

1 FUTTERMAN & DUPREE LLP  
MARTIN H. DODD (104363)  
2 160 Sansome Street, 17<sup>th</sup> Floor  
San Francisco, California 94104  
3 Telephone: (415) 399-3840  
Facsimile: (415) 399-3838  
4 martin@dfdlaw.com

5 *Attorneys for Receiver*  
Robert Sillen

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7 **UNITED STATES DISTRICT COURT**  
8 **FOR THE NORTHERN DISTRICT OF CALIFORNIA**  
9 **AND THE EASTERN DISTRICT OF CALIFORNIA**

10 MARCIANO PLATA, et al.,  
11 *Plaintiffs,*

12 v.

13 ARNOLD SCHWARZENEGGER, et al.,  
14 *Defendants.*

Case No. C01-1351 THE (N.D. Cal.)

**RECEIVER'S SUPPLEMENTAL  
REPORT RE OVERCROWDING**

15 RALPH COLEMAN, et al.,  
16 *Plaintiffs,*

17 v.

18 ARNOLD SCHWARZENEGGER, et al.,  
19 *Defendants.*

Case No. CIV S-90-0520 LKK JFM P  
(E.D. Cal.)

20  
21 Receiver Robert Sillen submits this Supplemental Report Re Overcrowding, and  
22 accompanying Declaration of John Hagar, in response to this Court's Orders, dated February 15,  
23 2007 and June 6, 2007.

24 **A. Summary Of Key Features Of The Receiver's Report Re Overcrowding.**

25 In his original Overcrowding Report, filed herein on May 14, 2007, the Receiver set forth  
26 in detail a history of the overcrowding crisis in California's prisons; described the manner in  
27 which overcrowding exacerbated the failings in the prison health care delivery system; and then  
28 discussed how overcrowding – and the State's inadequate and inconsistent responses to that

1 overcrowding – are currently interfering with the Receiver’s mission to bring the medical care  
2 delivery system up to constitutional standards.

3 In particular, the Receiver identified five “Crowding Related Obstacles” that were and are  
4 interfering substantively with his efforts to bring the prison health care system up to  
5 constitutional standards in a timely fashion.

- 6 1) Overcrowding is interfering with the Receiver’s ability to recruit, hire and retain  
7 competent medical personnel. The overwhelming number of prisoners needing care  
8 at the prisons, existing staffing shortages and inadequate clinical space are just a few  
9 of the consequences of overcrowding that make developing a competent medical staff  
10 a daunting challenge.
- 11 2) For many of these same reasons, overcrowding will make hiring competent  
12 managerial and executive staff more difficult.
- 13 3) One of the consequences of overcrowding has been extraordinary movement of  
14 prisoners between and among the prisons. A downstream effect of this movement is  
15 the need for many more correctional and clinical staff to manage reception center and  
16 inter-prison transportation procedures insofar as they relate to health care. That staff  
17 is currently lacking and, as a result, the rapidity of movement between prisons is  
18 continuing to create chaos in the health care system.
- 19 4) There is a dire need for additional clinical space and medical beds in the prisons  
20 because the existing capacity has been swamped by the number of inmates in the  
21 system. Until additional and adequate clinical space is constructed to accommodate  
22 the real needs of the prison population, the Receiver’s work will be made significantly  
23 more difficult.
- 24 5) The overcrowding crisis has also interfered with the Receiver’s ability to provide  
25 medical support services. Large numbers of prisoners needing care in outlying and  
26 remote areas often mean that CDCR must contract out for services that can, and  
27 should, be provided internally. Looking outside the prisons is in turn stressing local  
28 community health care systems. Similarly, overcrowding means inadequate space for

1 programs such as telemedicine that, if properly used, could result in better care at less  
2 cost.

3 The Receiver also emphasized in his Report that overcrowding creates “procedural”  
4 obstacles to the work he and his staff are undertaking. He highlighted six areas to illustrate how  
5 the day-to-day work of the Receivership is hampered as a result of overcrowding.

- 6 1) The State has responded to overcrowding by attempting to transfer prisoners out of  
7 state. The Receiver has endeavored to cooperate with this process. But, because of  
8 litigation, the passage of AB 900 and other factors, the transfers have started, and  
9 stopped, and started again, resulting in inefficiencies and frustration.
- 10 2) The State has responded to overcrowding by so-called “mission changes” and “yard  
11 flips” which result in large numbers of prisoners and different classes of prisoners  
12 being moved between prisons. Staff resources that the Receiver could allocate  
13 elsewhere are being consumed by the need to monitor and respond to mission changes  
14 and yard flips.
- 15 3) Overcrowding has resulted in increasing numbers of prisoner disturbances and  
16 “lockdowns” by prison authorities in response. Because of the heightened security  
17 measures associated with lockdowns, medical care to the inmates is delayed and made  
18 substantially more time-consuming and cumbersome.
- 19 4) The risk of communicable disease outbreaks in the prisons, as well as their  
20 transference to local communities is increased substantially by overcrowding and the  
21 attendant rapid movement of prisoners between prisons. The Receiver must devote  
22 significant staff resources to protecting against the possibility of disease outbreaks in  
23 such circumstances.
- 24 5) The extent of overcrowding in the prisons means that the entire health care system –  
25 medical, dental and mental health – is increasingly burdened. Because of staffing  
26 shortages and the overwhelming number of prisoners needing care, prison staff often  
27 must decide with which set of class action remedial orders they will comply at the  
28 expense of others. That creates inevitable crises and tensions all their own that must

1 require Receivership resources to address.

2 6) Related to the foregoing, the inadequacies in the health care system have resulted in  
3 tension and competition between the various providers over resources, space, beds  
4 and the like. Although the Receiver, special master in *Coleman* and court  
5 representatives in *Perez* and *Armstrong* are meeting regularly in an effort to  
6 coordinate their respective functions, overcrowding creates additional burdens on an  
7 already stressed system.

8 The Receiver concluded his Report by recommending that the Court enter three specific  
9 orders: (1) require the CDCR to file a report in 15 days, with supporting documentation and a  
10 brief executive summary, setting forth the CDCR's plan with respect to the "infill" project,  
11 particularly as it relates to the construction of additional clinical and non-clinical space; (2) issue  
12 an Order to Show Cause why the Receiver should not assume direct oversight of the correctional  
13 officer recruitment and hiring program and require the CDCR to respond in 15 days; and, (3)  
14 require the Governor to create a Plan of Action to address the serious correctional problems  
15 endemic to the CDCR.

16 **B. Recent Developments Further Illustrate The Substantive And Procedural Burdens**  
17 **On The Receivership Caused By Overcrowding.**

18 The consequences of severe overcrowding in the prisons, including specifically the  
19 CDCR's disorganized response to overcrowding, have continued to divert the Receiver's  
20 resources from his primary task of building a constitutionally adequate health care system. As a  
21 result, the Receiver concluded that he should bring to the Court's attention additional  
22 information that has arisen since the filing of the Receiver's Report and that further illustrates the  
23 impact of overcrowding on his remedial plans. That information is set forth in detail in the  
24 Declaration of John Hagar ("Hagar Decl."), filed herewith, and is summarized below.

25 1. **The "Mission Change" at California Rehabilitation Center ("CRC") Norco**  
26 **To An All Male Level II Prison.**

27 CRC consists primarily of wooden barracks and support buildings constructed prior to  
28 World War II. Until recently, CRC provided rehabilitation services to male and female drug

1 offenders. In April, 2007, the CDCR announced that CRC would transfer its female population  
2 and, thereafter, would house only male offenders. *See* Exh. 1 to Hagar Decl.<sup>1</sup> According to  
3 CDCR, more than 600 female prisoners will be removed from CRC by June 28, 2008. An  
4 unspecified number will be sent to Community Correctional Facilities (“CCFs”) and the  
5 remainder will be placed into “ugly beds” (day room floors, hallways, and gyms) at the California  
6 Institute for Women (“CIW”), California Central Women Facility (“CCWF”), and Valley State  
7 Prison for Women (“VSPW”).

8 Although the CDCR planned these transfers as early as February 2007 and understood  
9 that the Receiver’s approval and support would be required before the transfers could be  
10 accomplished (Exh. 2), the Receiver was not given sufficient notice of the contemplated changes  
11 to permit him to provide substantive input on the impact that the changes would have on the  
12 delivery of health care. In fact, specific information about the conversion was first provided to  
13 the Receiver’s staff at a meeting on May 24, 2007. By that time, the movement of hundreds of  
14 female prisoners from CRC had already begun.

15 The conversion could have adverse impacts on the delivery of health care at CRC. The  
16 clinical space at CRC is already woefully inadequate and structurally unsound. For example, a  
17 new digital x-ray machine purchased by CDCR cannot be installed due to the fact that the  
18 flooring at CRC cannot bear its weight. Any additional medical demands at the facility as a  
19 result of the influx of Level II inmates may swamp an already stressed health care delivery  
20 system. Despite the significant changes contemplated at CRC, CDCR officials have indicated  
21 that no provision has been, or will be, made to improve or increase clinical areas at CRC.<sup>2</sup>

22 Nor have the Receiver and his staff had adequate time to evaluate the impact on health

23 <sup>1</sup> Unless otherwise indicated, all Exhibit references are to the exhibits attached to Mr. Hagar’s declaration.

24 <sup>2</sup> The Receiver’s staff managed to head off a disaster in the making as a result of the conversion at CRC. Several  
25 years ago, CRC was approved for a dormitory replacement project. The plans called for the construction of new  
26 200-bed dormitories, each of which was to replace two older wooden dormitories. The first of the new dormitories is  
27 scheduled to be operational in September 2007, the second in March 2008. However, at the meeting on May 24,  
28 CDCR officials suggested that the 200-bed dormitories might be “*additional*” beds and *not* replacement beds. Using  
the new dormitories as additional beds would have meant that CRC exceeded AB 900 projections and would have  
meant 400 new prisoners within a very short time. The health care delivery system at the prison could not withstand  
such an onslaught. The Receiver’s staff raised this urgent issue with State officials and, fortunately, on June 6, 2007  
CDCR officials informed the Receiver that the new dorms at CRC will be replacement beds only and not addition  
housing.

1 care delivery at the receiving prisons as a result of the mass transfers of women prisoners from  
2 CRC. Undoubtedly, the changes will have significant, negative consequences at the receiving  
3 prisons. For example, VSPW is already at a crisis stage insofar as efforts to provide medical care  
4 are concerned. An influx of new prisoners because of the conversion at CRC may well cause the  
5 medical delivery system at VSPW to collapse entirely. As Dwight Winslow, Statewide Medical  
6 Director at DCHCS wrote in an e-mail to the Receiver, dated May 24, 2007:

7 . . . I got a call from [sic] Dawn Martin at VSPW this am and they are being  
8 overwhelmed with the influx of inmates and custody has closed down some of the  
9 off site transportation which is now causing a delay in care. She stated that they  
were at 200% of capacity and that there were inmates on the floors. She does not  
know how she is going to deliver care to these inmates.

10 Exh. 3.

11 The conversion at CRC will also result in potentially negative impacts on the delivery of  
12 mental health care in the receiving prisons. CRC is currently approved to house 299 CCCMS  
13 female mental health inmates. These CCCMS patients already have been, or soon will be,  
14 transferred to CIW, CCWF, or VSPW. However, each of these receiving prisons is already  
15 overcrowded with CCCMS patients. As of May 25, 2007, for example, (i) CCWF was operating  
16 at 132% of its CCCMS capacity, its Reception Center was operating at 145% of its CCCMS  
17 capacity, and its Administrative Segregation Unit housed 24 CCCMS patients; (ii) CIW was  
18 operating at 101% of its CCCMS capacity, its Reception Center was operating at 75% of its  
19 capacity and its Administrative Segregation Unit housed 89 CCCMS; and, (iii) VSPW was  
20 operating at 154% of its CCCMS capacity, its Reception Center was operating at 129% of its  
21 CCCMS capacity, its Administrative Segregation Unit held 15 CCCMS inmates and its Security  
22 Housing Unit housed another 32. *See* Exh. 4. In light of the existing overcrowding at these  
23 facilities, the influx of still more prisoners to these facilities may strain the system to the breaking  
24 point.

25 **2. Conversion Of The Sierra Conservation Center ("SCC") Level III facility To**  
26 **A Level III Sensitive Needs Yard ("SNY").**

27 On May 2, 2007, CDCR proposed that SCC be converted from a General Population  
28 Level III prison to a Level III SNY. Apparently, the reason for this mission change is the backlog

1 of Level III SNY inmates in reception centers and Administrative Segregation Units.

2 The Level III facility at SCC is known as "Tuolumne." As of May 16, 2007, it housed  
3 1,192 inmates. Because its design capacity is only 500 inmates, as of May 16, it was at 238.4%  
4 of capacity and thus very seriously overcrowded. There were 49 CCCMS inmates housed in the  
5 Administrative Segregation Unit in the Tuolumne facility, as well as an unknown number of  
6 general population CCCMS inmates. The tentative start date to begin moving inmates from SCC  
7 is June 25, 2007. *See* Exh. 5, p. 5.

8 The conversion at SCC will require the movement of more than one thousand inmates  
9 from SCC and the arrival of more than one thousand inmates into SCC. Each of these 2,000  
10 inmate movements will require Nursing Services to conduct an inmate evaluation or screening.  
11 The burden on the health care delivery system will, therefore, be extreme.

12 It is also important to underscore that the mission changes contemplated at SCC (and  
13 elsewhere) have real-life consequences for the affected inmates. The Receiver has received an  
14 outpouring of letters from inmates who believe that they have benefited greatly from the  
15 rehabilitation programs at SCC and who are now fearful that they will be sent to facilities that  
16 lack the same kind and quality of programming. *See* Exh. 12.

17 **3. Problems With the Delivery of Medical Care in CCFs.**

18 Both AB 900 and the CRC conversion contemplate the placement of additional prisoners  
19 into community beds. In anticipation of these changes, the Office of the Receiver has undertaken  
20 to investigate the adequacy of medical care at CCFs and has found serious problems.

21 For example, after receiving telephone complaints about conditions at the McFarland  
22 Community Correctional Facility ("MCCF"), the Receiver ordered an unannounced inspection by  
23 a team of nurses and a physician. The report from that visit, prepared by Director of Nursing  
24 Operations Jackie Clark, raises a number of serious questions about not only patient care, but  
25 also fundamental questions of responsibility, authority, policy, and monitoring. *See* Exh. 6 to  
26 Hagar Decl. Just a few of her observations and conclusions are set forth below:

27 1. . . . There are no on-site clinical staff to identify and respond to emergency  
28 medical issues from 8:00 p.m. to 8:00 a.m. seven days a week.

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1  
2 4. There is no physician backup or oversight for the [nurse practitioner].  
3 This factor and the clinical competency issues of the NP has [sic] resulted in the  
4 mismanagement of inmates medical problems.

5 5. Record keeping by [the private prison operator] staff is incomplete. There  
6 is no tracking system in place to track and follow[] chronic patients. There is no  
7 tracking system in place that tracks the inmates being sent out for medical (routine  
8 or emergent).

9 6. The arrangement with [North Kern State Prison] for emergency transfer of  
10 patients after hours is not adequate. There have been unnecessary and dangerous  
11 delays concerning the transfer of inmates who required urgent medical care.

12 Exh. 6, pp. 3-4.

13 The problems at MCCF are not unique. For example, in April 2007, the Facility Director  
14 of the Claremont Custody Center ("CCC") wrote a five-page, single spaced letter to Terry  
15 Dickinson, Correctional Administrator-Support Services at CDCR, to voice detailed concerns  
16 regarding various medical issues, including: (i) managing an influenza outbreak that spread from  
17 inmates to staff; (ii) the "10 inmates per week" limit on referring CCC patients to CDCR for  
18 medical or dental needs, regardless of the population at CCC or the seriousness of the medical or  
19 dental problem; (iii) the denial of funding to hire needed registered nurses; (iv) the expensive  
20 practice of sending CCC inmates to local hospitals via ambulance instead of transferring  
21 prisoners to Pleasant Valley State Prison ("PVSP"); (v) the waste of taxpayer funds concerning  
22 delayed officer transports; and (vi) the overall scope of practice necessary to deliver adequate  
23 care to CCC prisoners. *See generally* Exh. 7. Indeed, the available evidence indicates that these  
24 and other problems in the medical delivery system within the CCC system are of longstanding.<sup>3</sup>

25 Mr. Dickinson's one-and-a-half page response to the CCC Facility Director's letter is  
26 worthy of lengthy quotation for what it reveals about the bureaucracy and inaction characteristic  
27 of the CDCR medical delivery system.<sup>4</sup> He writes:

28 This is in response to your letter to me dated April 10, 2007, in which you express  
concerns for medical needs for inmates and staff and request additional Registered  
Nurses at the Claremont Custody Center (CCC).

<sup>3</sup>See, e.g., Exh. 9 (E-mail from Assoc. Warden in Nov. 2006, stating that CCC "is no where close to being in compliance with Plata guidelines or timeframes.") See also Exhs. 10 and 11.

<sup>4</sup>The Receiver is not criticizing Mr. Dickinson. Instead, the Receiver focuses on the response because it provides a window into the CDCR/State's "trained incapacity."



1 . . . . As you know, the CCC and all other Community Correctional Facilities  
2 (CCF) have limited capabilities regarding medical and dental treatment for  
3 inmates. . . . When it is determined . . . that an inmate medical problem exists that  
4 cannot be managed in a CCF, the contractor is required to contact the HCM/CMO  
5 or Medical Officer of the Day (MOD) at PVSP for direction. The  
6 HCM/CMO/MOD will decide the course of medical treatment for the inmate. . . .  
7 The Community Correctional Facilities Administration (CCFA) cannot determine  
8 or authorize the medical/dental treatment of inmates at CCC or any other CCF. . .

9 The CCFA has submitted the past two years a Budget Concept Statement (BCS)  
10 requesting the Department require 24-hour, Registered Nurse (RN) coverage at  
11 each CCF/MCCF. . . . Unfortunately, we have not received funding authority for  
12 RN positions.

13 It is recommended that you directly contact [the HCM or CMO] at PVSP to  
14 express your concerns for TB testing, Influenza vaccinations and inmate medical  
15 treatment for inmates at CCC. If we receive further information on converting  
16 your LVN's to RN's 24 hours a day, we will let you know. . . . Thank you for  
17 bringing up your concerns and feel free to contact me if you have any questions. . .

18 Exh. 8.

19 The net outcome of this perfectly bland response is that absolutely nothing changes –  
20 requests for staffing, improved transportation, improved communication, etc. are at best referred  
21 elsewhere and, at worst, ignored altogether. It is also worth noting that none of the  
22 documentation reflecting the longstanding problems in the CCFs has been shared with the  
23 Receiver's Office by CDCR. It is quite possible that the private contractors providing services to  
24 the CCFs have never even been notified by CDCR that their medical functions were put into  
25 receivership more than one year ago.

26 After an initial review, the Receiver has concluded that significant changes will be  
27 needed to bring the delivery of medical care at CCFs up to constitutional standards.  
28 Accomplishing this objective will require very basic and far reaching structural changes with  
respect to how CCFA manages medical problems. At this point, until basic health care services  
are provided in CCFs, the establishment of yet more CCFs may well jeopardize the medical  
health of all prisoners assigned to community correctional facilities.

### CONCLUSION

As discussed above, from what the Office of the Receiver has learned about the mission  
changes at CRC and SCC, CDCR's efforts to manage the overcrowding problem (i) has created  
hundreds of additional "ugly beds" for female prisoners; (ii) will exacerbate existing

1 inadequacies in the health care delivery system, while threatening to cause still others; and, (iii)  
2 until basic health care services are brought up to constitutional standards in CCFs generally, the  
3 establishment of still more CCFs in response to overcrowding may jeopardize the health of all  
4 prisoners housed in such facilities. Mission changes, yard flips, and prison-to-prison transfers,  
5 aggravated by the limited alternatives imposed by overcrowding, are now assuming a size, scope  
6 and frequency that will clearly extend the timeframes and costs of the receivership and may  
7 render adequate medical care impossible, especially for patients who require longer term chronic  
8 care.

9 Dated: June 11, 2007

FUTTERMAN & DUPREE, LLP

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By \_\_\_\_\_/s/\_\_\_\_\_  
Martin H. Dodd  
Attorneys for Receiver Robert Sillen

**CERTIFICATE OF SERVICE**

The undersigned hereby certifies as follows:

I am an employee of the law firm of Futterman & Dupree LLP, 160 Sansome Street, 17<sup>th</sup> Floor, San Francisco, CA 94104. I am over the age of 18 and not a party to the within action.

I am readily familiar with the business practice of Futterman & Dupree, LLP for the collection and processing of correspondence.

On June 11, 2007, I served a copy of the following document(s):

**RECEIVER'S SUPPLEMENTAL REPORT RE OVERCROWDING**

by placing true copies thereof enclosed in sealed envelopes, for collection and service pursuant to the ordinary business practice of this office in the manner and/or manners described below to each of the parties herein and addressed as follows:

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**NORTHERN DISTRICT SERVICE LIST:**

Andrea Lynn Hoch  
Legal Affairs Secretary  
Office of the Governor  
Capitol Building  
Sacramento, CA 95814

Robin Dezember  
Director (A)  
Division of Correctional  
Health Care Services  
CDCR  
P.O. Box 942883  
Sacramento, CA 94283-0001

Bruce Slavin  
General Counsel  
CDCR - Office of the Secretary  
P.O. Box 942883  
Sacramento, CA 94283-0001

Kathleen Keeshen  
Legal Affairs Division  
California Department of Corrections  
P.O. Box 942883  
Sacramento, CA 94283

- |    |  |   |
|----|--|---|
| 1  | Richard J. Chivaro<br>John Chen  | Molly Arnold<br>Chief Counsel, Dept. of Finance                   |
| 2  | State Controller<br>300 Capitol Mall, Suite 518                                  | State Capitol, Room 1145  |
| 3  | Sacramento, CA 95814   | Sacramento, CA 95814  |
| 4  | Laurie Giberson<br>Staff Counsel   | Matthew Cate<br>Inspector General                                 |
| 5  | Department of General Services<br>707 Third St., 7 <sup>th</sup> Fl., Ste. 7-330 | Office of the Inspector General<br>P.O. Box 348780                |
| 6  | West Sacramento, CA 95605  | Sacramento, CA 95834-8780   |
| 7  | Donna Neville<br>Senior Staff Counsel  | Warren C. (Curt) Stracener<br>Paul M. Starkey                     |
| 8  | Bureau of State Audits<br>555 Capitol Mall, Suite 300                            | Labor Relations Counsel<br>Department of Personnel Administration |
| 9  | Sacramento, CA 95814   | Legal Division<br>1515 "S" St., North Building, Ste. 400          |
| 10 |  | Sacramento, CA 95814-7243   |
| 11 | Gary Robinson<br>Executive Director  | Yvonne Walker<br>Vice President for Bargaining                    |
| 12 | UAPD<br>1330 Broadway Blvd., Ste. 730  | CSEA<br>1108 "O" Street   |
| 13 | Oakland, CA 94612  | Sacramento, CA 95814  |
| 14 | Pam Manwiller<br>Director of State Programs                                      | Richard Tatum<br>CSSO State President                             |
| 15 | AFSME<br>555 Capitol Mall, Suite 1225  | CSSO<br>1461 Ullrey Avenue  |
| 16 | Sacramento, CA 95814   | Escalon, CA 95320   |
| 17 | Tim Behrens<br>President   | Elise Rose<br>Counsel   |
| 18 | Association of California State Supervisors<br>1108 "O" Street                   | State Personnel Board<br>801 Capital Mall                         |
| 19 | Sacramento, CA 95814   | Sacramento, CA 95814  |
| 20 | Stuart Drown<br>Executive Director   | Michael Bien<br>Rosen, Bien & Asaro                               |
| 21 | Little Hoover Commission<br>925 L Street, Suite 805                              | 155 Montgomery Street, 8 <sup>th</sup> Floor                      |
| 22 | Sacramento, CA 95814   | San Francisco, CA 94104   |
| 23 | Rochelle East<br>Deputy Attorney General   | J. Michael Keating, Jr.<br>285 Terrace Avenue                     |
| 24 | 455 Golden Gate Avenue<br>Suite 11000  | Riverside, RI 02915   |
| 25 | San Francisco, CA 94102-7004   |   |
| 26 |  |   |
| 27 |  |   |
| 28 |  |   |

1 California State Personnel Board  
Office of the Attorney General  
2 1515 Clay Street, 20<sup>th</sup> Floor  
P.O. Box 70550  
3 Oakland, CA 94612-0550

4 **EASTERN DISTRICT SERVICE LIST:**

5 California Psychiatric Association  
6 445 S. Figueroa St., 31<sup>st</sup> Floor  
Los Angeles, Ca 90071-1602


Union of American Physicians and Dentists  
595 Market Street, Suite 1400  
San Francisco, CA 94105

7 SEIU Local 1000  
8 1808 14<sup>th</sup> Street, Building 1  
P.O. Box 160005  
9 Sacramento, CA 95816

Matthew A. Lopes, Jr.  
Holland & Knight LLP  
One Financial Plaza, 18<sup>th</sup> Floor  
Providence, RI 02903

10 Psychology Shield  
Theodora Oringer Miller & Richman PC  
11 2029 Century Park East, 6<sup>th</sup> Floor  
Los Angeles, CA 90067

12  
13 Dated: June 11, 2007

  
Lori Dotson

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15  
16  
17  
18  
19  
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23  
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