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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, et al.,

Plaintiffs,

v.

GAVIN NEWSOM, et al.,

Defendants.

Case No. 2:90-CV-00520-KJM-DB

PLAINTIFFS' SUPPLEMENTAL BRIEF FOLLOWING EVIDENTIARY HEARING ON DEPARTMENT OF STATE HOSPITAL TRANSFERS

Judge: Hon. Kimberly J. Mueller

INTRODUCTION

On November 19, 2020, the Court directed the parties to brief whether "the court [can or should] presume cognizable harm to class members whose transfer to necessary inpatient care is delayed beyond Program Guide timelines and for reasons outside the court-approved exceptions to those timelines." ECF No. 6961.

The court need not presume cognizable harm. There is ample evidence of cognizable harm from delays in inpatient care. The Court may infer harm to patients from the undisputed facts regarding the operation of the CDCR mental health system. Defendants' own witnesses have

testified that inpatient psychiatric hospital care, both acute and intermediate, is reserved for the most acutely ill patients. They have testified that these patients require 24-hour, 7-day a week care that can only be delivered in the inpatient programs. While a patient waits to be transferred to inpatient care, Defendants' clinicians review the patient's case regularly, and these clinicians rescind the referrals for patients whose conditions have improved. A patient's continued presence on a waiting list therefore demonstrates the professional judgment of Defendants' clinicians that inpatient care remains necessary. The only reasonable inference from these undisputed facts is that delays in inpatient care harm patients. In addition to this undisputed evidence, Plaintiffs have presented powerful evidence that patients have been actually harmed by the delays at issue here. Dr. Stewart's October 23, 2020 testimony and his November 13, 2020 declaration demonstrate harm to patients currently waiting for inpatient care.

The applicable legal standard under the Eighth Amendment recognizes not only harms that have already injured the plaintiffs, but also conditions that expose plaintiffs to substantial risks of serious harms in the future. A defendant who exposes plaintiffs to such risks cannot evade Eighth Amendment liability based on the lucky chance that the harm has not yet occurred. The undisputed evidence here shows that a referral to inpatient care, whether acute or intermediate, cannot be delayed without exposing the patient to a substantial risk of serious harm.

In short, the Court need not rely on any legal presumption of harm. Instead the Court must draw the only possible inference from the undisputed evidence, which is that patients are harmed by delays in access to necessary inpatient care. In addition, the Court should credit Dr. Stewart's testimony of actual harm suffered by patients whose access to inpatient care at DSH has been delayed for months.

LEGAL STANDARD

The Court's question uses the term "cognizable harm." The legal standard for cognizable harm under the Eighth Amendment recognizes both harms that the plaintiff has already suffered, as well as future harms that may arise from conditions to which the defendants expose the plaintiff. *Helling v. McKinney,* 509 U.S. 25, 33 (1993). In *Helling,* the Nevada prison authorities argued for a narrower view of the Eighth Amendment, under which there would be no protection

against "prison conditions that merely threaten to cause health problems in the future, no matter how grave and imminent the threat." *Id.* at 32-33. The Supreme Court rejected Nevada's argument, holding that the Eighth Amendment protects incarcerated persons not only from current harm, but also from likely harms that would not "occur immediately," and that "might not affect all of those exposed." *Id.* at 33. The *Helling* Court cited with approval lower court decisions which "recognized that a remedy for unsafe conditions need not await a tragic event." *Id.* at 33-34.

One year later, in *Farmer v. Brennan,* 511 U.S. 825 (1994), the Court again addressed an Eighth Amendment claim based on a "failure to prevent harm." *Id.* at 834. Again, the Court held that the cognizable harms include not only actual harm but also "a substantial risk of serious harm." *Id.* at 842. In describing the test for deliberate indifference under the Eighth Amendment, the Court rejected a requirement that the plaintiff already have suffered actual harm: "Under the test we adopt today, an Eighth Amendment claimant need not show that a prison official acted or failed to act believing that harm actually would befall an inmate; it is enough that the official acted or failed to act despite his knowledge of a substantial risk of serious harm." *Id.* The Court relied on *Helling* to reject the idea that the Eighth Amendment required a showing that the defendant knew that a specific incarcerated person would be harmed. Instead, the Court re-affirmed *Helling*'s focus on whether the conditions at issue posed a "'risk of serious damage to [the incarcerated person's] future health.'" *Id.* at 843 (quoting *Helling,* 509 U.S. at 35). The Court held that the risk need not be "personal to" a particular incarcerated person, but could be one that "all prisoners in his situation face." *Id.* And, *Farmer* reaffirmed *Helling*'s holding that the incarcerated plaintiff need not wait for the injury to occur before securing an injunction against the life-threatening conditions. *Id.* at 845.

The Supreme Court revisited the question of cognizable harms in this case, in affirming the three-judge court overcrowding relief. *Brown v. Plata,* 563 U.S. 493 (2011). The Court held that in this "systemwide" case, the cognizable harms from delays in care include the "substantial risk of serious harm" that result, not just individual instances of actual harm. *Id.* at 505 n. 3.

ARGUMENT

From the beginning of this case, the Court has not presumed harm from delayed access to care, but rather has found harm based on overwhelming evidence. This was the finding after the 1994 trial: "The evidence also demonstrates that inmates have in fact suffered significant harm as a result of those deficiencies; seriously mentally ill inmates have languished for months, or even years, without access to necessary care. They suffer from severe hallucinations, they decompensate into catatonic states, and they suffer the other sequela to untreated mental disease." *Coleman v. Wilson,* 912 F. Supp. 1282, 1316 (E.D. Cal. 1995); *see also id.* at 1316 n. 48 ("In the matter at bar members of the plaintiff class are not only facing substantial risks of serious injury, they are experiencing actual harm as a result of the systemic deficiencies identified in this order.").

Plaintiffs are aware that Defendants have asked the Court to disregard the evidence of harm to patients submitted in the Declaration of Dr. Pablo Stewart on November 13, 2020, ECF No. 6948-1. *See* Defs' Rebuttal Brief, ECF No. 6960 at 4-5. Defendants' objections to Dr. Stewart's declaration are unfounded, and the Court should consider the evidence of harm that Dr. Stewart presents. *See* ECF No. 6948 at 11-12 (Plaintiffs' Closing Brief for October 23, 2020 Evidentiary Hearing demonstrating that Defendants' objection to Dr. Stewart's patient review testimony was groundless). But even if the Court chooses not to consider Dr. Stewart's recent declaration, the Court may still rely on undisputed facts to find that delays in access to inpatient care cause harms.

The evidence of harm from delays in access to inpatient psychiatric hospital treatment has been reviewed in several evidentiary hearings over the past two decades. In June 2013, the Court conducted a three and a half-day evidentiary hearing addressing deficiencies in intermediate inpatient care at the DSH-run Salinas Valley Psychiatric Program. July 11, 2013 Order, ECF No. 4688. As part of their case in chief to show that CDCR and DSH were providing adequate inpatient care, Defendants put on Senior Supervising Psychiatrist Dr. Troncoso. Galvan Decl. Exh. A, 6/21/2013 RT 2:1-13. Dr. Troncoso testified that CDCR patients referred for intermediate inpatient hospitalization are in fact "are some of the sickest people in the state hospital system, as well as in CDCR." 6/21/2013 RT 19:18-20:1. "These patients present with major psychiatric

disorders. For example, psychotic disorders, mood disorders and major anxiety disorders." 6/21/2013 RT 20:2-4. Dr. Troncoso testified that the intermediate care programs receive incarcerated persons who are suicidal, and who are considered a serious risk to themselves or others. 6/21/2013 RT 77:8-16. Dr. Troncoso explained that patients in an intermediate inpatient program are seen by staff "almost continuously," with "eyes on these patients 24/7," and that the setting is "a therapeutic milieu in which the patient is immersed in." 6/21/2013 RT 11:15-12:4. Dr. Troncoso testified that this immersion in a therapeutic environment starts at the first moment that the patient arrives. 6/21/2013 RT 24:8-25:4. Dr. Troncoso testified that one of the needs addressed at an inpatient unit is diagnostic clarification, which in some cases results in urgent referrals to even higher levels of care. 6/21/2013 RT 23:5-21.

Dr. Troncoso's testimony regarding the importance of prompt access to inpatient care was confirmed by Plaintiffs' expert, psychiatrist Pablo Stewart, who testified at the same June 2013 evidentiary hearing. Dr. Stewart testified that the DSH intermediate inpatient level of care was similar to an "intensive care unit" in a hospital, "where the sickest patients would go." Galvan Decl. Exh. B, 6/19/2013 RT 26:23-25. "In a psychiatric system the inpatient hospital programs are where the people that are suicidal, that due to mental illness are suicidal, a danger to others, and are gravely disabled, such as not eating or drinking properly, and need to receive this level of care." 6/19/2013 RT 27:1-5. Dr. Stewart's testimony was based on five facility tours in early 2013, including interviews with staff and patients. 6/19/2013 RT 27:7-28:15. Dr. Stewart was asked whether patients who needed an inpatient level of treatment could be adequately served with a lower level of care. He explained why this is unsafe: "These are the most severely ill people in the system. They're in the hospital where every moment of their waking hours should be therapeutic in nature, from the time they get up to the time they go to bed." 6/19/2013 RT 49:23-50:2. The Court focused directly on the question at issue here, asking Dr. Stewart whether delay causes harm:

> THE COURT: … is it your view that any time somebody is sent to the hospital, that's an indication of a requirement for urgent care and something must be done relatively early in order to ensure that something like the suicide doesn't occur?
>
> THE WITNESS: Yes, Your Honor.

6/19/2013 RT 69:2-12. Dr. Stewart explained that inpatient treatment needs to begin immediately—without days-long delays for custody reasons—in order to prevent harm to the patient. *See* 6/19/2013 RT 72:23-73:16; 78:16-23.

Dr. Stewart's testimony in the October 23, 2020 trial confirms that patients are harmed by delays in access to inpatient care:

> Q Dr. Stewart, do patients who need inpatient care need to be given that level of care quickly?
>
> A Yes.
>
> Q Why is that?
>
> A Well, delays cause harm and suffering and sometimes this harm can be irreparable. … And the literature is also clear that in the absence of progressive treatment for psychotic symptoms, meaning if you allow a person to remain psychotic, it worsens the overall prognosis throughout the lifetime of the patient in question. Those are the potentially irreparable harms. But there's also a harm that the longer a patient remains symptomatic and not receiving proper care, the longer it will take for that person to be returned to a baseline of mental health stability, and during that time they're suffering harm.

10/23/2020 RT 258:20-259:13.

Dr. Stewart testified specifically about the ways in which inpatient transfer delays harm patients. Like Dr. Troncoso in 2013 (*see* Galvan Decl. Exh. A, 6/21/2013 RT 23:5-21), Dr. Stewart pointed to the importance of diagnostic clarification. A patient who is not getting better through outpatient treatment will often have unclear or conflicting diagnoses, which must be clarified quickly to allow the right kind of care to be delivered. Dr Stewart identified the need for diagnostic clarification in the medical files of the 55 persons awaiting transfer to DSH at the time of the October 2020 hearing:

> Q So based on this chart and your review of the treatment plans, were you able to come to any initial opinions about this group of 55 individuals waiting for a transfer?
>
> A Yes. After my initial review, based on the data from this spreadsheet regarding diagnoses and medications, I noticed that there was some issues regarding diagnoses. Sometimes there was several unspecified diagnoses. There was actually an example of a contradictory diagnosis and there was also multiple diagnoses, all of which raised a question in my mind about the quality of care that a person's getting.

Galvan Decl. Exh. C, 10/23/2020 RT 264:1-11. Dr. Stewart further testified that he saw many

examples of "persistent psychosis" among the persons waiting for access to DSH. 10/23/2020 RT 268:20-24. "Persistent psychosis" is "psychosis that continues to be present even in the face of being treated with antipsychotic medication or other types of medication." *Id.* at 268:16-19. Dr. Stewart testified that delaying treatment for persistent psychosis causes permanent harm:

> It is similar to like a seizure disorder. You don't allow patients to seize because the more they seize, the more they will seize. Same thing about psychiatric. The same thing has been studied with psychotic symptoms. The more you allow a patient to be psychotic, the more they will be psychotic in the future and it will be harder to address those persistent psychotic symptoms.

10/23/2020 RT 269:4-10. Defendants will say that they are preventing harm by treating the patients in their current programs, such as in an EOP unit, crisis bed, or PIP. This misses the point about the harm of "persistent psychosis." By definition a patient in persistent psychosis is not responding to the current treatment. That is why the clinician refers the patient to a higher level of care which has available the tools for diagnostic clarification and 24-hour treatment modalities that Dr. Troncoso, Dr. Stewart, as well as Dr. Warburton, testified about. *See* 10/23/2020 RT 43:11-19 (Dr. Warburton testifying that intermediate inpatient care is for "people [who] need certain types of consultation or long-term 24-hour care"). Patients who need intermediate inpatient care due to persistent psychosis, or for other reasons such as the need for prompt diagnostic clarification, cannot be treated safely in a mental health crisis bed, much less an outpatient unit. 10/23/2020 RT 275:13-16 (Dr. Stewart: "I'm very familiar with mental health crisis beds in correctional settings as well as inpatient care for the correctional settings, and a patient cannot receive inpatient equivalent care in a crisis bed."); *see also* 12/9/16 Order, ECF No. 5529 at 3 ("MHCBs are not … a substitute for the inpatient care provided through DSH programs. Referrals to DSH inpatient care represent the considered judgment of CDCR clinicians that those inmate patients need a higher level of care than is available in CDCR's EOP and MHCB programs. Thus, at most, defendants' representation suggests that efforts are being made to maintain an unacceptable status quo for these inmates while access to essential inpatient care is delayed.").

Defendants have not disputed any of the facts above regarding the need for inpatient care, most of which are confirmed by their own witnesses. The only reasonable inference from these

undisputed facts is that people whose transfers to inpatient care are delayed face a substantial risk of serious harm that is cognizable based on the Eighth Amendment under the Supreme Court's holdings in *Brown v. Plata,* 563 U.S. 493, 505 n.3 (2011), *Farmer v. Brennan,* 511 U.S. 825 (1994), and *Helling v. McKinney,* 509 U.S. 25, 33 (1993).

As is well-documented in the case, *Coleman* class members waiting to be transferred to DSH in the PIPs do not receive adequate inpatient mental health treatment. PIP patients often receive less treatment than they do in an EOP program. *See, e.g.*, Special Master Amended Report re Status of Class Member Access to Inpatient Care, April 6, 2020, ECF No. 6579 at 29 ("CDCR's PIPs are not providing adequate mental health care to patients, and the care that is being provided has been further constricted by the COVID-19 pandemic."); Special Master's Monitoring Report on Inpatient Care Programs, Aug. 30, 2018, ECF No. 5894 at 27 ("Individual treatment was rarely offered or provided across inpatient programs, and where provided was either woefully inadequate, or not accurately tracked."); *id.* ("Across programs, structured and unstructured out-of-cell activities were found wanting during site visits."). Furthermore, not only do Defendants' staffing rates in the PIPs consistently fall abysmally short of this Court's order to limit to ten percent the vacancy rate among psychiatrists, they routinely are among the lowest in the system. *See* Oct. 10, 2017 Order, ECF No. 5711 at 3; Defs.' Monthly Psychiatry Vacancy Report, ECF No. 6970 at 5 (Nov. 30, 2020) (reporting filled psychiatry rates of only 62% and 69%, respectively, at CMF PIP and SVSP PIP as of October 2020); *see also* Special Master's Monitoring Report on Inpatient Care Programs, Aug. 30, 2018, ECF No. 5894 at 17 ("[S]taffing vacancies in multiple disciplines across programs remained a significant impairment to providing appropriate care in inpatient settings.").

In addition to the testimonial evidence regarding inpatient care, the Court may look to undisputed facts regarding the ways in which the Defendants constantly review the waiting lists to remove people whose conditions improve while they are waiting for transfer. For example, on December 19, 2019, DSH Deputy Director of Hospital Strategic Planning and Implementation, Catherine Hendon, filed a declaration at ECF No. 6411-1, sponsoring a table that she identified as the Psychiatric Inpatient Timelines Report for the period from July 2017 through November 2019.

ECF No. 6411-1 at 4. The table shows a monthly average of 46 referrals to DSH care. *Id.* Patients are only accepted for treatment at DSH hospitals after DSH reviews each of those referrals "to ensure that clinical criteria are met." CDCR – DSH MOU dated 11/21/17, Defs' Exhibit D-3, at D-3-5; *see also* Joint Policy and Procedure No. 3601 re: Referral, Admission, and Movement, Defs' Exhibit D-4, at 6-7 (outlining clinical criterial utilized by DSH to determine if a patient qualifies for ICF admission). On average, 4 referrals, or 8.7%, were rescinded each month. *Id.* Referrals may be rescinded only "[i]f a treatment team determines that it is clinically appropriate." Mental Health Services Policy No. 12.11.2101, Defs' Exhibit D-5, at D-5-6. The patient's continued presence on a waitlist therefore shows Defendants' clinical determination that the patient needs 24-hour inpatient care.

In addition to these direct harms, the delays harm other patients who are waiting behind the directly impacted patients. After an evidentiary hearing in January 2017 on inpatient delays at DSH, this Court issued 26 pages of findings and conclusions. Order, March 24, 2017, ECF No. 5583. The Court reviewed earlier findings by the Special Master that inpatient transfer delays have a "resounding ripple effect" throughout the system. *Id.* at 5. Patients currently waiting for DSH beds are occupying crisis beds, or CDCR PIP beds that are needed by other patients. Currently, there is a waiting list of approximately 365 patients awaiting transfer to a PIP or DSH inpatient program, many of whom have been waiting for hundreds of days. *See* Galvan Decl. Exh. D (waitlist for ICF and APP level of care as of December 3, 2020); Eighth Joint Update on the Work of the COVID-19 Task Force, Dec. 4, 2020, ECF No. 6974 at 7 n.2.

Some of the patients being harmed by transfers delays are occupying CDCR PIP beds awaiting transfer to DSH hospital beds. By blocking these transfers Defendants harm not only the patients waiting in the PIPs, but also the patients waiting in crisis beds or outpatient units for the PIP beds that would be freed up by timely transfers to DSH. These are patients who have gone through an extensive clinical and custodial review process to determine that they can move to a "Least Restrictive Housing" (LRH) placement. *See generally* Joint Policy and Procedure No. 3601 re: Referral, Admission, and Movement, Defs' Exhibit D-4. LRH placements are a "therapeutic milieu for treating patients who are clinically and custodially suitable for receiving

treatment in an environment that is less punitive and more therapeutic" and are clinically beneficial to the referred patients because they allow treatment outside the high custody, locked down environment of the CDCR PIPs. *See* Special Master's Amended Report on Status of *Coleman* Class Member Access to DSH, April 6, 2020, ECF No. 6579 at 15. Honoring the LRH placement also benefits other patients who are still deemed to need a higher security bed in the CDCR PIP. These beds are in short supply, and when they are needlessly occupied by a patient who can move to an LRH, the higher security patients behind them languish in crisis beds and other placements that cannot provide inpatient care. *See* Special Master's 2016 Monitoring Report on Inpatient Care Programs, May 25, 2016, ECF No. 5448 at 9 ("[W]hen DSH-Atascadero beds are not open to CDCR patients, there is a resounding ripple effect throughout all of the DSH inpatient programs which treat these patients, creating almost instantly a re-shuffling for other beds at other DSH programs, and at CDCR a back-up of patients awaiting DSH placement.").

CONCLUSION

The Court need not employ any legal presumption to find that delays in accessing inpatient care harm incarcerated persons in need of psychiatric hospitalization. The record in this case is replete with undisputed facts establishing the harms caused by delays in access to inpatient care. The only reasonable inference from these facts is that such delays cause cognizable harms to the *Coleman* class.

DATED: December 7, 2020

Respectfully submitted,
ROSEN BIEN GALVAN & GRUNFELD LLP

By: */s/ Ernest Galvan*
Ernest Galvan
Attorneys for Plaintiffs

ACRONYMS USED

ACRONYM	FULL TEXT
CDCR	California Department of Corrections and Rehabilitation
DSH	Department of State Hospitals

ACRONYM	FULL TEXT
EOP	Enhanced Outpatient Program
ICF	Intermediate Care Facility
LRH	Least Restrictive Housing
MHCB	Mental Health Crisis Bed
MOU	Memorandum of Understanding
PIP	Psychiatric Inpatient Program
SVSP	Salinas Valley State Prison

CERTIFICATION

The undersigned counsel for Plaintiffs certifies that he reviewed the following relevant court orders:

Dkt. No.	Date	Subject
6961	11/19/2020	Order on Supplemental Post-Trial Briefing
6885	9/25/2020	Denying Motion to Modify Order at 6639
6660	5/7/2020	Denying Motion for Reconsideration and Clarifying Order Setting Evidentiary Hearing
6639	4/24/2020	DSH Transfers and Screening
6600	4/10/2020	Pandemic Measures, Opening Discovery on DSH Issues, Setting Evidentiary Hearing
6572	4/3/2020	Show Cause Re DSH Transfers
5711	10/10/2017	Staffing
5583	3/24/2017	Inpatient Care Order After Evidentiary Hearing
5343	8/21/2015	Access to DSH Inpatient Beds
4688	7/11/2013	Inpatient Care, Order After Evidentiary Hearing

DATED: Dec. 7, 2020

Respectfully submitted,
ROSEN BIEN GALVAN & GRUNFELD LLP

By: */s/ Ernest Galvan*
Ernest Galvan

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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

RALPH COLEMAN, et al.,

Plaintiffs,

v.

GAVIN NEWSOM, et al.,

Defendants.

Case No. 2:90-CV-00520-KJM-DB

DECLARATION OF ERNEST GALVAN IN SUPPORT OF PLAINTIFFS' SUPPLEMENTAL BRIEF FOLLOWING EVIDENTIARY HEARING ON DEPARTMENT OF STATE HOSPITAL TRANSFERS

Judge: Hon. Kimberly J. Mueller

I, Ernest Galvan, declare:

1. I am an attorney duly admitted to practice before this Court. I am a partner in the law firm of Rosen Bien Galvan & Grunfeld LLP, counsel of record for Plaintiffs. I have personal knowledge of the facts set forth herein, and if called as a witness, I could competently so testify. I make this declaration in support of Plaintiffs' Supplemental Brief Following Evidentiary Hearing on Department of State Hospital Transfers.

2. Attached hereto as **Exhibit A** is a true and correct copy of excerpts of the transcript of a hearing in this case that occurred on June 21, 2013, which includes the testimony of CDCR Senior Supervising Psychiatrist Dr. Troncoso.

3. Attached hereto as **Exhibit B** is a true and correct copy of excerpts of the transcript of a hearing in this case that occurred on June 19, 2013, which includes the testimony of Plaintiffs' expert, psychiatrist Dr. Pablo Stewart.

4. Attached hereto as **Exhibit C** is a true and correct copy of excerpts of the transcript of a hearing in this case that occurred on October 23, 2020, which includes the testimonies of Plaintiffs' expert, psychiatrist Dr. Pablo Stewart and DSH Medical Director, Dr. Katherine Warburton.

5. Attached hereto as **Exhibit D** is a true and correct copy of an email and an excerpt of an attached document that I received from counsel for CDCR on December 3, 2020, which shows the waitlist for intermediate and acute inpatient level of care.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct, and that this declaration is executed at El Cerrito, California this 7th day of December, 2020.

/s/ Ernest Galvan
Ernest Galvan

EXHIBIT A

IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

---O0O---

BEFORE THE HONORABLE LAWRENCE K. KARLTON, SENIOR JUDGE

RALPH COLEMAN, et al.,

Plaintiffs,

Vs. CASE NO. CIV. S-90-0520 LKK

EDMUND G. BROWN JR., et al.,
et al.,

Defendants.

_____/

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REPORTER'S TRANSCRIPT

RE: EXCERPT OF EVIDENTIARY HEARING - DAY 3

JUNE 21ST, 2013

---o0o---

Reported by: CATHERINE E.F. BODENE,
CSR. No. 6926

DIRECT EXAMINATION

BY MR. RUSSELL:

Q. Good morning, Dr. Troncoso.

A. Good morning, sir.

Q. Are you presently employed by the California Department of State Hospitals?

A. I am.

Q. What is your present position with DSH?

A. Senior supervising psychiatrist.

Q. Where do you work?

A. At DSH Salinas Valley.

Q. The Salinas Valley Psychiatric Program?

A. Yes.

Q. How long in your current position have you been at Salinas Valley Psychiatric Program?

A. Well, I'm not sure I understand. I've been at Salinas Valley Psychiatric Program for four and a half years. Then I had a small hiatus of six weeks and then I returned.

Q. So there was a period of time in which you left?

A. Correct.

Q. When did you return?

A. June 17th.

Q. So that was on Monday?

A. Correct.

Q. Before I get into your position with the Department

comes in, or just patients who are going to be on your workload?

THE WITNESS: The patients that are going to be on my workload. But if I'm the only psychiatrist there, I see everybody.

THE COURT: Okay.

THE COURT: As a supervising psychiatrist, do you see everybody or just get reports or what do you do?

THE WITNESS: No, I don't get reports. I follow -- I have a caseload so I see those --

THE COURT: Just that portion.

THE WITNESS: -- individually.

THE COURT: Okay. Thank you, sir.

BY MR. RUSSELL:

Q. Do other staff also see the patient while they're on orientation status?

A. It's amazing, but there is a lot of staff that really see the patient almost continuously. From the time they arrive in our facility, from the MTAs that escort our patient from the receiving and release unit to our unit, staff interacts with that patient constantly.

And by constantly, it seems like they have eyes on these patients 24/7. I'm not the only person that sees the patient. There is the registered nurse. There is the psychologist, the social worker who has a caseload, the

recreational therapist and others, like psych-techs, for example, that really have created a milieu, so to speak, a therapeutic milieu in which the patient is immersed in. So I'm not the only one.

Q. What is your understanding of the orientation status, what the patient -- well, what is your understanding of the orientation status?

A. It's a time period where they're given an opportunity to adjust to a new program. They may have come from another type of care in CDCR. And if they're, for example, EOP, they go to our intermediate facility, and they need a period of adjustment, so to speak.

We get to know the patient. They get to know us. And it is almost like a handshaking type of encounter.

THE COURT: Except they're in handcuffs.

THE WITNESS: Except they're in handcuffs. But we have a Level IV maximum security prison so we have that component to sort of contend with.

BY MR. RUSSELL:

Q. Your Honor anticipated my question. The inmates remain in cuffs during orientation status?

A. They do.

Q. They're in cuffs when outside of their cell, correct?

A. Only outside of their cell.

Q. During orientation status are patients prohibited

something because I'm assuming that they're really sick people.

Expecting them to fill out a form is, I would assume, frequently unreasonable -- not a reasonable expectation?

THE WITNESS: Well, they don't necessarily have to fill out a form, Your Honor. They can communicate to somebody else that they need to be seen.

THE COURT: To see people who are, I gather -- I mean, we've heard testimony that you see people who are essentially catatonic.

THE WITNESS: Well, I have to differ. We don't see the people with catatonia. That is more of an acute situation that has to be addressed at a higher level of care.

THE COURT: Okay. Let's say you're a Level IV and you're catatonic. Where do you go? Where do they send you?

THE WITNESS: You would go to Vacaville.

4 THE COURT: Okay. Okay. So you have people who are intermediate, but they're still quite sick.

Try and tell me, I know that there is no typical, but as a general matter can you describe the nature of the problems that have sent the patient to your hospital?

THE WITNESS: Well, the problems that we have sent to our hospital are quite different. We have the maximum security component, but we also have some of the sickest

people in the state hospital system, as well as in CDCR.

These patients present with major psychiatric disorders. For example, psychotic disorders, mood disorders and major anxiety disorders. So we come across a wide spectrum. They are usually medicated, some of them not. And -- I'm sorry.

THE COURT: No. No. I was afraid that the lawyer was about to interrupt you. I was trying to stop him.

Go ahead.

THE WITNESS: With those major categories, like take schizophrenia for example, we see all types of schizophrenia.

THE COURT: So you see people with schizophrenia. They may not even recognize where they are?

THE WITNESS: In rare cases. If they are gravely disabled, that may be so.

THE COURT: In any event, being schizophrenia -- asking you, not telling you. I can hear myself as if I'm telling you, and I don't mean to.

Whatever the level is, they are probably not able to accurately evaluate where they are and what's happening to them?

THE WITNESS: They're well aware of where they are because we check for that on initial assessment. We also make room for things that -- for instances where they are

In other words, there's -- we can't get the right treatment tailored to that patient, and they need a higher level of care. So I only know of Vacaville by referral. We send those people to Vacaville.

Q. Who are the people that you keep that, as you say, have moderate acuity?

Again, can you explain what you mean by that and the kind of patients that you are treating in layman's terms?

A. The patients that we treat are patients that are severely mentally ill. You know, if you look at a bell curve, there is going to be some outliers on the tail end of the curve on both ends.

That tail end of the curve going forward represents people who are severely mentally ill and that need a higher level of care.

And sometimes they come from CDCR with that level of care, and we recognize it early, we make a referral early.

When we work with them and we establish that their diagnosis, for example, may not be the clearest, or they need more attention because they're chronically suicidal, then we sends them to Vacaville.

Q. Now, going back to the IDTT, the Interdisciplinary Treatment Team, they meet on a formal basis every 30 days, correct?

A. Correct.

Q. That's not the only time in which the patient is seen; is that correct?

A. No. I gave you examples of when we see them outside of the IDT.

Q. In addition to you as the staff psychiatrist, who else treats the patients?

A. The whole milieu.

Q. Can you describe what that milieu is?

A. Well, a therapeutic environment. The environment that starts from the moment they're in reception -- receiving and release. There are two MTAs that bring them to our facility. That's the start of the therapeutic milieu.

Then when they come to our unit, they are essentially immersed in a therapeutic environment. Every contact with them is therapeutic in nature, from the MTAs, from the nursing staff, the psych-techs, the med nurse, and so on so forth, even down to the cleaning people. That's part of the therapeutic milieu. They are immersed in that.

So we have a multitude of people actually contributing to that milieu. Very therapeutic. You may not think that the guy that cleans the floor is therapeutic, but he cleans the cell of some of our patients, and he can tell us a lot of information about what they find in the cell that helps us direct our treatment.

Or the cook, for example, has special diets that

these patients are on, whether for religious or medical reasons. The cook plays a part in all of this.

So there is a hierarchy of people that contribute to this therapeutic milieu.

Q. As part of the treatment that is offered by you as one of the staff psychiatrists, you mentioned that you see patients on an individual basis.

Do you see them at their cell front?

A. Sometimes.

Q. When do you do that?

A. Well, for example, maybe they don't want to come out for some reason, then it is either myself or the whole team that actually goes to the cell front and tries to encourage the patient to come out and meet with us.

Q. Are there instances in which -- well, let me back up.

Are you, as a staff psychiatrist, able to provide what you consider to be effective care when you meet with a patient at their cell front?

A. It's not the most ideal of circumstances because there's a lack of confidentiality that goes with a cell front meeting, but it is sufficient enough to get an idea of where they are.

Q. If you do not believe that is sufficient, what do you do?

A. Then we ask them to come out again and repeatedly

Q. He was referred to the intermediate care program following that suicide attempt?

A. I don't see that. I see a referral from Sacramento to the mental health crisis bed in San Quentin.

Q. Then the next line?

A. DSH Intermediate Care Program. Referral to the program was made.

Q. You testified earlier about the kinds -- the acuity of the patients who come into the ICF program. Is it fair to say that after serious suicide attempts, inmates who are seriously suicidal is one type of inmate referred to your program?

A. Yes.

Q. That inmate might be considered a serious risk to himself or others?

A. Yes.

Q. After this suicide, while you were at the Salinas Valley Psychiatric Program, was there any discussion that you were privy to about changing the process of cuff status?

A. No discussion.

Q. Were any changes to the orientation status made?

A. No.

Q. Were any additional clinical monitoring obligations added to cuff status?

A. No.

REPORTER'S CERTIFICATE

---o0o---

STATE OF CALIFORNIA)
COUNTY OF SACRAMENTO)

I certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter.

IN WITNESS WHEREOF, I subscribe this certificate at Sacramento, California.

/S/_Catherine E.F. Bodene_____
CATHERINE E.F. BODENE, CSR NO. 6926
Official United States District Court Reporter

EXHIBIT B

IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

---O0O---

BEFORE THE HONORABLE LAWRENCE K. KARLTON, SENIOR JUDGE

RALPH COLEMAN, et al.,

Plaintiffs,

Vs. CASE NO. CIV. S-90-0520 LKK

EDMUND G. BROWN JR., et al.,
et al.,

Defendants.

_____/

---o0o---

REPORTER'S TRANSCRIPT

RE: EXCERPT OF EVIDENTIARY HEARING - Day 1

JUNE 19TH, 2013

---o0o---

Reported by: CATHERINE E.F. BODENE,
CSR. No. 6926

MR. NOLAN: Not unless the Court would like it -- Oh.

THE COURT: It is not your business.

MS. VOROUS: No. Defendants do not, Your Honor.

THE COURT: You may proceed, Mr. Nolan.

MR. NOLAN: Also I just want to point out that the paragraphs in Dr. Stewart's declaration in the termination proceedings that concern DSH are paragraphs 51 to 56, 377 to 391, 398 to 408, 411 to 451.

DIRECT EXAMINATION

BY MR. NOLAN:

Q. Dr. Stewart, your report discusses problems with premature discharges from inpatient care at Department of State Hospitals' programs and with the quality of care in DSH hospital programs. Why are these serious problems?

A. Well, they're serious problems in that hospital-based care in a given system is where the sickest patients go to receive care.

THE COURT: Sixth?

THE WITNESS: Sickest.

Most impaired, Your Honor. Excuse me.

THE COURT: That's all right. I just didn't hear you.

1 THE WITNESS: You can liken it to a medical hospital where the sickest patients would go to something like the intensive care unit.

In a psychiatric system the inpatient hospital programs are where the people that are suicidal, that due to mental illness are suicidal, a danger to others, and are gravely disabled, such as not eating or drinking properly, and need to receive this level of care.

BY MR. NOLAN:

Q. In your report you discuss the problem of premature returns, premature discharges from DSH hospitals.

How did you learn about this problem?

A. As you're aware, I did a number of tours of five facilities; Salinas Valley, the State Prison Sacramento, Lancaster, R.J. Donovan and San Quentin. In each one of these facilities I toured and spent a lot of time in the mental health crisis bed unit areas.

There, speaking with staff, the staff brought up to me, when I asked about the patients that they were taking care of in the mental health crisis bed units, that the staff were complaining that many of these people had recently been treated at the Department of State Hospital facilities, either intermediate care facilities or acute facilities, and had been sent back to the facility.

THE COURT: Sent back to?

THE WITNESS: To the state prison, Your Honor, from the DSH. And that the clinicians found that these individuals were in a similar psychiatric condition that they

had when they were sent. So they were unable to be housed in the general housing units, in the Ad. Seg. Units, et cetera. So they had to house them, for their own safety, in the mental health crisis bed units.

And then shortly thereafter, they were re-referred back to the Department of State Hospital. And this occurred -- this occurred in every mental health crisis bed unit I toured in the five facilities that I mentioned.

Q. Doctor, did you interview and evaluate some individuals who fall into this category of "Individuals Prematurely Discharged"?

A. Yes. And then as part of my tour in the mental health crisis bed, I did spend time and had these particular patients pulled out. And I interviewed them, and I had the opportunity to review their records also.

Q. Do you recall how many individuals you evaluated who were in this category of recently returned from Department of State Hospitals and going back?

A. In my tours that occurred at the end of January, beginning of February, there were six individuals who had recently been discharged from the state hospital, had been returned to the sending institutions, and at the time -- at that time CDCR staff, not myself, but CDCR had determined that they needed to be sent back to the state hospital. And they were being housed in the mental health crisis beds.

So they were getting -- they confirmed they were getting maybe five hours a week, which was later brought up with both Dr. Brim and Dr. Badeaux's declaration and in their deposition testimony.

Q. Doctor, I want to call your attention to the Exhibit D in your binder. These are photographs that were attached to your declaration, Docket 4381 at pages 245 through 247 -- I'm sorry -- through 250.

And it's appendix UU, VV and WW and XX, photographic appendixes.

Does this capture what the rooms looked like when you were touring?

A. Yes. The first two photos are of the permanent unit and the last two are of the temporary unit. See, this is exactly how they were. They were empty.

Sometimes when we go on tours, we take pictures of the units, we have to move patients out for confidentiality reasons. But there was no reason to do that in the pictures because there was nobody getting any treatment.

Q. In your opinion, Doctor, is five hours a week of therapeutic group activity sufficient for patients at the intermediate level of care?

A. I want to go back to this. These are the most severely ill people in the system. They're in the hospital where every moment of their waking hours should be

therapeutic in nature, from the time they get up to the time they go to bed. And these people were getting around five hours a week.

In the next lower level of care in the CDCR system, which is EOP, the program guide calls for a minimum of ten hours of treatment.

So this thing was all turned upside down. From the lower level, from a referring level to the hospital where you're supposed to get more care, they ended up getting less. So to answer your question, five hours is very inadequate in my opinion.

Q. Do you have an opinion about what level of treatment should be provided in an intermediate inpatient care program?

A. I believe that, as I was saying, the entire day should be therapeutic. People need to be out of their cells, they need to be attending recreation or therapy groups, meeting with clinicians, meeting with therapists, maybe even just going to yard, these sorts of things.

So given that, you know, a fair estimate would be 40 hours a week of some sort of activity, including recreation, including yard time.

Q. So tab E in the exhibit binder that I have given you is a declaration previously filed by defendants in this case in September of 2010. It was Docket 3913-3. The document is a declaration by Victor Brewer.

THE WITNESS: You're right, Your Honor.

THE COURT: Is it your view -- I'm asking you, not telling you, I want to make clear, you're the expert, not me -- is it your view that any time somebody is sent to the hospital, that's an indication of a requirement for urgent care and something must be done relatively early in order to ensure that something like the suicide doesn't occur?

THE WITNESS: Yes, Your Honor.

THE COURT: Is that an ideal requisite or is that something that is realistically what happens in hospitals?

THE WITNESS: I think it is very realistically what happens in hospitals.

THE COURT: Other than prison hospitals?

All right. Thank you.

BY MS. VOROUS:

Q. Doctor, isn't it correct that you don't have any knowledge what treatment that this inmate was receiving prior to being cleared for programming?

A. What I do know is that for the three weeks there, the only thing that was pointed out as far as treatment that he received was the two groups, the one the night before he hung himself and the one the morning before he hung himself.

Q. Doctor, would you look at page 9 of the suicide report.

A. Yes.

Q. Please refer to the last paragraph on page 9 that begins with the word "During" and continues on "the first two weeks."

If you look further down in that paragraph, isn't it correct that at the very least he was seen by his treatment team for 72 hours and a seven day team meeting?

A. That's what it says, yes.

Q. Doctor --

THE COURT: I'm sorry. I don't have any idea what those words mean. Do those words mean -- (Reading:)

During his orientation period he was described as pleasant and frequently asked staff for books. He has been seen by his treatment team for 72 hours and seven-day team meetings.

(Reading concluded.)

Do you know what that means?

THE WITNESS: How I understand what that is, Your Honor, is that within 72 hours the treatment team would meet with the patient to have --

THE COURT: So they would have one meeting?

THE WITNESS: One meeting. Then have another meeting at the end of seven days.

THE COURT: Excuse me, Miss Vorous. I'm just trying to read and understand it.

He was seen by his treatment team. Doesn't that

indicate to you there was a treatment team?

I don't know what it means, but there was something called the "treatment team"?

THE WITNESS: Yes.

THE COURT: Do you have any idea what that means?

THE WITNESS: The treatment team, as I understand it from reading the records of other cases, it includes a psychiatrist, as well as other members of the staff that would provide -- that work in that particular unit that provides some sort of care.

THE COURT: And as far as you can tell what that means is he met with them once -- met once within 72 hours; is that correct?

Is that the same thing?

THE WITNESS: He met with them for a 72 hour and seven day team meeting.

Now, we don't know exactly when that occurred, but they're calling it so I'm assuming this was within the 72 hours, the first meeting, then seven days -- within seven days for the second meeting.

THE COURT: In your opinion would that be sufficient for somebody who was being hospitalized for acute care?

THE WITNESS: No, Your Honor, it isn't, to answer your question.

THE COURT: Tell me what else.

THE WITNESS: When a person first comes into the hospital, they need to be met at the door almost. Once they're processed and made sure that, you know, they have the clothing and whatever, assigned to a room, they need to be seen then for an initial assessment to make sure that they're not at risk or what is going on with them or what kind of meds, all these sort of things.

They need to be met initially by, at a minimum, a psychiatrist and probably members of the nursing staff or other members of the staff that are there so you can get an idea.

And then once you have the person in the facility, and you get some initial idea of what is going on, based on what the initial eval included and reviewing the records, then you may have a little more leisurely time to have a more comprehensive team meeting.

So if they wish to initiate treatment right away, when he comes in, which they should, then they want to wait for three days to have a more comprehensive treatment meeting, then I don't see anything wrong with that.

But they need to be seen immediately when they step in the door, and the treatment needs to begin right then.

THE COURT: In an ideal situation that may be the most desirable procedure, but you're not in an ideal situation. You're in a prison situation, a prison hospital,

but still a prison situation. Do you believe that by virtue of that some other procedure would be acceptable?

THE WITNESS: Given that it is in a prison hospital, Your Honor, no, I don't. Because what they basically admitted to here is that for three days this guy was on his own. And fortunately nothing bad happened during that three-day period, but it wasn't because of anything the staff did. They had no idea what was going on with this guy for the first three days.

He needed -- in any hospital setting, be it a prison hospital or at the university hospital, when the people come into the room, come into the hospital, they're seen initially so that the staff, especially the psychiatrist, has an idea of what's going on with the person and can initiate a treatment plan that is then subject to modification when they see him more thoroughly, maybe a couple days later.

THE COURT: You may proceed, Miss Vorous.

BY MS. VOROUS:

Q. Dr. Stewart, I would like to clarify the record, if I may.

The question that you were asked related to acute care. The Salinas Valley Psychiatric Program is an intermediate care facility, correct?

A. It is intermediate care. I was referring to hospital-based care.

A. (Reading:)

The delay in transfer to the Department of State Hospital Salinas Valley may have frustrated him, but certainly the delay in his ability to program out of his cell aggravated him. Inmate A had been programming on the yard at State Prison Sacramento, but when transported to DSH Salinas Valley, he was placed alone in his cell and was not allowed to program as he had at Sacramento.

(Reading concluded.)

Do you wish me to continue?

Q. One more sentence.

A. (Reading:)

This was compounded by the one week delay of the ICC.

(Reading concluded.)

6 Q. So Doctor, in your opinion what would be an appropriate time to start group treatment and out-of-cell treatment for this individual?

A. I think after you have your initial assessment of him and the initial treatment plan and whatever custody things need to occur, they need to occur in that same time frame simultaneously. And the treatment should begin, you know, literally the same day or the next day at the latest.

MR. NOLAN: Thank you, Doctor.

THE COURT: Further cross, ma'am?

REPORTER'S CERTIFICATE

---o0o---

STATE OF CALIFORNIA)
COUNTY OF SACRAMENTO)

I certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter.

IN WITNESS WHEREOF, I subscribe this certificate at Sacramento, California.

/S/_Catherine E.F. Bodene_____
CATHERINE E.F. BODENE, CSR NO. 6926
Official United States District Court Reporter

EXHIBIT C

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF CALIFORNIA
--o0o--

RALPH COLEMAN, ET AL,) Docket No. 90-CV-520
) Sacramento, California
Plaintiffs,) October 23, 2020
) 9:24 a.m.
v.)
)
GAVIN NEWSOM, ET AL.,) Re: Evidentiary Hearing
)
Defendants.)

TRANSCRIPT OF PROCEEDINGS
BEFORE THE HONORABLE KIMBERLY J. MUELLER
UNITED STATES DISTRICT JUDGE

APPEARANCES (Via Zoom):

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(Appearances continued next page.)

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Also Present:
MATTHEW LOPES
Special Master
HAVEN GRACEY
Law Clerk for Chief Judge Mueller

psychiatric facilities that take patients from the most vulnerable institutions in our state, we just needed that time to build up that response so that we could start safely admitting people again.

Q Dr. Warburton, do you consider yourself a public health expert?

A I am certainly more of one now than I was in March, but I rely heavily on the public health experts that we have in our own facilities as well as those at the California Department of Public Health. I am a forensic psychiatrist.

Q Before getting into DSH's specific guidelines for transfer, I'd like to talk a little bit -- just take a step back and talk a little bit about the Coleman patients that DSH admits to its care. Can you describe the criteria for Coleman patients that are admitted to be treated at DSH?

A Well, it's ICF level of care, so things like psychotropic medications, stabilization, development of coping skills. If people need certain types of consultation or long term 24-hour care, they come to us for ICF treatment.

Q So is this an acute level of care?

A No. Psychiatric patients within the Department of Corrections who need acute level of care go to their crisis beds and/or their acute level of care.

Q And are you currently involved in the process for transferring inmates from the Department of Corrections during

Dr. Stewart may state his opinion in response to questions in that field.

MR. NOLAN: Thank you, Your Honor.

BY MR. NOLAN:

Q Dr. Stewart, what issues have you been asked to provide an expert opinion about for today's hearing?

A I was asked to offer opinions about whether any of the 55 patients that are awaiting transfer to DSH facilities are experiencing any clinical harm as well as are they receiving adequate care during this waiting period?

Q Dr. Stewart, did you come to a opinion regarding these issues?

A Yes. After my initial review, I came to the opinion that all 55 certainly are seriously mentally ill, and I agree with the CDCR clinicians that they all require inpatient treatment and further opinions were that they're not receiving adequate care during this waiting period and they are not receiving equivalent care in their current situations as they would receive in a DSH facility.

Q Dr. Stewart, do patients who need inpatient care need to be given that level of care quickly?

A Yes.

Q Why is that?

A Well, delays cause harm and suffering and sometimes this harm can be irreparable. For example, in the scientific

literature or psychiatric literature, it's very clear that delaying aggressive treatment for major depressive disorders puts the patient at higher risk for developing Alzheimer's disease sometime in the future. And the literature is also clear that in the absence of progressive treatment for psychotic symptoms, meaning if you allow a person to remain psychotic, it worsens the overall prognosis throughout the lifetime of the patient in question. Those are the potentially irreparable harms. But there's also a harm that the longer a patient remains symptomatic and not receiving proper care, the longer it will take for that person to be returned to a baseline of mental health stability, and during that time they're suffering harm.

And the last thing I just want to mention on suffering harm is that when you have a patient at a level of care that's not able to adequately manage that patient, it's likely that that person will have behavioral manifestations of the mental illness, resulting in things like assaults, fights, throwing urine and feces at guards and other patients as well as increase in self-injurious behaviors, and these sorts of issues put both the patient at risk for harm as well as the staff and other patients.

Q Thank you, Dr. Stewart. Dr. Stewart, when somebody is referred and accepted for inpatient treatment at a hospital, how soon should they be moved?

BY MR. NOLAN:

Q So based on this chart and your review of the treatment plans, were you able to come to any initial opinions about this group of 55 individuals waiting for a transfer?

A Yes. After my initial review, based on the data from this spreadsheet regarding diagnoses and medications, I noticed that there was some issues regarding diagnoses. Sometimes there was several unspecified diagnoses. There was actually an example of a contradictory diagnosis and there was also multiple diagnoses, all of which raised a question in my mind about the quality of care that a person's getting.

In addition, I looked at the medications and I found many examples of very complex polypharmacy going on. Sometimes polypharmacy is the right treatment for patients, but based on this initial review, it just raised a question in my mind about what else is going on with these patients when they're being treated, for example, with two different antipsychotic medications or just, you know, a lot of patients were on four and five different medications, so it was those areas that I looked at.

Q Dr. Stewart, if I could ask you what is the problem with unspecified diagnoses?

A Well, there's not a problem, per se, but an unspecified diagnosis is -- say there's a whole list of psychotic diagnoses, like schizophrenia, schizo-affective disorder. But

are more generally or broadly exemplary of all the 55 patients that are awaiting transfer.

Q And Dr. Stewart, can I ask you -- and how many examples did you find?

A Well, I found a large number and I eventually got the number down to 11 knowing that we're limited in our time to present to the Court and that I felt were exemplary of the overall cohort of 55 patients waiting.

Q And what documents did you review for those eleven?

A I asked for their medical records for two months prior to their referral to DSH and up to the present time or the most current records that were available, and I looked further at them.

Q Dr. Stewart, what is persistent psychosis?

A Say that again, please.

Q What is persistent psychosis?

A It's psychosis that continues to be present even in the face of being treated with antipsychotic medication or other types of medication.

Q Did you see many examples of persistent psychosis among the --

A Yeah.

Q -- patients you looked at?

A Yes.

Q What is the danger from persistent -- for a patient from

persistent psychosis?
A Well, as I mentioned earlier, untreated psychosis contributes to a poorer prognosis overall in the lifetime of the patient. It is similar to like a seizure disorder. You don't allow patients to seize because the more they seize, the more they will seize. Same thing about psychiatric. The same thing has been studied with psychotic symptoms. The more you allow a patient to be psychotic, the more they will be psychotic in the future and it will be harder to address those persistent psychotic symptoms.
Q And isn't an inpatient hospital the best place to address persistent psychotic symptoms?
A In my opinion, based on my experience working in various correctional systems and observing various correctional systems, persistent psychosis is an indicator for the need of inpatient hospitalization and close monitoring.
Q Okay. What else did you find in your more detailed review of the eleven cases you selected?
A Well, again, there were antipsychotics; and yet, they continued to have command auditory hallucinations that were telling them to hurt themselves. I had cases where people were being treated with multiple medications and they had persistent symptoms; not just auditory hallucinations but persistent suicidal ideation, they had persistent self-injurious behaviors and to the extent that some of the patients that I reviewed

Q Okay. In the Bates numbering.

So let me just go to the page -- treatment plan. So in this section on, you know, higher-level-of-care considerations do you see under the second paragraph where it says, "Summarize treatment modifications," the last three sentences there where it says, "Because it is not clear that patient will transfer to the PIP-ICF any time soon, patient is also engaged in a plan to meet the goals of ICF hospitalization within the next four weeks in MHCB." Do you remember reading that?

A Yes.

Q Dr. Stewart, is it possible for somebody to get -- receive ICF care in a mental health crisis bed?

A No, it is not. I'm very familiar with mental health crisis beds in correctional settings as well as inpatient care for the correctional settings, and a patient cannot receive inpatient equivalent care in a crisis bed.

Q What are the features of an inpatient setting that a mental health crisis bed does not have?

A Well, it allows the patient to be part of the milieu that the psychiatrist and the rest of the staff, nursing staff, et cetera, can observe and monitor. This is especially important for diagnostic clarification as well as we're doing these -- hopefully we're doing these nuanced medication monitoring in adding new medication or removing medication. That can only happen in the inpatient setting. It really

C E R T I F I C A T E

I certify that the foregoing is a true and correct transcript of the record of proceedings in the above-entitled matter.

/s/ JENNIFER L. COULTHARD November 2, 2020

DATE

JENNIFER L. COULTHARD, RMR, CRR
Official Court Reporter

EXHIBIT D

Greg Gonzalez

From: Weber, Nicholas@CDCR <Nicholas.Weber@cdcr.ca.gov>
Sent: Thursday, December 3, 2020 5:26 PM
To: Hockerson, Dillon@CDCR; Marc Shinn-Krantz; Melissa Bentz; Stafford, Carrie@CDCR; CDCR OLA Coleman CAT Mailbox; Rashkis, Sean@DSH-S; Nina Raddatz; Christine Ciccotti; Kent, Kristopher@DSH-S; Adriano Hrvatin; Damon McClain; Elise Thorn; Kyle Lewis; Lucas Hennes; Tyler Heath; Ryan Gille; Namrata Kotwani
Cc: Coleman Special Master Team; Coleman Team - RBG Only; Steve Fama
Subject: RE: Coleman: Renewed Information Request Re Inpatient Transfers; Request for Two Prompt Transfers from CMF MHCB [IWOV-DMS.FID6429]
Attachments: IRU Data Waitlist and Admissions 12.3.2020.pdf

Marc,

Please find attached point in time waitlist data, broken out by referred level of care. The last section includes a list of patients transferred externally over the past six months. Please note that this data is point in time and not validated between HCPOP and IRU, as is the practice more monthly court filings, and is provided on an expedited basis in order to give the parties as close to real time information as possible. Any discrepancies found in this data during the monthly validation process will be corrected prior to court filing. Please also note that some patients on the referred list may also be under consideration by their IDTTs for rescission. Finally, the ICF to ICF referral list should not be confused with an LRH referral list as not all patients on the ICF to ICF referral list are necessarily being referred to a less restrictive housing.

Nick Weber
Attorney
Department of Corrections & Rehabilitation
1515 S Street, Suite 314S
Sacramento, CA 95811-7243
[redacted]

From: Hockerson, Dillon@CDCR <Dillon.Hockerson@cdcr.ca.gov>
Sent: Thursday, December 3, 2020 3:34 PM
To: Marc Shinn-Krantz <MShinn-Krantz@rbgg.com>; Weber, Nicholas@CDCR <Nicholas.Weber@cdcr.ca.gov>; Bentz, Melissa@CDCR <Melissa.Bentz@cdcr.ca.gov>; Stafford, Carrie@CDCR <Carrie.Stafford@cdcr.ca.gov>; CDCR OLA Coleman CAT Mailbox <OLAColemanCAT@cdcr.ca.gov>; Rashkis, Sean@DSH-S <Sean.Rashkis@dsh.ca.gov>; Raddatz, Antonina@DSH-S <Antonina.Raddatz@dsh.ca.gov>; Christine Ciccotti <Christine.ciccotti@dsh.ca.gov>; Kent, Kristopher@DSH-S <Kristopher.Kent@dsh.ca.gov>; Adriano Hrvatin <Adriano.Hrvatin@doj.ca.gov>; Damon McClain <Damon.McClain@doj.ca.gov>; Elise Thorn <Elise.Thorn@doj.ca.gov>; Kyle Lewis <Kyle.Lewis@doj.ca.gov>; Lucas Hennes <Lucas.Hennes@doj.ca.gov>; Tyler Heath <Tyler.Heath@doj.ca.gov>; Ryan Gille <Ryan.Gille@doj.ca.gov>; Namrata Kotwani <Namrata.Kotwani@doj.ca.gov>

Cc: Coleman Special Master Team <ColemanSpecialMasterTeam@rbgg.com>; Coleman Team - RBG Only <ColemanTeam-RBGOnly@rbgg.com>; Steve Fama <sfama@prisonlaw.com>
Subject: RE: Coleman: Renewed Information Request Re Inpatient Transfers; Request for Two Prompt Transfers from CMF MHCB [IWOV-DMS.FID6429]

Dear Marc,

I write in response to Plaintiffs' December 2, 2020, Email (12/2/20 Email) requesting two patients to immediately transfer to the Intermediate Care Facility (ICF) Level of Care (LOC). Specifically, Plaintiffs' request pertains to [redacted], and [redacted], both of whom have been in the Mental Health Crisis Bed (MHCB) LOC at California Medical Facility (CMF) for several months. On December 3, 2020, CDCR reviewed case factors for both patients to assess appropriate LOC.

First, Ms. [redacted] was referred to ICF LOC on October 29, 2020, due to the emergence of trauma-related symptoms. On December 2, 2020, CDCR rescinded the referral to ICF because of Ms. [redacted] improved progress and presentation with her symptoms. Specifically, Ms. [redacted] has refrained from self-harm behavior and she is able to resist suicide ideations by identifying protective factors. Ms. [redacted] also presents herself as intact, motivated, and optimally ready for a trauma psychotherapy in a less restrictive level of care. Currently, the rescission note is pending as CMF's MHCB has been placed on quarantine since November 25, 2020, and is expected to come off quarantine status on December 9, 2020.

Second, Mr. [redacted] was referred to ICF on July 23, 2020. There were no ICF beds available at CMF PIP, and patients were admitted to available ICF beds based on emergency transfer requests, facility priority moves, and local admissions by waitlist date. On November 16, 2020, a bed became available but further analysis was required for potential safety concerns. CDCR decided to place Mr. [redacted] on MAX custody status to resolve the potential safety concern. On November 19, 2020, Mr. [redacted] was endorsed to ICF and a COVID test was ordered. On November 25, 2020, Mr. [redacted] test results were obtained, however as stated above, the MHCB was placed on quarantine that same day. Mr. [redacted] should transfer to ICF LOC shortly after the quarantine status is lifted.

CDCR will follow-up with Plaintiffs' remaining requests in the immediate future. If you have any questions regarding Ms. [redacted] or Mr. [redacted] feel free to contact me.

Respectfully,

Attorney
CDCR Office of Legal Affairs
Email: Dillon.Hockerson@cdcr.ca.gov
Phone: [redacted]
Cell: [redacted]

From: Marc Shinn-Krantz <MShinn-Krantz@rbgg.com>
Sent: Wednesday, December 2, 2020 4:35 PM
To: Weber, Nicholas@CDCR <Nicholas.Weber@cdcr.ca.gov>; Bentz, Melissa@CDCR <Melissa.Bentz@cdcr.ca.gov>; Hockerson, Dillon@CDCR <Dillon.Hockerson@cdcr.ca.gov>; Stafford, Carrie@CDCR <Carrie.Stafford@cdcr.ca.gov>; CDCR OLA Coleman CAT Mailbox <OLAColemanCAT@cdcr.ca.gov>; Rashkis, Sean@DSH-S <Sean.Rashkis@dsh.ca.gov>;

Raddatz, Antonina@DSH-S <Antonina.Raddatz@dsh.ca.gov>; Christine Ciccotti <Christine.ciccotti@dsh.ca.gov>; Kent, Kristopher@DSH-S <Kristopher.Kent@dsh.ca.gov>; Adriano Hrvatin <Adriano.Hrvatin@doj.ca.gov>; Damon McClain <Damon.McClain@doj ca gov>; Elise Thorn <Elise Thorn@doj ca.gov>; Kyle Lewis <Kyle.Lewis@doj.ca.gov>; Lucas Hennes <Lucas.Hennes@doj.ca.gov>; Tyler Heath <Tyler.Heath@doj.ca.gov>; Ryan Gille <Ryan.Gille@doj.ca.gov>; Namrata Kotwani <Namrata.Kotwani@doj.ca.gov>
Cc: Coleman Special Master Team <ColemanSpecialMasterTeam@rbgg.com>; Coleman Team - RBG Only <ColemanTeam-RBGOnly@rbgg.com>; Steve Fama <sfama@prisonlaw.com>
Subject: Coleman: Renewed Information Request Re Inpatient Transfers; Request for Two Prompt Transfers from CMF MHCB [IWOV-DMS.FID6429]

Dear OLA Team,

Plaintiffs write to state our deep concern regarding the ongoing and widespread delays in transfers to inpatient care and to again ask for related information about *Coleman* class members. At the November 10, 2020 Task Force meeting, Defendants committed to provide a list of the names and CDCR numbers of patients awaiting transfer to a PIP or DSH, including LRH moves, their lengths of time waiting, and their needed level of care. Defendants have previously reported there are about 300-400 people systemwide awaiting transfer to a PIP or DSH. *See* Sixth Joint Task Force Report ECF 6895 at 6 (as of the week of September 21-27, 2020, a total of 66 patients with pending acute referrals and 303 patients with pending ICF referrals). But Defendants have never provided a list of the individual patients. Also at the November 10, 2020 Task Force meeting, Defendants repeated their prior commitment to provide a list of all emergency transfers that have been made from a closed institution to a PIP over the last six months. On November 16, 2020, we wrote to follow up on Defendants' commitments to provide those two lists, and other commitments. At the November 17, 2020 Task Force meeting, Defendants again committed to provide this information, as memorialized in Plaintiffs' November 18, 2020 Commitments letter. (Attached here for reference). But we still have not received it. This information is critical to our ability to perform our role as class counsel, and we are entitled to it. Defendants have previously stated that they routinely track this information and have ready access to it. Please provide it.

We also write to raise concerns about two specific class members at CMF who we understand to be among the hundreds of class members awaiting inpatient care. We ask that each be promptly transferred to ICF care, which can be accomplished through internal movement at CMF. Ms. [redacted]) has been at the MHCB at CMF since June 17, 2020, when she was admitted due to suicidal ideation and being deemed a danger to herself. Despite being discharged to EOP on June 26, 2020, Ms. [redacted] remained in the MHCB for months until her symptoms deteriorated to the point that she was referred to the ICF level of care on October 28, 2020. Ms. [redacted] still remains in the MHCB, where she has been housed for nearly six months. Recent clinical notes document that Ms. [redacted] is experiencing "unprecedented sudden intense depression, accompanied by suicidal ideation" and state that she demonstrates a pattern of "decompensating into suicidal depression without disclosing to anyone, indicating significantly increased risk of successful suicide." *See* 12/1/20 MHPC Progress Note. Clinicians agree that Ms. [redacted] needs the increased monitoring and treatment available at the ICF level of care, yet she continues to be housed in the solitary and restrictive environment of the MHCB.

Similarly, Mr. [redacted]) was first transferred to the MHCB nearly five months ago on July 8, 2020, following a suicide attempt at MCSP. On July 18, 2020, Mr. [redacted] IDTT referred him to the ICF level of care. Mr. [redacted] treatment team has repeatedly referred him for transfer to ICF level of care at weekly IDTT meetings but he still has not transferred. Mr. [redacted] continues to report to mental health staff that he wants to transfer out of the MHCB. Clinical notes document "he is still frustrated that he remains housed in MHCB" and that Mr. [redacted] understands "he may have to wait until ICC in January to be given an endorsement for another institution." *See* November 20, 2020 MHPC Inpatient Progress Note. Notes from his November 24, 2020 IDTT indicate that he was finally endorsed for an

internal transfer to the CMF-PIP, yet his latest IDTT notes from yesterday, December 1, 2020, show he still has not transferred.

Please promptly and safely transfer Ms. [redacted] and Mr. [redacted] from the CMF MHCB to the CMF PIP (or a different PIP). If this internal movement within CMF cannot be promptly accomplished for some reason, please explain why given that Defendants routinely report that CMF PIP has dozens of vacant beds including in the most recently filed Inpatient Census and Waitlist Report filed Nov. 16, 2020 (ECF No. 6956).

Thank you for your attention to these individual class members' wellbeing, and please provide the requested systemwide information promptly.

Best,
Marc

Marc J. Shinn-Krantz
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NEW ACUTE REFERRALS AS OF DECEMBER 3, 2020

CDCR#	LAST NAME-FIRST INITIAL	Ref CDCR Facility	APP/ICF	Total Days since COVID Hold / Complete
[redacted]	[redacted]	COR	APP	220
		COR	APP	213
		CMC	APP	209
		LAC	APP	189
		COR	APP	160
		MCSP	APP	142
		COR	APP	134
		COR	APP	118
		SAC	APP	105
		VSP	APP	104
		COR	APP	101
		COR	APP	98
		CMC	APP	97
		COR	APP	91
		SATF	APP	91
		SAC	APP	84
		SAC	APP	78
		COR	APP	66
		SAC	APP	59
		SAC	APP	58
		CMC	APP	49
		COR	APP	49
		COR	APP	44
		SAC	APP	43
		CMC	APP	43
		SAC	APP	42
		SAC	APP	42
		SAC	APP	42
		SAC	APP	41
		SAC	APP	38
		CHCF	APP	37
		SAC	APP	36
		MCSP	APP	36
		MCSP	APP	35
		SAC	APP	31
		RJD	APP	30
		CIM	APP	28
		MCSP	APP	28
		SAC	APP	28
		SAC	APP	24
		SAC	APP	24
		SAC	APP	24

[redacted]	[redacted]		SAC	APP	24
			CHCF	APP	23
			KVSP	APP	23
			LAC	APP	21
			CHCF	APP	21
			WSP	APP	21
			SAC	APP	20
			SAC	APP	17
			CMF	APP	17
			CMF	APP	17
			CMC	APP	16
			COR	APP	16
			WSP	APP	15
			RJD	APP	15
			CMF	APP	13
			CMC	APP	13
			LAC	APP	13
			CMF	APP	10
			CMF	APP	10
			MCSP	APP	10
			LAC	APP	10
			SAC	APP	9
			SATF	APP	9
			LAC	APP	9
			SAC	APP	9
			CMF	APP	9
			CMC	APP	9
			SAC	APP	3
			CMF	APP	3
			NKSP	APP	2
			SAC	APP	2
			SAC	APP	2
			RJD	APP	2
			SAC	APP	2

NEW ICF REFERRALS AS OF DECEMBER 3, 2020

CDCR#	LAST NAME-FIRST INITIAL	Ref CDCR Facility	APP/ICF	Total Days since COVID Hold / Complete
[redacted]	[redacted]	CMF-SAC	ICF	282
		SAC	ICF	280
		LAC	ICF	275
		LAC	ICF	275
		LAC	ICF	262
		LAC	ICF	262
		CIM	ICF	262
		SAC	ICF	260
		LAC	ICF	260
		SAC	ICF	260
		COR	ICF	259
		SATF	ICF	260
		SATF	ICF	254
		LAC	ICF	251
		KVSP	ICF	244
		LAC	ICF	245
		MCSP	ICF	245
		COR	ICF	238
		LAC	ICF	232
		CMC	ICF	232
		SAC	ICF	227
		SAC	ICF	225
		SAC	ICF	216
		SAC	ICF	211
		MCSP	ICF	210
		SAC	ICF	210
		CIM	ICF	203
		CIM	ICF	203
		SATF	ICF	198
		COR	ICF	197
		LAC	ICF	197
		SAC	ICF	196
		LAC	ICF	196
		SAC	ICF	191
		SQ	ICF	188
		LAC	ICF	189
		RJD-NKSP	ICF	185
		CMC	ICF	184
		KVSP	ICF	182
		CMC	ICF	182
		CIM	ICF	182
		LAC	ICF	182

[redacted]	[redacted]		SATF	ICF	**176**
			CMC	ICF	**175**
			LAC	ICF	**170**
			LAC	ICF	**168**
			LAC	ICF	**162**
			CMC	ICF	**161**
			LAC	ICF	**156**
			CIM	ICF	**155**
			SAC	ICF	**148**
			SATF	ICF	**154**
			SAC	ICF	**154**
			LAC	ICF	**154**
			LAC	ICF	**150**
			LAC	ICF	**149**
			LAC	ICF	**147**
			LAC	ICF	**147**
			CIM	ICF	**148**
			SATF	ICF	**147**
			SATF	ICF	**147**
			SAC	ICF	**146**
			CMF	ICF	**146**
			KVSP	ICF	**143**
			SAC	ICF	**142**
			COR	ICF	**135**
			LAC	ICF	**141**
			COR	ICF	**141**
			SATF	ICF	**140**
			CMC	ICF	**140**
			LAC	ICF	**139**
			KVSP	ICF	**139**
			SATF	ICF	**139**
			SATF	ICF	**139**
			SATF	ICF	**136**
			LAC	ICF	**135**
			SAC	ICF	**134**
			LAC	ICF	**129**
			NKSP	ICF	**129**
			CMF	ICF	**133**
			MCSP	ICF	**132**
			SAC	ICF	**132**
			CMC	ICF	**128**
			SATF	ICF	**126**
			LAC	ICF	**126**
			LAC	ICF	**126**
			SAC	ICF	**112**
			MCSP	ICF	**125**
			MCSP	ICF	**125**

[redacted]	[redacted]		KVSP	ICF	125
			SAC	ICF	125
			SATF	ICF	122
			LAC	ICF	122
			CMF	ICF	122
			CMC	ICF	120
			LAC	ICF	115
			SAC	ICF	119
			SATF	ICF	113
			SATF	ICF	113
			RJD-LAC	ICF	112
			CMF	ICF	112
			CMC	ICF	92
			LAC	ICF	107
			COR	ICF	106
			LAC	ICF	101
			CMC	ICF	100
			SAC	ICF	99
			SATF	ICF	98
			LAC	ICF	98
			SATF	ICF	93
			SATF	ICF	91
			CMF	ICF	91
			CMC	ICF	73
			SAC	ICF	84
			SAC	ICF	80
			SATF	ICF	78
			SAC	ICF	78
			SATF	ICF	78
			LAC	ICF	76
			CMC	ICF	72
			CMC	ICF	73
			CMC	ICF	73
			VSP	ICF	72
			MCSP	ICF	72
			LAC-RJD	ICF	70
			SATF	ICF	71
			LAC	ICF	70
			SAC	ICF	69
			SATF	ICF	66
			CMF	ICF	66
			COR	ICF	65
			CMC	ICF	64
			CMC	ICF	62
			CMC	ICF	58
			SQ	ICF	59
			SAC	ICF	59

[redacted]	[redacted]		CMF	ICF	59
			CMC	ICF	52
			SAC	ICF	58
			SATF	ICF	58
			CMF	ICF	57
			SAC	ICF	57
			SATF	ICF	56
			SAC	ICF	55
			SAC	ICF	55
			SATF	ICF	51
			CHCF	ICF	51
			MCSP	ICF	50
			SAC	ICF	50
			SAC	ICF	45
			SATF	ICF	42
			CMC	ICF	43
			NKSP	ICF	38
			COR	ICF	38
			CMC	ICF	37
			LAC	ICF	42
			SAC	ICF	41
			SAC	ICF	38
			CHCF	ICF	35
			SATF	ICF	37
			LAC-RJD	ICF	36
			CMC	ICF	36
			NKSP	ICF	35
			SAC	ICF	35
			CMC	ICF	35
			KVSP	ICF	35
			CMF	ICF	35
			CMF	ICF	35
			CMC	ICF	31
			LAC	ICF	30
			LAC	ICF	30
			CHCF	ICF	21
			LAC	ICF	20
			LAC	ICF	23
			VSP	ICF	28
			LAC-RJD	ICF	20
			LAC	ICF	23
			MCSP	ICF	24
			CMF	ICF	24
			CMF	ICF	24
			CMC	ICF	23
			VSP	ICF	23
			CHCF	ICF	21

[redacted]	[redacted]		CHCF	ICF	17
			LAC	ICF	17
			VSP	ICF	16
			SAC	ICF	16
			RJD	ICF	16
			SAC	ICF	16
			CIW	ICF	10
			CMC	ICF	15
			KVSP	ICF	10
			VSP	ICF	13
			RJD	ICF	14
			KVSP	ICF	13
			CMF	ICF	10
			CMF	ICF	10
			CMF	ICF	10
			CMF	ICF	9
			CMF	ICF	9
			VSP	ICF	9
			CIM	ICF	9
			CMF	ICF	9
			CMF	ICF	9
			SVSP	ICF	9
			CMF	ICF	8
			WSP	ICF	8
			SATF	ICF	3
			COR	ICF	3
			SVSP	ICF	3
			SAC	ICF	1
			CMC	ICF	1
			CMC	ICF	1
			SAC	ICF	1
			CIM	ICF	1
			RJD	ICF	1

ICF TO ICF REFERRALS AS OF DECEMBER 3, 2020

CDCR#	LAST NAME-FIRST INITIAL	Ref CDCR Facility	APP/ICF	Total Days since COVID Hold / Complete
[redacted]	[redacted]	CHCF-PIP	ICF	213
		SVSP-PIP	ICF	195
		CHCF-PIP	ICF	189
		CHCF-PIP	ICF	182
		CHCF-PIP	ICF	181
		CHCF-PIP	ICF	167
		CHCF-PIP	ICF	167
		CHCF-PIP	ICF	161
		SVSP-PIP	ICF	161
		SVSP-PIP	ICF	154
		CHCF-PIP	ICF	153
		CHCF-PIP	ICF	149
		SVSP-PIP	ICF	141
		CHCF-PIP	ICF	136
		SVSP-PIP	ICF	135
		CHCF-PIP	ICF	129
		CHCF-PIP	ICF	129
		CHCF-PIP	ICF	127
		CMF-PIP	ICF	122
		SVSP-PIP	ICF	114
		CMF-PIP	ICF	111
		CMF-PIP	ICF	85
		SVSP-PIP	ICF	84
		SVSP-PIP	ICF	59
		CHCF-PIP	ICF	57
		CMF-PIP	ICF	55
		SVSP-PIP	ICF	48
		SVSP-PIP	ICF	28
		CMF-PIP	ICF	23
		CMF-PIP	ICF	20
		CHCF-PIP	ICF	16
		SVSP-PIP	ICF	16
		CHCF-PIP	ICF	14
		SVSP-PIP	ICF	13
		SVSP-PIP	ICF	10
		CHCF-PIP	ICF	3

ACUTE TO ICF REFERRALS AS OF DECEMBER 3, 2020

CDCR#	LAST NAME-FIRST INITIAL	Ref CDCR Facility	APP/ICF	Total Days since COVID Hold / Complete
[redacted]	[redacted]	CMF-PIP	ICF	135
		CMF-PIP	ICF	134
		CMF-PIP	ICF	105
		CMF-PIP	ICF	84
		CMF-PIP	ICF	80
		CMF-PIP	ICF	79
		CHCF-PIP	ICF	79
		CHCF-PIP	ICF	77
		CHCF-PIP	ICF	76
		CHCF-PIP	ICF	76
		CMF-PIP	ICF	76
		CHCF-PIP	ICF	72
		CHCF-PIP	ICF	71
		CHCF-PIP	ICF	71
		CHCF-PIP	ICF	69
		CHCF-PIP	ICF	69
		CHCF-PIP	ICF	65
		CMF-PIP	ICF	58
		CHCF-PIP	ICF	56
		CHCF-PIP	ICF	55
		CHCF-PIP	ICF	51
		CHCF-PIP	ICF	50
		CHCF-PIP	ICF	48
		CMF-PIP	ICF	44
		CHCF-PIP	ICF	34
		CHCF-PIP	ICF	34
		CHCF-PIP	ICF	30
		CHCF-PIP	ICF	30
		CHCF-PIP	ICF	30
		CHCF-PIP	ICF	29
		CHCF-PIP	ICF	14
		CMF-PIP	ICF	14
		CHCF-PIP	ICF	13
		CMF-PIP	ICF	9
		CMF-PIP	ICF	3
		CMF-PIP	ICF	2

ICF TO ACUTE REFERRALS AS OF DECEMBER 3, 2020

CDCR#	LAST NAME-FIRST INITIAL	Ref CDCR Facility	APP/ICF	Total Days since COVID Hold / Complete
[redacted]	[redacted]	SVSP-PIP	APP	111