OFFICE OF THE INSPECTOR GENERAL

STEVE WHITE, INSPECTOR GENERAL

MANAGEMENT REVIEW AUDIT

FRED C. NELLES YOUTH CORRECTIONAL FACILITY

SUPERINTENDENT VIVIAN CRAWFORD

JANUARY 2001

STATE OF CALIFORNIA

GRAY DAVIS, GOVERNOR

State of California

Office of the Inspector General
801 K Street, Suite 1900
Sacramento, CA 95814

Memorandum

Date: January 30, 2001

To: JERRY HARPER
Director, California Youth Authority

From: STEVE WHITE
Inspector General

Subject: Management Review Audit of Superintendent Vivian Crawford of the Fred C. Nelles Youth Correctional Institution

Enclosed is the final report of the management review audit conducted by the Office of the Inspector General of Superintendent Vivian Crawford of the Fred C. Nelles Youth Correctional Facility.

I appreciate the courtesy and cooperation extended to the audit team by Superintendent Crawford and her staff. If you have any questions, please contact John Chen, Chief Deputy Inspector General at (916) 928-0216.

cc: Robert Presley, Secretary, Youth and Adult Correctional Agency
Vivian Crawford, Superintendent, Fred C. Nelles Youth Correctional Facility

OFFICE OF THE INSPECTOR GENERAL

MANAGEMENT REVIEW AUDIT REPORT

SUPERINTENDENT VIVIAN CRAWFORD

FRED C. NELLES YOUTH CORRECTIONAL FACILITY
WHITTIER, CALIFORNIA

JANUARY 2001

Gray Davis, Governor • Promoting Integrity

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EXECUTIVE SUMMARY

California Penal Code Section 6051 requires the Office of the Inspector General to conduct a management review audit of any California Youth Authority superintendent who: (1) has held his or her position for more than four years; or (2) has been recently appointed, unless the Inspector General determines that the audit is not warranted at that time. A management review audit is a review intended to assess the superintendent's performance in carrying out the essential functions of the facility. In areas where weaknesses are noted, the Office of the Inspector General's management review team makes recommendations to correct the problems.

Pursuant to *California Penal Code* Section 6051, the Office of the Inspector General has conducted a management review audit of Superintendent Vivian Crawford of the Fred C. Nelles Youth Correctional Facility. This report presents the results of that audit.

The Office of the Inspector General's management review audit found that there are serious longstanding problems at the Fred C. Nelles Youth Correctional Facility. The problems encompass the full spectrum of the facility's operation, including the core functions of ward treatment services, ward education, and institution security. In her nineteen months at the facility, Superintendent Crawford has recognized many of these problems. However, some problems (such as ward education) are out of her control and others need more detailed analysis and planning than she has afforded them.

The Office of the Inspector General developed ten findings during the course of this management review audit. The principal findings of the audit are described below.

- **Wards at the Fred C. Nelles facility are not receiving required treatment services.** A sampling of 90 ward files revealed that only 36% of the wards received required formal weekly structured counseling sessions. Further, the wards' initial case conferences were attended by the youth correctional counselor only 6% of the time and treatment objectives were rarely set at these meetings. Moreover, in only 47% of the cases did the initial meeting take place within five weeks of the ward's arrival on the living unit, and in only 21% of the cases did the ward receive timely progress case conferences. In addition, only 76% of the wards received an explanation of the California Youth Authority's time-cut policy during orientation, and only 26% were assigned to school or work within four days of arrival at their permanent living units. In fact, the average interval between a ward's arrival at his permanent living unit and his assignment to school or work was 30 days. If time spent in the orientation period is included, the average interval between a ward's arrival at the institution and his assignment to school or work was 56 days. Moreover, 28% of the 566 annual review hearings held before the Youthful Offender Parole Board from August 1999 through June 2000 were late by one to three months, while another 29% were early. The suicide prevention program also has serious deficiencies. In addition, only a fraction of the wards in the residential substance abuse treatment program received required urinalysis testing.
- **Classes at Fred C. Nelles High School are poorly attended and wards' achievement levels are low compared to students at other California Youth Authority facilities.** Among all California Youth Authority high schools, Fred C. Nelles High School ranks near the bottom in standardized test scores. In 2000, 66% of the wards ranked below the 25th

percentile nationally, third worst of the California Youth Authority high schools. Further, student absenteeism averaged 22% from January 1999 through June 2000, the second highest rate of absenteeism in the system. Auditors also found that there are significant periods when no academic or vocational instruction is provided because of teacher absences, teacher vacancies, security concerns, and other facility-initiated class closures. As a result, from July 1999 through June 2000, the average ward received only 45% of his assigned educational programming. The institution also did not adequately address the wards' special education needs.

- **The Fred C. Nelles management has no way of knowing whether ward grievances have been addressed in a timely and appropriate manner or whether they have been addressed at all.** There is no formalized system by which the institution can record, track, monitor, and resolve ward grievances in a timely and appropriate manner. Among the problems: ward grievance forms were not pre-numbered; the Wards Rights Office did not receive copies of grievance files; and the Wards Rights Office did not maintain a central log or other system to record grievances filed or the status of those grievances. Only by going to each of the 13 living units was the facility able to provide a list of grievances to the auditors. Of the 1,903 grievances located, more than half were classified as unresolved. Of the unresolved grievances sampled, the facility could not locate documents for 44%. In addition, grievances against staff are not investigated in a timely fashion. Management also has not provided training for ward grievance clerks.

- **The investigative process at the Fred C. Nelles Youth Correctional Facility has numerous deficiencies.** Although the superintendent's secretary is responsible for logging and tracking open cases and maintaining investigative case files, the secretary was unable to print the investigative tracking report necessary to efficiently monitor all cases. This shortcoming necessitates the participation of an additional staff member to produce this information and potentially compromises confidentiality. Further, the individual case files are stored randomly in a closet and there is no checkout process used to control files and any confidential information contained therein. An unusually high percentage of cases (26%) involved excessive force by staff, and not all cases have been carried to their logical conclusion. Finally, some investigations were not completed in a timely manner, thereby jeopardizing the facility's ability to prosecute cases beyond mandatory deadlines.

- **Administrative procedures and controls relating to institution security are deficient in several areas.** For example, controls over stored weapons and chemical agents are weak, and the facility lacks a viable multi-hazard plan. Further, auditors found deficiencies in physical site maintenance and facility security. For example the perimeter fence is in poor repair at several points and there is inadequate fence-line camera coverage. The bio-scan entry/exit monitoring system is not used by all staff. Lastly, debris, surplus items, and scrap material capable of being used as weapons have been left unsecured at points within the secured perimeter.

Additional findings involving other aspects of the facility's operation, including the disciplinary decision-making system, facilities management, procurement, inventory control, and management of information are described in the main body of this report.

In addition to the recommendations accompanying the findings in this report, the Office of the Inspector General recommends that the management of the Fred C. Nelles Youth Correctional Facility, in consultation with the California Youth Authority headquarters, develop a comprehensive strategic plan to correct the various problems noted in this report. The strategic plan should include: clear statements of problems and the objectives intended to address them; methods and tasks for meeting each objective; resources (staff and material) necessary to accomplish each objective; names and titles of staff responsible for implementing each objective; realistic deadlines; quantifiable, outcome-based measures for evaluating success or failure; and methods for holding staff accountable.

Because some key problems noted in the audit are beyond the control of Superintendent Crawford, she needs strong support and assistance from the California Youth Authority administration to address the issues raised. In addition, because some of the problems stem from lack of oversight and clear policy direction from the California Youth Authority administration, it is likely that many of the deficiencies also exist in other California Youth Authority facilities.

The seriousness of the problems cited above necessitates follow-up by the Office of the Inspector General. Accordingly, approximately one year from the date of this report, the Office of the Inspector General will conduct a follow-up audit to ensure that Superintendent Crawford has developed and implemented a strategic plan and that problems identified in this report have been corrected.

INTRODUCTION

California Penal Code Section 6051 requires the Office of the Inspector General to conduct a management review audit of any California Youth Authority superintendent who: (1) has held his or her position for more than four years; or (2) has been recently appointed, unless the Inspector General determines that the audit is not warranted at that time. A management review audit is a review intended to assess the superintendent's performance in carrying out the essential functions of the facility. In areas where weaknesses are noted, the Office of the Inspector General's management review team makes recommendations to correct the problems.

Pursuant to the provisions of *California Penal Code* Section 6051, the Office of the Inspector General has conducted a management review audit of Vivian Crawford, superintendent of the Fred C. Nelles Youth Correctional Facility. The superintendent is an exempt employee appointed by the Governor. Superintendent appointments do not require California State Senate confirmation.

BACKGROUND

Vivian Crawford began her tenure as superintendent of the Fred C. Nelles Youth Correctional Facility in April 1999. This is her fourth assignment as a superintendent within the California Department of the Youth Authority. Her first superintendent assignment began in November 1989 at the O.H. Close Youth Correctional Facility in Stockton and was followed by assignments at the Southern Youth Correctional Reception Center and Clinic in Norwalk and the Ventura Youth Correctional Facility. Immediately preceding her assignment to the Fred C. Nelles Youth Correctional Facility, she served as the Assistant Deputy Director of the California Youth Authority Institutions and Camps Branch in Sacramento. A California Youth Authority employee for more than 24 years, Superintendent Crawford began her career with the agency as a psychologist.

The Fred C. Nelles Youth Correctional Facility is one of eleven youth correctional institutions within the California Youth Authority. Fred C. Nelles Youth Correctional Facility assists the California Youth Authority in meeting its mission of protecting the public from criminal activity by providing education, training, and treatment services for youthful offenders committed by the courts. Located on 90 acres in Whittier, California, the Fred C. Nelles Youth Correctional Facility is one of the oldest institutions in the California Youth Authority. Dedicated in 1890 as the Reform School for Juvenile Offenders, the facility houses approximately 736 male wards in the custody of the California Youth Authority. Most wards at the Fred C. Nelles Youth Correctional Facility are between 13 and 18 years of age, although wards classified as sex offenders are up to 25 years old.

For fiscal year 2000-01, the Fred C. Nelles Youth Correctional Facility has a budgeted staff of 452.6 full-time equivalent positions and an operating budget of $30,496,800. Staff positions include administrators, medical and dental professionals, administrative support personnel, youth correctional officers, and youth correctional counselors. In addition there are academic and vocational education instructors, administrators, and support staff, all of whom report to the California Youth Authority Education Services Branch rather than to the superintendent.

Wards at Fred C. Nelles Youth Correctional Facility are housed in thirteen living units known as cottages. Each cottage is named after a United States president. In addition to sleeping, showering, and carrying out other aspects of daily living in their cottages, wards also participate in programs in their living units, including group and individual counseling based on individual needs. Several cottages house general population wards, while others specialize in orienting newly transferred wards (Truman Cottage), treating sex offenders (Carter Cottage), treating substance abusers (Kennedy and Madison Cottages), and supervising wards needing special management (Nixon and Taft Cottages).

Wards leave the living units to participate in other ward programs at various locations on the institution's grounds. The programs include attending the facility's Fred C. Nelles High School; obtaining vocational training in business technology, culinary arts, landscape gardening, graphic arts, and other trades; obtaining medical and dental services; and attending religious services.

OBJECTIVES, SCOPE, AND METHODOLOGY

The objectives of the Office of the Inspector General's management review audit were:

(1) To assess how well Superintendent Vivian Crawford has managed the Fred C. Nelles Youth Correctional Facility in the first nineteen months of her superintendence; and

(2) To evaluate the operation of the Fred C. Nelles Youth Correctional Facility in order to identify areas of operation the superintendent must improve.

The Office of the Inspector General's management review team performed the following procedures in conducting the management review audit.

- Interviewed Superintendent Crawford, members of her administrative staff, and various employees and wards at the institution to gain insight and perspective on various issues.
- Administered a survey questionnaire to the Fred C. Nelles Youth Correctional Facility staff regarding Superintendent Crawford's communication with staff and wards.
- Conducted on-site visits and inspections of living units and ward programming areas, including Fred C. Nelles High School and various vocational education sites, and of administrative offices and facilities throughout the institution.
- Reviewed various laws, policies and procedures, and other authoritative documents related to key institution systems, functions, and processes.
- Gathered and reviewed institution logs, files, records, and transaction documents in various operational areas.
- Performed various analytical techniques, including sampling, to assess compliance with legal and procedural requirements.

FINDINGS AND RECOMMENDATIONS

In conducting its management review audit of the Fred C. Nelles Youth Correctional Facility, the Office of the Inspector General developed ten findings. Each finding, with its accompanying recommendations, is presented below.

FINDING 1

The Office of the Inspector General found that Fred C. Nelles Youth Correctional Facility wards have not been provided with required treatment services.

Wards at the Fred C. Nelles Youth Correctional Facility are consistently denied the treatment services to which they are entitled by the *California Welfare and Institutions Code* and Title 15, Division 4, of the *California Code of Regulations.* Consistent with these laws, Section 4000 *et seq.* of the *California Youth Authority Institutions and Camps Branch Manual* specifies the various types and frequency of treatment services wards are to receive. To evaluate the institution's compliance with these statutes and regulations, the Office of the Inspector General reviewed a sampling of 90 ward files from nine of the 13 living units. This sample represented 12% of the ward population at the Fred C. Nelles Youth Correctional Facility during the audit team's review. The review of the files revealed the following:

- **Only 32 of 90 wards (36%) in the sample reviewed received the required weekly formal, structured counseling sessions as specified in the *California Youth Authority Institutions and Camps Branch Manual.*** Section 4050 of the *California Youth Authority Institutions and Camps Branch Manual* requires a formal, structured counseling program that includes planned, scheduled staff time for counseling and provides for a minimum of one hour of formal counseling (individual or small group) per ward per week. In various general population living units, the auditors found periods of up to six months in which wards received no counseling. Counseling performance in the special management units (within the Nixon and Taft Cottages) was even poorer. Despite the need for intensive counseling of troublesome wards in special management units, counseling was a neglected service. In Nixon Cottage, two wards' files showed no counseling notes for one year and another ward's file disclosed no counseling for seven months. In Taft Cottage, auditors found gaps of up to four months between counseling sessions and one ward's file could not be found. It should be noted that even in living units with major non-compliance problems, some youth correctional counselors far exceeded the requirement for one weekly counseling session. The performance of these staff members clearly indicates that the standard is reasonable and that professionalism is possible in their working environment.

- **Wards' initial case conferences lacked proper staff representation.** Pursuant to *California Youth Authority Institutions and Camps Branch Manual* Section 4025, the superintendent is to ensure that each living unit has a case conference committee that, at a minimum, consists of the ward's youth correctional counselor, parole agent, and when possible, a teacher. *Institutions and Camps Branch Manual* Section 4030 specifies that at the ward's initial case conference, the case conference committee is to obtain input from the ward, assess the ward's needs, and set realistic, deadline-driven treatment objectives. The Office of the Inspector General found that some parole agents individually held briefings

with wards during their first week at the facility. However, the youth correctional counselor was present in only 5 (6%) of the 90 cases reviewed, and in no case was a teacher present. In addition, although individually determined treatment objectives are the cornerstone of a successful treatment program, with the youth correctional counselor normally the one to set the treatment objectives, none of the initial case conference reports in the sample files contained individually determined treatment objectives. Further, in only 42 (47%) of the 90 cases did the initial meeting take place within five weeks of the ward's arrival at the institution as required by *California Youth Authority Institutions and Camps Branch Manual* Section 4030.

- **Only 19 (21%) of the wards in the sample received timely progress case conferences.** Section 4035 of the *Institutions and Camps Branch Manual* provides that the case conference committee is to hold a progress case conference no more than 60 days following the initial case conference. Also, in the cases sampled, while a youth correctional counselor typically attended the meetings that took place, along with the ward and the parole agent, a teacher was not present. Moreover, because individual treatment objectives had not been set earlier, these meetings did not satisfy the intent of the progress case conference.

- **Orientation for 78 (76%) of the 90 wards sampled occurred more than ten working days after the ward's arrival.** Section 4015 of the *Institutions and Camps Branch Manual* provides that wards are to receive orientation within the first ten working days of their arrival at the institution.

- **Only 68 of the 90 wards in the sample (76%) received an explanation of the California Youth Authority's time-cut policy during their orientation.** In some cases, the wards' orientation forms were pre-printed with a "Yes" answer to the question regarding receipt of the time-cut policy explanation, rendering the credibility of the answer questionable. The time-cut policy awards up to nine days per month in credit toward a ward's release based on his progress in meeting treatment objectives. Section 4070 of the *California Youth Authority Institutions and Camps Branch Manual* states that ward orientation is to include an explanation of the California Youth Authority time-cut policy.

- **Only 24 (26 percent) of the 90 wards in the sample were assigned to school or work within four days of placement at their permanent living unit.** Section 4010.2 of the *Institutions and Camps Branch Manual* requires wards to be assigned to school or work within four days of arrival at their permanent living unit. In fact, the average interval between a ward's arrival at the permanent living unit and his assignment to school or work was 30 days. If time spent in the orientation period is included, the average interval between a ward's arrival at the institution and his assignment to school or work was 56 days.

- **For most wards, annual review hearings before the Youthful Offender Parole Board were either too late or too early.** Of 566 cases the institution brought before the board between August 1999 and July 2000, 28% were late by one to three months. Another 29% of the cases were early by up to two months. Section 3325 of the *Institutions and Camps Branch Manual* stipulates that the board is to reexamine each ward under its control at least once every twelve months. Cases brought too late or too early defeat the purpose of the annual review hearing, which is to give the board a uniform standard for awarding time-additions and time-credits based on the ward's response to prescribed treatment.

- **The institution's suicide prevention, assessment, and response program has serious deficiencies.** The auditors found that the suicide prevention program lacks essential components and had numerous other deficiencies. Examples of the deficiencies include the following:
  - √ None of the cottages maintain suicide risk lists to identify and monitor wards at risk of self-destructive behavior;
  - √ Taft Cottage, the site of the institution's suicide surveillance rooms, has no safety smocks;
  - √ Suicide surveillance rooms are located adjacent to the rooms of wards under special management, and there is sufficient space under the doors of some rooms to allow wards to pass pens, paperclips, notes, and other items from one room to another;
  - √ The institution has no "cut down kits" except for scissors, which are not effective for quickly rescuing wards attempting to hang themselves;
  - √ Meetings of the institution suicide prevention, assessment, and response program committee were not always attended by multi-disciplinary staff, including medical staff;
  - √ The suicide prevention, assessment, and response program is not supervised by a senior psychologist.

  The *Institutions and Camps Branch Manual,* Sections 5525 through 5530, requires the institution to have a comprehensive suicide prevention, assessment, and response program to minimize the potential for ward suicides. The manual requires the institution to take specific actions, including establishing a multi-disciplinary suicide prevention, assessment, and response committee; maintaining suicide risk lists; providing safety smocks and cut-down kits; and assessing and maintaining the physical safety of living areas.

  In October 1999 a ward hanged himself in Taft Cottage after allegedly being threatened and encouraged by another ward to commit suicide. The physical layout of Taft Cottage made it possible for wards housed in the cottage because of anti-social behavior to interact with suicidal wards, thereby increasing the likelihood of impulsive, self-destructive action. Although in that instance it does not appear that it would have made a difference, Taft Cottage also was not equipped with a cut-down kit. Strengthening the suicide prevention, assessment, and response program may minimize the potential for future suicides.

- **Only 10 (8%) of the 123 wards entering the residential substance abuse treatment program received urine testing within 72 hours of placement; only 15% of wards exiting the drug treatment program were tested; and only 22% of the required tests were performed.** The residential substance abuse treatment program requires mandatory urine testing for wards entering and leaving the program. Wards entering the formalized drug program are to be screened for drug use by undergoing urinalysis within 72 hours of program placement. In addition, wards exiting a formalized drug program are to be drug-screened by urinalysis within 30 days of exiting from the formalized drug program. Yet the

Office of the Inspector General found that only 10 (8%) of the 123 wards entering the residential substance abuse treatment program received the required urinalysis within 72 hours of placement. In addition, of a sample of 20 wards who participated in the formalized drug program and who subsequently were released on parole, only three (15%) were tested within the 30-day limit. Thirteen of the 20 exiting wards (65%) were not tested prior to exit. The residential substance abuse treatment program also requires 10% of the wards in the program to be randomly tested each week. The Office of the Inspector General found that only 22% of the required number of tests were performed.

Wards deprived of fundamental assessment, counseling, and testing activities designed to facilitate their growth and development are inadequately prepared for reintegration into society. Their chances of leading productive lives are diminished and they are at greater risk of committing crimes and returning to state custody.

The wards' performance in meeting treatment objectives is the basis for evaluating their eligibility for time-credit reductions (time cuts). The prospect of a recommendation for a time cut keeps wards focused on their overall treatment objectives. The degree to which the institution neglects to orient all wards to the time-cut policy and then fails to hold timely and proper initial and progress case conferences may minimize the degree to which wards will attempt to understand their anti-social behavior and accept learning methods to lessen such behavior.

Moreover, wards brought before the Youthful Offender Parole Board beyond their scheduled annual review date are deprived of the board's timely assessment of their treatment progress and the encouragement afforded by time-cut decisions. Conversely, wards brought before the board too early may not have had sufficient time to demonstrate satisfactory progress toward the annual standards, thereby diminishing their prospects for time cuts.

The factors contributing to inadequate ward treatment services include:

- **Confusion among the parole agents regarding policies and procedures governing the scheduling system for case conferences.** Following the initial case conference, many parole agents routinely schedule the first progress case conference out to 90 days rather than 60 days. Some said they believed they had 90 days to schedule the progress case meeting. Others said that 60 days was an impractical requirement given the difficulty of scheduling all parties to a conference.
- **Failure of supervisors to adequately monitor parole agents' work.** There was little evidence in ward case files or other documents that the treatment team supervisors (who are responsible for monitoring the work of their subordinates, the parole agents) were noting problems of the sort identified in this report and instructing their subordinates to take corrective action. The parole agent III also did not monitor ward case files. In addition, supervisors did not always redistribute the workload to compensate for absent parole agents and vacant parole agent positions, resulting in untimely casework and annual review hearings.
- **Failure to rotate all special management unit staff who have served in their assignments beyond the 24-month limit set by the state's collective bargaining agreement with the California Correctional Peace Officers Association.** Both the Nixon and Taft Cottages meet the criteria for designation as special management units. Because of the constant stress

involved in managing wards in such units, Section 24.05 of the collective bargaining agreement calls for peace officers' tours of duty in the special management units to not exceed 24 months. Staff members who exceed this limit (even voluntarily) are at risk of stress disorders and may pose a safety risk to themselves, other staff, and wards. Thus, they are also a liability risk to the State. Auditors noted that one youth correctional counselor assigned to the Nixon Cottage had worked there for 11 years. In response to an inquiry from the Office of the Inspector General and the superintendent, the California Youth Authority's assistant director of labor relations cited an obscure section of the collective bargaining agreement as the justification for excluding Nixon Cottage from the definition of a special management unit. This narrow interpretation is not only unsupported, but also is not in the best interests of any of the parties involved.

- **Lack of coordination between the treatment staff and the teaching staff, resulting in teachers not participating in ward assessment and counseling.** The Office of the Inspector General found no evidence of an effort to consider the availability of teachers when scheduling ward case conferences. This lack of a collaborative approach appears to be a product of past and present indifference to having living unit and education staff work together.
- **Misplaced priorities when scheduling annual review hearings.** Rather than always giving priority to preparing and scheduling cases ordered for annual review by the Youthful Offender Parole Board, the institution's practice is to schedule cases upon their completion by clerical staff. This practice contributes to some cases being heard in ten months, while others are not heard for fifteen months.
- **A large number of vacancies in the youth correctional counselor, senior youth correctional counselor, and parole agent classifications.** Several of these staff vacancies were created by staff being injured and out for extended periods of industrial leave.

RECOMMENDATION

The Office of the Inspector General recommends that the institution management take the following actions to improve ward assessment and counseling:

- Ensure that the Truman living unit's orientation curriculum contains a section devoted to the California Youth Authority time-cut policy and that the policy is discussed appropriately with newly arrived wards. Document this discussion in the ward's records.
- Develop a casework management system that meets the content and frequency criteria laid out in Section 4000 *et seq.* of the *California Youth Authority Institutions and Camps Branch Manual.* Of particular importance is the prompt and proper conducting of an initial case conference that includes all parties, including the youth correctional counselor. Included in this system should be a scheduling component that facilitates the availability of the ward, the parole agent, the youth correctional counselor, a teacher, and other staff as necessary.

- Clarify policies governing assessment and counseling procedures in order to eliminate confusion regarding issues such as 60-day versus 90-day progress conferences.
- Rotate all peace officer staff assigned to the Nixon and Taft Cottages within the 24-month limitation required by the collective bargaining agreement.
- Hold treatment team supervisors, the parole agent III, and the program administrator accountable for monitoring the work of parole agents, senior youth correctional counselors, and youth correctional counselors and for ensuring proper redistribution of workload when staff are absent and positions are vacant.
- Ensure that priority is given to preparing and scheduling cases based on their order for annual review from the Youthful Offender Parole Board, rather than on completion by clerical staff.
- Work with the education administrators at the Fred C. Nelles Youth Correctional Facility to ensure teacher availability and participation in ward assessment and counseling.
- Bring the institution into compliance with all requirements of the suicide prevention, assessment, and response program. Examples of items the institution must address include, but are not limited to: maintaining current suicide risk lists in each cottage; providing wards under suicide surveillance with safety smocks; isolating wards at risk of suicide from other wards; ensuring that rooms are configured to preclude the passing of items under, over, or around doors; providing cut-down kits to each living unit; hiring a senior psychologist to supervise the program; and requiring the regular attendance by all designated staff at meetings of the institution multi-disciplinary suicide prevention, assessment, and response committee.
- Make every effort to fill vacant positions, especially in the parole agent and youth correctional counselor ranks.

FINDING 2

The Office of the Inspector General found that Fred C. Nelles Youth Correctional Facility educational and vocational classes are poorly attended and that the wards' academic achievement is low compared to that of other California Youth Authority facilities.

An integral component of the California Youth Authority's mission is to provide education, training, and treatment services to wards in order to return them to society with the skills necessary to succeed and to avoid a return to criminal behavior. To this end, the California Youth Authority has adopted various policies and procedures that stress the importance of academic and vocational training. Further, a stipulation and order resulting from the 1990 *Nick O. v. Terhune* case states that the California Youth Authority is to provide eligible wards with a free, appropriate public education consistent with their unique needs.

The Office of the Inspector General's review of the academic and vocational education programs at the Fred C. Nelles Youth Correctional Facility found that the wards' educational needs are not being met. Specifically, the Office of the Inspector General found the following:

- **Among all California Youth Authority high schools, Fred C. Nelles High School ranks near the bottom in standardized test scores.** In 1998, 77% of the wards taking the standardized testing and reporting test placed below the 25th national percentile. The percentage of wards below the 25th national percentile improved to 58% in 1999, only to increase to 66% in 2000. Standardized scores at Fred C. Nelles ranked the third worst of all California Youth Authority schools in both 1998 and 2000.
- **Student absenteeism averaged 22% at Fred C. Nelles High School for the months of January 1999 through June 2000.** The 22% absence percentage at Fred C. Nelles High School is the second highest among California Youth Authority institutions. Absence percentages at other California Youth Authority institutions from July 1999 through June 2000 ranged from 10% to 25%, with the average percentage 14%. The absence percentages cited exclude absences caused by institution-wide lockdowns and other class closures initiated by the facility. In contrast, the California public school student absenteeism average is approximately 5%.
- **There are significant periods when no academic or vocational education is provided because of teacher absences, teacher vacancies, security concerns, and other facility-initiated class closures.** For example, in February 2000, 886 class periods were cancelled. In December 1999, 730 class periods were cancelled, and in September 1999, 745 class periods were cancelled. The class closures at Fred C. Nelles are reflected in a relatively low effectiveness rating — the measure used by the Education Services Branch to compare actual ward attendance and classes held to potential ward attendance and classes held. The Fred C. Nelles effectiveness rating amounts to 45%, meaning that on average, wards received only 45% of their assigned educational programming during the period July 1999 through June 2000.
- **The average percentage of wards receiving special education service time is far below the 90% threshold set by the California Youth Authority Education Services Branch.** For the period July 1999 through June 2000, auditors identified the following percentages of special education wards who obtained 90% or more of their individual education plan service time:

  Resource Specialist Program 47%
  Special Day Classes 38%
  Speech/Language Treatment..... 53%
  School Psychologist Therapy..... 77%

- **Monthly service provider reports from the Fred C. Nelles Youth Correctional Facility have not been provided to the Youth Law Center as specified in the *Nick O. v. Terhune* Stipulation and Order.** Under the terms of the stipulation and order, the institution is required to submit monthly service provider reports to the California Youth Authority Education Services Branch no later than the twentieth day of the following month. It is the responsibility of the Education Services Branch to provide the reports to the Youth Law

Center. While it appears that Fred C. Nelles prepared the reports on time, it is not clear from the record whether the institution also submitted the reports to the Education Services Branch in a timely manner. According to the Youth Law Center, as of November 15, 2000, it had not received the reports for the period June 2000 to October 2000 for the Fred C. Nelles facility, even though those reports are important to the center's monitoring function. The Education Services Branch also did not submit two other required reports, due on September 20 and October 31, 2000, outlining custody figures, staffing performance, and special education ward handicap statistics for each facility affected by the *Nick O. v. Terhune* Stipulation and Order (the other affected facilities are the Heman G. Stark Youth Correctional Facility and the N.A. Chaderjian Youth Correctional Facility). Failure on the part of the department to provide such information jeopardizes the release of these remaining institutions from federal monitoring, and places the California Youth Authority at risk for court penalties and the imposition of costly conditions.

Consequences for wards of low achievement. Poor attendance and low academic and vocational educational achievement significantly affect both wards and the California Youth Authority. Most importantly, inadequately educated wards are ill-prepared to acquire the jobs necessary to facilitate their return to productive lives in free society. Further, wards who are not attending academic and vocational education classes are not receiving the programming prescribed by the California Youth Authority and the Youthful Offender Parole Board. As a result, they may remain in state custody, at state expense, longer than necessary.

Fred C. Nelles High School accreditation jeopardized. Poor attendance and low achievement also jeopardize the accreditation of Fred C. Nelles High School, potentially diminishing the value of a diploma or certificate earned from the Fred C. Nelles Youth Correctional Facility. In 1996, the California Education Authority was created as a school district within the California Youth Authority, and the Western Association of Schools and Colleges began visiting and accrediting California Youth Authority high schools. After a visit to the Fred C. Nelles Youth Correctional Facility, the Western Association of Schools and Colleges on May 30, 2000 granted Fred C. Nelles High School candidacy accreditation for a period of three years. By way of contrast, other California Youth Authority high schools have received full accreditation for six years.

Low average daily attendance affects education funding. Wards not attending classes also are not generating average daily attendance for the California Youth Authority. Average daily attendance is the basis by which the California Youth Authority receives state lottery funds for education purposes. In addition, significant legal costs can result if the Fred C. Nelles Youth Correctional Facility fails to achieve compliance with legal mandates. Although a June 8, 2000 letter by a monitor from the Youth Law Center credits the facility with making excellent progress toward compliance with the *Nick O. v. Terhune* stipulation and order, failure to fully comply by the January 31, 2001 deadline could result in penalties and the imposition of costly conditions.

Reasons for the deficiencies. Several factors contribute to the wards' poor attendance and low achievement in academic and vocational education programs. The policies and practices of the Fred C. Nelles Youth Correctional Facility administration and the Education Services Branch are a significant component. However, the wards themselves must bear some of the responsibility. Unless they are willing to attend class, make the commitment to learn, and cooperate with each

other and the faculty to create an atmosphere conducive to learning, it is unrealistic to expect high levels of achievement.

The Office of the Inspector General identified the following factors that have contributed to the Fred C. Nelles Youth Correctional Facility's problems with its educational programs:

- **The Fred C. Nelles Youth Correctional Facility has a shortage of teachers and qualified substitutes willing to work inside the facility**. Teaching inside a youth correctional institution is potentially dangerous, and the current compensation is not competitive. The Office of the Inspector General confirmed that public school district pay scales were, on average, about 16% higher than those offered by the California Youth Authority. The teacher shortage is especially severe in special education. Five special education instructor and psychological counselor vacancies remained unfilled during the course of the audit team's fieldwork.
- **Classes are frequently canceled due to "trade holds."** "Trade hold" is a generic term for various events that cause a single class or all classes to be cancelled. These include interruptions in utility services, such as water and electricity, failures of the personal security system (Unisec) devices worn by education staff, and teacher shortages due to illness, vacation, extended leave, and other events.
- **Some education staff members exhibit little enthusiasm towards their work.** Some instructors habitually seek out reasons to remove wards from classes. The instructors also show little concern with accuracy in reporting attendance. The audit team reviewed 24 monthly teacher/instructor average daily attendance reports and found errors in every one. Further, the education staff does not interact with the trade advisory committees required by the *Education Services Branch Manual* Sections 3410 and 3420. Good trade advisory committees can identify ways of improving vocational education programs and enhancing wards' job opportunities. Although the institution provided a roster of trade advisory committee members, follow-up with the committee chairperson revealed that no trade advisory committee existed. There have been no meetings among those personnel listed. No minutes or agendas were available from prior meetings. Furthermore, there are no committee members listed from outside Fred C. Nelles. Consequently, none of the identified members are actively involved as required by *Education Services Branch Manual* Section 3420.

RECOMMENDATION

In order to improve attendance and academic and vocational achievement at the Fred C. Nelles Youth Correctional Facility, the Office of the Inspector General recommends that the institution management:

- Work with ward representatives and institution education administrators as well as Education Services Branch administrators to provide the best possible learning environment. Within the framework of institutional security, the superintendent should encourage the exchange of ideas through regular meetings and should activate the trade advisory committee.

The management of the California Youth Authority Education Services Branch and the institution's education administrators should:

- Promptly fill teaching vacancies, especially those in academic/special education. Work to provide competitive teacher compensation by upgrading pay scales, using compensation exceptions provided for by law and other suitable methods.
- Make every effort to compile a list of qualified substitute instructors so that classes can continue without cancellation when an instructor is sick, takes vacation, or is otherwise absent.
- Comply with all requirements of the *Nick O. v. Terhune* stipulation and order, including the timely submission of monthly service provider reports.
- Explore ways to lessen the disruption or cancellation of classes due to other types of trade holds. For example, the causes of Unisec failures should be examined and corrected.
- Ensure that all class cancellations are for valid reasons and that all alternatives to cancellation have been explored.
- Insist on the accurate reporting of ward attendance by instructors. Provide training as necessary and implement supervisory review and signature controls.
- Ensure the use of trade advisory committees as outlined in Sections 3410 and 3420 of the *Education Services Branch Manual.*
- Comply with all recommendations of the Western Association of Schools and Colleges in order to obtain full accreditation for Fred C. Nelles High School.

FINDING 3

The Office of the Inspector General found that the Fred C. Nelles management has no way of knowing whether ward grievances have been addressed in a timely and appropriate manner or whether they have been addressed at all. In reviewing the ward grievance process, the Office of the Inspector General found that the training, procedures, and oversight provided by management were so minimal that essentially no assurance was provided that ward grievances were promptly and properly addressed. Specifically, the Office of the Inspector General found:

- **Lack of accountability over ward grievances.** *California Youth Authority Institutions and Camps Branch Manual* Section 7130 requires the superintendent to develop and maintain a system to monitor the ward grievance process in order to ensure compliance with established department criteria. However, at Fred C. Nelles there is no accountability or control over ward grievances. Ward grievance forms are not pre-numbered, the Wards Rights Office does not receive copies of grievances filed, and the Wards Rights Office does not maintain a central log or other system to record grievances filed or the status of those grievances. Rather, the Wards Rights Office receives only copies of resolved grievances, and therefore has no information regarding the universe of grievances filed and outstanding.

  This lack of control, tracking, and monitoring was demonstrated by the fact that the facility was unable to provide a comprehensive list of grievances or information regarding the status, resolution, or dates for grievances filed from January 1997 through August 2000, the date audit fieldwork was initiated.

In fact, staff from the Wards Rights Office had to go to each of the 13 cottages and comb through the actual paperwork maintained at those locations in an attempt to identify the universe of grievances. This process identified 1,903 grievances for the period. However, as grievance forms were not pre-numbered and there are few other controls over the process, there is no certainty that this number is accurate. That is, it is possible that grievances were lost or otherwise destroyed, in which case the universe would be understated. Conversely, the listing of grievances appeared to include many duplicates, which would result in overstating the universe. Therefore, the true universe of grievances remains unknown.

- **Grievances are not resolved in a timely manner.** Of the 1,903 grievances identified for the period, 959 (50%) of the grievances were classified as unresolved. A review of the grievance summary, actual grievance forms, and discussions with wards revealed that many of the listed grievances were duplicates or were grievances that were re-filed due to a lack of response. The available data therefore indicates that at the time of the audit there were an estimated 535 unresolved grievances. The 535 unresolved grievances were distributed over the years 1997 through 2000 as follows:

1997	15%
1998	12%
1999	28%
2000	45%

The oldest grievance dated back to January 7, 1997 — more than three years — and was filed by a ward who is no longer at the facility. Clearly, many grievances are not resolved on a timely basis, and the institution currently has no way of tracking or monitoring unresolved grievances.

A few of the unresolved cases were potentially serious. For example, three wards filed a grievance in December 1999 alleging that one youth correctional counselor slapped a ward, broke the thumb of a second, and was verbally abusive to the wards in general. An investigation was opened for these three cases, but the investigations log did not document final action in the matter. In another case, a ward alleged verbal sexual harassment, but the investigations log contained no record that a case was opened in the matter.

On the other hand, several of the unresolved cases related to minor issues, such as the facility's failure to get the ward's signature on the grievance form.

Timeliness was an issue even for cases that were resolved. The auditors reviewed a sample of 25 resolved cases and found that 7 (28%) of those cases were not resolved within the seven-day time limit identified by the California Youth Authority *Ward Rights Handbook*. Therefore, the facility did not even meet time deadlines for a significant percentage of cases that it was able to resolve.

- **Grievance documents are frequently lost.** The auditors selected a sample of 46 (9%) unresolved grievances for review. Of those grievances, the facility could not provide grievance forms and supporting information for 20 grievances, meaning that the facility

could not locate documents for 43% of the unresolved grievances. This fact highlights the lack of control over grievance forms and the grievance process and undermines the credibility of the entire grievance system.

Similarly, auditors selected a sample of 25 resolved grievances for review. Of those grievances, the facility could not provide grievance forms and supporting information for six grievances. That is, the facility could not locate forms and other documents for 24% of the resolved cases selected for review. This fact again underscores the lack of accountability and control over the process.

Without the actual form, critical information such as the detailed complaint in the ward's own words, and the staff's written response is unavailable. Therefore, it is not possible to evaluate whether the grievance was addressed appropriately. Further, the lack of information potentially calls into question the legitimacy of classifying those grievances as resolved. The absence of a system to ensure accountability, combined with evidence that grievances are in fact lost, raises the specter of possible staff abuse, such as staff simply throwing away ward grievances.

- **Grievances against staff are not investigated in a timely manner.** Of the 26 unresolved grievances that the facility was able to locate, 15 related to grievances against staff. Of the 15 grievances, 14 had not been completed. All of the grievances were more than a month old, three were three months old, and five were six months old. While addressing charges against staff certainly requires caution and effort to protect the rights and interests of both the ward and the staff member, the institution should not allow investigations to be unnecessarily delayed. This is particularly important in light of the one-year deadline for taking administrative action against employees. Since five (36%) of the 14 unresolved grievances are more than six months old, there is cause for concern regarding the expeditious and timely resolution of these matters.

- **Ward grievance clerks typically receive no training.** *California Youth Authority Institutions and Camps Branch Manual* Section 7140 requires that new ward grievance clerks be provided with training regarding their responsibilities and the procedures they should follow within two weeks of their election. Interviews with 12 grievance clerks disclosed that not a single clerk had received any training. Essentially, the clerks were merely provided with a reference binder on the grievance process. No staff member reviewed the process or the reference manual with the clerks. As a result, the clerks may lack the skill and knowledge necessary to perform their duties.

  Given the absence of a formal grievance-tracking process and strong oversight, the lack of training for grievance clerks exacerbates the problem of grievances not being processed effectively or efficiently.

- **Ward grievance clerks are frequently selected by staff.** Although the *California Youth Authority Ward Rights Handbook* provides for the selection of ward grievance clerks by the wards themselves, at least two wards told us that they were given the job because their roommate had been the grievance clerk before being transferred. Further, unlike other

institutions, the Fred C. Nelles Youth Correctional Facility does not pay ward grievance clerks or grant them any benefits or additional privileges.

When grievance clerks are frequently not selected by their peers, they may not be the best wards to handle the responsibilities, may not represent the best interests of the other wards, may not be trusted by fellow wards, and may not be motivated to do the job well. All of these factors impair the effectiveness and efficiency of the grievance process in protecting ward rights.

- **There are no formal monthly meetings between the ward grievance clerks and the ward rights coordinator and the superintendent.** It is common in many institutions for the ward rights coordinator and the superintendent to hold meetings with grievance clerks on a weekly or monthly basis. In fact, *the Fred C. Nelles Institutions and Camps Manual Supplement,* Section 4254 ("Grievance Policy") establishes that monthly meetings are to be held with the grievance clerks. At Fred C. Nelles, however, documented meeting minutes show that only three meetings with the ward grievance clerks were held between January 1999 and September 2000. The absence of meeting indicates that the administration has not sufficiently monitored the grievance process, has not provided necessary and ongoing training and guidance to the clerks, and has given the impression to wards that facility management does not take the grievance process seriously. Such inaction hurts the efficiency, effectiveness, credibility, and integrity of the grievance process.

RECOMMENDATION

In order to improve the ward grievance process, the institution management should take the following actions:

- Establish a formal process for logging, tracking, and resolving ward grievances that includes the use of pre-numbered grievance forms and the logging of the sequence of grievance form numbers provided to the grievance clerk at each cottage, as well as the date the numbered forms were distributed.

- Implement an online database and tracking system that includes the following information:

  - ✓ Grievance number
  - ✓ Grievant's name (last and first)
  - ✓ Grievant's California Youth Authority number
  - ✓ Cottage
  - ✓ Date filed
  - ✓ Type of grievance
  - ✓ Staff member responsible for action
  - ✓ Due date for response
  - ✓ Appeal status
  - ✓ Due date for appeal
  - ✓ Resolution status

This tracking system should be established either on the California Youth Authority ward information system, or, in the short run, on a stand-alone system developed by the facility.

- Collect grievance forms from the cottages and enter them into the grievance tracking system daily.

- Make the ward rights coordinator responsible for monitoring compliance with due dates and producing a weekly report listing grievances that are late and identifying the staff members responsible for each late grievance.

- Require the ward rights coordinator to provide a copy of the late grievance report to the superintendent and all staff involved in the grievance process.

- Immediately investigate all backlogged adverse action grievances.

- Train all staff members and clerks involved in the ward grievance process. The training should cover the procedures recommended above, items required by California Youth Authority policy as identified in the *Institutions and Camps Branch Manual,* and specific procedures unique to Fred C. Nelles or described in its policy and operations manual. Specifically, the superintendent should ensure that:

  - New ward grievance clerks are trained within 10 days of appointment.
  - All grievance clerks and staff are provided with ongoing training at least annually regarding the ward grievance process.

- Ensure that ward grievance clerks are selected by their peers within the parameters, guidelines, and criteria established by the institution.

- Ensure that the ward rights coordinator and the superintendent meet with the ward grievance clerks monthly to provide interaction.

- Establish an oversight function to monitor the ward grievance process, regularly report any deficiencies directly to the superintendent, and hold staff members accountable for their responsibilities relative to the ward grievance process.

It should be noted that as a result of preliminary disclosures by the Office of the Inspector General staff during the course of the management review audit, the facility's management staff has already begun to implement several of the above recommendations.

FINDING 4

The Office of the Inspector General found that investigative files at the Fred C. Nelles facility are not adequately controlled and cases are not adequately monitored.

The superintendent is responsible for ensuring that investigations of alleged employee misconduct are performed in a timely and appropriate manner. Accordingly, at the Fred C. Nelles Youth Correctional Facility, all investigations are handled through the superintendent's office. In conjunction with California Youth Authority headquarters, the superintendent assigns the investigator for each case, while the superintendent's secretary is responsible for logging and tracking open cases and maintaining investigative case files. This tracking function is central to ensuring that cases are assigned and completed promptly, particularly because of the volume of cases involved: from January 1, 1999 through August 31, 2000, 105 staff investigations were opened at the Fred C. Nelles Youth Correctional Facility.

The Office of the Inspector General found several problems with the control and monitoring of the investigative function at the institution. Auditors analyzed the investigative function, reviewed the investigations tracking report, and sampled 12 case files. They noted the following:

- **The superintendent's secretary is unable to print the investigations tracking report.** This report lists open cases and the status of those cases. Without the capacity to print the report, the superintendent's secretary cannot efficiently monitor cases and ensure the timely completion of the investigations.

- **Since the superintendent's secretary is unable to print the investigations list, the participation of an additional staff member (the training officer) is required to produce this information.** The training officer is the only staff member who knows how to print the reports. While there is no reason to believe that the training officer poses a risk or a security breach, the institution should limit the number of people having access to such sensitive, confidential information.

- **The individual case files are stored randomly in a closet.** Moreover, the cases are not filed by case number, year, name of subject, or investigator. Further, no checkout process is used when files are removed from the closet. During the audit, files for two cases could not be located for several days. Overall, control over investigations is minimal, security over files is weak, and the lack of monitoring results in cases not being resolved expeditiously. As a result, the facility is at risk of performing substandard investigations, breaching confidentiality and security, and losing the ability to take administrative action if the investigations extend beyond one year.

- **An unusually high percentage of cases involve allegations of excessive force.** Of the 105 cases under investigation, 27 (26%) of the cases allege excessive force by staff against wards. By contrast, for approximately the same period, the Preston Youth Correctional Facility's investigative caseload included allegations of excessive force only 5% of the time. Fourteen of the Fred C. Nelles excessive force cases are still pending, with the oldest dating back to August 1999.

- **Not all cases are carried to their logical conclusion.** For example, one investigation sampled was of an alleged staff-on-ward assault. The allegation was not sustained and no action was taken. However, there was sufficient evidence to sustain charges of (a) failure to report physically restraining a ward, and (b) improperly restraining a ward.

- **Some investigations have exceeded reasonable time limits.** Three (25%) of the 12 cases sampled were either approaching or had exceeded one year. All three of the cases involved allegations of wrongdoing by peace officers and therefore were subject to the requirements of the Peace Officers Bill of Rights. The Peace Officers Bill of Rights requires that allegations be resolved within one year, with failure to do so diminishing the State's ability to take action against the officer. One investigation had an incident date of August 20, 1999, and was still pending in October 2000 — 14 months later. In another investigation with an incident date of July 8, 1999, the subject of the investigation was not interviewed until July 10, 2000, more than a year after the alleged incident. A third investigation had an incident date of December 1, 1999, was still pending as of October 2000, and likely will extend beyond one year.

Given the number of investigations at the Fred C. Nelles Youth Correctional Facility, it is important that all cases be logged, tracked, and managed appropriately. Without appropriate procedures and oversight, cases can be lost, not completed in a timely way, or not properly investigated.

It is imperative that investigations be performed appropriately and that correct conclusions are drawn. When investigations do not sustain allegations against staff that should have resulted in adverse action, confidence in the fairness of the investigative function is undermined; employees may believe that they can act inappropriately without fear of sanctions; the superintendent's ability to maintain security and safety at the institution is hampered; and the institution and the State are subject to potential liability. Therefore, it is imperative that investigations be conducted properly and that appropriate action be taken against staff found to violate policies, procedures, or laws.

RECOMMENDATION

In order to improve the quality of investigations, ensure the timely completion of investigations, and provide for the security and confidentiality of information, the Office of the Inspector General recommends that the institution management take the following actions:

- Establish a formalized case filing system that provides an alphanumerical basis for storing files, facilitates the location and control of files, provides for control over access to files, and establishes procedures for checking out files.

- Develop and implement policies regarding the appropriate handling of investigative files and ensure that all investigative staff members have been trained on those policies.

- Delegate responsibility for the investigative case tracking system to one person with a second person designated as a backup. The person responsible for the tracking system should be able to print reports and should prepare a monthly status update for the superintendent and the investigators. Time limits and target dates should be projected for each investigation, and the person responsible for the tracking system should send out notices when target dates are pending or have been missed.

- Establish an internal review process, including review of all investigative reports by the superintendent, to ensure that conclusions are appropriate and supported.

FINDING 5

The Office of the Inspector General found that lack of strong administrative procedures and controls, coupled with inadequate maintenance of physical plant and equipment, has weakened the security of the facility and compromised staff safety.

The Office of the Inspector General found several areas in which administrative procedures and physical conditions within the facility were not adequate to provide the highest level of safety and security. The auditors' review of procedures in place for the period February 22, 2000 through October 11, 2000 disclosed the following:

- **Inventory controls over the armory are inadequate.** The facility's procedures related to controlling the armory, including weapons, ammunition, and chemical agents, do not meet the requirements of *Institutions and Camps Branch Manual* Section 2901. The security supervisor did not always authorize the checking out or checking in of state-issued weapons. During the review period, weapons were checked out 45 times, but a supervisor authorized the removal of the weapon only five (11%) of those times. Thus, the requisite supervisory approval was either not obtained or not documented 89% of the time weapons were checked out. Further, of the 45 weapons checked out, only 40 were logged back in. Therefore, on five occasions either the weapon was not returned or the return of the weapon was not recorded on the log sheet. In addition, the facility does not conduct a daily inventory of weapons (including speed loaders and magazines), nor does it inventory ammunition quarterly. The situation is exacerbated by the fact that there is confusion over who is responsible for the armory.

- **Weak controls over chemical agents.** Not until August 2000 (during the management review audit) did the facility begin to maintain inventory information on chemical agents (mace, pepper spray, etc.). In addition, the facility does not maintain a record of the serial numbers of chemical agents in inventory or issued to staff, or even a record of when and how many canisters are issued to staff members. Without proper inventory controls and records there is no accountability for lost or stolen canisters and there is no management control over the excessive application of chemicals on wards.

- **Lack of a viable multi-hazard plan.** The facility had not developed a viable multi-hazard emergency plan that meets the requirements of *Institutions and Camps Branch Manual* Section 1807. Section 1807 requires the superintendent to prepare and have in effect at all times a plan for meeting emergencies related to ward disturbances, employee job actions, earthquakes, explosions, floods, fire, bomb threats, hazardous materials, nuclear accidents, routine institutional emergencies, and escapes. A memorandum dated August 4, 2000 from the chief of security to the superintendent stated that the Fred C. Nelles multi-hazard plan was 75% complete. However, the plan (dated January 2000) sent by the institution to the Office of the Inspector General contained multiple errors and flaws. For example, the telephone number provided to report a ward disturbance was incorrect, as were the telephone

numbers for the superintendent, the chief of security, and the local sheriff's department identified in the escape check list. Examples of other errors include misidentified secure areas for re-locating wards during disturbances and listing of staff from a different facility to cover roads around the facility. All the mistakes exist because the Fred C. Nelles Youth Correctional Facility is using a multi-hazard plan developed by another California Youth Authority facility and has neglected to make the necessary corrections and revisions. As a result, the facility does not have an effective or accurate multi-hazard plan.

[redacted]

- [redacted]

- **The sally port area adjacent to the control booth is not large enough to accommodate 40-foot trucks.** To accommodate large trucks, both gates have to be opened simultaneously, leaving a breach in the perimeter fence that could be exploited by a potential escapee.

[redacted]

- [redacted]

- **Monitoring and safety systems are not fully installed or functional, and are not tested on a regular basis.** *Institutions and Camps Branch Manual* Section 1810 requires that every institution have an intercom system that allows control booth staff to monitor activity throughout the facility. Further, Section 1817 requires that the security sound system be tested daily and that individual receivers be tested weekly.

  Interviews with staff members throughout the facility further determined that:

- **Debris, surplus items, and scrap materials were left unsecured in a corner of the sports field.** The Office of the Inspector General's tour of the facility grounds disclosed that debris, surplus items, and scrap materials were dumped in a corner of the facility's sports field. Some of the items found lying around included broken glass, nails, a tent stake approximately eight inches long, a 12-inch-long pipe, a piece of metal approximately 6 inches long, and a strand of rope approximately 18 inches long. All of these items could be used as or made into weapons by wards. Lying in the open just off the sports field and easily accessible to wards, the items pose a danger to the safety and security of wards and staff.

RECOMMENDATION

The Office of the Inspector General recommends that the institution management address deficiencies related to the armory, the multi-hazard plan, perimeter security, safety and monitoring equipment, and general facility upkeep. Specifically, the institution's management should:

- Designate specific custody staff, with a rank not lower than sergeant, to be responsible for the security and control of the armory. Post assignments and staff schedules should ensure that one of the armory supervisors is on duty at all times. Further, all staff should be notified of the identity of the designated staff members and should be advised which of the supervisors is on duty for each shift.

- Conduct a physical inventory of all items in the armory to establish the items currently in stock. Once the base inventory has been established, inventory should be received or disbursed only by an armory supervisor. All receipts should be signed off as received by the armory supervisor on duty, and a copy of the receiving report should be maintained at the armory.

- Use a similar logging process for chemical agents and other consumable items, ensuring that serial numbers for chemical canisters are recorded.

- Conduct daily physical inventories of weapons and quarterly inventories of ammunition and chemical agents. Hold armory supervisors accountable for maintaining adequate records and ensuring the accuracy and appropriateness of the inventory on hand.

- Assign responsibility for preparing the multi-hazard plan to one staff member, give the individual a deadline for completion, and hold the individual accountable for plan quality and timeliness. Review the plan and keep it current.

- Repair the perimeter fences. Such work should include replacing sections of fence that have been cut or damaged, ensuring that posts and other supports are structurally sound, and cutting vegetation away from all perimeter fence locations.

- If feasible, change the front gate sally port to accommodate larger trucks (up to 40 feet) without the need to open both sally port gates.

- Ensure that ancillary security devices related to the perimeter fence, including the fence alarm system and the camera system, are operating as designed.

- Ensure that all staff members use the bio-scan system to log in and log out. Review log reports monthly to identify employees not complying with the log in/log out procedures. Counsel non-compliant employees in accordance with the progressive discipline process.

- Locate the printer and the system alarm in the control booth so the custody staff on duty can monitor employees who are tardy showing up or leaving work via printouts and the audio alarm. Investigate any exceptions promptly to ensure the safety of the staff member in question.

- Install intercoms in all rooms used for ward instruction, including the vocational education classrooms.

- Repair the intercom system so the control booth staff can monitor activity in the ward cottages.

- Keep "Unisec" receivers in working order and test them regularly to ensure that systems in all buildings are functioning appropriately.

- Repair the "Unisec" system so that the time alarms are received is accurately recorded.

- Ensure that the debris, surplus items, and scrap materials located by the sports field are cleaned up immediately.

- Make more frequent tours and inspections of the facilities and grounds to ensure that problems such as accumulated debris do not occur again.

FINDING 6

The Office of the Inspector General found that the disciplinary decision-making system at the Fred C. Nelles Youth Correctional Facility needs improvement.

The disciplinary decision-making system is a process developed by the California Youth Authority to ensure that wards have the right to due process in disciplinary matters. The *California Youth Authority Institutions and Camps Branch Manual,* Sections 7300 through 7495, itemize specific policies and procedures to be followed in disciplinary actions. The manual categorizes ward violations as minor misconduct, Level A (intermediate misconduct), and Level B (serious misconduct). At the Fred C. Nelles Youth Correctional Facility, the disciplinary decision-making tracking system is maintained on a database developed in-house. This system closely parallels the department-wide ward information database that will be installed in the future. In the interim, this system is adequate to allow Fred C. Nelles staff to log, monitor, and dispose of disciplinary decision-making system cases in a timely manner.

Overall, the tracking and management of the disciplinary decision-making system process is better than that of most other systems and processes at the Fred C. Nelles Youth Correctional Facility. Nevertheless, the Office of the Inspector General determined that the management of the disciplinary decision-making system process at the facility could be improved to enhance the timeliness of the disposition hearings and the use of time extensions. Specifically, the Office of the Inspector General found the following:

- **Disposition hearings are frequently not held within 14 days.** The auditors' review of 39 disciplinary decision-making system cases and files disclosed that in 19 (49%) of the 39 cases, the disposition hearing was not held within 14 calendar days following the fact-finding hearing, as required by *Institutions and Camps Branch Manual* Section 7425.

- **Time extensions are routinely requested for cases with only minimal explanation of the need for the additional time.** Under Section 7410, all disciplinary decision-making system cases must be completed within 24 calendar days of the incident unless time extensions are granted. Under the current regulations and policies, time extensions may be granted as long as such extensions do not prejudice the case.

  Of the 39 cases reviewed, only three (7.7%) had extensions requested and granted. While this percentage is relatively low, the Office of the Inspector General noted that the extension requests for these three cases were included as part of a larger group of cases for which extensions were requested. The auditors therefore reviewed five extension requests made between August 28, 2000 and September 15, 2000. The request letters covered from 16 to 24 cases each; with the average number 19 cases. Extensions are good for only seven days and must be renewed every seven days thereafter. However, extensions were being requested for a significant number of cases in each request, and some cases were being extended several times.

  Further, the explanation of the need for the extensions was limited to a one-line explanation: "Major incident, multiple wards, and volume." This explanation does not provide adequate information as to why the volume of cases cannot be accommodated and what measures are being taken to address the backlog. Further, given the minimal information provided with the extension request, it appears that extensions are automatically granted without a critical evaluation of the request's legitimacy. In addition, the auditors noted that one extension request covering 18 cases was actually made three days after the due date had passed.

The effects of the problems described above are significant. Without the timely resolution of disciplinary cases, wards do not realize the consequences of their actions and may be less inclined to observe rules and regulations intended to protect staff and wards and foster the completion of their programming goals. In addition, by routinely extending deadlines for completing the disciplinary decision-making process, the facility gives the appearance it does not have to comply with California Youth Authority rules and regulations. Such a situation may lead to cynicism and disrespect for facility policies and procedures among the wards and may ultimately undermine institutional safety and security.

RECOMMENDATION

The Office of the Inspector General recommends that the California Youth Authority and the institution management closely monitor the disciplinary decision-making system to ensure that deadlines are met and that time extensions are granted only rarely, based upon criteria developed by the institution.

FINDING 7

The Office of the Inspector General found that maintenance at the Fred C. Nelles Youth Correctional Facility is deficient.

A major component in the operation of an institution is the maintenance and management of its facilities. The Office of the Inspector General found as a result of the audit that maintenance of the facilities and grounds at the Fred C. Nelles Youth Correctional Facility needs improvement.

The condition of both the landscaping and a number of the buildings was poor. The lawns at the rear of the facility were dry and weed-infested, leaves and debris were scattered throughout, and bushes needed trimming. Earthquake damage was evident in some of the buildings.

- **Buildings have deteriorated to an unacceptable level.** Buildings have deteriorated due to a lack of preventive maintenance, as well as to aging and natural causes, such as earthquakes. There were leaks in roofs, holes in ceilings, and broken windows. There were also leaks in pipes that flooded a sidewalk area between the school office and the auditorium, and prevented the fields from being watered. Such problems with broken pipes could potentially result in injury to employees and wards, and contribute to the overall deterioration of the buildings and grounds. One housing unit that is being replaced, the Taft Adjustment Cottage, was allowed to deteriorate to an unacceptable level, with water damage from a leaking roof and leaking pipes accounting for a significant portion of the damage.

  In addition, two areas on the institution grounds are unkempt and need clean-up. One area is located on the south corner of the institution where the horticulture vocational program formerly existed. The location is within approximately 20 feet of a softball field that, according to staff, is still used. The site is a potential health and safety risk as well as a security danger (see Finding 5). Numerous hazardous items, such as kerosene and paint supplies, are lying around. In addition, there are objects such as lead pipes, razor wire, broken glass, and other sharp instruments that can be used as weapons. Also present are objects such as desks, chairs, and file cabinets that could be used by wards to escape the institution if stacked on top of each other.

  The other area needing clean-up is located on the northwest section of the institution between the main warehouse and the assistant superintendent's residence. The items located at this location include old furniture, old appliances, underground piping, and cell doors that are no longer used by the facility. That site is less a threat than the south corner because fences surround the area, preventing wards from having direct access. However, it is still a risk and should be cleaned up.

- **The institution has no preventive maintenance program because of a lack of funding and staffing resources.** The institution processes work orders when it can, but only if funding is available. The funding issue appears to be a departmental problem. The California Youth Authority has $1.5 million in its budget for special repairs and recurring maintenance. Of that amount, $360,000 is set aside for hazardous material removal, which leaves only $1.14 million to fund the maintenance of 11 facilities and more than 3.2 million gross square feet contained in 335 buildings.

  The department recognizes the need for increased maintenance funding and submitted a fiscal year 2001-02 budget change proposal to increase the special repairs and recurring maintenance budget to $7.1 million; but that proposal was denied by the Department of Finance. Before increasing the level of funding, the Department of Finance has requested a comprehensive study of the department's facilities needs, to be performed by an external consultant. According to California Youth Authority staff, the Department of Finance has not provided funding in the proposed fiscal year 2001-02 Governor's budget for the study.

- **Maintenance staffing at the Fred C. Nelles Youth Correctional Facility appears to be deficient.** Compared to the Preston Youth Correctional Facility — the institution most similar to Fred C. Nelles in square footage and ward population — the Fred C. Nelles Youth Correctional facility has 7.0 fewer plant maintenance positions. Maintenance staffing deficiencies appear to be a departmental problem. The California Youth Authority submitted a fiscal year 2001-02 budget change proposal for 89.5 maintenance positions to be phased in over a four-year period, with the Fred C. Nelles facility to obtain 13.0 positions over the four-year period. But the budget change proposal has since been withdrawn by the Youth and Adult Correctional Agency because the Department of Finance limited the California Youth Authority's growth to 50 positions. In response to that decision, the Youth and Adult Correctional Agency has deemed other issues to be of higher priority than a maintenance staff increase. Fred C. Nelles, therefore, will continue to lag behind the Preston facility by 7.0 positions, since that institution is also scheduled to receive 3.0 positions from the budget change proposal.

- **Funding allocation and prioritization of repair and maintenance projects contributes to the maintenance deficiencies.** The method by which the California Youth Authority Facilities Planning Division allocates funding and prioritizes special repair and recurring maintenance budget change proposals may also be a factor in the problem. Because the department is bound by its budget, the Facilities Planning Division typically denies projects submitted by institutions if the budgeted cost exceeds $100,000. In general, the institutions are approved and funded only for projects totaling up to approximately $100,000.

  Two buildings at the Fred C. Nelles facility — the kitchen and the Taft Adjustment Cottage— have been awaiting approval for special repair projects since 1986-87, with the approval repeatedly denied. Because of the resulting deterioration of the two buildings, the repairs ultimately became categorized as "major capital outlay" projects and were submitted to the Department of Finance for approval through the budget process. The two buildings now are finally being replaced.

  In the fiscal year 2001-02 budget cycle, the Facilities Planning Division did in fact submit budget change proposals for individual "special repair" projects in addition to the budget change proposal to increase the base funding for maintenance repairs. As of November 20, 2000, six of the special repair projects had been approved.

- **Building age is another factor in the condition of the facilities.** An additional factor contributing to the current state of the facilities is the age of the buildings. Eight of the buildings are more than 66 years old and are designated as historic structures. Twenty-five other buildings are more than 30 years old. The age of the buildings and the effect of earthquakes that have occurred over the years have also contributed to the structural problems.

- **Ward labor is not being used.** The institution's failure to make substantial use of ward labor also contributes to the lack of a clean and safe environment. Wards are an abundant source of cheap or free labor that is now going unused. The need for supervision is a drawback in using wards to perform work, and a shortage of institution staffing limits the number of employees available for that purpose, but with proper planning and adequate security

measures, the use of additional ward labor could enhance the physical condition of the facility buildings and grounds.

- **Abuse of the facility property and staff by the wards contributes to maintenance problems at the institution.** According to staff, wards sometimes "gas" staff and deliberately clog toilets, requiring the maintenance staff to devote time and resources to fix problems and prevent incidents from being repeated.

Upon being informed by the Office of the Inspector General of the problems cited in this finding, the Fred C. Nelles management gave immediate attention to landscaping deficiencies. The auditors noted marked improvement-in that area. However, the superintendent does not have an immediate solution to the maintenance funding and staffing problems. The institution will continue to be limited in its ability to remedy the problems by the need to follow California Youth Authority procedures in seeking additional resources through the budgetary process

RECOMMENDATION

In order to improve facilities maintenance at the Fred C. Nelles Youth Correctional Facility, the Office of the Inspector General recommends that the institution management and the California Youth Authority take the following actions:

- The California Youth Authority should determine the consultant costs for a department-wide facilities assessment and request the maintenance resources needed through a Spring Finance Letter during the fiscal year 2001-02 budget process. There is no reason to delay addressing this issue until the subsequent budget year.

- The Facilities Planning Division should continue to seek funding for "special repair" projects on an individual project basis through the budgetary process. That approach led to the approval of six projects this year and those efforts should continue at least until the study of the California Youth Authority facility needs is concluded, a facilities plan is developed, and the required level of funding is ensured.

- The Fred C. Nelles superintendent should continue to expand the landscaping staff. Ward labor should continue to be used in all areas of the institution where manual ward labor can safely and effectively be used. In addition, the two areas on the south corner and in the northwest section of the institution described in this report as "unkempt" should be cleaned up immediately. If any of the items that have been discarded in these areas can be used they should be stored neatly, preferably in the plant operations warehouse. The cell doors that are located by the main warehouse should be returned if possible, or transferred to an institution or other agency that can use them.

FINDING 8

The Office of the Inspector General found deficiencies in the operation of the Fred C. Nelles Youth Correctional Facility warehouse.

The management of materials and supplies is an important function within a youth correctional institution such as the Fred C. Nelles Youth Correctional Facility. An integral component of the function is the warehouse, which serves as the repository for thousands of dollars worth of food, supplies, and other items critical to the efficient operation of the facility. Without strict internal control over functions such as accessing warehoused items, ordering items, and the rotation of stock on a first-in, first-out basis, there is significant potential for theft, fraud, wasteful over-ordering, and spoilage. Accordingly, the State has adopted specific requirements for the orderly management of the State's warehousing functions. The requirements are outlined in the *State Administrative Manual.*

The Office of the Inspector General inspected the operation of the Fred C. Nelles Youth Correctional Facility warehouse for compliance with sound management practices and with the *State Administrative Manual.* The review disclosed significant non-compliance. Specifically, the auditors found:

- **The institution has not conducted a physical inventory of the warehouse in more than three years.** *State Administrative Manual* Section 3535 requires agencies to conduct physical inventories annually. The warehouse manager told the Office of the Inspector General that he was hindered in meeting this requirement because he had no computer, but that the food manager conducts a monthly inventory of food items.

- **The institution does not file copies of each purchase order and its corresponding shipping receipt in the warehouse office.** Without purchase order and shipping receipt documents, receiving clerks do not know basic information such as quantity delivered versus quantity ordered, specifications and packaging requirements, the need for evidence of inspection stamps or special labeling before acceptance, and compliance with terms listed on the purchase order. *State Administrative Manual* Section 3510.2 provides detailed requirements for these types of controls. As a result of these deficient practices, the auditors noted at least one instance in which frozen food was allowed to spoil because the institution failed to reject a of shipment of 600 cases —a quantity ten times the normal order.

- **Non-warehouse personnel are allowed to enter the warehouse and pull items from stock.** When kitchen personnel need items beyond those in their weekly order, they are allowed to go into the warehouse and pull the items. In addition to kitchen personnel, plant maintenance personnel have keys to the warehouse, which allows them to enter and remove plant maintenance items stored there. In both cases, there is no monitoring or recording of items taken. In addition, security personnel are allowed in the warehouse unaccompanied to conduct searches. These practices violate fundamental tenets of internal control.

- **Stock is not always rotated efficiently**. Auditors noted that three pallets of a perishable food item were arranged in a manner that precluded the pallet with the oldest items from being used first. As a result, the warehouse staff were distributing only the newer food items, while the pallet with the oldest items was untouched. Again, this practice violates the first-in, first-out tenet of sound inventory management. As a result, food items are subject to costly spoilage.

The major cause of the warehousing problem appears to be a lack of adequate warehouse staffing. Two staff members are responsible for performing the entire warehousing function. Their duties include a number of functions that make it difficult to maintain control with only 2.0 staff positions: shipping, receiving, scheduling, order pulling, organization and rotation of stock, inventory management, and records management. With only 2.0 staff positions, it is also difficult to maintain warehousing functions when employees are absent. This staffing level represents approximately 2.0 fewer positions than the Preston Youth Correctional Facility, a comparable institution. Notwithstanding the staffing problem, however, lack of organization has also contributed to failure to rotate some stock items.

The facility business administrator has asked the warehouse supervisor to submit a plan to correct the deficiencies cited in this finding. The business administrator has directed the warehouse staff to conduct a physical inventory and to retain a copy of all purchase orders and shipping receipts. She has also instructed staff to ensure that stock items are appropriately rotated to ensure efficiency and eliminate spoilage. The business administrator is developing a plan to minimize the number of staff allowed to enter the warehouse and the number of staff who have access to the warehouse keys. In addition, she has moved a position that was originally budgeted for warehouse operations back to the warehouse from the plant maintenance section.

RECOMMENDATION

The Office of the Inspector General recommends that the institution management ensure that the business administrator completes the changes she has begun making to the warehousing function. In addition, the superintendent should:

- Reconfigure or eliminate the entrance to the warehouse so that non-warehouse personnel can be kept out of the warehouse or at least can be escorted when they enter the warehouse.
- Move all plant maintenance items into the warehouse in the plant maintenance facility.
- Clearly define the warehouse manager's duties, provide training as necessary, and hold the warehouse manager accountable to the business administrator for the efficient, orderly operation of the warehouse.

FINDING 9

The Office of the Inspector General found deficiencies in the data management system at the Fred C. Nelles facility.

A strong management information system can be a valuable tool in managing the voluminous and diverse amounts of information on wards, but the Fred C. Nelles Youth Correctional Facility has significant problems with its data management system. While the department-wide ward information system has not yet been implemented at Nelles, a staff member at the facility has developed a comprehensive ward database system capable of recording and tracking a wide

spectrum of information. The database is not being used to its full advantage, however. The information in the database includes the following:

- Population and specific wards by cottage
- Board categories
- Gang affiliations
- Registrations (such as sex offender, arsonist)
- Citizenship
- Disciplinary decision-making system cases
- Parole consideration dates
- Violence levels

This system closely parallels the department-wide ward information system that will ultimately be implemented. In general, the present ward database at Fred C. Nelles is adequate to effectively manage most major functions of the facility. In addition, the staff member who developed these systems, while no longer assigned information management system functions, is knowledgeable about the uses of the system and its report-generating capabilities.

Notwithstanding the existence of the ward database and its significant capabilities, most of its functions are manual. These manual functions are labor intensive, make verification more difficult, and inhibit the timely and efficient sharing of information. In addition, the Office of the Inspector General found the following:

- There are certain functions for which an adequate management information system is not in place to record, report, and analyze information.
- Staff do not consistently, systematically, and correctly use the automated information systems that are in place.
- Administration and staff do not use information, data, and reports available from existing information systems.
- There is no formal protocol for facility staff to submit programming requests.
- The facility lacks certain general controls to facilitate the use and reliability of automated data when staff do use it.

Examples of the weaknesses in the Fred C. Nelles information management system include the following:

- **The facility does not have a system to record and track ward grievances.** In the course of reviewing the ward grievance process, the Office of the Inspector General found that the facility had no formal system to identify, record, and track ward grievances filed. (See Finding 3.) This problem was demonstrated by the fact that the Ward Rights Office was not

able to provide a comprehensive list of ward grievances filed and the status of those grievances. For purposes of the management review audit, the staff had to attempt to compile that information from grievance forms maintained at each of the living cottages.

Given the large volume of grievances filed, it is important that a comprehensive ward grievance tracking system be implemented. Without a formal system to identify, record, and track ward grievances there is no assurance that all grievances are addressed and that such responses are timely and appropriate. Further, without a grievance-tracking system, the ward rights coordinator and the superintendent do not have sufficient data to identify problems, ensure timely and appropriate responses, hold staff accountable, or make complete, accurate and timely reports to California Youth Authority headquarters.

- **Facility staff members do not consistently update the database for wards in temporary detention, nor do they use the database for ward management.** The existing ward database allows staff to record information regarding wards assigned to temporary detention in the Taft and Nixon Cottages. The proper use and updating of this system would allow the superintendent, treatment team supervisors, senior youth correctional counselors, and staff to obtain reports that identify:

  - ✓ All wards in temporary detention.
  - ✓ Where the wards are located for temporary detention (Taft or Nixon).
  - ✓ The cottages where the wards normally are housed.
  - ✓ General information about why the wards are in temporary detention.
  - ✓ Date and time wards were placed in temporary detention.
  - ✓ Date and time wards were moved out of temporary detention.
  - ✓ Whether wards have received showers.
  - ✓ Whether the wards have been in temporary detention longer than three days.
  - ✓ Whether the ward confinement time has expired without being approved for extension.

  The existing database provides a potentially excellent tool for monitoring wards in temporary detention and for ensuring that wards are not retained in lock-up without appropriate review and authorization. But the database has not been consistently updated, nor are procedures in place to ensure that the data entered is accurate. Further, the superintendent and treatment team supervisors are not using reports from the database to monitor the status of wards in temporary detention. Therefore, the database is not being used as a tool to effectively manage temporary detention.

  That the database is not used or viewed as reliable by the superintendent was demonstrated by the fact that when the Office of the Inspector General conducted a review of wards in temporary detention programs, the superintendent did not use the database to provide the needed information. Rather, she had the staff compile information regarding wards in temporary detention by hand.

- **Administration and staff do not use information, data, and reports available from the existing information systems.** In obtaining data in response to this audit, facility staff did not provide or offer information from the ward database as a means of addressing the auditors' data requests, even though using information maintained on the database would

have been a common and appropriate way to fill such requests. The superintendent told the Office of the Inspector General she was unaware of many of the system capabilities identified during the audit.

- **The institution has no formal protocol for facility staff to submit programming requests.** The facility has not established a process, form, or protocol to enable staff to request specialized reports or programs that could improve operations management. The facility does have a local area network manager and a training officer (who developed the ward database), but there are no procedures available to staff for requesting specialized information using database resources. Furthermore, there is no process for reviewing, evaluating, and approving such requests if they are submitted.

- **Information is not always purged from databases, rendering the information of limited value.** In selecting test samples of wards by living unit from the program office automated ward database, the auditors discovered that ward names had not been purged when the wards transferred out of the cottages. Consequently, the database contained the names of far more wards than were currently assigned to each cottage. For example, one cottage with 50 wards was shown to have more than 120 wards. As a result, the database was useless for most management purposes and the auditors had to rely on rosters in the cottages to select samples.

RECOMMENDATION

To improve the usefulness of the facility's information network system, the Office of the Inspector General recommends that the Fred C. Nelles Youth Correctional Facility take the following actions:

Implement the California Youth Authority ward information system as soon as possible and provide adequate training and support to users. If the ward information system will not be implemented for a significant period of time (six months or longer), the superintendent should:

- Review facility policies and procedures governing the information system to ensure that they accomplish the following:

  √ Train staff in the use of available information system resources and clarify their responsibility for inputting, updating, and maintaining the system data. Responsibilities related to maintaining the database should be included in the periodic performance evaluation to ensure that employees are adequately discharging these functions.

  √ Train staff in the various reports, screen prints, and other outputs available that are useful in performing their duties and managing wards and employees.

- Restrict access to the information system consistent with sound general and application controls.

- Establish a process to control and prioritize information system programming requests consistent with the needs of the facility.

- Enforce the above policies and procedures by periodically auditing the information system.

FINDING 10

The Office of the Inspector General found that staff performance appraisals and probationary reports are overdue.

Evaluating and providing timely feedback to employees on their performance is important to effective management. Employees informed of positive and negative aspects of their job performance can continue to develop their strengths while working to correct their deficiencies. The result is more productive employees whose efforts help accomplish the organization's mission and goals. Employee performance appraisals documenting consistently unsatisfactory performance can also provide justification for dismissal.

The State of California recognizes the need for and value of performance appraisals by requiring such appraisals for state employees. *Government Code* Section 19992 requires that a system be in place to evaluate the performance of state employees and that performance reports be kept on file and made available to each employee. *Government Code* Section 19172 requires regular evaluation of the work and efficiency of state employees during their probationary periods. Probationary reports are especially important. New employees need prompt feedback, and it is easier to terminate poor performers during probation than after they have achieved permanent status.

The review by the Office of the Inspector General disclosed that Fred C. Nelles Youth Correctional Facility personnel do not receive performance appraisals and probationary reports on time. Permanent employees are to be evaluated annually; probationary employees generally are appraised more frequently, every 60 days or every 120 days, depending on their job classification. The auditors reviewed a sample of 31 personnel files and found that of the 24 files that required an annual performance appraisal, 19 files (79%) did not contain the required report. Of the 17 files that required probationary reports, 15 files (88%) did not contain the probationary reports commensurate with the employee's status at the institution. These evaluations were overdue by two months to 36 months, or even longer.

Personnel office staff said that many supervisors and managers regard generating performance appraisals and probationary reports as a low priority compared with their other duties. Personnel staff also told the Office of the Inspector General that they systematically track appraisals and reports and notify the responsible parties when they are due and reported that they keep a delinquent report log. However, that log is not current, and documentation of contacts made with supervisors and managers regarding delinquent reports is not kept. In addition, management meeting minutes show that the superintendent has made this issue a topic of discussion for executive management meetings on only one occasion during her tenure.

RECOMMENDATION

The Office of the Inspector General recommends that the superintendent take the following actions to ensure the prompt evaluation of employee performance:

- Notify every staff member of the importance of performance appraisals and probationary reports to the mission of the Fred C. Nelles Youth Correctional Facility.
- Instruct the personnel officer to log all delinquent appraisals and reports, including all contacts with supervisors and managers. This log should be submitted to the superintendent monthly and made a regular topic of management meetings.
- Include this responsibility in supervisors' and managers' own performance expectations and performance appraisals.

ATTACHMENT A

VIEWS OF RESPONSIBLE OFFICIAL

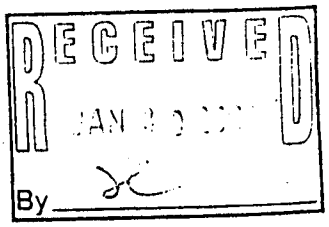
STATE OF CALIFORNIA--YOUTH AND ADULT CORRECTIONAL AGENCY

Gray Davis, GOVERNOR

DEPARTMENT OF THE YOUTH AUTHORITY
Fred C. Nelles Youth Correctional Facility

11850 East Whittier Blvd. Whittier, California 90601

January 18, 2001



John Chen, Chief Deputy Inspector General
Office of the Inspector General
3927 Lennnane Drive, Suite 220
Sacramento, California 95834-8780

Dear Chief Deputy Inspector General Chen,

In response to the Office of the Inspector General (OIG) draft Management Review Audit (MRA) report dated December 2000, this response has been prepared for your review. This response represents progress to date in further development of the Fred C. Nelles Youth Correctional Facility (FCNYCF) Comprehensive Strategic Action Plan aimed at correcting the broad range of long-standing operational deficiencies. Where such deficiencies require Department level response, I will continue to consult with appropriate Youth Authority representatives in order to correct problems identified in your report.

I would like to thank you and your staff for the timely, professional, and comprehensive manner in which the audit was conducted and the report was prepared. This information is invaluable to FCNYCF entry-level, supervisory, and administrative staff in achieving maximum operational effectiveness and efficiency.

RESPONSE

During and subsequent to the OIG Management Review Audit conducted at the FCNYCF, critical strategic initiatives were accomplished in order to correct known and OIG identified deficiencies. These accomplishments are enumerated below:

Problem	Accomplishments To Date
1. Wards are not receiving the required treatment services.	• The Parole Agent III and Program Administrator worked with members of the audit team to utilize audit information in development of a standardized casework system and ward cottage file format to ensure consistency throughout the facility. Training on the standardized system, procedures and format has been provided to all cottage managers, Parole Agents, Senior Youth Counselors and Youth Correctional Counselors. Files on each cottage will be audited each month and the Assistant Superintendent will track and review audit information to ensure accountability. Managers are instructed to audit ward case files maintained on the cottages each month for compliance with Institutions and Camps Branch Manual, Section 4000. Problems identified will be addressed through progressive discipline to ensure staff accountability. • Effective January 15, 2001, an Assistant Superintendent was assigned with primary responsibility for Special Management Units and coordination of Risk Management Program compliance.

Problem	Accomplishments To Date
2. Education classes are poorly attended and student achievement levels are low.	• The vacant Assistant Principal position has been filled and one additional Assistant Principal with Special Education expertise has been recently hired. These positions will enhance education management's ability to monitor attendance and enhance education service delivery. • Through extensive teacher recruitment efforts initiated by FCNYCF Education Services in December 2000, three teachers were added to the Nelles faculty. • Eight additional teacher applicants are being processed for full-time hire. • A partnership with California State University, Los Angeles is being pursued which will place upper division and graduate students as volunteers.
3. Ward grievances are not being addressed in a timely manner, and there is no tracking system.	• All grievances are now pre-numbered by the Wards Rights Section. • Pending installation of the Departmental Ward Information Network, a local computer-based grievance database has been developed and being used to log, track, and monitor all grievances using critical identifying information. • Copies of all ward grievances are received by the Wards Rights Section prior to the grievance response for tracking purposes. • Ward grievance policy and procedure training was conducted for peace officers and supervisory staff. • Wards Rights Coordinator meets with grievance clerks monthly.
4. Tracking and quality review of investigative files	• The Institutions & Camps Branch has developed a standardized system for recording and tracking investigations. Files are in alphabetical order. Internal Affairs is assisting to complete the large number of investigations. • IAU has implemented a process that moves responsibility for determining if allegations are sustained from the investigator to the Superintendent. • FCNYCF investigators have received additional training from IAU. • Additional managers are being trained to conduct investigations.
5. Inadequate plant maintenance and security practices	• The new armory has been supplied with shelving and storage. • Inventory of all security supplies and security supervisors given this as a secondary assignment are completing this task. • The I & C Branch has issued a revised restraint form which requires documentation of the amount of chemical dispersed in each use. • The Director and Deputy Director have provided support via Facilities Planning to assess the perimeter fence and develop proposals for correction of the problems. • The new Business Manager is developing procedures to ensure compliance with policy and is monitoring the process. • Local resources are being used to the degree possible to address the physical plant problems. Budget Change Proposals will be submitted per the state budget process to address the staffing and major capitol outlay problems.
6. DDMS System Improvement	• A manager with past experience in operation of the DDMS System has been assigned to address the problems. • Two retired-annuitants were recently authorized to assist the DDMS Section conduct fact finding and investigation activities. • Critical automation technology installed (fiber optic wiring), and equipment ordered (3 computers, 18 printers, and supplies) that will facilitate full implementation of the DDMS component of the Facility Ward Information Network. This will allow all staff access to a common DDMS database that will be monitored by supervisors, managers, and administrators.

Problem	Accomplishments To Date
7. Maintenance deficiencies 8. Ware house deficiencies	• See #5 above. • Local resources have been redirected to pilot a weekend ward work crew to avoid pulling wards out of school for this reason (FCN YCF age group must be in school. They are also prone to attempt escape and require direct supervision, especially with the community being in such close proximity) • Access to the warehouse has been limited and instructions given to security to obtain prior approval to remove items.
9. Data management systems problems.	• Support has been requested from headquarters to address the data management problems. We have been advised that assistance is forthcoming. Supervision of the local LAN Managers was removed from the facility to headquarters during the Y2K preparation. • The I & C Branch is initiating a project to begin by February 2001 to install the Departmental Ward Information Network (WIN) at all facilities. I have requested the project begin with FCNYCF. My request has been granted.
10. Performance appraisals.	• All performance appraisals are being brought up to date. • The new Personnel supervisor will develop a tracking system, provide projected due dates and notify the Office of the Superintendent of overdue reports each month.

COMPREHENSIVE STRATEGIC ACTION PLAN

Fred C. Nelles Youth Correctional Facility is developing a Risk Management Plan. This plan is a Departmental requirement and substantially supports consultation and coordination between Headquarters and the FCNYCF directed at prevention and pursuing strategic initiatives to correct operational deficiencies at various response levels (i.e., Departmental, Facility, Section). There is a clear correlation between the goals, objectives, methodology and strategies of the FCN-YCF Risk Management Plan and the Comprehensive Strategic Action plan that you have recommended in order to correct operations issues. For this reason, the facility Risk Management Plan will incorporate all operational issues identified in the OIG audit report.

Departmental support for correction of operational deficiencies is strong as the Director, Departmental and Branch administrators have traveled to the facility to assist in addressing the problems. In addition, the Directors management Team will be meeting with the FCNYCF management team on January 30, 2001 to discuss the problems and options for resolving all deficiencies.

FCNYCF is planning a workshop for a cross-section of facility staff representing various levels from entry through administrative staff. Department level staff will also be invited to facilitate the workshop process. The primary goal of this event will be full implementation of the Facility Risk Management Plan and OIG Audit Corrective Action Plan through goal, method, and strategy clarification; establishing an implementation schedule; identification of roles and responsibilities; and a process for ensuring staff accountability for accomplishing the goals of the Plan.

Should you have any questions, please contact me.

Vivian Crawford
Superintendent