OFFICE OF THE INSPECTOR GENERAL

BUREAU OF AUDITS AND INVESTIGATIONS

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INTRODUCTION

The Office of the Inspector General investigates and audits the California Department of Corrections and Rehabilitation to uncover criminal conduct, administrative wrongdoing, poor management practices, waste, fraud, and other abuses. This quarterly report summarizes the audit and investigation activities of the Office of the Inspector General for the period April 1, 2006 through June 30, 2006. The report satisfies the provisions of California Penal Code sections 6129(c)(2) and 6131(c), which require the Inspector General to publish a quarterly summary of investigations completed during the reporting period, including the conduct investigated and any discipline recommended and imposed. To provide a more complete overview of the Inspector General's activities and findings, this report also summarizes audits, special reviews, and warden candidate evaluations conducted by the office during the second quarter of 2006. All of the activities reported were carried out under California Penal Code section 6125 *et seq.,* which assigns the Office of the Inspector General responsibility for independent oversight of the California Department of Corrections and Rehabilitation.

EVALUATION OF WARDEN CANDIDATES

With the enactment of Senate Bill 737, which took effect on July 1, 2005, the Legislature assigned the Inspector General responsibility for evaluating the qualifications of every candidate nominated by the Governor for appointment as a state prison warden and to advise the Governor within 90 days whether the candidate is "exceptionally well qualified," "well qualified," "qualified," or "not qualified" for the position. To make the evaluation, California Penal Code section 6126.6 requires the Inspector General to consider, among other factors, the candidate's experience in effectively managing correctional facilities and inmate populations; knowledge of correctional best practices; and ability to deal with employees and the public, inmates, and other interested parties in a fair, effective, and professional manner. Under California Penal Code section 6126.6(e), all communications pertaining to the Inspector General's evaluation of warden candidates are confidential and absolutely privileged from disclosure.

During the second quarter of 2006, the Office of the Inspector General evaluated the qualifications of three candidates for warden and reported the results of the evaluations to the Governor in confidence.

SUMMARY OF AUDIT AND REVIEW ACTIVITIES

The Office of the Inspector General completed the largest audit in its history during the second quarter of 2006. The audit is summarized below.

Accountability Audit: Review of Audits of the California Department of Corrections and Rehabilitation Adult Operations and Adult Programs (2000-2004). In April 2006, the Office of the Inspector General issued a 363-page audit of the progress made by the California Department of Corrections and Rehabilitation in implementing past recommendations affecting the department's adult operations and programs. The recommendations resulted from 22 audits and reviews conducted by the Office of the Inspector General between 2000 and 2004. The full text of the audit can be viewed by clicking on the following links to the Inspector General's web site: Volume I: http://www.oig.ca.gov/reports/pdf/Accountability-Audit-CORR-Volume%20I.pdf
Volume II: http://www.oig.ca.gov/reports/pdf/Accountability-Audit-CORR-Volume%20II.pdf

The audit represents the third and final component of a comprehensive follow-up review of entities comprising the former California Department of Corrections (now the Adult Operations and Adult Programs in the reorganized California Department of Corrections and Rehabilitation). The first of the follow-up audits—a comprehensive follow-up of the former California Youth Authority (now the Division of Juvenile Justice)—was released in January 2005. The second of the follow-up audits—a follow-up of the Board of Prison Terms (now the Board of Parole Hearings)—was released in July 2005.

The audit revealed two broad findings. The first is that the staff and management of individual institutions have been highly responsive to recommendations resulting from past audits and reviews and have taken numerous steps to improve operations and security at the state's prisons. The second is that the department itself has been less

responsive to past recommendations and has yet to address three of its other most troubling and long-standing problems—the need to overhaul its antiquated information technology system; the need to provide inmates with adequate medical care in a fiscally sound manner; and the need to fulfill its broader public safety mission by better preparing inmates for release.

The accountability audit determined that of the 394 recommendations issued in the 22 previous audits and reviews, 241 (61 percent) have been fully implemented; 53 (14 percent) have been substantially implemented; 45 (11 percent) have been partially implemented; 39 (10 percent) have not been implemented; and 16 (4 percent) are no longer applicable. The Office of the Inspector General has issued 91 new recommendations to address the remaining deficiencies.

Following is a summary of the 2006 follow-up results of the 22 previous audits and reviews:

- **California Rehabilitation Center, Inmate Appeals Process**: Although the institution has improved its process for handling inmate appeals, it has not adequately addressed the timely transfer of inmate property when an inmate is transferred to another institution.

- **California State Prison, Sacramento**: The institution has substantially improved its financial management but still needs improvement in tracking the entry and departure of institution staff and visitors, providing timely inmate dental examinations, and completing staff performance evaluations.

- **California State Prison, Solano**: The facility more closely monitors inmates' tuberculosis status, better manages sentence reduction credits, and has improved its management of inmates in administrative segregation and its placement of inmates taking psychotropic medications. The institution has only partially implemented recommendations to properly house inmates taking anti-convulsant medications, however, and has not taken steps to monitor its pharmacy inventory.

- **California Substance Abuse Treatment Facility and State Prison at Corcoran**: The facility has developed the needed improvements to policies and procedures affecting medical services but has not implemented numerous recommendations from the January 2003 audit. Treatment at the institution is frequently interrupted for various reasons and many deficiencies in medical care services continue. Although the institution has made significant improvement in its pharmacy operations, the Department of Corrections and Rehabilitation has not made a significant effort to develop an automated pharmaceuticals inventory system across its institutions. Also, the Office of Substance Abuse Programs continues to fail to effectively monitor its contracts with the private providers of substance abuse program services at the institution.

- **Correctional Facility Mail Processing**: The prior departmental administration delayed the implementation of the recommendations from the July 2002 review by

neglecting to provide direction to the institutions on implementing the needed improvements to mail processing. It was only after the Office of the Inspector General's follow-up audit that instructions and guidelines were issued to the institutions.

- **Deuel Vocational Institution, Inmate Appeals Process**: The institution has improved its inmate appeals process by upgrading the software used for the inmate appeals tracking system and has begun including informal-level inmate appeals in the tracking system.

- **Education Programs at Level IV Institutions**: The department has made progress in developing alternative education programs for Level IV inmates but has not developed an effective monitoring system to ensure that institutions are complying with its education policies and procedures.

- **Employee Disciplinary Process**: The department has improved its employee disciplinary process and has fully or substantially implemented all previous recommendations.

- **High Desert State Prison**: The institution has addressed most of the recommendations from the November 2001 audit that were under its control, including institution programs and health care programs. The Department of Corrections and Rehabilitation, however, has made minimal progress in performing security modifications, including installing security cameras on the main yards and pursuing additional release allowance funding for inmates paroling from rural areas.

- **Inmate Appeals Branch**: The Inmate Appeals Branch has made efforts to enhance its inmate appeals tracking system to integrate appeals at the third-level review but other department priorities have hampered its efforts.

- **Konocti Conservation Camp Number 27**: The department has clarified rules and procedures governing the use of inmate labor for conservation camp work projects, has improved accountability over reimbursements for work projects, and has instituted limits on reimbursement amounts.

- **Leo Chesney Community Correctional Facility**: The facility has fully implemented most of the recommendations from the 2001 audit but the Department of Corrections and Rehabilitation has not addressed deficiencies identified in the audit relating to the need for written policies governing investigations into alleged misconduct at community correctional facilities by non-department employees.

- **Local Assistance Program**: The Parole and Community Services Division has made significant improvements in its oversight of the Local Assistance Program but still lacks the information technology needed to efficiently verify information on invoices submitted to reimburse local jurisdictions for services provided to state parolees.

- **Medical Contracting Process**: The department has implemented numerous changes to its medical contracting process but still needs to develop a more effective and efficient system for processing and monitoring medical services invoices.

- **Office of Compliance, Audit Functions**: Although the department has consolidated its audit functions into a single unit and elevated the chief of the unit to report directly to the undersecretary, it still has not corrected most of the deficiencies identified in the October 2002 review.

- **Office of Investigative Services**: While the department has reorganized and significantly improved its internal affairs operation, several deficiencies remain, including the lack of a system for prioritizing investigations; inadequacies in managing overtime use; inadequacies in completing employee background investigations; and failure to use the department's internal audits function to help identify pervasive problems.

- **Pharmaceutical Expenditures**: The department has made some progress in reducing its pharmaceutical expenditures but has only accomplished the preliminary steps required to replace its outdated management information system.

- **Prison Industry Authority Optical Program at the Richard J. Donovan Correctional Facility**: The recommendations made in May 2000 have been fully implemented and the optical laboratory program at the institution re-opened during August 2000.

- **Richard A. McGee Correctional Training Center**: The training center has significantly improved its cadet training program. Lesson plans for the now-expanded academy are complete and have been approved by the Commission on Correctional Peace Officer Standards and Training, now superseded by the Corrections Standards Authority.

- **Salinas Valley State Prison, Inmate Appeals and Disciplinary Process**: Although the institution has improved its inmate disciplinary process, it has not developed a corrective action plan to address the deficiencies in the disciplinary process identified in the September 2003 review. The disciplinary system procedures developed by the institution still fail to hold staff members accountable for the quality of their work.

- **Sierra Conservation Center**: The institution has successfully addressed nearly all of the deficiencies identified in the May 2001 management review audit, including enhancing the safety and security of its physical plant and improving procedures related to inmate appeals, the inmate disciplinary process, staff training, adverse personnel actions, employee grievances, equal employment opportunity complaints, and the reporting of inmate deaths.

- **Valley State Prison for Women**: The institution has improved employee morale and the timeliness and completion of important administrative processes. The institution remains deficient, however, in areas involving timeliness of employee performance

and probation reports, weapons qualification for armed staff, drug disposal, and drug interdiction training.

SUMMARY OF INVESTIGATIONS

The Office of the Inspector General receives about 300 complaints a month concerning the state correctional system. Most of the complaints arrive by mail or through the Inspector General's 24-hour toll-free telephone line. Others are brought to the attention of the Office of the Inspector General in the course of audits or related investigations. The Office of the Inspector General may also conduct investigations at the request of department officials in cases involving potential conflicts of interest or misconduct by high-level administrators.

The Inspector General's staff responds to each of the complaints and requests for investigation, with those involving urgent health and safety issues receiving priority attention. Most often the Inspector General's staff is able to resolve the complaints at a preliminary stage through informal inquiry by contacting the complainant and the institution or division involved and either establishing that the complaint is unwarranted or bringing about an informal remedy. Depending on the circumstances, the Office of the Inspector General may refer the case to the Department of Corrections and Rehabilitation's Office of Internal Affairs for investigation. Other complaints require further inquiry or full investigation by the Office of the Inspector General.

During the second quarter of 2006, the Office of the Inspector General completed four such investigations. Those cases are summarized in the table that follows. Cases referred to the Office of Internal Affairs are subject to monitoring by the Office of the Inspector General's Bureau of Independent Review. Such cases are not included in the quarterly report until the Office of Internal Affairs investigation is complete. The Bureau of Independent Review reports its monitoring activities semi-annually in a separate report.

Investigation	Result	Status
N. A. Chaderjian Youth Correctional Facility. The Office of the Inspector General received an allegation that a ward at the N. A. Chaderjian Youth Correctional Facility was not administered appropriate and adequate mental health services by the California Department of Corrections and Rehabilitation's Division of Juvenile Justice.	The Office of the Inspector General staff conducted an investigation at the N. A. Chaderjian Youth Correctional Facility that included a review of the ward's mental health treatment history and documentation of his access to mental health services. The Office of the Inspector General also interviewed the ward and facility staff. The Office of the Inspector General did not find that mental health services provided to this ward were inappropriate or inadequate.	The Office of the Inspector General has closed this investigation.
California Institution for Men. The Office of the Inspector General received information that a number of inmates arriving at Reception Center Central were being housed overnight in temporary holding cells. The concern was whether these inmates were being subjected to inhumane conditions because there were no beds or toilets in the holding cells.	The Office of the Inspector General conducted two unannounced site visits and confirmed that the California Institution for Men had been housing inmates in temporary holding cells overnight because it lacked bed space. That review revealed that Reception Center Central housed as many as 100 inmates in temporary holding cells overnight during May 2006 and that recent riots in the Los Angeles County jails, parole sweeps in Parole Region IV, and the lack of beds statewide for inmates with protective custody concerns had contributed to the overcrowding. Moreover, ongoing renovations to cells in Reception Center Central had created a temporary reduction in bed space, compounding the problem. While the Office of the Inspector General revealed some minor deficiencies related to the facility's holding cell operations, overall the institution had adapted well to the overcrowding and Reception Center Central staff were performing professionally. The	The Office of the Inspector General sent a letter concerning the findings to James Tilton, secretary, California Department of Corrections and Rehabilitation. The letter included several recommendations to address the findings.

Investigation	Result	Status
	inspection disclosed that inmates without beds spent only a short time in the holding cells, ranging from 14 to 72 hours. These inmates spent time daily outside the holding cells on the yards and, when retained overnight, received bedding and meals and had access to restrooms upon request. Inmates who were interviewed reported they had no personal safety concerns while spending the night in holding cells.	
Pleasant Valley State Prison. Following the August 5, 2005 homicide of an inmate, the Office of the Inspector General investigated an allegation that before his death, the inmate had sent a letter to the warden about safety concerns he had with his cellmate, asserting that staff refused to separate them. It was also alleged that the inmate wrote a letter to his wife regarding his safety concerns and provided her with names of staff who had ostensibly refused to address these concerns.	The Office of the Inspector General interviewed staff and reviewed documentation surrounding the inmate's death but did not obtain sufficient evidence to determine whether the warden received the alleged letter or was aware of the inmate's safety concerns. During its investigation, the Office of the Inspector General also located a letter sent to the inmate's wife but, upon examining the signature, determined that someone other than the inmate had signed the inmate's name. When it learned that the Office of Internal Affairs was conducting a preliminary investigation into the same allegations, the Office of the Inspector General provided that office with copies of documentation and interview tapes it had collected during its own investigation. Because the Office of Internal Affairs was conducting a parallel investigation into the same allegations, no further action was taken by the Office of the Inspector General.	The Office of the Inspector General has closed this investigation.
California Medical Facility. The Office of the Inspector General investigated a complaint alleging that a doctor had become the victim of retaliation after accusing a senior manager of racism. The doctor had been assigned to work	The Office of the Inspector General reviewed supporting documentation, conducted internet-based research, and made telephonic inquires. The investigation revealed that the doctor was a primary care physician who operated a family	The Office of the Inspector General has closed this investigation.

Investigation	Result	Status
part-time in a facility clinic reserved for physicians with a family practice background. The doctor professed that he was not qualified to work in family practice and that the reassignment placed inmates at risk.	practice in the local community. The Office of the Inspector General found no credible evidence to support either the allegation that the senior manager retaliated against the doctor by changing his assignment or that the doctor was not qualified to perform his new duties.	