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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

MARCIANO PLATA, et al., *Plaintiffs*, v. EDMUND G. BROWN, JR., et al., *Defendants*.	Case No. C01-1351 TEH **RECEIVER'S RESPONSE TO DEFENDANTS' OBJECTIONS TO RECEIVER'S 22ND REPORT**

On January 25, 2013, the Receiver filed his 22nd Tri-Annual Report ("22nd Report"). Not quite three weeks later, on February 13, 2013, Defendants filed objections to two statements made by the Receiver in the 22nd Report, not merely objecting to those statements, but asking that they be stricken. (Dkt. # 2532.) On February 15, this Court requested that the Receiver file a response to Defendants' objections. (Dkt. # 2536.)

This constitutes the Receiver's response. As set forth below, the Court should overrule Defendants' objections and surely should not strike the Receiver's statements from the 22nd Report.

ARGUMENT

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

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

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

> So long as the State was meeting its court-ordered targets, there was no need in our reports last year to comment specifically on the effects of overcrowding other than to note that population and overcrowding were indeed decreasing as ordered by the three-judge panel. However, in its brief recently filed with the three-judge court, the State attempts to 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.

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

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

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

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

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

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

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

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

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

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

CONCLUSION

Defendants' objections to, and request to strike, the Receiver's statements in the 22nd Report should be denied.

Dated: February 22, 2013

FUTTERMAN DUPREE DODD CROLEY MAIER LLP

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

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

MARCIANO PLATA, et al.,

Plaintiffs,

v.

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

Defendants.

Case No. C01-1351 TEH

DECLARATION OF J. CLARK KELSO IN SUPPORT OF RECEIVER'S RESPONSE TO DEFENDANTS' OBJECTIONS TO RECEIVER'S 22ND REPORT

I, J. Clark Kelso, declare as follows:

1. I am the Court-appointed Receiver in *Plata*, appointed pursuant to the *Plata* Court's Order, dated January 23, 2008. I have custody of the files pertaining to the Receivership and am familiar with the contents thereof. The facts set forth herein are based on my review of the Receivership records and documents which are a matter of public record as well as my own personal knowledge. If called as a witness, I could competently testify thereto.

2. In the 22nd Tri-Annual Report, I included a discussion of the continued impact of prison overcrowding on the delivery of medical health care. My conclusion that overcrowding remains a barrier to the delivery of quality care is supported by unmistakably clear data. For almost three years now, my staff has been developing robust reporting measures that

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

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

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

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

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

Dated: February 22, 2013

/s/ J. Clark Kelso
J. Clark Kelso

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

/s/ Martin H. Dodd
Martin H. Dodd
Attorneys for Receiver J. Clark Kelso

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 suppor
SAC*, KVSP*, NKSP 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 institution
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 suppor*

**institution has completed draft or final PIWP*

	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
Overall	**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**
Results: 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
Results: 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
Results: 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**
Results: 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
Results: 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
Results: 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
Results: 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
Results: 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:

Top Third
Mid Third
Bottom Third
Bottom 6 of the Bottom Third

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 Helath Contact Intevals, 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 NO.	CHANGE SINCE 11/09/11 PCT.	DESIGN CAPACITY	PERCENT OCCUPIED	STAFFED CAPACITY
A. TOTAL IN-CUSTODY	133,176	191	133,367	-21,891	-14.0			
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	123,683	183	123,866	-20,232	-14.0	84,130	147.2	123,365
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	677	8	685	-809	-54.1	2,679	25.6	
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)	8,535	0	8,535	-904	-9.5			
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	60,525	709	61,234	-43,078	-41.2			
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	1,248	0	1,248	-170	-11.9			
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	11,382	91	11,473	-1,764	-13.3			
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	206,331	991	207,322	-66,903	-24.3			

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
MALE TOTAL:	117,801	122	117,923	78,790	149.7	117,441
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
FEMALE TOTAL:	5,882	61	5,943	4,896	121.4	5,924
TOTAL:	123,683	183	123,866	84,130	147.2	123,365

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 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.