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 July 1, 2006 through September 30, 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 third 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 third quarter of 2006, the Office of the Inspector General evaluated the qualifications of four candidates for warden and reported the results of the evaluations to the Governor in confidence.

SUMMARY OF AUDIT DIVISION ACTIVITIES

The Office of the Inspector General completed one special review and three evaluations during the third quarter of 2006. The special review and evaluations are summarized below.

Special Review into Management of Union Leave Time by the California Department of Corrections and Rehabilitation. In July 2006, the Office of the Inspector General issued a 24-page special review of the California Department of Corrections and Rehabilitation's management of union leave time. The review determined that the department failed to adequately manage millions of dollars in public resources and created an operational burden both on itself and its institutions because it did not accurately control and account for union leave time.

Union leave time allows representatives of employee unions to conduct union activities that are either compensated by the state or its employees. California Government Code sections 3512 through 3524 (the Ralph C. Dills Act) require state agencies to designate to a reasonable number of representatives of employee unions a reasonable amount of time off without loss of compensation to meet and confer with state representatives on matters within the scope of union representation. Examples of such activities are labor-management meetings, arbitration hearings, state contract negotiations, *Skelly* hearings,[1] supervisory interviews, investigatory interviews, grievance conferences, and State Personnel Board hearings. These costs are absorbed by the state. Union leave time also permits union members to participate in other union functions. The union compensates the agency for the lost time either monetarily or, in the case of the California Correctional Peace Officers Association, through hours donated by union members. From January 2000 through December 2005, Department of Corrections and Rehabilitation employees used a total of 318,317 hours of union leave, amounting to approximately $12 million in staff resources.

[1] An informal proceeding in which an employee may respond to a manager above the employee's supervisor before discipline becomes effective.

The majority of this time, 197,802 hours, were recorded by union members of the California Correctional Peace Officers Association.

The Office of the Inspector General found from its review that the Department of Corrections and Rehabilitation had failed to provide adequate oversight of union leave time in accordance with the Financial Integrity and State Manager's Accountability Act of 1983, wasting potentially millions of dollars in public resources and creating an operational burden on the state correctional institutions. Although the Office of the Inspector General was able to estimate the fiscal impact of some specific union leave accounting errors, the department's failure to maintain accurate and reliable records on union leave time precluded the Office of the Inspector General from either quantifying the total fiscal impact of the department's mismanagement of union leave time or identifying resulting monies that may still be owed to the state. Specifically, the Office of the Inspector General found:

- The department did not establish sound accounting for the release time bank.
- Errors make it impossible to tell whether the release time bank is overdrawn.
- The department cannot reconcile its time bank records with those of the union.
- The department did not enforce the release time bank cap.
- The department has failed to manage the supervisors' release time banks.
- The department has allowed release time without verifying authorization.
- The department has not consistently charged time to the release time bank.
- In some instances, the department has failed to account for time at all.
- The department has not controlled the individual use of union release time.
- The department has not required timesheets for employees on union leave.
- The department has failed to consistently bill for reimbursable union leave time.
- The department failed to request funding to cover leave for union officials.
- The department has exceeded its funding for the union's annual conference.

The Office of the Inspector General made nine recommendations to address these issues. The full text of the special review into the management of union leave time can be viewed by clicking on the following link to the Inspector General's website:
http://www.oig.ca.gov/pdf/071406_UnionLeave.pdf

Evaluation of circumstances surrounding a ward's suicide attempt. In July 2006, the Office of the Inspector General sent a letter to the director of the Division of Juvenile Facilities describing the circumstances surrounding a recently transferred ward's suicide attempt. The Office of the Inspector General identified concerns in the conditions of the ward's transfer that appear to have precipitated the suicide attempt. The letter advised the director to review the division's transfer policy for mental health.

The Office of the Inspector General received a complaint that a family was not permitted to visit the ward in the hospital. During its evaluation of the complaint, the Office of the Inspector General found that the ward's suicide attempt appeared to have been precipitated by the ward's transfer to a general population living unit and the division's failure to follow required protocols concerning wards who have a significant mental health history including suicide attempts. In fact, the ward was not given a required Suicide Risk Screening Questionnaire on his arrival to the general population unit and prior to his transfer was improperly classified as having a low suicide risk. Further, the division did not properly resolve a clinical dispute between two different psychologists over the proper placement for the ward and seek the opinion of a senior psychologist.

The Office of the Inspector General did not make any recommendations as a result of this evaluation, but did advise the division to review its transfer policy.

Evaluation of Draft Policies for Advance Directives and Do-Not-Resuscitate Orders. In July 2006, the Office of the Inspector General sent a letter to the director of the Division of Correctional Healthcare with recommendations to consider as the division developed policy related to advance directives and do-not-resuscitate orders for inmate-patients.

The Office of the Inspector General reviewed the California Hospital Association's *Consent Manual*, the *Standards for Health Services in Prisons* published by the National Commission on Correctional Health Care, and procedures used by other states. An "advance directive" communicates an individual's written or oral directions concerning healthcare decisions, or a written designation of an agent to make healthcare decisions for that individual. A "do-not-resuscitate order" instructs that resuscitative efforts are not to be initiated in the event of cardiac or respiratory arrest. Two categories of do-not-resuscitate orders exist. A "pre-hospital do-not-resuscitate order" applies to settings outside of the hospital and must be signed by the patient or the patient's legal representative and by a physician. Once admitted to a hospital, the patient's attending physician can initiate a "hospital do-not-resuscitate order" by entering the order into the patient's medical record. Such a record does not require approval from the patient or the patient's representative.

In developing department-wide policy for advance directives and do-not-resuscitate orders, the Office of the Inspector General made the following recommendations to the department:

- The policy should address both pre-hospital and hospital do-not-resuscitate orders to avoid confusion and provide proper guidance to staff.

- A standardized form should be developed for pre-hospital do-not-resuscitate orders.

- Establish a consistent method for institution staff to identify an inmate who has established a do-not-resuscitate order, both throughout institution hospitals and within institution general population settings.

- Evaluate and assess the legality and propriety of including in its policy a provision by which a physician can establish a do-not-resuscitate order over the telephone.

- Include in the policy a requirement that the treating physician periodically review do-not-resuscitate orders to ensure they conform to the inmate-patient's wishes or are otherwise appropriate. In addition, document the periodic review in the progress notes of the inmate-patient's medical records.

- Clearly mark pre-hospital and hospital do-not-resuscitate orders or forms that have been revoked.

- Provide that advance directives may be witnessed by two adult witnesses as an alternative to being notarized.

- Include in its advance directive form specific life-prolonging measures to document inmates' understanding of their options in making end-of-life decisions and to provide medical staff with clear direction on inmates' wishes.

Evaluation of the Parole Suitability Hearing Process for Prisoners Serving Life Sentences. In September 2006, the Inspector General sent a letter to a senator addressing the senator's concerns with the parole suitability hearing process for prisoners serving life sentences. The senator had requested that the Office of the Inspector General look into the following issues:

- How many prisoners serving life sentences did not receive rescission hearings, as required by California Code of Regulations, Title 15, and is action warranted regarding their cases?

- Were the hearings that were chaired by one of the commissioners as an "experiment" conducted appropriately, pursuant to California Code of Regulations, Title 15? Specifically, did those inmates receive a fair and consistent parole suitability hearing without regard to the board member presiding?

- Do all parole suitability hearings include direction to the inmate about what is required to achieve parole suitability?

California law requires that a Board of Parole Hearings panel meet with a prisoner who is serving a life sentence one year prior to the inmate's minimum eligible parole date to consider parole suitability. This is referred to as the initial hearing. By law, murderers can be denied parole for up to five years at a time, and prisoners serving a life sentence for crimes other than murder can be denied parole for up to two years at a time. Each parole suitability hearing following the initial hearing is referred to as a subsequent hearing. When a prisoner serving a life sentence has been found suitable for parole by a Board of Parole Hearings

panel, California law allows the Governor to request that the full board, sitting *en banc* (nine randomly selected commissioners), review the panel's decision to grant parole. Historically, the Board of Parole Hearings reviews these cases at its monthly full board meeting, and votes to either affirm the original panel's recommendation for parole or to schedule a rescission hearing to consider the issues raised in the Governor's letter.

The Office of the Inspector General found that five prisoners serving life sentences did not receive mandatory rescission hearings in 2005. On August 22, 2006, however, the board reconsidered each case, affirming parole for one inmate and scheduling rescission hearings for the remaining four inmates. The Office of the Inspector General also determined that those hearings conducted by the commissioner as an "experiment" were performed in accordance with regulations, and that parole suitability hearings do incorporate direction to the inmate about requirements for achieving parole suitability. The Office of the Inspector General did not make any recommendations as a result of this evaluation.

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 third quarter of 2006, the Office of the Inspector General completed four 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 a letter from a Department of Corrections and Rehabilitation employee alleging that he was terminated from his job in retaliation for initiating an investigation against a subordinate employee.	The Office of the Inspector General reviewed various documents and concluded that the allegation of improper termination did not meet the legal requirements of retaliation.	The Office of the Inspector General has closed this investigation.
The Office of the Inspector General received a case referral regarding an allegation that large amounts of money were being sent by an inmate's family member to a correctional officer in exchange for protection and drugs for the inmate.	The Office of the Inspector General conducted an investigation that included interviewing the complainant and reviewing information from the department. The Office of the Inspector General could not substantiate the allegation because the complainant could not provide a witness or documentation to substantiate the allegation.	The Office of the Inspector General has closed this investigation.
The Office of the Inspector General investigated an anonymous complaint alleging that an inmate was refused admission to a local hospital because the department owed the hospital money. The complaint further alleged that the inmate died as a result of being transported 60 miles to another hospital.	The Office of the Inspector General reviewed documents prepared by the transporting ambulance company and an investigative report prepared by the department's Office of Internal Affairs and found that the inmate was not turned away by the local hospital but instead was transported directly to and admitted by the hospital chosen by the prison's medical staff.	The Office of the Inspector General has closed this investigation.
The Office of the Inspector General investigated a complaint from a correctional sergeant that he was the victim of an inmate assault. The sergeant alleged that two days before his assault, institution management was warned of a specific threat from gang members to attack staff, that management failed to notify staff of the threats, and that he was consequently stabbed by an inmate identified as a gang member.	The Office of the Inspector General interviewed staff and reviewed documents relating to the case, including an undated memorandum notifying custody workers of the threats to staff. The investigation revealed that the warning was not, as alleged by the complainant, issued before his assault, but had been provided to the California Correctional Peace Officers Association after the assault. The investigation also found that, although a confidential memorandum prepared by another correctional sergeant did confirm a planned inmate attack on two particular yard officers, it did not identify any additional officers or reflect a broad, coordinated gang attack on correctional staff.	The Office of the Inspector General has closed this investigation.