OFFICE OF THE INSPECTOR GENERAL

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, 2006, through December 31, 2006. The report satisfies the provisions of California Penal Code sections 6129(c)(2) and 6131(c), which require the Inspector General to publish a quarterly summary of investigations completed during the reporting period, including the conduct investigated and any discipline recommended and imposed. To provide a more complete overview of the Inspector General's activities and findings, this report also summarizes audits, special reviews, and warden candidate evaluations conducted by the office during the fourth quarter of 2006. All of the activities reported were carried out under California Penal Code section 6125 *et seq.,* which assigns the Office of the Inspector General responsibility for independent oversight of the California Department of Corrections and Rehabilitation.

EVALUATION OF WARDEN CANDIDATES

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

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

SUMMARY OF AUDIT DIVISION ACTIVITIES

During the fourth quarter of 2006, the Office of the Inspector General completed one special review and followed up on two special reviews it had previously completed. The reviews and follow-ups are summarized below.

Follow-up Review of Recommendations Pertaining to the Former Commission on Correctional Peace Officer Standards and Training. In October 2006, the Office of the Inspector General issued a report that followed up on the implementation of its recommendations contained in a May 2005 special review of the former Commission on Correctional Peace Officer Standards and Training. The commission has since been abolished and its duties assumed by the Corrections Standards Authority and the Office of Training and Professional Development. The follow-up review assessed the progress of the successor entities to the former Commission on Peace Officer Standards and Training in implementing the recommendations from the Office of the Inspector General's May 2005 special review.

The Office of the Inspector General found that most of the recommendations from its 2005 special review of the former Commission on Peace Officer Standards and Training have not been implemented. The Corrections Standards Authority has made limited progress toward developing selection and training standards for correctional peace officers, and the Office of Training and Professional Development has not yet implemented recommendations pertaining to the correctional peace officer apprenticeship program. Of the seven recommendations from the earlier review, only two have been substantially or partially implemented, while four have not been implemented, and one is no longer applicable.

The Office of the Inspector General made six additional recommendations to address these issues. The full text of the follow-up review related to the former Commission on

Correctional Peace Officer Standards and Training can be viewed by clicking on the following link to the Inspector General's Web site:
http://www.oig.ca.gov/reports/pdf/follow-up_final_092706.pdf

Special Review into Concerns Related to Substance Abuse Treatment Contractors. In October 2006, the Office of the Inspector General issued a 20-page special review of the California Department of Corrections and Rehabilitation's oversight of substance abuse treatment program service providers. The review determined that the department had failed to adequately monitor its providers and had prescribed policies that allowed providers to keep state property.

The special review revealed that the department overpaid three substance abuse treatment contractors nearly $5 million over a four-year period. The overpayments were not detected by the department because it failed to enforce contract terms requiring contractors to reconcile their revenues with their actual costs. One of the contractors also did not follow normal accounting rules and overstated its expenses by more than $250,000 by expensing the entire value of 22 automobiles purchased with state funds.

The review also revealed that the department had violated the California Constitution and state policy by allowing contractors to retain ownership of potentially millions of dollars of equipment that the contractors purchased with state funds but had a unit cost of less than $5,000. Finally, the review disclosed that the department may have failed to hold a substance abuse treatment contractor accountable for mishandling confidential inmate information.

The Office of the Inspector General made 12 recommendations to address these issues. The full text of the special review into the management oversight of substance abuse treatment program service providers can be viewed by clicking on the following link to the Inspector General's Web site:
http://www.oig.ca.gov/reports/pdf/FinalRptMasterDoc103106.pdf

Follow-up Review of the Special Review into the Death of Correctional Officer Manuel A. Gonzalez, Jr. on January 10, 2005, at the California Institution for Men. In December 2006, the Office of the Inspector General issued a report following up on the implementation of its recommendations contained in a March 2005 special review into the circumstances surrounding the stabbing death of Correctional Officer Manuel Gonzalez, Jr. on January 10, 2005, at the California Institution for Men.

The Office of the Inspector General found that although the California Institution for Men had made significant progress in implementing the recommendations presented in the March 2005 special review, the Department of Corrections and Rehabilitation's progress in addressing the recommendations for which it was responsible has been limited. While the institution fully implemented 75 percent (15 of 20) of the recommendations for which it is responsible, the department fully implemented only 50 percent (10 of 20) of the recommendations for which it is responsible. Similarly, while the institution achieved at least some degree of implementation on each of the 20 recommendations for which it is responsible, the department left 30 percent (6 of 20) of the recommendations for which it is responsible unimplemented.

Among the most significant findings of this follow-up review are the following:

- The California Institution for Men requires that any newly received inmate be placed in administrative segregation if that inmate's previous housing assignment or history of violence warrants such placement. The institution is also retrofitting certain cells for use as additional administrative segregation housing.

- While the institution's procedures and practices governing controls over tools have improved significantly, the Office of the Inspector General found that maintenance staff members were storing tools and equipment in three container exchange boxes (room-sized metal containers) located within the institution's secure perimeter and were accessing tools from these locked units without conducting required daily inventories and without the knowledge of the institution's tool control officers. One of the boxes contained ladders of varying lengths, which could be deployed as escape aids.

- The institution has either issued protective vests or has otherwise made them available to custody staff.

- The institution has equipped its medical clinics in a manner consistent with the department's guidelines as they relate to the expected level of care for medical emergencies, which restricts the level of available care to cardiopulmonary resuscitation and basic first aid. Therefore, staff members or inmates who suffer serious injury or trauma requiring treatment beyond basic first aid must rely on the prompt response of outside emergency medical care providers.

- The Department of Corrections and Rehabilitation still has not conducted the recommended evaluation of the scope and responsibility of institution investigative services units as the primary criminal investigation entities for securing crime scenes and for preserving and processing evidence. The department reports that it is waiting for funding approval for a pilot study to accomplish this, as well as for a review of all formal agreements between the institutions and the local law enforcement agencies that serve them.

- Institution security has been enhanced through the addition of a five-member security squad to its investigative services unit, which is undergoing specialized training in securing crime scenes and preserving evidence.

- Although the Office of the Inspector General recommended that the department evaluate and modify regulations and policies governing confidential calls between inmates and attorneys, the department has still not modified its regulations. Similarly, the department reports that it continues to evaluate the need for additional procedures to improve communications among key staff members with respect to dealing with external inquiries regarding inmates who require special handling.

The Office of the Inspector General made 11 additional recommendations to address these issues. The full text of the follow-up review related to the implementation of recommendations contained in the March 2005 special review can be viewed by clicking on the following link to the Inspector General's Web site:
http://www.oig.ca.gov/reports/pdf/CIM_Public_%20REPORT_121206.pdf

SUMMARY OF INTAKE AND INVESTIGATIONS DIVISION ACTIVITIES

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

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

During the fourth quarter of 2006, 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
The Office of the Inspector General received an allegation that a California Department of Corrections and Rehabilitation supervisor was allowing a subordinate employee on extended leave to document time off as time worked. It was also alleged the supervisor ordered an employee to submit false records relating to the program's services.	The Office of the Inspector General reviewed documentation of the employee attendance and documentation of services provided to the program. Interviews were conducted but offered no evidence other than conjecture. The Office of the Inspector General found insufficient evidence to support either allegation.	The Office of the Inspector General has closed this investigation.
The Office of the Inspector General received a case referral alleging that a California Department of Corrections and Rehabilitation employee abused his/her authority by accessing confidential information in order to subject another department employee to an unwarranted investigation. It was further alleged that a conflict of interest existed between the complainant and the subject employee and that the subject employee's actions were retaliatory.	The Office of the Inspector General conducted an investigation that included interviewing the complainant, California Department of Corrections and Rehabilitation staff, and the subject employee. In addition, the Office of the Inspector General collected and reviewed audiotapes and documentation from various sources and completed a computer forensic examination. The Office of the Inspector General concluded that sufficient evidence existed to sustain allegations of misconduct against the subject employee.	The Office of the Inspector General has closed this investigation after determining that the hiring authority served the subject employee with a notice of termination.
The Office of the Inspector General received information questioning the implementation of do-not-resuscitate orders within the medical records of two inmates who died after being admitted to acute care hospitals.	The Office of the Inspector General reviewed inmate medical files in addition to laws, regulations, and policies relating to the do-not-resuscitate orders. Interviews were also conducted with the medical personnel. The Office of the Inspector General found no evidence of staff misconduct regarding the implementation of do-not-resuscitate orders and no evidence that the deaths of the two inmates resulted from other than natural causes and the progression of acute disease processes.	The Office of the Inspector General has closed this investigation.

Investigation	Result	Status
The Office of the Inspector General received a case referral regarding an allegation that a California Department of Corrections and Rehabilitation employee was viewing pornographic images of adult women via the Internet on a state-assigned computer during normal duty hours.	The Office of the Inspector General reviewed supporting documentation, conducted computer forensic data analysis, and interviewed staff members. The investigation confirmed the allegations that the California Department of Corrections and Rehabilitation employee was viewing pornographic images of adult women via the Internet on a state-assigned computer during normal duty hours.	The Office of the Inspector General has referred this matter to the hiring authority for review and action. As of May 2, 2007, the hiring authority has taken no action.
The Office of the Inspector General received a complaint alleging that a prison supervisor retaliated against an employee and gave false testimony during an inmate disciplinary hearing.	The Office of the Inspector General initiated an investigation consisting of a site visit to the prison, interviews with California Department of Corrections and Rehabilitation staff, and a review of logbooks and documentation. After finding that the California Department of Corrections and Rehabilitation had already initiated an investigation into some of the issues surrounding the incident, the Office of the Inspector General made recommendations for investigating additional allegations to the hiring authority. After monitoring the progress and completion of the investigation, the Office of the Inspector General conducted a review of the documentation and determined that the investigation made appropriate findings based upon the evidence.	The Office of the Inspector General has closed this investigation after determining that the hiring authority has issued adverse action consistent with department policy.

Investigation	Result	Status
The Office of the Inspector General received an allegation that senior management of the California Department of Corrections and Rehabilitation were inappropriately using state resources to conduct activities on behalf of a non-state organization.	The Office of the Inspector General conducted an investigation that consisted of interviews with California Department of Corrections and Rehabilitation staff, review of recordkeeping documents for the cited non-profit organization, and research of applicable government codes. The investigation revealed that the incidental use of state resources was done in accordance with Government Code section 8314. In addition, the activities of the non-profit organization were directly related to state business; therefore, there was no violation of policy or code.	The Office of the Inspector General has closed this investigation.
The Office of the Inspector General received a complaint from a correctional officer alleging that he had been placed under investigation, was required to work in a hostile work environment, and was assigned a job change without appropriate notice in retaliation for alleging that another correctional officer assaulted an inmate.	The Office of the Inspector General interviewed witnesses and reviewed documentation related to the case and concluded that the allegation did not meet the legal requirements of retaliation.	The Office of the Inspector General has closed this investigation.
The Office of the Inspector General investigated an allegation that a confidential document was provided to an individual or individuals outside of the facility. The individual or individuals were not authorized to review or possess the document.	The Office of the Inspector General conducted an investigation that included a site visit, interviews of staff members, review of documentation, and examination of evidence by the California Department of Justice for latent prints. The Office of the Inspector General was unable to determine who provided the confidential document to an unauthorized individual.	The Office of the Inspector General has closed this investigation.

Investigation	Result	Status
The Office of the Inspector General investigated allegations that parole agents were violating state law by hiding high-risk sex offenders in the Los Angeles communities of Norwalk, South Gate, and Pico Rivera by "shuffling" them from motel to motel every few days within one-half mile of local schools.	The Office of the Inspector General's investigation determined that when parole agents in the Los Angeles County region told supervisors that they were unable to find housing for high-risk sex offenders outside the half-mile limit, a mid-level parole administrator ordered agents to begin shifting the parolees from motel to motel every four days. The investigation also found that his supervisor, a senior parole administrator in the department's Division of Adult Parole Operations, sanctioned the order. In addition, both administrators made false statements in interviews with the Office of the Inspector General and in answer to questions posed by members of the state legislature, denying involvement in or knowledge of the order to repeatedly move the parolees. The Office of the Inspector General's investigation resulted in additional findings concerning neglect of duty and dishonesty by other parole supervisors.	The Office of the Inspector General has closed this investigation after determining that the hiring authority has issued adverse action consistent with department policy.