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J. Clark Kelso

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8 **UNITED STATES DISTRICT COURT**  
9 **NORTHERN DISTRICT OF CALIFORNIA**

10

11 MARCIANO PLATA, et al.,

Case No. C01-1351 TEH

12 *Plaintiffs,*

13 v.

**RECEIVER’S RESPONSE TO  
DEFENDANTS’ OBJECTIONS TO  
RECEIVER’S 22<sup>ND</sup> REPORT**

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

15 *Defendants.*

16

17 On January 25, 2013, the Receiver filed his 22<sup>nd</sup> Tri-Annual Report (“22<sup>nd</sup> Report”). Not  
18 quite three weeks later, on February 13, 2013, Defendants filed objections to two statements  
19 made by the Receiver in the 22<sup>nd</sup> Report, not merely objecting to those statements, but asking  
20 that they be stricken. (Dkt. # 2532.) On February 15, this Court requested that the Receiver file a  
21 response to Defendants’ objections. (Dkt. # 2536.)

22 This constitutes the Receiver’s response. As set forth below, the Court should overrule  
23 Defendants’ objections and surely should not strike the Receiver’s statements from the 22<sup>nd</sup>  
24 Report.

25 **ARGUMENT**

26 Defendants object to the Receiver’s statements that “[o]vercrowding and its consequences  
27 are and have been a chronic, widespread and continuing problem for almost twenty years” and  
28 “there is no persuasive evidence that a constitutional level of medical care has been achieved

1 system-wide at an overall population density that is significantly higher than what the three-judge  
2 court has ordered.” (Dkt.# 2532, p.1, quoting 22<sup>nd</sup> Report, Dkt. #2525, pp. 35, 36-37.) For the  
3 reasons discussed below, the objections should be overruled.

4 First, Defendants may be unhappy that the Receiver saw fit to include his comments  
5 regarding overcrowding in the 22<sup>nd</sup> Report, but they bear significant responsibility for his  
6 decision to do so. The Receiver was clear about why at this juncture he chose to present his  
7 views on the continued impact of overcrowding.

8 So long as the State was meeting its court-ordered targets, there was no need in our  
9 reports last year to comment specifically on the effects of overcrowding other than to note  
10 that population and overcrowding were indeed decreasing as ordered by the three-judge  
11 panel. However, in its brief recently filed with the three-judge court, the State attempts to  
12 cite our recognition of the State’s prior compliance with Court orders and our silence  
regarding particular problems caused by overcrowding as an endorsement of the State’s  
position that further compliance with the overcrowding order is unnecessary. That  
distorts the content of our reports and misrepresents the Receiver’s position.

13 (Dkt. #2525 p. 35.) Since the State chose, without the Receiver’s permission, to conscript him  
14 into the service of the State’s own advocacy before the three-judge court, the Receiver had little  
15 choice but to speak up, lest his silence truly be construed as assent.

16 Second, the Receiver believed that it was essential to remind the State that whether  
17 constitutional care in the prisons is being delivered has yet to be determined, notwithstanding the  
18 many improvements which have been made under the Receiver’s watch. Defendants seem to  
19 have confused their own view of the current impact of overcrowding on the delivery of medical  
20 care with judicially-established fact. Just because they believe overcrowding is no longer an  
21 impediment to constitutional care does not make it so. This Court has established a process by  
22 which the court experts will assess the care being delivered in the prisons and report their  
23 findings. Then the Court will decide. That process has only recently gotten under way.

24 While it is undeniable that the audits regarding delivery of care which have been  
25 performed by the Office of Inspector General (“OIG”) have shown marked improvement in the  
26 care prisoners are receiving, it is equally undeniable that this Court has decided that it will not  
27 rely on the OIG reports alone. Last year, during the meet and confer process leading up to this  
28 Court’s order pertaining to how the Receivership and the *Plata* case would be terminated, the

1 State made its pitch that the Court should rely exclusively on the OIG reports in deciding whether  
2 a particular institution was delivering care at or above the constitutional minimum. The Court  
3 rejected that suggestion and chose instead to rely most heavily upon the reports to be submitted  
4 by the court experts. Accordingly, unless and until the experts provide the Court with their  
5 opinion that constitutional care is being delivered system-wide, “there is,” as the Receiver stated,  
6 “no persuasive evidence that a constitutional level of medical care has been achieved system-  
7 wide” at the current population density. Given the centrality of the, as yet unreported, court  
8 experts’ opinions as to whether constitutional care is currently being delivered, the State’s  
9 continued touting of the OIG scores as the measure to “prove” that overcrowding is no longer an  
10 impediment to such care is puzzling to say the least. The Receiver could not let Defendants’  
11 statements go un rebutted.

12 Third, Defendants apparently misconceive the purpose of the Receiver’s reports. In its  
13 Order Appointing Receiver (“OAR”), dated February 14, 2006, this Court required the Receiver  
14 to file periodic reports. Among the items on which the Receiver must report are “particular  
15 problems being faced by the Receiver, including any specific obstacles presented by institutions  
16 or individuals.” (OAR, ¶I.D.) Like a Special Master or compliance monitor, the Receiver  
17 functions as the “eyes and ears” of the Court during the remedial phase of the *Plata* litigation.  
18 (See *Madrid v. Woodford*, 2004 U.S. Dist. LEXIS 11561, \*29-\*30 (N.D. Cal., June 24, 2004);  
19 *Diaz v. San Jose Unified Sch. Dist.*, 633 F. Supp. 808, 824 (N.D. Cal. 1985); *Palmigiano v.*  
20 *Garrahy*, 443 F. Supp. 956, 986 (D.R.I. 1977). The Receiver is not an advocate. To the  
21 contrary, he has an obligation, as an agent of the Court, to bring to the Court’s attention his  
22 observations and candid assessment of circumstances which may make implementation of  
23 remedial measures more difficult. Consistent with his charge, and based upon his expertise and  
24 his experience over the last five years as the Court’s officer, the Receiver believes that  
25 overcrowding continues to interfere with the delivery of care, and he has discussed in some detail  
26 in the 22<sup>nd</sup> Report why he holds that belief. It was particularly important for him to stress his  
27 opinion since Defendants had chosen to use the Receiver’s recent silence on the subject as  
28 “evidence” to corroborate their view of the facts. As it turns out, Defendants misread the

1 Receiver's position on the overcrowding issue. Defendants may disagree with the Receiver's  
2 assessment – and they will have an opportunity to try and convince this and the three-judge  
3 courts that overcrowding is no longer the primary cause of unconstitutional care – but that is not  
4 a basis upon which this Court should disregard and *strike* the Receiver's considered opinions.

5 Finally, the Receiver's conclusion that overcrowding remains a barrier to the delivery of  
6 quality care is supported by unmistakably clear data. For almost three years now, the Receiver's  
7 staff has been developing robust reporting measures that enable institution-level performance  
8 tracking. This data is generally collected more frequently than OIG reviews, and reflects more  
9 diversity of information than that which underlies the OIG scores. In other words, the Receiver's  
10 internal data is generally more current and more comprehensive than the OIG scores.

11 The statewide Quality Management Committee (“QMC”) has recently been using a report  
12 based primarily upon information gathered and maintained in the ordinary course of business and  
13 then reported in the Receiver's monthly dashboard. Attached as Exhibit 1 to the Declaration of J.  
14 Clark Kelso, filed herewith, is the November 2012 version of the QMC report, entitled  
15 “Prioritizing Institutions for Performance Improvement & Targeted Support.” The QMC report,  
16 which was designed for management use and not for use in this litigation, has been organized by  
17 the QMC to help the Receiver and his staff prioritize institutions for performance improvement  
18 and targeted support. As shown on the report, each institution is rated based on a list categories  
19 including, “Scheduling and Access,” High Risk Care Management” and “Medication  
20 Management,” among others. Each institution is ranked on how well it has performed with  
21 respect to each individual category and then the institutions are ranked by their respective overall  
22 scores. The top third in each category are identified in green, the middle third in yellow and the  
23 bottom third in red. The bottom six institutions in the bottom third are separately identified as  
24 well.

25 Attached as Exhibit 2 to the Kelso Declaration is a copy of the “Weekly Report of  
26 Population,” as of midnight, November 7, 2013, issued by the Data Analysis Unit of the CDCR.  
27 Cross-referencing the QMC report to the Weekly Report of Population reveals that, for the time-  
28 period covered by the most recent QMC report (i.e., November 2012), the top one-third of the

1 institutions had an average population density of 134%, and the bottom two-thirds had an  
2 average population density of 154%. The bottom one-third of the institutions – the institutions  
3 which the Receiver’s QMC has determined have the greatest need for improvement – had an  
4 average population density of 155%. These numbers make it clear that overcrowding is still  
5 having a direct impact upon the ability to deliver quality health care.

6 **CONCLUSION**

7 Defendants’ objections to, and request to strike, the Receiver’s statements in the 22<sup>nd</sup>  
8 Report should be denied.

9 Dated: February 22, 2013

FUTTERMAN DUPREE DODD  
CROLEY MAIER LLP

11 By: /s/Martin H. Dodd  
12 Martin H. Dodd  
13 Attorneys for Receiver J. Clark Kelso

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11 MARCIANO PLATA, et al.,

12 *Plaintiffs,*

13 v.

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

15 *Defendants.*

Case No. C01-1351 TEH

**DECLARATION OF J. CLARK KELSO  
IN SUPPORT OF RECEIVER'S  
RESPONSE TO DEFENDANTS'  
OBJECTIONS TO RECEIVER'S 22<sup>ND</sup>  
REPORT**

16  
17  
18 I, J. Clark Kelso, declare as follows:

- 19 1. I am the Court-appointed Receiver in *Plata*, appointed pursuant to the *Plata* Court's  
20 Order, dated January 23, 2008. I have custody of the files pertaining to the Receivership  
21 and am familiar with the contents thereof. The facts set forth herein are based on my  
22 review of the Receivership records and documents which are a matter of public record as  
23 well as my own personal knowledge. If called as a witness, I could competently testify  
24 thereto.
- 25 2. In the 22<sup>nd</sup> Tri-Annual Report, I included a discussion of the continued impact of prison  
26 overcrowding on the delivery of medical health care. My conclusion that overcrowding  
27 remains a barrier to the delivery of quality care is supported by unmistakably clear data.  
28 For almost three years now, my staff has been developing robust reporting measures that

1 enable institution-level performance tracking. This data is generally collected more  
2 frequently than the reviews conducted by the Office of Inspector General (“OIG”), and  
3 reflects more diversity of information than that which underlies the OIG scores. In other  
4 words, this internal data is generally more current and more comprehensive than the OIG  
5 scores.

6 3. The statewide Quality Management Committee (“QMC”) has recently been using a report  
7 based primarily upon information gathered and maintained in the ordinary course of  
8 business and then reported in the Receiver’s monthly dashboard. Attached hereto as  
9 Exhibit 1 is a true and correct copy of the November 2012 version of the QMC report,  
10 entitled “Prioritizing Institutions for Performance Improvement & Targeted Support.”  
11 The QMC report, which was designed for management use and not for use in this  
12 litigation, has been organized by the QMC to help the Receiver and his staff prioritize  
13 institutions for performance improvement and targeted support. As shown on Exhibit 1,  
14 each institution is rated based on a list categories including, “Scheduling and Access,”  
15 High Risk Care Management” and “Medication Management,” among others. Each  
16 institution is ranked on how well it has performed with respect to each individual  
17 category and then the institutions are ranked by their respective overall scores. The top  
18 third in each category are identified in green, the middle third in yellow and the bottom  
19 third in red. The bottom six institution in the bottom third are separately identified as  
20 well.

21 4. Attached hereto as Exhibit 2 is a true and correct copy of the “Weekly Report of  
22 Population,” as of midnight, November 7, 2012, issued by the Data Analysis Unit of the  
23 CDCR. Cross-referencing the QMC report to the Weekly Report of Population reveals  
24 that, for the time-period covered by the most recent QMC report (i.e., November 2012),  
25 the top one-third of the institutions had an average population density of 134%, and the  
26 bottom two-thirds had an average population density of 154%. The bottom one-third of  
27 the institutions – the institutions which the Receiver’s QMC has determined have the  
28 greatest need for improvement – had an average population density of 155%. These

1 numbers make it clear that overcrowding is still having a direct impact upon the ability to  
2 deliver quality health care.

3 I declare under penalty of perjury under the laws of the United States of America that the  
4 foregoing is true and correct.

5 Dated: February 22, 2013

/s/ J. Clark Kelso  
J. Clark Kelso

6  
7 I hereby attest that I have on file all holograph signatures for any signatures indicated by a  
8 “conformed” signature (/s/) within this efiled document.

9  
10 /s/ Martin H. Dodd  
Martin H. Dodd  
11 Attorneys for Receiver J. Clark Kelso  
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**EXHIBIT 1**

## Prioritizing Institutions for Performance Improvement & Targeted Support

**Summary of Findings:**

**CMF\***, **COR** and **RJD\*** are institutions that 4 or more QMC members targeted for assistance. Objective performance measurement also places these institutions among the 6 institutions requiring the most performance improvement support. **SAC\***, **KVSP\***, **NKSP\***, **NSP** and **SVSP** were targeted for additional support by 2-3 QMC members, and their objective performance assessment places them in the bottom third of all institutions. **CMC\*** performs in the top half of all institutions based on objective performance measures, although 4 QMC members would like to target CMC for additional performance improvement support.

*\*Institution has completed draft or final PWP*

	ASP	CAL	CCC	CCI	CCWF	CEN	CIM	CIW	CMC	CMF	COR	CRC	CTF	CVSP	DVI	FSP	HDSP	ISP	KVSP	LAC	MCSP	NKSP	PBSP	PVSP	RJD	SAC	SATF	SCC	SOL	SQ	SVSP	VSP	WSP
<b>Overall</b>	14	3	1	9	23	7	22	20	15	31	30	8	16	4	17	2	12	5	28	25	19	27	11	13	32	33	29	6	17	20	26	10	24
Consistent Care Teams	15	17	24	20	25	23	11	29	22	17	19	2	4	4	30	8	28	9	27	26	6	32	1	14	31	15	12	7	2	13	9	33	20
Scheduling & Access	9	3	2	12	14	3	15	13	11	24	20	21	22	6	16	6	19	17	25	25	10	32	27	3	28	32	30	8	31	18	28	1	23
Population & Care Management	20	7	2	9	23	12	19	18	11	25	32	21	30	5	17	8	10	3	33	13	14	29	1	16	27	14	26	4	22	28	23	6	31
High Risk Care Management	16	1	1	20	11	1	18	30	25	33	27	14	10	1	15	1	17	6	22	26	28	9	23	12	29	32	24	8	7	13	31	21	19
Medication Management	20	10	1	11	24	3	16	22	21	33	25	14	9	5	12	6	18	1	13	15	27	7	7	23	29	32	18	4	31	29	27	26	17
Health Information Management	14	8	3	5	21	22	31	7	12	18	27	2	24	20	23	1	6	16	10	29	11	32	33	19	9	30	28	26	13	15	17	4	25
Resource Management	9	3	12	5	21	1	30	28	32	33	20	11	15	4	25	16	12	1	27	16	23	6	24	18	19	30	14	6	25	29	22	10	6
Other Patterns and Trends	31	5	1	22	25	7	20	8	5	15	25	4	31	12	12	1	17	10	21	17	33	27	9	27	30	22	29	3	19	10	12	16	24
Number of Times Selected by QMC Members for Assistance							1		4	5	5	1	1						2			2	1	1	4	2	1		2	2	3		

**Methodology Background**

Institution performance is stratified into three score groups as follows:



Institutions are sorted by the sum of their rankings in the following Primary Care Model domains based on the November 2012 Health Care Services Dashboard:

**Consistent Care Teams** : Primary Care Provider Continuity, Mental Health Primary Clinician Continuity, Psychiatrist Continuity and Cell Bed Changes.

**Scheduling & Access** : RN Episodic Care, PCP Episodic Care, PCP Chronic Care, Specialty Consultation, PCP Specialty Follow-up, PCP Hospital Follow-up, Mental Health Contact Intervals, Mental Health Referrals and Mental Health Level of Care Change Requests.

**Population & Care Management** : Prevention - Colorectal Cancer Screening and Breast Cancer Screening, Disease Management - Diabetes Care, Asthma Care, Therapeutic Anticoagulation, Potentially Avoidable Hospitalizations and Specialty Care Referrals.

**High Risk Care Management** : Mental Health High Utilizers

**Medication Management** : Access to Medications, %NF prescriptions by Medical Providers, %NF prescriptions by Mental Health Providers and Prescriptions dispensed per inmate per month.

**Health Information Management** : Percent of documents scanned within one business day.

**Resource Management** : Specialty Appointments via Telemedicine and Total Medical Costs per Inmate per month.

**Other Patterns and Trends** : Appeals Submitted and Approved per 1,000 inmates per month and Prison Population Capacity.

**EXHIBIT 2**

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

Department of Corrections and Rehabilitation  
 State of California  
 November 13, 2012

WEEKLY REPORT OF POPULATION  
 AS OF MIDNIGHT November 7, 2012

TOTAL CDCR POPULATION								
	FELON/ OTHER #1	CIVIL ADDICT	TOTAL	CHANGE SINCE 11/09/11		DESIGN CAPACITY	PERCENT OCCUPIED	STAFFED CAPACITY
				NO.	PCT.			
A. TOTAL IN-CUSTODY	<u>133,176</u>	<u>191</u>	<u>133,367</u>	<u>-21,891</u>	<u>-14.0</u>			
I. IN-STATE	124,641	191	124,832	-20,987	-14.3			
(MEN, Subtotal)	118,674	122	118,796	-18,091	-13.2			
(WOMEN, Subtotal)	5,967	69	6,036	-2,896	-32.4			
1. INSTITUTIONS/CAMPS	<u>123,683</u>	<u>183</u>	<u>123,866</u>	<u>-20,232</u>	<u>-14.0</u>	<u>84,130</u>	<u>147.2</u>	<u>123,365</u>
INSTITUTIONS	119,991	183	120,174	-19,867	-14.1	79,650	150.9	119,127
CAMPS(CCC, CIW & SCC)*	3,692		3,692	-365	-8.9	4,480	82.4	4,238
2. IN-STATE CONTRACT BEDS	<u>677</u>	<u>8</u>	<u>685</u>	<u>-809</u>	<u>-54.1</u>	<u>2,679</u>	<u>25.6</u>	
CCF PRIVATE	595		595	-8	-1.3	2,557	23.3	
PRISONER MOTHER PGM	16		16	-19	-54.2	47	34.0	
FRCCC(BAKERSFIELD)	64	8	72	+18	+33.3	75	96.0	
SRITA(SANTA RITA)**	2		2	-448	-99.5			
3. DMH STATE HOSPITALS	281		281	+54	+23.7			
II. OUT OF STATE(COCF)	<u>8,535</u>	<u>0</u>	<u>8,535</u>	<u>-904</u>	<u>-9.5</u>			
ARIZONA	4,411		4,411	-149	-3.2			
MISSISSIPPI	2,501		2,501	-72	-2.7			
OKLAHOMA	1,623		1,623	-683	-29.6			
B. PAROLE	<u>60,525</u>	<u>709</u>	<u>61,234</u>	<u>-43,078</u>	<u>-41.2</u>			
COMMUNITY SUP(Active)	57,995	709	58,704	-31,215	-34.7			
COOP CASES (Active) #3	1,626		1,626	+115	+7.6			
MNRP & NRP (Inactive)	904		904	-11,978	-92.9			
C. NON-CDC JURISDICTION #4	<u>1,248</u>	<u>0</u>	<u>1,248</u>	<u>-170</u>	<u>-11.9</u>			
OTHER STATE/FED. INST.	520		520	+11	+2.1			
OUT OF STATE PAROLE	544		544	-165	-23.2			
OUT OF STATE PAL	29		29	-11	-27.5			
CYA-W&IC 1731.5(c) INSTITUTIONS #5	155		155	-5	-3.1			
D. OTHER POPULATIONS #6	<u>11,382</u>	<u>91</u>	<u>11,473</u>	<u>-1,764</u>	<u>-13.3</u>			
INMATES								
OUT-TO-COURT, etc.	1,187	20	1,207	-545	-31.1			
ESCAPED	210		210	-5	-2.3			
PAROLEES (PAL/RAL)	9,985	71	10,056	-1,214	-10.7			
TOTAL CDCR POPULATION	<u>206,331</u>	<u>991</u>	<u>207,322</u>	<u>-66,903</u>	<u>-24.3</u>			
CHANGE FROM LAST WEEK								
A. TOTAL IN-CUSTODY	-45	-3	-48					
(MEN, Subtotal)	-63	-2	-65					
(WOMEN, Subtotal)	-14	-1	-15					
B. PAROLE	-597	-12	-609					
D. PAROLEES (PAL/RAL)	+41	+10	+51					

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 3,722. Base camp at CMC is included in institution counts.

\*\*Santa Rita count is in error. Data are being reviewed.

Report # TPOP-1W. Questions: (916) 323-3639.

WEEKLY INSTITUTION/CAMPS POPULATION DETAIL

MIDNIGHT November 7, 2012

INSTITUTIONS/CAMPS	FELON/ OTHER	CIVIL ADDICT	TOTAL	DESIGN CAPACITY	PERCENT OCCUPIED	STAFFED CAPACITY
MALE						
ASP (AVENAL SP)	5,041		5,041	2,920	172.6	4,481
CCC (CAL CORRECTL CTR)	4,589		4,589	3,883	118.2	4,718
CCI (CAL CORRECTL INSTITN)	4,602		4,602	2,783	165.4	4,337
CIM (CAL INSTITN FOR MEN)	4,787	4	4,791	2,976	161.0	4,505
CMF (CAL MEDICAL FACIL)	2,328		2,328	2,297	101.3	2,598
CMC (CAL MEN'S COLONY)	5,185		5,185	3,838	135.1	5,157
CRC (CAL REHAB CTR, MEN)	3,318	106	3,424	2,491	137.5	3,381
CAL (CAL SP, CALIPATRIA)	3,545		3,545	2,308	153.6	3,833
CEN (CAL SP, CENTINELA)	3,580		3,580	2,308	155.1	3,508
COR (CAL SP, CORCORAN)	4,715		4,715	3,116	151.3	4,619
LAC (CAL SP, LOS ANGELES CO)	3,803		3,803	2,300	165.3	3,866
SAC (CAL SP, SACRAMENTO)	2,559		2,559	1,828	140.0	2,743
SQ (CAL SP, SAN QUENTIN)	3,878		3,878	3,082	125.8	3,775
SOL (CAL SP, SOLANO)	4,267		4,267	2,610	163.5	4,050
SATF (CAL SATF AND SP - COR)	5,675	2	5,677	3,424	165.8	5,550
CVSP (CHUCKAWALLA VALLEY SP)	2,791		2,791	1,738	160.6	2,453
CTF (CORRL TRAING FAC)	5,829		5,829	3,312	176.0	5,480
DVI (DEUEL VOCATL INSTITN)	2,394	7	2,401	1,681	142.8	2,478
FOL (FOLSOM SP)	2,553		2,553	2,469	103.4	2,895
HDP (HIGH DESERT SP)	3,519		3,519	2,324	151.4	3,695
IRON (IRONWOOD SP)	3,477		3,477	2,200	158.0	3,300
KVSP (KERN VALLEY SP)	3,990		3,990	2,448	163.0	4,344
MCSP (MULE CREEK SP)	2,914		2,914	1,700	171.4	2,821
NKSP (NORTH KERN SP)	4,715	2	4,717	2,694	175.1	4,789
PBSP (PELICAN BAY SP)	3,043		3,043	2,380	127.9	3,143
PVSP (PLEASANT VALLEY SP)	3,675		3,675	2,308	159.2	3,558
RJD (RJ DONOVAN CORR FACIL)	3,481		3,481	2,200	158.2	3,340
SVSP (SALINAS VAL SP)	3,573		3,573	2,452	145.7	3,554
SCC (SIERRA CONSERV CTR)	4,546		4,546	3,736	121.7	4,601
VSPM (VALLEY SP MEN)	549		549	444	123.6	632
WSP (WASCO SP)	4,880	1	4,881	2,984	163.6	5,237
<b>MALE TOTAL:</b>	<b>117,801</b>	<b>122</b>	<b>117,923</b>	<b>78,790</b>	<b>149.7</b>	<b>117,441</b>
FEMALE						
CIW (CAL INST FOR WOMEN)	1,652	34	1,686	1,356	124.3	1,822
CCWF (CENT CAL WOMEN'S FACIL)	3,159	27	3,186	2,004	159.0	3,082
VSP (VALLEY SP)	1,071		1,071	1,536	69.7	1,020
<b>FEMALE TOTAL:</b>	<b>5,882</b>	<b>61</b>	<b>5,943</b>	<b>4,896</b>	<b>121.4</b>	<b>5,924</b>
<b>TOTAL:</b>	<b>123,683</b>	<b>183</b>	<b>123,866</b>	<b>84,130</b>	<b>147.2</b>	<b>123,365</b>

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

Department of Corrections and Rehabilitation  
State of California  
November 13, 2012

WEEKLY REPORT OF POPULATION  
NOTES  
AS OF MIDNIGHT November 7, 2012

- #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 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.