with custody and have identified barriers		
2006 Court Order	Custody Welfare Checks	Completed	Custody performs hourly welfare checks	Currently working with DAI to provide three wellness checks in 60 minutes instead of two	Initial recommendation was to have custody perform welfare checks. CDCR has implemented but is trying to increase frequency
2006 Court Order	Double Celling	Ongoing	DAI reviews all inmate-patient suitability to be doubled celled		
2006 Court Order	Emergency Response	Completed	Addressed in 2010 Submittal		
2006 Court Order	Clinical Rounding	Completed	Addressed in 2010 Submittal		
2006 Court Order	Strike Team on site Reviews of ASU Bed Utilization	Completed/ In Process	Strike Team completed	Modifications to departmental policy are being addressed in the MH/DAI ASU workgroup	
2010 Court Order	SRE Mentor Program	Ongoing	Over 90 clinicians trained; Audit tool developed; Each institution has at least one primary mentor	Memorandum with specific timelines is currently being routed for approval prior to dissemination. Policy and Procedure currently en route to JCET. Will be monitored through QI process.	Recommendation stated to only mentor "new and unlicensed staff.," MH expanded to all staff who administer SRE's and mentoring and training is ongoing and cyclical w/peer consultation.
2010 Court Order	Review and Revise Program Guide	In Process	MH has completed revisions and are currently with Debbie Vorous for review	Follow up with Debbie Vorous, once revisions are approved disseminate to field	

Source	Recommendation	Status	Status Explained	Next Steps	Extra
2010 Court Order	Improve Suicide Review Quality	Completed	Template revised, training implemented, additional reviewers trained		
2010 Court Order	Improve CDP Development	Completed	Process updated to ensure better collaboration with all institutional staff; DAI HQ is now involved with development of CDP prior to SCR		
2010 Court Order	Changes of conditions in ASU	Unable to Proceed	Pilot developed to change conditions in ASU at PBSP. Based on the findings from the pilot, this is unable to be rolled out statewide due to staffing and physical plant restrictions and conflict with DOM.	MH will still change as much conditions as possible, where possible. Example's are property privileges, provision of group treatment when space permitting, increase usage of Recreation Therapists, and problem-focused clinical treatment.	
2010 Court Order	High Risk Inmate-Patient Management	Ongoing	Each institution has identified a "High Risk" specialist (mostly DSH Coordinators)	Follow Up with institutions with new policy in concordance with court requirements.	Overlaps with sustainable process
2010 Court Order	Shared documentation with DSH	Completed	Created SharePoint Site		

Source	Recommendation	Status	Status Explained	Next Steps	Extra
Hayes Report	Problems with emergency response timeliness (based on review of 2010 suicides)	Non-Issue	Review of 2011 and 2012 suicides did not reveal this to still be a problem	Will continue to examine timelines through SCR process.	
Hayes Report	Inmate-patients committed suicide after discharge from observation status or Inmate-Patients threatened suicide, expressed SI and/or had other suicide risk factors that did NOT result in placement on suicide observation (based on review of 2010 suicides)	In Process	2011 and 2012 suicides are being investigated to see if this is still true	Ensure that staff follow guidelines for what constitutes suicide observation. Will conduct audits and this will also be trained in the SRE mentoring program.	
Hayes Report	Inmate-patients found in rigor or review determined that cell checks not performed as required (based on reviews of 2010 suicides)	In Process	2011 and 2012 suicides are being investigated to see if this is still true	Will follow up with DAI	
Hayes Report	Several ASU inmates who committed suicide were not in intake cells (based on reviews of 2010 suicides)	In Process	MH/DAI workgroup currently discussing issue		
Hayes Report	60% of cases involved multiple problem areas (based on review of 2010 suicides)	Completed	Rating system developed to determine if problems are systematic		
Hayes Report	Threshold for placement on Suicide Observation is set too high	Disagree	Do not feel changes are appropriate. We do not support lowering threshold.	Ensure staff develop enhanced treatment plans for inmate-patients who have moderate risk. This will also be trained in the SRE mentoring program.	
Hayes Report	Revise definitions necessitating placement on SP or SW in PG.	In Process	Will clearly define Suicide Precaution and Suicide Watch; if revisions are not in those currently under review by Debbie Vorous, we will add them.	Confirm revisions to language have already been changed. If not, make the changes and resubmit for review.	

Source	Recommendation	Status	Status Explained	Next Steps	Extra
Hayes Report	Recommended changes to Chapter 10: page 11, under Peer Consultation, recommends adding "correctional staff" and "medical staff" as peers that need to be consulted.	Disagree	Peer consultation is specific to clinical consultation as it relates to mental health	Peer Consultation/Review is still being completed throughout the state. Will still consult and collaborate with custody and medical staff on an ongoing basis.	
Hayes Report	Recommended changes to Chapter 10: page 11, bottom and page 12, top. Additional language change on peer consultation. In one place it says that peer consultation can be one of the most important clinical safeguards and later it says it is not always necessary. He suggests deleting the latter.	In Process	If revisions are not in those currently under review by Debbie Vorous, we will add them.	Confirm revisions to language have already been changed. If not, make the changes and resubmit for review.	SRE mentoring program encourages peer consultation
Hayes Report	Recommended changes to Chapter 10: page 12, under Suicide History Tracking: Suggests expanding MHTS.net to include ALL inmates who have attempted suicide, engaged in SIB, or been placed on suicide observation regardless of whether or not they are "high risk mental health inmate-patients" or in MHSDS.	In Process	Any changes to MHTS.Net are required to be on a change list. This list is prioritized by a change control board. Need to determine whereabouts of change on the priority list.	Submit to change control board	All inmate's are in MHTS.Net. If suicide information has been entered into MHTS.Net, the information will follow the inmate no matter his/her level of care, even GP.

Source	Recommendation	Status	Status Explained	Next Steps	Extra
Hayes Report	Recommended changes to Chapter 10: page 12, Language change suggested. Currently reads, "When an inmate-patient verbalizes suicidal ideation without other signs and symptoms of increased risk for suicide, the mental health clinician is responsible for evaluating any contributing environmental stressors and communicating with custody staff and supervisor's regarding any potentially solvable custody issues." Refers to inmate who may be manipulating and/or malingering. Concern: Inmate-Patients who are manipulative or malingering can still be suicidal and require placement on suicide observation status. Recommends review and clarification.	In Process	Alteration of language currently being discussed	SRE mentoring program will address this	
Hayes Report	Recommended changes to Chapter 10, page 14, under Inmate and Cell Search, delete reference to "bed frames" being "removed" from the cell as well as "on the floor." Insert narrative that all inmates on suicide observation status shall be provided with suicide resistant beds.	In Process	Beds are in place. If Program Guide revisions are not in those currently under review by Debbie Vorous, we will add them	Confirm revisions to language have already been changed. If not, make the changes and resubmit for review.	

Source	Recommendation	Status	Status Explained	Next Steps	Extra
Hayes Report	Recommended changes to Chapter 10, page 14, under Inmate and Cell Search, no narrative describing items or privileges (shower, out of cell time, telephone calls, visitation, etc.), if any, is permitted. Found restrictive conditions for inmates on suicide observation status. No clothing - confined to cells at all other times - no visitation. Was informed these were correctional (not MH) decisions. Concern that inmates will say they are no longer suicidal in order to escape harsh conditions.	In Process	Agree that MHCB's are to restrictive, and property needs to be handled on a case by case basis.	Going to address with custody, will be culture change. Will also develop procedure consistent with how CHCF is handling their MHCB's, which is different than our current practice.	
Hayes Report	Recommended changes to Chapter 10, page 15 and 16, revise definitions of both Suicide Precaution and Suicide Watch (loosen definition)	Disagree	We do not plan on expanding either definition	Will ensure current definitions are clearly defined through SRE mentor program.	
Hayes Report	Recommended changes to Chapter 10, page 16 and 17, within the boxes that indicated Guidelines for Clinician-Ordered Suicide Precaution and Suicide Watch: delete reference to "remove all furniture" and insert provision of suicide-resistant beds.	In Process	If revisions are not in those currently under review by Debbie Vorous, we will ad them	Confirm revisions to language have already been changed. If not, make the changes and resubmit for review.	

Source	Recommendation	Status	Status Explained	Next Steps	Extra
Hayes Report	Recommended changes to Chapter 10, page 19, under Discharge and Return, argues that inmates sent to OHU for suicide observation status should receive same 5-day clinical follow-up as inmates placed on the MHCB for similar reasons. Suggest language changes to reflect this.	Completed/ In Process	This is implemented. Just need to confirm language is updated in Chapter 10 revision.	Confirm revisions to language have already been changed. If not, make the changes and resubmit for review.	All inmate-patients, not just those admitted for suicide observation, who are discharged from any crisis care receive a 5 Day Follow Up.
Hayes Report	Recommended changes to Chapter 10, page 19, under both Discharge and Return and MHCB Discharge, recommends deleting the word "imminent." Argues that lack of imminent or immediate danger of self-harm should not be the only criteria for removal from suicide observation status.	In Process	"Imminent" is a community standard, we will define better	Define more clearly through SRE mentoring program.	
Hayes Report	Recommended changes to Chapter 10, page 20, language regarding frequency of Wellness checks for MHCB discharges. Recommends frequency of greater than 60 minutes.	In Process	Currently working with DAI to provide three wellness checks in 60 minutes instead of two.		
Hayes Report	Recommended changes to Chapter 10, page 21 & 22, under Custody Protocol and Hanging sections. Reference to term "if trained to do so" when referring to custody performing CPR.	Completed/ In Process	Staff have been trained. If revisions are not in those currently under review by Debbie Vinnedge, we will add them.	Confirm revisions to language have already been changed. If not, make the changes and resubmit for review.	
Hayes Report	Use of OHUs for Suicide Precautions - lengthy discussion. Suggests using OHUs as crisis treatment areas for non SMI I/Ps.	Disagree	Plaintiffs do not support this; addressed in OHU memo		

Source	Recommendation	Status	Status Explained	Next Steps	Extra
Hayes Report	Use of OHUs - concern about cleanliness.	In Process	Vastly improved per regional administration site visits	Will be monitored through QI process	
Hayes Report	Use of OHUs - lower the threshold for crisis placement and utilize OHUs more	Disagree	Threshold for crisis placement is appropriate and do not believe it needs to be lowered. Plaintiffs also do not agree with use of OHU's.	MH will continue to monitor MHCB waitlist. MH believes a licensed facility it the most clinically appropriate placement for inmate-patients.	
Hayes Report	Use of Suicide Resistant Beds in MHCB's	Completed			
Hayes Report	Use of ZZ cells for housing inmate-patients on suicide observation. Suggests prohibiting their use for suicide observation.	Non-Issue	No longer an ongoing issue. MHCB's have been built, MHCB waitlist has decreased.	MH will continue to monitor MHCB waitlist. MH believes a licensed facility it the most clinically appropriate placement for inmate-patients.	
Hayes Report	Cadet Academy - add: 1. self-injurious v. suicidal behavior and effectively dealing with manipulative inmates 2. identifying inmates at risk for suicide despite their denial of risk; 3. updates	In Process	Curricla revised, we are currently reviewing MH components. QP to be distributed statewide.	Develop best way to disseminate information	
Hayes Report	Suicide Prevention Training Curricula - HCNED - Expand to 2.5 hours and include above	In Process	Discussing training with CDHCS	Continue to work with CDHCS	
Hayes Report	Suicide Prevention Training Curricula - Annual IST. Good content but expand to include QIPs.	Disagree	IST is not the best method for this	Disseminate QIP; the best method for this would be through the local SPRFT committee, who will then disseminate to all staff.	
Hayes Report	Local SPRFT - Determine if they are functioning effectively, are they proactive?	In Process/Ongoing	Requesting minutes and assigned a staff member to review.	Minutes will be reviewed on a monthly basis and QIP's will be implemented for institutions who fail to meet the minimum requirements. Will be monitored through QI process.	
Hayes Report	ASUs for Suicide Observation - believes premature to discuss ASU as an option.	Disagree	Do not support use of ASU for Suicide Observation	Due to sufficient MHCB's, there is not a need to use ASU for Suicide Observation	

Source	Recommendation	Status	Status Explained	Next Steps	Extra
Dvoskin Report	Integration of MH, Custody and Medical	Completed	MH, Custody and Medical staff are now integrated throughout all steps of the SCR process.		
Dvoskin Report	Serious issues need to be addressed immediately and should not wait for SCR	Completed	Training has been provided to all reviewers to capture serious issues, and these issues are addressed immediately and often before the SCR.		
Dvoskin Report	Requests for additional information and attention to recommendations should be issued directly from the Secretary's office.	Disagree	Requests will be elevated through chain of command, if necessary up to the Secretary's office		
Dvoskin Report	All recommendations should be categorized according to a new scheme	Completed	Categorization scheme developed		
Dvoskin Report	Informal recommendations should be followed up by HQ	Completed	HQ eliminating informal recommendations		
Dvoskin Report	QIP usage - suggestion is to refer to QIP for the institution, and have numbered recommendations under the QIP plan.	Disagree	Change to current language will be confusing to field staff.	Will continue to follow current QIP process to alleviate confusion. Will be sure to define through SRE mentor program.	
Dvoskin Report	SCRs should be routed to receiver. Receiver receiving information only copies.	Disagree	Routing to Receiver, for signature, will cause delay and will result in failure to meet required timelines.	Informational copies will continue to be provided to the Receiver.	
Dvoskin Report	DRC not folded into SCR process.	Disagree	Can not fold DRC into SCR due to timelines.	Consultation with DRC will continue prior to completion of SCR.	

Source	Recommendation	Status	Status Explained	Next Steps	Extra
Dvoskin Report	Special Master Reports on suicide available immediately	Unable to Proceed	Not an actionable item for CDCR		
Dvoskin Report	Issues in SCRs related to employee discipline, security group issues, institutional security, etc.	Disagree	Deferred to Internal Affairs, information is confidential.	Continue current process; receive number when case is assigned and are notified once it is completed.	
Dvoskin Report	Reconsider "automatic" referrals to ASU in absence of a specific finding of danger.	In Process	Currently being discussed in MH/DAI ASU workgroup.	MH will review RVR and this may affect placement, also Captain reviews will result in discharge if inmate-patient is determined not to be a danger	
Dvoskin Report	Interval between admission to ASU and first clinical contact. Former PC see an I/P within the same institution sooner than current policy mandates. If transfer to another institution, then use Tele-therapy or have another clinician make immediate contact.	In Process	Discussing feasible ways to implement.	CCCMS inmate-patient to be seen by next day after placements into ASU.	
Dvoskin Report	Inmate-patient housed in ASU pending transfer to EOP should be placed at the front of the waiting list for transfer.	Disagree	There is already a priority placement list for inmate-patients awaiting transfer. CDCR stands behind the current list.	Will continue to use the current priority placement list for transfer.	

Source	Recommendation	Status	Status Explained	Next Steps	Extra
Dvoskin Report	"The Department has made a significant effort to provide ASU inmates with the possibility of televisions in their cells, which can significantly decrease the distress inmates experience in segregation."	In Process	Currently being discussed in MH/DAI ASU workgroup.	This monitored and allowed where possible. Retrofitting other cells to provide electricity is cost prohibitive.	
Dvoskin Report	When a recent DSH discharge commits suicide, CDCR should notify DSH to conduct its own investigation. Share investigations when complete. Formal notification and meeting to discuss findings.	Ongoing	First test case occurred 1/24/2013 at SVSP.	Will implement recommendation., CDCR to contact DSH.	
Dvoskin Report	Unable to gain access to medical record in one case. Due to no EMR.	In Process	eUHR implementation has helped with this issue.	CDCR is currently developing a "true" EMR which will void the issue identified.	
Dvoskin Report	Custody employees refuse to be interviewed.	In Process	All staff are encouraged to participate in interviews. If an issue arises where a staff refuses to be interviewed, it is raised through the chain of command.	Continue to work with DAI Staff when issues arise	
Dvoskin Report	Quality of SREs.	In Process/Ongoing	Addressed with SRE mentoring program	Memorandum with specific timelines is currently being routed for approval prior to dissemination.	

Source	Recommendation	Status	Status Explained	Next Steps	Extra
25th Round	SRE Mentor Program is on partially implemented	Ongoing	Over 90 clinicians trained; Audit tool developed; Each institution has at least one primary mentor	Memorandum with specific timelines is currently being routed for approval prior to dissemination. Policy and Procedure currently en route to JCET. Will be monitored through QI process.	Recommendation stated to only mentor "new and unlicensed staff.," MH expanded to all staff who administer SRE's and mentoring and training is ongoing and cyclical w/peer consultation.
25th Round	SPRFIT Meetings not meeting requirements	In Process/Ongoing	Requesting minutes and assigned a staff member to review.	Minutes will be reviewed on a monthly basis and QIP's will be implemented for institutions who fail to meet the minimum requirements. Will be monitored through QI process.	
25th Round	Nine institutions did not provide data on if they had an ERRC during the reporting period	In Process	Eight of the Nine institutions have provided proof of practice that they are holding ERRC's.	The last institution, CMF, is expected to provide data on Monday 1/28/2019	
25th Round	11 institutions did not provide data relative to CPR training during the reporting period	In Process	The institutions train CPR on an annual basis, the only way to get an accurate account of the staff that did not receive the training is to request the two years prior to the last day of the reporting period. It should be a very small number if any at all; at the most it would be around 10-30 staff at each institution and that number would put each institution above 90%.	Work with DAI to ensure institutions are holding trainings for CPR annually and that minimum attendance requirements are being met.	

Source	Recommendation	Status	Status Explained	Next Steps	Extra
25th Round	Only three institutions were fully compliant with the conduct of five-day clinical follow ups for inmate-patients discharged from crisis care.	Ongoing	Based on data pulled from MHTS.Net for October 2012-December, 84% of the follow ups were completed on time.	Continue to monitor data from MHTS.Net to ensure five-day clinical follows up are being provided.	All inmate-patients, not just those admitted for suicide observation, who are discharged from any crisis care receive a 5 Day Follow Up.
25th Round	"If Staggering 30-minute welfare checks in administrative segregation has been an ongoing problem that, again, remained unresolved during the twenty-fifth monitoring – only nine institutions completed these checks correctly."	In Process/Ongoing	"Staggering" has never been clearly defined. Institutions conduct periodic paper audits.	Monitor through QI process	
25th Round	"Further, compliance levels for completion of the 31-item screen for newly-arriving inmates in administrative segregation have deteriorated, with only seven institutions compliant, as compared to 70 percent during the twenty-third round monitoring period.	In Process	Data from MHTS.Net is inaccurate and does not reflect the actual work performed. Have identified the data entry issue.	Develop and disseminate joint memorandum from MH and Nursing leadership to direct field on way to enter data correctly in MHTS.Net. Nursing staff provide the screenings, therefore the memorandum needs to be a dual signature.	

Acronyms:	
MH - Mental Health	QIP - Quality Improvement Plan
QI - Quality Improvement (Specific to new process requested by Coleman Special Master)	LOS - Length of Stay
SRE - Suicide Risk Evaluations	DRC - Death Review Committee
SCR - Suicide Case Review	EMR - Electronic Medical Record

Exhibit 93

From: Jane E. Kahn <JKahn@rbgg.com>
Sent: Friday, March 01, 2013 6:55 PM
To: Coleman Team - RBG Only
Subject: FW: Updated Activation Schedules
Attachments: Activation Updates, March 1 2013.pdf.pdf

From: Debbie Vorous[SMTP:DEBBIE.VOROUS@DOJ.CA.GOV]
Sent: Friday, March 01, 2013 6:54:45 PM
To: Kerry Courtney Hughes, MD; Patricia M. Williams; Haunani Henry; Mary Perrien; Henry D. Dlugacz; Raymond F. Patterson, MD; Kathryn Burns, MD, MPH; Paul Nicoll; Matt Lopes; Linda Holden; Kristina Hector; Mohamedu Jones; Steve Raffa; kwalsh@pldw.com; Jeff Metzner
Cc: Debbie Vorous; Steve Fama; Jane E. Kahn; Michael W. Bien
Subject: Updated Activation Schedules
Auto forwarded by a Rule

Dear Special Master Lopes:

Attached are Defendants' updated activation schedules for the court-ordered projects.

Thank you,

CONFIDENTIALITY NOTICE: This communication with its contents may contain confidential and/or legally privileged information. It is solely for the use of the intended recipient(s). Unauthorized interception, review, use or disclosure is prohibited and may violate applicable laws including the Electronic Communications Privacy Act. If you are not the intended recipient, please contact the sender and destroy all copies of the communication.

Coleman Construction Activation Schedules
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Exhibit #1

Acronyms

Acronym List

Term	Definition
A/E	Architectural / Engineering
AB	Assembly Bill
ADA	Americans With Disabilities Act
ASU	Administrative Segregation Unit
CCC	Consolidated Care Center (also known as California Health Care Facility)
CCPOA	California Correctional Peace Officers Association
CCWF	Central California Women's Facility
CDCR	California Department of Corrections and Rehabilitation
CEQA	California Environmental Quality Act
CHCF	California Health Care Facility (also known as Consolidated Care Facility)
CIW	California Institution for Women
CMC	California Men's Colony
CMF	California Medical Facility
COBCP	Capital Outlay Budget Change Proposal
Compl.	Completed
Const.	Construction
COR	California State Prison, Corcoran
DGS	Department of General Services
DSH	Department of State Hospitals
DOF	Department of Finance
DPH	Department of Public Health
EOP	Enhanced Outpatient Program
FPC&M	Facility Planning, Construction & Management
ICF	Intermediate Care Facility
ISP	Ironwood State Prison
IWL	Inmate Ward Labor
JLBC	Joint Legislative Budget Committee
LAC	California State Prison, Los Angeles County
LAO	Legislative Analysts Office
LD	Liquidated Damages
MHCB	Mental Health Crisis Bed
N. O. D.	Notice of Determination
NTP	Notice To Proceed
OSHPD	Office of Statewide Health Planning and Development
PC	Penal Code
PIA	Prison Industry Authority
PMIA	Pooled Money Investment Account
PMIB	Pooled Money Investment Board
PP	Preliminary Plans
PSU	Psychiatric Services Unit
PWB	Public Works Board
Resp.	Responsible
SAC	California State Prison, Sacramento
SFM	State Fire Marshal
SM	Special Master
SMY	Small Management Yard
SVSP	Salinas Valley State Prison
TBD	To Be Determined
VSPW	Valley State Prison for Women
WD	Working Drawings

Exhibit #2

California Men's Colony
50 Mental Health Crisis Beds

50 Bed Mental Health Crisis Facility (Licensed Facility) [1]

Report Period Ending: February 25, 2013

Responsible Person:	Deborah Hysen/CDCR	Stephen Benson/DOF	
Address of Resp. Person:	9838 Old Placerville Rd., Suite B Sacramento California	915 L Street, Sacramento California 95814	
Project Architect:	Nacht and Lewis Architects		
Location:	California Mens Colony, San Luis Obispo (CMC)		
Funding Source:	AB 900 (GC 15819.40)		

Primary Tasks	Duration (Cal. Days)	Planned Start	Actual Start	Days (Ahead) Behind	Planned Complete	Actual Complete	Days (Ahead) Behind	Completion Certification to SM	Lead Person	Key Sub-Tasks	Status
Develop Scope, Cost, and Schedule for AB 900 30 Day Funding Request Package						3/13/09				Develop Preliminary Program, Conceptual Scope, Schedule, and Cost. Develop Preliminary Staffing Requirements. Prepare 30 Day Letter Funding Request. Submit to DOF for approval.	
Review Funding Request Package					3/25/09	3/25/09				DOF review of funding request package. If package complies with applicable laws, the DOF prepares transmittal letter to the Legislature for approval.	Funding request package completed on 3/25/09.
Legislative Approval of Scope, Schedule, and Cost					4/10/09	4/10/09			JLBC	DOF Review and Submission to the Legislature. Legislative Approval of Scope, Cost, and Schedule.	
PWB Recognition of Project Scope, Cost, and Schedule		4/10/09	4/10/09		4/10/09	4/10/09			S. Benson	Upon legislative approval, obtain PWB recognition of Scope, Cost, and Schedule.	
Request Loan from PMIA		4/1/09	4/1/09		4/1/09	4/1/09			D. Borg	Submit Loan Documents to request loan from the Pooled Money Investment Account. (PMIA)	
Approval of PMIA Funding		4/15/09	4/15/09		4/15/09	4/15/09		4/23/09	Director of Finance, State Controller and State Treasurer	Submit Loan application for initial design phase to Pooled Money Investment Board (PMIB) for approval. Note that PMIA loans are for the project's cash needs for the next 12 months and are renewed annually or more often, until the sale of lease revenue bonds.	Next loan renewal March 2010 and every year thereafter for the duration of the project.
Architectural/Engineering Contracting		4/15/09	4/15/09		4/15/09	4/15/09		4/23/09	J. Cummings	Select A/E firm, Negotiate Scope and Fee, Execute Contracts).	Notice to Proceed (NTP) issued 4/15/09.
Preliminary Plans	251	4/20/09	4/15/09	(5)	12/27/09	12/28/09	1		K. Beland	Clinical/Architectural Programming, Schematic Design, Design Development, Design Review, Develop Initial Group II Equipment List, Update Staffing Requirements, Update Project Cost and Schedule, Prepare JLBC 45-day notice and PWB Preliminary Plan approval Submittal Package.	Preliminary plans are complete.
California Environmental Quality Act Compliance (CEQA)	237	4/20/09	4/15/09	(5)	12/13/09	6/24/10	193		B. Sleppy	Select Consultant, Negotiate/Execute Contract, Prepare CEQA Documents, Circulate/Comment Period, File Notice of Determination (N. O. D.), Litigation Period.	Initial Study/Mitigated Negative Declaration public comment period ended 10/31/09. Delay due to responding to the large volume of public comments. NOD was filed 01/7/10. CCPOA filed litigation on 02/04/10. On 05/07/10, the case was transferred to the Eastern District Court. On 6/24/10, the parties to the CMC litigation stipulated to dismiss the action with prejudice.
JLBC Approval of Preliminary Plans	45	12/28/09	12/28/09		2/11/10	2/11/10			JLBC	JLBC Approval. PC 7000 provides the JLBC a 45-day review period before PWB can approve preliminary plans. JLBC responded prior to 45-day review.	Design schedule accelerated 45 days, based on early JLBC package submittal.
PWB Approval of Preliminary Plans	45	12/29/09	1/7/10	9	2/12/10	2/16/10	4		S. Benson	PWB Approval.	PWB meeting changed to 02/16/10. There is no impact to the overall project schedule.
Working Drawings (Construction Documents)	187	2/15/10	2/17/10	2	8/21/10	9/29/10	39		K. Beland	Complete Construction Documents, Obtain Regulatory Reviews (SFM, ADA, etc.), Finalize Group II Equipment List, Update Project Schedule and Cost, Prepare Approval of Working Drawings and Proceed to Bid Package and submit to DOF for approval. Submit loan documents to DOF and obtain PWB approval for loan for the project's cash needs for the next 12 months. Submit loan application to PMIB for approval.	WD's are complete. The Construction Manager is selected and the contract is in process. The added scope from the SFM has changed the planned complete date of WD's to 09/29/10.

Primary Tasks	Duration (Cal. Days)	Planned Start	Actual Start	Days (Ahead) Behind	Planned Complete	Actual Complete	Days (Ahead) Behind	Completion Certification to SM	Lead Person	Key Sub-Tasks	Status
Bid and Award	90	8/23/10	9/30/10	38	11/21/10	1/13/11	53		K. Beland	Advertise for Bids, Hold Pre-Bid Conference, Receive Bids, Verify Lowest Responsive Bidder, Request DOF Approval to Award, Award Contract.	The 53 days of delay was attributed to: a) SFM added scope (fire access road end modification to sally port gates; 39 days), and b) advertising, bidding & award of construction contract over the holiday period (14 days).
Construction [2]	600	11/22/10	1/14/11	53	7/14/12		226		K. Beland	Mobilize Construction Contractor, Construction Manager, Inspector of Record, Construct Project, Purchase and Install Group II Equipment, Testing of Systems (Fire alarm, Nurse Call, etc.), Punch list, SFM Temporary Certificate of Occupancy and Final Certificate of Occupancy. Submit loan documents to DOF and obtain PWB approval for loan for the project's cash needs for the next 12 months. Submit loan application to PMIB for approval.	The overall construction is approximately 94% complete. Final site grading is almost complete. All gypboard has been installed. Data cabling is complete on the 2nd floor. Epoxy flooring is complete in the housing wings. Paving of the access road around the new building is complete up to the secured perimeter. The anticipated completion date ranges from 6/3/2013 to 9/3/2013. CDCR continues to monitor the contractor's performance.
Hire Staff	543	1/10/11	9/1/11	234	7/6/12		234		M. McAloon E. Valenzuela	Advertise, Hire, and Train Staff.	Based on the construction delay range above, the revised start date is 9/1/11 and revised completion date is 5/1/13.
Prepare Final Verified Office of Statewide Health Planning and Development (OSHPD) Reports	600	11/22/10	1/14/11	53	7/14/12		226		Chris Meyer	Including final as-built drawings.	See construction completion range above.
Self Certification	15	7/16/12		224	7/31/12		209		Chris Meyer		Based on the construction delay range above, the revised earliest start date is 6/4/13 and latest completion date is 9/18/13.
License Approval	7	8/1/12		208	8/8/12		201		K. Martin E. Valenzuela	DPH Survey, DPH Approval.	Based on the construction delay range above, the earliest license start date is 5/3/13 and latest license start date is 8/5/13.
Activation	56	8/9/12		200	10/4/12		144		M. McAloon E. Valenzuela	Initial staff occupancy, staff orientation, develop policies and procedures, stock supplies/inventory, placement of Group II equipment.	Based on the construction delay range above, the earliest activation start date is 5/3/13 and the latest activation start date is 8/5/13.
Patient Admissions	56	8/9/12		200	10/4/12		144		M. McAloon E. Valenzuela	Assumes Patients will be admitted at a rate of six per week.	Based on the construction delay range above, the earliest first patient admission date is 7/5/13 and the latest first patient admission date is 10/3/13. The earliest full facility occupancy is 8/9/13 and the latest full facility occupancy is 11/9/13.

[1] Court Orders) filed 3/27/07, Docket No. #2173; filed 4/16/08, Docket No. #2757; and filed 10/20/06, Docket No. #1998

[2] Special Master shall receive updates on construction every 90 days.

Project: CMC 50 Bed Mental Health Crisis Facility (Licensed Facility)

Lead Person Roster

Name			Address		
Last	First	Agency/Dept.	Street	City	Zip
Beland	Keith	CDCR/FPC&M	9839 Old Placerville Rd.	Sacramento	95827
Benson	Stephen	DOF	915 L Street	Sacramento	95814
Borg	Dean	CDCR/FPC&M	9839 Old Placerville Rd.	Sacramento	95827
Chiang	John	State Controller	300 Capitol Mall, Suite 1850	Sacramento	95814
Cummings	Jackson	CDCR/FPC&M	9838 Old Placerville Rd.	Sacramento	95827
Hysen	Deborah	CDCR/FPC&M	9838 Old Placerville Rd.	Sacramento	95827
Lockyer	Bill	State Treasurer	915 Capitol Mall C-15	Sacramento	94209
Matosantos	Ana J.	Director, DOF	915 L Street	Sacramento	95814
McAloon	Margaret	CDCR/DCHCS	9271 Laguna Springs Dr.	Elk Grove	95758
Martin	Kenneth	HCSHQ	9838 Old Placerville Rd	Sacramento	95827
Meyer	Chris	CDCR/FPC&M	9838 Old Placerville Rd.	Sacramento	95827
Sleppy	Bob	CDCR/FPC&M	9838 Old Placerville Rd.	Sacramento	95827
Valenzuela	Elvin	CDCR/CMC	P.O. Box 8101	San Luis Obispo	93409

Exhibit #3

Salinas Valley State Prison
Treatment and Office Space Project

Project:	Treatment and Office Space Project		Report Period Ending: February 25, 2013
Responsible Person:	Deborah Hysen/CDCR	Stephen Benson /DOF	
Address of Resp. Person:	9838 Old Placerville Rd., Suite B Sacramento California	915 L Street, Sacramento California 95814	
Project Architect:	Nacht and Lewis Architects		
Location:	Salinas Valley State Prison, Soledad (SVSP)		
Funding Source:	AB 900 (GC 15819.40)		

Primary Tasks	Duration (Cal. Days)	Planned Start	Actual Start	Days (Ahead) Behind	Planned Complete	Actual Complete	Days (Ahead) Behind	Completion Certification to SM	Lead Person	Key Sub-Tasks	Status
Develop Scope, Schedule and Budget for AB 900 30 Day Funding Request Package	111	10/19/09	10/19/09		2/7/10	2/8/10	1		K. Beland	Develop Preliminary Program, Conceptual Scope, Schedule, and Cost. Develop Preliminary Staffing Requirements. Prepare 30 Day Letter Funding Request. Submit to DOF for approval.	
Review Funding Request Package	30	2/8/10	2/8/10		3/10/10	3/12/10	2		S. Benson	DOF review of funding request package. DOF prepares transmittal letter to legislature for approval.	
Legislative Approval of Scope, Schedule, and Cost And PWB Recognition of Project Scope, Schedule, and Budget	30	3/11/10	3/13/10	2	4/11/10	4/11/10			JLBC	DOF Review and Submission to the Legislature. Legislative Approval of Scope, Schedule, Budget.	
PWB Recognition of Project Scope, Cost, and Schedule	1	4/12/10	4/12/10		4/12/10	4/12/10			S. Benson	Upon legislative approval, obtain PWB recognition of Project, Scope, Cost, and Schedule.	
Request loan from PMIA	21	3/30/10	3/15/10	(15)	4/20/10	4/20/10			D. Borg	Submit Loan Documents to request loan from the Pooled Money Investment Account (PMIA).	
Approval of PMIA Funding	1	4/21/10	4/21/10		4/21/10	4/21/10			Director of Finance, State Controller and State Treasurer	Submit Loan Documents to DOF and Obtain PWB Approval for Loan. Submit Loan application for initial design phase to PMIB for Approval. Note that PMIA loans are for the project's cash needs for the next 12 months and are renewed annually or more often, until the sale of lease revenue bonds.	
Architectural/Engineering Contracting	32	4/22/10	4/22/10		5/24/10	6/24/10	31		J. Cummings	Select A/E firm, Negotiate Scope and Fee, Execute Contract(s).	
Preliminary Plans	187	5/25/10	6/25/10	31	11/28/10	11/19/10	(9)		K. Beland	Clinical/Architectural Programming, Schematic Design, Design Development, Design Review, Develop Initial Group II Equipment List, Update Staffing Requirements, Update Project Cost and Schedule, Prepare JLBC 45-day notice and PWB Preliminary Plan approval Submittal Package.	
California Environmental Quality Act Compliance (CEQA)	205	4/22/10	4/22/10		11/13/10	12/9/10	26		B. Sleppy	Select Consultant, Negotiate/Execute Contract, Prepare CEQA Documents, Circulate/Comment Period, File Notice of Determination (N. O. D.), Litigation Period.	The NOD was filed at the State Clearinghouse on 11/8/10. The 30-Day statute of limitations period expired on 12/9/10 with no public comment or litigation. There is no impact to the overall schedule.
JLBC Approval of Preliminary Plans	45	11/29/10	11/19/10	(10)	1/13/11	1/13/11			JLBC	JLBC Approval. PC 7000 provides the JLBC a 45-day review period before PWB can approve preliminary plans.	
PWB Approval of Preliminary Plans	45	11/30/10	11/19/10	(11)	1/14/11	1/14/11			S. Benson	PWB Approval.	
Working Drawings (Construction Documents)	221	1/18/11	1/18/11		8/27/11	8/11/11	(16)		K. Beland	Complete Construction Documents, Obtain Regulatory Reviews (SFM, ADA, etc.), Finalize Group II Equipment List, Update Project Schedule and Cost, Prepare Approval of Working Drawings and Proceed to Bid Package and submit to DOF for approval.	

Primary Tasks	Duration (Cal. Days)	Planned Start	Actual Start	Days (Ahead) Behind	Planned Complete	Actual Complete	Days (Ahead) Behind	Completion Certification to SM	Lead Person	Key Sub-Tasks	Status
Bid and Award	70	8/29/11	8/31/11	2	11/7/11	2/1/12	86		K. Beland	Advertise for Bids, Hold Pre-Bid Conference, Receive Bids, Verify Lowest Responsive Bidder, Request DOF Approval to Award, Award Contract.	Project was advertised on 8/31/11 and was re-advertised on 10/4/11 to avoid a potential protest due to ambiguous advertisement language. Pre-bid conference was held on 11/2/11 and bid opening was held on 11/21/11. The NTP for the construction contract was issued on 2/2/12.
Construction[2]	630	11/8/11	2/2/12	86	7/30/13				K. Beland	Mobilize Construction Contractor, Construction Manager, Inspector of Record, Construct Project, Purchase and Install Group II Equipment, Testing of Systems (Fire alarm, Nurse Call, etc.), Punch list, SFM Temporary Certificate of Occupancy and Final Certificate of Occupancy.	The overall construction is approximately 62% complete. Roofing system, exterior security glazing, fire proofing, and EFIS System are complete. Rough electrical, plumbing, HVAC, security fence and high impact board installation is in progress. A time impact analysis settlement has been reached with the contractor, extending the project completion date from 9/8/13 to 9/19/13. There is no impact to the baseline activation schedule.
Hire Staff	153	1/28/13			6/30/13				M. McAloon A. Hedgpeth	Advertise, Hire, and Train Staff.	Based on the construction delay above, hire staff will begin March 2013.
Activation	63	7/31/13			10/2/13				M. McAloon A. Hedgpeth	Initial staff occupancy, staff orientation, stock supplies/inventory, placement of Group II equipment.	Based on the construction delay above, activation activities will start 8/20/13 and the building will be fully occupied on 9/23/13.

[1] Court Order filed 1/4/10, Docket No. #3761

[2] Special Master shall receive updates on construction every 90 days.

Project: **SVSP Treatment and Office Space Project**

Lead Person Roster

Name		[redacted]	Address		
Last	**First**	**Agency/Dept.**	**Street**	**City**	**Zip**
Beland	Keith	CDCR/FPC&M	9839 Old Placerville Rd.	Sacramento	95827
Benson	Stephen	DOF	915 L Street	Sacramento	95814
Borg	Dean	CDCR/FPC&M	9839 Old Placerville Rd.	Sacramento	95827
Chiang	John	State Controller	300 Capitol Mall, Suite 18	Sacramento	95814
Cummings	Jackson	CDCR/FPC&M	9838 Old Placerville Rd.	Sacramento	95827
Hedgpeth	Anthony	CDCR/SVSP	P.O. Box 1020	Soledad	93960
Hysen	Deborah	CDCR/FPC&M	9838 Old Placerville Rd.	Sacramento	95827
Lockyer	Bill	State Treasurer	915 Capitol Mall C-15	Sacramento	94209
Matosantos	Ana J.	Director, DOF	915 L Street	Sacramento	95814
McAloon	Margaret	CDCR/DCHCS	9271 Laguna Springs Dr.	Elk Grove	95758
Sleppy	Bob	CDCR/FPC&M	9838 Old Placerville Rd.	Sacramento	95827

Exhibit #4

California State Prison, Sacramento
128 Psychiatric Services Unit beds

Project:	128 Psychiatric Services Unit (PSU) Beds		Report Period Ending: February 25, 2013
Responsible Person:	Deborah Hysen/CDCR	Stephen Benson/DOF	
Address of Resp. Person:	9838 Old Placerville Rd., Suite B Sacramento California	915 L Street, Sacramento California 95814	
Project Architect:	Cannon Design		
Location:	California State Prison, Sacramento		
Funding Source:	AB 900 (GC 15819.40)		

Primary Tasks	Duration (Cal. Days)	Planned Start	Actual Start	Days (Ahead) Behind	Planned Complete	Actual Complete	Days (Ahead) Behind	Completion Certification to SM	Lead Person	Key Sub-Tasks	Status
Develop Scope, Cost, and Schedule for AB 900 30 Day Funding Request Package	114	8/17/09	8/17/09		12/9/09	12/9/09			K. Beland	Develop Preliminary Program, Conceptual Scope, Schedule, and Cost. Develop Preliminary Staffing Requirements. Prepare 30 Day Letter Funding Request. Submit to DOF for approval.	
Review Funding Request Package	33	12/10/09	12/10/09		1/12/10	1/12/10			S. Benson	DOF review of funding request package. If package complies with applicable laws, the DOF prepares transmittal letter to the Legislature for approval.	
Legislative Approval of Scope, Schedule, and Cost	30	1/13/10	1/15/10	2	2/12/10	2/14/10	2		JLBC	DOF Review and Submission to the Legislature. Legislative Approval of Scope, Cost, and Schedule.	
PWB Recognition of Project Scope, Cost, and Schedule	1	2/16/10	2/16/10		2/16/10	2/16/10			S. Benson	Upon legislative approval, obtain PWB recognition of Project Scope, Cost, and Schedule.	
Request Loan from PMIA	20	1/27/10	1/27/10		2/16/10	2/16/10			D. Borg	Submit Loan Documents to request loan from the Pooled Money Investment Account (PMIA).	
Approval of PMIA Funding	1	2/17/10	2/17/10		2/17/10	2/17/10			Director of Finance, State Controller and State Treasurer	Submit loan application for initial design phase to Pooled Money Investment Board (PMIB) for approval. Note that PMIA loans are for the project's cash needs for the next 12 months and are renewed annually or more often, until the sale of lease revenue bonds.	
Architectural/Engineering Contracting	90	2/18/10	2/18/10		5/19/10	8/13/10	86		J. Cummings	Select A/E firm, Negotiate Scope and Fee, Execute Contract(s).	Additional A/E scope extended negotiations and contract development. Negotiations are complete and the contract was executed on 8/13/10.
Preliminary Plans	248	5/20/10	8/16/10	88	1/23/11	2/15/11	23		K. Beland	Clinical/Architectural Programming, Schematic Design, Design Development, Design Review, Develop Initial Group II Equipment List, Update Staffing Requirements, Update Project Cost and Schedule, Prepare JLBC 45-day notice and PWB Preliminary Plan approval Submittal Package.	The A/E design recovery schedule can recover 58 days in PP's. This will target the April 2011 PWB for approval of the PP's. PP's were completed 02/15/11. Mitigation of the remaining delay will be evaluated in the WD and construction phases. CDCR anticipates no impact to the overall schedule.
California Environmental Quality Act Compliance (CEQA)	270	2/18/10	2/18/10		11/15/10	12/21/10	36		B. Sleppy	Select Consultant, Negotiate/Execute Contract, Prepare CEQA Documents, Circulate/Comment Period, File Notice of Determination (N. O. D.), Litigation Period.	The NOD was filed with the State Clearing House on 11/16/10 and the litigation period expired on 12/21/10. There is no impact to the overall schedule.
JLBC Approval of Preliminary Plans	45	1/24/11	2/16/11	23	3/10/11	4/7/11	28		JLBC	JLBC Approval. PC 7000 provides the JLBC a 45-day review period before PWB can approve preliminary plans.	The JLBC submittal was released on 2/18/11.
PWB Approval of Preliminary Plans	45	1/25/11	2/17/11	23	3/11/11	4/8/11	28		S. Benson	PWB Approval.	PP's were approved by PWB on 4/8/2011.
Working Drawings (Construction Documents)	180	3/14/11	4/11/11	28	9/10/11	9/21/11	11		K. Beland	Complete Construction Documents, Obtain Regulatory Reviews (SFM, ADA, etc.), Finalize Group II Equipment List, Update Project Schedule and Cost, Prepare Approval of Working Drawings and Proceed to Bid Package and submit to DOF for approval. Submit loan documents to DOF and obtain PWB approval for loan for the project's cash needs for the next 12 months. Submit loan application to PMIB for approval.	The A/E has addressed the SFM concerns and WD are complete. There is no known impact to overall schedule.

Primary Tasks	Duration (Cal. Days)	Planned Start	Actual Start	Days (Ahead) Behind	Planned Complete	Actual Complete	Days (Ahead) Behind	Completion Certification to SM	Lead Person	Key Sub-Tasks	Status
Bid and Award	80	9/12/11			12/1/11				K. Beland	Advertise for Bids, Hold Pre-Bid Conference, Receive Bids, Verify Lowest Responsive Bidder, Request DOF Approval to Award, Award Contract.	This task is no longer necessary with the use of IWL to perform construction.
Construction [2]	480	12/2/11	11/28/11	(4)	3/26/13				K. Beland	Mobilize Construction Contractor, Construction Manager, Inspector of Record, Construct Project, Purchase and Install Group II Equipment, Testing of Systems (Fire alarm, Nurse Call, etc.), Punch list, SFM Temporary Certificate of Occupancy and Final Certificate of Occupancy. Submit loan documents to DOF and obtain PWB approval for loan for the project's cash needs for the next 12 months. Submit loan application to PMIB for approval.	The overall construction is approximately 58% complete. Interior CMU block wall, structural steel and pan decking are complete. Interior rough plumbing, electrical, HVAC, framing and roofing are in progress. The completion date of 4/25/13 has been delayed due to weather and changed site conditions. The revised completion date is 7/1/13.
Hire Staff	150	9/27/12			2/24/13				M. McAloon T. Virga	Advertise, Hire, and Train Staff.	Based on the above revised construction completion date of 7/1/13, the revised Hire Staff date will start May 2013.
Activation	60	3/27/13			5/26/13				M. McAloon T. Virga	Initial staff occupancy, staff orientation, stock supplies/inventory, placement of Group II equipment.	Based on the above revised construction completion date of 7/1/13, the revised activation start date is 7/2/13 with a phased patient activation commencing 8/1/13.

[1] Court Order filed 1/4/10, Docket No. #3761

[2] Special Master shall receive updates on construction every 90 days.

Project: **SAC 128 Psychiatric Services Unit (PSU) Beds**

Lead Person Roster

Name			Address		
Last	**First**	**Agency/Dept.**	**Street**	**City**	**Zip**
Beland	Keith	CDCR/FPC&M	9838 Old Placerville Rd.	Sacramento	95827
Benson	Stephen	DOF	915 L Street	Sacramento	95814
Borg	Dean	CDCR/FPC&M	9838 Old Placerville Rd.	Sacramento	95827
Chiang	John	State Controller	300 Capitol Mall, Suite 1850	Sacramento	95814
Cummings	Jackson	CDCR/FPC&M	9838 Old Placerville Rd.	Sacramento	95827
Hysen	Deborah	CDCR/FPC&M	9838 Old Placerville Rd.	Sacramento	95827
Lockyer	Bill	State Treasurer	915 Capitol Mall C-15	Sacramento	94209
Matosantos	Ana J.	Director, DOF	915 L Street	Sacramento	95814
McAloon	Margaret	CDCR/DCHCS	9271 Laguna Springs Dr.	Elk Grove	95758
Sleppy	Bob	CDCR/FPC&M	9838 Old Placerville Rd.	Sacramento	95827
Virga (A)	Tim	CDCR/SAC	P.O. Box 71	Represa	95671

Exhibit #5

California Medical Facility
Treatment and Office Space Project

Project: Treatment and Office Space Project
Responsible Person: Deborah Hysen/CDCR
Address of Resp. Person: 9838 Old Placerville Rd., Suite B Sacramento California
Project Architect: Nacht and Lewis Architects
Location: California Medical Facility, Vacaville (CMF)
Funding Source: AB 900 (GC 15819.40)

Stephen Benson/DOF
915 L Street, Sacramento California 95814

Report Period Ending: February 25, 2013

Primary Tasks	Duration (Cal. Days)	Planned Start	Actual Start	Days (Ahead) Behind	Planned Complete	Actual Complete	Days (Ahead) Behind	Completion Certification to SM	Lead Person	Key Sub-Tasks	Status
Develop Scope, Cost, and Schedule for AB 900 30 Day Funding Request Package						3/13/09				Develop Preliminary Program, Conceptual Scope, Schedule, and Cost. Develop Preliminary Staffing Requirements. Prepare 30 Day Letter Funding Request. Submit to DOF for approval.	
Review Funding Request Package						3/25/09			S. Benson	DOF review of funding request package. If package complies with applicable laws, the DOF prepares transmittal letter to the Legislature for approval.	
Legislative Approval of Scope, Schedule, and Cost	30	3/25/09	3/25/09		4/24/09	5/7/09	13		S. Benson	DOF Review and Submission to the Legislature. Legislative Approval of Scope, Cost, and Schedule.	LAO had concerns with building costs.
PWB Recognition of Project Scope, Cost, and Schedule		5/8/09	5/8/09		5/8/09	5/8/09			S. Benson	Upon legislative approval, obtain PWB recognition of Project Scope, Cost, and Schedule.	Reduced costs at PWB per LAO concerns.
Request Loan from PMIA						3/26/09			D. Borg	Submit Loan Documents to request loan from the Pooled Money Investment Account (PMIA).	
Approval of PMIA Funding	63	4/15/09	4/15/09		4/15/09	6/12/09	58		Director of Finance, State Controller and State Treasurer	Submit loan application for initial design phase to Pooled Money Investment Board (PMIB) for approval. Note that PMIA loans are for the project's cash needs for the next 12 months and are renewed annually or more often, until the sale of lease revenue bonds.	Loan request was made on 5/20/09 and was denied by PMIB on a 2-1 vote. Executive Order E 08/09-136 authorized General Fund loan for Preliminary Plans (PP). On 7/15/09 PMIB approved the loan for PP funding, and General Fund loan will be retired. There is no impact to design or overall schedule.
Architectural/Engineering Contracting	82	6/18/09	6/18/09		9/8/09	9/17/09	9		J. Cummings	Select A/E firm, Negotiate Scope and Fee, Execute Contract(s).	Contract executed 09/17/09. No impact to overall schedule.
Preliminary Plans	217	9/9/09	9/17/09	8	4/14/10	5/25/10	41		K. Beland	Clinical/Architectural Programming, Schematic Design, Design Development, Design Review, Develop Initial Group II Equipment List, Update Staffing Requirements, Update Project Cost and Schedule, Prepare JLBC 45-day notice and PWB Preliminary Plan approval Submittal Package.	Contract execution delayed start of PP and there is no impact to the overall schedule. PP phase is complete.
California Environmental Quality Act Compliance (CEQA)	235	9/9/09	8/5/09	(35)	5/2/10	9/21/09	(223)		B. Sleppy	Select Consultant, Negotiate/Execute Contract, Prepare CEQA Documents, Circulate/Comment Period, File Notice of Determination (N. O. D.), Litigation Period.	Comment period complete, no protests filed. Accelerated time was gained by completing a less restrictive environmental document (Notice of Exemption vs. Initial Study/ Mitigated Negative Declaration).
JLBC Approval of Preliminary Plans	45	4/26/10	5/27/10	31	6/10/10	7/9/10	29		JLBC	JLBC Approval. PC 7000 provides the JLBC a 45-day review period before PWB can approve preliminary plans	The JLBC submittal was released on 05/27/10. There is no impact to the overall schedule.
PWB Approval of Preliminary Plans	45	4/27/10	5/27/10	30	6/11/10	7/12/10	31		S. Benson	PWB Approval.	PP's were approved by PWB on 07/12/10.
Working Drawings (Construction Documents)	187	6/14/10	7/13/10	29	12/18/10	12/18/10			K. Beland	Complete Construction Documents, Obtain Regulatory Reviews (SFM, ADA, etc.), Finalize Group II Equipment List, Update Project Schedule and Cost, Prepare Approval of Working Drawings and Proceed to Bid Package and submit to DOF for approval. Submit loan documents to DOF and obtain PWB approval for loan for the project's cash needs for the next 12 months. Submit loan application to PMIB for approval.	

Primary Tasks	Duration (Cal. Days)	Planned Start	Actual Start	Days (Ahead) Behind	Planned Complete	Actual Complete	Days (Ahead) Behind	Completion Certification to SM	Lead Person	Key Sub-Tasks	Status
Bid and Award	**70**	**12/20/10**	**12/20/10**		**2/28/11**	**3/10/11**	**10**		K. Beland	Advertise for Bids, Hold Pre-Bid Conference, Receive Bids, Verify Lowest Responsive Bidder, Request DOF Approval to Award, Award Contract.	
Construction [2]	**720**	**3/1/11**	**3/11/11**	**10**	**2/18/13**				K. Beland	Mobilize Construction Contractor, Construction Manager, Inspector of Record, Construct Project, Purchase and Install Group II Equipment, Testing of Systems (Fire alarm, Nurse Call, etc.), Punch list, SFM Temporary Certificate of Occupancy and Final Certificate of Occupancy. Submit loan documents to DOF and obtain PWB approval for loan for the project's cash needs for the next 12 months. Submit loan application to PMIB for approval.	The project is approximately 99.6% complete. CDCR received the final Certificate of Occupancy on 2/8/2013. The contractor is working on a few remaining punch list items and the project team has commenced contract close-out activities.
Hire Staff	**153**	**8/19/12**			**1/19/13**				M. McAloon B. Duffy (A)	Advertise, Hire, and Train Staff.	Based on the Department's analysis of population realignment, no additional staffing will be needed.
Activation	**59**	**2/19/13**	**1/11/13**	**(39)**	**4/19/13**	**1/25/13**	**(84)**		M. McAloon B. Duffy (A)	Initial staff occupancy, staff orientation, stock supplies/inventory, placement of Group II equipment.	Based on the revised construction completion date of 1/15/13, activation activities began on 12/10/12 and concluded on 1/25/13. A phased building activation and patient treatment started the week of 1/7/13.

[1] Court Order's) filed 10/7/08, Docket No. #3072; and filed 10/18/07, Docket No. #2461

[2] Special Master shall receive updates on construction every 90 days.

Project: **CMF Treatment and Office Space Project**

Lead Person Roster

Name		[redacted]	Address		
Last	**First**	**Agency/Dept.**	**Street**	**City**	**Zip**
Beland	Keith	CDCR/FPC&M	9839 Old Placerville Rd.	Sacramento	95827
Benson	Stephen	DOF	915 L Street	Sacramento	95814
Borg	Dean	CDCR/FPC&M	9839 Old Placerville Rd.	Sacramento	95827
Chiang	John	State Controller	300 Capitol Mall, Suite 1850	Sacramento	95814
Cummings	Jackson	CDCR/FPC&M	9838 Old Placerville Rd.	Sacramento	95827
Duffy	Brian	Chief Deputy Admin, CMF	1600 California Drive	Vacaville	95696
Lockyer	Bill	State Treasurer	915 Capitol Mall C-15	Sacramento	94209
Matosantos	Ana J.	Director, DOF	915 L Street	Sacramento	95814
McAloon	Margaret	CDCR/DCHCS	9271 Laguna Springs Dr.	Elk Grove	95758
Singh	Vimal J.	Warden, CMF	1600 California Drive	Vacaville	95696
Sleppy	Bob	CDCR/FPC&M	9838 Old Placerville Rd.	Sacramento	95827

Exhibit #6

California State Prison, Los Angeles County
Treatment Space for Enhanced Outpatient Program

Project:	Enhanced Outpatient Program Treatment and Office Space [1]		**Report Period Ending: February 25, 2013**
Responsible Person:	Deborah Hysen/CDCR	Stephen Benson /DOF	
Address of Resp. Person:	9838 Old Placerville Rd., Suite B Sacramento California	915 L Street, Sacramento California 95814	
Project Architect:	Nacht and Lewis Architects		
Location:	California State Prison, Los Angeles County, Lancaster (LAC)		
Funding Source:	AB 900 (GC 15819.40)		

Primary Tasks	Duration (Cal. Days)	Planned Start	Actual Start	Days (Ahead) Behind	Planned Complete	Actual Complete	Days (Ahead) Behind	Completion Certification to SM	Lead Person	Key Sub-Tasks	Status
Develop Scope, Schedule and Cost for AB 900 30 Day Funding Request Package					4/23/09	4/23/09				Develop Preliminary Program, Conceptual Scope, Schedule, and Cost. Develop Preliminary Staffing Requirements. Prepare 30 Day Letter Funding Request. Submit to DOF for approval.	
Review Funding Request Package	46	4/24/09	4/24/09		6/9/09	6/9/09			S. Benson	DOF review of funding request package. If package complies with applicable laws, the DOF prepares transmittal letter to the Legislature for approval.	
Legislative Approval of Scope, Schedule, and Cost	30	6/10/09	6/9/09	(1)	7/9/09	7/9/09			S. Benson	DOF Review and Submission to the Legislature. Legislative Approval of Scope, Schedule, Cost.	
PWB Recognition of Project Scope, Cost, and Schedule		7/10/09	7/14/09	4	7/10/09	7/14/09	4		S. Benson	Upon legislative approval, obtain PWB recognition of Project Scope, Cost, and Schedule.	PWB meeting rescheduled to July 14. There is no impact to overall schedule.
Request Loan from PMIA	67	5/5/09	5/5/09		7/11/09	7/11/09			D. Borg	Submit Loan Documents to request loan from the Pooled Money Investment Account (PMIA).	
Approval of PMIA Funding		7/15/09	7/15/09		7/15/09	7/15/09			Director of Finance, State Controller and State Treasurer	Submit Loan application for initial design phase to Pooled Money Investment Board (PMIB) for approval. Note that PMIA loans are for the project's cash needs for the next 12 months and are renewed annually or more often, until the sale of lease revenue bonds.	
Architectural/Engineering Contracting	82	7/16/09	7/16/09		10/6/09	10/22/09	16		J. Cummings	Select A/E firm, Negotiate Scope and Fee, Execute Contract(s).	Contract executed 10/22/09. No impact to overall schedule.
Preliminary Plans	229	10/7/09	10/23/09	16	5/24/10	5/25/10	1		K. Beland	Clinical/Architectural Programming, Schematic Design, Design Development, Design Review, Develop Initial Group II Equipment List, Update Staffing Requirements, Update Project Cost and Schedule, Prepare JLBC 45-day notice and PWB Preliminary Plan approval Submittal Package.	Contract execution delayed start of PP. PP phase is complete.
California Environmental Quality Act Compliance (CEQA)	235	10/7/09	8/5/09	(63)	5/30/10	9/21/09	(251)		B. Sieppy	Select Consultant, Negotiate/Execute Contract, Prepare CEQA Documents, Circulate/Comment Period, File Notice of Determination (N. O. D.), Litigation Period.	Comment period complete, no protests filed. Accelerated time was gained by completing a less restrictive environmental document (Notice of Exemption vs. Initial Study/Mitigated Negative Declaration).
JLBC Approval of Preliminary Plans	45	5/24/10	5/26/10	2	7/8/10	7/8/10			JLBC	JLBC Approval. PC 7000 provides the JLBC a 45-day review period before PWB can approve preliminary plans.	The JLBC submittal was released on 05/26/10. There is no impact to the overall schedule.
PWB Approval of Preliminary Plans	45	5/25/10	5/26/10	1	7/9/10	7/12/10	3		S. Benson	PWB Approval.	PP were approved by PWB on 07/12/10.
Working Drawings (Construction Documents)	203	7/12/10	7/15/10	3	1/31/11	11/29/10	(63)		K. Beland	Complete Construction Documents, Obtain Regulatory Reviews (SFM, ADA, etc.), Finalize Group II Equipment List, Update Project Schedule and Cost, Prepare Approval of Working Drawings and Proceed to Bid Package and submit to DOF for approval. Submit loan documents to DOF and obtain PWB approval for loan for the project's cash needs for the next 12 months. Submit loan application to PMIB for approval.	WD's are complete and were approved by the SFM 11/29/10. The WD's and a request to use the IWL program for construction were approved by DOF on 01/25/11.

Primary Tasks	Duration (Cal. Days)	Planned Start	Actual Start	Days (Ahead) Behind	Planned Complete	Actual Complete	Days (Ahead) Behind	Completion Certification to SM	Lead Person	Key Sub-Tasks	Status
Bid and Award	80	2/1/11	N/A	N/A	4/22/11	N/A	N/A		K. Beland	Advertise for Bids, Hold Pre-Bid Conference, Receive Bids, Verify Lowest Responsive Bidder, Request DOF Approval to Award, Award Contract.	This task is no longer necessary with the use of IWL to perform construction. See WD comment.
Construction [2]	440	4/25/11	3/14/11	(42)	7/8/12	6/11/12	(27)		K. Beland IWL	Mobilize Construction Contractor, Construction Manager, Inspector of Record, Construct Project, Purchase and Install Group II Equipment, Testing of Systems (Fire alarm, Nurse Call, etc.), Punch list, SFM Temporary Certificate of Occupancy and Final Certificate of Occupancy. Submit loan documents to DOF and obtain PWB approval for loan for the project's cash needs for the next 12 months. Submit loan application to PMIB for approval.	Construction of the originally scoped project is 100% complete. However, the scope of this project is being revised from GP EOP to ASU EOP based on the Department's analysis of the impact of realignment on the mental health population. The scope change was approved by the PWB on 1/11/13 . The revised IWL date for completion of construction is 3/1/14.
Hire Staff	151	1/9/12			6/8/12				M. McAloon S. McEwen	Advertise, Hire, and Train Staff.	Based on the Department's analysis of realignment on the mental health population, no additional staff will be needed.
Activation	65	7/9/12	10/1/12	84	9/12/12		166		M. McAloon S. McEwen	Initial staff occupancy, staff orientation, stock supplies/inventory, placement of Group II equipment.	Activation will take place in two phases. Temporary activation for placing staff in the Administrative half of the building was completed on 10/1/12. Based on the above construction completion date of 3/1/14, the revised activation start date is 3/3/14 with patient activation commencing on 3/31/14.

[1] Court Order(s) filed 10/18/07, Docket No. #2461; filed 10/20/06, Docket No. #1998

[2] Special Master shall receive updates on construction every 90 days.

Project: **LAC Enhanced Outpatient Program Treatment and Office Space**

Lead Person Roster

Name			Address		
Last	**First**	**Agency/Dept.**	**Street**	**City**	**Zip**
Beland	Keith	CDCR/FPC&M	9839 Old Placerville Rd.	Sacramento	95827
Benson	Stephen	DOF	915 L Street	Sacramento	95814
Borg	Dean	CDCR/FPC&M	9839 Old Placerville Rd.	Sacramento	95827
Chiang	John	State Controller	300 Capitol Mall, Suite 1850	Sacramento	95814
Cummings	Jack	CDCR/FPC&M	9838 Old Placerville Rd.	Sacramento	95827
Lockyer	Bill	State Treasurer	915 Capitol Mall C-15	Sacramento	94209
McEwan	Scott	CDCR/LAC	44750 60th Street West	Lancaster	93536
Matosantos	Ana J.	Director, DOF	915 L Street	Sacramento	95814
McAloon	Margaret	CDCR/DCHCS	9271 Laguna Springs Dr.	Elk Grove	95758
Sleppy	Bob	CDCR/FPC&M	9838 Old Placerville Rd.	Sacramento	95827

Exhibit #7

California State Prison, Corcoran
Treatment and Office Space for Administrative Segregation - Enhanced Outpatient Program

Project:	**EOP-ASU Treatment and Office Space (for 45 bed EOP-ASU) [1]**		**Report Period Ending: February 25, 2013**
Responsible Person:	**Deborah Hysen/CDCR**	**Stephen Benson/DOF**	
Address of Resp. Person:	**9838 Old Placerville Rd., Suite B Sacramento California**	**915 L Street, Sacramento California 95814**	
Project Architect:	**HDR**		
Location:	**California State Prison, Corcoran**		
Funding Source:	**AB 900 (GC 15819.40)**		

Primary Tasks	Duration (Cal. Days)	Planned Start	Actual Start	Days (Ahead) Behind	Planned Complete	Actual Complete	Days (Ahead) Behind	Completion Certification to SM	Lead Person	Key Sub-Tasks	Status
Develop Scope, Cost, and Schedule for AB 900 30 Day Funding Request Package	**87**	**9/13/09**	**9/13/09**		**12/9/09**	**12/9/09**			K. Beland	Develop Preliminary Program, Conceptual Scope, Schedule, and Cost. Develop Preliminary Staffing Requirements. Prepare 30 Day Letter Funding Request. Submit to DOF for approval.	
Review Funding Request Package	**33**	**12/10/09**	**12/10/09**		**1/12/10**	**1/12/10**			S. Benson	DOF review of funding request package. If package complies with applicable laws, the DOF prepares transmittal letter to the Legislature for approval.	
Legislative Approval of Scope, Schedule, and Cost	**30**	**1/13/10**	**1/15/10**	**2**	**2/12/10**	**2/14/10**	**2**		JLBC	DOF Review and Submission to the Legislature. Legislative Approval of Scope, Cost, and Schedule.	
PWB Recognition of Project Scope, Cost, and Schedule	**1**	**2/16/10**	**2/16/10**		**2/16/10**	**2/16/10**			S. Benson	Upon legislative approval, obtain PWB recognition of Project Scope, Cost, and Schedule.	
Request Loan from PMIA	**20**	**1/27/10**	**1/27/10**		**2/16/10**	**2/16/10**			D. Borg	Submit Loan Documents to request loan from the Pooled Money Investment Account (PMIA).	
Approval of PMIA Funding	**1**	**2/17/10**	**2/17/10**		**2/17/10**	**2/17/10**			Director of Finance, State Controller and State Treasurer	Submit loan application for initial design phase to Pooled Money Investment Board (PMIB) for approval. Note that PMIA loans are for the project's cash needs for the next 12 months and are renewed annually or more often, until the sale of lease revenue bonds.	
Architectural/Engineering Contracting	**90**	**2/18/10**	**2/18/10**		**5/19/10**	**8/6/10**			J. Cummings	Select A/E firm, Negotiate Scope and Fee, Execute Contract(s).	Additional A/E scope extended negotiations and contract development. Negotiations are complete and the contract was executed on 8/6/10.
Preliminary Plans	**220**	**5/20/10**	**8/6/10**	**78**	**12/26/10**	**1/23/11**	**28**		K. Beland	Clinical/Architectural Programming, Schematic Design, Design Development, Design Review, Develop Initial Group II Equipment List, Update Staffing Requirements, Update Project Cost and Schedule, Prepare JLBC 45-day notice and PWB Preliminary Plan approval Submittal Package.	The A/E design recovery schedule recovered 45 days of the 79 days lost in the execution of the contract. PP's are complete. Mitigation of the remaining delay will be recovered in the WD and construction phases. CDCR anticipates no impact to the overall schedule.
California Environmental Quality Act Compliance (CEQA)	**270**	**2/18/10**	**2/18/10**		**11/15/10**	**3/29/10**	**(231)**		B. Sleppy	Select Consultant, Negotiate/Execute Contract, Prepare CEQA Documents, Circulate/Comment Period, File Notice of Determination (N. O. D.), Litigation Period.	Notice of Exemption officially filed on 02/22/10. Statute of limitations ended 3/29/10 with no comments. Accelerated time was gained by completing a less restrictive environmental document (Notice of Exemption vs. Initial Study/ Mitigated Negative Declaration).
JLBC Approval of Preliminary Plans	**45**	**12/27/10**	**1/24/11**	**28**	**2/10/11**	**3/10/11**	**28**		JLBC	JLBC Approval. PC 7000 provides the JLBC a 45-day review period before PWB can approve preliminary plans	
PWB Approval of Preliminary Plans	**45**	**12/28/10**	**1/25/11**	**28**	**2/11/11**	**3/11/11**	**28**		S. Benson	PWB Approval.	

Primary Tasks	Duration (Cal. Days)	Planned Start	Actual Start	Days (Ahead) Behind	Planned Complete	Actual Complete	Days (Ahead) Behind	Completion Certification to SM	Lead Person	Key Sub-Tasks	Status
Working Drawings (Construction Documents)	203	2/14/11	3/14/11	28	9/5/11	9/9/11	4		K. Beland	Complete Construction Documents, Obtain Regulatory Reviews (SFM, ADA, etc.), Finalize Group II Equipment List, Update Project Schedule and Cost, Prepare Approval of Working Drawings and Proceed to Bid Package and submit to DOF for approval. Submit loan documents to DOF and obtain PWB approval for loan for the project's cash needs for the next 12 months. Submit loan application to PMIB for approval.	WD's are complete. PWB approved project cost & use of IWL for construction on 9/9/11. PMIB approved construction loan on 9/21/11.
Bid and Award	73	9/6/11			11/18/11				K. Beland	Advertise for Bids, Hold Pre-Bid Conference, Receive Bids, Verify Lowest Responsive Bidder, Request DOF Approval to Award, Award Contract.	This task is no longer necessary with the use of IWL to perform construction.
Construction [2]	450	11/21/11	11/8/11	(13)	2/13/13		12		K. Beland	Mobilize Construction Contractor, Construction Manager, Inspector of Record, Construct Project, Purchase and Install Group II Equipment, Testing of Systems (Fire alarm, Nurse Call, etc.), Punch list, SFM Temporary Certificate of Occupancy and Final Certificate of Occupancy. Submit loan documents to DOF and obtain PWB approval for loan for the project's cash needs for the next 12 months. Submit loan application to PMIB for approval.	The overall construction is approximately 75% complete. Roofing and rooftop units are set in place. Second floor rough-in for plumbing, electrical and HVAC is in progress. CDCR is pursuing resolution of a potential protest on the procurement of the Fire Alarm system. The construction completion date of 2/13/13 has been delayed due to inmate worker availability resulting from a prison riot and subsequent lockdown of the institution. The revised completion date is 5/1/13.
Hire Staff	150	8/17/12			1/14/13				M. McAloon C. Gipson	Advertise, Hire, and Train Staff.	Based on the Department's analysis of realignment on the mental health population, no additional staff will be needed.
Activation	60	2/14/13		11	4/15/13				M. McAloon C. Gipson	Initial staff occupancy, staff orientation, stock supplies/inventory, placement of Group II equipment.	Based on the revised construction completion date of 5/1/13, the activation start date will begin 5/2/13 with patient activation commencing 6/3/13.

[1] Court Order filed 1/4/10, Docket No. #3781

[2] Special Master shall receive updates on construction every 90 days.

Project: **COR ASU/EOP Treatment and Office Space**

Lead Person Roster

Name			Address		
Last	**First**	**Agency/Dept.**	**Street**	**City**	**Zip**
Beland	Keith	CDCR/FPC&M	9839 Old Placerville Rd.	Sacramento	95827
Benson	Stephen	DOF	915 L Street	Sacramento	95814
Borg	Dean	CDCR/FPC&M	9839 Old Placerville Rd.	Sacramento	95827
Chiang	John	State Controller	300 Capitol Mall, Suite 1850	Sacramento	95814
Cummings	Jackson	CDCR/FPC&M	9838 Old Placerville Rd.	Sacramento	95827
Gipson	Connie	Warden (A), CSP COR	4001 King Street	Corcoran	93212
Hysen	Deborah	CDCR/FPC&M	9838 Old Placerville Rd.	Sacramento	95827
Lockyer	Bill	State Treasurer	915 Capitol Mall C-15	Sacramento	94209
Matosantos	Ana J.	Director, DOF	915 L Street	Sacramento	95814
McAloon	Margaret	CDCR/DCHCS	9271 Laguna Springs Dr.	Elk Grove	95758
Sleppy	Bob	CDCR/FPC&M	9838 Old Placerville Rd.	Sacramento	95827

Exhibit #8

Consolidated Care Center /
California Health Care Facility

Project: California Health Care Facility (CHCF) / Consolidated Care Facility (CCC) [1,2]
Responsible Person: Chris Meyer/CDCR
Address of Resp. Person: 9838 Old Placerville Rd., Suite B Sacramento California
Project Architect: Kitchell CEM (Criteria Architect)
Location: Stockton, CA
Funding Source: AB 900 (GC 15819.40)

Stephen Benson/DOF
915 L Street, Sacramento California 95814

Report Date: February 25, 2013

Primary Tasks	Duration (Cal. Days)	Planned Start	Actual Start	Days (Ahead) Behind	Planned Complete	Actual Complete	Days (Ahead) Behind	Completion Certification to SM	Lead Person	Key Sub-Tasks	Status
Develop Scope, Cost, and Schedule for AB 900 30 Day Funding Request Package	33	11/6/09	11/6/09		12/9/09	12/9/09			M. Meredith/ CPR	Develop Preliminary Program, Conceptual Scope, Schedule, and Cost. Develop Preliminary Staffing Requirements. Prepare 30 Day Letter Funding Request. Submit to DOF for approval.	
DOF Review and Approval of Design Build approach					12/7/09	12/7/09			S. Benson	Pursuant to Government Code Section 14661.1.I	
Review Funding Request Package	32	12/10/09	12/10/09		1/11/10	1/14/10	3		S. Benson	DOF review of funding request package. If package complies with applicable laws, the DOF prepares transmittel letter to the Legislature for approval.	
Legislative Approval of Scope, Schedule, and Cost	30	1/12/10	1/15/10	3	2/11/10	6/11/10	120		JLBC	DOF Review and Submission to the Legislature. Legislative Approval of Scope, Cost, and Schedule.	AB 552 was signed into law and the project was placed on the June PWB agenda.
PWB Recognition of Project Scope, Cost, and Schedule	1	2/16/10	6/14/10	118	2/16/10	6/14/10	118		S. Benson	Upon legislative approval, obtain PWB recognition of Project Scope, Cost, and Schedule.	
Request Loan from PMIA	20	1/27/10	1/13/10	(14)	2/16/10	6/15/10	119		D. Borg	Submit Loan Documents to request loan from the Pooled Money Investment Account (PMIA).	
Approval of PMIA Funding	1	2/17/10	6/16/10	119	2/17/10	6/16/10	119		Director of Finance, State Controller and State Treasurer	Submit loan application for initial design phase to Pooled Money Investment Board (PMIB) for approval. Note that PMIA loans are for the project's cash needs for the next 12 months and are renewed annually or more often, until the sale of lease revenue bonds.	
California Environmental Quality Act Compliance (CEQA)	31	10/20/09	10/19/09	(1)	11/20/09	6/29/10	221		B. Sleppy	Select Consultant, Negotiate/Execute Contract, Prepare CEQA Documents, Circulate/Comment Period, File Notice of Determination (N. O. D.), Litigation Period.	NOD filed 10/19/09; litigation period ended 11/18/09. Protest filed 11/17/09. Case was removed to Federal court 11/25/09. The litigation has been dismissed by an order adopted by Judge Lawrence Karlton on 06/29/10. There is no remaining CEQA litigation pending against this project.
Select Bridging Architect	18	2/18/10	6/17/10	119	3/8/10	8/2/10	147		M. Meredith	Select A/E firm, Negotiate Scope and Fee, Execute Contract(s). Assumes CM/Bridging Architect selected from pre-approved list.	FPCM in-house A/E design for IWL work for the IWL site prep work. DLR is A/E for the abatement/demolition design. Kitchell CEM is selected as the Bridging/Criteria Architect. The combination of phasing of multiple bid packages, acceleration of design and activation will mitigate the delay to the overall schedule.
Prepare Bridging Document	136	2/16/10	6/17/10	121	7/2/10	2/7/11	220		M. Meredith	Includes development of basis of design, pre-qualification of Design-Build entities, preparation of Bridging Documents including performance criteria.	PP's for abatement/demolition were approved at the 12/13/10 PWB. WD's are complete and were released for bid on 01/11/11. The Design-Build package # 1 RFP is complete. Design-Build package #2 is complete and the RFP was issued on 02/07/11. The combination of phasing of multiple bid packages, acceleration of design and activation will mitigate the delay to the overall schedule.
PWB Approval	45	7/2/10	12/13/10	164	8/16/10	1/14/11	151		S. Benson	PWB Approval of performance criteria	The Design-Build criteria was approved at the 01/14/11 PWB.

Primary Tasks	Duration (Cal. Days)	Planned Start	Actual Start	Days (Ahead) Behind	Planned Complete	Actual Complete	Days (Ahead) Behind	Completion Certification to SM	Lead Person	Key Sub-Tasks	Status
Design-Build Competition/Contractor Selection	90	8/16/10	9/27/10	42	11/14/10	8/1/11	260		M . Meredith	Selection of Design-Build entities. Firms submit Design-Build proposals. CDCR evaluates and selects contractor.	The Granite Hensel Phelps Joint Venture for DB#1 was issued an NTP on 6/30/11. Clark/McCarthy Joint Venture was awarded DB#2 and started work 8/2/11.
Award Design Build Contract	28	11/14/10	8/2/11	261	12/12/10	8/2/11	233		J. Cummings	Issue Notice to Proceed, Execute contract.	See comment on Design-Build Competition/Contractor Selection.
Design Build Duration [3,4]	816	12/12/10	4/4/11	113	3/7/13				M. Meredith	Mobilize Design-Build Entity, Construction Manager, Inspector of Record. Finalize programming and complete drawings; Construct Project, Purchase and install Group II Equipment, Testing of Systems (Fire Alarm, Nurse Call, etc.) Punch list, SFM Temporary Certificate of Occupancy and Final Certificate of Occupancy. This includes construction of the Design-Bid-Build portion of the project.	DB #1 started on 6/30/11, the contract completion date is 8/21/13. Overall construction is approximately 90% complete. Meteriel Service Center doors, hardware and finishes are complete. Central plant is operating for the support of DB2's activities. Fencing activities are ongoing. Armory punch list is underway. DB #2 started on 8/2/11, the contract completion date is 8/27/13. Overall construction is approximately 89% complete. Paving of roads continue. Concrete masonry continues at RN stations, and exterior wall activities, including windows, are ongoing. Punch list activities began in first housing building. The project team is continuing to evaluate opportunities to improve the overall schedule for a July 22, 2013 first patient/inmate.
Activation Planning/Workforce Development/Hire Staff/Procurement	1041	2/17/10	6/15/10	118	12/24/12		63		M. McAloon K. Baker	Schedule development, policy and procedures, workforce planning, advertise, hire and train staff, group II/III equipment planning and equipment certification, long lead items acquisition, contracts/vendors, labor relations, training. This will impact DSH/CDCR/Receivers office and has to be coordinated between the three departments. DSH does not have the lead on this but will provide technical assistance and comply with the agreed upon dates.	Activities are currently underway. Procurement and staff hires will be on a phased occupancy basis through October 2013 for the entire project.
Preparation of Final Verified Office of Statewide Health Planning and Development (OSHPD) Reports	816	12/13/10	4/4/11	112	3/8/13				M. Meredith	Including final as-built drawings.	See comment on Design-Build Competition/Contractor Selection. Actual start date now added to schedule.
Self Certification	7	3/8/13			3/15/13				C. Meyer		
Licensing Application & Approval	60	1/11/13	45		3/12/13				K. Martin K. Baker	DPH initial licensing survey. Will license entire facility, suspend, then activate beds tied to a staff activation schedule.	Licensing surveys will be phased based on completion-turnover of the buildings and patient intake. Projected dates for this activity to start is May 2013 and will conclude in March 2014. Licensing of mental health buildings will be coordinated to commence mental health patient admissions by 7/22/13.
Activation	60	1/11/13	45		3/12/13				M. McAloon K. Baker	Transitional training, initial staff occupancy, staff orientation, building acceptance/shakedown, furniture/fixture installation, stock supplies/inventory, placement of Group II equipment.	Activation will be on a phased occupancy basis as building construction completes, subject to SFM approval. Projected dates for this activity are 5/22/13 to 7/19/13.

Primary Tasks	Duration (Cal. Days)	Planned Start	Actual Start	Days (Ahead) Behind	Planned Complete	Actual Complete	Days (Ahead) Behind	Completion Certification ID SN	Lead Person	Key Sub-Tasks	Status
Patient Admissions	270	3/12/13			12/8/13				M. McAdoo K. Baker	This will impact DSH/CDCR/OSP HCS office and has to be coordinated between the three departments. DSH does not have the lead on this but will provide technical application. DSH expects to admit 5 inmate-patients per week for each licensed unit that is completely staffed due to clinical and safety reasons.	CDCR completed a focused analysis to determine whether start up delays that were encountered at the onset of the project will impact patient admission dates. As a result, the revised patient admissions start date will change from 3/13/13 to 7/22/13. The targeted date for completion of mental health patient admissions is 12/31/13. DSH Note: DSH will make every effort to comply with the proposed timelines, but success is dependent on recruitment and staffing.

[1] This facility is intended to include 137 MHCB, 40 ACUTE, 412 ICF-H, and 1,110 non-mental health beds.

[2] Court Order filed 1/4/10. Docket No. #3781

[3] Special Master shall receive updates on construction every 90 days.

[4] Design-Bid-Build construction contract for abatement & demolition is enclosed

Project: **California Health Care Facility (CHCF) / Consolidated Care Facility (CCC)**

Lead Person Roster

Name			Address		
Last	**First**	**Agency/Dept.**	**Street**	**City**	**Zip**
Baker	Karen	CPHCS-Receiver's Representative	9838 Old Placerville Rd.	Sacramento	95827
Benson	Stephen	DOF	915 L Street	Sacramento	95814
Borg	Dean	CDCR/FPC&M	9839 Old Placerville Rd.	Sacramento	95827
Chiang	John	State Controller	300 Capitol Mall, Suite 1850	Sacramento	95814
Cummings	Jackson	CDCR/FPC&M	9838 Old Placerville Rd.	Sacramento	95827
Lockyer	Bill	State Treasurer	915 Capitol Mall C-15	Sacramento	94209
Martin	Kenneth	CDCR	9838 Old Placerville Rd.	Sacramento	95827
Matosantos	Ana J.	Director, DOF	915 L Street	Sacramento	95814
Meredith	Michael	CDCR/FPC&M	9838 Old Placerville Rd.	Sacramento	95827
Meyer	Chris	CDCR/FPC&M	9838 Old Placerville Rd.	Sacramento	95827
McAloon	Margaret	CDCR/DCHCS	9271 Laguna Springs Dr.	Elk Grove	95758
Sleppy	Bob	CDCR/FPC&M	9838 Old Placerville Rd.	Sacramento	95827
TBD		Warden			

Exhibit #9

Central California Women's Facility
Treatment and Office Space for
Enhanced Outpatient Program- General Population

Project: EOP-GP Treatment and Office Space
Responsible Person: Deborah Hysen/CDCR
Address of Resp. Person: 9838 Old Placerville Rd., Suite B Sacramento California
Project Architect: TBD
Location: Central California Women's Facility
Funding Source: AB 900 (GC 15819.40)

Stephen Benson/DOF
915 L Street, Sacramento California 95814

Report Period Ending: February 25, 2013

Primary Tasks	Duration (Cal. Days)	Planned Start	Actual Start	Days (Ahead) Behind	Planned Complete	Actual Complete	Days (Ahead) Behind	Completion Certification to SM	Lead Person	Key Sub-Tasks	Status
Develop Scope, Cost, and Schedule for AB 900 30 Day Funding Request Package	143	3/15/10	3/15/10		8/5/10	8/2/10	(3)		K. Beland	Develop Preliminary Program, Conceptual Scope, Schedule, and Cost. Develop Preliminary Staffing Requirements. Prepare 30 Day Letter Funding Request. Submit to DOF for approval.	
Review Funding Request Package	32	8/6/10	8/3/10	(3)	9/7/10	10/15/10	38		S. Benson	DOF review of funding request package. If package complies with applicable laws, the DOF prepares transmittal letter to the Legislature for approval.	DOF released the 30-Day notification to JLBC on 10/15/10.
Legislative Approval of Scope, Schedule, and Cost	30	9/8/10	10/18/10	40	10/8/10	11/12/10	35		JLBC	DOF Review and Submission to the Legislature. Legislative Approval of Scope, Cost, and Schedule.	
PWB Recognition of Project Scope, Cost, and Schedule	1	10/11/10	11/15/10	35	10/11/10	11/15/10	35		S. Benson	Upon legislative approval, obtain PWB recognition of Project Scope, Cost, and Schedule.	PWB approved scope, schedule end cost on 11/15/10. Impact to overell schedule is under review.
Request Loan from PMIA	20	9/29/10	10/13/10	14	10/19/10	10/13/10	(6)		D. Borg	Submit Loan Documents to request loan from the Pooled Money Investment Account (PMIA).	Funding was approved at the 12/15/10 PMIA meeting.
Approval of PMIA Funding	1	10/20/10	10/14/10	(6)	10/20/10	12/15/10	56		Director of Finance, State Controller and State Treasurer	Submit loan application for initial design phase to Pooled Money Investment Board (PMIB) for approval. Note that PMIA loans are for the project's cash needs for the next 12 months and are renewed annually or more often, until the sale of lease revenue bonds.	
Architectural/Engineering Contracting	90	10/21/10	12/18/10	56	1/19/11	3/29/11	69		J. Cummings	Select A/E firm, Negotiate Scope and Fee, Execute Contract(s).	A/E NTP was issued on 3/29/11. Project schedule recovered by restructuring A/E activities in PP & WD phases. There is no impact to overall schedule.
Preliminary Plans	218	1/20/11	3/30/11	69	6/26/11	9/22/11	27		K .Beland	Clinical/Architectural Programming, Schematic Design, Design Development, Design Review, Develop Initial Group II Equipment List, Update Staffing Requirements, Update Project Cost and Schedula, Prepare JLBC 45-day notice and PWB Preliminary Plan approval Submittal Package.	Pre-design activities commenced on 3/30/11. PP's are 100% complete. The revised PP completion date is 9/22/11. See JLBC approval of PP's below.
California Environmental Quality Act Compliance (CEQA)	270	10/21/10	11/15/10	25	7/18/11	11/23/10	(237)		B. Sleppy	Select Consultant, Negotiate/Execute Contract, Prepare CEQA Documents, Circulate/Comment Period, File Notice of Determination (N. O. D.), Litigation Period.	The Notice of Exemption was filed and the litigation period expired on 11/23/10. Accelerated time was gained by completing a less restrictive environmental document (Notice of Exemption vs. Initial Study/ Mitigated Negative Declaration). The method and required time were not reported in the 11/22/10 action plan and the appropriate "days bahind" calculation is included in this report.
JLBC Approval of Preliminary Plans	45	6/29/11		546	10/13/11		501		JLBC	JLBC Approval. PC 7000 provides the JLBC a 45-day review period before PWB can approve preliminary plans.	The scope of this project has been revised based on the Department's analysis of the impact of realignment on the female mental health population. The scope change was approved by PWB on 9/11/12 and preliminary plan submittal is targeted for release to JBLC on 2/28/13.

Primary Tasks	Duration (Cal. Days)	Planned Start	Actual Start	Days (Ahead) Behind	Planned Complete	Actual Complete	Days (Ahead) Behind	Completion Certification to SM	Lead Person	Key Sub-Tasks	Status
PWB Approval of Preliminary Plans	45	8/30/11		545	10/14/11		500		S. Benson	PWB Approval.	The revised PP documents are complete and PWB approval is targeted for 4/15/13. There is no impact to the 9/26/13 completion of working drawings.
Working Drawings (Construction Documents)	203	10/17/11		497	5/7/12		294		K. Beland	Complete Construction Documents, Obtain Regulatory Reviews (SFM, ADA, etc.), Finalize Group II Equipment List, Update Project Schedule and Cost, Prepare Approval of Working Drawings and Proceed to Bid Package and submit to DOF for approval. Submit loan documents to DOF and obtain PWB approval for loan for the project's cash needs for the next 12 months. Submit loan application to PMIB for approval.	Based on 9/11/12 PWB scope change approval, the revised completion date for WD is 9/26/13.
Bid and Award	90	5/8/12		293	8/6/12		203		K. Beland	Advertise for Bids, Hold Pre-Bid Conference, Receive Bids, Verify Lowest Responsive Bidder, Request DOF Approval to Award, Award Contract.	
Construction [1]	450	8/7/12		202	10/31/13				K. Beland	Mobilize Construction Contractor, Construction Manager, Inspector of Record, Construct Project, Purchase and Install Group II Equipment, Testing of Systems (Fire alarm, Nurse Call, etc.), Punch list, SFM Temporary Certificate of Occupancy and Final Certificate of Occupancy. Submit loan documents to DOF and obtain PWB approval for loan for the project's cash needs for the next 12 months. Submit loan application to PMIB for approval.	Based on the 9/11/12 PWB scope change approval and subsequent to completion of WD, CDCR will provide a revised construction schedule once a project delivery method is selected.
Hire Staff	151	5/3/13			10/1/13				M. McAloon D. K. Johnson	Advertise, Hire, and Train Staff.	
Activation	60	11/1/13			12/31/13				M. McAloon D. K. Johnson	Initial staff occupancy, staff orientation, stock supplies/inventory, placement of Group II equipment.	

[1] Special Master shall receive updates on construction every 90 days.

Project: **EOP-GP Treatment and Office Space**

Lead Person Roster

Name			Address		
Last	First	Agency/Dept.	Street	City	Zip
Beland	Keith	CDCR/FPC&M	9839 Old Placerville Rd.	Sacramento	95827
Benson	Stephen	DOF	915 L Street	Sacramento	95814
Borg	Dean	CDCR/FPC&M	9839 Old Placerville Rd.	Sacramento	95827
Chiang	John	State Controller	300 Capitol Mall, Suite 1850	Sacramento	95814
Cummings	Jackson	CDCR/FPC&M	9838 Old Placerville Rd.	Sacramento	95827
Hysen	Deborah	CDCR/FPC&M	9838 Old Placerville Rd.	Sacramento	95827
Johnson	Deborah K.	Warden, CCWF	23370 Rd 22	Chowchilla, CA	93610
Lockyer	Bill	State Treasurer	915 Capitol Mall C-15	Sacramento	94209
Matosantos	Ana J.	Director, DOF	915 L Street	Sacramento	95814
McAloon	Margaret	CDCR/DCHCS	9271 Laguna Springs Dr.	Elk Grove	95758
Sleppy	Bob	CDCR/FPC&M	9838 Old Placerville Rd.	Sacramento	95827

Exhibit #10

Dewitt Nelson
375 Enhanced Outpatient Program –
General Population and
50 Enhanced Outpatient Program-
Administrative Segregation Unit beds

Project: DeWitt Nelson Correctional Annex
Responsible Person: Chris Meyer/CDCR
Address of Resp. Person: 9838 Old Placerville Rd., Suite B Sacramento California
Project Architect: Kitchell CEM (Criteria Architect)
Location: DeWitt Nelson, Stockton
Funding Source: AB 900 (GC 15819.40)

Report Date: February 25, 2013

Stephen Benson/DOF
915 L Street, Sacramento California 95814

Primary Tasks	Duration (Cal. Days)	Planned Start	Actual Start	Days (Ahead) Behind	Planned Complete	Actual Complete	Days (Ahead) Behind	Completion Certification to SM	Lead Person	Key Sub-Tasks	Status
Develop Scope, Cost, and Schedule for AB 900 30 Day Funding Request Package	153	11/6/09	11/6/09		4/8/10	4/8/10			M. Meredith	Develop Preliminary Program, Conceptual Scope, Schedule, and Cost. Develop Preliminary Staffing Requirements. Prepare 30 Day Letter Funding Request. Submit to DOF for approval.	
DOF Review and Approval of Design Build Approach						10/22/10			S. Benson	Pursuant to Government Code Section 14661.1.i	CDCR received approval for use of Design-Build from DOF on 10/22/10.
Review Funding Request Package	32	4/9/10	4/12/10	3	5/11/10	5/13/10			S. Benson	DOF review of funding request package. If package complies with applicable laws, the DOF prepares transmittal letter to the Legislature for approval.	
Legislative Approval of Scope, Schedule, and Cost	30	5/12/10	5/14/10	2	6/11/10	6/11/10			JLBC	DOF Review and Submission to the Legislature. Legislative Approval of Scope, Cost, and Schedule.	
PWB Recognition of Project Scope, Cost, and Schedule	1	6/14/10	6/14/10		6/14/10	6/14/10			S. Benson	Upon legislative approval, obtain PWB recognition of Project Scope, Cost, and Schedule.	
Request Loan from PMIA	21	5/25/10	5/11/10	(14)	6/15/10	6/15/10			D. Borg	Submit Loan Documents to request loan from the Pooled Money Investment Account (PMIA).	
Approval of PMIA Funding	1	6/16/10	6/16/10		6/16/10	6/16/10			Director of Finance, State Controller and State Treasurer	Submit loan application for initial design phase to Pooled Money Investment Board (PMIB) for approval. Note that PMIA loans are for the project's cash needs for the next 12 months and are renewed annually or more often, until the sale of lease revenue bonds.	
California Environmental Quality Act Compliance (CEQA)	265	6/17/10	6/17/10		3/9/11	1/28/11	(40)		B. Sleppy	Select Consultant, Negotiate/Execute Contract, Prepare CEQA Documents, Circulate/Comment Period, File Notice of Determination (N. O. D.), Litigation Period.	The NOD was filed 12/29/10. The 30-Day statute of limitations period expired on 01/29/11 with no public comment or litigation. The final EIR was approved on 12/30/10.
Select Bridging Architect	18	2/16/10	6/17/10	119	3/8/10	8/2/10	147		M. Meredith	Select A/E firm, Negotiate Scope and Fee, Execute Contract(s). Assumes CM/Bridging Architect selected from pre-approved list.	Kitchell CEM was selected as the Criteria Architect.
Prepare Bridging Document	249	6/17/10	8/3/10	47	2/21/11	8/11/11	171		M. Meredith	Includes development of basis of design, pre-qualification of Design-Build entities, preparation of Bridging Documents including performance criteria.	Bridging Documents are 100% complete.
PWB Approval	45	2/22/11	6/30/11	128	4/8/11	8/12/11	126		S. Benson	PWB Approval of performance criteria.	PWB issued a conditional approval for the RFP design criteria at August 2011 PWB, consistent with concerns raised by the JLBC. As a condition of approval, CDCR needs to demonstrate the need for mental health and medical beds at Dewitt before a DB construction contract is awarded.
Design-Build Competition/Contractor Selection	120	4/11/11	8/13/11	124	8/9/11	12/14/11	127		M. Meredith	Selection of Design-Build entities. Firms submit Design-Build proposals. CDCR evaluates and selects contractor.	The selection process was completed on 12/14/11 with Hensel Phelps Construction Company being announced as the selected firm.

Primary Tasks	Duration (Cal. Days)	Planned Start	Actual Start	Days (Ahead) Behind	Planned Complete	Actual Complete	Days (Ahead) Behind	Completion Certification to SM	Lead Person	Key Sub-Tasks	Status
Award Design Build Contract	11	8/10/11	6/16/12	280	8/21/11	7/3/12	317		J. Cummings	Issue Notice to Proceed, Execute contract.	CDCR has evaluated the impacts of realignment on its prison pppulation and has determined that this project is still necessary. On April 23, 2012, CDCR finalized and distributed an operational plan that reflects the construction of this project. PMIB approved construction loan on 5/16/12. The construction contract and the NTP was issued to Hensel Phelps Construction Co. on 7/3/12.
Design Build Duration [3]	560	8/22/11	7/3/12	316	3/4/13				M. Meredith	Mobilize Design-Build Entity, Construction Manager, Inspector of Record. Finalize programming and complete drawings; Construct Project, Purchase and Install Group II Equipment, Testing of Systems (Fire Alarm, Nurse Call, etc.) Punch list, SFM Temporary Certificate of Occupancy and Final Certificate of Occupancy.	Based on a 7/3/12 NTP the revised construction completion data is 2/10/14. Miscellaneous demo within existing buildings continue. Site utility activities are ongoing. Installation of the stairs, metal decking and roof structures at guard towers are ongoing. Foundation activities for new EOP buildings continues. The overall percentage complete for design is 99% and construction is 22%.
Activation Planning/Workforce Development/Hire Staff/Procurement	540	10/4/11		510	3/27/13				M. McAloon K. Baker	Schedule development, policy and procedures, workforce planning, advertise, hire and train staff, group II/III equipment planning and equipment certification, long lead items acquisition, contracts/vendors, labor relations, training. This will impact DSH/CDCR/Receivers office and has to be coordinated between the three departments. DSH does not have the lead on this but will provide technical assistence and comply with the agreed upon dates.	Based on 7/3/12 NTP, the revised planned start date for pre-activation (i.e., advertising, interviewing, etc.) staff hiring is March 2013 and November 2013 for activation staff.
Preparation of Final Verified Office of Statewide Health Planning and Development (OSHPD) Reports	560	8/22/11	7/3/12	316	3/4/13				M. Meredith	Including final as-built drawings.	Note: This activity is not applicable. Project is not a licensed facility.
Self Certification	7	3/5/13			3/12/13				C. Meyer		
Licensing Application & Approval	45	3/13/13			4/27/13					DPH initial licensing survey. Will license entire facility, suspend, then activate beds tied to a staff activation schedule.	Note: This activity is not applicable. Project is not a licensed facility.
Activation	32	3/28/13			4/29/13				M. McAloon K. Baker	Transitional training, initial staff occupancy, staff orientation, building acceptance/shakedown, furniture/fixture installation, stock supplies/inventory, placement of Group II equipment.	Based on 2/10/14 construction completion, the revised activation start date is 1/10/14.
Patient Admissions	112	4/28/13			8/18/13				M. McAloon K. Baker		Based on 2/10/14 construction completion, the revised start date for inmate-patient treatment is 2/17/14 and the facility will be fully occupied by 5/31/14.

[1] This facility is intended to include 375 EOP, 50 EOP/ASU, and 708 non-mental health beds.

2 Special master shall receiver updates on construction every 90 days.

[3] Activation is contingent upon full activation of the California Health Care Facility construction project, which has a planned complete date of 12/31/2013.

Project: **DeWitt Nelson Conversion**

Lead Person Roster

Name			Address		
Last	First	Agency/Dept.	Street	City	Zip
Baker	Karen	CPHCS-Receiver's Representative	9838 Old Placerville Rd.	Sacramento	95827
Benson	Stephen	DOF	915 L Street	Sacramento	95814
Borg	Dean	CDCR/FPC&M	9839 Old Placerville Rd.	Sacramento	95827
Chiang	John	State Controller	300 Capitol Mall, Suite 1850	Sacramento	95814
Cummings	Jackson	CDCR/FPC&M	9838 Old Placerville Rd.	Sacramento	95827
Lockyer	Bill	State Treasurer	915 Capitol Mall C-15	Sacramento	94209
Matosantos	Ana J.	Director, DOF	915 L Street	Sacramento	95814
Meredith	Michael	CDCR/FPC&M	9838 Old Placerville Rd.	Sacramento	95827
Meyer	Chris	CDCR/FPC&M	9838 Old Placerville Rd.	Sacramento	95827
McAloon	Margaret	CDCR/DCHCS	9271 Laguna Springs Dr.	Elk Grove	95758
Sleppy	Bob	CDCR/FPC&M	9838 Old Placerville Rd.	Sacramento	95827
TBD		Warden			

Exhibit 94

STATE OF CALIFORNIA CAPITAL OUTLAY BUDGET CHANGE PROPOSAL (COBCP) COVER PAGE (REV 01/08)	DEPARTMENT OF FINANCE 915 L Street Sacramento, CA 95814 IMS Mail Code: A15

BUDGET YEAR 2012-13

ORG CODE: 5225 COBCP NO. ____ PRIORITY: _____ PROJECT ID: 51.01.039

DEPARTMENT: California Department of Corrections and Rehabilitation

PROJECT TITLE: Statewide Medication Distribution Improvements

TOTAL REQUEST (DOLLARS IN THOUSANDS): $ 25,303 MAJOR/MINOR: MA

PHASE(S) TO BE FUNDED: PWC PROJ CAT: PDC-HC CCCI/EPI: _____

SUMMARY OF PROPOSAL:

Existing medication distribution facilities do not allow for safe, efficient and effective distribution of medications and do not allow for compliance with federal and state infection control standards. Physical plant modifications are necessary to allow California Department of Corrections and Rehabilitation (CDCR) to provide the appropriately sized space with the proper infrastructure for secure distribution, infection control, environmentally controlled and secure medication storage. Construction of these improvements will increase staff productivity and safety and ensure the right inmate-patient receives the correct medication, the correct dosage, at the correct intervals.

This request proposes funding for design and construction of improvements to CDCR medication distribution facilities at 22 existing state prisons. The total estimated cost of this project is $25,303,000.

HAS A BUDGET PACKAGE BEEN COMPLETED FOR THIS PROJECT? (E/U/N/?): N

REQUIRES LEGISLATION (Y/N): N IF YES, LIST CODE SECTIONS: _____

REQUIRES PROVISIONAL LANGUAGE (Y/N) N

IMPACT ON SUPPORT BUDGET: ONE-TIME COSTS (Y/N): N FUTURE COSTS (Y/N): N

FUTURE SAVINGS (Y/N): Y REVENUE (Y/N): N

DOES THE PROPOSAL AFFECT ANOTHER DEPARTMENT (Y/N): N IF YES, ATTACH COMMENTS OF AFFECTED DEPARTMENT SIGNED BY ITS DIRECTOR OR DESIGNEE.

SIGNATURE APPROVALS:

PREPARED BY: DATE	Dean L. Borg, Associate Director, CPPS REVIEWED BY DATE
Richard Kirkland, Corrections Srvcs, CCHCS 7/12/12 DEPARTMENT DIRECTOR DATE	Deborah Hysen, Deputy Director, FPCM 7/13/12 AGENCY SECRETARY DATE

DOF ANALYST USE

DOF ISSUE #____ PROGRAM CAT: PROJECT CAT: BUDG PACK STATUS: ____

ADDED REVIEW: SUPPORT: OTROS: FSCU: OSAE: CALSTARS: ___

PPBA: _____ Date: _____

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A. PURPOSE OF THE PROJECT

Introduction:
The California Department of Corrections and Rehabilitation (CDCR) has insufficient space, or in some locations no space, to accommodate effective and efficient medication distribution to inmate-patients. The medication distribution areas that exist typically lack sinks, contributing to limited hand washing and increased infection control concerns. These medication rooms additionally lack Heating, Ventilation and Air Conditioning (HVAC) systems to control temperature, leading to spoilage and waste of certain medications. In addition, inadequate space and the insufficient lighting leads to errors in medication preparation and administration. Medication errors can lead to deterioration of a patient's medical condition and subject the Department to medical liability claims. Proper, efficient, and timely medication distribution is one of the core components for treatment of medical ailments. In order to provide safe, efficient, and effective medication distribution, physical plant modifications and improvements must be completed at all CDCR prisons.

Background/History:
The plaintiffs alleged in the case *Plata vs. Cate* that CDCR violated the cruel and unusual punishment clause of the Eighth Amendment of the United States Constitution and that CDCR medical services were deliberately indifferent to the serious medical needs of inmate-patients by failing to provide necessary health care services in a timely manner. As a result, a Federal Court judge in 2006 placed the CDCR medical delivery system under a Federal Receiver. CDCR and the Federal Receiver have developed a Health Care Facility Improvement Program (HCFIP) to address deficiencies in the out-patient health care delivery system. Medication distribution is one of the primary program components. The objective of this COBCP is to provide the physical plant modifications and improvements to allow timely medication distribution to inmate patients.

Medication distribution windows are the most efficient and secure method of medication distribution to General Population (GP) inmate-patients. Medication distribution activities must be coordinated with custody operations. Most prescribed medications require that they be administered with meals; therefore, requiring timely distribution at specific time periods. In order to minimize impact on custody programs and allow inmates to participate in rehabilitative, custodial, educational, and vocational activities, each medication distribution cycle must be completed within a two-hour timeframe. Time-motion studies were conducted by CDCR to determine the parameters required to accomplish timely medication distribution. In the FY 10/11 Budget Act CDCR received additional Licensed Vocational Nurse (LVN) positions to provide medication distribution based on the results of the nursing medication distribution workload study. The workload study determined that one LVN can safely pass medications via a medication distribution window to up to 60 inmate-patients within a maximum two-hour period. One medication distribution window is required for each 60 inmate-patients requiring medications during each two-hour medication

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distribution cycle. There are three medication cycles per day; morning, noon, and evening.

In order to effectively provide custodial supervision over inmate movement during medication distribution, it has been determined that no more than four medication distribution windows shall be provided in order to provide for safe custodial coverage. This would equate to 240 inmate-patients per cycle or a maximum number of four medication distribution windows per facility. In the event that the number of inmate-patients receiving medication per yard exceeds 240, CDCR plans to utilize a combination of strategies, including adjusting program scheduling or adjust housing assignments to equalize the medication workload.

The Medication Distribution Improvements addressed in this proposal will be based on the evaluation of the medication distribution work load by prison and yard compared to the existing medication distribution facilities existing at the prison. Improvements will be developed to address prototypical prison designs in a standardized fashion where ever possible. Institutions that are not prototypical will be provided with unique improvement solutions that address the medication distribution needs while being sensitive to custodial requirements of the prison.

Problem:
Currently there is insufficient (and in some instances, no) facility space and infrastructure in CDCR institutions to appropriately perform medication distribution activities. Lack of adequate medication distribution rooms and windows does not allow for timely, effective, and secure medication distribution. Without adequate medication distribution windows, nursing staff are exposed to safety risks daily as medication must be distributed from an open medication cart or podium on a housing unit dayroom floor, housing unit tier, or through an open doorway. In addition, existing space is inadequately sized to accommodate proper distribution protocols and procedures. The space also lacks sinks in medication rooms violating infection control standards. The spaces are also not equipped with HVAC temperature control systems leading to spoilage of medications, degradation of the medication's strength and inadequate clinical response to medications, and further health complications for the inmate-patient. The space also lacks appropriate secure storage for narcotics and needles. Data connectivity is also not available for connection to information management systems for review of inmate-patient medical records and accurate recording of medication administration.

Using the parameters established as part of the workload study, site assessments were performed at all 33 existing institutions to identify the conceptual scope of work necessary to provide the required improvements to address the existing deficiencies. The medication distribution improvements provided by this project will remedy existing deficiencies in medication distribution space and services at 22 prison facilities. The remaining prison facilities are designated to be the initial prisons within the HCFIP program, and will receive medication distribution improvements within the scope of the HCFIP improvements planned at those facilities.

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The medication distribution improvements funded by this project are to be performed at the following prisons:

- San Quentin State Prison (SQ)
- Deuel Vocation Institution (DVI)
- North Kern State Prison (NKSP)
- Wasco State Prison (WSP)
- Central California Women's Facility (CCWF)
- Avenal State Prison (ASP)
- Calipatria State Prison (CAL)
- California Correctional Center (CCC)
- California Correctional Institution (CCI)
- California State Prison, Corcoran (COR)
- Centinela State Prison (CEN)
- Correctional Training Facility (CTF)
- Chuckawalla Valley State Prison (CVSP)
- High Desert State Prison (HDSP)
- Ironwood State Prison (ISP)
- Kern Valley State Prison (KVSP)
- Pelican Bay State Prison (PBSP)
- Pleasant Valley State Prison (PVSP)
- Substance Abuse Treatment Facility and State Prison (SATF)
- Sierra Conservation Center (SCC)
- Salinas Valley State Prison (SVSP)
- Valley State Prison (VSP)

B. RELATIONSHIP TO THE STRATEGIC PLAN

This proposal supports Objective 3.3 of Goal 3 of the 2010-2015 CDCR Strategic Plan; Upgrade facilities to meet CDCR's space standards for custody, healthcare and rehabilitation and Objective 6.1 of Goal 6 of the Receiver's Turnaround Plan of Action; Provide for necessary clinical administrative and housing facilities.

C. ALTERNATIVES

Alternative #1: Design and construct medication distribution improvements in 22 prison facilities utilizing the AB 900 General Fund appropriation.

Project Advantages:

- Will provide modifications necessary to remedy existing deficiencies in medication distribution space allowing compliance with the Department's

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health care requirements and established nursing and pharmaceutical protocols.

- The improvements will support timely medication distribution to the inmate-patient population and provide safe, efficient and effective distribution of medications by staff.
- Will provide physical plant modifications necessary for COCR to address deficiencies cited in the *Plata vs. Cate* case.
- As the full roll-out of HCFIP to all prisons will take 5-6 years, separating out these improvements will allow for a more timely solution to the medication distribution concerns currently experienced.

Project Disadvantages:
- None.

Estimated Project Cost: $25,303,000.

Funding Source: AB 900 General Fund Appropriation.

Alternative #2: Include medication distribution improvements within the Health Care Improvement Program to be funded via Assembly Bill 900 lease revenue bond authority.

Project Advantages:
- None.

Project Disadvantages:
- Due to the phased roll-out of HCFIP, most prisons will not see improvements to their medication distribution facilities for 5-6 years from the initiation of HCFIP.
- LVN staff are currently available to perform medication distribution tasks in the prisons, but physical plant impediments are delaying timely access to care.
- Performing medication distribution improvements within the scope of HCFIP will delay these improvements by at least 18-24 months when compared to Alternative #1.

Estimated Project Cost: $25,303,000.

Funding Source: AB 900 Lease-Revenue Bond funding.

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D. RECOMMENDED SOLUTION

1. Which alternative and why?
   Design and construct improvements in prison medication distribution facilities at 22 prisons using the AB 900 General Fund appropriation. This alternative will provide these improvements on a much quicker schedule then if included in the scope of other HCFIP improvements for each prison. These improvements will allow medication distribution to occur in a timely, safe, efficient and effective manner.

2. Detailed scope description.
   The scope of work is based upon the existing physical plant of the prison facility, and the medication utilization factors of the types of population housed at each facility. To the extent possible, prototypical design solutions will be used for similar physical plants. The scope of work at each facility may include a combination of the following components:
   - Renovation within existing support building to provide medication distribution workspace;
   - Construction within existing housing units to provide medication distribution workspace;
   - Construction of a new stand-alone building to provide medication distribution workspace.

   All of these improvements would include all or part of the following components: security upgrades to ensure safe storage of medications; HVAC and electrical improvements; casework, lighting and sinks for medication preparation; an injection room and window; medication distribution windows, data and telecommunications connectivity; and inmate drinking fountains. Please consult Attachment A for detailed scope information by each prison.

3. Basis for cost information

   Conceptual estimates developed by the CDCR Program Manager based upon field visits with CDCR staff and medical experts and use of prototypical design solutions have been used to estimate the costs. See Attachment A for detailed cost information by each prison.

4. Factors/benefits for recommended solution other than the least expensive alternative.

   This proposal will assist CDCR in addressing a critical component of the *Plata vs. Cate* case, providing good faith and a reduction of legal fees related to court oversight.

5. Complete description of impact on support budget.

   Medication distribution activities in existing prisons are currently operated with existing budgeted staff. No new staff will be required based upon the construction conducted with this proposal. Implementation of this proposal will lead to completion of one component of CDCR's responsibilities in the Health Care

STATE OF CALIFORNIA	DEPARTMENT OF FINANCE
CAPITAL OUTLAY	915 L Street
BUDGET CHANGE PROPOSAL (COBCP)	Sacramento, CA 95814
COVER PAGE (REV 01/08)	MS Mail Code: A15
BUDGET YEAR 2012-13	

ORG CODE: 5225 COBCP NO. _____ PRIORITY: _____ PROJECT ID: 61.01.039

Facility Improvement Program and contribute to the reduction of future costs for attorneys and court experts.

6. Identify and explain any project risks.

   This proposal contains no identifiable risks.

7. List requested interdepartmental coordination and/or special project approval (including mandatory reviews and approvals, e.g. technology proposals).

   State Fire Marshal approval will be required.

8. Project Schedule

Preliminary Plans-	Start September 2012	Complete July 2013
Working Drawings-	Start July 2013	Complete November 2013
Construction-	Start November 2013	Complete May 2015

E. CONSISTENCY WITH CHAPTER 1016, STATUTES OF 2002 – AB 857

1. Does the recommended solution (project) promote infill development by rehabilitating existing infrastructure and how? Explain.

   Not applicable as this project will be completed at an existing CDCR facility.

2. Does the project improve the protection of environmental and agricultural resources by protecting and preserving the state's most valuable natural resources? Explain.

   Not applicable as this project will be completed at an existing CDCR facility.

3. Does the project encourage efficient development patterns by ensuring that infrastructure associated with development, other than infill, support efficient use of land and is appropriately planned for growth? Explain.

   Not applicable as this project will be completed at an existing CDCR facility.

ATTACHMENTS

Attachment A: Statewide Medication Distribution Improvements Scope/Cost Matrix

Health Care Facility Improvement Program (HCFIP)
Statewide Medication Distribution Improvements
Project / Cost Summary

Institution (by yard)	Problem Statement	Scope of Work	Design Estimate	Conceptual Construction Estimate	Due Diligence	Total Project Estimate
San Quentin State Prison (SQ)						
North Block	Existing medication room is 80 SF. Medications and injections are passed through open doorways. There is insufficient counter space, distribution windows, and storage. There is no secure storage or drinking fountains.	Construct new medication distribution room with 4 windows, and an adjacent injection room with 1 window, at the exterior of North Block. Provide new data and telecom. Provide 4 sinks and 3 drinking fountains.				
South Block	Medications are prepared and pre-packaged at the Upper Yard Health Care Building. Individually pre-packaged medications are then transported by cart across the open yard to the Carson and Donner ASU housing units. It is unsecure and inefficient to prepackage and cart medications across the institution. There are no drinking fountains.	Construct 2 new medication rooms utilizing existing holding cells at Neumiller. They will both include new casework. One room will include 4 windows, 1 sink, and 3 drinking fountains, the other will include 1 new window and 1 new drinking fountain; an existing window and sink will remain. Also included is 1 injection room.				
San Quentin State Prison (SQ)		TOTAL	$ 228,000	$ 1,551,000	$ 11,000	$ 1,791,000
Deuel Vocational Institution (DVI)						
Wing C	Currently medications are distributed at each housing unit tier entrance across a non-secure cart. There is no handwashing sink, worksurfaces, or data connectivity. There is no secure storage and no drinking fountain.	Renovate the existing custody office into a secure medication distribution room adjacent the housing unit entry door and the dayroom. It will include data and telecom, 1 window, casework and 1 sink, and a drinking fountain.				
Wing D	Currently medications are distributed at each housing unit tier entrance across a non-secure cart. There is no handwashing sink, worksurfaces, or data connectivity. There is no secure storage and no drinking fountain.	Renovate the existing custody office into a secure medication distribution room adjacent the housing unit entry door and the dayroom. It will include data and telecom, 1 window, casework and 1 sink, and a drinking fountain.				
Wing E	Currently medications are distributed at each housing unit tier entrance across a non-secure cart. There is no handwashing sink, worksurfaces, or data connectivity. There is no secure storage and no drinking fountain.	Renovate the existing custody office into a secure medication distribution room adjacent the housing unit entry door and the dayroom. It will include data and telecom, 1 window, casework and 1 sink, and a drinking fountain.				
Wing H	Currently medications are distributed at each housing unit tier entrance across a non-secure cart. There is no handwashing sink, worksurfaces, or data connectivity. There is no secure storage and no drinking fountain.	Renovate the existing custody office into a secure medication distribution room adjacent the housing unit entry door and the dayroom. It will include data and telecom, 1 window, casework and 1 sink, and a drinking fountain.				
Wing J	Currently medications are distributed at each housing unit tier entrance across a non-secure cart. There is no handwashing sink, worksurfaces, or data connectivity. There is no secure storage and no drinking fountain.	Renovate the existing custody office into a secure medication distribution room adjacent the housing unit entry door and the dayroom. It will include data and telecom, 1 window, casework and 1 sink, and a drinking fountain.				
East Hall	Currently medications are distributed at each housing unit tier entrance across a non-secure cart. There is no handwashing sink, worksurfaces, or data connectivity. There is no secure storage and no drinking fountain.	Construct an enclosed medication distribution room on the housing wing adjacent to the shower, relocating the shower ramp. It will include data and telecom, 1 window, casework and 1 sink, and a drinking fountain.				
West Hall	Currently medications are distributed at each housing unit tier entrance across a non-secure cart. There is no handwashing sink, worksurfaces, or data connectivity. There is no secure storage and no drinking fountain.	Construct an enclosed medication distribution room on the housing wing adjacent to the shower, relocating the shower ramp. It will include data and telecom, 1 window, casework and 1 sink, and a drinking fountain.				
Deuel Vocational Institution (DVI)		TOTAL	$ 74,000	$ 765,000	$ 11,000	$ 850,000

Health Care Facility Improvement Program (HCFIP)
Statewide Medication Distribution Improvements
Project / Cost Summary

Institution (by yard)	Problem Statement	Scope of Work	Design Estimate	Conceptual Construction Estimate	Due Diligence	Total Project Estimate
North Kern State Prison (NKSP)						
Facility A	The existing space used for medication distribution is too small to accommodate both the current LVN/OT staff and functions and the number of windows needed. There are no provisions to secure medications, no sink, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent Clothing Exchange. Provide new data and telecom, new casework and 1 sink, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Facility D, ASU HU 6	Data connectivity is not available for connection to information management systems for review of inmate-patient medical records and accurate recording of medication administration.	Provide data and telecom infrastructure improvements				
North Kern State Prison (NKSP)		TOTAL	$ 22,000	$ 221,000	$ 11,000	$ 254,000
Wasco State Prison (WSP)						
Facility A	The existing space used for medication distribution is too small to accommodate both the current LVN/OT staff and functions and the number of windows needed. There are no provisions to secure medications, no sink, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent Clothing Exchange. Provide new data and telecom, new casework and 1 sink, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Facility D, ASU HU 6	Data connectivity is not available for connection to information management systems for review of inmate-patient medical records and accurate recording of medication administration.	Provide data and telecom infrastructure improvements				
Facility H	The existing space used for medication distribution is too small to accommodate both the current LVN/OT staff and functions and the number of windows needed. There are no provisions to secure medications, no sink, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent Clothing Exchange. Provide new data and telecom, new casework and 1 sink, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Wasco State Prison (WSP)		TOTAL	$ 44,000	$ 407,000	$ 11,000	$ 462,000
Central California Women's Facility (CCWF)						
Facility A	The existing space used for medication distribution is too small to accommodate the number of windows needed. There are no provisions to securely store medications, no sinks, and the pass through windows and drinking fountain are not accessible.	Construct new medication distribution room in Building 703. Provide new data and telecommunication. Provide new casework, 3 windows, 2 sinks, and 2 drinking fountains.				
Facility A, Bldg 504	The existing space used for medication distribution in the housing unit is too small to accommodate the number windows needed by the EOP population. Medication and injections are required to be passed through an open doorway. There is no handwashing sink.	Construct new medication distribution room adjacent the dayroom with 2 windows, and 1 injection room with 1 window. Provide new data and telecom. Provide 2 sinks and 1 drinking fountain.				
Facility B	The existing space used for medication distribution is too small to accommodate the number of windows needed. There are no provisions to securely store medications, no sinks, and the pass through window and drinking fountain are not accessible.	Construct new stand-alone medication distribution room with 2 windows, and an adjacent injection room with 1 window. Provide new data and telecom. Provide 2 sinks, 1 drinking fountain, and exterior canopy for weather protection.				
Facility C	The existing space used for medication distribution is too small to accommodate the number of windows needed. There are no provisions to securely store medications, no sinks, and the pass through window and drinking fountain are not accessible.	Construct new stand-alone medication distribution room with 2 windows, and an adjacent injection room with 1 window. Provide new data and telecom. Provide 2 sinks, 1 drinking fountain, and exterior canopy for weather protection.				
Facility D	The existing space used for medication distribution is too small to accommodate the number of windows needed. There are no provisions to securely store medications, no sinks, and the pass through window and drinking fountain are not accessible.	Construct new stand-alone medication distribution room with 2 windows, and an adjacent injection room with 1 window. Provide new data and telecom. Provide 2 sinks, 1 drinking fountain, and exterior canopy for weather protection.				
Central California Women's Facility (CCWF)		TOTAL	$ 228,000	$ 1,693,000	$ 11,000	$ 1,932,000

Health Care Facility Improvement Program (HCFIP)
Statewide Medication Distribution Improvements
Project / Cost Summary

Institution (by yard)	Problem Statement	Scope of Work	Design Estimate	Conceptual Construction Estimate	Due Diligence	Total Project Estimate
Avenal State Prison (ASP)						
Facility 1	The existing medication space is too small to accommodate the medication distribution function of 1 window and is not large enough to accommodate a second window. There are no provisions to secure medications, no sink, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge the (E) medication room by expanding into the adjacent corridor alcove. Combine and renovate two vacated exam rooms into a 2nd medication distribution room. Provide data and telecom, casework and sink, 1 medication distribution window and 1 drinking fountain at each room. Install 1 injection window.				
Facility 1, ASU HU	Data connectivity is not available for connection to information management systems for review of inmate-patient medical records and accurate recording of medication administration.	Provide data and telecom infrastructure improvements				
Facility 2	The existing medication space is too small to accommodate the medication distribution function of 1 window and is not large enough to accommodate a second window. There are no provisions to secure medications, no sink, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge the (E) medication room by expanding into the adjacent corridor alcove. Combine and renovate two vacated exam rooms into a 2nd medication distribution room. Provide data and telecom, casework and sink, 1 medication distribution window and 1 drinking fountain at each room. Install 1 injection window.				
Facility 3	The existing medication space is too small to accommodate the medication distribution function of 1 window and is not large enough to accommodate a second window. There are no provisions to secure medications, no sink, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge the (E) medication room by expanding into the adjacent corridor alcove. Combine and renovate two vacated exam rooms into a 2nd medication distribution room. Provide data and telecom, casework and sink, 1 medication distribution window and 1 drinking fountain at each room. Install 1 injection window.				
Facility 4	The existing medication space is too small to accommodate the medication distribution function of 1 window and is not large enough to accommodate a second window. There are no provisions to secure medications, no sink, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge the (E) medication room by expanding into the adjacent corridor alcove. Combine and renovate two vacated exam rooms into a 2nd medication distribution room. Provide data and telecom, casework and sink, 1 medication distribution window and 1 drinking fountain at each room. Install 1 injection window.				
Facility 5	The existing medication space is too small to accommodate the medication distribution function of 1 window and is not large enough to accommodate a second window. There are no provisions to secure medications, no sink, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge the (E) medication room by expanding into the adjacent corridor alcove. Combine and renovate two vacated exam rooms into a 2nd medication distribution room. Provide data and telecom, casework and sink, 1 medication distribution window and 1 drinking fountain at each room. Install 1 injection window.				
Facility 6	The existing medication space is too small to accommodate the medication distribution function of 1 window and is not large enough to accommodate a second window. There are no provisions to secure medications, no sink, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge the (E) medication room by expanding into the adjacent corridor alcove. Combine and renovate two vacated exam rooms into a 2nd medication distribution room. Provide data and telecom, casework and sink, 1 medication distribution window and 1 drinking fountain at each room. Install 1 injection window.				
Avenal State Prison (ASP)		TOTAL	$ 166,000	$ 1,429,000	$ 11,000	$ 1,606,000

Health Care Facility Improvement Program (HCFIP)
Statewide Medication Distribution Improvements
Project / Cost Summary

Institution (by yard)	Problem Statement	Scope of Work	Design Estimate	Conceptual Construction Estimate	Due Diligence	Total Project Estimate
Calipatria State Prison (CAL)						
Facility A	The existing space used for medication distribution is too small to accommodate both the current LVN/OT staff and functions and the number of windows needed. There are no provisions to secure medications, no sink, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent Clothing Exchange. Provide new data and telecom, new casework and 1 sink, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Facility A, ASU HU 5	Data connectivity is not available for connection to information management systems for review of inmate-patient medical records and accurate recording of medication administration.	Provide data and telecom infrastructure improvements				
Facility B	The existing space used for medication distribution is too small to accommodate both the current LVN/OT staff and functions and the number of windows needed. There are no provisions to secure medications, no sink, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent Clothing Exchange. Provide new data and telecom, new casework and 1 sink, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Facility C	The existing space used for medication distribution is too small to accommodate both the current LVN/OT staff and functions and the number of windows needed. There are no provisions to secure medications, no sink, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent Clothing Exchange. Provide new data and telecom, new casework and 1 sink, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Facility D	The existing space used for medication distribution is too small to accommodate both the current LVN/OT staff and functions and the number of windows needed. There are no provisions to secure medications, no sink, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent Clothing Exchange. Provide new data and telecom, new casework and 1 sink, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Stand-Alone ASU Bldg	Data connectivity is not available for connection to information management systems for review of inmate-patient medical records and accurate recording of medication administration.	Provide data and telecom infrastructure improvements				
Calipatria State Prison (CAL)		TOTAL	$ 88,000	$ 814,000	$ 11,000	$ 913,000
California Correctional Center (CCC)						
Facility C (Lassen)	The existing space used for medication distribution is too small to accommodate both the current LVN/OT staff and functions and the number of windows needed. There are no provisions to secure medications, no sink, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent Clothing Exchange. Provide new data and telecom, new casework and 1 sink, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Facility C, ASU HU 4 (Lassen)	Data connectivity is not available for connection to information management systems for review of inmate-patient medical records and accurate recording of medication administration.	Provide data and telecom infrastructure improvements				
Cascade	The existing space used for medication distribution is too small to accommodate both the current LVN/OT staff and functions and the number of windows needed. There are no provisions to secure medications, no sink, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) medical space in the Facility Support Building C by expanding into the adjacent space. Provide new data and telecom, new casework and 1 sink, 2 medication distribution windows and 1 injection room with window. Install 1 drinking fountain.				
Sierra	The existing space used for medication distribution is too small to accommodate both the current LVN/OT staff and functions and the number of windows needed. There are no provisions to secure medications, no sink, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) medical space in the Facility Support Building C by expanding into the adjacent space. Provide new data and telecom, new casework and 1 sink, 2 medication distribution windows and 1 injection room with window. Install 1 drinking fountain.				
California Correctional Center (CCC)		TOTAL	$ 66,000	$ 593,000	$ 11,000	$ 670,000

Health Care Facility Improvement Program (HCFIP)
Statewide Medication Distribution Improvements
Project / Cost Summary

Institution (by yard)	Problem Statement	Scope of Work	Design Estimate	Conceptual Construction Estimate	Due Diligence	Total Project Estimate
California Correctional Institution (CCI)						
Facility C (Facility III)	The existing space used for medication distribution is too small to accommodate both the current LVN/OT staff and functions and the number of windows needed. There are no provisions to secure medications, no sink, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent Clothing Exchange. Provide new data and telecom, new casework and 1 sink, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Facility A, HU 1&2	The existing space used for medication preparation is too small to accommodate the medication preparation nursing functions and storage needs. There are no provisions to securely store medications and no sink.	Renovate (E) enclosed space at sallyport of 180 housing unit. Provide new data and telecom. Provide sink and drinking fountain. Replace existing non-secure window with a secure medication distribution window.				
Facility A, HU 3&4	The existing space used for medication preparation is too small to accommodate the medication preparation nursing functions and storage needs. There are no provisions to securely store medications and no sink.	Renovate (E) enclosed space at sallyport of 180 housing unit. Provide new data and telecom. Provide sink and drinking fountain. Replace existing non-secure window with a secure medication distribution window.				
Facility A, HU 5&6	The existing space used for medication preparation is too small to accommodate the medication preparation nursing functions and storage needs. There are no provisions to securely store medications and no sink.	Renovate (E) enclosed space at sallyport of 180 housing unit. Provide new data and telecom. Provide sink and drinking fountain. Replace existing non-secure window with a secure medication distribution window.				
Facility A, HU 7&8	The existing space used for medication preparation is too small to accommodate the medication preparation nursing functions and storage needs. There are no provisions to securely store medications and no sink.	Renovate (E) enclosed space at sallyport of 180 housing unit. Provide new data and telecom. Provide sink and drinking fountain. Replace existing non-secure window with a secure medication distribution window.				
Facility B, HU 1&2	The existing space used for medication preparation is too small to accommodate the medication preparation nursing functions and storage needs. There are no provisions to securely store medications and no sink.	Renovate (E) enclosed space at sallyport of 180 housing unit. Provide new data and telecom. Provide sink and drinking fountain. Replace existing non-secure window with a secure medication distribution window.				
Facility B, HU 3&4	The existing space used for medication preparation is too small to accommodate the medication preparation nursing functions and storage needs. There are no provisions to securely store medications and no sink.	Renovate (E) enclosed space at sallyport of 180 housing unit. Provide new data and telecom. Provide sink and drinking fountain. Replace existing non-secure window with a secure medication distribution window.				
Facility B, HU 5&6	The existing space used for medication preparation is too small to accommodate the medication preparation nursing functions and storage needs. There are no provisions to securely store medications and no sink.	Renovate (E) enclosed space at sallyport of 180 housing unit. Provide new data and telecom. Provide sink and drinking fountain. Replace existing non-secure window with a secure medication distribution window.				
Facility B, HU 7&8	The existing space used for medication preparation is too small to accommodate the medication preparation nursing functions and storage needs. There are no provisions to securely store medications and no sink.	Renovate (E) enclosed space at sallyport of 180 housing unit. Provide new data and telecom. Provide sink and drinking fountain. Replace existing non-secure window with a secure medication distribution window.				
California Correctional Institution (CCI)		TOTAL:	$ 124,000	$ 1,196,000	$ 11,000	$ 1,331,000
CSP - Corcoran (COR)						
Facility 3A	The existing space used for medication distribution is too small to accommodate both the current LVN/OT staff and functions and the number of windows needed. There are no provisions to secure medications, no sink, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent Clothing Exchange. Provide new data and telecom, new casework and 1 sink, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Facility 3A, ASU HU 3 & 4	Data connectivity is not available for connection to information management systems for review of inmate-patient medical records and accurate recording of medication administration.	Provide data and telecom infrastructure improvements				
Facility 3B	The existing space used for medication distribution is too small to accommodate both the current LVN/OT staff and functions and the number of windows needed. There are no provisions to secure medications, no sink, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent Clothing Exchange. Provide new data and telecom, new casework and 1 sink, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				

Health Care Facility Improvement Program (HCFIP)
Statewide Medication Distribution Improvements
Project / Cost Summary

Institution (by yard)	Problem Statement	Scope of Work	Design Estimate	Conceptual Construction Estimate	Due Diligence	Total Project Estimate
Facility 3B, HU 1	The existing space used for medication distribution in the housing unit is too small to accommodate the number windows needed by the ECP population. Medication and injections are required to be passed through an open doorway. There is no handwashing sink.	Construct new medication distribution room adjacent the dayroom with 2 windows, and 1 injection room with 1 window. Provide new data and telecom. Provide 2 sinks and 1 drinking fountain.				
Facility 3C	The existing space used for medication distribution is too small to accommodate both the current LVN/OT staff and functions and the number of windows needed. There are no provisions to secure medications, no sink, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent Clothing Exchange. Provide new data and telecom, new casework and 1 sink, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Facility 4A, HU 1L & 1R	The existing space used for medication preparation is too small to accommodate the medication preparation nursing functions and storage needs. There are no provisions to securely store medications and no sink.	Renovate (E) enclosed space at sallyport of 180 housing unit. Provide new data and telecom. Provide sink and drinking fountain. Replace existing non-secure window with a secure medication distribution window.				
Facility 4A, HU 2L & 2R	The existing space used for medication preparation is too small to accommodate the medication preparation nursing functions and storage needs. There are no provisions to securely store medications and no sink.	Renovate (E) enclosed space at sallyport of 180 housing unit. Provide new data and telecom. Provide sink and drinking fountain. Replace existing non-secure window with a secure medication distribution window.				
Facility 4A, HU 3L &3R	The existing space used for medication preparation is too small to accommodate the medication preparation nursing functions and storage needs. There are no provisions to securely store medications and no sink.	Renovate (E) enclosed space at sallyport of 180 housing unit. Provide new data and telecom. Provide sink and drinking fountain. Replace existing non-secure window with a secure medication distribution window.				
Facility 4A, HU 4L & 4R	The existing space used for medication preparation is too small to accommodate the medication preparation nursing functions and storage needs. There are no provisions to securely store medications and no sink.	Renovate (E) enclosed space at sallyport of 180 housing unit. Provide new data and telecom. Provide sink and drinking fountain. Replace existing non-secure window with a secure medication distribution window.				
Facility 4B, HU 1L & 1R	The existing space used for medication preparation is too small to accommodate the medication preparation nursing functions and storage needs. There are no provisions to securely store medications and no sink.	Renovate (E) enclosed space at sallyport of 180 housing unit. Provide new data and telecom. Provide sink and drinking fountain. Replace existing non-secure window with a secure medication distribution window.				
Facility 4B, HU 2L & 2R	The existing space used for medication preparation is too small to accommodate the medication preparation nursing functions and storage needs. There are no provisions to securely store medications and no sink.	Renovate (E) enclosed space at sallyport of 180 housing unit. Provide new data and telecom. Provide sink and drinking fountain. Replace existing non-secure window with a secure medication distribution window.				
Facility 4B, HU 3L & 3R	The existing space used for medication preparation is too small to accommodate the medication preparation nursing functions and storage needs. There are no provisions to securely store medications and no sink.	Renovate (E) enclosed space at sallyport of 180 housing unit. Provide new data and telecom. Provide sink and drinking fountain. Replace existing non-secure window with a secure medication distribution window.				
Facility 4B, HU 4L & 4R	The existing space used for medication preparation is too small to accommodate the medication preparation nursing functions and storage needs. There are no provisions to securely store medications and no sink.	Renovate (E) enclosed space at sallyport of 180 housing unit. Provide new data and telecom. Provide sink and drinking fountain. Replace existing non-secure window with a secure medication distribution window.				
Stand-Alone ASU Bldg	Data connectivity is not available for connection to information management systems for review of inmate-patient medical records and accurate recording of medication administration.	Provide data and telecom infrastructure improvements				
CSP - Corcoran (COR)		TOTAL	$ 202,000	$ 1,936,000	$ 11,000	$ 2,149,000

Health Care Facility Improvement Program (HCFIP)
Statewide Medication Distribution Improvements
Project / Cost Summary

Institution (by yard)	Problem Statement	Scope of Work	Design Estimate	Conceptual Construction Estimate	Due Diligence	Total Project Estimate
Centinela State Prison (CEN)						
Facility A	The existing space used for medication distribution is too small to accommodate both the current LVN/OT staff and functions and the number of windows needed. There are no provisions to secure medications, no sink, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent Clothing Exchange. Provide new data and telecom, new casework and 1 sink, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Facility A, ASU HUS	Data connectivity is not available for connection to information management systems for review of inmate-patient medical records and accurate recording of medication administration.	Provide data and telecom infrastructure improvements				
Facility B	The existing space used for medication distribution is too small to accommodate both the current LVN/OT staff and functions and the number of windows needed. There are no provisions to secure medications, no sink, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent Clothing Exchange. Provide new data and telecom, new casework and 1 sink, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Facility C	The existing space used for medication distribution is too small to accommodate both the current LVN/OT staff and functions and the number of windows needed. There are no provisions to secure medications, no sink, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent Clothing Exchange. Provide new data and telecom, new casework and 1 sink, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Facility D	The existing space used for medication distribution is too small to accommodate both the current LVN/OT staff and functions and the number of windows needed. There are no provisions to secure medications, no sink, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent Clothing Exchange. Provide new data and telecom, new casework and 1 sink, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Stand-Alone ASU Bldg	Data connectivity is not available for connection to information management systems for review of inmate-patient medical records and accurate recording of medication administration.	Provide data and telecom infrastructure improvements				
Centinela State Prison (CEN)		TOTAL	$ 89,000	$ 813,000	$ 11,000	$ 913,000
Correctional Training Facility (CTF)						
Central Facility Wing B	Currently medications are distributed at each housing unit tier entrance across a non-secure cart. There is no handwashing sink, worksurfaces, or data connectivity. There is no secure storage and no drinking fountain.	Convert and renovate the existing inmate restroom in the housing unit to a medication distribution room. It will include data and telecom, casework and 1 sink, a drinking fountain and a secure pass-through window within the door.				
Central Facility Wing C	Currently medications are distributed at each housing unit tier entrance across a non-secure cart. There is no handwashing sink, worksurfaces, or data connectivity. There is no secure storage and no drinking fountain.	Convert and renovate the existing inmate restroom in the housing unit to a medication distribution room. It will include data and telecom, casework and 1 sink, a drinking fountain and a secure pass-through window within the door.				
Central Facility Wing D	Currently medications are distributed at each housing unit tier entrance across a non-secure cart. There is no handwashing sink, worksurfaces, or data connectivity. There is no secure storage and no drinking fountain.	Convert and renovate the existing inmate restroom in the housing unit to a medication distribution room. It will include data and telecom, casework and 1 sink, a drinking fountain and a secure pass-through window within the door.				
Central Facility Wing E	Currently medications are distributed at each housing unit tier entrance across a non-secure cart. There is no handwashing sink, worksurfaces, or data connectivity. There is no secure storage and no drinking fountain.	Convert and renovate the existing inmate restroom in the housing unit to a medication distribution room. It will include data and telecom, casework and 1 sink, a drinking fountain and a secure pass-through window within the door.				
Central Facility Wing F	Currently medications are distributed at each housing unit tier entrance across a non-secure cart. There is no handwashing sink, worksurfaces, or data connectivity. There is no secure storage and no drinking fountain.	Convert and renovate the existing inmate restroom in the housing unit to a medication distribution room. It will include data and telecom, casework and 1 sink, a drinking fountain and a secure pass-through window within the door.				

Health Care Facility Improvement Program (HCFIP)
Statewide Medication Distribution Improvements
Project / Cost Summary

Institution (by yard)	Problem Statement	Scope of Work	Design Estimate	Conceptual Construction Estimate	Due Diligence	Total Project Estimate
Central Facility Wing G	Currently medications are distributed at each housing unit tier entrance across a non-secure cart. There is no handwashing sink, worksurfaces or data connectivity. There is no secure storage and no drinking fountain.	Convert and renovate the existing inmate restroom in the housing unit to a medication distribution room. It will include data and telecom, casework and 1 sink, a drinking fountain and a secure pass-through window within the door.				
Central Facility Wing Y	Currently medications are distributed at each housing unit tier entrance across a non-secure cart. There is no handwashing sink, worksurfaces or data connectivity. There is no secure storage and no drinking fountain.	Convert and renovate the existing barber shop in the housing unit to a medication distribution room. It will include data and telecom, casework and 1 sink, a drinking fountain and a secure pass-through window within the door.				
Central Facility Wing Z	Currently medications are distributed at each housing unit tier entrance across a non-secure cart. There is no handwashing sink, worksurfaces or data connectivity. There is no secure storage and no drinking fountain.	Convert and renovate the existing barber shop in the housing unit to a medication distribution room. It will include data and telecom, casework and 1 sink, a drinking fountain and a secure pass-through window within the door.				
Correctional Training Facility (CTF)		TOTAL	$ 50,000	$ 627,000	$ 11,000	$ 688,000
Chuckawalla Valley State Prison (CVSP)						
Facility A	The existing space used for medication distribution is too small to accommodate both the current LVN/OT staff and functions and the number of windows needed. There are no provisions to secure medications, no sink, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent Clothing Exchange. Provide new data and telecom, new casework and 1 sink, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Facilty A, ASU HU	Data connectivity is not available for connection to information management systems for review of inmate-patient medical records and accurate recording of medication administration.	Provide data and telecom infrastructure improvements				
Facility B	The existing space used for medication distribution is too small to accommodate both the current LVN/OT staff and functions and the number of windows needed. There are no provisions to secure medications, no sink, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent Clothing Exchange. Provide new data and telecom, new casework and 1 sink, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Facility C	The existing space used for medication distribution is too small to accommodate both the current LVN/OT staff and functions and the number of windows needed. There are no provisions to secure medications, no sink, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent Clothing Exchange. Provide new data and telecom, new casework and 1 sink, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Facility D	The existing space used for medication distribution is too small to accommodate both the current LVN/OT staff and functions and the number of windows needed. There are no provisions to secure medications, no sink, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent Clothing Exchange. Provide new data and telecom, new casework and 1 sink, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Chuckawalla Valley State Prison (CVSP)			$ 89,000	$ 776,000	$ 11,000	$ 876,000

Health Care Facility Improvement Program (HCFIP)
Statewide Medication Distribution Improvements
Project / Cost Summary

Institution (by yard)	Problem Statement	Scope of Work	Design Estimate	Conceptual Construction Estimate	Due Diligence	Total Project Estimate
High Desert State Prison (HDSP)						
Facility A	The existing space used for medication distribution is too small to accommodate both the current LVN/OT functions and the number of windows needed. There are no provisions to securely store medications, insufficient sinks, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent storage room. Provide new data and telecom, new casework and 2 sinks, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Facility B	The existing space used for medication distribution is too small to accommodate both the current LVN/OT functions and the number of windows needed. There are no provisions to securely store medications, insufficient sinks, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent storage room. Provide new data and telecom, new casework and 2 sinks, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Facility C	The existing space used for medication distribution is too small to accommodate both the current LVN/OT functions and the number of windows needed. There are no provisions to securely store medications, insufficient sinks, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent storage room. Provide new data and telecom, new casework and 2 sinks, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Facility D	The existing space used for medication distribution is too small to accommodate both the current LVN/OT functions and the number of windows needed. There are no provisions to securely store medications, insufficient sinks, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent storage room. Provide new data and telecom, new casework and 2 sinks, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Stand-Alone ASU Bldg	Data connectivity is not available for connection to information management systems for review of inmate-patient medical records and accurate recording of medication administration.	Provide data and telecom infrastructure improvements				
High Desert State Prison (HDSP)		TOTAL	$ 63,000	$ 624,000	$ 11,000	$ 698,000
Ironwood State Prison (ISP)						
Facility A	The existing space used for medication distribution is too small to accommodate both the current LVN/OT staff and functions and the number of windows needed. There are no provisions to secure medications, no sink, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent Clothing Exchange. Provide new data and telecom, new casework and 1 sink, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Facility A, ASU HU 5	Data connectivity is not available for connection to information management systems for review of inmate-patient medical records and accurate recording of medication administration.	Provide data and telecom infrastructure improvements				
Facility B	The existing space used for medication distribution is too small to accommodate both the current LVN/OT staff and functions and the number of windows needed. There are no provisions to secure medications, no sink, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent Clothing Exchange. Provide new data and telecom, new casework and 1 sink, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Facility C	The existing space used for medication distribution is too small to accommodate both the current LVN/OT staff and functions and the number of windows needed. There are no provisions to secure medications, no sink, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent Clothing Exchange. Provide new data and telecom, new casework and 1 sink, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Facility D	The existing space used for medication distribution is too small to accommodate both the current LVN/OT staff and functions and the number of windows needed. There are no provisions to secure medications, no sink, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent Clothing Exchange. Provide new data and telecom, new casework and 1 sink, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Ironwood State Prison (ISP)		TOTAL	$ 88,000	$ 776,000	$ 11,000	$ 875,000

Health Care Facility Improvement Program (HCFIP)
Statewide Medication Distribution Improvements
Project / Cost Summary

Institution (by yard)	Problem Statement	Scope of Work	Design Estimate	Conceptual Construction Estimate	Due Diligence	Total Project Estimate
Kern Valley State Prison (KVSP)						
Facility A	The existing space used for medication distribution is too small to accommodate both the current LVN/OT functions and the number of windows needed. There are no provisions to securely store medications, insufficient sinks, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent storage room. Provide new data and telecom, new casework and 2 sinks, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Facility B	The existing space used for medication distribution is too small to accommodate both the current LVN/OT functions and the number of windows needed. There are no provisions to securely store medications, insufficient sinks, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent storage room. Provide new data and telecom, new casework and 2 sinks, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Facility C	The existing space used for medication distribution is too small to accommodate both the current LVN/OT functions and the number of windows needed. There are no provisions to securely store medications, insufficient sinks, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent storage room. Provide new data and telecom, new casework and 2 sinks, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Facility C, HU 8	The existing space used for medication preparation is too small to accommodate the medication preparation nursing functions and storage needs. There are no provisions to securely store medications and no sink.	Renovate (E) enclosed space at sallyport of 180 housing unit. Provide new data and telecom. Provide sink and drinking fountain. Replace existing non-secure window with a secure medication distribution window.				
Facility D	The existing space used for medication distribution is too small to accommodate both the current LVN/OT functions and the number of windows needed. There are no provisions to securely store medications, insufficient sinks, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent storage room. Provide new data and telecom, new casework and 2 sinks, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Facility D, HU 7&8 (THU)	There is no existing space for medication distribution in the housing unit for the EOP population. Medication and injections are required to be passed across a non-secure cart on the dayroom floor or cell to cell instead of through a medication line. There is no handwashing sink.	Construct new space in the 180 housing unit dining room to accommodate 1 medication distribution room and 1 injection room, each with 1 window. Provide new data and telecom. Provide 2 sinks and drinking fountain.				
Stand-Alone ASU Bldgs (2)	Data connectivity is not available for connection to information management systems for review of inmate-patient medical records and accurate recording of medication administration.	Provide data and telecom infrastructure improvements				
Kern Valley State Prison (KVSP)		TOTAL	$ 104,000	$ 1,004,000	$ 11,000	$ 1,119,000
Pelican Bay State Prison (PBSP)						
Facility A	The existing space used for medication distribution is too small to accommodate both the current LVN/OT staff and functions and the number of windows needed. There are no provisions to secure medications, no sink, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent Clothing Exchange. Provide new data and telecom, new casework and 1 sink, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Facility A, HU 1 & 3 (locate in HU 1)	The existing space used for medication preparation is too small to accommodate the medication preparation nursing functions and storage needs. There are no provisions to securely store medications and no sink.	Renovate (E) enclosed space at sallyport of 160 housing unit. Provide new data and telecom. Provide sink and drinking fountain. Replace existing non-secure window with a secure medication distribution window.				
Facility B	The existing space used for medication distribution is too small to accommodate both the current LVN/OT staff and functions and the number of windows needed. There are no provisions to secure medications, no sink, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent Clothing Exchange. Provide new data and telecom, new casework and 1 sink, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				

Health Care Facility Improvement Program (HCFIP)
Statewide Medication Distribution Improvements
Project / Cost Summary

Institution (by yard)	Problem Statement	Scope of Work	Design Estimate	Conceptual Construction Estimate	Due Diligence	Total Project Estimate
Facility B, HU 1&2	The existing space used for medication preparation is too small to accommodate the medication preparation nursing functions and storage needs. There are no provisions to securely store medications and no sink.	Renovate (E) enclosed space at sallyport of 180 housing unit. Provide new data and telecom. Provide sink and drinking fountain. Replace existing non-secure window with a secure medication distribution window.				
Facility B, HU 3	The existing space used for medication preparation is too small to accommodate the medication preparation nursing functions and storage needs. There are no provisions to securely store medications and no sink.	Renovate (E) enclosed space at sallyport of 180 housing unit. Provide new data and telecom. Provide sink and drinking fountain. Replace existing non-secure window with a secure medication distribution window.				
SHU (2 wings)	Data connectivity is not available for connection to information management systems for review of inmate-patient medical records and accurate recording of medication administration.	Provide data and telecom infrastructure improvements				
Stand-Alone ASU	Data connectivity is not available for connection to information management systems for review of inmate-patient medical records and accurate recording of medication administration.	Provide data and telecom infrastructure improvements				
Pelican Bay State Prison (PBSP)		TOTAL	$ 82,000	$ 856,000	$ 11,000	$ 949,000
Pleasant Valley State Prison (PVSP)						
Facility A	The existing space used for medication distribution is too small to accommodate both the current LVN/OT staff and functions and the number of windows needed. There are no provisions to secure medications, no sink, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent Clothing Exchange. Provide new data and telecom, new casework and 1 sink, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Facility B	The existing space used for medication distribution is too small to accommodate both the current LVN/OT staff and functions and the number of windows needed. There are no provisions to secure medications, no sink, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent Clothing Exchange. Provide new data and telecom, new casework and 1 sink, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Facility C	The existing space used for medication distribution is too small to accommodate both the current LVN/OT staff and functions and the number of windows needed. There are no provisions to secure medications, no sink, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent Clothing Exchange. Provide new data and telecom, new casework and 1 sink, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Facility D	The existing space used for medication distribution is too small to accommodate both the current LVN/OT staff and functions and the number of windows needed. There are no provisions to secure medications, no sink, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent Clothing Exchange. Provide new data and telecom, new casework and 1 sink, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Facility D, ASU HU 4	Data connectivity is not available for connection to information management systems for review of inmate-patient medical records and accurate recording of medication administration.	Provide data and telecom infrastructure improvements				
Stand-Alone ASU Bldg	Data connectivity is not available for connection to information management systems for review of inmate-patient medical records and accurate recording of medication administration.	Provide data and telecom infrastructure improvements				
Pleasant Valley State Prison (PVSP)		TOTAL	$ 89,000	$ 813,000	$ 11,000	$ 913,000
Substance Abuse Treatment Facility & State Prison (SATF)						
Facility A	The existing space used for medication distribution is too small to accommodate both the current LVN/OT functions and the number of windows needed. There are no provisions to securely store medications, insufficient sinks, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent storage room. Provide new data and telecom, new casework and 2 sinks, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				

Health Care Facility Improvement Program (HCFIP)
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Institution (by yard)	Problem Statement	Scope of Work	Design Estimate	Conceptual Construction Estimate	Due Diligence	Total Project Estimate
Facility B	The existing space used for medication distribution is too small to accommodate both the current LVN/OT functions and the number of windows needed. There are no provisions to securely store medications, insufficient sinks, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent storage room. Provide new data and telecom, new casework and 2 sinks, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Facility C	The existing space used for medication distribution is too small to accommodate both the current LVN/OT functions and the number of windows needed. There are no provisions to securely store medications, insufficient sinks, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent storage room. Provide new data and telecom, new casework and 2 sinks, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Facility D	The existing space used for medication distribution is too small to accommodate both the current LVN/OT functions and the number of windows needed. There are no provisions to securely store medications, insufficient sinks, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent storage room. Provide new data and telecom, new casework and 2 sinks, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Facility E	The existing space used for medication distribution is too small to accommodate both the current LVN/OT functions and the number of windows needed. There are no provisions to securely store medications, insufficient sinks, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent storage room. Provide new data and telecom, new casework and 2 sinks, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Facility E, ASU HU 1	Data connectivity is not available for connection to information management systems for review of inmate-patient medical records and accurate recording of medication administration.	Provide data and telecom infrastructure improvements				
Facility F	The existing space used for medication distribution is too small to accommodate both the current LVN/OT functions and the number of windows needed. There are no provisions to securely store medications, insufficient sinks, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent storage room. Provide new data and telecom, new casework and 2 sinks, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Facility F, HU 3	The existing space used for medication distribution in the housing unit is too small to accommodate the number windows needed by the EOP population. Medication and injections are required to be passed through an open doorway. There is no handwashing sink.	Construct new medication distribution room adjacent the dayroom with 2 windows, and 1 injection room with 1 window. Provide new data and telecom. Provide 2 sinks and 1 drinking fountain.				
Facility G	The existing space used for medication distribution is too small to accommodate both the current LVN/OT functions and the number of windows needed. There are no provisions to securely store medications, insufficient sinks, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent storage room. Provide new data and telecom, new casework and 2 sinks, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Facility G, HU 1	The existing space used for medication distribution in the housing unit is too small to accommodate the number windows needed by the EOP population. Medication and injections are required to be passed through an open doorway. There is no handwashing sink.	Construct new medication distribution room adjacent the dayroom with 2 windows, and 1 injection room with 1 window. Provide new data and telecom. Provide 2 sinks and 1 drinking fountain.				
Stand-Alone ASU Bldg	Data connectivity is not available for connection to information management systems for review of inmate-patient medical records and accurate recording of medication administration.	Provide data and telecom infrastructure improvements				
Substance Abuse Treatment Facility & State Prison		TOTAL	$ 179,000	$ 1,627,000	$ 11,000	$ 1,817,000

Health Care Facility Improvement Program (HCFIP)
Statewide Medication Distribution Improvements
Project / Cost Summary

Institution (by yard)	Problem Statement	Scope of Work	Design Estimate	Conceptual Construction Estimate	Due Diligence	Total Project Estimate
Sierra Conservation Center (SCC)						
Facility A (Calaveras)	The existing space used for medication distribution is too small to accommodate the number of windows needed. There are no provisions to securely store medications, no sinks, and the pass-through window and drinking fountain are not accessible.	Construct new stand-alone medication distribution room with 2 windows, and an adjacent injection room with 1 window. Provide new data and telecom. Provide 2 sinks, 1 drinking fountain, and exterior canopy for weather protection.				
Facility B (Mariposa)	The existing space used for medication distribution is too small to accommodate the number of windows needed. There are no provisions to securely store medications, no sinks, and the pass-through window and drinking fountain are not accessible.	Construct new stand-alone medication distribution room with 2 windows, and an adjacent injection room with 1 window. Provide new data and telecom. Provide 2 sinks, 1 drinking fountain, and exterior canopy for weather protection.				
Facility C (Tuolumne)	The existing space used for medication distribution is too small to accommodate both the current LVN/OT staff and functions and the number of windows needed. There are no provisions to secure medications, no sink, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent Clothing Exchange. Provide new data and telecom, new casework and 1 sink, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Facility C, ASU HU 2 (Tuolomne)	Data connectivity is not available for connection to information management systems for review of inmate-patient medical records and accurate recording of medication administration.	Provide data and telecom infrastructure improvements				
Sierra Conservation Center (SCC)		TOTAL	$ 139,000	$ 1,021,000	$ 11,000	$ 1,171,000
Salinas Valley State Prison (SVSP)						
Facility A	The existing space used for medication distribution is too small to accommodate both the current LVN/OT functions and the number of windows needed. There are no provisions to securely store medications, insufficient sinks, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent storage room. Provide new data and telecom, new casework and 2 sinks, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Facility A, HU A5	Construct new medication distribution room adjacent the dayroom with 2 windows, and 1 injection room with 1 window. Provide new data and telecom. Provide 2 sinks and 1 drinking fountain.	Construct new medication distribution room adjacent the dayroom with 2 windows, and 1 injection room with 1 window. Provide new data and telecom. Provide 2 sinks and 1 drinking fountain.				
Facility B	The existing space used for medication distribution is too small to accommodate both the current LVN/OT functions and the number of windows needed. There are no provisions to securely store medications, insufficient sinks, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent storage room. Provide new data and telecom, new casework and 2 sinks, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Facility C	The existing space used for medication distribution is too small to accommodate both the current LVN/OT functions and the number of windows needed. There are no provisions to securely store medications, insufficient sinks, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent storage room. Provide new data and telecom, new casework and 2 sinks, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				
Facility C, IDF HU 5&6	There is no existing space for medication distribution in the housing unit for the EOP population. Medication and injections are required to be passed across a non-secure cell on the dayroom floor or cell to cell instead of through a medication line. There is no handwashing sink.	Construct new space in the 180 housing unit dining room to accommodate 1 medication distribution room with 2 windows and 1 injection room with 1 window. Provide new data and telecom. Provide 2 sinks and drinking fountain.				
Facility D	The existing space used for medication distribution is too small to accommodate both the current LVN/OT functions and the number of windows needed. There are no provisions to securely store medications, insufficient sinks, and the pass-through window and drinking fountain are not accessible.	Renovate and enlarge (E) LVN/OT workstation by expanding into the adjacent storage room. Provide new data and telecom, new casework and 2 sinks, 1 additional medication distribution window and 1 injection window. Install 1 drinking fountain.				

Health Care Facility Improvement Program (HCFIP)
Statewide Medication Distribution Improvements
Project / Cost Summary

Institution (by yard)	Problem Statement	Scope of Work	Design Estimate	Conceptual Construction Estimate	Due Diligence	Total Project Estimate
Facility D, HU 3&7	The existing space used for medication preparation is too small to accommodate the medication preparation, nursing functions and storage needs. There are no provisions to securely store medications and no sink.	Renovate (E) enclosed space at sallyport of 180 housing unit. Provide new data and telecom. Provide sink and drinking fountain. Replace existing non-secure window with a secure medication distribution window.				
Facility D Hu 5&6	There is no existing space for medication distribution in the housing unit for the EOP population. Medication and reactions are required to be passed across a non-secure cell on the Bayspoint 7 pod or cell to cell instead of through a medication - slot. There is no handwashing sink.	Construct new space in the 180 housing unit dining room to accommodate 1 medication distribution room with 2 windows and 1 injection room with 1 window. Provide new data and telecom. Provide 2 sinks and drinking fountain.				
Facility D, Bldg 7&8	The existing space used for medication preparation is too small to accommodate the medication preparation, nursing functions and storage needs. There are no provisions to securely store medications and no sink.	Renovate (E) enclosed space at sallyport of 180 housing unit. Provide new data and telecom. Provide sink and drinking fountain. Replace existing non-secure window with a secure medication distribution window.				
Sierra Alpine ASU Bldg	Data connectivity is not available for connection to information management systems for review of remote-based medical records and accurate recording of medication administration.	Provide data and telecom infrastructure improvements.				
Salinas Valley State Prison (SVSP)		TOTAL	$ 184,000	$ 1,614,000	$ 11,000	$ 1,809,000

Valley State Prison (VSP)						
Facility A	Data connectivity is not available for connection to information management systems for review of remote-based medical records and accurate recording of medication administration.	Provide data and telecom infrastructure improvements.				
Facility A, ASU HU 4	Data connectivity is not available for connection to information management systems for review of remote-based medical records and accurate recording of medication administration.	Provide data and telecom infrastructure improvements.				
Facility B	The existing space used for medication distribution is too small to accommodate the number of windows needed. There are no provisions to securely store medications, no sinks, and the pass-through window and drinking fountain are not accessible.	Construct new stand-alone medication distribution room with 2 windows and an adjacent injection room with 1 window. Provide new data and telecom. Provide 2 sinks, 1 drinking fountain, and exterior canopy for weather protection.				
Facility C	The existing space used for medication distribution is too small to accommodate the number of windows needed. There are no provisions to securely store medications, no sinks, and the pass-through window and drinking fountain are not accessible.	Construct new stand-alone medication distribution room with 2 windows and an adjacent injection room with 1 window. Provide new data and telecom. Provide 2 sinks, 1 drinking fountain, and exterior canopy for weather protection.				
Facility D	The existing space used for medication distribution is too small to accommodate the number of windows needed. There are no provisions to securely store medications, no sinks, and the pass-through window and drinking fountain are not accessible.	Construct new stand-alone medication distribution room with 2 windows and an adjacent injection room with 1 window. Provide new data and telecom. Provide 2 sinks, 1 drinking fountain, and exterior canopy for weather protection.				
Valley State Prison (VSP)		TOTAL	$ 175,000	$ 1,323,000	$ 11,000	$ 1,509,000

GRAND TOTAL	$ 2,876,000	$ 22,486,000	$ 242,000	$ 25,303,000

Exhibit 95

MENTAL HEALTH SERVICES DELIVERY SYSTEM

PROGRAM GUIDE

2009 REVISION

Division of Correctional Health Care Services

Department of Corrections & Rehabilitation

Rick Johnson
February 25, 2013
Exhibit No. 2
Megan F. Alvarez
RPR, CSR No. 12470

hour care is needed, an inmate-patient shall be placed in a MHCB for continuous nursing care.

B. PROGRAM OBJECTIVES

The primary objective of the MHCB is to evaluate the symptoms associated with the crisis and provide initial stabilization and recommendations for follow-up care, post discharge. More specific objectives include:

1. To observe, monitor, and provide continuous nursing assistance to inmate-patients whose condition requires 24 hours or more to achieve stabilization.

2. To assess the inmate-patient's symptoms, formulate a provisional or differential diagnosis, and develop an initial treatment plan. This may include a medical/neurological evaluation or an initiation of referral for such.

3. To control symptoms of serious mental illness, using emergency medication when necessary.

4. To alleviate psychiatric distress with appropriate therapy or counseling.

5. To refer the inmate-patient for placement in an appropriate level of care.

6. To provide an alternative to hospitalization for inmate-patients whose condition allows placement within ten calendar days to a less intensive level of care.

C. POPULATION SERVED

Overall Treatment Criteria

Overall treatment criteria have been developed for the Mental Health Services Delivery System (MHSDS). An inmate must meet the criteria in either 1 or 2 below in order to receive MHSDS treatment at any level of care:

1. Treatment and monitoring are provided to any inmate who has ***current*** symptoms and/or requires treatment for the current Diagnostic and Statistical Manual (DSM) diagnosed (may be provisional) Axis I serious mental disorders listed below:

   Schizophrenia (all subtypes)
   Delusional Disorder
   Schizophreniform Disorder
   Schizoaffective Disorder

Brief Psychotic Disorder
Substance-Induced Psychotic Disorder (exclude intoxication and withdrawal)
Psychotic Disorder Due To A General Medical Condition
Psychotic Disorder Not Otherwise Specified
Major Depressive Disorders
Bipolar Disorders I and II

2. Medical Necessity: Mental health treatment shall be provided as needed. Treatment is continued as needed, after review by the Interdisciplinary Treatment Team (IDTT), for all cases in which:

   Mental health intervention is necessary to protect life and/or treat significant disability/dysfunction in an individual diagnosed with, or suspected of having, a mental disorder. Treatment is continued for these cases only upon reassessment and determination by the IDTT that the significant or life threatening disability/dysfunction continues or regularly recurs.

Specific Treatment Criteria for MHCB

In addition to the overall treatment criteria above, an inmate must meet the following specific criteria to receive treatment at the MHCB level of care:

- Marked impairment and dysfunction in most areas (daily living activities, communication and social interaction) requiring 24-hour nursing care; and/or
- Dangerousness to Others as a consequence of a serious mental disorder/Dangerousness to Self.
- These conditions usually result in a Global Assessment of Functioning (GAF) score of less than 30.

D. REFERRAL AND TRANSFER

Referrals

An inmate-patient suffering from an acute, serious mental disorder resulting in serious functional disabilities, or who is dangerous to self or others, shall be referred to a MHCB.

MHCB Transfer

If the institution does not have a MHCB or there are no MHCB beds available in the institution where the inmate-patient is currently housed, the inmate-patient shall be

transferred to a designated MHCB institution. The inmate-patient shall be transferred within 24 hours of referral.

(See Inmate Medical Services Policies and Procedures, *Volume 4, Chapter 3, Health Care Transfer Process* and *Volume 6, Chapter 18, Transfer of Patient Health Records Within CDCR; Institution to Institution*, for specific requirements concerning transfers and Unit Health Records)

If the MHCB beds are not available at the designated hub institution, the inmate-patient shall be taken to an available MHCB bed that is able to provide MHCB care while simultaneously providing the commensurate level of custody and security. In most cases, movement from an institution to a MHCB bed shall be completed by institutional transportation staff via special transport within 24 hours. On weekends and after normal business hours, the mental health clinician on call or the physician on call at the referring institution shall contact the mental health clinician on call or the physician on call at other institutions to locate a vacant MHCB bed. **The Health Care Placement Oversight Program (HCPOP) may be contacted seven days a week to assist in locating a vacant MHCB bed.**

MHCB transfers shall be done under authority as "Emergency Medical Transfers" (Department Operations Manual [DOM] 62080.17). Since MHCB transfers are typically viewed as emergency moves, they do not require classification committee action or Classification Staff Representative (CSR) endorsement. MHCB transfers shall be done on a "Psychiatric and Return" basis.

Generally, the transfer process shall be initiated by the inmate-patient's psychiatrist, psychologist, or the Chief of Mental Health.

The transferring psychiatrist, psychologist, or Chief of Mental Health shall determine whether the inmate-patient is "medically cleared" to transfer. State law provides that, before a patient may be transferred to a health facility, the patient must be sufficiently stabilized to be safely transported. The transferring physician is responsible for determining whether the inmate-patient's condition will allow transfer. The CCR provides, in part, that a transfer or discharge may not be carried out if, in the opinion of the inmate-patient's physician, such transfer or discharge would create a medical hazard. The transferring physician must initially evaluate the relative benefits and risks associated with transporting the inmate-patient. The determination of whether the transfer creates an unacceptable risk or a "medical hazard" will depend upon the inmate-patient's condition, the expected benefits to the inmate-patient if he or she is transferred, and whether the risks to the inmate-patient's health are outweighed by the benefits.

The receiving facility must consent to the transfer. CCR, Title XXII, licensing standards provide that a patient shall not be transferred unless and until the receiving facility has

consented to accept the patient. Specifically, the CCR provides, in part, that no patient shall be transferred, or discharged for purposes of transferring, unless arrangements have been made in advance for admission to a health facility. Therefore, the transferring clinician must secure the receiving health facility's approval in advance for the inmate-patient's admission. The transferring clinician shall document in the inmate-patient's Unit Health Record (UHR) that approval was obtained and from whom.

Appropriate housing of inmate-patients pending MHCB transfer shall be determined by the sending institution and in the following order of preferred locations:

1. Inpatient beds
2. Outpatient Housing Unit
3. Outpatient Housing Unit overflow cells
4. Large holding cells with water/toilets including, but not limited to, "ZZ cells," "wet cells," and/or "clinic cells." Many CTC buildings have holding cells located outside of the entrance to the licensed bed area. These are typically located in the Specialty Care Clinic area. These cells are permissible for temporary housing pending transfer without violating licensing restrictions of the licensed bed area of the CTC building.
5. Large holding cells without water/toilets such as "Contraband Cells" (not in a CTC licensed area)
6. Triage and Treatment Area or other clinic physical examining room
7. Other unit-housing where complete and constant visibility can be maintained
8. When none of the above are available, small holding cells (not in a CTC licensed bed area) that are designed for the inmate-patient to sit or stand may be used for up to four hours by which time consideration of a rotation to one of the above listed options shall have been considered and the outcome of such consideration documented. Inmate-patients shall be retained in sit/stand cells only with approval of the watch commander and notification of on-call clinical staff.
9. Holding cells within the licensed bed area of the CTC building (notification to Department of Health Services of an unusual occurrence is required)

All inmates-patients housed in one of the above sites while pending transfer to a MHCB shall be provided, at minimum, with a safety (no-tear) mattress, safety (no-tear) blanket, and safety (no-tear) smock. If the inmate-patient subsequently attempts to use any or all of these items

to harm him or herself, a clinician may then order that one or more of these items be removed. Inmate-patients who are subsequently returned to their housing units shall receive appropriate clinical follow-up, which may include five-day custody and clinical wellness checks.

When an inmate-patient, identified as requiring MHCB care, is housed in an Outpatient Housing Unit, Administrative Segregation Unit, or any of the above sites, the HCPOP shall be notified of the need for MHCB placement.

Procedure

The Chief of Mental Health or designee at the sending institution shall contact the MHCB Clinical Director or designee at the receiving institution to obtain approval for the transfer.

In cases where the Clinical Director or designee at the receiving institution does not agree to the transfer, and the Chief of Mental Health at the sending institution believes the clinical need for transfer remains, the case shall be referred to the HCPOP and/or Mental Health Services at headquarters central office for assistance. If an agreement cannot be reached, the inmate shall be admitted and evaluated.

Upon receipt of approval to transfer, from the MHCB Clinical Director or designee at the receiving institution, the Chief of Mental Health or designee at the sending institution shall complete a CDCR 128-C, *Chrono – Medical/Psychiatric/Dental*, indicating acceptance. Copies of the completed CDCR 128-C, *Chrono – Medical/Psychiatric/Dental,* shall be forwarded to the MHCB Clinical Director or designee at the receiving institution and the Classification & Parole Representative (C&PR) at the sending institution.

The C&PR at the sending institution shall forward a copy of the completed CDCR 128-C, *Chrono – Medical/Psychiatric/Dental*, to the C&PR at the receiving institution.

The Chief of Mental Health or designee, MHCB Clinical Director or designee, and the C&PRs at both the sending and receiving institutions shall communicate to ensure all health care/classification/transportation aspects are addressed. The escort needs for each transport are different given the variation of custody and health care concerns that may arise. At times, the transportation may be accomplished with just custody staff. However, occasions do arise when a combination of custody and clinical staff are needed to accompany an escort. This may occur when the inmate-patient has highly sensitive and varying medication needs or when the presence of a clinical staff member may substantially reduce decompensating or disruptive inmate-patient behavior during transportation.

The C&PR at the receiving institution shall contact the Classification Services Unit (CSU) for teletype transfer approval. The transfer approval shall be obtained from a CSR if available on site.

Documentation and classification of inmate-patients accepted for transfer to another institution shall be consistent with procedures outlined in the DOM. The sending institution shall clearly indicate on CDCR 135, *Inmate Transfer Record*, that the purpose of the transfer is for psychiatric treatment.
The inmate-patient shall be informed of the reasons for and destination of the transfer.

The Receiving and Release sergeant at the receiving institution shall notify the MHCB when the inmate-patient arrives. An inmate-patient who arrives by special transport because of urgent acuity shall be screened by a physician. If immediate admission is not possible, an inmate-patient shall be housed in an appropriate medical setting until a bed is available (CCR, Title XXII, Section 79789).

E. ADMISSION

Pre-admission Screening

All inmate-patients referred to the MHCB shall receive a pre-admission screening for the purpose of determining the appropriateness of the admission to the MHCB program. During regular working hours, the screening shall be performed by a psychiatrist or a licensed psychologist privileged to practice in the MHCB, and documented in the Progress Notes. During weekends, holidays, and after normal business hours, the screening shall be performed by an on-site physician on duty or any other licensed health care staff. The pre-admission screening may be performed via telephone prior to transfer when the inmate-patient is at an institution without an available MHCB. An inmate-patient in crisis may be screened where the crisis occurs (such as in the cell), or in the emergency service area of the CTC/GACH/SNF, prior to admission to the MHCB.

All inmates attempting suicide and those having suicidal ideation or showing signs and symptoms of suicide potential will be evaluated by a mental health clinician (psychiatrist, psychologist, or Clinical Social Worker) on an emergency basis. Inmates referred to health care by custody because of suicide concerns, shall be immediately evaluated for suicide risk by a mental health clinician, which shall include a Suicide Risk Assessment Checklist (SRAC). On weekends, evenings, and holidays, the SRAC shall be performed by the Physician on Call (POC), Medical Officer of the Day (MOD), or Registered Nurse (RN) trained to administer the SRAC if mental health clinicians are not available. It is the responsibility of the Health Care Manager to establish procedures for suicide risk assessment by clinical staff outside of normal work hours. All SRACs shall be filed in the inmate-patient's UHR whether or not the inmate-patient is admitted to the MHCB. An inmate

Exhibit 96

1 ☐ Statewide SPR FIT Teleconference/Webinar

February 2011

Robert Canning, DCHCS
Kathleen O'Meara, DCHCS
Catherine Prudhomme, DCHCS

2 ☐ Agenda

3 ☐ HQ Projects

- Pocket card for custody and nursing
- Training issues
  - Proctoring
  - Assessment guide
  - Updated training for clinicians
  - Updating Program Guide
  - High risk patient project
- Program Guide updates

4 ☐ SPR FIT Coordinator Duties and Workload Discussion

- How much time is spent on SPR FIT duties?
- How many coordinators have a CCCMS or EOP caseload?
- How to increase visibility of issue in institutions
- Partnering with custody

5 ☐ Revision of 31-Item ASU Screener

- Right now:
  - General MH questionnaire
  - Only administered to non-MH inmates entering ASU
  - Some irrelevant questions
- Proposed
  - Focused on relevant psychological domains
  - Administered to all inmates entering ASU

6 ☐ Proposed Revision Timeline

- General outline developed by HQ SPR FIT (3/11)
- Work group creates pilot version (6/11)
  - SPR FIT coordinators
  - Chiefs
  - ASU clinicians

DPRD2-27-000008

- Nursing representative(s)
- Pilot the proposed screener (7/11-8/11)
- Final version – (10/11)
- Approval & Implementation (12/11)

7 ☐ Suicide Attempt Work Group

- Re-start project this month
- Distribute materials to members
- Draft proposal for standard
- Pilot draft to 5-6 varied institutions
- Finalize
- Implement to field

8 ☐ Wrap Up & Closing

- Unfinished business
- Items for next meeting
- Date of next meeting
- Adjourn

DPRD2-27-000009

Exhibit 97

Division of Correctional Health Care Services
Suicide Prevention and Response-Focused Improvement Team (SPR FIT)

PRISONER NAME REDACTED

Meeting Agenda

Meeting Date: **Monday January 28, 2013**
Meeting Location: ***Elk Grove Campus, G-2, MH Director's Conference Room***
Call-in Number: ***877-213-1782, Participant Code 664226***
Meeting Time: 10:00 AM – 11:00 AM

Timekeeper: Robert Canning
Minutes: Alicia Aguilar

Item	Who
Announcements, introductions, additions to the agenda	
New items Follow-up on ongoing items: 1. Update on proposal for new ASU screening tool (to replace 31-item questionnaire) 2. Changes to referral criteria for RC screening (from [redacted] suicide review) 3. Suicide prevention posters 4. Proctor-mentor program update 5. 2011 Report from Special Master/ Other legal 6. Data project 7. Auditing of ASU Pre-placement screening 8. Auditing of 30-minute ASU welfare checks	 Canning Canning Canning O'Meara Canning Scholl w/ Nursing w/ DAI
Ongoing items (updates as needed until item closed) 1. Training issues	 Canning
9. Periodic (recurring) items a. Suicide Prevention Videoconference agenda	 Canning
10. Ongoing, Tabled, and Postponed Items	
11. Wrap-up and Other Business	

Next Meeting:

Date: February 11, 2013
Time: 10:00 AM
Location: **Elk Grove G-2 MH Director's Conference Room**

Exhibit 98

From: Canning, Robert@CDCR
Sent: Wednesday, October 10, 2012 9:32 AM
To: Chaiken, Shama@CDCR; Wheeler, (Ralph) David@CDCR; Switzer, Heidi@CDCR; Gauch, Gerardine@CDCR; Rushe, Regina H@CDCR
Subject: DRAFT of new ASU screener - comments requested

Greetings,

I'm writing to you because you all have extensive experience with the segregated housing environment in CDCR and the screening practices we currently use. Attached is a draft of a new screening instrument that we are proposing to pilot in a number of institutions around the state in hopes that it will be a better alternative and more effective screening measure than the current 31-item questionnaire.

Currently CDCR uses the 31-item Reception Center screening measure to screen for mental health needs within 72 hours of a non-MHSDS inmate's entry to ASU. This measure uses a subset of 14 items (the Referral Decision Scale) plus two more items focusing on suicidal thinking and history. Decision rules determine whether an inmate is referred.

The 31-item screener has never been validated in the CRCR setting, takes too long to administer, and does not address what we believe are the most important psychological factors effecting an inmate's behavior soon after entry into ASU: distress, isolation, loneliness, fear, and possibly thoughts of suicide.

We propose replacing the 31-item measure with this shorter, 12-item measure which combines two validated screeners: the Kessler Six (K6) and the Columbia Suicide Severity Rating Scale (C-SSRS). The K6 is a widely used scale of general distress that has high AUC's for detection of DSM disorders, and the C-SSRS is new validated measure of suicidal thinking and behavior that has been found useful in non-clinical settings. The C-SSRS is beginning to find its way into correctional settings and the K6 has been used on a trial basis in prisons in Illinois.

We also propose that the measure be used to screen all inmates placed in ASU rather than the current practice of only screening those who are not participants in the MHSDS. The rationale for this change is that historically the ASU screening was to determine mental health needs and since those in the MHSDS were already by default identified as needing mental health services, there was no need to screen them upon entry to ASU.
The current proposal assumes that anyone placed in ASU could be experiencing increased levels of distress and isolation thus we ought to identify these inmates quickly to be able to provide the services they may need.

When used together psychiatric technicians can quickly and easily screen for distress and suicidal thinking and make referrals. The structure of the instrument is algorithmic and if administered in a standardized fashion will facilitate, we believe, a better screening regimen in ASU.

I would be interested in ANY feedback you may have about this proposed screener – format, rules, page layout – anything. Thanks in advance for your help and if you have any questions, please let me know.

Thanks in advance.

Robert D. Canning, Ph.D.
Senior Psychologist Specialist
Statewide Mental Health Program

Desk: **(916) 691-0276**
Cell: **(530) 400-8965**
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Proposal for new ASU screening measure

Currently CDCR uses the 31-item Reception Center screening measure to screen for mental health needs within 72 hours of a non-MHSDS inmate's entry to ASU. This measure uses a subset of 14 items (the Referral Decision Scale) plus two more items focusing on suicidal thinking and history. Decision rules determine whether an inmate is referred.

The 31-item screener has never been validated in the CRCR setting, takes too long to administer, and does not address what we believe are the most important psychological factors effecting an inmate's behavior soon after entry into ASU: distress, isolation, loneliness, fear, and possibly thoughts of suicide.

We propose replacing the 31-item measure with a shorter, 12-item measure which combines two short, validated screeners: the Kessler Six[1] (K6) and the Columbia Suicide Severity Rating Scale (C-SSRS).[2] The K6 is a widely used scale of general distress that has high AUC's for detection of DSM disorders, and the C-SSRS is new validated measure of suicidal thinking and behavior that has been found useful in non-clinical settings. The C-SSRS is beginning to find its way into correctional settings and the K6 has been used on a trial basis in prisons in Illinois.

We also propose that the measure be used to screen <u>all</u> inmates placed in ASU rather than the current practice of only screening those who are not participants in the MHSDS. The rationale for this change is that historically the ASU screening was to determine mental health needs and since those in the MHSDS were already identified as needing mental health services by default, there was no need to screen them upon entry to ASU. The current proposal assumes that anyone placed in ASU could be experiencing increased levels of distress and isolation thus we ought to identify these inmates quickly to be able to provide the services they may need.

When used together (see page 2 for a draft of the measure) psychiatric technicians can quickly and easily screen for distress and suicidal thinking and make referrals. The structure of the instrument is algorithmic and if administered in a standardized fashion will facilitate a better screening regimen in ASU.

In the next year we will pilot the measure in approximately six institutions and then implement system-wide.

---

[1] Kessler, et al. (2002). Short screening scales to monitor population prevalences and trends in non-specific psychological distress. *Psychological Medicine 32*:959-976.

[2] Posner, et al. (2012). The Columbia-Suicide Severity Rating Scale: Initial validity and internal consistency findings from three multisite studies with adolescents and adults. *American Journal of Psychiatry 168*: 1266-1277.

Exhibit 99

From: Chaiken, Shama@CDCR
Sent: Thursday, October 11, 2012 2:42 PM
To: Canning, Robert@CDCR
Subject: RE: DRAFT of new ASU screener - comments requested

This part is really clunky and could be difficult to follow:

If NO to Question 8 or Question 9, Skip to Question 12 and stop.
If YES to Question 9, ask Questions 10 & 11, DO NOT ask Question 12.

The instructions and scoring rules are a bit complicated for the staff who would be doing these screenings...

Shama Chaiken, Ph.D.
Chief of Mental Health
California State Prison, Sacramento
Division of Correctional Health Care Services

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CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

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From: Canning, Robert@CDCR
Sent: Thursday, October 11, 2012 2:39 PM
To: Chaiken, Shama@CDCR
Subject: RE: DRAFT of new ASU screener - comments requested

Thanks. But not in other ASU's?

Sorry for my somewhat brusque reply yesterday.

Did you take a look at the proposed screener? Do you think it is too complicated?

Robert D. Canning, Ph.D.
Senior Psychologist Specialist
Statewide Mental Health Program

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CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

From: Chaiken, Shama@CDCR
Sent: Thursday, October 11, 2012 2:36 PM
To: Canning, Robert@CDCR
Subject: FW: DRAFT of new ASU screener - comments requested

SAC does a full SRE within 24 business-hours of arrival in ASU EOP, based on a local suicide prevention decision. It's not a screen. It's a full review of the inmate-patient's records, interview...etc.

Shama Chaiken, Ph.D.
Chief of Mental Health
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CALIFORNIA CORRECTIONAL
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From: Wheeler, (Ralph) David@CDCR
Sent: Thursday, October 11, 2012 6:01 AM
To: Chaiken, Shama@CDCR
Cc: Coss, Natalie@CDCR
Subject: RE: DRAFT of new ASU screener - comments requested

It isn't required but I instituted that change when I ran the Ad Seg EOP unit based on suicide statistics in Ad Seg units. I thought it a best practice.

David Wheeler, PsyD
Chief Psychologist
CSP-Sacramento

916 985-8610 x6105
916 628-5966 iPhone
916 294-3121 Confidential fax
ralph.wheeler@cdcr.ca.gov

CALIFORNIA CORRECTIONAL
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From: Chaiken, Shama@CDCR
Sent: Wednesday, October 10, 2012 5:10 PM
To: Wheeler, (Ralph) David@CDCR
Subject: Fwd: DRAFT of new ASU screener - comments requested

Do you know the history of why we do a full SRE within 24 hrs of placement in ASU EOP? I was not aware of this and don't think it's required by statewide policy.

Begin forwarded message:

From: "Coss, Natalie@CDCR" <Natalie.Coss@cdcr.ca.gov>
To: "Chaiken, Shama@CDCR" <Shama.Chaiken@cdcr.ca.gov>
Subject: RE: DRAFT of new ASU screener - comments requested

It's in our LOP, page 5 under Assessment and Treatment Planning. It is a full SRE, not a screening. In the event the assigned clinician is on RDO, the backup performs the SRE to keep within the 24-hour time frame. I am attaching the 2011 revision because the 2012 revision I sent forth months ago is apparently still awaiting signatures and is not yet on the server. I can't speak to the length of time it takes someone to do it as that would likely vary by clinician...I can ask the staff if you would like for me to do so.

Natalie Coss, Ph.D.
Senior Psychologist Supervisor
AdSeg EOP program
California State Prison, Sacramento
(916) 985-8610 ext. 3175
natalie.coss@cdcr.ca.gov

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-----Original Message-----
From: Chaiken, Shama@CDCR
Sent: Wednesday, October 10, 2012 12:02 PM
To: Coss, Natalie@CDCR
Subject: FW: DRAFT of new ASU screener - comments requested

Do you know why we do a SRE within 24 hours of arrival into ASU EOP (what policy/procedure requires it)?

Shama Chaiken, Ph.D.
Chief of Mental Health
California State Prison, Sacramento

Division of Correctional Health Care Services

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-----Original Message-----
From: Canning, Robert@CDCR
Sent: Wednesday, October 10, 2012 11:57 AM
To: Chaiken, Shama@CDCR
Subject: RE: DRAFT of new ASU screener - comments requested

I am curious why a full SRE is done upon entry to ASU?

I actually think that screening instruments done well save time. It's a training and fidelity issue.

Also - what is the quality of the SRE done at entry to ASU? The last time I asked David how long people take to do an SRE and he said 15 minutes - which seems like a screening to me.

Robert D. Canning, Ph.D. Desk: (916) 691-0276
Senior Psychologist Specialist Cell: (530) 400-8965
Statewide Mental Health Program Fax: (916) 691-0534
mail: robert.canning@cdcr.ca.gov

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From: Chaiken, Shama@CDCR
Sent: Wednesday, October 10, 2012 11:40 AM
To: Canning, Robert@CDCR
Subject: FW: DRAFT of new ASU screener - comments requested

FYI – From Dr. Coss, supervisor of ASU EOP. We think a pre-screening, then a full SRE within 24 hours is sufficient without this additional workload.

Shama Chaiken, Ph.D.
Chief of Mental Health
California State Prison, Sacramento
Division of Correctional Health Care Services

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From: Coss, Natalie@CDCR
Sent: Wednesday, October 10, 2012 11:17 AM
To: Chaiken, Shama@CDCR
Subject: RE: DRAFT of new ASU screener - comments requested

I agree with your assessment about it duplicating suicide prevention efforts. I don't consider this instrument to be particularly user friendly in our setting in AdSeg EOP. Psych techs are going to have to spend more time wading through it to see that they are asking the right question (if no, proceed to this item, if yes, proceed to that one). My guess is that it will slow them down from their other job responsibilities. Additionally an SRE is done within 24 hours of the inmate-patient

coming into the unit by the PC.

Natalie Coss, Ph.D.
Senior Psychologist Supervisor
AdSeg EOP program
California State Prison, Sacramento
(916) 985-8610 ext. 3175
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[cid:image002.jpg@01CDA6D6.A3D4D920]

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From: Chaiken, Shama@CDCR
Sent: Wednesday, October 10, 2012 9:55 AM
To: Anderson, Wendy@CDCR; Chatman, Cynthia@CDCR; Worrell, Wendy@CDCR; Coss, Natalie@CDCR
Cc: Franklin, Loretta@CDCR; Oloyede, Tutu@CDCR; Wheeler, (Ralph) David@CDCR
Subject: FW: DRAFT of new ASU screener - comments requested

Please review the attached draft of a possible new ASU Screen – to replace the 31-item questionnaire. (Read the email below first)

I responded that I thought screening IPs currently included in MHSDS duplicates current suicide prevention efforts and is not necessary. I also think the tool needs instructions about those who refuse to participate.

Please send any feedback to me by Friday 10/12. Thanks!

Shama Chaiken, Ph.D.
Chief of Mental Health
California State Prison, Sacramento
Division of Correctional Health Care Services

916-294-3160 Office
916-508-2047 Cell

916-294-3122 Fax
shama.chaiken@cdcr.ca.gov<mailto:first.lastname@cdcr.ca.gov>

[cid:image002.jpg@01CDA6D6.A3D4D920]

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From: Canning, Robert@CDCR
Sent: Wednesday, October 10, 2012 9:32 AM
To: Chaiken, Shama@CDCR; Wheeler, (Ralph) David@CDCR; Switzer, Heidi@CDCR; Gauch, Gerardine@CDCR; Rushe, Regina H@CDCR
Subject: DRAFT of new ASU screener - comments requested

Greetings,

I'm writing to you because you all have extensive experience with the segregated housing environment in CDCR and the screening practices we currently use. Attached is a draft of a new screening instrument that we are proposing to pilot in a number of institutions around the state in hopes that it will be a better alternative and more effective screening measure than the current 31-item questionnaire.

Currently CDCR uses the 31-item Reception Center screening measure to screen for mental health needs within 72 hours of a non-MHSDS inmate's entry to ASU. This measure uses a subset of 14 items (the Referral Decision Scale) plus two more items focusing on suicidal thinking and history. Decision rules determine whether an inmate is referred.

The 31-item screener has never been validated in the CRCR setting, takes too long to administer, and does not address what we believe are the most important psychological factors effecting an inmate's behavior soon after entry into ASU: distress, isolation, loneliness, fear, and possibly thoughts of suicide.

We propose replacing the 31-item measure with this shorter, 12-item measure which combines two validated screeners: the Kessler Six (K6) and the Columbia Suicide Severity Rating Scale (C-SSRS). The K6 is a widely used scale of general distress that has high AUC's for detection of DSM disorders, and the C-SSRS is new validated measure of suicidal thinking and behavior that has been found useful in non-clinical settings. The C-SSRS is beginning to find its way into correctional settings and the K6 has been used on a trial basis in prisons in Illinois.

We also propose that the measure be used to screen all inmates placed in ASU rather than the current practice of only screening those who are not participants in the MHSDS. The rationale for this change is that historically the ASU screening was to determine mental health needs and since those in the MHSDS were already by default identified as needing mental health services, there was no need to screen them upon entry to ASU.
The current proposal assumes that anyone placed in ASU could be experiencing increased levels of distress and isolation thus we ought to identify these inmates quickly to be able to provide the services they may need.

When used together psychiatric technicians can quickly and easily screen for distress and suicidal thinking and make referrals. The structure of the instrument is algorithmic and if administered in a standardized fashion will facilitate, we believe, a better screening regimen in ASU.

I would be interested in ANY feedback you may have about this proposed screener – format, rules, page layout – anything. Thanks in advance for your help and if you have any questions, please let me know.

Thanks in advance.

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Statewide Mental Health Program Fax: (916) 691-0534
mail: robert.canning@cdcr.ca.gov<mailto:robert.canning@cdcr.ca.gov>

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[cid:image003.png@01CDA6D6.A3D4D920]

Exhibit 100

MENTAL HEALTH SERVICES DELIVERY SYSTEM

PROGRAM GUIDE

2009 REVISION

Division of Correctional Health Care Services

Department of Corrections & Rehabilitation

CHAPTER 2
Reception Center Mental Health Assessment

A. INTRODUCTION

The Reception Center (RC) program provides mental health assessment for all inmates committed to the California Department of Corrections and Rehabilitation (CDCR) and basic treatment for those inmates identified as having a serious mental disorder while awaiting transfer.

By enhancing and standardizing screening and evaluation efforts at the entry point into the institution system, the CDCR can best ensure that all inmates in need of mental health treatment are identified and provided necessary services at the earliest possible time. Early and easy access to care has been shown to have both therapeutic as well as fiscal benefits in managing mental illness at its lowest level of acuity. This is particularly true in the high stress environment of an institution setting.

This program utilizes clinical and clerical positions to achieve the following objectives:

1. Provide a standardized system for universal screening of all inmates received in the CDCR for possible symptoms of mental disorder or suicide risk.

2. Conduct in-depth clinical evaluations of individuals identified in the screening process for diagnosis of serious mental disorder, level of functioning, and necessary level of care.

3. Through the Inmate Mental Health Identifier System, CDCR is able to track inmate-patients who have been identified as seriously mentally disordered and enrolled in one of the Mental Health Services Delivery System (MHSDS) levels of care. This information provides a management tool and is utilized in program planning.

It is important to emphasize that the population this program seeks to identify is defined as those inmates who are dysfunctional in the prison environment as a result of a serious mental disorder. Specifically, these are inmates with a Diagnostic and Statistical Manual (DSM) Axis I diagnosis, with current symptoms, or evidence of medical necessity. Inmates who are prescribed psychotropic medications are also included in MHSDS. Inmates suffering suicidal

Exhibit 101

MENTAL HEALTH SERVICES DELIVERY SYSTEM

PROGRAM GUIDE

2009 REVISION

Division of Correctional Health Care Services

Department of Corrections & Rehabilitation

Specific program objectives include:

1. Continuation of care for inmate-patients with identified mental health treatment needs through regular case management activities and medication monitoring to enable inmate-patients to maintain adequate levels of functioning and avoid decompensation.

2. Daily clinical rounds of ALL inmates.

3. Mental Health screening of inmates who are not currently in the MHSDS caseload to identify mental health needs, and referral for further mental health evaluation as indicated.

4. Referral to a more intensive level of care for inmate-patients whose mental health needs cannot be met in the ASU, including expeditious placement into Mental Health Crisis Beds (MHCB) for inmate-patients requiring inpatient mental health care.

5. Mental health assessments and input into the classification decision-making process during ICC meetings, including the inmate-patient's current participation in treatment, medication compliance, suitability of single celling or double celling, risk assessment of self-injurious or assaultive behavior, status of Activities of Daily Living (ADL), ability to understand Due Process proceedings, likelihood of decompensation if retained in ASU, recommendations for alternative placement, and any other custodial and clinical issues that have impact on inmate-patients' mental health treatment.

6. Mental health assessments and input into the adjudication of Rules Violation Report (RVR) hearing proceedings involving MHSDS inmate-patients. Mental health information includes the quality of the inmate-patients' participation in their current MHSDS treatment plan, mental condition that may have been a contributing factor in the alleged misbehavior, and the ability to comprehend the nature of the charges or participate meaningfully in the disciplinary process. Final housing decisions are made by the ICC after considering all relevant clinical and custody factors.

D. TREATMENT POPULATION

Refer to the Treatment Criteria for the level of care in the MHSDS, Chapter 1, Overview Program Guide.

Referral for Mental Health Services

1. Pre-placement mental health screening: All inmates are screened by medical personnel for possible suicide risk, safety concerns, and mental health problems before placement in ASU (see Inmate Medical Services Policy and Procedure, *Volume 4, Chapter 16: CDCR 7219*). If an inmate screens positive on the CDCR 128-MH7, *ASU Pre-Placement*

Chrono, they are referred for a mental health evaluation on an Emergent, Urgent, or Routine basis, depending on their answers to the screening questions. After completion, the CDCR Form 128-MH7, *ASU Pre-Placement Chrono,* shall be placed in the mental health chrono section of the Unit Health Record (UHR). For Urgent and Routine referrals, the medical staff conducting the screening shall complete a CDCR 128-MH5, *Mental Health Referral Chrono,* and follow the referral process below.

2. Current MHSDS inmate-patients: All inmates placed into ASU shall be reviewed for identification of current MHSDS treatment status by the time of the initial CDCR-114D, *Order and Hearing on Segregated Housing*, review. This shall occur on the first work day following an inmate's placement. Current MHSDS inmate-patients are identified by checking the ASU placements reported on the Institutional Daily Movement Sheet with the treatment identifier code in the Distributed Data Processing System (DDPS) or the Mental Health Tracking System (MHTS) for inmate-patient treatment cases. During the initial review, mental health staff will ensure the continuity of mental health care, including the delivery of prescribed medications. Upon inmate's placement into ASU, nursing staff shall transfer the inmate's Medication Administration Record to ASU, consistent with the post orders.

3. Staff referral: Any staff member who observes possible signs or symptoms of a serious mental disorder shall refer an inmate for clinical evaluation by completing a CDCR 128-MH5, *Mental Health Referral Chrono.* The Referral Chrono shall be processed by following the referral process below. Any inmate who is observed to be a suicide risk, or in any other condition that requires crisis care, shall be immediately screened by the PC to assess the potential for suicide and, if appropriate, referral to the MHCB for admission.

4. Inmates who receive a CDCR 115, *Rules Violation Report,* for Indecent Exposure or Intentionally Sustained Masturbation Without Exposure shall be referred for all of the following:

    - CDCR 115-MH *Rules Violation Report: Mental Health Assessment;*

    - A mental health assessment shall be completed within 24 hours to rule-out decompensation and/or intoxication. The referral shall be made by telephone to the local Chief of Mental Health who shall arrange this assessment; and,

    - For inmate-patients included in the MHSDS, to the inmate-patient's Primary Clinician

5. Self referral: Inmates in ASU may request a clinical interview to discuss their mental health needs. These requests are made on a CDCR 7362, *Health Care Services Request.* Inmates shall receive the attached pamphlet, "*Administrative Segregation Inmate*

Orientation Mental Health Guide" (available in Spanish), within 24 hours of placement into ASU.

NOTE: When an IDTT determines that an inmate-patient requires treatment of exhibitionism, that inmate-patient's level of care shall be changed to CCCMS, Medical Necessity (or higher if appropriate), bypassing the standard referral process.

Referral process

Mondays through Fridays, the following shall occur:

1. A health care staff member shall collect the CDCR 7362, *Health Care Services Request,* and staff referral forms each day from the designated areas.

2. Upon receipt of the collected forms, a Registered Nurse (RN)/Licensed Vocational Nurse shall initial and date each CDCR 7362, *Health Care Services Request,* and the CDCR 128-MH5, *Mental Health Referral Chrono.*

3. The CDCR 7362, *Health Care Services Request*, and the CDCR 128-MH5, *Mental Health Staff Referral*, shall be delivered to the designated program representative in mental health services, dental services, or pharmacy services for same-day processing.

On weekends and holidays, the following shall occur:

1. The Triage and Treatment Area RN shall review each CDCR 128-MH5, *Mental Health Staff* Referral, and CDCR 7362, *Health Care Services Request*, for medical, dental, and mental health services, shall establish priorities on an emergent and non-emergent basis, and shall refer accordingly.

2. If a mental health clinician is not available, the medical officer of the day (MOD), physician on call or psychiatrist on call shall be contacted.

Inmates will be seen by a mental health clinician, or on weekends, by the MOD, physician, or psychiatrist on-call within the clinically determined time frame.

- Emergent: Emergency cases will be seen immediately or escorted to the Triage and Treatment area

- Urgent: Urgent cases will be seen within 24 hours

- Routine: Other cases will be seen within five working days

E. CLINICAL ROUNDS AND SCREENING

Clinical rounds

A mental health staff member, usually a Licensed Psychiatric Technician (LPT), shall conduct rounds seven days per week in all ASUs to attend to the mental health needs of all inmates. The LPT shall make initial contact with each inmate placed into ASU within 24 hours of placement.

A morning "check-in" meeting between custody and clinical staff shall be held each day. At minimum, an ASU Sergeant and an assigned ASU Mental Health clinician (psychologist or social worker) shall attend the morning meeting. During the meeting, involved personnel shall identify new arrivals, discuss current behavioral issues and concerns, and share any pertinent information regarding new arrivals and/or at-risk inmates. Pertinent suicide risk information from the MHTS Suicide Tracking Report will be discussed. This meeting shall be documented in the ASU Log book and salient clinical information shall be documented in the UHR and, if necessary, a referral for mental health services shall be made at the appropriate level of urgency.

In order to establish contact and provide information, mental health staff shall attend to developing rapport with new inmates on the first day of mental health rounds.

Each institution is to ensure that effective communication is observed when inmates have limited ability to speak English or are hearing impaired. Interpreter services information shall be posted in all areas where phones may be used for that purpose, and all staff assigned to ASU shall be provided documented training regarding access and use of services and available translation equipment.

Those inmates not previously identified as having mental health treatment needs who exhibit possible signs and symptoms of serious mental disorders are referred, via CDCR 128-MH5, *Mental Health Staff Referral*, for clinical evaluation. Interaction shall be sufficient to ascertain the inmate's mental condition particularly during the first ten days. The LPT shall maintain an individual record of clinical rounds on both MHSDS and non-patients by initialing next to the inmate's name on the CDCR 114, *Isolation Log Book*, each time the inmate is seen. Any unusual findings that may require closer observation by custody shall be documented on the CDCR 114-A, *Daily Log*, on the same day of occurrence. For identified MHSDS inmate-patients, the LPT shall document a summary of daily clinical rounds on a CDCR 7230, *Interdisciplinary Progress Notes*, in the UHR on a weekly basis. Notes will be clearly labeled as "Weekly Summary of LPT Clinical Rounds." If clinically indicated, the LPT may provide additional documentation.

Screening Questionnaire

All inmates who are not in the MHSDS and who are retained in ASU shall receive, within 72 hours of placement in ASU, a mental health screening interview utilizing the 31-question mental health screening questionnaire also used in the Reception Centers. The interview shall be conducted by a mental health clinician or trained nursing staff in private and confidential settings that afford confidentiality of sight and sound from other inmates, and confidentiality of sound from staff. Screening interview appointments shall be announced by custody staff as "health appointments" to avoid stigmatization and possible retribution by other inmates. Every effort shall be made to encourage inmates to attend these appointments.

The results of the questionnaire are evaluated either by hand-scoring or on an approved automated scoring system to determine the need for further evaluation. The scoring sheet shall be filed in the UHR. All inmates scoring positive on the questionnaire shall be referred to a mental health clinician to be seen within the clinically appropriate time frame. Emergent cases shall be seen immediately, Urgent cases shall be seen within 24 hours, all others shall be seen within 5 working days.

All referrals and results of evaluations are documented in individual inmates' UHR on approved forms and entered into the institutional MHTS. Decisions to provide treatment via placement into an outpatient program or MHCB shall be entered into DDPS.

F. CLINICAL EVALUATION

Referral evaluations will be completed within the time frames listed above and consist of the following:

1. A review of the UHR and, if necessary, the Central File, shall be completed and documented on approved forms as a part of the assessment process. Past treatment needs, medications, and program placements shall be noted.

2. An individual clinical interview to determine the nature of the problem and a full mental status examination. The examination is documented on a CDCR 7386, *Mental Health Evaluation*, and placed into the UHR.

3. When necessary, as determined by the evaluating clinician in consultation with the IDTT, psychological and neuropsychological testing may be conducted as a part of the diagnostic assessment of all cases not previously identified as having mental health treatment needs (testing is discretionary for inmate-patients currently receiving care who have not previously undergone such testing). When suicidality is an issue, a suicide risk assessment shall be conducted using the Suicide Risk Assessment Checklist (SRAC).

Exhibit 102

EXHIBIT 20
Deponent
Date
Rptr
12 12:17PM

Exhibit 103

12/16/11

Subject: Assessment of need for a higher level of care and CDCR's sustainable self-monitoring process (Coleman Case)

To: Benjamin T. Rice, General Counsel

From: Jeffrey A. Beard, PhD, Consultant

As a result of an order from the court on August 15, 2011 CDCR staff worked with the Coleman Special Master to develop and conduct an assessment process by December 9, 2011. This assessment process was focused on determining whether or not inmates in need of inpatient care were being identified, referred and transferred to such care in a timely manner. The court had great interest in such an assessment because prior assessments (Una in 2004 and MHARP in 2009) had found hundreds of inmates who needed such care but were not getting it. A secondary, but important part of the assessment process was to test CDCR's plan for a sustainable self- monitoring process for ensuring that inmates in need of such care are getting it on an ongoing basis. These two matters along with a plan addressing the inpatient (ICF) waitlist are seen as the major remaining components of this case.

CDCR staff and the special master initially agreed to use the annual Headquarters review portion of CDCR's proposed sustainable process to conduct an assessment of the DMH referral process at five institutions. However, during this part of the assessment the special master became concerned that the process was not "MHarpish" enough to satisfy the Judge's order. He came to this conclusion because the process allowed institutions to "re-do" documentation before the actual onsite review, and at some institutions these "re-does" were substantial.

As a result he added nine institutions to the assessment process making for a total of fourteen. For the added nine institutions, the same basic assessment process was utilized, except that the institutions did not receive prior notice of who would be reviewed and thus could not "re-do" documentation. Another factor in the

PLF EXHIBIT 9
Date 3-5-13
Witness
BEARD

special masters decision was that the fourteen institutions reviewed consisted of those institutions where most of the inmates needing referral to higher level care were found during MHARP.

The first five institutions were reviewed between 10/3/11 and 10/25/11. The second nine were completed from 11/8/11 to 12/8/11. I participated in thirteen of these reviews along with CDCR HQ staff, special master (for some) and his clinicians, and at a few institutions the plaintiffs as well.

Nine hundred sixty-six cases were reviewed by the special masters clinicians in the fourteen institutions, of those reviewed the clinicians only recommended 44 cases for DMH consideration. The institutions staff, after further review of 34 of these cases referred 18 inmates for inpatient care. Ten cases are still pending review by the institutions.

It should be noted that the special masters clinicians have been part of the monitoring process for years. They know most of the staff, the facilities and in some cases the inmates themselves. So they know where to look, and how to find potentially problematic cases. Considering the process that they used and their knowledge of the facilities it is unlikely that they would have missed inmates who were languishing. The cases they did find were what I would term the "tough ones." These are the cases that institution staff are struggling with, often trying different interventions. They are cases that two clinicians can look at and come to a different conclusion on what is best for that person. Sometimes they are cases that if referred, they are unlikely to benefit (i.e. dementia, fetal alcohol syndrome). In virtually all of these cases the clinical staff at the institution were well aware of the case and were actively working with them.

Therefore, unlike LINA and MHART, inmates are not languishing without proper care. They are being appropriately worked with, identified and referred if needed, and then transferred to DMH for ICF care. The fact that the average referral rate has risen to 78 per month also supports the conclusion that the system is working. Whatever impediments existed in 2009 and earlier (high staff turnover rate, lack of training for clinicians, failure to refer because of large wait lists, etc.) appear to have been addressed.

While inmates are being dealt with appropriately there are still documentation and data entry issues that exist at most institutions. In some cases they are substantial in nature. The problems found revolved around the automated MHTS.Net program, inadequate information in the eUHR and improper completion of the main treatment plan document, the 7388B. In most cases there are training issues involved (some training was actually completed during the review process), and in some there needs to be program changes to capture all the relevant information. There are some other issues that only affect one facility or are minor in nature. All of the problems found, however, can be fixed over the next few months by system changes, training and/or procedure changes at the institution level. I might also note that the problems found are consistent with what would be expected in the deployment of new systems (MHTS.net, eUHR) and forms (7388B) across a large system.

It is important that these changes be completed because most of the issues affect some aspect of documentation or data in the MHTS.net or eUHR. The institutions use both of these systems to manage the mentally ill inmates within their population. But more importantly, they are major components of the sustainable self-monitoring process developed by CDCR. If accurate data and documentation is not available in these systems then headquarters cannot properly monitor institution operations.

The third key piece to the Coleman case is the Wait list. As long as a wait list exists it will be difficult to get the court to let go of this case. CDCR's current plan to address the wait list is a good one, and should result in a surplus of inpatient beds when completed about 7/15/2012, if not before. The need for these types of beds fluctuates during the course of a year so any plan needs to account for this fluctuation, and I believe CDCRs plan will do so. In fact with only part of the plan in place the wait list has dropped below 100 and the wait time below 40 days. These numbers reflect substantial improvement in this important area.

The plaintiff's raised two other issues one during the San Quentin tour and the other at the all parties meeting on 12/9/11. While they are not part of the assessment process I note them here because if not addressed they could be used to

try to extend the case and because I think they are easily addressed. The first revolves around inpatient care for condemned inmates who need a higher level of care. A year ago there were a number of inmates in the condemned unit that needed more care than a typical EOP program. CDCR initiated an enhanced program for these inmates but one short of an inpatient level of care. Over half of the inmates got better with this extra care. But about five did not improve. One possible way to deal with this is to start a small (5 or 6) bed inpatient program at San Quentin for these inmates. Since the need for MHCB's are going down under AB109 it would be easy to convert a few of these beds to provide this care. The facility is excellent, trained staff are available and they appear to have adequate staffing levels.

The second issue is that some institutions which have Ag. Seg. Hubs for EOP care have mixed non-mentally ill inmates in these units. This makes programming more difficult but the real problem is that inmates who are waiting for placement cannot get in because the beds are full. While they get some care at their current institution it is not to the level that they would get in the hub institution. Overcrowding largely caused this issue. AB109 is significantly addressing the overcrowding so those institutions with the EOP hubs should be able to move the non-mentally ill inmates out of these units. This would free up space and make this a nonissue.

CDCR is currently identifying, referring and transferring inmates who need higher level care to DMH ICF programs. The wait list should be eliminated and adequate inpatient care capacity should be available by Spring/Summer 2012. From now to that point in time CDCR has ample opportunity to provide the training and make the changes necessary to ensure a viable sustainable self-monitoring process is in place. It would be my opinion that when the last two issues (wait list; sustainable process) are in place it would be time for serious discussions relative to ending Coleman. At that point I believe it would be very difficult to make a case that CDCR is not providing constitutionally adequate care to mentally ill inmates.

I make this statement based upon the following facts:

1) I have reviewed MH policy and procedure and found them to be detailed and appropriate.

2) I have reviewed staffing levels, and observed the use of staff and found them to be if anything excessive.

3) I have observed MH program space in thirteen facilities and found it to range from marginally adequate in some facilities to substantial in others.

4) I have observed new MH program space and housing being constructed at a number of facilities, which will serve to significantly upgrade MH program space and housing. This will also give CDCR flexibility in conjunction with AB109 population reductions to not use some less desirable space.

5) I have also observed the MH program space being actively used for both group and individual programming in all the institutions visited.

6) Inmates who need higher level inpatient care are not languishing. Staff are actively working with them, they are getting appropriate care, staff are aware of the referral process, and they are referring when necessary. Those that are referred are being placed in DMH inpatient programs. A process is in place to deal with any problems that arise in the referral process.

Therefore except for the fact that some inmates who are referred for higher level care have to wait for DMH placement all the pieces of constitutionally adequate care are in place. The significantly shortened wait times coupled with the fact that many inmates who are waiting receive enhanced care while still in CDCR are beginning to mitigate the wait list issue. But within six months elimination of the wait list will make it a moot point. At the same time CDCR should have a sustainable process in place to ensure that the current level of care for mentally ill inmates is maintained and if not any breakdown is swiftly detected and corrected.

Exhibit 104

From: O'Meara, Kathleen@CDCR
Sent: Monday, January 28, 2013 8:59 AM
To: Handian-Shirikian, Sylvia@CDCR
Subject: Re: do not forward

Re-informed them of that -just got the sob story - were just too busy. It wasn't until I told dave that McCarver would jump start them TODAY that he said they would get back to me with dates

From: Handian-Shirikian, Sylvia@CDCR
Sent: Monday, January 28, 2013 08:29 AM Pacific Standard Time
To: O'Meara, Kathleen@CDCR
Subject: RE: do not forward

Clever way of saying they haven't done anything. They do know that we will have a court monitor with us next month for their major visit right?

Sylvia Shirikian, Psy.D.
Senior Psychologist Specialist
Northern Region
Statewide Mental Health Program
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From: O'Meara, Kathleen@CDCR
Sent: Monday, January 28, 2013 8:28 AM
To: Handian-Shirikian, Sylvia@CDCR
Subject: Re: do not forward

I checked. It doesn't mean that. Means its not done. I've talked to dave. I'm tired of this BS

From: Handian-Shirikian, Sylvia@CDCR
Sent: Monday, January 28, 2013 08:25 AM Pacific Standard Time
To: O'Meara, Kathleen@CDCR
Subject: RE: do not forward

Does "in process" mean they did not pass the first time and require further mentoring? That's how I interpret it, in which case, there seems to be a problem at CMF

Sylvia Shirikian, Psy.D.
Senior Psychologist Specialist
Northern Region
Statewide Mental Health Program
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From: O'Meara, Kathleen@CDCR
Sent: Thursday, January 24, 2013 1:02 PM
To: Handian-Shirikian, Sylvia@CDCR
Subject: do not forward

How's this for meaningful? I asked them to get back to me with anticipated completion dates.

Not heard back from Telander on offer to send you there...

From: Huntington, Gretchen@CDCR
Sent: Thursday, January 24, 2013 11:59 AM
To: O'Meara, Kathleen@CDCR; Silbaugh, David@CDCR; Gerbasi, Joan@CDCR
Subject: RE: SRE Mentor Program status

Here's the list thus far from the MHCBF.

Gretchen Huntington, Psy.D.
Senior Psychologist, Specialist
PSY 23141
Higher Level of Care Team Coordinator
California Medical Facility
iPhone 707-471-8139
Phone 707-448-6841 ext 2515
Page 707-417-2154

From: O'Meara, Kathleen@CDCR
Sent: Wednesday, January 23, 2013 3:57 PM
To: Huntington, Gretchen@CDCR; Silbaugh, David@CDCR; Gerbasi, Joan@CDCR
Subject: RE: SRE Mentor Program status

Wow! Good start. If you can get me the MHCB by the end of the month, it would be much appreciated.

From: Huntington, Gretchen@CDCR
Sent: Wednesday, January 23, 2013 3:49 PM
To: Silbaugh, David@CDCR; Gerbasi, Joan@CDCR; O'Meara, Kathleen@CDCR
Subject: FW: SRE Mentor Program status

Here you go! I don't have the one for the MHCBF but this is for MHSDS.

Gretchen Huntington, Psy.D.
Senior Psychologist, Specialist
PSY 23141
Higher Level of Care Team Coordinator
California Medical Facility
iPhone 707-471-8139
Phone 707-448-6841 ext 2515
Page 707-417-2154

From: Silbaugh, David@CDCR
Sent: Wednesday, January 23, 2013 3:48 PM
To: O'Meara, Kathleen@CDCR
Cc: Huntington, Gretchen@CDCR; Gerbasi, Joan@CDCR
Subject: RE: SRE Mentor Program status

Hi Kathy,

Yes, we are making good progress. Gretchen will send you her log shortly.

Let me know what else you may need.

Thanks, Dave

David Silbaugh, Ph.D.
Chief Psychologist/Chief of Mental Health
Mental Health Services Delivery System
California Medical Facility
Office: (707) 453-7038
Blackberry: (707) 330-6778

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

From: O'Meara, Kathleen@CDCR
Sent: Wednesday, January 23, 2013 10:18 AM
To: Silbaugh, David@CDCR
Cc: Huntington, Gretchen@CDCR; Gerbasi, Joan@CDCR
Subject: SRE Mentor Program status

Hi Dave,
I trust the mentor program is off and running at this point. We need to have some proof of practice that it is happening and will continue to happen.
You may use the attached template for logging in the status of staff who have been mentored. Gretchen had a template a while back, I don't really care if you use the one she developed or this one (although I think the attached is a bit simpler and therefore probably easier)
Again, we are not collecting "scores," just whether or not the mentoring is completed.
If someone is actively being mentored just put "in process." For the upcoming months, please show the schedule indicating when all staff will be mentored.
Thanks,
Kathy

Exhibit 105

From: Krista Stone-Manista
Sent: Monday, December 10, 2012 2:26 PM
To: Matt Lopes; Debbie Vorous; Donald Specter; diana.toche@cdcr.ca.gov; Benjamin Rice
Cc: 'Walsh, Kerry F.'; Michael W. Bien; Debbie Vorous; Donald Specter; diana.toche@cdcr.ca.gov; Benjamin Rice; Holden, Linda E.; Mohamedu Jones; Steve Fama; Katherine.Tebrock@cdcr.ca.gov; Henry D. Dlugacz; Kerry Courtney Hughes, MD; Haunani Henry; Jeff Metzner; Mary Perrien; Steve Raffa; Kristina Hector; Misty Delgado; Coleman Team - RBG Only
Subject: Coleman: DSH Staffing Letter for 12/14/12 Meet and Confer [IWOV-DMS.FID6429]
Attachments: Supplement re DSH staffing and suicide for December 2012 meet and confer, 12-10-12, 489-3.DOCX; State_Hospital_Financial_Activity_Report_2012.pdf; Cost Savings Report FY11-12_Final.pdf; Coleman - ICF Treatment at VPP and SVPP [IWOV-DMS.FID6429]

Dear all,

Please find attached a letter from Michael Bien, with related references, regarding the agenda for Friday's meet and confer session.

Best,

Krista Stone-Manista

Krista Stone-Manista
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December 10, 2012

VIA ELECTRONIC MAIL ONLY

Matthew A. Lopes, Jr.
Coleman Special Master
Pannone Lopes Devereaux & West LCC
317 Iron Horse Way, Suite 301
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Debbie Vorous
Deputy Attorney General
State of California
Department of Justice
1300 I Street
Sacramento, CA 94244-2550

Re: *Coleman v. Brown*
Agenda for Meet and Confer Meeting, December 14, 2012
Our File No. 0489-3

Dear Matty and Debbie:

Plaintiffs write to request an important item concerning inpatient psychiatric hospitalization to be discussed as part of the agenda for the meeting scheduled for December 14, 2012.

We have received notification of the suicide on December 2, 2012 of a *Coleman* class member, Terry Wolfe (K-08158), housed at SVPP—the first suicide of a class member at a Department of State Hospitals ("DSH") facility in more than 5 years. While we do not yet know the details of this unfortunate death, we are concerned about the role that chronic DSH staffing shortages may have played in this suicide, and more generally, about the impact of serious understaffing on *Coleman* class members in DSH facilities throughout the State.

While the number of patients in DSH facilities has remained at high levels, there have been many recent layoffs of clinical staff at DSH facilities. A notice from Acting Director Cliff Allenby, posted on the State Hospitals website earlier this year, stated that "the Department must eliminate 600 positions to meet its budgetary obligations." The Department's "Cost Savings Report" for Fiscal Year 2011-2012 reflects that 259.9 such positions were eliminated as part of a reduction of the ICF treatment team ratio from 1:25 to 1:35. (*See* attached report, "Department of State Hospitals, Actual Cost Savings Achieved, Fiscal Year 2011-12," at 1.) These staffing reductions occurred even though the average daily census at DSH facilities housing *Coleman* class members, including

Coalinga, Patton, Salinas Valley, and Vacaville, increased in Fiscal Year 2011-2012 relative to the previous year. (*See* attached report, "Department of State Hospitals Report on State Hospital Financial Activity," at 1.)

Alarmingly, as of November 1, 2012, there were 20 unfilled positions for licensed psychiatric technicians at Salinas Valley, the location of the recent suicide—a vacancy rate of 100%. (Earlier data reflects that these LPT positions have long gone unfilled at Salinas Valley.) In October, Salinas Valley suffered from an overall vacancy rate of 39%, or 36% after adjusting for the use of full-time contractors. This is an even worse vacancy report than that we noted in a July 27, 2012 email to Defendants' counsel, when there was an overall functional vacancy report of 33% at SVPP. (*See* attached email from Aaron J. Fischer, 7/27/12.) At that time, we had received a number of disturbing reports from class members describing cancellation of groups, recreational therapy, and access to therapeutic yard as a result of staffing shortages.

While we highlight Salinas Valley as a result of the recent suicide there, chronic understaffing at DSH facilities is a severe problem affecting *Coleman* class members across the system. High vacancy rates in critical staff positions persist across the DSH system. The DSH Monthly Data produced to Plaintiffs for October 2012 indicated that as of November 1, 2012, there were 478.65 total vacant positions in *Coleman*-related jobs, for an overall vacancy rate of 12%. This troubling situation is only slightly alleviated by the use of 120 full-time contract staff, which reduced the functional vacancy rate to 9%.

We hope to have a productive discussion regarding this serious ongoing concern. We look forward to the meeting on December 14, 2012, and are available to answer any questions or concerns before that date.

Sincerely,

ROSEN BIEN
GALVAN & GRUNFELD LLP

/s/ Michael W. Bien

By: Michael W. Bien

MWB:ksm:amc
cc: *Coleman* Special Master Team
Coleman Co-Counsel
William Downer, AG
Heather McCray, CDCR Legal
Michael Stone, CDCR Legal

Department of State Hospitals

Report on State Hospital Financial Activity

Fiscal Year 2011-12 Through Fiscal Year 2012-13

CLIFF ALLENBY
Acting Director

DEPARTMENT OF STATE HOSPITALS REPORT
ON STATE HOSPITAL FINANCIAL ACTIVITY

Executive Summary

FY 2011-12 and FY 2012-13
State Hospital Allotment and Expenditure Comparisons

The Department of State Hospitals (DSH) Report on State Hospital Financial Activity is enclosed. The report is prepared in accordance with Item 4440-011-0001, Provision (15) of the Budget Act of 2012 which requires DSH to report State Hospital allotments and expenditures by October 15, 2012 and as part of the Governor's Budget and May Revision. The report includes all State Hospital allotments and actual expenditures for FY 2011-12 and projected allotments and expenditures for FY 2012-13.

Population Growth

The chart below displays State Hospital population growth from 2009-10 to present. Since FY 2009-10, the State Hospital population grew at an average rate of 2.5 percent annually.

	Average Daily Census			
	2009-10	**2010-11**	**2011-12**	**3-Year Annual Average**
ASH	1,030	1,141	1,032	1,068
CSH	890	904	962	919
MSH	647	606	620	624
NSH	1,136	1,149	1,169	1,151
PSH	1,504	1,490	1,506	1,500
SVPP	232	232	347	270
VPP	251	286	312	283
Total	**5,690**	**5,808**	**5,948**	**5,815**
Annual growth rate	2.97%	2.07%	2.41%	2.48%

Expenditure Detail

FY 2011-12

- Initial DSH-Stockton activation began, generating expenditures related to core executive and clinical team hiring.
- Activation of DSH-Vacaville L-Wing began, generating expenditures related to staffing and operating expenses.

FY 2012-13

- Continued DSH-Stockton activation, including hiring remaining administrative and clinical staff. Patient admissions will begin June 2013.
- Continued activation of DSH-Vacaville L-Wing.

Cost Savings

DSH implemented cost savings plans mid-year in FY 2011-12, generating $121.9 million in savings. Full year implementation of cost savings proposals in FY 2012-13 is expected to generate $193.1 million in savings.

Contracts

Contracts managed at the Headquarters on behalf of the State Hospitals represent system-wide and specialty contracts.

- Human Resources – California Department of Personnel Administration, Cooperative Personnel Services
- Information Technology – Personal Duress Alarm System, California Department of Technology Services, AT&T DataCom
- Legal Representation – Various independent law firms, California Department of Justice
- Licensing – The Joint Commission, California Department of Public Health
- Miscellaneous – Disability Rights California; National Association of State Mental Health Program Directors Research Institute; California State University, Sacramento; Human Potential Consulting Group (Court Monitor)

State Hospital Position Detail

The State Hospital vacancy rate has decreased from FY 2011-12 by three percent. DSH is continuing recruitment efforts to further reduce the vacancy rate.

Fiscal Year 2011-12

STATE HOSPITALS	FY 11/12 AUTHORIZED POSITONS	VACANT	% VACANT
ATASCADERO	2173.3	241.9	11.13%
COALINGA	1914.9	292.2	15.26%
METROPOLITAN	1563.4	224.6	14.37%
NAPA	2313.0	223.8	9.68%
PATTON	2588.7	218.9	8.46%
STOCKTON	0.0	0.0	0.00%
SALINAS	733.0	300.0	40.93%
VACAVILLE	570.3	145.9	25.58%
Totals	11856.6	1647.3	14%

Fiscal Year 2012-13

STATE HOSPITALS	FY 12/13 AUTHORIZED POSITONS	VACANT	% VACANT
ATASCADERO	2029.7	219.9	10.83%
COALINGA	1880.3	153.2	8.14%
METROPOLITAN	1359.8	115.2	8.47%
NAPA	2245.8	211.5	9.42%
PATTON	2385.5	153.7	6.44%
STOCKTON	82.9	82.9	100.00%
SALINAS	561.5	113.5	20.21%
VACAVILLE	725.6	216.0	29.77%
Totals	11271.1	1265.9	11%

Assumptions:

FY 11-12 authorized positions based on Schedule 7A. Filled positions include 7A filled, contractor filled and temporary help.

FY 12-13 authorized positions based on 7A and blanket authorized as a result of the salary savings drill. Filled positions based on 7A, blanket filled, contractor filled and temporary help.

Vacant positions are counted as filled when offset by registry contractors to maintain required clinical staffing ratios during the recruitment process. Stockton State Hospital position recruitment is based on a phase-in schedule related to facility activation.

Staffing Ratios

DSH treatment team ratios for FY 2012-13 are 1:35 on average, effective December 2011. Treatment team ratios are dependent on patient acuity and may fluctuate to meet patient mental health treatment needs and ensure security of both staff and patients.

DSH implemented a 1:64 Physician/Surgeon ratio in December 2011, a change from the prior ratio of 1:62. The ratio achieved through streamlining documentation, allows physician/surgeons to increase their caseload. The ratio change allows DSH to maintain adequate patient staffing and comply with licensing requirements.

Capital Outlay Projects

For Fiscal Year 2012-13, the projected capital outlay projects are displayed below.

HOSPITAL	PROJECT DESCRIPTION	DGS PROJECT NUMBER	CURRENT PHASE
MSH	New fire water line	116367A	Construction
MSH	Roof replacement	132302	Construction
MSH/NSH	Fire sprinkler systems	133197	Working Drawings
NSH	New main kitchen	122198	Working Drawings
NSH	Fire alarm replacement	133190	Working Drawings
PSH	New main kitchen	122189	Working Drawings
PSH	New residential housing	132595BP	Study

All State Hospitals Expenditure Comparison					
		2011-2012		2012-2013	
		Allotment	Actuals	Allotment	Projections
PERSONAL SERVICES					
Salaries					
003	Salaries & Wages	730,447,649	696,456,842	673,040,888	672,437,757
033	Temp Help	10,690,703	17,641,413	16,023,342	16,023,342
083	Overtime	79,174,622	93,353,342	81,989,237	81,883,104
	TOTAL SH Salaries	**820,312,974**	**807,451,597**	**771,053,468**	**770,344,204**
TOTAL Salaries (w/ Central Hospital Support)		**820,312,974**	**807,451,597**	**816,730,468**	**770,344,204**
Staff Benefits					
103	OASDI	24,462,781	22,083,432	19,829,016	19,792,720
106	Retirement	122,819,967	119,241,715	118,579,935	118,445,542
125	Workers' Compensation	29,030,854	29,151,077	29,094,820	29,084,153
127	Industrial Disability Leave	9,336,201	9,816,507	10,444,151	10,443,674
132	Nonindustrial Disability Leave	3,232,800	3,148,896	3,473,760	3,469,542
133	Unemployment Insurance	1,609,541	1,930,089	2,083,983	2,083,029
134	Other	89,402,227	92,720,120	95,599,199	95,540,906
	TOTAL SH Staff Benefits	**279,894,371**	**278,091,837**	**279,104,864**	**278,859,567**
TOTAL Staff Benefits (w/ Central Hospital Support)		**280,420,109**	**278,599,883**	**279,104,864**	**278,859,567**
TOTAL PERSONAL SERVICES		**1,100,733,083**	**1,086,051,480**	**1,095,835,332**	**1,049,203,770**
	Percent Change for Personal Services Expenditures		**2.1%**		**-3.5%**
OPERATING EXPENSES & EQUIPMENT					
311	General Expense	6,582,651	8,043,021	5,428,536	5,418,937
312	Printing	1,671,933	1,658,534	1,646,662	1,646,253
313	Communications	3,740,118	3,236,403	2,823,181	2,823,018
314	Postage	341,913	261,763	231,813	231,810
315	Insurance	760,767	940,366	1,001,283	1,001,279
317	Travel-In-State	982,526	1,094,413	1,092,192	1,091,852
318	Travel-Out-of-State	0	0	0	0
321	Training	447,815	367,052	466,255	465,334
323	Facilities Operation	8,617,082	8,973,731	7,556,366	7,555,276
352	Special Repairs & Deferred Maint.	1,428,217	1,268,634	1,594,756	1,594,756
324	Utilities	15,717,341	15,290,274	15,555,937	15,555,937
325	C&PS-Interdepartmental	6,905,215	6,930,995	7,500,686	7,500,509
326	C&PS-External	28,585,005	23,725,943	11,051,947	11,051,947
328	Consolidated Data Centers	406,338	310,035	338,417	338,226
329	Data Processing/IT	12,469,714	11,745,143	35,810,537	35,808,212
332	Equipment	2,096,097	2,750,308	1,141,468	1,140,589
413	C&PS-External-Hlth & Med.	32,397,557	34,425,143	31,747,378	31,719,834
418	Outside Services/Other Services	24,509,728	33,913,018	25,693,796	25,693,796
503	Other-Clothing/Personal Supplies	2,103,564	1,792,277	1,466,289	1,465,942
505	Other-Recreation & Religion	236,221	233,664	272,219	271,931
505 01	BYCHOICE	264,357	144,149	61,800	61,800
506	Foodstuffs	15,698,346	15,686,778	15,276,065	15,276,031
512	Quartering & Housekeeping	2,735,037	2,814,054	2,444,399	2,444,391
513	Laundry	3,597,390	3,232,962	3,001,240	3,001,240
514	Misc Client Services	2,082,647	1,886,134	1,828,928	1,828,928
516	Chemicals, Drugs & Lab Supplies	6,818,875	6,239,623	4,731,702	4,731,266
516 01	Pharmacueticals	44,376,211	39,984,037	34,763,726	34,763,726
517	Other-Educational Supplies	115,789	117,246	49,011	48,889
520	Other-Uniform Allowance	313,336	343,947	560,872	559,900
524	Other-Vehicle Operations	921,661	1,154,360	1,075,434	1,075,352
444	Interest & Penalties	624,585	427,399	22,105	22,091
568	Other-Not Otherwise Classified, Goods	561,076	726,471	709,152	709,144
569	Other-Not Otherwise Classified, Services	328,052	1,201,632	389,518	389,518
	Lottery	0	29,000	0	0
TOTAL OE&E (w/ Central Hospital Support)		**228,466,165**	**230,948,508**	**217,333,668**	**217,287,711**
	Percent Change for OE&E Expenditures		**13.8%**		**-6.3%**
GRAND TOTAL: PS & OE&E		**1,329,199,248**	**1,316,999,987**	**1,313,169,000**	**1,266,491,481**
	TOTAL Percent Change for PS & OE&E Expenditures		**4.2%**		**-4.0%**

Atascadero State Hospital

Expenditure Comparison

		2011-2012		2012-2013	
		Allotment	Actuals	Allotment	Projections
PERSONAL SERVICES					
Salaries					
003	Salaries & Wages	137,352,260	124,936,687	118,581,431	118,581,431
033	Temp Help	253,000	3,262,191	2,937,384	2,937,384
083	Overtime	3,104,031	11,417,087	11,226,304	11,226,304
	TOTAL Salaries	**140,709,291**	**139,615,965**	**132,745,119**	**132,745,119**
Staff Benefits					
103	OASDI	1,219,738	1,223,996	1,149,038	1,149,038
106	Retirement	21,785,246	21,058,236	19,954,462	19,954,462
125	Workers' Compensation	6,713,153	7,967,783	6,567,783	6,567,783
127	Industrial Disability Leave	2,247,197	2,468,786	2,468,786	2,468,786
132	Nonindustrial Disability Leave	689,685	992,945	992,945	992,945
133	Unemployment Insurance	255,000	428,881	428,881	428,881
134	Other	18,612,444	19,448,123	18,265,390	18,265,390
	TOTAL Staff Benefits	**51,522,463**	**53,588,750**	**49,827,285**	**49,827,285**
TOTAL PERSONAL SERVICES		**192,231,754**	**193,204,715**	**182,572,404**	**182,572,404**
	Percent Change for Personal Services Expenditures		**-0.6%**		**-5.8%**
OPERATING EXPENSES & EQUIPMENT					
311	General Expense	600,000	672,975	672,975	672,975
312	Printing	190,000	178,538	178,538	178,538
313	Communications	449,000	485,538	485,538	485,538
314	Postage	48,200	36,286	36,286	36,286
315	Insurance	57,000	52,358	52,358	52,358
317	Travel-In-State	249,700	284,873	284,873	284,873
318	Travel-Out-of-State	0	0	0	0
321	Training	40,600	50,697	50,697	50,697
323	Facilities Operation	1,146,000	1,434,477	1,234,477	1,234,477
352	Special Repairs & Deferred Maint.	413,306	403,942	0	0
324	Utilities	2,650,978	2,277,207	2,277,207	2,277,207
325	C&PS-Interdepartmental	604,718	600,238	600,238	600,238
326	C&PS-External	165,900	128,452	128,452	128,452
328	Consolidated Data Centers	65,000	37,781	37,781	37,781
329	Data Processing/IT	1,520,000	1,391,209	1,391,209	1,391,209
332	Equipment	50,000	375,737	50,000	50,000
413	C&PS-External-Hlth & Med.	1,973,226	1,976,136	2,015,659	2,015,659
418	Outside Services/Other Services	8,369,284	9,344,208	5,467,229	5,467,229
503	Other-Clothing/Personal Supplies	221,468	267,737	273,092	273,092
505	Other-Recreation & Religion	18,148	22,134	22,134	22,134
505 01	BYCHOICE	23,400	23,398	0	0
506	Foodstuffs	2,365,000	2,225,261	2,366,388	2,366,388
512	Quartering & Housekeeping	367,200	352,011	359,052	359,052
513	Laundry	494,500	462,317	471,563	471,563
514	Misc Client Services	337,200	358,766	365,941	365,941
516	Chemicals, Drugs & Lab Supplies	500,000	596,993	608,933	608,933
516 01	Pharmacueticals	9,260,000	7,057,700	4,467,155	4,467,155
517	Other-Educational Supplies	9,000	2,908	2,908	2,908
520	Other-Uniform Allowance	75,000	75,330	75,330	75,330
524	Other-Vehicle Operations	71,000	124,717	124,717	124,717
444	Interest & Penalties	9,766	9,766	0	0
568	Other-Not Otherwise Classified, Goods	120,000	76,224	76,224	76,224
569	Other-Not Otherwise Classified, Services	4,759	3,085	3,085	3,085
TOTAL OE&E		**32,469,353**	**31,388,998**	**24,180,038**	**24,180,038**
	Percent Change for OE&E Expenditures		**-38.6%**		**-29.8%**
GRAND TOTAL: PS & OE&E		**224,701,107**	**224,593,713**	**206,752,442**	**206,752,442**
	TOTAL Percent Change for PS & OE&E Expenditures		**-5.9%**		**-8.6%**

Coalinga State Hospital

Expenditure Comparison

		2011-2012		2012-2013	
		Allotment	**Actuals**	**Allotment**	**Projections**
PERSONAL SERVICES					
Salaries					
003	Salaries & Wages	110,052,243	94,533,354	92,605,248	92,605,248
033	Temp Help	967,203	607,343	550,967	550,967
083	Overtime	10,300,000	9,470,596	5,071,800	5,071,800
	TOTAL Salaries	**121,319,446**	**104,611,293**	**98,228,015**	**98,228,015**
Staff Benefits					
103	OASDI	3,000,000	1,296,387	1,223,999	1,223,999
106	Retirement	16,595,241	15,985,889	15,706,604	15,706,604
125	Workers' Compensation	2,239,695	2,450,223	2,395,235	2,395,235
127	Industrial Disability Leave	994,182	1,032,127	1,032,132	1,032,132
132	Nonindustrial Disability Leave	670,508	568,261	568,260	568,260
133	Unemployment Insurance	291,532	457,067	457,200	457,200
134	Other	11,531,724	14,908,899	14,795,316	14,795,316
	TOTAL Staff Benefits	**35,322,882**	**36,698,853**	**36,178,747**	**36,178,747**
TOTAL PERSONAL SERVICES		**156,642,328**	**141,310,146**	**134,406,763**	**134,406,763**
	Percent Change for Personal Services Expenditures		**5.0%**		**-5.1%**
OPERATING EXPENSES & EQUIPMENT					
311	General Expense	604,062	616,114	554,042	554,042
312	Printing	217,562	354,011	318,612	318,612
313	Communications	503,646	675,731	675,732	675,732
314	Postage	98,005	35,589	35,585	35,585
315	Insurance	80,596	103,114	89,913	89,913
317	Travel-In-State	51,286	228,497	205,680	205,680
318	Travel-Out-of-State	0	0	0	0
321	Training	77,365	48,266	38,604	38,604
323	Facilities Operation	1,258,711	1,663,831	1,580,640	1,580,640
352	Special Repairs & Deferred Maint.	2,358	1,269	2,500	2,500
324	Utilities	2,142,331	2,980,296	2,980,296	2,980,296
325	C&PS-Interdepartmental	164,370	544,321	535,801	535,801
326	C&PS-External	3,500,000	33,138	18,144	18,144
328	Consolidated Data Centers	9,810	0	0	0
329	Data Processing/IT	230,054	563,029	494,556	494,556
332	Equipment	190,796	232,952	209,664	209,664
413	C&PS-External-Hlth & Med.	4,042,947	9,064,495	7,879,022	7,879,022
418	Outside Services/Other Services	8,102,701	16,211,616	12,711,612	12,711,612
503	Other-Clothing/Personal Supplies	235,657	315,320	283,788	283,788
505	Other-Recreation & Religion	14,614	70,729	63,000	63,000
505 01	BYCHOICE	62,020	42,483	8,800	8,800
506	Foodstuffs	2,207,540	3,062,581	3,062,580	3,062,580
512	Quartering & Housekeeping	38,100	311,086	295,536	295,536
513	Laundry	352,238	529,245	529,243	529,243
514	Misc Client Services	380,330	379,841	379,848	379,848
516	Chemicals, Drugs & Lab Supplies	3,570,161	2,807,943	1,124,788	1,124,788
516 01	Pharmacueticals	0	2,782,524	3,776,847	3,776,847
517	Other-Educational Supplies	26,420	7,321	4,800	4,800
520	Other-Uniform Allowance	276	976	126,500	126,500
524	Other-Vehicle Operations	95,267	119,842	119,838	119,838
444	Interest & Penalties	290,794	35,197	8	8
568	Other-Not Otherwise Classified, Goods	0	64,705	58,284	58,284
569	Other-Not Otherwise Classified, Services	17,149	0	1,500	1,500
TOTAL OE&E		**28,567,166**	**43,886,062**	**38,165,763**	**38,165,763**
	Percent Change for OE&E Expenditures		**8.8%**		**-15.0%**
GRAND TOTAL: PS & OE&E		**185,209,494**	**185,196,208**	**172,572,525**	**172,572,525**
	TOTAL Percent Change for PS & OE&E Expenditures		**5.9%**		**-7.3%**

Metropolitan State Hospital

Expenditure Comparison

		2011-2012		2012-2013	
		Allotment	**Actuals**	**Allotment**	**Projections**
	PERSONAL SERVICES				
Salaries					
003	Salaries & Wages	101,498,417	90,481,670	86,667,283	86,667,283
033	Temp Help	260,500	5,160,658	4,265,524	4,265,524
083	Overtime	3,008,566	12,601,038	10,920,229	10,920,229
	TOTAL Salaries	**104,767,483**	**108,243,366**	**101,853,036**	**101,853,036**
Staff Benefits					
103	OASDI	5,101,472	5,009,141	1,203,594	1,203,594
106	Retirement	17,289,117	15,559,526	15,980,498	15,980,498
125	Workers' Compensation	6,748,051	5,736,907	6,561,794	6,561,794
127	Industrial Disability Leave	1,442,282	1,833,052	2,248,582	2,248,582
132	Nonindustrial Disability Leave	189,447	147,280	145,700	145,700
133	Unemployment Insurance	216,155	234,118	275,000	275,000
134	Other	11,284,752	11,254,260	14,933,690	14,933,690
	TOTAL Staff Benefits	**42,271,276**	**39,774,285**	**41,348,858**	**41,348,858**
TOTAL PERSONAL SERVICES		**147,038,759**	**148,017,651**	**143,201,894**	**143,201,894**
	Percent Change for Personal Services Expenditures		**0.04%**		**-3.4%**
	OPERATING EXPENSES & EQUIPMENT				
311	General Expense	577,940	346,724	350,000	350,000
312	Printing	304,445	203,698	201,230	201,230
313	Communications	1,249,310	756,796	760,000	760,000
314	Postage	82,098	35,545	37,000	37,000
315	Insurance	125,217	167,522	175,000	175,000
317	Travel-In-State	459,807	295,779	304,445	304,445
318	Travel-Out-of-State	0	0	0	0
321	Training	80,652	55,359	56,000	56,000
323	Facilities Operation	2,025,849	1,834,630	1,168,000	1,168,000
352	Special Repairs & Deferred Maint.	198,688	79,366	700,000	700,000
324	Utilities	3,974,032	3,100,404	2,418,505	2,418,505
325	C&PS-Interdepartmental	592,683	416,692	402,187	402,187
326	C&PS-External	335	96,463	63,636	63,636
328	Consolidated Data Centers	136,028	76,478	72,945	72,945
329	Data Processing/IT	794,841	645,414	500,000	500,000
332	Equipment	19,211	219,121	30,000	30,000
413	C&PS-External-Hlth & Med.	1,009,897	1,461,917	1,521,517	1,521,517
418	Outside Services/Other Services	1,069,894	813,129	825,000	825,000
503	Other-Clothing/Personal Supplies	694,264	255,176	200,000	200,000
505	Other-Recreation & Religion	14,892	4,577	4,500	4,500
505 01	BYCHOICE	23,937	13,347	0	0
506	Foodstuffs	3,880,855	2,635,740	2,906,245	2,906,245
512	Quartering & Housekeeping	532,103	382,692	375,000	375,000
513	Laundry	1,400,652	991,256	768,434	768,434
514	Misc Client Services	340,117	249,371	250,000	250,000
516	Chemicals, Drugs & Lab Supplies	782,439	623,427	605,486	605,486
516 01	Pharmacueticals	9,216,211	5,986,020	4,968,000	4,968,000
517	Other-Educational Supplies	8,867	19,406	0	0
520	Other-Uniform Allowance	47,360	41,032	43,636	43,636
524	Other-Vehicle Operations	151,814	191,732	150,000	150,000
444	Interest & Penalties	72,242	19,849	18,433	18,433
568	Other-Not Otherwise Classified, Goods	11,483	48,046	44,166	44,166
569	Other-Not Otherwise Classified, Services	98076	95,754	92,416	92,416
TOTAL OE&E		**29,976,239**	**22,162,461**	**20,011,781**	**20,011,781**
	Percent Change for OE&E Expenditures		**13.5%**		**-10.7%**
GRAND TOTAL: PS & OE&E		**177,014,998**	**170,180,112**	**163,213,675**	**163,213,675**
	TOTAL Percent Change for PS & OE&E Expenditures		**1.8%**		**-4.3%**

Napa State Hospital
Expenditure Comparison

		2011-2012		2012-2013	
		Allotment	Actuals	Allotment	Projections
PERSONAL SERVICES					
Salaries					
003	Salaries & Wages	136,640,474	143,324,697	136,489,485	136,489,485
033	Temp Help	360,000	70,525	279,330	279,330
083	Overtime	28,000,000	24,144,472	19,674,273	19,674,273
	TOTAL Salaries	**165,000,474**	**167,539,694**	**156,443,088**	**156,443,088**
Staff Benefits					
103	OASDI	6,479,454	6,221,273	5,964,654	5,964,654
106	Retirement	23,308,020	23,440,073	22,987,539	22,987,539
125	Workers' Compensation	5,551,035	5,712,195	6,044,606	6,044,606
127	Industrial Disability Leave	2,317,912	2,166,651	2,009,838	2,009,838
132	Nonindustrial Disability Leave	623,115	510,223	488,643	488,643
133	Unemployment Insurance	275,323	301,266	330,000	330,000
134	Other	17,904,986	17,494,324	17,465,377	17,465,377
	TOTAL Staff Benefits	**56,459,845**	**55,846,006**	**55,290,657**	**55,290,657**
TOTAL PERSONAL SERVICES		**221,460,319**	**223,385,700**	**211,733,745**	**211,733,745**
	Percent Change for Personal Services Expenditures		**1.6%**		**-5.5%**
OPERATING EXPENSES & EQUIPMENT					
311	General Expense	1,550,000	3,377,196	1,001,170	1,001,170
312	Printing	355,605	316,911	362,897	362,897
313	Communications	350,000	217,512	262,468	262,468
314	Postage	25,000	65,789	44,964	44,964
315	Insurance	237,654	367,575	373,500	373,500
317	Travel-In-State	40,000	127,292	131,308	131,308
318	Travel-Out-of-State	0	0	0	0
321	Training	80,000	83,532	120,305	120,305
323	Facilities Operation	1,500,000	1,398,961	1,489,192	1,489,192
352	Special Repairs & Deferred Maint.	224,070	194,262	0	0
324	Utilities	4,000,000	3,984,013	4,879,929	4,879,929
325	C&PS-Interdepartmental	1,220,000	1,334,279	1,678,136	1,678,136
326	C&PS-External	3,000,000	2,270,620	1,525,370	1,525,370
328	Consolidated Data Centers	80,500	88,489	116,000	116,000
329	Data Processing/IT	1,200,000	1,141,463	1,191,361	1,191,361
332	Equipment	750,000	820,953	268,652	268,652
413	C&PS-External-Hlth & Med.	8,500,000	5,459,926	4,131,732	4,131,732
418	Outside Services/Other Services	25,000	11,891	29,951	29,951
503	Other-Clothing/Personal Supplies	238,000	244,633	263,134	263,134
505	Other-Recreation & Religion	38,000	29,863	55,171	55,171
505 01	BYCHOICE	60,000	19,942	53,000	53,000
506	Foodstuffs	2,500,000	3,054,317	3,084,658	3,084,658
512	Quartering & Housekeeping	200,000	181,441	174,500	174,500
513	Laundry	500,000	538,320	497,000	497,000
514	Misc Client Services	425,000	373,008	339,056	339,056
516	Chemicals, Drugs & Lab Supplies	1,100,000	1,308,916	1,496,122	1,496,122
516 01	Pharmacueticals	10,400,000	8,696,350	6,947,712	6,947,712
517	Other-Educational Supplies	29,000	48,030	16,481	16,481
520	Other-Uniform Allowance	185,000	224,779	242,503	242,503
524	Other-Vehicle Operations	337,580	454,622	404,797	404,797
444	Interest & Penalties	150,000	275,795	0	0
568	Other-Not Otherwise Classified, Goods	344,395	497,246	492,722	492,722
569	Other-Not Otherwise Classified, Services	200,322	127,172	292,061	292,061
TOTAL OE&E		**39,845,126**	**37,335,098**	**31,965,852**	**31,965,852**
	Percent Change for OE&E Expenditures		**3.7%**		**-16.8%**
GRAND TOTAL: PS & OE&E		**261,305,445**	**260,720,798**	**243,699,597**	**243,699,597**
	TOTAL Percent Change for PS & OE&E Expenditures		**1.9%**		**-7.0%**

Patton State Hospital Expenditure Comparison					
		2011-2012		2012-2013	
		Allotment	Actuals	Allotment	Projections
PERSONAL SERVICES					
Salaries					
003	Salaries & Wages	168,000,000	167,080,799	153,400,182	153,400,182
033	Temp Help	8,850,000	8,540,696	7,990,137	7,990,137
083	Overtime	24,013,000	25,751,879	21,645,645	21,645,645
	TOTAL Salaries	**200,863,000**	**201,373,374**	**183,035,964**	**183,035,964**
Staff Benefits					
103	OASDI	6,400,000	6,301,915	6,155,536	6,155,536
106	Retirement	28,500,000	28,389,526	26,816,332	26,816,332
125	Workers' Compensation	6,000,000	5,748,861	6,075,000	6,075,000
127	Industrial Disability Leave	1,780,000	1,739,485	2,093,198	2,093,198
132	Nonindustrial Disability Leave	670,000	600,219	877,442	877,442
133	Unemployment Insurance	500,000	431,803	500,000	500,000
134	Other	22,373,000	22,294,826	21,341,199	21,341,199
	TOTAL Staff Benefits	**66,223,000**	**65,506,635**	**63,858,707**	**63,858,707**
TOTAL PERSONAL SERVICES		**267,086,000**	**266,880,009**	**246,894,671**	**246,894,671**
	Percent Change for Personal Services Expenditures		**0.9%**		**-8.1%**
OPERATING EXPENSES & EQUIPMENT					
311	General Expense	950,000	925,131	1,099,960	1,099,960
312	Printing	525,000	483,717	495,000	495,000
313	Communications	930,000	874,660	591,544	591,544
314	Postage	85,000	82,172	74,526	74,526
315	Insurance	260,000	249,550	310,208	310,208
317	Travel-In-State	75,000	59,341	69,303	69,303
318	Travel-Out-of-State	0	0	0	0
321	Training	85,000	82,076	92,490	92,490
323	Facilities Operation	2,115,000	2,113,370	2,001,006	2,001,006
352	Special Repairs & Deferred Maint.	589,795	589,795	892,256	892,256
324	Utilities	2,950,000	2,948,354	3,000,000	3,000,000
325	C&PS-Interdepartmental	675,000	525,992	525,000	525,000
326	C&PS-External	875,000	862,021	835,000	835,000
328	Consolidated Data Centers	100,000	94,499	97,500	97,500
329	Data Processing/IT	965,000	921,118	1,300,000	1,300,000
332	Equipment	780,000	778,156	300,000	300,000
413	C&PS-External-Hlth & Med.	14,597,742	14,597,741	14,150,000	14,150,000
418	Outside Services/Other Services	0	0	0	0
503	Other-Clothing/Personal Supplies	700,000	675,315	420,000	420,000
505	Other-Recreation & Religion	125,000	75,405	95,000	95,000
505 01	BYCHOICE	95,000	44,980	0	0
506	Foodstuffs	4,725,000	4,713,166	3,850,000	3,850,000
512	Quartering & Housekeeping	1,550,000	1,543,990	1,200,000	1,200,000
513	Laundry	850,000	711,824	735,000	735,000
514	Misc Client Services	500,000	457,299	429,847	429,847
516	Chemicals, Drugs & Lab Supplies	825,000	806,348	860,000	860,000
516 01	Pharmacueticals	15,500,000	15,461,443	14,604,012	14,604,012
517	Other-Educational Supplies	10,000	7,824	10,000	10,000
520	Other-Uniform Allowance	0	0	0	0
524	Other-Vehicle Operations	260,000	257,652	270,000	270,000
444	Interest & Penalties	96,000	85,675	2,654	2,654
568	Other-Not Otherwise Classified, Goods	15,000	10,913	10,000	10,000
569	Other-Not Otherwise Classified, Services	0	975,000	0	0
	Lottery	29,000	29,000	0	0
TOTAL OE&E		**51,837,537**	**52,043,527**	**48,320,306**	**48,320,306**
	Percent Change for OE&E Expenditures		**8.0%**		**-7.7%**
GRAND TOTAL: PS & OE&E		**318,923,537**	**318,923,536**	**295,214,977**	**295,214,977**
	TOTAL Percent Change for PS & OE&E Expenditures		**2.1%**		**-8.0%**

Salinas Valley Psychiatric Program

Expenditure Comparison

		2011-2012		2012-2013	
		Allotment	**Actuals**	**Allotment**	**Projections**
		PERSONAL SERVICES			
Salaries					
003	Salaries & Wages	38,013,372	37,668,072	36,678,679	36,678,679
033	Temp Help	0	0	0	0
083	Overtime	6,275,025	5,504,401	5,554,130	5,554,130
	TOTAL Salaries	**44,288,397**	**43,172,473**	**42,232,809**	**42,232,809**
Staff Benefits					
103	OASDI	203,334	201,125	196,585	196,585
106	Retirement	7,756,848	7,228,843	7,134,938	7,134,938
125	Workers' Compensation	809,966	692,635	656,702	656,702
127	Industrial Disability Leave	386,629	496,547	556,125	556,125
132	Nonindustrial Disability Leave	76,942	83,824	86,976	86,976
133	Unemployment Insurance	26,604	23,250	21,920	21,920
134	Other	4,508,671	4,373,061	4,460,923	4,460,923
	TOTAL Staff Benefits	**13,768,994**	**13,099,285**	**13,114,169**	**13,114,169**
TOTAL PERSONAL SERVICES		**58,057,391**	**56,271,757**	**55,346,978**	**55,346,978**
	Percent Change for Personal Services Expenditures		**11.9%**		**-1.7%**
		OPERATING EXPENSES & EQUIPMENT			
311	General Expense	170,301	137,839	134,232	134,232
312	Printing	49,965	62,723	59,976	59,976
313	Communications	40,969	19,030	35,736	35,736
314	Postage	3,418	6,165	3,229	3,229
315	Insurance	0	0	0	0
317	Travel-In-State	80,161	71,653	71,243	71,243
318	Travel-Out-of-State	0	0	0	0
321	Training	52,954	26,731	39,663	39,663
323	Facilities Operation	11,164	2,080	1,961	1,961
352	Special Repairs & Deferred Maint.	0	0	0	0
324	Utilities	0	0	0	0
325	C&PS-Interdepartmental	215,466	112,297	105,962	105,962
326	C&PS-External	0	0	0	0
328	Consolidated Data Centers	0	0	0	0
329	Data Processing/IT	659,514	275,828	263,391	263,391
332	Equipment	117,137	230,936	217,731	217,731
413	C&PS-External-Hlth & Med.	0	0	0	0
418	Outside Services/Other Services	6,942,849	7,532,174	6,660,004	6,660,004
503	Other-Clothing/Personal Supplies	2,602	434	434	434
505	Other-Recreation & Religion	15,324	11,667	11,000	11,000
505 01	BYCHOICE	0	0	0	0
506	Foodstuffs	17,951	3,732	3,660	3,660
512	Quartering & Housekeeping	35,874	41,859	39,703	39,703
513	Laundry	0	0	0	0
514	Misc Client Services	100,000	67,849	64,236	64,236
516	Chemicals, Drugs & Lab Supplies	10,043	4,000	3,937	3,937
516 01	Pharmacueticals	0	0	0	0
517	Other-Educational Supplies	18,938	6,045	5,700	5,700
520	Other-Uniform Allowance	0	610	575	575
524	Other-Vehicle Operations	0	0	0	0
444	Interest & Penalties	4,433	0	0	0
568	Other-Not Otherwise Classified, Goods	65,196	28,801	27,197	27,197
569	Other-Not Otherwise Classified, Services	5,746	621	456	456
TOTAL OE&E		**8,620,005**	**8,643,075**	**7,750,025**	**7,750,025**
	Percent Change for OE&E Expenditures		**-16.9%**		**-11.5%**
GRAND TOTAL: PS & OE&E		**66,677,396**	**64,914,833**	**63,097,003**	**63,097,003**
	TOTAL Percent Change for PS & OE&E Expenditures		**8.1%**		**-2.9%**

Vacaville Psychiatric Program

Expenditure Comparison

		2011-2012		2012-2013	
		Allotment	**Actuals**	**Allotment**	**Projections**
	PERSONAL SERVICES				
Salaries					
003	Salaries & Wages	38,890,883	38,431,563	42,987,314	42,409,570
033	Temp Help	0	0	0	0
083	Overtime	4,474,000	4,463,869	7,896,856	7,790,723
	TOTAL Salaries	**43,364,883**	**42,895,432**	**50,884,170**	**50,200,293**
Staff Benefits					
103	OASDI	2,058,783	1,829,595	2,077,293	2,049,374
106	Retirement	7,585,495	7,579,622	9,999,562	9,865,169
125	Workers' Compensation	968,954	842,473	793,700	783,033
127	Industrial Disability Leave	167,999	79,859	35,491	35,014
132	Nonindustrial Disability Leave	313,103	246,144	313,793	309,576
133	Unemployment Insurance	44,927	53,704	70,982	70,028
134	Other	3,186,650	2,946,627	4,337,303	4,279,010
	TOTAL Staff Benefits	**14,325,911**	**13,578,024**	**17,628,124**	**17,391,204**
TOTAL PERSONAL SERVICES		**57,690,794**	**56,473,456**	**68,512,294**	**67,591,497**
	Percent Change for Personal Services Expenditures		**7.1%**		**16.4%**
	OPERATING EXPENSES & EQUIPMENT				
311	General Expense	344,086	240,892	259,041	255,559
312	Printing	29,000	58,591	30,409	30,000
313	Communications	14,400	11,167	12,163	12,000
314	Postage	192	218	223	220
315	Insurance	300	247	304	300
317	Travel-In-State	20,000	20,627	25,341	25,000
318	Travel-Out-of-State	0	0	0	0
321	Training	28,000	17,256	68,496	67,575
323	Facilities Operation	111,630	82,476	81,090	80,000
352	Special Repairs & Deferred Maint.	0	0	0	0
324	Utilities	0	0	0	0
325	C&PS-Interdepartmental	8,100	87,553	13,177	13,000
326	C&PS-External	360	0	0	0
328	Consolidated Data Centers	15,000	12,788	14,191	14,000
329	Data Processing/IT	135,000	76,176	173,020	170,695
332	Equipment	188,953	92,452	65,421	64,542
413	C&PS-External-Hlth & Med.	2,273,745	1,864,927	2,049,448	2,021,904
418	Outside Services/Other Services	0	0	0	0
503	Other-Clothing/Personal Supplies	11,573	33,662	25,842	25,494
505	Other-Recreation & Religion	10,243	19,289	21,414	21,126
505 01	BYCHOICE	0	0	0	0
506	Foodstuffs	2,000	2,261	2,534	2,500
512	Quartering & Housekeeping	11,760	975	608	600
513	Laundry	0	0	0	0
514	Misc Client Services	0	0	0	0
516	Chemicals, Drugs & Lab Supplies	31,232	91,996	32,436	32,000
516 01	Pharmacueticals	0	0	0	0
517	Other-Educational Supplies	13,564	25,712	9,123	9,000
520	Other-Uniform Allowance	5,700	1,220	72,328	71,356
524	Other-Vehicle Operations	6,000	5,795	6,082	6,000
444	Interest & Penalties	1,350	1,117	1,010	996
568	Other-Not Otherwise Classified, Goods	5,002	536	558	551
569	Other-Not Otherwise Classified, Services	2,000	0	0	0
TOTAL OE&E		**3,269,190**	**2,747,933**	**2,964,257**	**2,924,418**
	Percent Change for OE&E Expenditures		**9.3%**		**6.0%**
GRAND TOTAL: PS & OE&E		**60,959,984**	**59,221,388**	**71,476,551**	**70,515,915**
	TOTAL Percent Change for PS & OE&E Expenditures		**7.2%**		**16.0%**

Stockton Psychiatric Program

Expenditure Comparison

		2011-2012		2012-2013	
		N/A	N/A	Allotment	Projections
PERSONAL SERVICES					
Salaries					
	Salaries & Wages			5,631,266	5,605,879
	TOTAL Salaries	**0**	**0**	**5,631,266**	**5,605,879**
Staff Benefits					
	Staff Benefits			1,858,318	1,849,940
	Retirement				
	Workers' Compensation				
	Industrial Disability Leave				
	Nonindustrial Disability Leave				
	Unemployment Insurance				
	Other				
	TOTAL Staff Benefits	**0**	**0**	**1,858,318**	**1,849,940**
TOTAL PERSONAL SERVICES		**0**	**0**	**7,489,584**	**7,455,819**
	Percent Change for Personal Services Expenditures				
OPERATING EXPENSES & EQUIPMENT					
311	General Expense			1,357,116	1,350,998
312	Printing				
313	Communications				
314	Postage				
315	Insurance				
317	Travel-In-State				
318	Travel-Out-of-State				
321	Training				
323	Facilities Operation				
352	Special Repairs & Deferred Maint.				
324	Utilities				
325	C&PS-Interdepartmental				
326	C&PS-External				
328	Consolidated Data Centers				
329	Data Processing/IT				
332	Equipment				
413	C&PS-External-Hlth & Med.				
418	Outside Services/Other Services				
503	Other-Clothing/Personal Supplies				
505	Other-Recreation & Religion				
505 01	BYCHOICE				
506	Foodstuffs				
512	Quartering & Housekeeping				
513	Laundry				
514	Misc Client Services				
516	Chemicals, Drugs & Lab Supplies				
516 01	Pharmacueticals				
517	Other-Educational Supplies				
520	Other-Uniform Allowance				
524	Other-Vehicle Operations				
444	Interest & Penalties				
568	Other-Not Otherwise Classified, Goods				
569	Other-Not Otherwise Classified, Services				
TOTAL OE&E		**0**	**0**	**1,357,116**	**1,350,998**
	Percent Change for OE&E Expenditures				
GRAND TOTAL: PS & OE&E		**0**	**0**	**8,846,700**	**8,806,817**
	TOTAL Percent Change for PS & OE&E Expenditures				

Central Hospital Support

Expenditure Comparison

		2011-2012				2012-2013	
		Allotment	Actuals			Allotment	Projections
PERSONAL SERVICES							
Salaries & Wages							
		0	0		L-Wing Funding	3,000,000	0
		0	0		FY 2012-13 PLP Reduction	39,000,000	0
		0	0		Reimbursements	3,427,000	0
		0	0		AB 756 20/20 Training Program	250,000	0
	TOTAL Salaries	**0**	**0**		**TOTAL Salaries**	**45,677,000**	**0**
Staff Benefits							
	Staff Benefits	525,738	508,046		Staff Benefits		
	TOTAL Staff Benefits	**525,738**	**508,046**		**TOTAL Staff Benefits**	**0**	**0**
TOTAL PERSONAL SERVICES		**525,738**	**508,046**	**TOTAL PERSONAL SERVICES**		**45,677,000**	**0**
OPERATING EXPENSES & EQUIPMENT							
311	General Expense	1,786,262	1,726,150	311	General Expense	0	0
312	Printing	356	344	312	Printing	0	0
313	Communications	202,793	195,969	313	Communications	0	0
314	Postage	0	0	314	Postage	0	0
315	Insurance	0	0	315	Insurance	0	0
317	Travel-In-State	6,572	6,351	317	Travel-In-State	0	0
318	Travel-Out-of-State	0	0	318	Travel-Out-of-State	0	0
321	Training	3,244	3,135	321	Training	0	0
323	Facilities Operation	448,728	443,907	323	Facilities Operation	0	0
352	Special Repairs & Deferred Maint.	0	0	352	Special Repairs & Deferred Maint.	0	0
325	C&PS-Interdepartmental	3,424,878	3,309,623	325	C&PS-Interdepartmental		
					Legal	950,262	950,262
					Human Resources	100,000	100,000
					Licensing	103,771	103,771
					Miscellaneous	300,000	300,000
					IT	2,186,152	2,186,152
326	C&PS-External	21,043,410	20,335,249	326	C&PS-External		
					Legal	894,127	894,127
					Human Resources	22,325	22,325
					Licensing	143,789	143,789
					Human Potential Consulting	110,000	110,000
					Liberty Healthcare	4,064,982	4,064,982
					Disability Rights of CA	1,264,000	1,264,000
					Sylmar Health	1,282,122	1,282,122
					Miscellaneous	700,000	700,000
329	Data Processing/IT	6,965,305	6,730,906	329	Data Processing/IT		
					PDAS - MSH & PSH	22,761,000	22,761,000
					PDAS - NSH	446,000	446,000
					Psych. Program IT	3,790,000	3,790,000
					IT Misc.	3,500,000	3,500,000
332	Equipment	0	0	332	Equipment	0	0
506	Foodstuffs	0	-10,280	506	Foodstuffs	0	0
444	Interest & Penalties	0	0	444	Interest & Penalties	0	0
568	Other-Not Otherwise Classified, Goods	0	0	568	Other-Not Otherwise Classified, Goods	0	0
569	Other-Not Otherwise Classified, Services	0	0	569	Other-Not Otherwise Classified, Services	0	0
TOTAL OE&E		**33,881,549**	**32,741,354**	**TOTAL OE&E**		**42,618,530**	**42,618,530**
GRAND TOTAL: PS & OE&E		**34,407,287**	**33,249,400**	**GRAND TOTAL: PS & OE&E**		**88,295,530**	**42,618,530**

Department of State Hospitals
Actual Cost Savings Achieved
Fiscal Year 2011-12
($ in millions)

Savings Proposal	Description	FY 2011-12					
		Dollar Target	*Dollars Achieved to Date*	*% Dollars Achieved to Date*	*Position Reduction Target*	*Position Reduction Achieved to Date*	*% Position Reduction to Date*
Staffing Ratios							
Revise ICF Treatment Team Ratio from 1:25 to 1:35.	Implement ratio adjustments while maintaining necessary staffing to address patient acuity.	$21.17	$21.20	100%	253.9	259.9	102%
Adjust Nursing Staff Percentage	Ratio shift to 70% Psych Tech/30% Registered Nurse for hospitals not already operating at the proposed level. Maintains adequate staffing as required by licensing.	$0.14	$0.14	95%	0.0	0.0	0%
Staff Redirection							
Redirect staff to units	Redirect staff from lower priority activities back to unit, reducing overtime/temp help costs.	$8.29	$9.19	111%	15.0	12.0	80%
Redirect security staff to additional grounds patrol	Redirect security staff from kiosks (NSH); close two CSH sports yards, reduce CSH package center operations.	$0.14	$0.14	96%	0.0	0.0	0%
Eliminate/restructure programs/departments/services							
Assessment Teams	Assessment teams not required by Civil Rights for Institutionalized Persons Act (CRIPA) Consent Judgment. Alternative classifications may be used to perform assessments when appropriate.	$0.09	$0.05	56%	2.0	1.0	50%
Positive Behavioral Support Teams	Establish one team per hospital for training new staff and providing consultation.	$2.03	$1.63	80%	17.0	13.0	76%
Modify By Choice program	Modify By Choice program to best serve each hospitals' patients based on the demonstrated effectiveness of By Choice as a treatment participation incentive.	$1.36	$0.98	72%	1.0	0.0	0%
Modify Mall Services	Hold Mall groups on the unit to decrease staffing needs off unit and address unit coverage for patients not attending mall groups.	$1.56	$1.31	84%	10.0	6.1	61%
Restructure various disciplines/departments	Reduce staffing for psychology, rehabilitation therapy, housekeeping, records management, medical services, Central Program Services, supervisory/lead discipline structure.	$2.59	$3.48	134%	22.0	20.0	91%
Discontinue Adult Education Program	Discontinue adult education programs; retain Special Education as required by law.	$0.60	$0.46	77%	14.8	11.8	80%
Contract for Pre-Employment Physicals	Services to be provided via contract with local clinics or personal physician.	$0.32	$0.18	57%	2.0	0.9	45%
Laboratory Services	Provide laboratory services during core business hours only (CSH)	$0.02	$0.02	90%	0.0	0.0	0%
Streamline Documentation							
Standards Compliance, Admission and Assessment Documentation	Streamline documentation requirements while maintaining licensing standards; revise frequency of patient treatment team conferences.	$6.93	$6.71	97%	3.0	2.0	67%
Additional Savings Proposals							
Nursing Staff Training	Provide up to two days annual training via alternative methods, i.e., web-based training. Eliminate dedicated staff for Psychiatric Technician 20/20 training program at ASH. Does not impact statewide program.	$1.57	$1.18	75%	0.0	0.0	0%
Physician On-Call, Psychiatric Medical Officer of the Day (PMOD), Medical Officer of the Day (MOD)	Modify on call, MOD, PMOD schedule for after hours	$2.80	$1.95	70%	0.0	0.0	0%

Department of State Hospitals
Actual Cost Savings Achieved
Fiscal Year 2011-12
($ in millions)

Savings Proposal	Description	FY 2011-12					
		Dollar Target	*Dollars Achieved to Date*	*% Dollars Achieved to Date*	*Position Reduction Target*	*Position Reduction Achieved to Date*	*% Position Reduction to Date*
Utilize alternate classifications	Transfer necessary functions to lower cost classifications. Patients will continue to receive current level of care and treatment.	$0.19	$0.17	93%	0.0	0.0	0%
Streamline Internal Investigations	Streamline current investigation process for abuse/neglect complaints while remaining compliant with timelines required by licensing.	$0.12	$0.10	83%	0.0	0.0	0%
Abolish Miscellaneous Vacancies	Abolish hospital vacancies.	$0.20	$0.28	141%	5.5	5.5	100%
HQ Redirected positions	Return redirected HQ administrative positions to the hospitals.	$1.94	$1.75	91%	0.0	0.0	0%
Operating Expense Reductions							
Misc. OE Reductions	Utilize existing hospital services more efficiently; revise external contracts.	$4.54	$5.76	127%	0.0	0.0	0%
Pharmacy/Medical							
Pharmaceuticals	Prescribe generic drugs when appropriate.	$2.00	$1.18	59%	0.0	0.0	0%
System-wide Savings							
Other one-time savings		$64.00	$64.72	101%	0.0	0.0	0%
	Grand Total, All Savings Proposals	**$122.60**	**$122.60**	**100%**	**346.2**	**333.2**	**96%**

Department of State Hospitals
Actual Cost Savings Achieved
Fiscal Year 2011-12
($ in millions)

Savings Proposal	Description	FY 2011-12															
		ASH		CSH		MSH		NSH		PSH		SVPP		VPP		GRAND TOTAL	
Staffing Ratios		Dollars Achieved	Positions Achieved	Dollars Achieved	Positions Achieved	Dollars Achieved	Positions Achieved	Dollars Achieved	Positions Achieved	Dollars Achieved	Positions Achieved	Dollars Achieved	Positions Achieved	Dollars Achieved	Positions Achieved	Dollars Achieved	Positions Achieved
Revise ICF Treatment Team Ratio from 1:25 to 1:35.	Implement ratio adjustments while maintaining necessary staffing to address patient acuity.	$3.52	17.70	$2.55	0.00	$0.23	2.00	$1.43	14.70	$0.92	8.00	$9.79	170.50	$2.76	47.00	$21.20	259.90
Adjust Nursing Staff Percentage	Ratio shift to 70% Psych Tech/30% Registered Nurse for hospitals not already operating at the proposed level. Maintains adequate staffing as required by licensing.	$0.04	0.00	$0.00	0.00	$0.00	0.00	$0.10	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.14	0.00
Staff Redirection																	
Redirect staff to units	Redirect staff from lower priority activities back to unit, reducing overtime/temp help costs.	$6.88	2.00	$0.05	0.00	$1.33	0.00	$0.15	0.00	$0.78	10.00	$0.00	0.00	$0.00	0.00	$9.19	12.00
Redirect security staff to additional grounds patrol	Redirect security staff from kiosks (NSH); close two CSH sports yards, reduce CSH package center operations.	$0.00	0.00	$0.14	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.14	0.00
Eliminate/restructure programs/departments/services																	
Assessment Teams	Assessment teams not required by Civil Rights for Institutionalized Persons Act (CRIPA) Consent Judgment. Alternative classifications may be used to perform assessments when appropriate.	$0.00	0.00	$0.00	0.00	$0.05	1.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.05	1.00
Positive Behavioral Support Teams	Establish one team per hospital for training new staff and providing consultation.	$0.43	12.00	$0.32	0.00	$0.36	1.00	$0.52	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$1.63	13.00
Modify By Choice program	Modify By Choice program to best serve each hospitals' patients based on the demonstrated effectiveness of By Choice as a treatment participation incentive.	$0.07	0.00	$0.17	0.00	$0.06	0.00	$0.36	0.00	$0.33	0.00	$0.00	0.00	$0.00	0.00	$0.98	0.00
Modify Mall Services	Hold Mall groups on the unit to decrease staffing needs off unit and address unit coverage for patients not attending mall groups.	$0.05	2.10	$0.00	0.00	$0.28	2.00	$0.08	2.00	$0.91	0.00	$0.00	0.00	$0.00	0.00	$1.31	6.10
Restructure various disciplines/departments	Reduce staffing for psychology, rehabilitation therapy, housekeeping, records management, medical services, Central Program Services, supervisory/lead discipline structure.	$0.00	0.00	$0.05	1.00	$1.81	10.00	$0.00	0.00	$1.63	10.00	$0.00	0.00	$0.00	0.00	$3.48	21.00
Discontinue Adult Education Program	Discontinue adult education programs; retain Special Education as required by law.	$0.00	0.00	$0.20	5.40	$0.00	0.00	$0.03	0.00	$0.24	6.40	$0.00	0.00	$0.00	0.00	$0.46	11.80
Contract for Pre-Employment Physicals	Services to be provided via contract with local clinics or personal physician.	$0.14	0.90	$0.04	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.18	0.90
Laboratory Services	Provide laboratory services during core business hours only (CSH)	$0.00	0.00	$0.02	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.02	0.00
Streamline Documentation																	
Standards Compliance, Admission and Assessment Documentation	Streamline documentation requirements while maintaining licensing standards; revise frequency of patient treatment team conferences.	$1.02	0.00	$1.26	0.00	$1.32	2.00	$1.26	0.00	$1.84	0.00	$0.00	0.00	$0.00	0.00	$6.71	2.00
Additional Savings Proposals																	
Nursing Staff Training	Provide up to two days annual training via alternative methods, i.e., web-based training. Eliminate dedicated staff for Psychiatric Technician 20/20 training program at ASH. Does not impact statewide program.	$0.08	0.00	$0.08	0.00	$0.07	0.00	$0.09	0.00	$0.85	0.00	$0.00	0.00	$0.00	0.00	$1.18	0.00
Physician On-Call, Psychiatric Medical Officer of the Day (PMOD), Medical Officer of the Day (MOD)	Modify on call, MOD, PMOD schedule for after hours	$0.09	0.00	$0.05	0.00	$0.59	0.00	$0.57	0.00	$0.65	0.00	$0.00	0.00	$0.00	0.00	$1.95	0.00
Utilize alternate classifications	Transfer necessary functions to lower cost classifications. Patients will continue to receive current level of care and treatment.	$0.00	0.00	$0.17	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.17	0.00
Streamline Internal Investigations	Streamline current investigation process for abuse/neglect complaints while remaining compliant with timelines required by licensing.	$0.10	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.10	0.00
Abolish Miscellaneous Vacancies	Abolish hospital vacancies.	$0.00	0.00	$0.00	0.00	$0.04	1.00	$0.24	4.50	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.28	5.50
HQ Redirected positions	Return redirected HQ administrative positions to the hospitals.	$0.26	0.00	$0.65	0.00	$0.00	0.00	$0.55	0.00	$0.22	0.00	$0.08	0.00	$0.00	0.00	$1.75	0.00
Operating Expense Reductions																	
Misc. OE Reductions	Utilize existing hospital services more efficiently; revise external contracts.	$0.00	0.00	$0.03	0.00	$1.70	0.00	$4.07	0.00	$0.29	0.00	$0.00	0.00	$0.00	0.00	$5.76	0.00
Pharmacy/Medical																	
Pharmaceuticals	Prescribe generic drugs when appropriate.	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$1.18	0.00
System-wide Savings																	
Other one-time savings		$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$64.72	0.00
	Grand Total, All Savings Proposals	**$12.68**	**34.70**	**$5.78**	**6.40**	**$7.84**	**19.00**	**$9.44**	**21.20**	**$8.67**	**34.40**	**$9.87**	**170.50**	**$2.76**	**47.00**	**$122.60**	**333.20**

From: Aaron Fischer
Sent: Friday, July 27, 2012 11:17 AM
To: Debbie Vorous; 'Craig Parker'
Cc: 'William Downer'; Michael Stone; Coleman Special Master Team; Coleman Team - RBG Only; Steve Fama
Subject: Coleman - ICF Treatment at VPP and SVPP [IWOV-DMS.FID6429]
Attachments: VPP, High Custody ITC STEP Program Manual.pdf

Debbie and Craig:

We write to express some of our concerns about the ICF treatment programs at Vacaville Psychiatric Program (VPP) at CMF and the Salinas Valley Psychiatric Program (SVPP), including: (1) limited treatment and programming due to staffing shortages and other factors; (2) lengthy stays at the Discretionary Program Status (DPS) level, and the resulting impact on patients' treatment and well-being, and the continued blanket use of restraints for all arriving ICF patients; and (3) reported instances of early discharges from the program and policies that have the effect of discouraging patients from expressing concerns about their treatment.

Limited Treatment and Programming Due to Staffing Shortages

We have recently received several disturbing reports regarding class members currently or recently in the ICF program in VPP's P-3 unit. Identified problems include extremely limited group therapy and one-to-one clinical contacts, as well as lack of yard and out-of-cell time. Class members have been told many of these issues are the result of staff shortages in the program. We have received similar reports from SVPP patients regarding staffing issues, causing cancellation of groups and limited recreational therapy and yard.

Defendants' staffing data confirms significant staffing shortages at both VPP and SVPP. See DMH Staffing Classifications/Vacancy Rate Report as of June 1, 2012 (**VPP functional vacancy rate** for psychologist: 23%, staff psychiatrist: 13%, rehabilitation therapist (recreation-safety): 38%, clinical social worker: 20%; **SVPP functional vacancy rate** for psych tech: 100%, psychologist: 17%, clinical social worker: 30%). VPP's and SVPP's overall functional vacancy rates, 22% and 33%, respectively, are much higher than those for other DMH programs (for which functional vacancy rates are between 5% and 15%).

Lengthy Stays at DPS Level and Blanket Use of Restraints

Class members have also reported being kept at the DPS level in DMH's STEP Program for lengthy periods of time, extending to 3-5 weeks or more (including several months in some reported cases). While patients remain at the DPS level, they receive very limited out-of-cell time, are required to wear waist and ankle restraints when outside their cell, have no contact visits, have no canteen privileges, and get no access to outside yard. They further report that they are not allowed to attend group therapy and do not have regular clinical contacts. Patients report that their mental health conditions are getting worse during these extended periods at the DPS level, and that they experience great difficulty coping with the reduced treatment, program restrictions, and the use of restraints.

We have previously raised our concerns about the practice of using restraints for all arriving ICF patients, as well as their often lengthy stays at the DPS level (*e.g.*, the parties' June 1 meet-and-confer and Jane Kahn's May 30 email). Defendants have stated that their goal is to get ICF patients into the best possible treatment situation as quickly as possible, and that lengthy retention at the DPS level is unusual. *See also* ICF MOU at 13 (requiring that "SVSP classification to clear inmate-patients for programming *shall not exceed* 10 working days from admission" (emphasis added)). The reports we have received suggest that lengthy DPS stays continue to occur more often than suggested.

We again state our objection to the non-clinical use of restraints in these inpatient units. Established clinical requirements for restraints should inform the use of restraints, not blanket imposition of restraints upon admission. *See, e.g.*, Program

Guide at 12-5-16 ("Restraints and/or seclusion shall be used only as a last resort and in response to an emergency to protect the inmate-patient and/or others from imminent harm, after less intrusive and non-physical interventions have been attempted or ruled out.") At a minimum, timeframes for moving patients to higher levels in the STEP program, where use of restraints is not automatic and is instead informed by clinical factors, should be clearly established and very short.

Early ICF Discharges and Policies that Discourage Patients from Expressing Treatment Concerns

We have received reports regarding class members being discharged prematurely from the P-3 ICF program after submitting 602s regarding some of the issues described above. Such early discharges can and do lead to costly and otherwise avoidable admissions into acute care beds. In addition, we have received reports that class members are not allowed to bring paperwork to the dayroom floor, a blanket prohibition that makes little sense and further discourages patients' documenting concerns about their treatment.

These reports are of great concern. Defendants have made notable progress in addressing the waitlists for ICF level of care. Lack of available treatment and programming in DMH's VPP and SVPP ICF programs (whether due to staff shortages or other reasons), along with the discharge of patients before it is clinically appropriate, serve to undermine the fundamental goal of Defendants' recent efforts – that is, to provide timely and clinically necessary inpatient treatment to patients requiring that level of care.

We request that Defendants review and provide a report on the issues discussed above. Plaintiffs are available for a phone conference on these important matters. We hope to work with Defendants and the Special Master to build on recent achievements in addressing barriers to appropriate inpatient care.

Thank you for your attention and efforts. We look forward to receiving your response.

Best,
Aaron J. Fischer, Esq.
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Exhibit 106

MENTAL HEALTH SERVICES DELIVERY SYSTEM

PROGRAM GUIDE

2009 REVISION

Division of Correctional Health Care Services

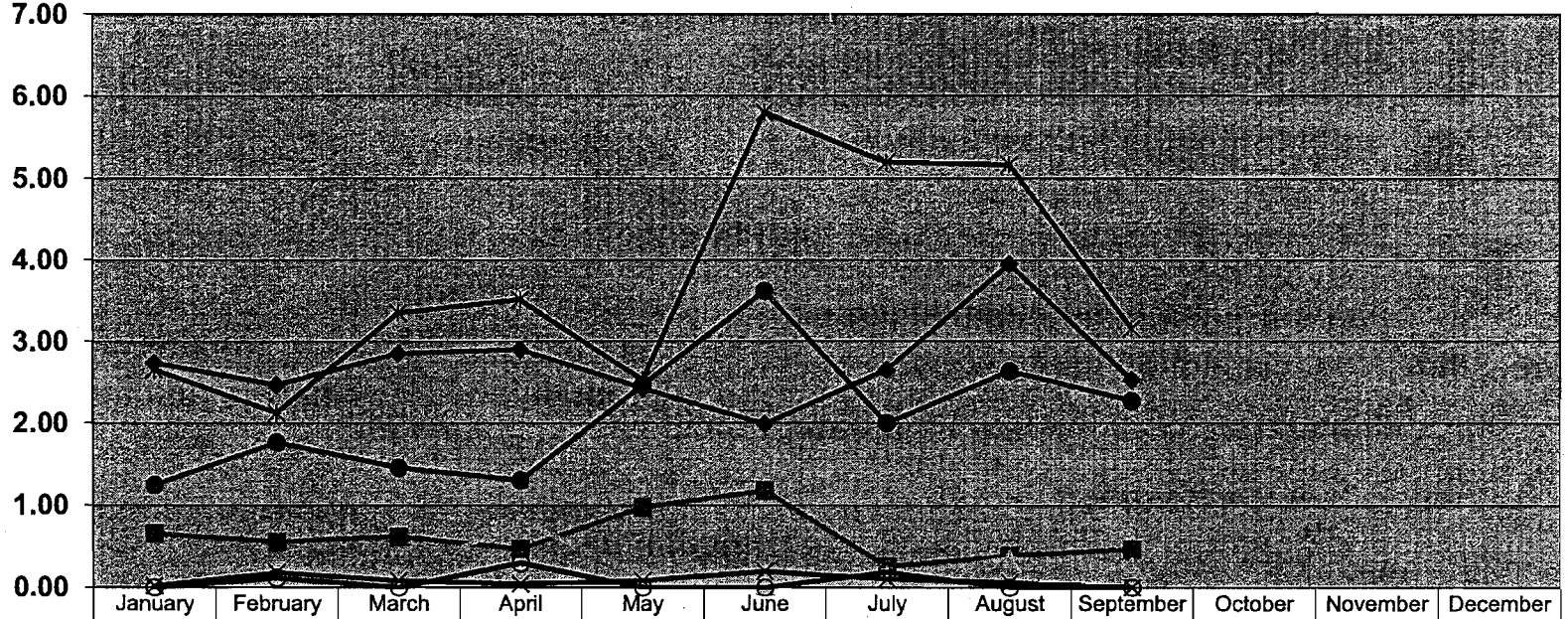
Department of Corrections & Rehabilitation

From:	To:	
Setting/Level of care	**Setting/Level of Care**	**Timeline for Transfer**
RC/CCCMS	Mainline/ CCCMS	Within 90 days of referral; 60 days of referral if clinically indicated
RC/EOP	Mainline/EOP	Within 60 days of referral; 30 days of referral if clinically indicated
Any setting/level of care	MHCB	Within 24 hours of referral
Any institution/ level of care	Any Acute DMH placement	Within ten days of referral, if accepted to DMH. (Referral must be completed within two working days of identification. Transport must be completed within 72 hours of bed assignment)
Any institution/level of care	Any Intermediate Care DMH placement	Within 30 days of referral, if accepted to DMH. (Referral must be completed within five working days of identification by IDTT if inmate-patient consent is obtained, and within ten working days of identification if due process hearing is required. Transport must be completed within 72 hours of bed assignment).
Mainline (General Population)/ CCCMS	Mainline (General Population) /EOP	Within 60 days of referral; 30 days of referral if clinically indicated
Desert institutions (CAL, CEN, ISP, CVSP, CCC)/CCCMS	CCCMS	Within 30 days if inappropriately transferred; otherwise 90 days of referral or 60 days of referral if clinically indicated
Desert institutions (CAL, CEN, ISP, CVSP, CCC)/EOP	EOP	Within 21 days if inappropriately transferred; otherwise 60 days of referral or 30 days of referral if clinically indicated
EOP ASU	EOP ASU Hub	Within 30 days of ASU placement or referral to EOP level of care.
EOP ASU/ EOP ASU Hub	PSU	Within 60 days of endorsement to PSU
Outpatient Housing Unit	EOP	Within 30 days of endorsement to EOP

Exhibit 107

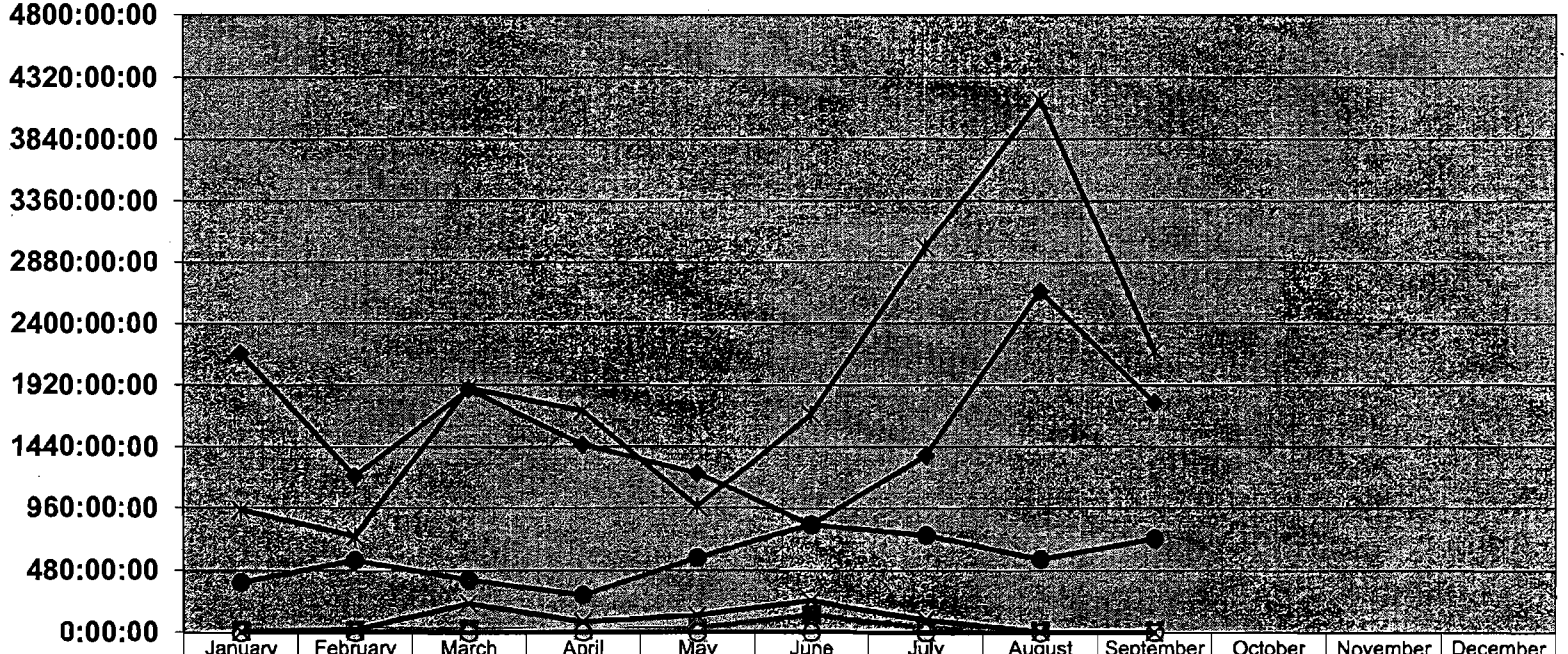
John Brim
March 1, 2013
Exhibit No. 8
Megan F. Alvarez
RPR, CSR No. 12470

Department of State Hospitals
Number of Seclusion Episodes by Month and Facility
(per 1,000 Patient Days)
2012



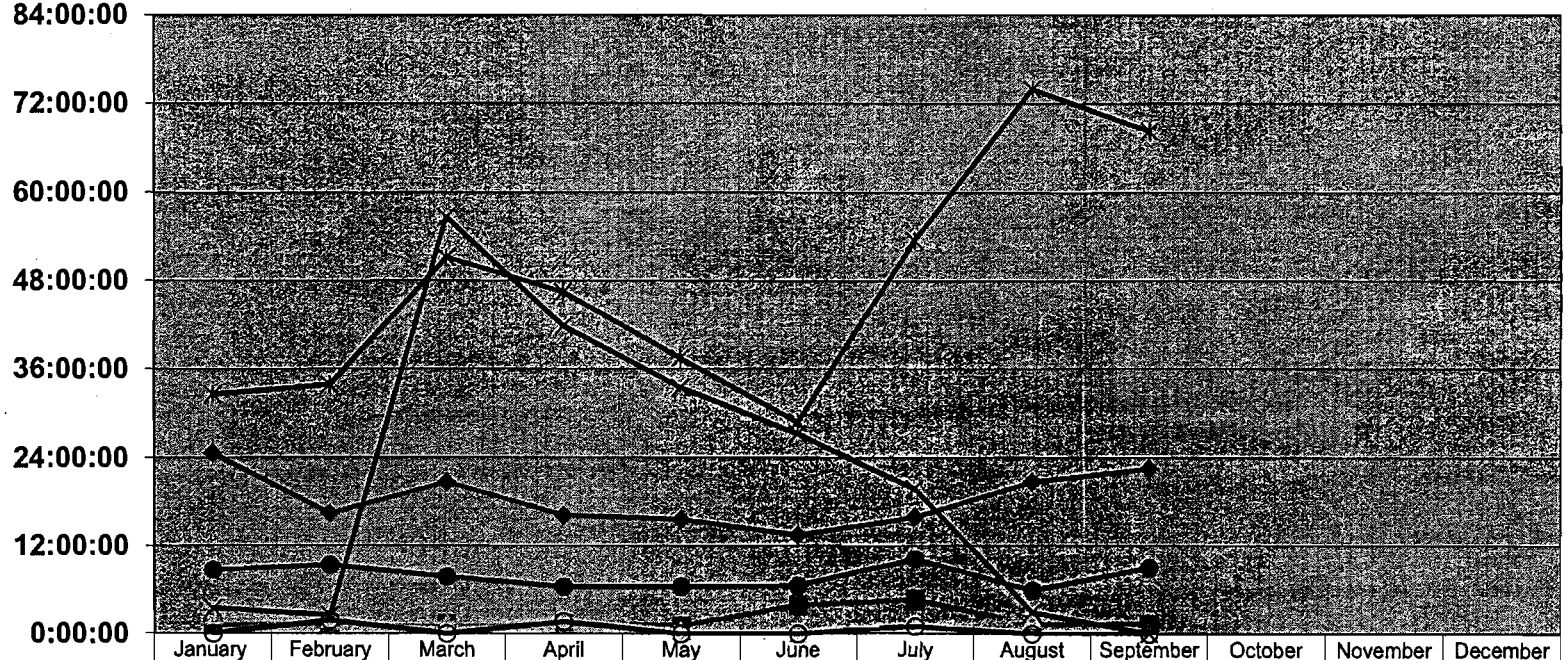
	January	February	March	April	May	June	July	August	September	October	November	December
ASH	2.74	2.46	2.85	2.90	2.43	1.99	2.65	3.95	2.52			
CSH	0.66	0.56	0.62	0.47	0.98	1.18	0.26	0.39	0.47			
MSH	0.15	0.28	0.15	0.80	0.15	0.00	0.15	0.35	0.26			
NSH	1.25	1.77	1.46	1.30	2.46	3.62	2.00	2.63	2.27			
PSH	0.02	0.18	0.09	0.04	0.09	0.20	0.11	0.06	0.00			
SVPP	2.65	2.13	3.35	3.51	2.52	5.80	5.20	5.17	3.16			
VPP	0.00	0.12	0.00	0.30	0.00	0.00	0.19	0.00	0.00			

Department of State Hospitals
Total Hours in Seclusion by Month and Facility
2012



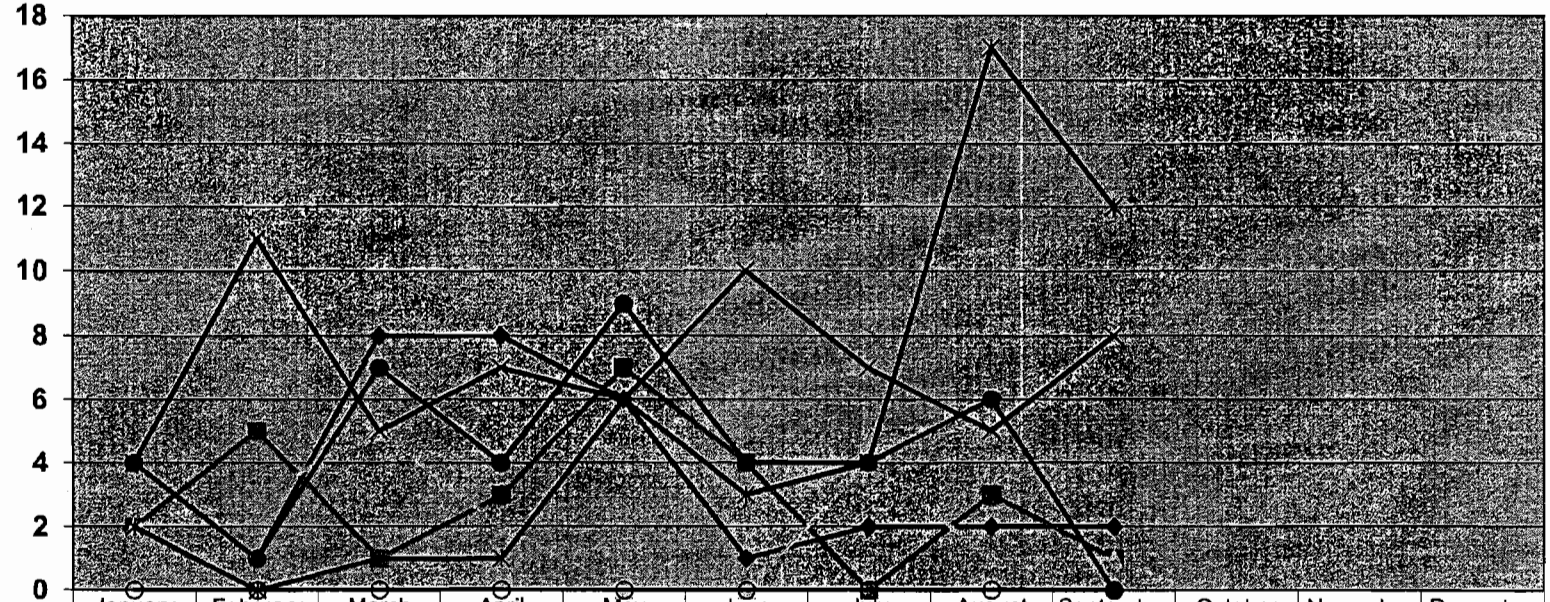
	January	February	March	April	May	June	July	August	September	October	November	December
ASH	2173:11:00	1214:12:00	1885:59:00	1456:26:00	1232:37:00	834:13:00	1373:44:00	2654:20:00	1781:57:00			
CSH	21:29:00	23:03:00	27:30:00	20:09:00	34:29:00	137:36:00	37:23:00	16:14:00	19:23:00			
MSH	7:30:00	9:30:00	4:30:00	30:18:00	1:18:00	0:00:00	4:05:00	14:22:00	26:35:00			
NSH	389:18:00	561:08:00	410:26:00	292:49:00	578:05:00	835:51:00	753:57:00	569:59:00	726:19:00			
PSH	3:29:00	20:24:00	226:53:00	83:39:00	133:56:00	244:59:00	99:13:00	8:50:00	0:00:00			
SVPP	945:28:00	744:54:00	1896:02:00	1720:28:00	973:48:00	1696:14:00	2998:34:00	4144:42:00	2185:30:00			
VPP	0:00:00	1:50:00	0:00:00	5:00:00	0:00:00	0:00:00	2:00:00	0:00:00	0:00:00			

Department of State Hospitals
Average Length of Time (Hours) in Seclusion by Month and Facility
2012



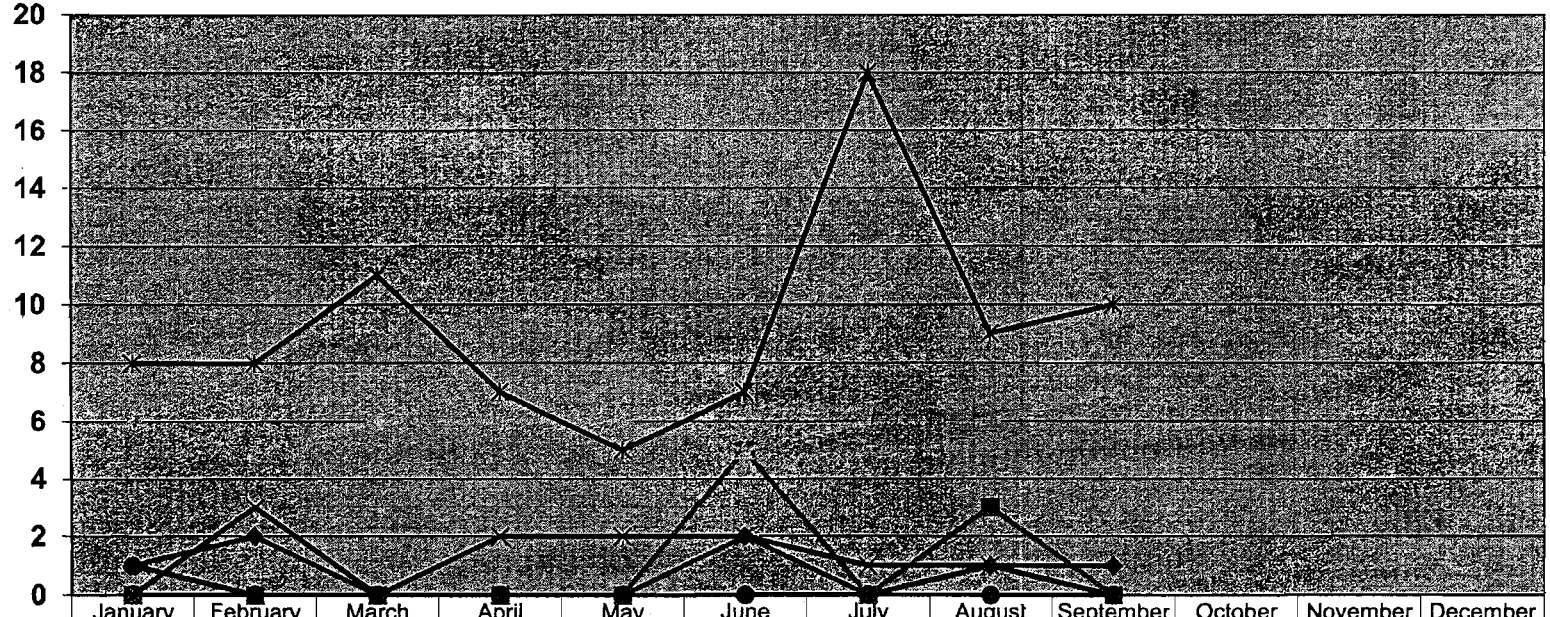
	January	February	March	April	May	June	July	August	September	October	November	December
ASH	24:41:43	16:24:29	20:43:30	16:10:57	15:36:10	13:27:18	15:58:25	20:44:13	22:33:23			
CSH	1:04:27	1:26:26	1:26:51	1:26:21	1:08:58	3:55:53	4:40:22	1:21:10	1:23:04			
MSH	2:30:00	1:54:00	1:30:00	2:01:12	0:26:00	0:00:00	1:21:40	2:03:09	5:19:00			
NSH	8:39:04	9:21:08	7:44:38	6:21:56	6:25:23	6:31:48	10:11:19	5:52:34	8:58:01			
PSH	3:29:00	2:33:00	56:43:15	41:49:30	33:29:00	27:13:13	19:50:36	2:56:40	0:00:00			
SVPP	32:36:08	33:51:33	51:14:39	46:29:57	37:27:14	28:44:59	53:32:45	74:00:45	68:17:49			
VPP	0:00:00	1:50:00	0:00:00	1:40:00	0:00:00	0:00:00	1:00:00	0:00:00	0:00:00			

Department of State Hospitals
Number of State Hospital Staff Injuries by Month and Facility
2012



	January	February	March	April	May	June	July	August	September	October	November	December
ASH	4	1	8	8	6	1	2	2	2			
CSH	2	5	1	3	7	4	0	3	1			
MSH	2	3	5	2	0	0	4	1	1			
NSH	4	1	7	4	9	4	4	6	0			
PSH	4	11	5	7	6	10	7	5	8			
SVPP	2	0	1	1	6	3	4	17	12			
VPP	0	0	0	0	0	0	0	0	0			

Department of State Hospitals
Number of Patient Injuries by Month and Facility
2012



	January	February	March	April	May	June	July	August	September	October	November	December
ASH	1	2	0	0	0	2	0	1	1			
CSH	0	0	0	0	0	5	0	3	0			
MSH	6	5	6	6	6	5	6	6	7			
NSH	1	0	0	0	0	0	0	0	0			
PSH	0	3	0	2	2	2	1	1	0			
SVPP	8	8	11	7	5	7	18	9	10			
VPP	0	0	0	0	0	0	0	0	0			

Exhibit 108

Department of State Hospitals
Actual Cost Savings Achieved
Fiscal Year 2011-12
($ in millions)

Savings Proposal	Description	FY 2011-12															
		ASH		CSH		MSH		NSH		PSH		SVPP		VPP		GRAND TOTAL	
		Dollars Achieved	Positions Achieved	Dollars Achieved	Positions Achieved	Dollars Achieved	Positions Achieved	Dollars Achieved	Positions Achieved	Dollars Achieved	Positions Achieved	Dollars Achieved	Positions Achieved	Dollars Achieved	Positions Achieved	Dollars Achieved	Positions Achieved
Staffing Ratios																	
Revise ICF Treatment Team Ratio from 1.25 to 1.35	Implement ratio adjustments while maintaining necessary staffing to address patient acuity.	$3.52	17.70	$2.55	0.00	$0.23	2.00	$1.43	14.70	$0.92	8.00	$9.79	170.50	$2.76	47.00	$21.20	259.90
Adjust Nursing Staff Percentage	Ratio shift to 70% Psych Tech/30% Registered Nurse for hospitals not already operating at the proposed level. Maintains adequate staffing as required by licensing.	$0.04	0.00	$0.00	0.00	$0.00	0.00	$0.10	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.14	0.00
Staff Redirection																	
Redirect staff to units	Redirect staff from lower priority activities back to unit, reducing overtime/temp help costs.	$6.88	2.00	$0.05	0.00	$1.33	0.00	$0.15	0.00	$0.78	10.00	$0.00	0.00	$0.00	0.00	$9.19	12.00
Redirect security staff to additional grounds patrol	Redirect security staff from kiosks (NSH); close two CSH sports yards, reduce CSH package center operations.	$0.00	0.00	$0.14	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.14	0.00
Eliminate/restructure programs/disciplines/services																	
Assessment Teams	Assessment teams not required by Coleman/Plata/Armstrong Remedial Plans or Valdivia/Jensen Stipulated Agreements. Alternative arrangements may be used to perform assessments when appropriate.	$0.00	0.00	$0.00	0.00	$0.05	1.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.05	1.00
Positive Behavioral Support Teams	Establish one team per hospital for training new staff and providing consultation.	$0.43	12.00	$0.32	0.00	$0.36	1.00	$0.52	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$1.63	13.00
Modify By Choice program	Modify By Choice program to best serve each hospitals' patients based on the demonstrated effectiveness of By Choice as a treatment participation incentive.	$0.07	0.00	$0.17	0.00	$0.06	0.00	$0.36	0.00	$0.33	0.00	$0.00	0.00	$0.00	0.00	$0.98	0.00
Modify Mall Services	Hold Mall groups on the unit to decrease staffing needs off unit and address unit coverage for patients not attending mall groups.	$0.05	2.10	$0.00	0.00	$0.28	2.00	$0.08	2.00	$0.91	0.00	$0.00	0.00	$0.00	0.00	$1.31	6.10
Restructure various disciplines/departments	Reduce staffing for psychology, rehabilitation therapy, housekeeping, records management, medical services, Central Program Services, supervisory/lead discipline structure.	$0.00	0.00	$0.06	1.00	$1.81	10.00	$0.00	0.00	$1.63	10.00	$0.00	0.00	$0.00	0.00	$3.48	21.00
Discontinue Adult Education Program	Discontinue adult education programs; retain Special Education as required by law.	$0.00	0.00	$0.20	5.40	$0.00	0.00	$0.03	0.00	$0.24	6.40	$0.00	0.00	$0.00	0.00	$0.46	11.80
Contract for Pre-Employment Physicals	Services to be provided via contract with local clinics or personal physician.	$0.14	0.90	$0.04	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.18	0.90
Laboratory Services	Provide laboratory services during core business hours only (CSH)	$0.00	0.00	$0.02	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.02	0.00
Streamline Documentation																	
Standards Compliance, Admission and Assessment Documentation	Streamline documentation requirements while maintaining licensing standards; revise frequency of patient treatment team conferences.	$1.02	0.00	$1.26	0.00	$1.32	2.00	$1.26	0.00	$1.84	0.00	$0.00	0.00	$0.00	0.00	$6.71	2.00
Additional Savings Proposals																	
Nursing Staff Training	Provide up to two days annual training via alternative methods, i.e., web-based training. Eliminate dedicated staff for Psychiatric Technician 2003 training program at ASH. Does not impact statewide program.	$0.08	0.00	$0.08	0.00	$0.07	0.00	$0.09	0.00	$0.85	0.00	$0.00	0.00	$0.00	0.00	$1.18	0.00
Physician On-Call, Psychiatric Medical Officer of the Day (PMOD), Medical Officer of the Day (MOD)	Modify on call, MOD, PMOD schedule for after hours	$0.09	0.00	$0.05	0.00	$0.59	0.00	$0.57	0.00	$0.65	0.00	$0.00	0.00	$0.00	0.00	$1.95	0.00
Utilize alternate classifications	Transfer necessary functions to lower cost classifications. Patients will continue to receive current level of care and treatment.	$0.00	0.00	$0.17	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.17	0.00
Streamline Internal Investigations	Streamline current investigation process for abuse/neglect complaints while remaining compliant with timelines required by licensing.	$0.10	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.10	0.00
Abolish Miscellaneous Vacancies	Abolish hospital vacancies.	$0.00	0.00	$0.00	0.00	$0.04	1.00	$0.24	4.50	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.28	5.50
HQ Redirected positions	Return redirected HQ administrative positions to the hospitals.	$0.26	0.00	$0.86	0.00	$0.00	0.00	$0.55	0.00	$0.22	0.00	$0.08	0.00	$0.00	0.00	$1.75	0.00
Operating Expense Reductions																	
Misc. OE Reductions	Utilize existing hospital services more efficiently; revise external contracts.	$0.00	0.00	$0.03	0.00	$1.70	0.00	$4.07	0.00	$0.39	0.00	$0.00	0.00	$0.00	0.00	$6.76	0.00
Pharmacy/Medical																	
Pharmaceuticals	Prescribe generic drugs when appropriate.	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$1.18	0.00
System-wide Savings																	
Other one-time savings		$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$0.00	0.00	$84.72	0.00
	Grand Total: All Savings Proposals	$12.68	34.70	$5.78	6.40	$7.84	19.00	$9.44	21.20	$8.67	34.40	$9.87	170.50	$2.76	47.00	$122.80	333.20

John Brim
March 1, 2013
Exhibit No. 18
Megan F. Alvarez
RPR, CSR No. 12470

Exhibit 109

THE SACRAMENTO BEE sacbee.com

Gov. Jerry Brown says federal prison oversight a waste of money

sstanton@sacbee.com

Published Tuesday, Mar. 12, 2013

On the eve of a showdown in federal court over the future of California's prisons, Gov. Jerry Brown is speaking out at length about his view that the state is being forced to waste millions of tax dollars on federal oversight that is no longer necessary.

"During the life of these lawsuits, the prison health care budget has gone from $700 million to $2 billion," Brown said in an interview with The Bee, his first on the issue since the state filed court documents in January seeking to regain control of its prisons.

"That money is coming out of the university, it's coming out of child care. It's a situation you wouldn't dream anyone would want."

The governor's comments came as lawyers prepare for a battle in Sacramento federal court later this month over whether the state is providing a constitutional level of mental health and medical care for inmates. Oral arguments are scheduled for March 27 on California's motion to terminate oversight of mental health care by U.S. District Judge Lawrence K. Karlton.

Another motion by the state, also filed in January, seeks to vacate or modify an order by a specially convened three-judge court to reduce inmate population. Oral arguments on that motion have not yet been scheduled.

In the interview, the governor revealed that he has been visiting with prison officials to discuss the issue and recently met with all of the state's wardens during a session in Galt.

"These are good people doing their level best," Brown said. "All the second-guessing and Monday-morning quarterbacking are just making the job more difficult. You've heard it. No matter what they do, it's wrong.

"That line is getting old, and it's not right. It's not Sunday school out there, but they're doing a hell of a job, and it's constitutional."

Brown and his administration have argued that California has solved its long-standing problems inside state prisons, where inmates once were warehoused in crowded gymnasiums and other areas.

Overcrowding, which the three-judge court found was the primary reason for unconstitutional health care in the prisons, once was so bad that the state's 33 adult institutions had double the number of inmates they were built to hold. The three-judge court decreed that overcrowding was preventing access to proper care and was responsible for an alarming number of inmate deaths.

Prisoner advocates say the situation remains dire, with the prisons still crowded and the

provision of mental health care - particularly efforts to reduce inmate suicides - woefully inadequate.

"I wish the governor was right," said Michael Bien, lead attorney for the inmates, who has spent years fighting for improvements in California's prisons. "That would mean a success for me.

"It would mean we haven't worked all these years for nothing. Unfortunately for everybody, California's prisons are far from free of constitutional violations."

The state is under orders from the three-judge court to reduce its inmate population to 137.5 percent of capacity by the end of the year, a feat that would require trimming prison population by about 9,000 inmates to a total of about 110,000. The 33 prisons were designed to hold about 80,000 inmates.

The governor contends the state is no longer guilty of "deliberate indifference" to the plight of inmates and that he believes the highest court in the nation will agree.

"Deliberate indifference is the constitutional standard, and that's not present in today's prisons in California," Brown said. "We are committed to keeping it that way, and it's not plausible to say otherwise.

"I have no doubt that if we can get this back before the (U.S.) Supreme Court, it will agree."

The high court affirmed the three-judge court's reduction order when it considered the issue in 2011.

Brown conceded that there were problems in years past, but said the state has made tremendous progress, particularly with his realignment program that assigns responsibility for low-level, nonviolent offenders to the counties. Since the court-ordered reduction in 2009, the state inmate population has dropped from about 150,000 to 119,000 today.

"I'm not arguing that the system was not seriously dysfunctional in years past," he said. "But that time is behind us. We've invested a massive amount of resources. Realignment is bringing the inmate population down.

"But if there's much additional reduction we're looking at far more serious offenders on the streets. Obviously, it isn't worth risking the welfare of our citizens."

He argued in the interview that federal oversight - which includes a Karlton-appointed special master and numerous lawyers and experts who work for him - has turned into a permanent industry with no end in sight. Court papers show the state has paid attorneys representing the inmates, the special master and his staff, and a court-appointed receiver who runs prison medical care and his staff hundreds of millions of dollars over the past 23 years.

"These people are collecting their hourly rates, flying out here to do whatever it is they do, eating peanuts and watching TV on the plane," the governor said. "When they get here, their usual hourly rate kicks in again. These guys are just rolling."

The governor said he has taken a personal interest in the issue, visiting prisons to get to the heart of the matter.

"I just talked to personnel at one prison that has 32 psychologists, 10 psychiatrists and 24 psychiatric technicians for 3,600 patients," he said. "That kind of firepower is not available to anybody who is not in prison.

"People who say prison officials are willfully looking on as inmates commit suicide are so far removed from reality they are not credible. They are wrongly accusing civil servants who are honest, hardworking employees trying to do a job."

Call The Bee's Denny Walsh, (916) 321-1189.

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Exhibit 110

8/8/12
8/10/12

COLEMAN AUDIT BEST PRACTICE RECOMMENDATIONS FOR USE OF FORCE

1) Revisit referral/investigation requirements per Use of Force Regs 51020

Discussion: Currently, pursuant to 51020.17.7, the only mandatory referral of an UOF incident must involve deadly force, death, great bodily injury (GBI), or serious bodily injury (SBI), see 51010.4 for definitions of GBI/SBI.

Currently, pursuant to 51020.20, the only mandatory investigations conducted are for deadly force, death, GBI or SBI.

Referral criteria should not be limited to death, deadly force, GGBI/SBI. Criteria should be expanded to include: unexplained injuries, impact strikes to lethal target areas (head, eyes, throat, spine or groin) regardless of seriousness of injury, incomplete/conflicting reports, and application of non-lethal weaponry that exceeds what would normally be expected for the type of force reported, e.g., unarmed inmate in cell subjected to great amounts of chemical agents via multiple delivery systems such as MK-9, MK-46 and - Grenades (see Corcoran, COR-04B-11-12-0793). Once one of these incidents is referred there should be an operating presumption that it will be investigated.

2) Currently, there is virtually no guidance in 51020 regarding the use of the expandable baton.

Discussion: The expandable baton is a tactical impact weapon deployed for self-defense typically when an officer is subject to active or targeted aggression by an inmate. If misused it is often converted into offensive weapon used for pain-compliance or an instrumentality of corporal punishment. I did not review any incidents in which I detected any such misuse; however, there were numerous instances in which it was used to intervene in inmate/inmate assaults (see RJD 101-11010-53). I take no firm position on such use other than to suggest adoption of some standard or training that will limit its use in such situations where other less potentially injurious means have been exhausted or are impractical or there is an immediate threat of SBI/GBI.

3) Currently, MK-9 OC cannisters are standard issue to line-level CO's. The MK-9 it is classified as a "crowd management" delivery system (Defense Technology® Product Spec Manual).

Discussion: 51020.15 Chemical Agents provides that: "Employees shall only administer the amount of chemical agents necessary and reasonable to accomplish the control objective." While I don't question the tactical deployment of a MK-9 cannister in an open area (yard, dayroom, gym, etc.) to intervene in a inmate/inmate assault, I do question the use of crowd control delivery systems into a cell of an unarmed or unbarricaded inmate. The current regs offer no guidance regarding when OC delivery systems may be used (51020.15.1 does suggest that when the MK-46 is used in cells that it be used with the wand applicator attachment in order to avoid soft tissue damage to the inmate). Finally, I suggest some consideration be given to adopting a procedure whereby OC cannisters are weighed before and after use.

4) I strongly endorse the recommendation made in the OIG Report on Use of Force, May 2012, wherein it was recommended that the Institutional Appeals Coordinator should notify the Use of Force Coordinator of all inmate appeals containing use of force allegations (see Report Recommendation #5, at page 21).

Discussion: "The OIG examined 268 allegations of unreasonable force reported through the adult institutions' inmate appeal process or through written or oral complaints from staff, members of the public, or inmates. Nearly half (121) of the allegations of unreasonable force in our examination escaped executive committee review..." (see OIG Report, at page 16).

COLEMAN AUDIT RVR PROCESS OBSERVATIONS

Audit Methodology:
–Reviewed approximately 440 RVR packets from 10 facilities
–Interviewed RVR hearing officers, RVR Coordinators, and clinicians at 8 of 10 facilities
–Reviewed all relevant LOPs and CDCR regs related to Mental Health Assessment Process for Rule Violations (RVR MH Process)
–Reviewed CDCR memoranda and local memoranda related to RVR MH Process
–Reviewed facility training materials and training records related to RVR MH Process
–Reviewed facility RVR reporting data
–Reviewed 22nd, 23rd, & 24th Monitor Reports related to RVR MH Process
–Reviewed CDCR Program Guide for MH Services Delivery System (2009 Revision), Attachment B-Inmate Disciplinary Process

Observations:
–The CDCR RVR MH Process establishes structured mechanisms to reasonably accommodate inmates who while receiving mental health services, or may need such services, are charged with disciplinary rule violations.
–The CDCR has established and implemented a correctional sound training program for both hearing officers and clinicians who administer the RVR MH Process.
–Both hearing officers and clinicians routinely and consistently provide reasonable accommodation to inmates whose mental health status requires consideration in determining a fair disposition of the RVR.
–Of the approximately 440 RVR packets reviewed, only on rare occasions (less than 10), did I find instances in which the Mental Health Assessment Request had not been completed when required.
–Of the approximately 440 RVR packets reviewed, when clinicians determined that the inmate's mental disorder appeared to contribute to the behavior that led to the RVR, and that the hearing officer should consider mental health factors in assessing the peanlty, reasonable accommodation was made to the charged inmate.

COLEMAN BEST PRACTICE RECOMMENDATIONS RVR PROCESS

1) Establish protocols for hearing officers and clinicians to meet periodically to discuss and resolve issues related to the RVR MH Assessment.

> Discussion: It is evident from interviews with the hearing officers and clinicians that they don't communicate in any ongoing fashion to address MH Assessment issues. Both hearing officers and clinicians related that they sometimes lack information about the respective assessment practices of the other group, e.g., some clinicians related they are not well acquainted with all the penalty options available to hearing officers. It is noted that the two groups at RJD routinely meet/confer and it was reflected in the quality of their RVR MH assessments.

2) The model for the RVR process at RJD should be closely examined for possible replication at all facilities.

> Discussion: RJD officials have developed a very comprehensive set of local operating procedures for the MH Assessment Process (see RJD Operational Plan #66, December 2011). Moreover, based on an interview with the RVR Coordinator (the Senior Psy Supervisor), he chose to create an Assessment Unit in order to have dedicated specialists in making such assessments. The benefits of such specialists were evident in both the consistency and quality of the RJD assessment process. The RVR Coordinator intends to conduct continuing in-service training for both hearing officers and clinicians at the facility.

3) The hearing officers should affirmatively state whether they modified or mitigated the penalties based on the MH Assessment (see also Recommendation #4, below).

> Discussion: In my review of the hearing packets it was not always clear whether the hearing officer modified or mitigated the penalties.

4) Consider revising the RVR: Mental Health Assessment Request (CDCR 115-MH (Rev. 06/06).

> Discussion: Question 2 on the form requires the clinician to express an opinion on whether the inmate's mental disorder appeared to contribute to the behavior that led to the RVR. Question 3 asks the clinician if there are any mental health factors the hearing officer should consider in assessing the penalty. My interview with both hearing officers and clinicians produced inconsistent answers on what the hearing officer should do when Question 2 is answered in the affirmative, and in turn, whether those mental health

factors had to be considered for purposes of Question 3.

I offer two possible recommendations to simply suggest ways to bring more clarity to the form. The second option would likely be the easiest to implement.

1). Revise Question #3 as follows: "If the answer to Question #2 is yes, explain the MH factors that the hearing officer should consider in assessing the penalties." This revisions would be accompanied by a requirement for the hearing officer in the Disposition Section of the Rules Violation Report-Part C, to document what, if any, modifications were made to the penalties assessed in response to the MH factors as identified in Question #2.

2) Currently, Question #3 requires the clinician to "Explain" only if he/she answers "yes." The "yes" should be deleted and an explanation should be provided regardless of whether the clinician answers "yes" or "no." This would be a means to address those situations in which the answer to Question #2 is in the affirmative.

COLEMAN AUDIT USE OF FORCE OBSERVATIONS

Audit Methodology:

–Reviewed approximately 220 use of force incident packets from 10 facilities
–Interviewed Use of Force Coordinators at 8 of 10 facilities
–Attended IREC meetings at 4 facilities
–Reviewed all relevant LOPs and CDCR regs related to use of force
–Reviewed OIG Use of Force Reports (2) which covered incidents from Sept 2010-Dec 2011
–Reviewed UOF data system-wide from 22nd, 23rd & 24th Monitoring Rounds
–Reviewed CDCR Program Guide for MH Services Delivery System (2009 Revision) and CDCR compliance reports re same

Observations:

–No pattern/practice of unnecessary/excessive force as relates to *Coleman* class inmates
–Identified 5 use of force incidents at 3 facilities (RJD/Corcoran/CSP-LA) in which there appeared to evidence of unnecessary/excessive force.
–None of the 5 incidents were referred for investigation
–3 of the 5 involved baton strikes, 2 of which resulted in injuries to inmates
–2 of the 5 involved possibly unnecessary/excessive OC spray
–All 8 Use of Force Coordinators are competent and perform their assigned tasks in timely fashion and are absolutely essential to the IERC review process
–The IERCs regularly meet and engage in substantive review of UOF incidents
–While the UOF administrative review process is multi-tiered and comprehensive, it results in very few referrals for investigation (see also, OIG Use of Force within CDCR, July-December 2011, at page 5)

distinguish unnecessr vis-a-vis excessiv

Teform

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

---oOo---

RALPH COLEMAN, et al., Plaintiffs, vs. EDMUND G. BROWN, JR., et al., Defendants.	No. Civ S 90-0520 LKK-JFM Volume I Page 1 - 300

DEPOSITION OF

STEVE J. MARTIN

THURSDAY, FEBRUARY 28, 2013

CONFIDENTIAL PURSUANT TO PROTECTIVE ORDER

REPORTED BY:

HOLLY THUMAN, CSR No. 6834, RMR, CRR

JAN BROWN & ASSOCIATES

WORLDWIDE DEPOSITION & VIDEOGRAPHY SERVICES

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(Cont'd)

Exhibit 111

SALINAS VALLEY
31625 Highway 101 - P.O. Box 1080
Soledad, CA 93960

Wednesday, January 23, 2013

Name Charles DaSilva,
Executive Director, Salinas Valley Psychiatric Program
Address 31625 Highway 101,
Soledad, CA 93960

Executive Director DaSilva,

As staff psychiatrists, we are writing you collectively to express our serious concern about the level of staffing at SVPP. At the end of January, we will have lost our 3rd psychiatrist in the past (6) weeks.

This will leave us only (7) full-time psychiatrists, including a senior, plus 1 part-time psychiatrist, covering (6) Units that average about 60 beds each. Other disciplines such as social work, psychology, and rehab therapy have 15 to 16 staff covering the same number of patients. The SVPP census issued today shows that there are 351 patients in the program. Across the (6) Units we have also been averaging about (2) to (3) admissions and discharges per Unit per week.

The DSH standard for Stockton and elsewhere is a (15) patient caseload for a team that does admissions, with about (2) admissions per week. When administration visited our facility recently to present the Stockton program, we were told that a 15 patient caseload would also be the standard at SVPP as well as Stockton. At present we have been averaging a caseload of about (40) with (2) admissions per week, and all psychiatrists are taking admissions. Some psychiatrists are already covering (60) patients daily, (4) times the accepted standard. We find a caseload of (40) to be unsafe, and a caseload of (60) is even more perilous.

As psychiatrists, we are united in our belief that the level of staffing currently present is not safe or appropriate for an ICF level of patient care. We believe that it potentially creates an unsafe situation for both staff and patients. When patient safety is at stake, we cannot in good conscience continue to take on a higher and higher caseload without making you aware of our concerns. In November, 2012 SVPP had its first completed suicide. Current staffing levels will create an unacceptable level of risk as far as patient safety.

We will continue to do our best for every patient, under every

John Brim
March 1, 2013
Exhibit No. 1
Megan F. Alvarez
RPR, CSR No. 12470

circumstance. ***But we need to inform you that we will be working in a state of protest regarding our caseload and the rate of admissions.*** We are also extremely concerned about further attrition of psychiatrists, which seems very likely considering the present workload and conditions.

We understand that since SVPP is being downsized that it may be difficult to attract new psychiatrists. However, in the past, staff from other facilities have been brought in on a temporary basis. This would be a tremendous help. We also believe the situation could be made significantly better through a reduction in admissions as we scale back and prepare to close C and D yards.

Thank you for listening to our concerns.

Sincerely,

Joel Badeaux, MD

John Brim, MD

Gayle Gaines, MD

Minhas Kapadia, MD

Muhammad Saleem, MD

Mary Stoller, MD

Ariel Troncoso, MD

Lei Wei, DO

Indu Aramandla, MD

Position Staff and Senior Psychiatrists
Division DSH SVPP

cc: Katherine Warburton, DO, Chief Psychiatrist, DSH
Nereyda Rivera, UAPD

Exhibit 112

SALINAS VALLEY
31625 Highway 101 – P.O. Box 1080
Soledad, CA 93960

Tuesday, February 12, 2013

Name Charles DaSilva,
Executive Director, Salinas Valley Psychiatric Program
Address 31625 Highway 101,
Soledad, CA 93960

Dear Executive Director DaSilva,

This letter will confirm our verbal communication to you during the psychiatry meeting today. We alerted you to the severe psychiatry staffing shortage in our letter of three weeks ago. Now, as you know, our psychiatry staffing shortage has devolved from serious to crisis level. With three more psychiatrists leaving in the near future we must take urgent action. After extensive discussion and consideration, the psychiatry staff at SVPP have unanimously determined that we cannot safely manage more than 40 patients per psychiatrist. We will not abandon additional patients beyond this limit, but can provide only emergency psychiatry services for such additional patients.

Thank you.

Sincerely,

Joel Badeaux, MD — Ariel Troncoso, MD

John Brim, MD — Lei Wei, DO

Minhas Kapadia, MD — Indu Aramandla, MD

Muhammad Saleem, MD — Mary Stoller, MD

cc: Katherine Warburton, DO, Chief Psychiatrist, DSH
Nereyda Rivera, UAPD

John Brim
March 1, 2013
Exhibit No. 2
Megan F. Alvarez
RPR, CSR No. 12470

Exhibit 113

National Center on Institutions and Alternatives
Rate Sheet
Fiscal Year 2010/11 through 2013/14

National Center on Institutions and Alternatives
California Department of Corrections and Rehabilitation
Budget Rate Sheet

Agreement Number: 5600001125
Exhibit B.1

	FY10/11	Due Dates	FY11/12	Due Dates	FY12/13	Due Dates	FY13/14	Due Dates	TOTAL
Initial (Year Zero): Preliminary document review. Deliverable 1a (16 hours @ $300.00/hr)	$ 4,800.00	9/15/2010 or within 15 days of award							$ 4,800.00
Initial (Year Zero): Headquarters site visit. Deliverable 1b & 1d (16 hours @ $300.00/hr)	$ 4,800.00	10/30/2010							$ 4,800.00
Initial (Year Zero): Institution site visits (four CDCR and DMH facilities). Deliverable 1c (24 hours @ $300.00/hr)	$ 7,200.00	1/1/2011							$ 7,200.00
Initial (Year Zero): Consultatnt will deliver a report with findings and recommendations 30 days after final site visit. Deliverable 1e (24 hours @ $300.00/hr)	$ 7,200.00	2/1/2011							$ 7,200.00
Year One Follow-Up: Document Review. Deliverable 2a (8 hours @ $300.00/hr)			$ 2,400.00	7/15/2011					$ 2,400.00
Year One Follow-Up: Headquarters Site Visit. Deliverable 2b (8 hours @ $300.00/hr)			$ 2,400.00	8/30/2011					$ 2,400.00
Year One Follow-Up: Institutional site visits. Deliverable 2c (24 hours @ $300.00/hr)			$ 7,200.00	11/30/2011					$ 7,200.00
Year One Follow-Up: Consultant will deliver a follow-up report with findings and recommendations 30 days after final site visit. Deliverable 2d (24 hours @ $300.00/hr)			$ 7,200.00	3/1/2012					$ 7,200.00
Year Two Follow-Up: Document review. Deliverables 3a (8 hours @ $300.00/hr)					$ 2,400.00	7/15/2012			$ 2,400.00
Year Two Follow-Up: Distance consultation with Mental Health Program Headquarters. Deliverables 3b (8 hours @ $300.00/hr)					$ 2,400.00	8/30/2012			$ 2,400.00
Year Three Follow-Up: Document review. Deliverables 4a (8 hours @ $300.00/hr)							$ 2,400.00	7/10/2013	$ 2,400.00
Year Three Follow-Up: Distance consultation with Mental Health Program Headquarters. Deliverables 4b (8 hours @ $300.00/hr)							$ 2,400.00	07/20/2013-08/30/2013	$ 2,400.00
Total	$ 24,000.00		$ 19,200.00		$ 4,800.00		$ 4,800.00		$ 52,800.00
	Grand Totals								$ 52,800.00

updated 2/24/10

Δ π EXHIBIT 3
Deponent HAYES
Date 2/15/13 Rptr
WWW.DEPOBOOK.COM

Suicide Expert Consultant Services for CDCR's Suicide Prevention Program

I. INTRODUCTION

The National Center on Institutions and Alternatives (NCIA) shall provide a comprehensive and system-wide review of the California Department of Corrections and Rehabilitation (CDCR)'s Suicide Prevention Program. This consultation will directly respond to the *Coleman* court's stated concerns about the CDCR's suicide review process and other aspects of suicide prevention in the department. This consultation will directly contribute to resolution of the *Coleman* litigation.

II. BACKGROUND

Suicide crosses all professional and organizational boundaries of the CDCR. A successful suicide prevention program in the CDCR environment targets all inmates, all staff, and all levels of custody. In the last ten years the CDCR has experienced an increase in the rate of suicide. For most years in the last decade the suicide rate in the CDCR has exceeded the national rate of suicide among state prisoners. Recently the CDCR has stumbled in the timeliness of its suicide reviews and the adequacy of the responses to these reviews by institutions and the CDCR as a whole. The recognition of and response to suicide risk in the correctional environment is one of the most important and difficult tasks for mental health staff, yet it is apparent from the CDCR's own reviews of suicide and those of the *Coleman* court's suicide expert that assessments are often subpar and inadequate, leading to poor follow-up and trajectories that may contribute to an eventual suicide. In addition, the CDCR has struggled with how to assure that local policies, procedures, and practices reflect departmental standards and are consistent across institutions. Finally, the ability of the CDCR to adequately track, monitor, and prevent suicide attempts has eroded until at the current time the CDCR has no active database of suicide attempts and no plan to systematically collect data on attempts as a way to better understand who may and who may not attempt, and ultimately complete a suicidal act. These factors have contributed to the CDCR's inability to make progress toward an exit from the *Coleman* litigation. The Contractor's experience (more than 25 years) with correctional suicide prevention programs will allow the CDCR to make immediate, short-term, and long-term changes in its suicide prevention program to begin to decrease the overall rate of suicide over the long-term. This consultation will allow the CDCR to implement a more effective suicide prevention policy and demonstrate to the *Coleman* court its resolve to deal with a issue that impedes its ability to resolve the litigation.

III. CONTRACTOR RESPONSIBLITIES

As a special court monitor, a National Institute of Corrections grantee, and consultant to state correctional systems, the Contractor has developed a framework to allow state correctional systems to more effectively meet the problem of the suicide of inmates and resolve litigation. The Contractor will apply eight critical components of a suicide

prevention policy[1] (staff training, identification/screening, communication, housing, levels of supervision, intervention, reporting, and follow-up/mortality review) to his consultation with the CDCR. The Contractor will be retained for a period of three years. The consultation will include an initial consultation resulting in comprehensive recommendations, and three annual follow-up consultations.

IV. TASKS

Due to the complexity of evaluating suicide prevention programs in correctional settings, and because the full extent of changes secondary to recommendations may not be apparent for several years, the full consultation will extend over a three year period: an initial consultation and three annual follow-up consultations (year one follow-up on-site and the remainder via document review and teleconference).

The initial consultation (FY 2010-2011) will require Contractor to first review documents provided by the CDCR concerning current policies, its review process, court documents pertaining to suicide prevention, and examples of suicide evaluations, recommendations derived from the reviews, and the responses of institutions to the recommendations.

Following the review of documents, the Contractor will visit the CDCR headquarters for on-site consultation with senior clinical and custodial staff to discuss current suicide prevention policies, training protocols (with staff from the Office of Training & Professional Development), custodial/mental health liaison processes, facilities construction and planning, and current suicide review policies and practices.

The Contractor will then visit several institutions to review suicide policies and procedures in action. He will visit high security institutions, institutions with significant mental health missions, and institutions that experienced increased numbers of suicides in recent years. The purpose of these visits will be to meet with staff, review local practices and their contexts, and discuss possible recommendations.

Finally the initial visit will close with a second visit to the CDCR's headquarters to discuss preliminary recommendations and identified problem areas.

A report with recommendations will be delivered to the CDCR approximately one month after the end of the on-site visit.

The one-year follow-up will include a document review of changes made pursuant to the report's recommendations, annual suicide and suicide attempt data, and new and revised policies/procedures. It will be followed by a three-day site visit: one day at CDCR headquarters and two days in institutions. A follow-up report will be delivered approximately after the site visit.

---

[1] This protocol was developed in accordance with both Standard 4-4373 of the American Correctional Association's *Standards for Adult Correctional Institutions* (2003) and Standard P-G-05 of the National Commission on Correctional Health Care's *Standards for Health Services in Prisons* (2003).

The year-two follow-up will consist of document review and a distance consultation with senior clinical and custodial staff followed by a report approximately one month after the consultation.

The final (year three) consultation will again consist of a document review and distance consultation with the CDCR staff. A final report and recommendations for long-term changes will be delivered one month following the final consultation.

V. DELIVERABLES

1) FY 2010-2011: Initial Consultation (7 days)

a) Preliminary Document Review (2 days)

Due Date: 09/15/2010 or within 15 days of award of contract

b) Headquarters Visit (1 Day)

Due Date: 10/30/2010 or within 45 days of initial review

c) Site Visits (3 Days)

i) California State Prison, Sacramento & Folsom State Prison
ii) California Medical Facility (CDCR & DMH)
iii) Mule Creek State Prison

Due Date: 01/01/2011 or within 90 days of HQ on-site consultation

d) Headquarters Visit (1 Day)

Due Date: 01/15/2011 or within 15 days of Institution site visits.

e) Report and recommendations (30 days after site visit)

Due Date: 02/01/2011 or within 30 days of Institution site visits.

2) FY 2011-2012: Year One follow-up consultation (5 days)

a) Document Review (1 Days)

Due Date: 07/15/2011 or within 15 days of new fiscal year

b) Headquarter Visits (1 Day)

Due Date: 08/30/2011 or within 45 days of document review

c) Site Visits (3 days)

Due Date: 11/30/2011 or within 90 days of HQ consultation visit

d) Year One Follow-up Report

Due Date: 03/01/2012 or within 30 days of last Institution on site visit.

3) **FY 2012-2013: Year Two follow-up consultation (2 days)**

a) Document Review (1 Days)

Due Date: 07/15/2012 or within 15 days of new fiscal year.

b) Headquarter Distance-Consultation (1 Day)

Due Date: 08/30/2012 or within 30 days of document review

4) **FY 2013-2014: Year Two follow-up consultation (2 days)**

a) Document Review (1 Days)

Due Date: 07/10/2013 or within 10 days of new fiscal year.

b) Headquarter Distance Consultation (1 Day)

Due Date: 07/20/2013 or within 10 days of document review

Final Report for Project Due 08/30/2013 or within 30 days of Consultation.

VI. CDCR RESPONSIBILITIES

1. The CDCR shall identify a Program Manager for this contract.
2. The CDCR shall provide the Contractor with the data necessary to complete the scope of this project.
3. The CDCR shall make staff available as needed to provide support and other assistance.
4. The CDCR shall be responsible for reviewing deliverables detailed under the Contractor's Responsibilities.
5. The CDCR shall identify the positions and/or classifications to participate in this project; and upon identification shall notify the Contractor.
6. The CDCR shall responsible for all travel arrangements during the site visits.

VII. DEPARTMENT OF CORRECTIONS AND REHABILITATION CONTACT INFORMATION

Should questions or problems arise during the term of this contract, the Contractor should contact the following offices:

Billing/Payment Issues:

Headquarters Accounting Services
Phone Number: (916) 255-2042
Fax Number (916) 255-5418

CDCR Program Manager

Robert D. Canning, Ph.D.
Senior Psychologist Specialist, and
Suicide Prevention Coordinator
Statewide Mental Health Program
Division of Correctional Health Care Services (DCHCS)
Phone: (916) 322-4344
Email: robert.canning@cdcr.ca.gov

General Contract Issues:

Services Contract Management Branch
Phone Number: (916) 255-5612
Fax Number: (916) 255-6187

Exhibit 114

Office of the Inspector General
Robert A. Barton
Inspector General
State of California

Initial Report on Use of Force within the California Department of Corrections and Rehabilitation

November 2011

EXECUTIVE DIGEST

Summary

In *Madrid v. Hickman* (filed over a decade ago), subsequently re-designated *Madrid v. Cate*, the federal court found that Department of Corrections and Rehabilitation (department) officials had permitted and condoned the use of excessive force against inmates in violation of the Eighth Amendment of the United States Constitution. The court further found that department internal affairs investigations into alleged staff misconduct were pursued not to ascertain the truth, but to avoid finding officer misconduct as often as possible. As a result of those findings, in 2007 the federal court asked the Office of the Inspector General (OIG) to monitor the department's use-of-force review process. Since that time, the department has made significant progress in appropriately addressing use-of-force issues, resulting in the federal court removing its oversight of the department and officially dismissing the *Madrid* case in 2011. In doing so, however, the court expressed concerns about potential regression to the prior unconstitutional practices and encouraged the department to honor its commitment to reform and continue OIG oversight of the department.

This report provides an analysis of the department's use-of-force practices from September 2010 through June 2011. To create this use-of-force report, the OIG obtained relevant data concerning incidents involving force. The OIG also conducted a comprehensive analysis of the department's use-of-force review process by attending use-of-force review committee meetings at adult institutions and parole regions, as well as, through document-based structured reviews of use-of-force incidents.

In August 2010, the department, with OIG input, implemented a new use-of-force policy, conducted statewide use-of-force training, and focused significant resources to make the new policy work. Although this report indicates that the department's use-of-force review process is plagued with delays, sometimes experiences incomplete reviews, and has some inefficiencies, the institutions' review committees determined that 91 percent of the incidents reviewed were in compliance with the new use-of-force policy. For all incidents considered, the OIG concurred with the committees' final decision 90 percent of the time. Overall however, the data and observations contained in this report demonstrate the need for continued improvements in policy, uniform application of policy, and continued oversight related to the execution of the process.

Results in Brief

There were over 6,300 reported use-of-force incidents which occurred in the department during the reporting period. Although in most cases the OIG concurred with the department's use-of-force committee in finding the use-of-force appropriate, in a number of instances improper conduct by department staff created or contributed to the incident necessitating the use of force. A sampling of other significant results from the monitoring data include: incident commanders in three quarters of the institutions did not request clarification for at least half of the incidents reviewed; one adult parole region did not hold any use-of-force review committee meetings despite having reported use-of-force incidents; the overall average time for reviewing a use-of-force incident was 51 days, which was outside the department policy of 30 days; and, on average the department complied with the policy regarding video taped interviews with inmates alleging unnecessary or excessive use of force only 70 percent of the time.

Conclusion and Recommendations

Through analysis of the available use-of-force data and observations while performing contemporaneous monitoring, the OIG provides the following five conclusions and recommendations for the department to consider further improving and refining the department's use-of-force practices and policies:

1. THE DEPARTMENT SHOULD DISTINGUISH BETWEEN NON-COMPLIANCE WITH THE USE-OF-FORCE POLICY VERSUS NON-COMPLIANCE IN OTHER DEPARTMENT POLICIES.

   Use-of-force critiques often conclude that staff actions were out of policy for reasons unrelated to the use-of-force policy. As a result, the OIG observed inconsistent decisions not only between institutions, but within the levels of review within the same institution.

   - *The OIG recommends that the department reviewers continue to identify and address issues arising during a use-of-force incident related to other policies and procedures within the department, but distinguish between non-compliance with use-of-force policy and non-compliance with other department policies.*

2. THE DEPARTMENT SHOULD ENSURE ALL USE-OF-FORCE REPORTS ARE COMPLETE, ACCURATE, AND DOCUMENTS ARE SUBMITTED TIMELY PRIOR TO FINAL REVIEW DECISIONS.

   Almost all of the institutions and facilities made policy decisions based on inadequate reports. Thus, in most incidents involving force, the department made determinations about whether uses of force complied with policies, regulations and applicable laws without complete information.

   - *The OIG recommends that the department provide better training for report writing and insist on greater accountability for its reviewers. In particular, the department should focus on the first level manager review as the data suggests these managers consistently failed to request clarifying information needed to determine policy compliance.*

3. THE DEPARTMENT SHOULD ENSURE USE-OF-FORCE EXECUTIVE REVIEW COMMITTEES ARE HELD IN COMPLIANCE WITH DEPARTMENT POLICIES.

   Adult parole regions I and II held limited use-of-force review meetings, while the Richard J. Donovan Correctional Facility did not have its use-of-force review committee evaluate each use-of-force incident.

   - *The OIG recommends that all parole regions be required to hold use-of-force meetings. Further, the department should either require all institutions to review each incident as the use-of-force policy requires, or amend the policy to allow lower levels of force a more efficient review.*

4. THE DEPARTMENT SHOULD ENSURE THAT USE-OF-FORCE VIDEO RECORDED INTERVIEWS BE CONDUCTED IN A MANNER THAT IS CONSISTENT WITH POLICY.

   In instances where a video recording was required by department policy, a recording was conducted pursuant to policy on average only 70 percent of the time.

   - *The OIG recommends the department make efforts to increase its compliance with the use-of-force video recording policy. In particular, the department should address the complete lack of compliance with this policy at more than one adult institution.*

5. THE DEPARTMENT SHOULD ENSURE APPROPRIATE TRAINING FOR PEPPER SPRAY USE DURING CELL EXTRACTIONS, INCLUDING GUIDELINES FOR ASSESSING EXPOSURE ELEMENTS, TIME, AND EFFECTIVENESS.

   Great disparities exist within the department related to the use of pepper spray for cell extractions. Although current training requires officers to use only the amount of chemical agents reasonable to gain compliance, the department does not have clear guidelines establishing what is a reasonable amount of pepper spray or a reasonable amount of time between pepper spray applications.

   - *The OIG recommends that the department provide additional guidelines regarding the use of pepper spray during cell extractions. These guidelines should include: how to assess whether or not the inmate received an adequate exposure to pepper spray; the amount of time to let the pepper spray take effect once adequate exposure has been achieved before initiating additional applications; and how to determine when pepper spray is ineffective and another use-of-force option should be considered.*

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INTRODUCTION

In 1990 a group of inmates incarcerated at Pelican Bay State Prison filed a class action civil rights lawsuit, *Madrid v. Cate*. Subsequently, in 1995 United States District Court Judge Thelton E. Henderson found that department officials had permitted and condoned the use of excessive force against inmates in violation of the Eighth Amendment of the United States Constitution. The court further found that department internal affairs investigations into alleged misconduct were pursued not to ascertain the truth, but to avoid finding officer misconduct as often as possible. As stated by Judge Henderson, "[a] meaningful disciplinary system is essential, for if there are no sanctions imposed for misconduct, the prison's policies and procedures become dead letter."

"A meaningful disciplinary system is essential, for if there are no sanctions imposed for misconduct, the prison's policies and procedures become dead letter."

Honorable Thelton Henderson

During the 1990s, the department's use-of-force policies and practices fell under heavy scrutiny by the courts and the Legislature because of the significant number of inmates that had been shot and killed by correctional officers in the California state institutions. Between 1989 and 1994, California correctional officers shot and killed more than 30 inmates, as compared to only six inmates who were shot and killed in all other state and federal prisons combined. In some cases, inmates engaging in fist fights without weapons were shot, while in other cases officers shot victims or bystanders rather than the perpetrators. During Senate hearings in 1998, which included an independent review panel of deadly force experts, legislators concluded that department management had failed to appropriately address the situation.

As the court noted in *Madrid*, custody personnel are in constant contact with a difficult and often openly hostile inmate population. Officers have a myriad of weapons and significant manpower at their disposal, and are required to exercise effective control over the inmates under their supervision. In addition, the physical environment within penal institutions "reinforces a sense of isolation and detachment from the outside world, and helps create a palpable distance from ordinary compunctions, inhibitions, and community norms."

As a result of these findings, in 2007 the federal court requested that the OIG's Bureau of Independent Review attend the department's use-of-force review committee meetings to: provide public transparency; assure the court and the public that use-of-force reviews are adequate; and, when appropriate, ensure cases are forwarded to the department's Office of Internal Affairs for investigation or approval to take action without further investigation. Since the OIG's use-of-force monitoring commenced, the department has, with OIG input and court approval, revised and updated its use-of-force regulations and some corresponding policies beginning in August 2010.

This report covers the OIG's monitoring of the department's use-of-force process from September 2010 through June 2011. Force is most often used by the department in the adult institutions which, at the end of this reporting period housed over 160,000 inmates and employed approximately 30,000 peace officers authorized to use force. Further, at times, parole agents supervising adult parolees engage in the use of force. This report addresses the use-of-force review process only for the adult programs and parole. The report does not address use-of-force in the Division of Juvenile Justice because that process is currently being reviewed by court appointed experts.

USE-OF-FORCE PROCESS OVERVIEW

The department is tasked with maintaining the safety and security of staff, inmates, wards, and visitors. At times, this responsibility results in the reasonable use of force by officers. On many occasions, the use of force is justified and necessary. For example, force may be necessary to stop an inmate from attacking another inmate or staff member, to stop a riot, or to take a parolee into custody.

The department defines language usage in the use-of-force policy in the following way:

- Reasonable Force – Reasonable force is the force that an objective, trained, and competent correctional employee faced with similar facts and circumstances, would consider necessary and reasonable to subdue an attacker, overcome resistance, effect custody, or gain compliance with a lawful order.
- Unnecessary Force – Unnecessary force is the use of force when none is required or appropriate.
- Excessive Force – Excessive force is the use of more force than is objectively reasonable to accomplish a lawful purpose.

Department policy requires that, whenever possible, verbal persuasion or orders be attempted before resorting to force. When verbal persuasion is ineffective, staff may use force. Use-of-force options are not executed in any particular sequence; rather staff chooses the force options he or she reasonably believes will stop the particular threat. Staff is only authorized to use reasonable force.

Any department employee who uses force, or observes another employee use force, is required to report the incident to a supervisor *and* submit a written report prior to being relieved from duty. After the report is submitted, the review process begins. This is multi-tiered and also seeks to identify any necessary follow-up action regarding the incident. If deadly force is used, or if any force is used that could have caused death or great bodily injury, the incident is reviewed by the department's Deadly Force Review Board (DFRB) and monitored by the OIG. During the time the DFRB review is pending, all other reviews specific to the case cease until the DFRB process has been completed. Moreover, certain use-of-force incidents are also reviewed at the division and executive level of the department.

Per department policy, use-of-force options include but are not limited to the following:

(a) Chemical agents

(b) Hand-held batons

(c) Physical strength and holds: A choke hold or any other physical restraint which prevents the person from swallowing or breathing shall not be used unless the use of deadly force would be authorized.

(d) Less-than-lethal weapons: A less-than-lethal weapon (figure 1) is any weapon not likely to cause death. A 37mm or 40mm launcher and any other weapon used to fire less-lethal projectiles is a less lethal weapon.

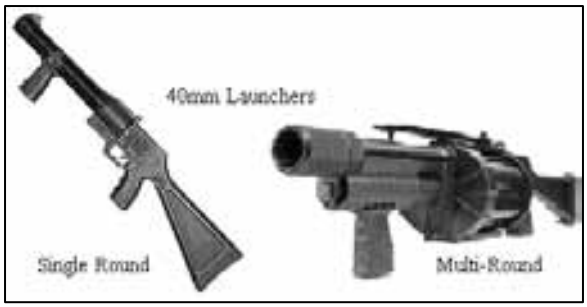


Figure 1

(e) Lethal weapons: A firearm is a lethal weapon because it is used to fire lethal projectiles. A lethal weapon is any weapon that is likely to result in death.

MONITORING METHODOLOGY

The OIG reviews identified use-of-force incidents utilizing two primary methods: attendance at select use-of-force review committee meetings and document based structured reviews. The OIG participates as an active stakeholder in, and monitors, the department's promulgation of new use-of-force regulations and policies.

Institutional and Facility Use-of-Force Review Committee Attendance

OIG representatives attend select use-of-force review committee meetings at all adult institutions statewide. Prior to attending these meetings, the department provides the OIG with the incident package, which includes the report of the incident, the staff reports regarding the incident, and any medical evaluations of inmates, and in limited circumstances, staff involved in the incident. The OIG evaluates all departmental reviews completed prior to the meeting and makes independent conclusions as to the appropriateness of the use of force. During the meeting, the OIG observes the review process and engages in contemporaneous oversight by raising concerns about the incidents, asking for clarifications if reports were inconsistent or incomplete, and engaging in discussions with the committee about the incidents. Through this process, the OIG draws independent conclusions about whether the force used was in compliance with policies, procedures, and applicable laws and whether the review process is thorough and meaningful. When appropriate, the OIG recommends that an incident be referred to the department's Office of Internal Affairs for investigation or approval to take action based on the information already available. In the event that the OIG has a significant disagreement with the decision made by the institution, or parole region, the OIG may elevate the issue to higher level department managers.

Structured Reviews

The OIG performs random structured reviews for incidents where the OIG did not attend the use-of-force committee meetings but evaluated video recordings, officer reports, and the documented conclusions of the department's review process. The OIG evaluates staff compliance with use-of-force policies before, during, and after the incident. In addition, the OIG evaluates whether or not each application of force effectively stopped the threat that led to the need for force, and whether staff actions contributed to the need to use force. If the OIG discovers an issue during a structured review, the OIG alerts the institution or parole region and seeks further review of the incident. As a result of the OIG's structured reviews, certain incidents are placed back on the use-of-force review

committee calendar to address issues raised by the OIG. If the OIG does not consider the issue resolved, it may be elevated to higher level management.

Regulation and Policy Review

In addition to monitoring the use-of-force review process in the department, the OIG participates as an active stakeholder in, and monitors, the department's promulgation of new use-of-force regulations and policies. In this capacity, the OIG has reviewed amendments to the department's regulations and Operations Manual regarding the Division of Adult Institutions and continues to review proposed policies for the Division of Adult Parole Operations. The OIG monitors the department's ongoing effort to promulgate regulations specific to the use of deadly force by the department in its institutions and out in the community.

DIVISION OF ADULT INSTITUTIONS

In the ten month reporting period, the department, through the Daily Information Reporting System (DIRS), reported a total of 6,295 incidents involving force at institutions housing adult inmates. Of these 6,295 incidents, the OIG monitored 34 percent of the incidents by attending use-of-force review committee meetings and completing structured reviews. Specifically, the OIG attended 176 use-of-force meetings, where a total of 995 incidents were evaluated and further completed 1,173 structured reviews for a total of 2,168 incidents evaluated by the OIG.

The department found the use of force employed by staff complied with department policies in 1,816 of the 2,168 incidents and that staff did not comply with department policies in 182 of the incidents. Many of the remaining 170 incidents were brought to committee in order to meet the 30-day requirement for review, but were not actually ready for review.

In 106 incidents the OIG monitored, staff actions created or contributed to the need to use force. For example, policy violations related to the use of restraints or unauthorized inmates allowed to enter restricted areas resulted in the need to use force. Some incidents resulted in adverse actions if a policy was violated and serious injury resulted. The OIG also influenced the committees' recommendation to the warden for 259 of the incidents by requesting clarification, investigations, or employee training. When performing reviews, the OIG concurred with the department's committee decision 90 percent of the time.

The OIG influenced the committees' recommendation to the warden for 259 of the incidents by requesting clarification, investigations, or employee training.

The department groups the adult institutions into primary missions: female programs, which classifies and houses all female inmates; reception centers, which evaluate and classify incoming male inmates; high security-males, which house the most dangerous male inmates; and general population-males, which provide dormitory and in-cell housing for lower security male inmates. 4,692 total use-of-force incidents occurred within the high security and reception center missions, while only 374 incidents occurred in the female programs mission.

Female programs and general population missions present lower percentages of use-of-force incidents compared to reception centers and high security missions when considering statewide inmate population. With an average population of 9,309 inmates per month, female programs mission comprised 6 percent of the statewide average monthly inmate population as well as 6 percent of the reported use-of-force incidents. General population missions averaged 56,757 inmates per month and comprised 39 percent of the statewide inmate population with only 20 percent of the reported use-of-force incidents.

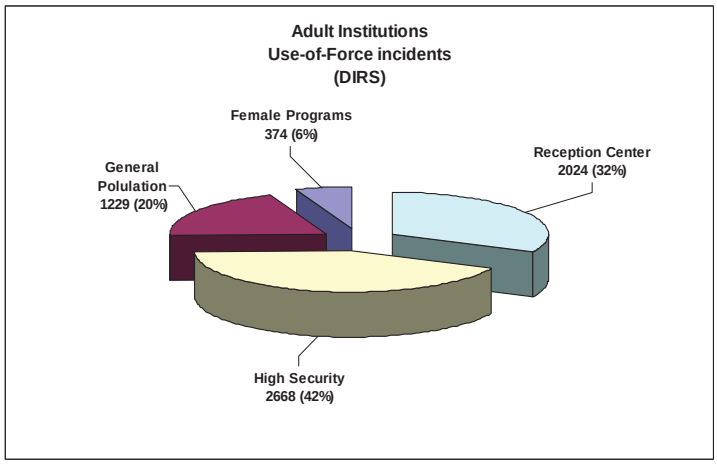


Figure 2a

When comparing these missions with the high security and reception center missions, the data suggests a disparate difference. High security mission institutions averaged 47,506 inmates per month and comprised 32 percent of the statewide inmate population with 42 percent of the reported use-of-force incidents. Reception center mission institutions averaged 34,230 inmates per month and comprised 23 percent of the statewide inmate population with 32 percent of the reported use-of-force incidents.

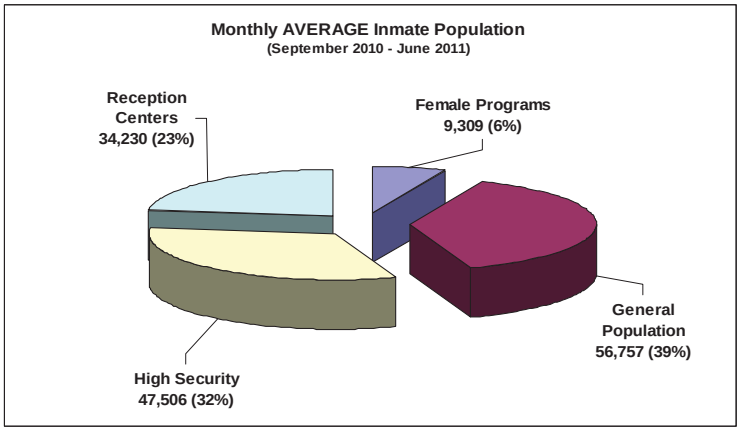


Figure 2b

Figures 2a and 2b illustrate average inmate population and reported use-of-force incidents in each mission.

Unreasonable, Unnecessary, or Excessive Use of Force

The department's Office of Internal Affairs received 89 requests for investigation from the adult institutions related to use-of-force incidents. Of the 89 requests, there were allegations of misconduct against 200 officers. 63 of the allegations were alleged to be unreasonable uses of force. Other significant allegations included the failure to report the use of force and unnecessary or excessive force causing injury. On the following page, figure 3 provides a table summarizing the types of allegations received for investigation.

Allegation	Total	Percentage
Unreasonable use of force	63	26%
Failure to report use of force witnessed	87	35%
Failure to report own use of force	47	19%
Unnecessary/excessive force likely to cause injury	27	11%
Undetermined/ other	22	9%
Total Allegations included in 89 Requests	*246*	*100%*

Figure 3

Deadly Force

In addition to evaluating allegations of unnecessary or excessive force, the department Office of Internal Affairs takes preliminary charge of investigations involving the use of deadly force, and any use of force resulting in death or great bodily injury. In this reporting period, the department referred eight allegations to the Deadly Force Investigation Team (DFIT), which subsequently conducted criminal and administrative investigations. These DFIT investigations are, by policy, required for every use of deadly force because of the severity of the potential consequences.

Types of Force

An incident requiring the use of force may involve more than one application of force and the use of different types of force. For example, during a riot, officers may use chemical agents, expandable batons, and less-than-lethal force to address different threats as the riot escalates. The 1,173 incidents monitored in the structured review process by the bureau included 3,271 separate applications of force.

In the reporting period, adult institutions used chemical agents in 46 percent of the applications of force, while physical force was used in 36 percent of the applications of force. All other types of force were each used in less than 10 percent of the applications of force, for a cumulative total of18 percent.

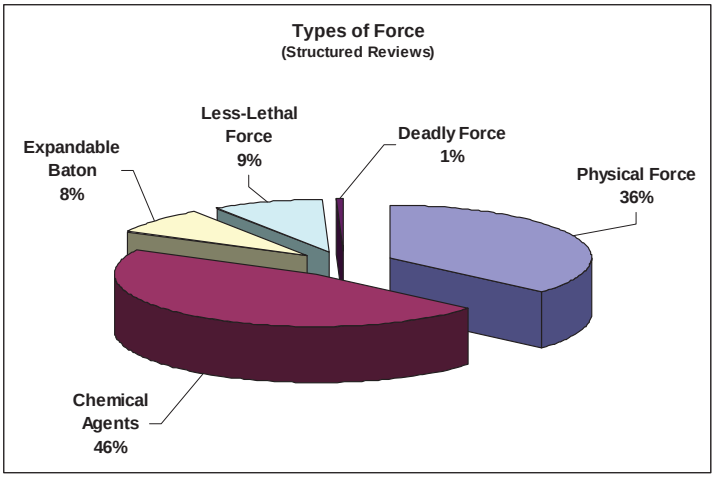
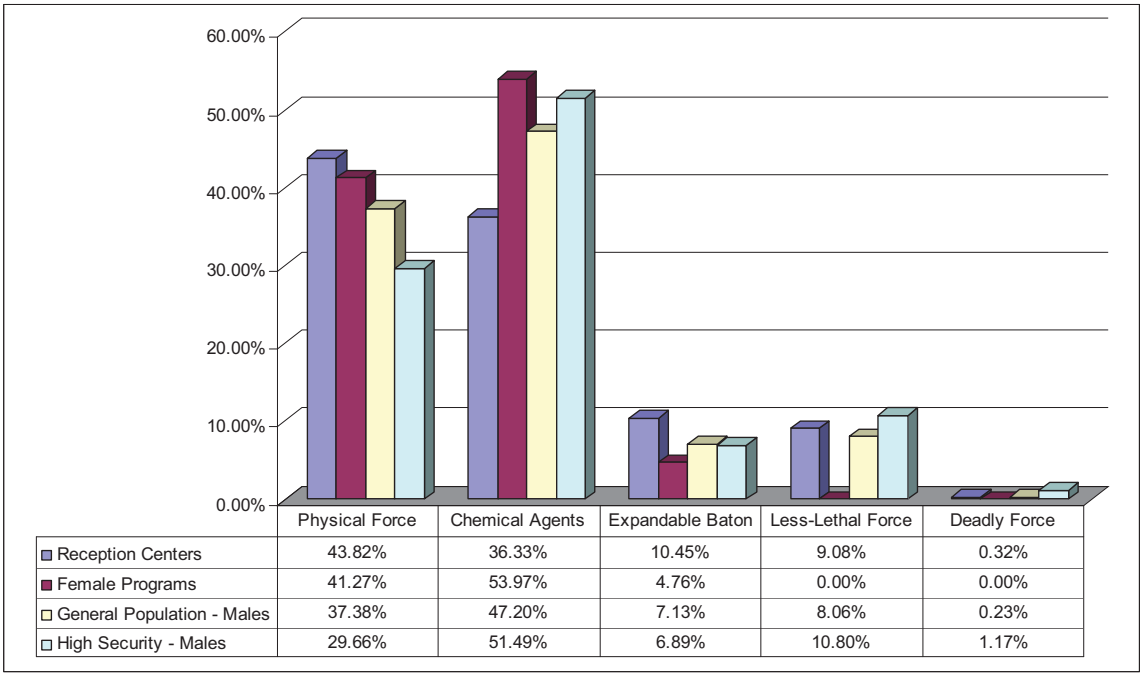


Figure 4 illustrates the relative percentage of types of force used in the adult institutions from bureau monitored structured reviews.

Figure 4

When each mission is examined separately, the most prevalent type of force is different depending on mission. Physical force and chemical agents are used most often in the adult institutions, regardless of the mission. There are minor variations depending on mission. Significantly, there were no instances of deadly force or less-than lethal force in female programs. Figure 5 includes data of instances monitored and illustrates the types of force used in each mission.



	Physical Force	Chemical Agents	Expandable Baton	Less-Lethal Force	Deadly Force
Reception Centers	43.82%	36.33%	10.45%	9.08%	0.32%
Female Programs	41.27%	53.97%	4.76%	0.00%	0.00%
General Population - Males	37.38%	47.20%	7.13%	8.06%	0.23%
High Security - Males	29.66%	51.49%	6.89%	10.80%	1.17%

Figure 5

A list of the adult institutions, along with their acronyms can be found in Appendix A. For a comprehensive list of the types of force used in the reporting period at each of the department's adult institutions, please refer to Appendix B.

Effectiveness of Use of Force

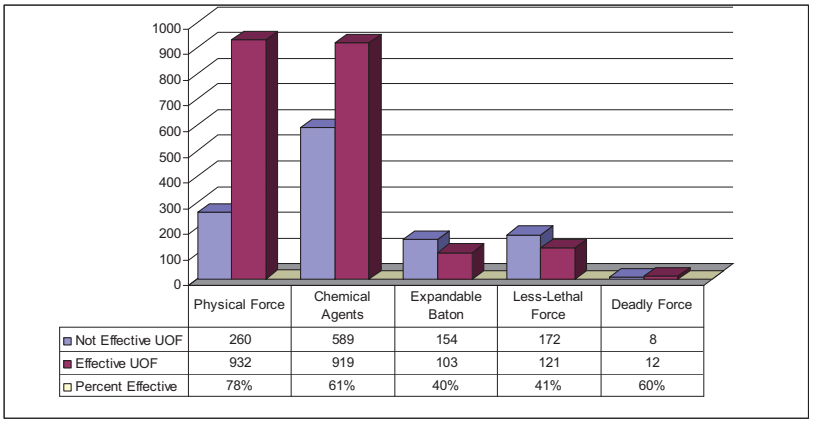
Along with the types of force, the OIG examined the effectiveness of each application of force. To do so, the officer's description of the need for force was compared with the inmate's reaction to the force. The OIG then determined whether the use of force was effective in stopping the threat that justified the use of force. If more than one officer simultaneously used force on an inmate and the threat stopped, the force was considered effective for each application of the simultaneous force. If the goal of gaining compliance from the inmate was not met, the force was considered ineffective for all applications of the simultaneous force. The reason effectiveness must be considered is to determine whether subsequent applications of force were necessary.

The OIG evaluated 3,271 applications of force incidents and found physical force the most effective 78 percent of the time. Chemical agents were effective 61 percent of the time, while less-lethal force and use of the baton were only effective 40 percent of the time. Deadly force was effective 60 percent of the time. Two examples of instances where deadly force is not effective are:

1. The officer fired a shot which did not hit any person and the threat that required deadly force continued; or

2. The officer shot the intended target, but the threat continued because the injury was not sufficient enough to stop the suspect's actions.

Figure 6 illustrates the statewide relative averages for effectiveness for the five types of force.



	Physical Force	Chemical Agents	Expandable Baton	Less-Lethal Force	Deadly Force
Not Effective UOF	260	589	154	172	8
Effective UOF	932	919	103	121	12
Percent Effective	78%	61%	40%	41%	60%

Figure 6

Monitoring revealed a disparity in the techniques applied in the use of chemical agents, specifically pepper spray, when forcibly removing inmates from cells. The department is inconsistent in their use of pepper spray for cell extractions. In reviewing several cell extractions with similar case factors, the use of pepper spray ranged from a single application with a waiting period to numerous applications of pepper spray over a short period of time. According to department training, the amount of pepper spray, and the amount of time between applications has an impact on the effectiveness of this type of force. However, the amount used and the time waited before finding it ineffective varied widely amongst the reviewed incidents. For a comprehensive list of the effectiveness of the types of force used during the reporting period at each of the department's adult institutions, please refer to Appendix C.

Use-of-Force Reports

As part of its structured reviews, staff reports were evaluated for an adequate description of the circumstances that led to force and a sufficient description of the force used. Staff reports for 1,173 incidents were evaluated. The OIG found that on average 96 percent of all reports reviewed adequately described the *need* for force, but only 66 percent appropriately described the *actual* force used during the incident. For example, at Folsom State Prison, 100 percent of the reports reviewed adequately described the need for force, but only 37 percent adequately described the force used during the incidents. More favorable results were found at the California Chuckawala Valley State Prison, with 100 percent of the reports adequately describing the need for force and 92 percent appropriately documenting the force used.

Institutional Use-of-Force Reviews

At each level of review, the reviewer is tasked with evaluating reports, requesting necessary clarifications, identifying deviations from policy, and determining whether the use of force was within policies, regulations, and applicable laws. The levels of review are: the initial review conducted by the incident commander; the first level management review conducted by a captain; the second level management review conducted by an associate warden; and the final level of review where the incident is reviewed by the use-of-force review committee, with the ultimate determination made by the institution head or designee.

Of the 1,173 incidents for which structured reviews were conducted, the OIG found failures to identify issues at every level of the review process.

The incident commander is responsible for evaluating all officer reports for quality, accuracy, content, and request clarifications when reports have missing or conflicting information. The incident commander determines compliance with policy, procedure, and applicable law. The incident commander, at the initial review, found 531 incidents had missing or conflicting information at the time of determination regarding policy compliance. Of the 531 incidents, the incident commander requested clarification for 28 percent of the incidents. After requesting clarifications, the incident commander addressed deviations in 22 percent of the incidents reviewed. Overall, incident commanders in most of the adult institutions failed to address clarifications or policy deviations at least half of the time. A complete failure to request clarifications at this initial level of review was evident at Folsom State Prison, where incident commanders requested necessary clarifications in none of the incidents the OIG reviewed. On the other hand, Pelican Bay State Prison incident commanders requested clarifications in almost all of the reports with missing or conflicting information.

Incident commanders in most of the adult institutions ***did not*** address clarification or policy deviations at least half of the time.

Within the first level management review, the quality of reports is evaluated to ensure the use of force was properly documented and reviewed. First level management review requires an in-depth analysis to determine if the force described in the incident package was within policy. At the initial first level management review, deviations were addressed in 27 percent of the incidents reviewed. At this level, reviews identified issues missed in a third of the cases reviewed. The second level management review is the final level of review before the completed incident package is sent to the use-of-force coordinator. This level of review includes an in-depth analysis to determine if the force used was in compliance with policy, procedure, and applicable law. After this level review, incidents are referred for investigation, when applicable. At the second level management review, there were identified missed problems in over a quarter of the cases. This cumulative average for the second level management review was significantly impacted by 7 of the 33 adult institutions not addressing any issues. Within first and second level management reviews, problems were addressed on average in 21 percent of the cases for incidents at all institutions.

By the time the incident package reached the use-of-force review committee and institution-head level review, 25 percent of the incidents reviewed by the OIG still had issues not previously addressed by the review process. This final level of review only addressed outstanding issues in a third of the incidents where issues still existed. This statewide average was impacted by eight institutions where reviewers at this level identified less than 20 percent of the missed policy deviations or the need for clarifications. In five institutions, managers identified all of the clarifications or policy deviations not previously addressed by the time the last review was conducted.

In five of the institutions, managers identified all of the clarifications or policy deviations not previously addressed by the time the last review was conducted.

The OIG found inconsistent standards utilized by the various reviewers to determine whether a use-of-force incident complied with department policy. Some reviewers found a use-of-force

incident not in compliance if any department policy was violated, while other reviewers found an incident to violate policy only if the use-of-force policy was implicated.

Timeliness of Reviews

According to the department's Operations Manual, use-of- force incidents should normally be reviewed within 30 days. This includes all levels of the review process, as well as obtaining any necessary clarifications. For the 1,173 structured reviews the OIG conducted, the overall average time for review from the time of incident to the time of completion at the institutional head level was 51 days. Total average review time exceeded 80 days at several of the adult institutions with only three institutions meeting the 30 day threshold. Delays can compromise the department's ability to take disciplinary action. If misconduct is not timely identified, the department is precluded from taking disciplinary action regardless of the egregiousness of the misconduct. For a list of all adult institutions regarding the timeliness of reviews, please refer to Appendix D, and for a statewide review summary, please refer to Appendix E.

Video Recorded Interviews

Video recorded interviews are required by the department's use-of-force policy if the inmate has alleged unnecessary or excessive use of force or if the inmate has sustained serious bodily injury that could have been caused by a use of force. The video recording should be completed within 48 hours of discovery of the injury or allegation. If the inmate refuses to be video recorded, the department's Operations Manual requires staff to record the refusal.

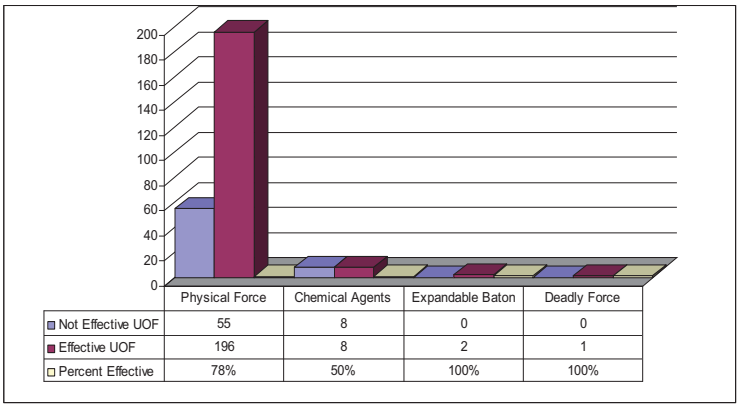
In the structured reviews, 165 incidents were identified as requiring video recorded interviews. The OIG found 115 incident recordings were conducted according to policy guidelines. Although the statewide average for compliance with the video recording policy was 70 percent, only 11 institutions conducted video recordings according to policy 100 percent of the time. At two of the institutions, none of the video recordings met policy requirements.

DIVISION OF ADULT PAROLE OPERATIONS

The Division of Adult Parole Operations is divided into four regions and responsible for supervising over 100,000 parolees. The adult parole regions reported 74 incidents statewide involving the use of force. In parole regions I and II, there were 43 incidents involving force and in parole regions III and IV, there were 31 incidents. Although with the highest number of use-of-force incidents, only one use-of force review meeting was held in parole region II, while parole region I held no meetings. At the OIG's urging that these important meetings take place, parole regions I and II have asserted that they will now conduct the required use-of-force review meetings.

The OIG attended 19 meetings and completed structured reviews of all 74 use-of-force incidents occurring in the parole regions. Within 74 incidents, there were 271 applications of force. The OIG found that the two reviewed incidents involving use of the baton and one incident of deadly force by parole agents were found to be 100 percent effective. The OIG found that physical force was 78 percent effective, while chemical agents were effective only half of the time.

Figure 7 provides a summary of the type and effectiveness of the force used in the parole regions.



The structured reviews revealed that 98 percent of parole agents' use-of- force reports adequately described the need to use force. However, only 74 percent of parole agents' use-of- force reports provided an appropriate description of the force used.

Figure 7

Statewide, unit supervisors failed to request clarifications for inadequate reports in three quarters of the incidents while only addressing 15 percent of missed issues and policy deviations. The next level of reviewers addressed the remaining deficiencies in only 18 percent of the incidents. The final level of reviewers in the parole regions failed to address issues in more than 23 percent of incidents they reviewed, with a total of 15 incidents left unaddressed after the final review.

Figure 8 illustrates the results of the adequacy of reports initially submitted by parole agents and the percentage of incidents for which supervisors and managers addressed inadequate reports or policy deviations. The table also includes the total days the review process took from the date of the incident to the date the last reviewer signed his or her review.

	Parole Agent Reports		Requested Clarification	Clarifications or Policy Deviations Addressed		
Parole Region	Incidents Evaluated	All Reports Adequate	Unit Supervisor	District Administrator	Hiring Authority	Total Days for Review
Region I	22	88%	22%	8%	0%	49
Region II	21	94%	33%	25%	0%	19
Region III	11	35%	0%	10%	27%	102
Region IV	20	78%	40%	50%	0%	168
Statewide	***74***	***74%***	***24%***	***23%***	***7%***	***85***

Figure 8

RECOMMENDATIONS

The OIG makes the following recommendations:

1. THE DEPARTMENT SHOULD DISTINGUISH BETWEEN NON-COMPLIANCE WITH THE USE-OF-FORCE POLICY VERSUS NON-COMPLIANCE IN OTHER DEPARTMENT POLICIES.

   Use-of-force critiques often conclude that staff actions were out of policy for reasons unrelated to the use-of-force policy. As a result, inconsistent decisions were made not only between institutions, but within the levels of review within the same institution. The OIG recommends that the department provide instruction to use-of-force reviewers, and clarify the

use-of-force review questions to ensure decisions are made utilizing a department-wide standard focusing on the use-of-force policy. The OIG also believes that it is important for the department reviewers to identify and address issues arising during a use-of-force incident related to other policies and procedures within the department. However, there should be a clear distinction between determining compliance with the use-of-force policy and identifying issues related to compliance with other department policies and procedures. Figure 9 provides an example of how the same facts are applied differently and result in a different compliance finding.

QUESTIONS	ANSWER EXAMPLE A	ANSWER EXAMPLE B
1. *Were staff actions **PRIOR** to the use of force in compliance with departmental standards and policy?*	**No**, staff actions were out of policy because an officer used his radio instead of activating his personal alarm device. In addition, an officer failed to properly apply handcuffs.	**Yes**, staff actions were in compliance to the use of force policy. However, an officer used his radio instead of activating his personal alarm device. In addition, an officer failed to properly apply handcuffs.
2. *Were staff actions **DURING** the use of force in compliance with departmental standards and policy?*	**No**, the control booth officer violated policy by opening the fire doors creating an unsafe condition.	**Yes**, officers used a reasonable amount of force to address the threat and affect custody. However, the control booth officer created an unsafe condition by opening the fire doors.
3. *Were staff actions **AFTER** the use of force in compliance with departmental standards and policy?*	**No**, staff failed to record 15 minute welfare checks on the holding cell log while the inmate was in the holding cell pending a new housing assignment.	**Yes**, staff actions were in compliance with the use of force policy. However, staff failed to record 15 minute welfare checks on the holding cell log while the inmate was in the holding cell pending a new housing assignment.

Figure 9

2. <u>THE DEPARTMENT SHOULD ENSURE USE-OF-FORCE REPORTS ARE COMPLETE, ACCURATE, AND DOCUMENTS ARE SUBMITTED TIMELY PRIOR TO FINAL REVIEW DECISIONS.</u>

The vast majority of the institutions and facilities made policy decisions based on inadequate reports and staff reports frequently omitted important descriptions of how the force was applied. Staff in a position to witness force often did not initially submit a report with their observations as required by policy. Thus, in most incidents involving force, the department made determinations about whether uses of force complied with policies, regulations and applicable laws without complete information. As the reasonableness of the use of force is fact sensitive to each situation, it is imperative that complete information be obtained and that reviews address any inconsistent or incomplete information in the use-of-force incident documentation. Therefore, the OIG recommends that the department provide better training for report writing and insist on greater accountability for its reviewers. In particular, the department should focus efforts on first level review as the data suggests that managers consistently failed to request further information needed to determine policy compliance.

3. THE DEPARTMENT SHOULD ENSURE USE-OF-FORCE EXECUTIVE REVIEW COMMITTEES ARE HELD IN COMPLIANCE WITH DEPARTMENT POLICIES.

   Adult parole regions I and II combined held limited use-of-force review meetings. Appropriately reviewing whether each use of force complies with department policy is critical to effectively manage use-of-force by the department and to identify potential misconduct by staff. The OIG recommends that these parole regions be required to hold meetings for all incidents of force.

   Richard J. Donovan Correctional Facility does not have its use-of-force review committee evaluate each use-of-force incident. Instead the vast majority of incidents are simply signed off by supervisors and managers. The OIG recommends that the department either require all institutions to review each incident as the use-of-force policy requires or amend the policy to allow certain incidents to be finalized through management review, and provide appropriate criteria with OIG input.

4. THE DEPARTMENT SHOULD ENSURE VIDEO RECORDED INTERVIEWS BE CONDUCTED IN A MANNER THAT IS CONSISTENT WITH POLICY

   Video recording was conducted only 70 percent of the time where it was required by department policy. As the purpose of video recordings is to preserve critical evidence related to allegations of use-of-force, the OIG recommends the department make efforts to increase its compliance with the video recording policy. In particular, the department should address the complete lack of compliance with this policy at more than one adult institution.

5. THE DEPARTMENT SHOULD ENSURE APPROPRIATE TRAINING FOR PEPPER SPRAY USE DURING CELL EXTRACTIONS AND SHOULD INCLUDE GUIDELINES FOR ASSESSING EXPOSURE ELEMENTS, TIME, AND EFFECTIVENESS

   Pepper spray is a chemical agent that causes tearing of the eyes, impaired vision, coughing, difficulty breathing, burning sensation, and inflammation of the skin. When used to remove an inmate from a cell, the use of pepper spray may avoid the need to use physical force against the inmate. Although current training requires officers to use only the amount of chemical agents reasonable to gain compliance, the department does not have clear guidelines establishing what is a reasonable amount of pepper spray or a reasonable amount of time between pepper spray applications. In reviewing use-of-force incidents, we discovered great disparities in the use of pepper spray for cell extractions during which the department forcibly removes an inmate from a cell. The OIG recommends that the department provide additional guidelines regarding the use of pepper spray during cell extractions. These guidelines should include: how to assess whether or not the inmate received an adequate exposure to pepper spray; the amount of time to let the pepper spray take effect once adequate exposure has been achieved before initiating additional applications; and how to determine when pepper spray is ineffective and another use-of-force option should be considered.

APPENDIX A: Acronyms for Adult Institutions

	Adult Institutions Location	*City*
ASP	Avenal State Prison	Avenal
CCC	California Correctional Center	Susanville
CCI	California Correctional Institution	Tehachapi
CIM	California Institution for Men	Chino
CIW	California Institution for Women	Frontera
CMF	California Medical Facility	Vacaville
CMC	California Men's Colony	San Luis Obispo
CRC	California Rehabilitation Center	Norco
COR	California State Prison, Corcoran	Corcoran
LAC	California State Prison, Los Angeles County	Lancaster
SAC	California State Prison, Sacramento	Represa
SQ	California State Prison, San Quentin	San Quentin
SOL	California State Prison, Solano	Vacaville
SATF	Substance Abuse Treatment Facility & State Prison at Corcoran	Corcoran
CAL	Calipatria State Prison	Calipatria
CEN	Centinela State Prison	Imperial
CCWF	Central California Women's Facility	Chowchilla
CVSP	Chuckawalla Valley State Prison	Blythe
CTF	Correctional Training Facility	Soledad
DVI	Deuel Vocational Institution	Tracy
FOL	Folsom State Prison	Represa
HDSP	High Desert State Prison	Susanville
ISP	Ironwood State Prison	Blythe
KVSP	Kern Valley State Prison	Delano
MCSP	Mule Creek State Prison	Ione
NKSP	North Kern State Prison	Delano
PBSP	Pelican Bay State Prison	Crescent City
PVSP	Pleasant Valley State Prison	Coalinga
RJD	Richard J. Donovan Correctional Facility	San Diego
SVSP	Salinas Valley State Prison	Soledad
SCC	Sierra Conservation Center	Jamestown
VSPW	Valley State Prison for Women	Chowchilla
WSP	Wasco State Prison	Wasco

APPENDIX B: Incidents Involving Force - Adult Institutions

Applications of Force

Adult Institutions

Institution	Mission	Incidences of Force	Physical Force	Chemical Agents	Expandable Baton	Less-Lethal Force	Deadly Force
CCWF	Female Offenders	72	29.17%	66.67%	4.17%	0.00%	0.00%
CIW	Female Offenders	55	38.18%	54.55%	7.27%	0.00%	0.00%
VSPW	Female Offenders	62	58.06%	38.71%	3.23%	0.00%	0.00%
ASP	General Population	49	42.86%	57.14%	0.00%	0.00%	0.00%
CCC	General Population	45	42.22%	42.22%	4.44%	8.89%	2.22%
CMC	General Population	153	60.13%	33.99%	5.88%	0.00%	0.00%
CMF	General Population	68	39.71%	58.82%	1.47%	0.00%	0.00%
CRC	General Population	84	58.33%	36.90%	4.76%	0.00%	0.00%
CTF	General Population	46	50.00%	43.48%	0.00%	6.52%	0.00%
CVSP	General Population	27	25.93%	51.85%	22.22%	0.00%	0.00%
FOL	General Population	125	12.00%	64.00%	6.40%	16.80%	0.80%
ISP	General Population	73	1.37%	57.53%	21.92%	19.18%	0.00%
PVSP	General Population	76	50.00%	26.32%	9.21%	14.47%	0.00%
SCC	General Population	23	34.78%	52.17%	0.00%	13.04%	0.00%
SOL	General Population	87	22.99%	52.87%	9.20%	14.94%	0.00%
CAL	High Security	87	18.39%	63.22%	2.30%	14.94%	0.00%
CCI	High Security	76	48.68%	30.26%	11.84%	9.21%	0.00%
CEN	High Security	112	11.61%	60.71%	9.82%	14.29%	3.57%
COR	High Security	182	43.41%	51.65%	1.65%	3.30%	0.00%
HDSP	High Security	107	15.89%	56.07%	0.00%	18.69%	9.35%
KVSP	High Security	183	32.79%	45.90%	5.46%	15.85%	0.00%
MCSP	High Security	84	13.10%	50.00%	23.81%	13.10%	0.00%
PBSP	High Security	143	24.48%	62.94%	4.20%	7.69%	0.70%
SAC	High Security	144	47.92%	33.33%	9.72%	9.03%	0.00%
SATF	High Security	94	30.85%	43.62%	13.83%	11.70%	0.00%
SVSP	High Security	67	19.40%	79.10%	0.00%	1.49%	0.00%
CIM	Reception Centers	125	25.60%	57.60%	2.40%	13.60%	0.80%
DVI	Reception Centers	143	52.45%	31.47%	16.08%	0.00%	0.00%
LAC	Reception Centers	99	52.53%	27.27%	9.09%	11.11%	0.00%
NKSP	Reception Centers	158	42.41%	27.22%	14.56%	14.56%	1.27%
RJD	Reception Centers	183	58.47%	27.87%	8.74%	4.92%	0.00%
SQ	Reception Centers	90	26.67%	51.11%	11.11%	11.11%	0.00%
WSP	Reception Centers	149	38.93%	40.27%	10.07%	10.74%	0.00%
SUMS		**3,271**					

APPENDIX C: Effective Use of Force – Averages by Type of Force

Averages by Type of Force

Adult Institutions

Institution	Instances Evaluated	Physical Force	Chemical Agents	Expandable Baton	Less-Lethal Force	Deadly Force
ASP	49	21	28	0	0	0
Effective		*62%*	*89%*			
CAL	87	16	55	2	13	0
Effective		*87%*	*47%*	*50%*	*15%*	
CCC	45	19	19	2	4	1
Effective		*84%*	*90%*	*0%*	*50%*	*100%*
CCI	76	37	23	9	7	0
Effective		*72%*	*78%*	*67%*	*29%*	
CCWF	72	21	48	3	0	0
Effective		*91%*	*85%*	*33%*		
CEN	112	13	68	11	16	4
Effective		*100%*	*63%*	*73%*	*31%*	*25%*
CIM	125	32	72	3	17	1
Effective		*69%*	*51%*	*100%*	*30%*	*0%*
CIW	55	21	30	4	0	0
Effective		*100%*	*53%*	*25%*		
CMC	153	92	52	9	0	0
Effective		*47%*	*52%*	*11%*		
CMF	68	27	40	1	0	0
Effective		*93%*	*55%*	*100%*		
COR	182	79	94	3	6	0
Effective		*79%*	*35%*	*33%*	*83%*	
CRC	84	49	31	4	0	0
Effective		*78%*	*64%*	*0%*		
CTF	46	23	20	0	3	0
Effective		*96%*	*55%*		*100%*	
CVSP	27	7	14	6	0	0
Effective		*86%*	*64%*	*67%*		
DVI	143	75	45	23	0	0
Effective		*84%*	*49%*	*13%*		
FOL	125	15	80	8	21	1
Effective		*93%*	*59%*	*25%*	*33%*	*100%*
HDSP	107	17	60	0	20	10
Effective		*82%*	*68%*		*25%*	*60%*
ISP	73	1	42	16	14	0
Effective		*100%*	*83%*	*62%*	*43%*	
KVSP	183	60	84	10	29	0
Effective		*57%*	*63%*	*40%*	*38%*	

Averages by Type of Force (continued)

Adult Institutions

Institution	Instances Evaluated	Physical Force	Chemical Agents	Expandable Baton	Less-Lethal Force	Deadly Force
LAC	99	52	27	9	11	0
Effective		*96%*	*74%*	*22%*	*73%*	
MCSP	84	11	42	20	11	0
Effective		*64%*	*79%*	*15%*	*46%*	
NKSP	135	67	43	23	23	2
Effective		*79%*	*44%*	*44%*	*39%*	*100%*
PBSP	143	35	90	6	11	1
Effective		*89%*	*34%*	*17%*	*36%*	*100%*
PVSP	76	38	20	7	11	0
Effective		*79%*	*50%*	*43%*	*64%*	
RJD	183	107	51	16	9	0
Effective		*78%*	*71%*	*75%*	*68%*	
SAC	144	69	48	14	13	0
Effective		*84%*	*77%*	*21%*	*23%*	
SATF	94	29	41	13	11	0
Effective		*76%*	*63%*	*23%*	*55%*	
SCC	23	8	12	0	3	0
Effective		*100%*	*92%*		*33%*	
SOL	87	20	46	8	13	0
Effective		*80%*	*59%*	*50%*	*23%*	
SQ	90	24	46	10	10	0
Effective		*96%*	*72%*	*80%*	*50%*	
SVSP	67	13	53	0	1	0
Effective		*100%*	*70%*		*0%*	
VSPW	62	36	24	2	0	0
Effective		*83%*	*58%*	*100%*		
WSP	149	58	60	15	16	0
Effective		*71%*	*70%*	*40%*	*69%*	
SUM	3271	1192	1508	257	293	20
Averages		78.19%	60.94%	40.07%	41.29%	60.00%

APPENDIX D: Timeliness of Reviews – Adult Institutions

Timeliness of Reviews						
Adult Institutions						
Institution	**Incidents Evaluated**	**Incident Commander**	**1st Level Manager**	**2nd Level Manager**	**Institution Head/ IERC**	**Total Days for Review**
ASP	30	5	7	12	14	38
CAL	31	4	9	4	17	33
CCC	19	3	6	6	49	63
CCI	27	1	7	5	28	41
CCWF	29	1	10	7	32	49
CEN	38	3	7	6	25	41
CIM	34	2	14	1	24	41
CIW	22	3	9	10	27	54
CMC	30	3	21	10	25	59
CMF	30	6	18	8	18	49
COR	43	3	10	7	16	37
CRC	28	1	6	4	15	26
CTF	23	1	4	4	23	31
CVSP	13	1	5	2	19	26
DVI	46	1	3	3	21	27
FOL	40	1	6	4	27	38
HDSP	38	8	9	2	23	43
ISP	35	1	10	6	61	78
KVSP	62	2	15	8	51	77
LAC	37	1	9	5	66	80
MCSP	27	1	8	5	34	48
NKSP	47	2	9	8	21	40
PBSP	52	15	7	7	27	58
PVSP	28	4	9	14	37	64
RJD	71	2	9	11	66	87
SAC	43	1	9	5	23	39
SATF	39	1	9	13	26	49
SCC	16	1	7	6	46	60
SOL	32	2	20	10	47	79
SQ	43	1	9	5	70	85
SVSP	37	2	9	4	71	85
VSPW	26	1	6	8	21	36
WSP	57	2	10	7	14	33
SUM / AVGS	**1173**	**3**	**9**	**7**	**33**	**51**

(Timelines were rounded to the nearest day)

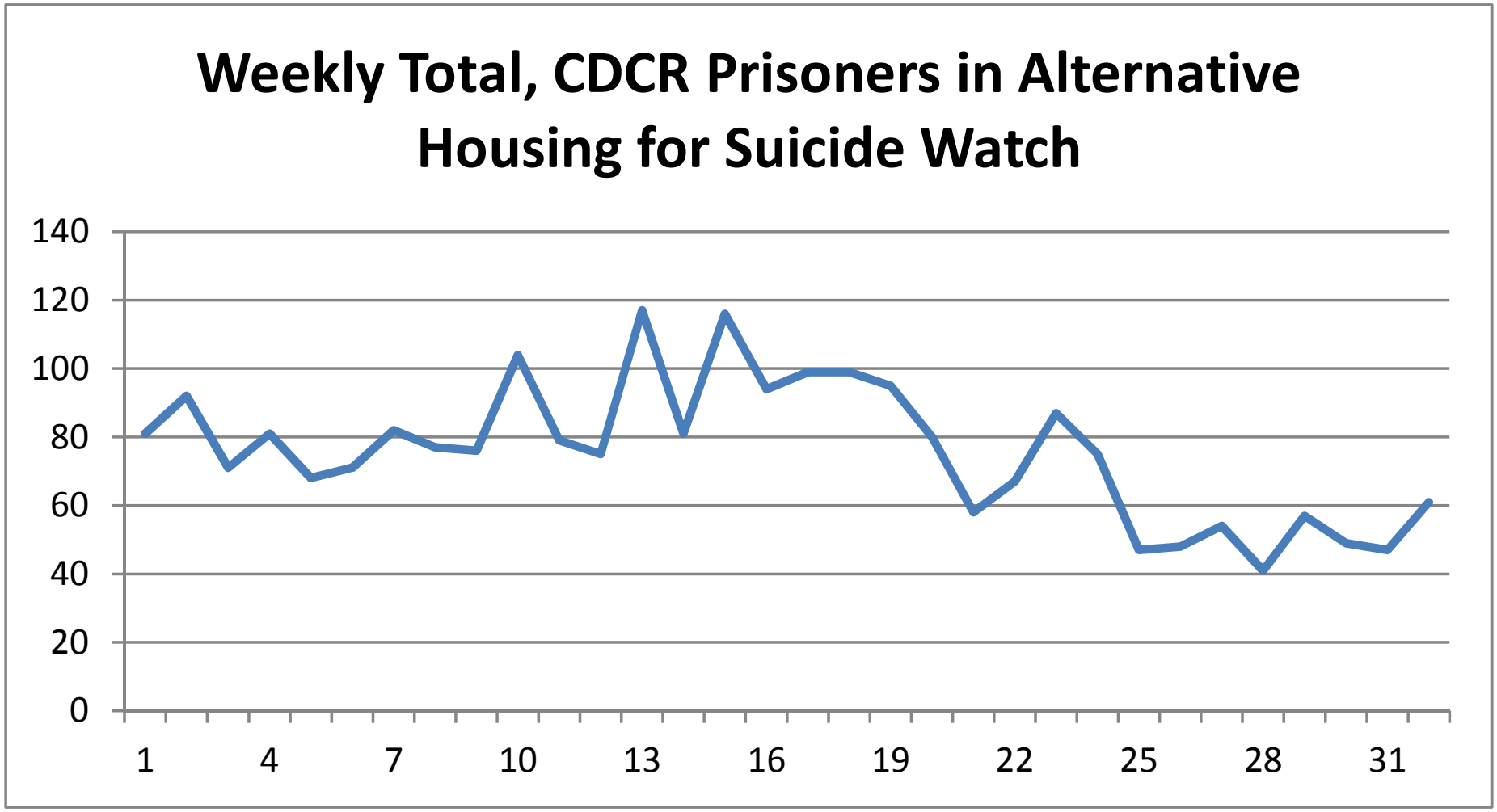
APPENDIX E: Statewide Review Summary – Adult Institutions

Statewide Review Summary

Adult Institutions

Institution	Officer Reports		Requested Clarifications	Clarifications or Policy Deviations Addressed		
	Incidents Evaluated	All Reports Adequate	Incident Commander	1st Level Manager	2nd Level Manager	Institution Head
ASP	30	64.3%	30.0%	0.0%	33.3%	100.0%
CAL	31	70.1%	40.0%	20.0%	11.1%	22.2%
CCC	19	84.2%	0.0%	0.0%	0.0%	100.0%
CCI	27	55.6%	17.6%	84.6%	50.0%	100.0%
CCWF	29	72.4%	12.1%	0.0%	30.0%	16.7%
CEN	38	36.8%	8.3%	12.1%	4.5%	38.1%
CIM	34	73.5%	33.3%	62.1%	0.0%	25.0%
CIW	22	60.0%	50.0%	0.0%	20.0%	50.0%
CMC	30	50.0%	12.1%	46.2%	14.3%	22.2%
CMF	30	79.3%	62.1%	58.3%	44.4%	87.1%
COR	43	44.2%	8.3%	13.6%	22.2%	62.1%
CRC	28	67.9%	22.2%	18.2%	0.0%	0.0%
CTF	23	65.2%	0.0%	0.0%	0.0%	12.1%
CVSP	13	92.3%	0.0%	0.0%	0.0%	0.0%
DVI	46	95.5%	92.6%	16.7%	20.0%	33.3%
FOL	40	37.1%	0.0%	3.8%	0.0%	8.0%
HDSP	38	50.0%	47.4%	33.3%	50.0%	50.0%
ISP	35	48.6%	26.3%	53.8%	16.7%	33.3%
KVSP	62	56.5%	3.4%	11.5%	0.0%	64.3%
LAC	37	70.3%	16.7%	37.1%	20.0%	33.3%
MCSP	27	59.3%	9.1%	9.1%	10.0%	30.0%
NKSP	47	57.4%	34.8%	85.7%	83.3%	50.0%
PBSP	52	95.7%	90.9%	40.0%	25.0%	50.0%
PVSP	28	59.3%	8.3%	45.5%	66.7%	50.0%
RJD	71	54.9%	8.8%	2.9%	2.9%	5.9%
SAC	43	48.8%	13.0%	13.0%	10.0%	5.3%
SATF	39	56.4%	0.0%	16.7%	6.7%	26.7%
SCC	16	43.8%	11.1%	44.4%	20.0%	100.0%
SOL	32	71.9%	57.1%	33.3%	12.1%	0.0%
SQ	43	86.0%	30.8%	7.7%	30.8%	46.2%
SVSP	37	100.0%	80.0%	N/A	100.0%	66.7%
VSPW	26	80.8%	0.0%	50.0%	75.0%	100.0%
WSP	57	59.6%	30.4%	66.7%	33.3%	75.0%
AVGS	**1173**	**64.19%**	**27.87%**	**26.68%**	**16.35%**	**33.33r%**

Exhibit 115


Weekly Total, CDCR Prisoners in Alternative Housing for Suicide Watch
140
120
100
80
60
40
20
0
1
4
7
10
13
16
19
22
25
28
31

From: Michael W. Bien <MBien@rbgg.com>
Sent: Wednesday, February 20, 2013 5:03 PM
To: Armstrong Team - RBG only
Subject: FW: Coleman discovery [IWOV-DMS.FID25914]
Attachments: AH DATA 1-28.xlsx; AH DATA 1-32.xlsx; AH summaries1-23.pdf; AH Summary 1-32.pdf; AH Summary May-Nov 2012.pdf

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From: Jay Russell[SMTP:JAY.RUSSELL@DOJ.CA.GOV]
Sent: Wednesday, February 20, 2013 5:02:06 PM
To: Aaron Fischer
Cc: Patrick McKinney; William Downer; Maneesh Sharma; Debbie Vorous; Coleman Team - RBG Only; Steve Fama; Katherine@CDCR Tebrock (katherine.tebrock@cdcr.ca.gov); Schwartz, Jennifer@CDCR (jennifer.schwartz@cdcr.ca.gov)
Subject: RE: Coleman discovery [IWOV-DMS.FID25914]
Auto forwarded by a Rule

Aaron –

In response to your email message below, documents responsive to Plaintiffs' second request for production are being delivered to your office overnight for delivery tomorrow. As you are surely aware, William Downer, who has been coordinating document responses, is at Kern Valley today accompanying Plaintiffs' counsel and experts during their inspection. When Mr. Downer returns to the office, documents responsive to the third request will be reviewed, Bates stamped, and then delivered to your office on February 22.

During our telephone conference last Friday, Defendants agreed to use their best efforts to provide further responses to Plaintiffs' requests, but made no promises to provide documents by today. Indeed, during the telephone conference, you demanded that documents be provided by Thursday February 21, *not* today. Moreover, at no time during that call did you place any particular primacy in documents responsive to requests 76 through 78. For you to now ask for production of these document within hours of your email below, sent yesterday afternoon at 3:00 p.m., is simply unreasonable.

In any event, we are completing preparation of documents responsive to requests numbers 76 and 77, and they should be included in the delivery to your office on Friday. At this juncture, CDCR has determined there are no further documents responsive to request 78 that are not already in Plaintiffs' position. In addition, I am attaching to this email documents in native format documents that are responsive to request number 76. (A second email with remaining documents will immediately follow this transmission.) These have *not* been Bates stamped but, as stated above, will be included in the formal production provided to your office on Friday. To that end, if you intend to use any of these documents during Mr. Johnson's deposition on Monday, I ask that the Bates stamped version of these documents be introduced into the record, rather than the unmarked documents that accompany this email.

Should you have any questions, please contact me.

From: Aaron Fischer [mailto:AFischer@rbgg.com]
Sent: Tuesday, February 19, 2013 3:03 PM
To: Jay Russell

Cc: Patrick McKinney; William Downer; Maneesh Sharma; Debbie Vorous; Coleman Team - RBG Only; Steve Fama
Subject: RE: Coleman discovery [IWOV-DMS.FID25914]

Jay,

I am following up on Friday's meet and confer regarding *Coleman* discovery. I know that you and Maneesh are making further inquiries as to a number of Plaintiffs' requests for production for which Defendants had initially indicated in their written responses that they would not produce responsive documents (RFPs 28, 31, 33, 35, 38, 39, 40, 47, 53, 59, 60, 61, 64, 65, 83, 84, 90, 91, 92, 93, 94, 95, 96, 99). Please let me know the status of these follow-up inquiries as soon as possible and no later than tomorrow, 2/20. Please also let me know when we can expect to receive the privilege log you agreed Defendants would produce for all RFPs, as appropriate.

As we agreed, Defendants will produce in *native format* all responsive charts and other documents that cannot be practically viewed in PDF or hard copy form. Plaintiffs agreed to this on the understanding that Defendants would promptly re-produce any other documents, upon Plaintiffs' request, in native format as appropriate.

We have yet to receive any production of documents responsive to Request Sets 2 and 3; we requested that we receive all or the bulk of the production by tomorrow, 2/20. As you know, the court-ordered discovery cut-off is 10 days from now, and production must move forward without delay. Depositions of Defendants' declarants begin *this week*. If we have not received a sufficient production in advance of these depositions, we may have to continue certain depositions over to a second day. For example, we must have produced, by Noon tomorrow (2/20), *all documents responsive to RFPs 76-78*.

In an effort to reduce the burden of discovery on Defendants, we agreed to provide search terms and custodians in order to narrow the search for documents responsive to RFPs 48, 81, and 85. We expect to provide that information shortly.

Thank you for your attention and ongoing efforts. Let me know if you have any questions about the above.

Many thanks,
Aaron

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From: Jay Russell [mailto:Jay.Russell@doj.ca.gov]
Sent: Friday, February 15, 2013 10:21 AM
To: Aaron Fischer

Cc: Patrick McKinney; William Downer; Maneesh Sharma
Subject: RE: Coleman discovery [IWOV-DMS.FID25914]

Aaron – Are you available for a telephone conference with Maneesh Sharma of our office and me at 11 am?

Also, responses to the third set of Requests for Production were served both via email and regular mail last night.

Jay C. Russell
Supervising Deputy Attorney General
California Department of Justice
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
415.703.5717
415.703.5843 Facsimile
jay.russell@doj.ca.gov

From: Aaron Fischer [mailto:AFischer@rbgg.com]
Sent: Thursday, February 14, 2013 5:39 PM
To: Debbie Vorous; William Downer
Cc: Lisa Ells; Coleman Team - RBG Only
Subject: Coleman discovery [IWOV-DMS.FID25914]

Debbie and Sonny,

We would like to meet and confer regarding Defendants' responses to Plaintiffs' Second Set of Requests for Production of Documents. Please let me know when you are available on Friday for a phone call.

Also, we have not yet received responses to Plaintiffs' Third Set of Requests for Production of Documents, which are due today pursuant to the Court's order. When can we expect those to arrive?

Thank you,
Aaron

Aaron J. Fischer, Esq.
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SUMMARY OF CASES IN ALTERNATIVE HOUSING

May 18, 2012 - December 27, 2012

Week	Total in Alt Housing	Referred to HC-POP for MHCB	% Referred	Not Referred to HC-POP	% Not Referred	Hours in Alt Housing				Total in Alt Housing 24 hrs or less	% in Alt Housing 24 hrs or less
						High	Low	Median	Mean		
1 May 18 - May 24	81	48	59%	33	41%	170.00	0.58	20.87	32.39	47	58%
2 May 25 - May 31	92	43	47%	49	53%	170.00	1.50	20.25	31.25	61	66%
3 June 1 - June 8	71	42	59%	29	41%	70.00	0.00	22.60	28.09	41	58%
4 June 9 - June 14	81	47	58%	34	42%	78.75	0.00	15.71	17.55	62	77%
5 June 15 - June 21	68	44	65%	24	35%	84.25	0.67	18.79	21.03	50	74%
6 June 22 - June 28	71	51	72%	20	28%	63.42	0.00	19.25	22.51	48	68%
7 June 29 - July 5	82	64	78%	18	22%	63.42	0.32	19.43	22.09	59	72%
8 July 6 - July 12	77	65	84%	12	16%	82.15	0.20	19.33	25.33	49	64%
9 July 13 - July 19	76	62	82%	14	18%	57.75	0.50	20.25	21.15	52	68%
10 July 20 - July 26	104	85	82%	19	18%	96.17	1.23	21.18	27.94	66	63%
11 July 27 - Aug 2	79	63	80%	16	20%	84.25	0.08	21.00	25.87	47	59%
12 Aug 3 - Aug 9	75	58	77%	17	23%	49.50	0.03	16.67	20.32	54	72%
13 Aug 10 - Aug 16	117	108	92%	9	8%	106.00	0.03	18.83	23.71	78	67%
14 Aug 17 - Aug 23	81	72	89%	9	11%	50.65	0.25	20.13	22.03	59	73%
15 Aug 24 - Aug 30	116	113	97%	3	3%	90.22	1.48	19.80	24.46	79	68%
16 Aug 31 - Sep 6	94	87	93%	7	7%	105.55	0.92	23.37	29.90	51	54%
17 Sep 7 - Sep 13	99	91	92%	8	8%	106.58	1.50	20.67	25.91	57	58%

SUMMARY OF CASES IN ALTERNATIVE HOUSING

May 18, 2012 - December 27, 2012

Week	Total in Alt Housing	Referred to HC-POP for MHCB	% Referred	Not Referred to HC-POP	% Not Referred	Hours in Alt Housing				Total in Alt Housing 24 hrs or less	% in Alt Housing 24 hrs or less
						High	Low	Median	Mean		
18 Sep 14 - Sep 20	99	88	89%	11	11%	69.33	0.52	18.75	20.70	71	72%
19 Sep 21- Sep 27	95	83	87%	12	13%	61.95	0.25	17.50	19.65	67	71%
20 Sep 28 - Oct 4	80	67	84%	13	16%	44.60	0.33	17.67	18.59	61	76%
21 Oct 5 - Oct 11	58	52	90%	6	10%	44.58	2.08	18.33	18.81	46	79%
22 Oct 12 - Oct 18	67	53	79%	14	21%	51.50	0.52	17.58	17.06	55	82%
23 Oct 19 - Oct 25	87	80	92%	7	8%	38.25	1.50	16.50	16.33	74	85%
24 Oct 26 - Nov 1	75	67	89%	8	11%	45.58	4.65	17.75	19.18	61	81%
25 Nov 2 - Nov 8	47	42	89%	5	11%	43.50	0.25	19.46	21.09	32	68%
26 Nov 9 - Nov 15	48	43	90%	5	10%	44.08	2.58	17.61	17.95	40	83%
27 Nov 16 - Nov 22	54	40	74%	14	26%	84.72	0.30	20.44	22.50	37	69%
28 Nov 23 - Nov 29	41	36	88%	5	12%	64.50	0.50	21.18	22.57	26	63%
29 Nov 30 - Dec 6	57	39	68%	18	32%	48.83	0.83	15.42	15.37	49	86%
30 Dec 7 - Dec 13	49	38	78%	11	22%	42.67	2.25	18.88	19.99	38	78%
31 Dec 14 - Dec 20	47	40	85%	7	15%	43.92	0.18	19.75	21.11	37	79%
32 Dec 21 - Dec 27	61	48	79%	13	21%	44.58	1.50	18.42	20.53	46	75%
TOTAL	**2429**	**1959**	**81%**	**470**	**19%**					**1700**	**70%**
AVG/WK	**76**	**61**	**81%**	**15**	**19%**	**71.91**	**0.86**	**19.17**	**22.28**	**53**	**70%**

SUMMARY OF CASES IN ALTERNATIVE HOUSING

May 18, 2012 - December 27, 2012

DISPOSITION OF CASES IN ALTERNATIVE HOUSING				
Week	MHCB Placement	No MHCB Placement	TOTAL CASES	% Placed
1 May 18 - May 24	49	32	81	60%
2 May 25 - May 31	39	53	92	42%
3 June 1 - June 8	36	35	71	51%
4 June 9 - June 14	43	38	81	53%
5 June 15 - June 21	35	33	68	51%
6 June 22 - June 28	40	31	71	56%
7 June 29 - July 5	42	40	82	51%
8 July 6 - July 12	43	34	77	56%
9 July 13 - July 19	38	38	76	50%
10 July 20 - July 26	55	49	104	53%
11 July 27 - Aug 2	47	32	79	59%
12 Aug 3 - Aug 9	35	40	75	47%
13 Aug 10 - Aug 16	78	39	117	67%
14 Aug 17 - Aug 23	44	37	81	54%
15 Aug 24 - Aug 30	58	58	116	50%
16 Aug 31 - Sep 6	64	30	94	68%
17 Sep 7 - Sep 13	55	44	99	56%
18 Sep 14 - Sep 20	57	42	99	58%
19 Sep 21- Sep 27	53	42	95	56%
20 Sep 28 - Oct 4	36	44	80	45%
21 Oct 5 - Oct 11	32	26	58	55%
22 Oct 12 - Oct 18	32	35	67	48%
23 Oct 19 - Oct 25	41	46	87	47%
24 Oct 26 - Nov 1	37	38	75	49%
25 Nov 2 - Nov 8	24	23	47	51%
26 Nov 9 - Nov 15	22	26	48	46%
27 Nov 16 - Nov 22	26	28	54	48%
28 Nov 23 - Nov 29	26	15	41	63%
29 Nov 30 - Dec 6	28	29	57	49%
30 Dec 7 - Dec 13	32	17	49	65%
31 Dec 14 - Dec 20	27	20	47	57%
32 Dec 21 - Dec 27	27	34	61	44%
TOTAL	1301	1128	2429	54%
AVG/WK	41	35	76	54%

SUMMARY OF CASES IN ALTERNATIVE HOUSING

May 18, 2012 - December 27, 2012

DISPOSITION DETAIL OF CASES REFERRED TO HC-POP					DISPOSITION DETAIL OF CASES NOT REFERRED TO HC-POP				
Week	Transferred to MHCB	Intra-Inst MHCB Placement	Rescinded (Deemed no MHCB, Outpatient Placement)	TOTAL REFERRED	Intra-Inst MHCB Placement	Deemed no MHCB, Outpatient Placement	DMH	Parole	TOTAL NOT REFERRED
1 May 18 - May 24	22	14	12	48	13	19	0	1	33
2 May 25 - May 31	13	8	22	43	18	31	0	0	49
3 June 1 - June 8	14	11	17	42	11	18	0	0	29
4 June 9 - June 14	13	21	13	47	9	25	0	0	34
5 June 15 - June 21	19	9	16	44	7	17	0	0	24
6 June 22 - June 28	23	8	20	51	9	11	0	0	20
7 June 29 - July 5	25	10	29	64	7	11	0	0	18
8 July 6 - July 12	14	25	26	65	4	8	0	0	12
9 July 13 - July 19	29	6	27	62	3	11	0	0	14
10 July 20 - July 26	25	26	34	85	4	15	0	0	19
11 July 27 - Aug 2	29	15	19	63	3	13	0	0	16
12 Aug 3 - Aug 9	12	18	28	58	5	12	0	0	17
13 Aug 10 - Aug 16	39	35	34	108	4	5	0	0	9
14 Aug 17 - Aug 23	12	29	31	72	3	6	0	0	9
15 Aug 24 - Aug 30	33	24	56	113	1	2	0	0	3
16 Aug 31 - Sep 6	30	32	25	87	2	5	0	0	7
17 Sep 7 - Sep 13	23	28	40	91	4	4	0	0	8
18 Sep 14 - Sep 20	24	28	36	88	5	6	0	0	11
19 Sep 21- Sep 27	22	27	34	83	4	8	0	0	12
20 Sep 28 - Oct 4	13	19	35	67	4	9	0	0	13
21 Oct 5 - Oct 11	23	5	24	52	4	2	0	0	6
22 Oct 12 - Oct 18	11	17	25	53	4	10	0	0	14
23 Oct 19 - Oct 25	17	23	40	80	1	6	0	0	7
24 Oct 26 - Nov 1	20	15	32	67	2	5	1	0	8
25 Nov 2 - Nov 8	14	9	19	42	1	4	0	0	5
26 Nov 9 - Nov 15	15	7	21	43	0	5	0	0	5
27 Nov 16 - Nov 22	12	8	20	40	6	8	0	0	14
28 Nov 23 - Nov 29	12	11	13	36	3	2	0	0	5
29 Nov 30 - Dec 6	9	9	21	39	10	8	0	0	18
30 Dec 7 - Dec 13	13	13	12	38	6	5	0	0	11
31 Dec 14 - Dec 20	13	10	17	40	4	3	0	0	7
32 Dec 21 - Dec 27	17	6	25	48	4	9	0	0	13
TOTAL	610	526	823	1959	165	303	1	1	470
AVG/WK	19	16	26	61	5	9	0	0	15

Exhibit 116

From: Yi, Chris@CDCR [Chris.Yi@cdcr.ca.gov]
Sent: Thursday, December 27, 2012 3:14 PM
To: Laura Ceballos; Belavich, Tim@CDCR; Debbie Vorous
Cc: Johnson, Jennifer (HCS)@CDCR; Stanley, Nathan@CDCR; Jefferson, Cathy@CDCR; Holcomb, Lisa@CDCR; Greene, Andrew@CDCR
Subject: RE: LOS Data
Attachments: Outlier Analysis.xlsx

Hello,

I added my findings from examining outliers to relevant areas below (in red). For the queries with a number of hits in the hundreds or even thousands, I picked a small sample of cases with extreme LOS numbers among outliers to see if there was any major reason for the delay.

For more detailed information, please refer to the attached excelsheet, which contains the following tabs:

- CCCMS-EOP at Desert awaitg txfr (corresponds to #1, 2, and 3 below)
- RC awaiting txfr to CCCMS (#5 "without CDCR"; #4 is the combination of #5 and #6)
- RC awaiting txfr to EOP (#6 "without CDCR")
- ML awaiting txfr to EOP (#8)
- Pending txfr from RC to ML EOP (#9)

I do not have access to SOMS, so almost all of my analysis for outliers came from looking at each inmate's patient record individually in MHTS and browsing through transaction/movement history.

Please let me know if there are any questions.

Thank you,
Chris

From: Yi, Chris@CDCR
Sent: Wednesday, December 26, 2012 5:00 PM
To: Ceballos, Laura@CDCR; Belavich, Tim@CDCR; 'Debbie.Vorous@doj.ca.gov'
Cc: Johnson, Jennifer (HCS)@CDCR; Stanley, Nathan@CDCR; Jefferson, Cathy@CDCR; Holcomb, Lisa@CDCR; Greene, Andrew@CDCR
Subject: RE: LOS Data

Hello all,

I re-queried and calculated the median, as requested. Please note that some of the numbers have been updated. (Please scroll down to the original message from Dr. Ceballos.) Since some of the files containing query results are rather large, I am not attaching any of them in this e-mail, but you can find those files at the following location (in our unit share drive):

\\accounts\HCS\HQ\Main\Public\Mental Health\Chris Yi\LOS Data

Tomorrow, I will calculate and analyze outliers (either 2 or 3 standard deviation from the mean) and report the results.

Thank you,

Chris Yi
AGPA
Policy Support

Statewide Mental Health Program
Division of Health Care Services
Phone: 916.691.9937
E-mail: Chris.Yi@cdcr.ca.gov

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From: Johnson, Jennifer (HCS)@CDCR
Sent: Wednesday, December 26, 2012 10:58 AM
To: Ceballos, Laura@CDCR; Belavich, Tim@CDCR; 'Debbie.Vorous@doj.ca.gov'
Cc: Stanley, Nathan@CDCR; Jefferson, Cathy@CDCR; Holcomb, Lisa@CDCR; Yi, Chris@CDCR; Greene, Andrew@CDCR
Subject: RE: LOS Data

Thanks All. I will have Chris work on this. Thanks.

Jennifer Johnson
Chief, Policy Support
Statewide Mental Health Program
Division of Health Care Services
Office 916.691.0265

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From: Ceballos, Laura@CDCR
Sent: Wednesday, December 26, 2012 10:47 AM
To: Belavich, Tim@CDCR; 'Debbie.Vorous@doj.ca.gov'
Cc: Stanley, Nathan@CDCR; Jefferson, Cathy@CDCR; Johnson, Jennifer (HCS)@CDCR; Holcomb, Lisa@CDCR
Subject: Re: LOS Data

Okay. So Jen- it looks like we will need Chris to re run some of the data. The excel spreadsheets I forwarded at least cover some of it but not all.

From: Belavich, Tim@CDCR
Sent: Wednesday, December 26, 2012 10:43 AM Pacific Standard Time
To: Debbie Vorous <Debbie.Vorous@doj.ca.gov>
Cc: Ceballos, Laura@CDCR; Stanley, Nathan@CDCR; Jefferson, Cathy@CDCR; Johnson, Jennifer (HCS)@CDCR; Holcomb, Lisa@CDCR
Subject: Re: LOS Data

I think it will be a stronger and more sound argument. And it will look better so we don't have to play with dropping outliers.

Timothy G. Belavich, Ph.D., MSHCA, CCHP,
Deputy Director (A),
Statewide Mental Health Program

Office: 1-916-691-0296
Mobile: 1-661-857-1948

On Dec 26, 2012, at 10:39 AM, "Debbie Vorous" <Debbie.Vorous@doj.ca.gov> wrote:

Tim, I agree. If it is possible to run the median numbers, please do. Thank you!

From: Belavich, Tim@CDCR [mailto:Tim.Belavich@cdcr.ca.gov]
Sent: Wednesday, December 26, 2012 10:37 AM
To: Debbie Vorous
Cc: Ceballos, Laura@CDCR; Stanley, Nathan@CDCR; Jefferson, Cathy@CDCR; Johnson, Jennifer (HCS)@CDCR; Holcomb, Lisa@CDCR
Subject: Re: LOS Data

I hate to say this but are you better off reporting the median so you can take those outliers into account and thy don't have the weight on the total.

Tim

Timothy G. Belavich, Ph.D., MSHCA, CCHP,
Deputy Director (A),
Statewide Mental Health Program

Office: 1-916-691-0296
Mobile: 1-661-857-1948

On Dec 26, 2012, at 10:32 AM, "Debbie Vorous" <Debbie.Vorous@doj.ca.gov> wrote:

> Thank you Laura. Jennifer, can you please have Chris check the outliers as Laura notes below. Thank you.
>
> **From:** Ceballos, Laura@CDCR [mailto:Laura.Ceballos@cdcr.ca.gov]
> **Sent:** Monday, December 24, 2012 2:50 PM
> **To:** Debbie Vorous
> **Cc:** Stanley, Nathan@CDCR; Belavich, Tim@CDCR; Jefferson, Cathy@CDCR; Johnson, Jennifer (HCS)@CDCR; Holcomb, Lisa@CDCR
> **Subject:** LOS Data
>
> Hi, Debbie.
>
> Below is the LOS data requested.
>
> **Reference: Page 2, Section 5. Transfers from Desert Institutions. All LOCs.**
>
> From August 1-November 30, 2012, the average LOS for inmates at the CCCMS and EOP LOCs awaiting transfer to a MHSDS institution was 53.0 days, with a range of .3-122 days.
>
> File: 1 - LOS of CCCMS and EOP inmates at Desert Institutions.xlsx
> - Average LOS = 27.2
> - Median LOS = 22.2
> - Range: 0 - 122
>
> **Summary:**
>
> - From 8/1/2012 to 11/30/2012, 98.44% of CCCMS and EOP LOC inmates had LOS within the policy required transfer times (CCCMS – 90 days; EOP – 60 days).

Breakdown: CCCMS Inmates at Desert Institutions

Of the CCCMS inmates, the average LOS was 27.5 and the range was 1-122 days.

Of those CCCMS inmate with a LOS of 77.2 or higher (outliers although I did not statistically determine this) – one inmate with 122 days LOS as of Nov. 30, is still at a desert institution (ISP). This inmate is SNY.

All others were transferred to other institution. Data appears to accurate for all of these inmates.

File: 2 - LOS of CCCMS inmates at Desert Institutions.xlsx

- Average LOS = 27.5
- Median LOS = 23.4
- Range: 0 - 122

Summary:

- From 8/1/2012 to 11/30/2012, 98.39% of CCCMS LOC inmates had LOS within the policy required transfer time (90 days).
- Among four cases where the LOS was greater than 90days, three inmates were still at their desert institution, and one inmate moved to SAC. Two of the four inmates are SNY.

EOP Inmates at Desert Institutions:

The Average LOS from August 1-Nov. 30, 2012 was 18.4 days, with a range of 17.6 to 35.9 days.

There were no significant outliers in this data set.

File: *3 - LOS of EOP inmates at Desert Institutions.xlsx*

- Average LOS = 18.4
- Median LOS = 13.7
- Range: 0 - 35.9

Summary:

- From 8/1/2012 to 11/30/2012, 100% of EOP LOC inmates had LOS within policy required transfer times (60 days).

Reference: Page 3, RC Transfers to ML MHSDS Programs.

From August 1, 2012 to November 30, 2012, the average LOS inmates at the RC awaiting transfer to a ML CCCMS or EOP program was 123.2 days. Due the large size of this data, the range was not available. **This can be hand counted if necessary but will take a significant amount of time.**

NOTE: When I ran with every institution (including CDCR) selected in the "institution" part of the query window, I got 123.2, but when I ran without CDCR selected (but all the institutions selected), I got a different result. I thought CDCR should be unselected when querying for all the institutions. Please advise on which data to use.

File: 4 (without CDCR)- LOS for inmates at RC waiting transfer to ML CCCMS or EOP.*xlsx*

- Average LOS = 84.1
- Median LOS = 49.8
- Range: 0 - 1697

File: 4 (with CDCR)- LOS for inmates at RC waiting transfer to ML CCCMS or EOP.*xlsx*

- Average LOS = 123.2
- Median LOS = 59.6
- Range: 0 - 1697

Breakdown: CCCMS RC inmates awaiting transfer

The average LOS from August 1, 2012, to Nov. 30, 2012 for RC inmates awaiting transfer to a CCCMS program was 90.1 days. Due to the large size of this data, the range was not available. **This can be hand counted if needed.**

File: 5 (without CDCR) - LOS for inmates at RC waiting transfer to ML CCCMS.*xlsx*

- Average LOS = 90.1
- Median LOS = 53.9
- Range: 0 – 1150

Timeline: 8/1/2012 to 11/30/2012

Summary:

Total # of inmates in RC awaiting to transfer to ML CCCMS Program	6572
# of inmates in RC (awaiting to transfer to CCCMS) whose LOS is greater than 90 days	2078
# of inmates with LOS less than 90	4494
% of inmates in RC transferred within policy required transfer times to ML CCCMS program (90 days):	68%
Total # of cases (LOS greater than 90 days):	2078
# of cases checked:	50
# of 1s (SNY)	37
# of 0s (non-SNY)	13
% of inmates requiring and moving to SNY	74%

- Based on the sample size of 50 cases with most extreme LOSs, SNY appears to a major reason for the delay.

File: 5 (with CDCR) - LOS for inmates at RC waiting transfer to ML CCCMS.*xlsx*

- Average LOS = 130.1
- Median LOS = 64.3
- Range: 0 - 1697

The average LOS from August 1, 2012 to Nov. 30, 2012 for RC inmates awaiting transfer to an EOP program was 35.9 days, with a range of .2-122 days.

File: 6 (without CDCR) - LOS for inmates at RC waiting transfer to ML EOP.*xlsx*

- Average LOS = 37.8
- Median LOS = 23.3
- Range: 0 - 891

Timeline:	8/1/2012 to 11/30/2012

Summary:

Total # of inmates in RC awaiting to transfer to ML EOP Program	849
# of inmates in RC (awaiting to transfer to EOP) whose LOS is greater than 60 days	213
# of inmates with LOS less than 60 days	636
% of inmates in RC with LOS within policy required transfer times to ML EOP program (60 days):	75%
Total # of cases (LOS greater than 60 days):	213
# of cases checked:	30
# of 1s (SNY)	22
# of 0s (non-SNY)	8
% of inmates requiring and moving to SNY	73%

- Again, waiting for SNY appears to a major reason for the delay.

File: 6 (with CDCR) - LOS for inmates at RC waiting transfer to ML EOP.*xlsx*

- Average LOS = 68.9
- Median LOS = 32.6
- Range: 0 - 891

I did not check the outliers. If needed, Jennifer Johnson is prepared to have Chris Yi complete this on Wed.

Reference: Page 4, Section 9, Current data regarding transfer timelines for EOP.

1. **Inmates pending transfer from ML CCCMS to an EOP Program**

How Data were run: We ran the LOS report for Dec. 17. Because the computer doesn't know the different between an inmate who is in ML housing and in an actual EOP program vs. one who is pending arrival to an official EOP program (both designation are ML EOP: ML is ML housing and EOP is LOC), we selected only institutions that DO NOT have an EOP program. Keep in mind inmates who are pending placement in an official EOP program who are at an institution that DOES HAVE an EOP are excluded from this sample.

As of December 17, 2012 (we ran one week prior to allow data entry time), the average LOS for inmates at a ML program awaiting transfer to an EOP program was 50.4
Range: 0.1 – 271.5

File: *7 - LOS for inmates at ML prog waiting transfer to EOP.xlsx*

- Average LOS = 50.4
- Median LOS = 27.4
- Range: 0.1 – 271.5

Timeline: 12/17/2012

Summary

Total # of inmates in ML awaiting to transfer to ML EOP Program	42
# of inmates in ML (awaiting to transfer to EOP) whose LOS is greater than 60 days	13
# of inmates with LOS less than 60 days	29
% of inmates in ML with LOS within policy required transfer times to an EOP program (60 days):	69%
Total # of cases (LOS greater than 60 days):	13
# of cases checked:	13
# of 1s (SNY)	9
# of 0s (non-SNY)	4
% of inmates requiring and moving to SNY	69%

- Again, waiting for any SNY slot to open up appears to a major reason for the delay.

I did not check the outliers on this data. If needed, Chris can do so on Wed.

2. **Inmates pending transfer from Desert Institutions to ML EOP**
   How data were run: We ran the LOS (beta) report for Dec. 17. Desert institutions were selected and EOP LOC.

As of Dec. 17, the average LOS for inmates housed at Desert Institutions awaiting EOP was 6.6 days. There was only one inmate awaiting transfer at this time.

File: *8 - LOS for inmates at Desert Institutions awaiting EOP.xlsx*

- Average LOS = 6.6
- Median LOS = 6.6
- **Range: No range (sample size of 1)**

I checked all inmates with a LOS greater than 60 days (current requirement). Of those 12 cases, 6 were SNY, 2 were in the MHCB, one has since transferred to an EOP program (on 12/19, just outside of the parameter of this report – total LOS was 273.5 days for this I/P- top of our range), and the remaining three were still pending and no evidence of data problems was identified.

I did not check the outliers for this but if needed Chris can do so on Wed.

3. Inmates pending transfer from RC to a ML EOP.

As of Dec. 17, the average LOS for inmates housed at a reception center awaiting transfer to an EOP was 43.7 days, with a range of .1-283.3 days.

File: *9 - LOS for inmates at RC awaiting transfer to EOP.xlsx*

- Average LOS = 43.7
- Median LOS = 28.8
- Range: 0.1 – 283.2

Timeline: 12/17/2012

Summary:

Total # of inmates pending transfer from RC to a ML EOP	152
# of inmates whose LOS is greater than 60 days	39
# of inmates with LOS less than 60 days	113
% of inmates in RC with LOS within policy required transfer times to a ML EOP (60 days):	74%
Total # of cases (LOS greater than 60 days):	39
# of cases checked:	11
# of 1s (SNY)	0
# of 0s (non-SNY)	11
% of inmates requiring and moving to SNY	0%

- Based on all the cases I checked, I could not tell why these inmates have not been moved as of 12/17. Except for one inmate who was moved from SQ to SAC and placed in ML EOP, all the other ones were still at their institution and in RC.

I did not check the outliers for this but if needed Chris can do so on Wed.

I will be out the rest of the week but Jennifer knows what is needed and has said she will pass this along to Chris as needed. I will try to also check my blackberry but will not be on it constantly.

Thank You,

Laura Ceballos, Ph.D.
Chief Psychologist, Quality Management
CDCR-DCHCS Mental Health Program
(916) 691-0308

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Exhibit 117

Presiding Judge Section - 1996 Court
Handles all cases in Colorado
Judgement letter - review - pay of marbles
Judge ~~Section~~ Bills
Section - does not take stated by affirm
rules of evidence not applied -
conformity -
takes plenty of pleadings as truth
e.g. languishing + dying -
consistent - DR rules, must last
proposes on Board, should more
beds, & capacity, allocate
goals - focus on system - not pleasing public

Consultants Role -
spreadsheet - understanding levels Colorado
Codes, agreements
Isolate constitutional requirements
Madrid - already states rights of MI

Exhibit 118

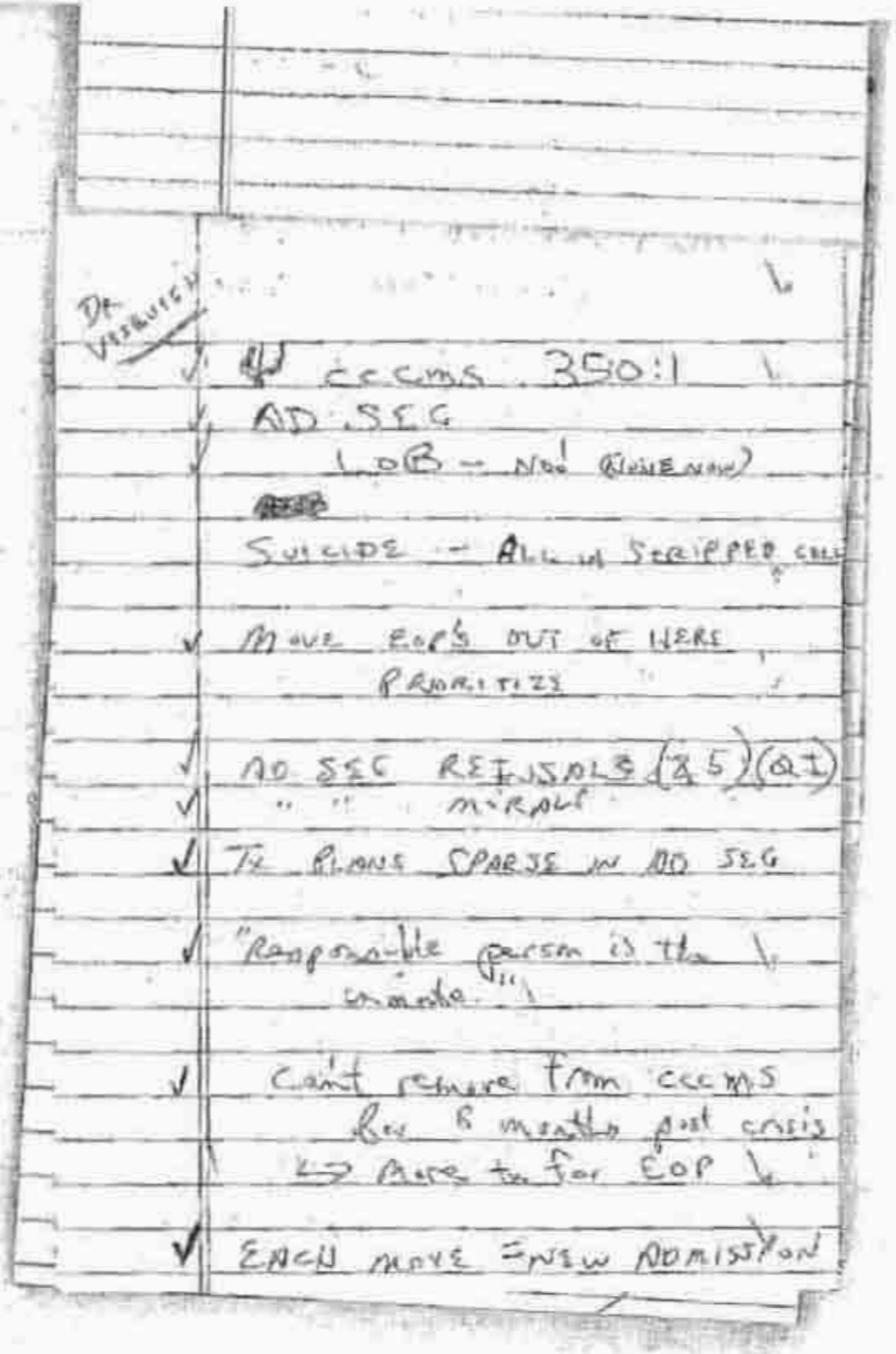

Dr. VERBURGH
CCCMS 350:1
AD SEG
LOB - NO! (CLOSE NOW)
SUICIDE - ALL IN STRIPPED CELL
MOVE EOP'S OUT OF HERE, PRIORITIZE
NO SEG REFUSALS (15)(21)
" " MORALE
TX PHONE SPARSE IN NO SEG
"Responsible person is the inmate"
Can't remove from CCCMS for 6 months post crisis
↳ More tx for EOP
EACH MOVE = NEW ADMISSION

Exhibit 119

9 Seg

8:35 make rounds in elevator
1:30 enhanced rounds

(1) Get roster on morning of whose
(2) 5 day FU - if released from MH
Crisis see for 5 days
(3) self referral

gets roster from Prison - wants
have alpha roster
housing #

APT do add seg assessment -
needs 31 questions came in them
from R+R -
if go from East + west yard
go thru R+R -

LOB - have meds out, use sheffart
signal, appt medical
MH request usually verbal -
if issue documents on security log -
add seg staffed LPC - 5pm -
no nursing staff -
once x wk see MH clinician
psychiatrist 1-x4 wks
unless D meds
pay issues - M-W-F doctor
Follow-up appts -

Exhibit 120

Have lost 14 psychologists
2 mental health supervisors
- reduction in supervisors less ability to do oversight -
non clinical positions (OTurk)
caught up to CWHR -
may be
- Deb Login knows CWHR
Biggest challenge:
LOB - lack of bed certified
lack of general psych beds here -
300 Beds overflow may
go into Ad Seg:
~~Do Ad Seg~~ Ad Seg housing
has it used by
Ad Seg rules, even
if not actual Ad Seg
client -

Exhibit 121

Judge Karlton
Notes state & NG.

New Audit Tool

Pgm guide has 550 things — things the Special Master monitors on

They measure + report 120 items
by level of care

Dashboard Indicators = 6

CEO runs medical at each prison - "warden is not in the game"

; Not is now 80+ % accurate

RVR = Rules Violation Report
I/M's at lower level of care CCCMS
clinical assessment
Did Bronsin evals for all
Now doing NB + C offenses
Plaint + Monitor wanted more included eg lots of RVR's

RD seg
people waiting 90 days Seg → EP

Detailed use of force
No taser

Exhibit 122

Patrick McKinney

From: Jackie Moore <moor143@attglobal.net>
Sent: Thursday, February 14, 2013 8:58 AM
To: Patrick McKinney
Subject: FW: Report

From: Joel Dvoskin [mailto:joelthed@aol.com]
Sent: Monday, December 10, 2012 9:36 AM
To: moor143@attglobal.net; charles.scott@ucdmc.ucdavis.edu
Cc: Debbie.Vorous@doj.ca.gov; Patrick.McKinney@doj.ca.gov
Subject: Report

Dear Jackie and Charles -

Charles sent the draft report to Patrick today. It included a lot of what Jackie reported at exit conferences. This will give them a pretty good idea of where the team is headed, and meets the Governor's Office's deadline. Jackie, I'd suggest two steps. First, as soon as it's possible and convenient, read what we've written to make sure that we haven't misquoted your overall findings. The sooner you can do this the better, but it won't take too long. Then, when you have more time, you can add whatever needs to be added.

I wish we had all been given a little more time, but I understand. Our original plan was a good one, but then the Governor's Office and the Attorney General's Office decided that they needed the report sooner than we had anticipated. A lot of the facility-by-facility work that Charles and I had done on our part became moot. Anyway, they were really nice about it, as always, but we were told that Dec. 10 was a "drop-dead" date for a draft of the report. I think we've met that deadline, and look forward to seeing Jackie's additions to the final report as soon as she can get them completed.

Jackie, I hope that your friend's surgery goes well.

I've copied this note to Patrick and Debbie as well, so they can let us know when they will need Jackie's additions and our final edit of the report.

Warm holiday regards to all,
Joel

Joel A. Dvoskin, Ph.D., ABPP (Forensic)
University of Arizona College of Medicine

Exhibit 123

EXECUTIVE SUMMARY

The Future of California Corrections

A blueprint to save billions of dollars, end federal court oversight and improve the prison system

INTRODUCTION

For years, California's prison system has faced costly and seemingly endless challenges. Decades-old class-action lawsuits challenge the adequacy of critical parts of its operations, including its health care system, its parole-revocation process, and its ability to accommodate inmates with disabilities. In one case, a federal court seized control over the prison medical care system and appointed a Receiver to manage its operations. The Receiver remains in place today. The state's difficulty in addressing the prison system's multiple challenges was exacerbated by an inmate population that—until recently—had been growing at an unsustainable pace. Overcrowded prison conditions culminated in a ruling last year by the United States Supreme Court ordering the California Department of Corrections and Rehabilitation to reduce its prison population by tens of thousands of inmates by June 2013. At the same time that prison problems were growing, California's budget was becoming increasingly imbalanced. By 2011, California faced a $26.6 billion General Fund budget deficit, in part because the department's budget had grown from $5 billion to over $9 billion in a decade.

To achieve budgetary savings and comply with federal court requirements, the Governor proposed, and the Legislature passed, landmark prison realignment legislation to ease prison crowding and reduce the department's budget by 18 percent. Realignment created and funded a community-based correctional program where lower-level offenders remain under the jurisdiction of county governments. In the six months that realignment has been in effect, the state prison population has dropped considerably—by approximately 22,000 inmates. This reduction in population is laying the groundwork for sustainable solutions. But realignment alone cannot fully satisfy the Supreme Court's order or meet the department's other multi-faceted challenges.

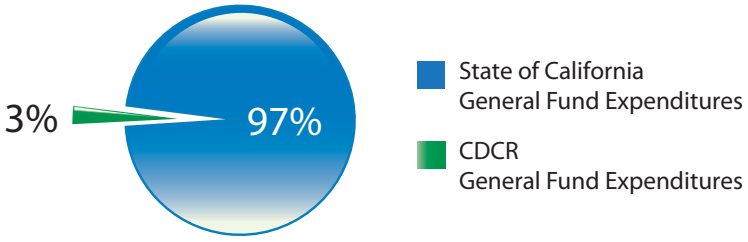
This plan builds upon the changes brought by realignment, and delineates, for the first time, a clear and comprehensive plan for the department to save billions of dollars by achieving its targeted budget reductions, satisfying the Supreme Court's ruling, and getting the department out from under the burden of expensive federal court oversight.

Saving Billions of Dollars

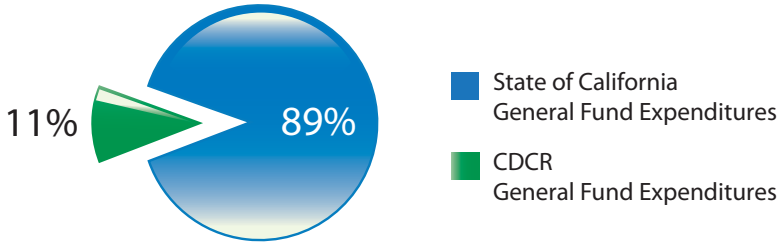
Given the ongoing budget problems facing California it has become increasingly important to reexamine the mission and priorities of the corrections system. With dedicated funding directed to county

governments to manage lower-level offenders, realignment allows the state to focus on managing the most serious and violent offenders. And it allows counties to focus on community-based programs that better promote rehabilitation. Not only is this good corrections policy, but it also allows the state to achieve significant budgetary savings from a department whose share of General Fund expenditures had grown from 3 to 11 percent over the last 30 years.

CDCR Percentage of State General Fund Expenditures in 1979-80



CDCR Percentage of State General Fund Expenditures in 2008-09



One of the primary benefits of realignment is the ability of the department to comply with the Supreme Court's order without releasing tens of thousands of inmates or building costly new prisons. Absent realignment, and given the public safety risk associated with releasing offenders early, the state would have had to build up to nine new prisons and house more inmates in private contract facilities in order to comply with the Supreme Court's order. Instead, the Administration is now proposing legislation to eliminate approximately $4.1 billion of the lease revenue bond authority in Assembly Bill 900. Eliminating this bond authority and no longer needing to build new stand-alone prisons will avoid $2.2 billion annually in new operating costs and facility debt service costs.

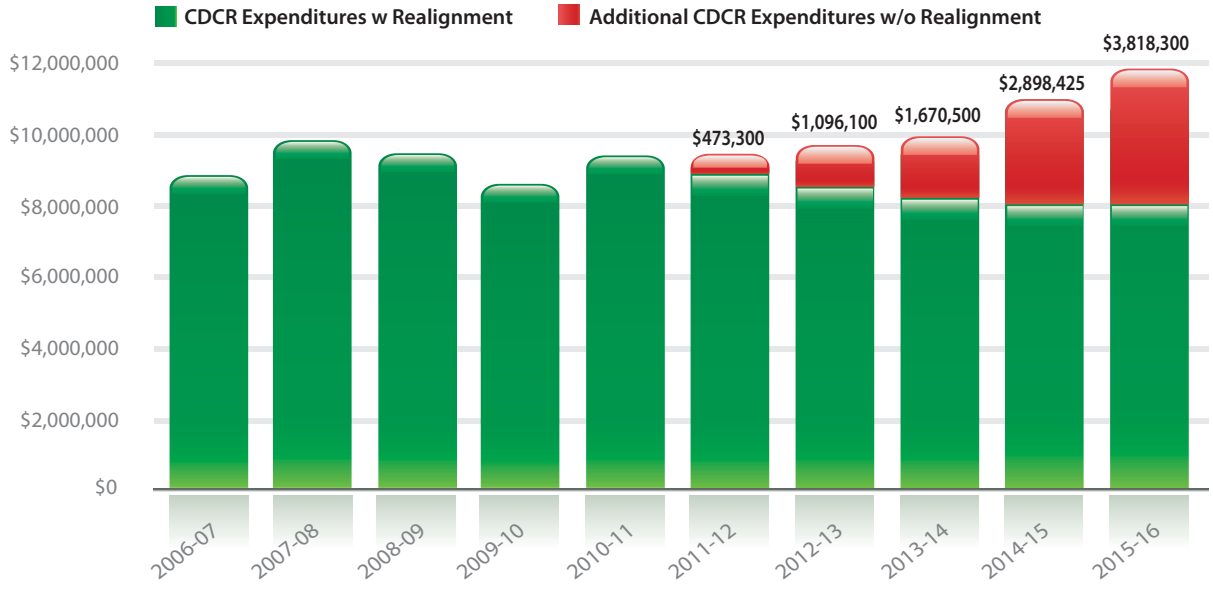
In addition to billions of dollars in avoided costs, upon full implementation of realignment, the department's annual budget will be

reduced by $1.5 billion through reduced expenditures associated with declining offender populations and new efficiencies. Consequently, the department's budget will account for approximately 7.5 percent of state General Fund expenditures in the future. All departmental operations, including headquarters and administration, have reassessed their budgets to correspond with the smaller offender populations being served in prison and on parole. As a result of the declining populations, the state will be able to save nearly half a billion dollars by closing the California Rehabilitation Center—one of its oldest, most costly, and inefficient prisons to operate—and ending contracts for out-of-state prison facilities. The savings contemplated in this plan will be attained by safely reclassifying inmates, housing inmates in facilities that are commensurate with their custody level, and working to reduce recidivism. Capitalizing on the opportunities created by realignment will create a safer, more effective correctional system, and allow the state to regain control of its prison system by satisfying federal court requirements.

Combining the actual budget savings with the avoided expenditures that would have been required without realignment, over a ten year span the state will have saved and avoided over $30 billion in General Fund costs that may now be used to help balance the state budget or for other critical areas such as education and health care.

Fiscal Impact from Realignment

(Dollars in thousands)



Realignment is Reducing Prison Crowding and Facilitating Compliance with the Supreme Court's Order

Between 1986 and 2006, California's prison population soared from approximately 60,000 inmates to an all-time high of 173,479 inmates. At its peak, the inmate population had grown to more than double the designed housing capacity, forcing the department to house close to 20,000 inmates in gymnasiums, dayrooms, and other nontraditional housing areas—often in triple-bunks. To help alleviate the overcrowded conditions, an executive order was issued in late 2006 that authorized the department to involuntarily transfer inmates to privately-owned prisons out-of-state. Since then, the department has housed an annual average of about 10,000 inmates in other states.

The United States Supreme Court ruling in 2011 ordered the department to reduce prison crowding to 137.5 percent of the prison system's design bed capacity by June 2013. In the interim, the court ordered the department to meet incremental crowding-reduction targets at six-month intervals. The Court's final population requirement equates to a reduction of over 40,000 inmates from the department's all-time high just a few years ago.

Few options are available to satisfy the Supreme Court's order. Releasing tens of thousands of dangerous felons onto the streets would endanger public safety. And spending taxpayer dollars the state does not have to build several more costly prisons would be fiscally irresponsible. A safer and less expensive alternative—realignment—was proposed by the Administration, adopted by the California Legislature, and went into effect on October 1, 2011. Under realignment, lower-level offenders serve their sentences locally, and lower-level offenders released from state prison are supervised by local probation officers instead of state parole agents. Offenders who have been convicted of violent, sex-related, or other serious offenses continue to serve their sentences in prison. Realignment also ends the revolving door of parole violators returning to prison for only weeks or months at a time by having them serve their revocation terms in local jails rather than state prison.

Since realignment took effect, the department's offender population has dropped by approximately 22,000 inmates and 16,000 parolees. Crowding has been reduced from a high of over 200 percent of design capacity to just 155 percent today. The state achieved the first of its four court-ordered population-reduction benchmarks on time and has already met its second, two months early. The thousands of makeshift beds in gymnasiums and dayrooms that the department has been forced to use for years are now gone.

(right) *Before and after photographs of the gymnasium at the California Institution for Men show the dramatic effect realignment has had on reducing nontraditional housing*

Even After Realignment, Serious Challenges Remain

Although the state's prison population continues to shrink, realignment alone will not be enough to bring the department into compliance with the Supreme Court's order. The department's newly released spring population projections suggest that although the state will meet the December 2012 court-ordered population target, it will fall a few percentage points short of meeting the final benchmark of 137.5 percent of design capacity in June 2013. The new projections indicate that the prison population will drop to about 141 percent of design capacity by June 2013. Assuming the current projections remain accurate, the additional measures in this plan will be needed to satisfy the Supreme Court's order.

Realignment itself is also creating new issues that must be addressed and managed. For example, under realignment, less serious offenders who were housed in prison camps and dormitories are now under local jurisdictions, but more serious offenders have remained in the department's celled housing units. This is resulting in increasingly uneven staffing ratios and uneven distribution of inmates throughout the state's prisons. Moreover, the 9,500 inmates being housed outside of California in expensive private facilities should be brought back. California should be housing these inmates in its own prisons and investing the money in California where jobs are needed. This plan adjusts prison housing and reforms the inmate classification system to accommodate the realities of the remaining prisoner population.

The reduction in overcrowding brought about by realignment will also not completely solve the department's other challenges—although it will help tremendously. Realignment, for example, will do nothing to address limitations in existing clinical treatment space. Improving

this space as contemplated in this plan will enable the department to provide court-ordered health care services to a greater number of inmates within existing prisons instead of building costly new treatment facilities.

The measures contained in this plan will complete the substantial progress the department has made in showing the federal courts that it can ensure legally- acceptable conditions of confinement. This will allow the department to free itself from the Receivership and the numerous class-action cases in which it is entangled. These cases disrupt democratic principles by shifting control away from the state and to federal courts, make managing prison affairs more difficult, and impose enormous fiscal costs. The state spends millions of dollars each year in class-action litigation costs alone. This plan, combined with the effects of realignment, will put California in a position to end these lawsuits as soon as possible.

This Plan Addresses the Department's Remaining Challenges and Will Allow California to Satisfy Federal Court Requirements, Achieve Significant Savings, and Maintain an Effective Prison System for Years to Come

This plan will allow the department to satisfy the Supreme Court's order, end the class-action cases, maintain an effective prison system, and achieve significant savings. The key components will accomplish the following:

Improve the Inmate Classification System. As a result of research produced by a panel of correctional experts and input from seasoned professionals, the department is modifying its classification system. The modified system will enable the department to safely shift about 17,000 inmates to less costly housing where they can benefit from more access to rehabilitative programs. These modifications will begin to be implemented within six months, and they will eliminate the need to build expensive, high-security prisons.

Return Out-of-State Inmates. The department began sending inmates out-of-state when overcrowding was at its worst in 2007. Currently, there are more than 9,500 inmates outside of California. The department will be able to bring these inmates back as the prison population continues to drop, classification changes are made, and additional housing units are constructed at existing facilities. Returning these inmates to California will stop the flow of taxpayer dollars to other states, and is expected to save the state $318 million annually.

Improve Access to Rehabilitation. This plan enables the department to improve access to rehabilitative programs and place at least 70 percent of the department's target population in programs consistent with their academic and rehabilitative needs. Increasing access to rehabilitative programs will reduce recidivism by better preparing inmates to be productive members of society. In doing so, it will help lower the long-term prison population and save the state money.

The department will establish reentry hubs at certain prisons to concentrate program resources and better prepare inmates as they get closer to being released. It will also designate enhanced programming yards, which will incentivize positive behavior. For parolees, the department will build a continuum of community-based programs to serve, within their first year of release, approximately 70 percent of parolees who need substance-abuse treatment, employment services, or education.

Standardize Staffing Levels. Realignment's downsizing has left the department with uneven, ratio-driven staffing levels throughout the system. Continued use of these increasingly outdated staffing ratios as the inmate population declines would be costly and prevent efficient operations. This plan establishes new and uniform staffing standards for each institution that will enable the department to operate more efficiently and safely.

Comply with Court Imposed Health Care Requirements. In recent years, numerous measures have been implemented that have significantly improved the quality of the department's health care system. The Inspector General regularly reviews and scores the department's medical care system, and these scores have been steadily rising. In addition, the capacity of the health care system will soon increase. Slated for completion during the summer of 2013, the California Health Care Facility in Stockton is designed to house inmates requiring long-term medical care and intensive mental health treatment. Its annex, the DeWitt Nelson Youth Correctional Facility, will open in the summer of 2014 to create a unified Stockton complex, allowing both facilities to efficiently transition inmate-patients between the two, while avoiding transportation and security costs as well as the need for expensive services in community hospitals and clinics. These projects, in addition to ongoing mental health and dental projects and new plans to increase medical clinical capacity at existing prisons, will satisfy court imposed requirements.

Satisfy the Supreme Court's Order to Reduce Prison Crowding. As previously mentioned, the department's newly released spring population projections suggest that the department may fall a few percentage points short of meeting the final court-ordered crowding-reduction benchmark even with realignment. In June 2013, the department's prison population is projected to be at 141 percent of design capacity rather than the 137.5 percent goal identified by the Supreme Court. The additional measures proposed in this plan will allow the state to seek and obtain from the court a modification to raise the final benchmark to 145 percent of design capacity. Otherwise, alternatives such as continuing to house inmates out-of-state will have to be considered.

In its order, the Supreme Court contemplated that appropriate modifications to its order may be warranted. The Court explained that as the state implements the order, "time and experience" may reveal effective ways of ensuring adequate health care—other than through population reductions. The state "will be free to move" the Court for modification of the order on that basis, and "these motions would be entitled to serious consideration." This plan sets forth necessary reforms to satisfy this order as well as other court imposed requirements related to the provision of health care services.

The reduced prison population has already substantially aided the department's ability to provide the level of care required by the courts. As the population further declines, the department's ability to provide the required level of prison health care will continue to improve. New health care facilities and enhanced treatment and office space at existing prisons will enable the department to maintain a health care system capable of providing this level of care for a higher density prison population than the Court originally contemplated. This plan will provide critical support for the state's ability to satisfy the Supreme Court's order without having to maintain expensive out-of-state prison beds or release inmates early.

Realignment has provided California an historic opportunity to create not just a less-crowded prison system, but one that is safer, less expensive, and better equipped to rehabilitate inmates before they are released. This plan seizes on that opportunity. Each of the following sections describes key aspects of a prison system that combines the inmate reductions achieved in realignment with a facility-improvement plan that will enable a more efficient inmate health care delivery system. This is the prison system that best serves California.