QUARTERLY REPORT

OCTOBER – DECEMBER 2010

OFFICE OF THE INSPECTOR GENERAL

BUREAU OF AUDITS

AND

BUREAU OF INVESTIGATIONS

Introduction

The Office of the Inspector General (OIG) investigates, inspects, monitors 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 of October 1, 2010 through December 31, 2010. These functions are performed primarily by the Bureau of Audits (BOA) and the Bureau of Investigations (BOI).

This 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 medical inspections completed during the fourth quarter of 2010. All the activities reported were carried out under California Penal Code section 6125 et seq., which assigns our office responsibility for independent oversight of 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 on 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 absolutely privileged and confidential from disclosure.

During the fourth quarter of 2010, the Governor submitted three warden candidates to the OIG for evaluation. Also in this quarter, the OIG completed its evaluation of one warden, and we presented our recommendations to the Governor's Office for final determination. The OIG suspended three warden vetting evaluations during this quarter, one of which was submitted to our office in the previous quarter.

Medical Inspections

Background

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 federal court established a receivership and stripped 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 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 Federal Receiver's Office, the department, and the plaintiffs' attorney. This effort resulted in a medical inspection instrument that collects over 1,000 data elements for each institution in 20 components of medical delivery.

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 considered more serious—or those that pose the greatest medical risk to the inmate-patient—are given more weight compared to those considered less serious.

Results

During the fourth quarter of 2010, the medical inspection unit issued medical inspection reports for four institutions: Salinas Valley State Prison, California Institution for Men, Pelican Bay State Prison, and Wasco State Prison. The following schedule summarizes the weighted scores for the four institutions for which public reports were issued during the quarter.

	Salinas Valley State Prison	California Institution for Men	Pelican Bay State Prison	Wasco State Prison
	Report issued October 2010	Report issued October 2010	Report issued November 2010	Report issued November 2010
Chronic Care	57.1%	61.5%	70.2%	51.7%
Clinical Services	61.1%	74.0%	69.1%	74.0%
Health Screening	83.7%	86.1%	85.1%	86.3%
Specialty Services	71.0%	83.3%	96.2%	70.5%
Urgent Services	83.8%	79.6%	92.3%	85.2%
Emergency Services	82.8%	90.4%	81.0%	72.8%
Prenatal Care/Childbirth/Post-Delivery	N/A	N/A	N/A	N/A
Diagnostic Services	77.1%	67.7%	57.1%	89.2%
Access to Healthcare Information	88.2%	77.5%	100.0%	75.5%
Outpatient Housing Unit	N/A	93.1%	N/A	N/A
Internal Reviews	72.5%	95.7%	68.8%	87.5%
Inmate Transfers	85.3%	93.3%	92.9%	88.9%
Clinic Operations	95.5%	94.8%	92.6%	89.7%
Preventive Services	42.0%	70.7%	81.3%	70.0%
Pharmacy Services	100.0%	95.9%	93.4%	86.2%
Other Services *	89.3%	100.0%	100.0%	68.8%
Inmate Hunger Strikes	26.3%	100.0%	100.0%	N/A
Chemical Agent Contraindications	100.0%	100.0%	78.8%	94.1%
Staffing Levels and Training	100.0%	100.0%	100.0%	80.0%
Nursing Policy	100.0%	92.9%	50.0%	100.0%
Overall Score	**74.1%**	**81.4%**	**81.0%**	**75.9%**

*Other services include the prison's provision of therapeutic diets, its handling of inmates who display poor hygiene, and the availability of the current version of the department's Inmate Medical Services Policies and Procedures.

By the end of the first quarter we had performed medical inspections at eleven institutions for which results were not yet published. Those inspections include: Richard J. Donovan Correctional Facility; Central California Women's Facility; Centinela State Prison; California Men's Colony; California Rehabilitation Center; Pleasant Valley State Prison; Sierra Conservation Camp; North Kern State Prison; California State Prison, Los Angeles County; San Quentin State Prison; and Valley State Prison for Women.

Audits

One-Year Review

In the fourth quarter of 2010, the Audits Division issued a one-year review on the performance of the warden at Avenal State Prison. The purpose of this audit is to assess the warden's performance one year after his or her appointment to the position. During the review, the OIG surveyed employees, key stakeholders, and department executives; analyzed operational data compiled and maintained by the department; interviewed employees, including the warden; and toured the institution.

Warden James Hartley at Avenal State Prison (ASP)

In October 2010, we issued a one-year review of Warden James Hartley at Avenal State Prison (ASP). Our review found that Warden Hartley has successfully transitioned to his role as warden and has gained a reputation as a strong disciplinarian and accessible leader, who has promoted staff accountability at ASP. ASP employees we interviewed rated his management skills and qualities as 'very good' overall; and the employees we surveyed agreed that he is an effective leader, given all of the institution's challenges. However, we do note an area that Hartley can improve upon—employee management relations with custody line staff. Generally, custody staff at the rank of sergeant and below rated Hartley's overall job performance as only "satisfactory" while other staff members and external stakeholders rated his performance between "very good" and "outstanding."

According to some staff members, Hartley's focus on discipline had a negative effect on his relations with some custody employees. In particular, some custody staff members expressed unfavorable perceptions about the warden's attitude and demeanor towards them. Several survey respondents and various staff members we interviewed indicated that Hartley's personal demeanor could be too direct, confrontational, and unprofessional, such as, incidents that occurred in the open and in front of various staff members.

However, 85 percent of the staff members and stakeholders we interviewed reported that ASP has been operating better since Hartley arrived.

Special Reviews

Special Review – CDCR's Legal Costs Associated with 12 Significant Class Action Lawsuits

In November 2010, the OIG released a special review of CDCR's legal costs associated with 12 significant class action lawsuits. The report identifies more than $139 million in payments since 1997 by CDCR to plaintiffs' and defense attorneys for legal fees and costs, as well as payments to special masters and experts on these major lawsuits. The lawsuits in question concern the treatment and care of inmates and wards within CDCR's institutions.

The duration of the federal courts' involvement in these class-action settlements, as well as the escalating legal expenses, indicate that efforts taken by CDCR to remedy the underlying deficiencies have been ineffective. Furthermore, it does not appear that CDCR has submitted quantifiable plans to the courts for the purpose of determining when the department has complied with the settlements reached in a number of these cases. Without specific plans in place identifying the steps required to comply with the courts' orders, it will be much more difficult for the department to extract itself from the ongoing substantial litigation costs associated with these class action suits. Therefore, the OIG recommended that the department develop such plans.

Special Reports

Inspection of Out-of-State Facilities

In December 2010, the OIG issued a letter to the Secretary of CDCR informing him of concerns noted during our inspections of five privately run out-of-state facilities that house California inmates. The facilities inspected were the Tallahatchie County Correctional Facility in Tutwiler, Mississippi; North Fork Correctional Facility in Sayre, Oklahoma; La Palma Correctional Center in Eloy, Arizona; Florence Correctional Center in Florence, Arizona; and Red Rock Correctional Center in Eloy, Arizona.

Our visits were part of the OIG's facility inspection program whose purpose is to identify issues that, if left unaddressed, could develop into more significant problems. In addition to touring the five facilities and interviewing management, employees and inmates, we also reviewed certain terms and conditions of the out-of-state prison housing contract

between CDCR and the Corrections Corporation of America. Because the OIG's inspection program is not as extensive as an audit, we performed only a limited review and testing of documents.

Areas of concern raised by the OIG's inspection program included denial of inmate rights or privileges; safety and security weaknesses; and unenforced rules, policies, practices or contract provisions. We urged the CDCR secretary to immediately address the issues regarding the denial of inmate rights and safety and security weaknesses.

Intake and Investigations

Letter to Federal Receiver J. Clark Kelso and CDCR Secretary Matthew L. Cate regarding the Monitoring of Redirected Health Care Employees who are Subjects of Administrative or Criminal Investigations

In November 2010, the Inspector General sent a letter to Federal Receiver J. Clark Kelso and CDCR Secretary Matthew L. Cate reporting the results of an OIG review to determine the salary costs associated with health care staff redirected from their clinical duties while earning professional salaries. This review was limited to redirected CDCR health care state employees as of July 1, 2009 and as of March 31, 2010. Health care employees included the medical, dental, and mental health services areas. During the review, the OIG found that most of the redirected health care employees' positions were filled behind. Therefore, the true cost of redirecting health care employees from their clinical functions is the cost to backfill the positions with registry workers or overtime. Based on information from CDCR relating to those positions actually filled behind by a temporary means, we estimated the cost to backfill redirected health care employees to be over $8.6 million as of July 31, 2009. Another survey as of March 31, 2010, showed the cost had decreased to $3.3 million.

However, there was conflicting information received from various CDCR staff. This brought into question the true cost of backfilling redirected employees as no single source within CDCR tracks the cost to backfill positions. There appeared to be a disconnect in what employees consider a redirected employee. Some institution staff considered a redirected employee as someone who was redirected to another part of the institution, outside health care. Other staff defined a redirected employee as someone who was redirected from performing their assigned duties, regardless of their location. And yet others did not consider an employee redirected if they remained in the health care area even if their clinical privileges had been removed. While our review might indicate CDCR and California Prison Health Care Services (CPHCS) have made improvements, we

question whether we received an accurate account of every health care employee redirected from their clinical duties.

We included a list of recommendations in order to help establish a more standardized procedure in identifying an accurate account of redirected health care employees.

Intake and Investigations Case Activity

The OIG received 694 complaints this quarter concerning the state correctional system, an average of 231 complaints a month. Most complaints arrive by mail or through the OIG's 24-hour toll-free telephone line. Others are brought to our attention during audits or related investigations. We may conduct investigations at the request of CDCR officials in cases that involve potential conflicts of interest or misconduct by high-level administrators. The OIG may also initiate investigations upon request by the Governor's Office or the California State Legislature.

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 through informal inquiry by contacting the complainant and the institution or division involved to either establish that the complaint is unwarranted or bring about an informal remedy.

Depending on the circumstances surrounding a complaint, we may refer cases to CDCR's Office of Internal Affairs (OIA) for investigation. Cases referred to the OIA may be monitored by the OIG's Bureau of Independent Review (BIR) if they meet applicable criteria. The BIR reports its monitoring activities semiannually in a separate report.

Some allegations or incidents require preliminary or full investigation by the OIG. In addition to large-scale investigations, the OIG initiates routine preliminary investigations into critical incidents occurring within CDCR, such as inmate deaths, civilian homicides committed by parolees, civil rights violations and major security concerns occurring in the department. When the OIG identifies a critical incident, a preliminary investigation is conducted to identify any misconduct by staff or inmates, potential policy violations, or systemic issues that may warrant further action by the OIG. During the fourth quarter of 2010, the BOI had 34 ongoing inquiries and investigations and completed one criminal investigation, two administrative investigations, one retaliation investigation and eleven preliminary investigations. Those completed investigations are summarized in the table that follows.[1]

[1] Please refer to Appendix A.

Allegation/Incident	Investigation	Result
The OIG received an allegation that prison staff conspired to allow certain inmates to assault inmate sex offenders.	The OIG conducted a preliminary investigation that included interviews with prison staff and a collection and review of documentation pertaining to the allegations.	The OIG determined there was insufficient evidence to warrant further investigation into this matter. The OIG closed this investigation.
The OIG received an allegation from a private citizen claiming CDCR investigative staff ignored repeated requests to cease harassing communications from an inmate.	The OIG conducted a preliminary investigation that included interviews with prison staff and a review of evidence.	The OIG determined that CDCR investigative staff responded appropriately to the request for assistance by the private citizen. The OIG closed this investigation.
The OIG conducted a routine review of the circumstances surrounding the arrest of a parolee for murder to determine whether the parolee was properly supervised while on parole.	The OIG conducted a preliminary investigation that included interviews with the parole staff and a review of CDCR records.	The OIG found that parole staff followed CDCR policy in the supervision of the parolee. The OIG closed this investigation.
The OIG received a fraud referral from CDCR's Office of Audits and Compliance alleging a medical doctor was overbilling CDCR for medical services.	The OIG conducted a criminal investigation that included a review of CDCR's audit findings and serving of a search warrant to obtain necessary documentation. The OIG also conducted witness and subject interviews.	The investigation determined the subject had fraudulently overbilled CDCR approximately $102,221 for the fiscal year 2008-2009. The amount of the fraud could go higher when other fiscal years are considered. Subsequently, a criminal report was completed alleging the subject violated numerous California Penal Codes. The report was submitted to the Kings County District Attorney's Office for a criminal filing against the subject. The District Attorney issued an arrest warrant charging the subject with violations of the following California Penal Code Sections: Section 72, Fraudulent claims, Section 487(a), Grand Theft, Section 470(d), Forgery, Section 550(a)(5) Preparing a Writing in Support of a False Claim, Section 471.5, Altering a Medical Record with Fraudulent Intent. The subject was arrested by OIG inspectors and booked into the local county jail. The OIG closed the case and the matter is being adjudicated by the Kings County Superior Court.
The OIG received an anonymous letter, alleging a CDCR medical employee was working at an outside medical facility on State time.	The OIG conducted a preliminary investigation that included a review of the applicable bargaining unit contract and Department of Personnel Administration rules, and interviews with staff from the private medical facility.	The OIG found the staff member was not working at a private medical facility on State time. The OIG closed this investigation.

Allegation/Incident	Investigation	Result
The California Highway Patrol Inspector General's Office advised that correctional staff is defrauding CDCR by upgrading their Southwest Airlines flights for the purposes of receiving free drink tickets and additional mileage credits and that CDCR pays without reviewing the bills.	The OIG conducted a preliminary investigation that included a review of policies within CDCR's Department Operation's Manual, Department of Personnel Administration rules, and the State Administrative Manual relating to aircraft travel. The OIG discovered that the Governor's Waste Watchers Organization had previously received a complaint similar to these allegations. This resulted in a memorandum notifying all CDCR employees that they will be held personally liable for choosing airfare rates in excess of State-contract rates without approved justification.	The OIG found that appropriate policies are in place prohibiting CDCR employees from upgrading their airfares without adequate justification and approval. Additionally, CDCR has since notified all employees that those who violate this policy will be held liable for additional amounts resulting from unapproved airfare upgrades. The OIG closed its investigation.
The OIG received an allegation that the Division of Juvenile Justice (DJJ) had received an AmeriCorps grant to "employ" some juvenile parole volunteers. According to the allegation, some juvenile parolees were receiving checks via the grant who had never actually worked for the agency.	The OIG found that this allegation stemmed from an AmeriCorps Program Associate's site visit to a parole office when an allegation was received that one of the program members was not working the hours reported on their time sheets. DJJ later terminated this member from the program. This appeared to have been an isolated incident. During this site visit, certain members' time sheets were reviewed and several discrepancies were found. This prompted a fiscal audit for program years 07/08 and 08/09, resulting in a request that DJJ repay $118,125 for disallowed educational awards that were paid to members that the audit disclosed had not worked the minimum 1,700 hours in a program year to qualify for the award.	The OIG found that DJJ had terminated the AmeriCorps member that appeared to have overstated their working hours. Additionally, a fiscal audit of all members' timesheets was completed, resulting in a request that DJJ repay monies for certain educational awards. The OIG closed its investigation.
The OIG received information that the State Board of Registered Nursing (BRN) discovered thousands of California registered nurses (RN's) were punished for misconduct in other states.	The OIG conducted a preliminary investigation in order to determine how many, if any, CDCR employed RN's were included in BRN's finding. The BRN ran the names of the CDCR employed RN's and registry RN's working in CDCR facilities against their listing of RN's found sanctioned in other states. No registry RN's were identified as sanctioned in other states, although thirteen CDCR employed RN's were sanctioned in other states. Of the thirteen, five were already processed by the BRN. The remaining eight are pending BRN review, and all currently have clear licenses.	The OIG found that adequate checks and balances are in place to assure that only licensed RN's, without misconduct in other states, are working in CDCR institutions. The OIG closed this investigation.

Allegation/Incident	Investigation	Result
The OIG received an allegation regarding the use of dual appointments by mental health providers within CDCR prisons. The complaint alleged that dual appointments were being utilized to circumvent the governor's mandated furlough program. The OIG opened an investigation to review the allegation that the dual appointment program was being misused by mental health providers to supplement their pay in lieu of the furlough program.	The OIG conducted a preliminary investigation that included a review of Department of Personnel Administration regulations regarding the use of dual appointments by State employees in conjunction with the State mandated furlough program and payroll records. The OIG also interviewed CPHCS staff to identify the use and criteria of dual appointments by mental health providers. The OIG obtained copies of documents from the Division of Correctional Health Care Services (DCHCS) addressing the use of dual appointments for mental health providers.	The OIG's investigation found the use of dual appointments for mental health staff was properly authorized by DCHCS staff to ensure compliance with the Coleman court. The OIG closed its investigation.
The OIG received an allegation that a CDCR employee was the subject of retaliation based upon a protected disclosure.	The OIG conducted a retaliation investigation that included interviews with staff from the institution and a review and collection of documentation.	The OIG determined there was insufficient evidence to warrant further investigation into this matter. The OIG closed this investigation.
The OIG received an allegation that a CDCR employee abused his authority and improperly directed medical investigations.	The OIG conducted an investigation that included interviews with staff and the collection and review of documentation pertaining to the allegation.	The OIG determined there was insufficient evidence to warrant further investigation into this matter and closed this investigation.
The OIG received an allegation that Department of Mental Health (DMH) staff was allowing parolees, who were civilly committed to a State hospital, to violate their conditions of parole.	The OIG conducted a preliminary investigation that included contact with CDCR parole staff and DMH staff, along with a review of documents pertaining to the allegation.	The OIG determined that CDCR parole staff took action by bringing the concerns to the attention of DMH and notifying DMH's oversight agency of the issues. However, CDCR parole staff did not ensure that all parolees at the State hospital have signed special conditions of parole so that DMH employees are aware of prohibited conduct. This information was referred to the Director of the Division of Adult Parole Operations for review and appropriate further action. The OIG has closed this investigation.
The OIG received an allegation that alleged a parole administrator had encouraged parole staff to inappropriately reduce caseload points, which may have negatively affected public safety.	The OIG conducted a preliminary investigation that included reviewing pertinent documents and interviewing the subject and witnesses to obtain information related to the alleged improper influence.	The OIG found no evidence to support the allegations. The OIG closed this investigation.
The OIG received an allegation that CDCR Office of Legal Affairs staff member engaged in preferential/disparate treatment.	The OIG conducted a preliminary investigation that included interviews and a review of documentation pertaining to the allegation.	The OIG found no evidence to support the allegations.

Allegation/Incident	Investigation	Result
The OIG received an allegation that a prison staff member falsified an official CDCR training document to reflect the employee's attendance at training courses.	The OIG conducted an administrative investigation that included interviews with prison staff and a review of timekeeping logs and training records.	The OIG's investigation found the allegations were not sustainable. The OIG closed this investigation.