OFFICE OF THE INSPECTOR GENERAL

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BUREAU OF AUDITS AND INVESTIGATIONS

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STATE OF CALIFORNIA

INTRODUCTION

The Office of the Inspector General investigates and audits the California Department of Corrections and Rehabilitation to uncover criminal conduct, administrative wrongdoing, poor management practices, waste, fraud, and other abuses. This quarterly report summarizes the audit and investigation activities of the Office of the Inspector General for the period October 1, 2005 through December 31, 2005. The report satisfies the provisions of California Penal Code sections 6129(c)(2) and 6131(c), which require the Inspector General to publish a quarterly summary of investigations completed during the reporting period, including the conduct investigated and any discipline recommended and imposed. To provide a more complete overview of the Inspector General's activities and findings, this report also summarizes audits, special reviews, and warden candidate evaluations conducted by the office during the fourth quarter. All of the activities reported were carried out under California Penal Code section 6125 *et seq.,* which assigns the Office of the Inspector General responsibility for independent oversight of the California Department of Corrections and Rehabilitation.

EVALUATION OF WARDEN CANDIDATES

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

During the fourth quarter of 2005, the Office of the Inspector General evaluated the qualifications of two candidates for warden positions and reported the results of the evaluations to the Governor in confidence.

SUMMARY OF AUDIT AND REVIEW ACTIVITIES

The Office of the Inspector General completed one audit during the fourth quarter of 2005. The audit is summarized below.

Special review into the Death of a Ward at the N.A. Chaderjian Youth Correctional Facility. In December 2005 the Office of the Inspector General issued a 29-page special review into the circumstances surrounding the August 31, 2005 death of a ward at the N.A. Chaderjian Youth Correctional Facility in Stockton. The review determined that the ward had committed suicide by hanging after having been locked in his room alone nearly 24 hours a day for eight weeks. The ward had been a member of a northern Hispanic gang whose members had violently attacked three staff members, leading to an extended lockdown at the facility. Even though he had not been involved in the attack and had no history of attacking staff, the ward was included in the lockdown because he refused to renounce his gang loyalty. As the lockdown continued, the facility administration tried to persuade wards to earn back privileges by ending gang activities, yet wards who did so were subject to potentially violent retaliation by other gang members. The developments left the ward in what he apparently saw as an intolerable situation.

The Office of the Inspector General found that during the lockdown the ward had received virtually no mental health, education, exercise, family visits, or other services. The Office of the Inspector General noted that the extended isolation was inconsistent with the Division of Juvenile Justice's mission to provide wards with education, treatment, and training. The review determined in addition that the Division of Juvenile Justice had failed to assess or act on the ward's mental health needs and had missed several signals that should have prompted it to provide the ward with mental health

services. Among these signals were four requests by the ward to see mental health professionals.

The review also found that at the time of the suicide, the staff of the living unit and the communication center, in violation of key policies and procedures, delayed opening the ward's door for 38 minutes after discovering that he had covered his windows and was not responding to repeated inquiries about whether he was all right. Whether a faster response would have saved the ward's life could not be determined.

The Office of the Inspector General issued 16 recommendations as a result of the special review. A key recommendation was that the Department of Corrections and Rehabilitation immediately end the practice of isolating wards in their rooms over extended periods of time.

The full text of the special review into the ward's death can be viewed by clicking on the following link to the Inspector General's website:
http://www.oig.ca.gov/reports/pdf/death_of_a_ward.pdf

SUMMARY OF INVESTIGATIONS

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

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

During the fourth quarter of 2005, the Office of the Inspector General completed nine such investigations. Those cases are summarized in the table that follows. Cases referred to the Office of Internal Affairs are subject to monitoring by the Office of the Inspector General's Bureau of Independent Review. Such cases are not included in the quarterly report until the Office of Internal Affairs investigation is complete. The Bureau of Independent Review reports its monitoring activities semi-annually in a separate report.

Investigation	Result	Status
California Department of Corrections and Rehabilitation. The Office of the Inspector General received a complaint from a private citizen stating that the system of providing inmate medical services through a contract with a private medical group worked against subcontracting physicians. Specifically, the complainant alleged that subcontracting physicians were precluded from negotiating terms with the private medical group; that physicians were reimbursed at "sub-par" rates; that the private medical group charged excessive middleman rates; and that the contract was non-competitively bid.	The Office of the Inspector General found that the contract between the private medical group and the subcontracting physicians established a reimbursement rate at "six percent less than the rates contained in the 1998 Physicians Fee and Coding Guide." The Office of the Inspector General also found that the six percent administrative fee appeared to be justified and that the contract was not competitively bid but that competitive bidding was not required at that time. (Effective January 26, 2005, such contracts are required to be competitively bid.) The Office of the Inspector General found no violations of state laws, rules, or regulations. The complainant's allegations involved civil matters between physicians and the medical group with which they subcontracted.	The Office of the Inspector General has closed this investigation.
California Correctional Center and Valley View Conservation Camp #34. The Office of the Inspector General received a complaint alleging that two supervisors neglected their duty to prevent an inmate escape because one of the supervisors failed to respond to reports that the inmate was mistreated by other inmates. The other supervisor allegedly failed to take action after being told that an officer overheard a telephone conversation in which the inmate discussed escape plans with his girlfriend. The inmate escaped the next day. The complaint also alleged that a senior manager at the institution negotiated a plea bargain for the inmate with the district attorney's office to avoid a trial and to conceal supervisory staff's failure to prevent the escape.	The Office of the Inspector General did not find sufficient evidence during the investigation to sustain the allegations against the supervisors. The Office of the Inspector General also did not find sufficient evidence that the manager negotiated a plea bargain to avoid a trial and to conceal supervisory staff misconduct. Pursuant to state law, only a prosecutor has the power to enter a plea bargain on behalf of the state.	The Office of the Inspector General has closed this investigation.

Investigation	Result	Status
In addition, the plea bargain precluded the inmate from receiving a third strike and a possible 25-years-to-life sentence.		
Salinas Valley State Prison. An inmate submitted multiple complaints to the Office of the Inspector General that he was continually harassed in retaliation for having testified in a matter that led to the dismissal of two correctional officers. The inmate further alleged that he was placed in administrative segregation by a correctional officer in retaliation for an incident that occurred between the correctional officer and the inmate at a different institution.	The Office of the Inspector General conducted a site visit, made inquiries, reviewed related documents, and conferred with the Office of Internal Affairs. These procedures did not develop sufficient evidence to merit additional action within the one-year time limit for investigations of peace officers mandated by the Public Safety Officers Procedural Bill of Rights.	The Office of the Inspector General has closed this investigation.
Salinas Valley State Prison. A supervisor reported staff misconduct in 2001 and alleged he was the victim of retaliation by the former Salinas Valley State Prison senior manager because of his report. The alleged retaliation included the supervisor's inability to obtain a promotion and his assignment to relief positions.	The Office of the Inspector General conducted interviews and reviewed supporting documentation and did not find substantial or credible evidence that the senior manager retaliated against the supervisor by either blocking the supervisor's possible promotion or directing the supervisor into relief positions.	The Office of the Inspector General has closed this investigation.
California Men's Colony. A physician alleged that an inmate diagnosed as suffering from an acute mental health crisis was transferred from California Men's Colony to Ironwood State Prison, a trip of seven hours in a van, while covered with feces. The complainant alleged that the inmate ate a sack lunch during the seven-hour trip without first being cleaned of the feces and that the contamination put the inmate at risk of becoming seriously ill. The physician said that such situations occur when the department transports mentally ill inmates	The Office of the Inspector General interviewed custody and medical staff, reviewed documents, laws, and court decisions. The evidence confirmed that the inmate was contaminated with his own feces while being transported. No evidence was found, however, that the absence of medical personnel during the transfer caused the inmate harm or compromised his health either upon his arrival or during his treatment for psychological symptoms. The medical staff found no physiological condition that could be attributed to the inmate ingesting his own feces.	The Office of the Inspector General has closed this investigation.

Investigation	Result	Status
over long distances without medicine or medical personnel on board.	In addition, staff doctors interviewed told the Office of the Inspector General that the inmate ingesting his own feces presented only a low-level risk to the inmate for becoming ill because of naturally occurring antibodies. The Office of the Inspector General referred this matter to the Division of Correctional Health Care Services for consideration in developing policies regarding the transportation of acutely mentally ill inmates.	
Office of Internal Affairs. An Office of Internal Affairs special agent complained to the Office of the Inspector General that one of his reports describing the findings of an investigation conducted in 1999 had been altered to delete the last finding. The special agent reported that he became aware of the alteration in October 2005.	The Office of the Inspector General reviewed the agent's original report and reports prepared by other special agents assigned to related investigations. The Office of the Inspector General also reviewed final investigative reports maintained by the Office of Internal Affairs and interviewed the complainant and other special agents who conducted the related investigations. The Office of the Inspector General found that the reports of the original investigations had been changed and then signed by supervisors or other agents. The Office of the Inspector General concluded, however, that the changes were either grammatical or stylistic or were otherwise justified. The Office of the Inspector General also determined that the last finding lacked sufficient support and that its deletion was justified.	The Office of the Inspector General has closed this investigation.
California State Prison, Los Angeles County. The Office of the Inspector General received a complaint from an inmate alleging that, as a result of harassment by correctional officers	The Office of the Inspector General conducted a site visit to the institution, reviewed the inmate's central file and health record, and interviewed the inmate and a psychiatrist. The	The Office of the Inspector General has closed this investigation.

Investigation	Result	Status
and denial of outside recreational exercise, he became emotionally distressed. The inmate stated that, as a result of this distress, he covered his cell window, blocking all vision to what he was doing, and used a razor to make large cuts in his left forearm. He further stated that while the cell window was still covered, he repeatedly requested to speak with a psychiatrist or a sergeant. The inmate alleges that his requests were ignored for approximately 10 hours. He further alleged he should have been placed under suicide watch after receiving medical treatment and that he was sedated and coerced into signing medical documents.	records reflected that the inmate received medical treatment for the cuts on his wrist. Records also indicate that he was evaluated by mental health staff two days later. The psychiatrist explained that this inmate is a "self-cutter" and that this behavior is to relieve stress, not to commit suicide. When interviewed by the Office of the Inspector General, the inmate admitted that he cut himself to relieve stress, not to kill himself. Further he admitted that he did not tell medical staff that he was suicidal, and that he had agreed to sign a medication consent form before receiving the medication and had accepted the medication in order to calm himself down.	
Correctional Training Facility. The Office of the Inspector General investigated a complaint from an inmate that a correctional officer used excessive force against him while the inmate was standing in line to go into the yard. Before submitting the complaint, the inmate filed an appeal concerning the matter, which was denied. The inmate stated in the complaint that he did not agree with the outcome of the appeal.	The Office of the Inspector General visited the Correctional Training Facility in Soledad, reviewed the appeal documentation and analysis, interviewed prison staff, and reviewed various policy and procedure documents. Based on the review, the Office of the Inspector General determined that the institution properly considered the inmate's appeal concerning excessive use of force.	The Office of the Inspector General has closed this investigation.
California Correctional Center. The Office of the Inspector General received several complaints from a supervisor alleging that the institution is at considerable risk for violence between Northern and Southern Hispanic inmates because of the department's policy of deferring requests for transfers of Northerners. In the past, to prevent violence between the two gangs, the institution was able to place Northerners in administrative segregation until	The Office of the Inspector General reviewed extensive documentation the complainant provided, interviewed institution staff to gain a better understanding of the current process and issues, and contacted wardens at two other institutions to discuss their policies. The Office of the Inspector General determined from the review that the issue is a systemic problem affecting all institutions. After numerous discussions with the department about the	The Office of the Inspector General has closed this investigation.

Investigation	Result	Status
they transferred to other institutions. The supervisor alleged that the classification services representatives are now requiring that Northerners be placed in the general population, resulting in a significant increase in violence.	policy, the Office of the Inspector General determined that department administrators are aware of the problem and are developing correctional policies and practices to address the issues.	