



QUARTERLY REPORT

BUREAU OF AUDITS AND INVESTIGATIONS

JULY–SEPTEMBER 2008

OFFICE OF THE INSPECTOR GENERAL

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Introduction

The Office of the Inspector General (OIG) investigates and audits the California Department of Corrections and Rehabilitation (CDCR) to uncover criminal conduct, administrative wrongdoing, poor management practices, waste, fraud, and other abuses. This quarterly report summarizes the OIG's audit and investigation activities for the period July 1, 2008, through September 30, 2008. 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 our inspectors' activities and findings, this report also summarizes audit activities, warden and superintendent candidate evaluations, and facility and medical inspections completed during the third quarter of 2008. All the activities reported were carried out under California Penal Code section 6125 et seq., which assigns our office responsibility for independent oversight of the CDCR.

Evaluation of Warden and Superintendent 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 the Governor nominates for appointment as a state prison warden. In 2006, California Penal Code section 6126.6 was amended to also require the Governor to submit to the Inspector General the names of youth correctional facility superintendent candidates for review of their qualifications. Within 90 days, the Inspector General advises the Governor 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/ward populations; knowledge of correctional best practices; and ability to deal with employees, the public, inmates, and other interested parties in a fair, effective, and professional manner. Under California Penal Code section 6126.6(e), all communications that pertain to the Inspector General's evaluation of warden and superintendent candidates are confidential and absolutely privileged from disclosure.

During the third quarter of 2008, the Governor's office submitted two warden candidates to the OIG for review, and the OIG submitted one warden evaluation to the Governor.

Medical Inspections

In 2001, California faced a class action lawsuit (*Plata v. Schwarzenegger*, previously *Plata v. Davis*) over the quality of medical care in its prison system. The suit alleged that the state did not protect inmates' Eighth Amendment rights, which prohibit cruel and unusual punishment. In 2002, the parties agreed to several changes designed to improve medical care at the prisons. Subsequently, the court established a receivership and relieved the state of its authority to manage medical care operations in the prison system, handing that responsibility to the receiver.

To evaluate and monitor the state's progress in providing medical care to inmates, the receiver requested that the OIG establish an objective, clinically appropriate, and metric-oriented medical inspection program. In response, we developed a program based on the CDCR's policies and procedures; relevant court orders; guidelines developed by the department's Quality Medical Assurance Team and the American Correctional Association; professional literature on correctional medical care; and input from clinical experts, the court, the receiver's office, the department, and the plaintiffs' attorney, the Prison Law Office. This effort resulted in a 20-component medical inspection instrument that we use to evaluate each institution.

The inspection process collects over 1,000 data elements for each institution using up to 165 questions on the following 20 component areas of medical delivery:

- Chronic care
- Clinical services
- Health screening
- Specialty services
- Urgent services
- Emergency services
- Prenatal care/
childbirth/post-
delivery
- Diagnostic services
- Access to health care
information
- Outpatient housing unit
- Internal reviews
- Inmate transfers
- Clinic operations
- Preventive services
- Pharmacy services
- Other services
- Inmate hunger strikes
- Chemical agent
contraindications
- Staffing levels and training
- Nursing policy

To make the inspection results meaningful to both an expert in medical care and a lay reader, we consulted with clinical experts to create a weighting system that factors the relative importance of each component compared to other components. The result of this weighting ensures that components that we consider more serious—or those that pose the greatest

medical risk to the inmate-patient—are given more weight compared to those we consider less serious.

As of September 30, 2008, after completing pilot inspections at five institutions, we fine-tuned the inspection program and automated most of the functions related to the data collection and data entry. In preparation for implementing the statewide medical inspections, we also collaborated with stakeholders to get final input on the inspection tool and to reach an accord on the inspection program as we move forward.

On September 25, 2008, we began the statewide program by completing the first public medical inspection at California State Prison, Sacramento. For this inspection, we reviewed the institution's data related to medical care delivery, and we examined random samples of inmate health records for those inmates who received or required specific medical services. In addition, we conducted a live medical emergency drill and observed the adequacy of medical care delivered to inmates. We also interviewed medical and custody staff members about the delivery of inmate medical care. At the end of the third quarter, the inspection results were not yet made public because the inspection process includes a department review and response before publication of the inspection report. The final report is now available on the OIG's Web site.

As we move into the statewide medical inspection phase with one inspection team, we are in the process of automating the reporting function of the medical inspection program. We anticipate this process to be completed during the next quarter. We also anticipate completing medical inspections at three more institutions during the next quarter.

Summary of Audits Division Activities

WARDEN AND INSTITUTION AUDITS

In the third quarter of 2008, the Audits Division continued its audits of the California Institution for Men; Salinas Valley State Prison; and California State Prison, Solano. The purpose of these audits is to assess the warden's performance one year after his or her appointment to the position and to evaluate the institution's overall performance.

During this quarter, we issued a draft of the Salinas Valley State Prison audit to the CDCR for comment. The areas of concern presented in the draft report included the prison's procedures for assigning inmates to work or education programs, frequent cancellation of education classes for inmates, and non-compliance with requirements for reviewing use-of-force incidents, weapons proficiency training for correctional officers assigned to armed posts, and searching inmate cells.

The final public report of the Salinas Valley State Prison audit was published in October 2008, and the final public report of the California Institution for Men audit was published in November 2008. We anticipate publishing the California State Prison, Solano, audit report in December 2008.

Summary of Intake and Investigations Division Activities

The OIG received 915 complaints this quarter concerning the state correctional system, an average of 305 complaints a month. Most complaints arrive by mail or through the Inspector General's 24-hour toll-free telephone line. Others are brought to our attention during audits or related investigations. We may also conduct investigations at the request of CDCR officials in cases that involve potential conflicts of interest or misconduct by high-level administrators.

Our staff responds to each complaint or request for investigation; complaints that involve urgent health and safety issues receive priority attention. Most often, our staff resolves the complaints at a preliminary stage through informal inquiry by contacting the complainant and the institution or division involved either to bring about an informal remedy or to establish that the complaint is unwarranted. Depending on the circumstances, we may refer the case to the CDCR's Office of Internal Affairs for investigation. Other complaints require further inquiry or full investigation by the OIG.

During the third quarter of 2008, the Intake and Investigations Division had 37 ongoing investigations and completed seven administrative investigations and one criminal investigation. Those completed investigations are summarized in the table that follows. Cases referred to the Office of Internal Affairs may be monitored by the OIG's Bureau of Independent Review if the case meets applicable criteria. 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 semiannually in a separate report.

Allegation	Investigation	Result
<p>The OIG received a complaint alleging conspiracy by a CDCR staff member to conceal information pertaining to staff misconduct at a prison.</p>	<p>We conducted a criminal investigation that included interviewing department staff and collecting and reviewing evidentiary documents. We found insufficient evidence to support that the staff member conspired to conceal documentary evidence regarding staff misconduct.</p>	<p>We opened an administrative investigation into staff misconduct.</p>
<p>The OIG received a complaint alleging that CDCR management failed to investigate an incident in which one staff member threatened another, while two staff members were dishonest about the incident.</p>	<p>We conducted an investigation that included reviewing documents and conducting interviews with department staff. The investigation revealed that management received the complaint and assigned it for investigation. The investigation was not completed until the statute of limitations expired, preventing the subjects from receiving any discipline. Our investigation revealed that management failed to properly monitor the investigation to ensure its completion.</p>	<p>We provided the results of our investigation to the hiring authority for appropriate disciplinary action.</p>
<p>The OIG learned of potential fraudulent activity by contractors that provide commodities to the CDCR.</p>	<p>We conducted an investigation that included a review of small business statutes, bid documents, and accounting records. The investigation also included interviews with Department of General Services (DGS) staff and site visits to outside contractors. The investigation found insufficient evidence to submit the case for criminal filing. However, the investigation did find evidence that may be of interest to the DGS Small Business Certification Unit.</p>	<p>We forwarded our investigation report and its supporting documentation to DGS for review and action as appropriate.</p>
<p>The OIG received a complaint alleging that a high-control parolee was permitted to travel without proper authorization.</p>	<p>We conducted an investigation that included documentary review and staff interviews. We found no policy violations in the authorization of the visits; however, we did find that the parolee's record of supervision was not properly updated, as required by policy.</p>	<p>We forwarded our administrative investigation report to the secretary of the CDCR for review and action as appropriate.</p>

Allegation	Investigation	Result
The OIG received a complaint alleging that CDCR correctional officers at one prison are gang-affiliated and have gang tattoos.	We conducted a field inquiry that included an inmate interview, interviews with staff, and a review of records.	We found no evidence to support the allegation or warrant a formal investigation into the matter.
The OIG received a complaint alleging that the CDCR did not follow appropriate procedures following a parolee's arrest.	We conducted an investigation that included staff interviews and documentary review. We found no policy violations in the handling of this case; however, we discovered a staff error that may have affected the outcome of the inmate's probable cause hearing.	We provided the secretary of the CDCR a letter informing him of the results of the investigation for review and action as appropriate.
The OIG received a complaint alleging that a civilian staff member engaged in sexual misconduct with an inmate and provided contraband to inmates.	We conducted a site visit at the prison, went to the location where the misconduct was alleged to have occurred, conducted victim and witness interviews, and reviewed documentary evidence.	We referred the case to the prison, with a recommendation that it be forwarded to the CDCR's Office of Internal Affairs for further investigation or appropriate disciplinary action.
The OIG received a complaint alleging that two staff members intentionally concealed and/or removed evidentiary items related to the illegal discharge and possession of a weapon by an on-duty correctional officer.	The investigation found sufficient evidence to support the allegations, and the case was referred to the hiring authority for appropriate disciplinary action.	As a result of our investigation, the subject employees were disciplined by the hiring authority.